Merit Contractors Association is pleased to introduce to you a comprehensive benefit program. Your employer understands the need for such a service and is committed to making this plan available for all hourly paid field or shop employees. Yours is a portable hour bank program that enables you to continue receiving benefits when you work for any firm participating in the Merit Contractors Association Benefit Plan.

The Merit plan contains life insurance, long term disability and accidental death and dismemberment coverage. Should you have a spouse and/or dependents, further life insurance protection for them is included. In addition, your plan contains a comprehensive dental program, an extended health package including reimbursement for prescription drugs, eyeglasses and out-of-country medical expenses, to name a few of the services. Also, coverage under the plan includes free access to the Employee and Family Assistance Program and Best Doctors services for you and your eligible dependents.

Consistent with the objective of providing a high quality program, the plan is constantly under review. We have added additional benefits numerous times since the plan was developed in 1986. Together with your employer, we continue to be responsive to your suggestions.

We hope that you and your family will seldom have need for the extensive programs offered. However, if you do, you will find this program provides reimbursement of many of the costs associated with such needs.

Sincerely,

Malcolm D. Kirkland
President
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- prescription drugs ................................................................ 80%
- all other covered health expenses ........................................100%* (to specified limits)
- vision care maximum ......................................................... $350
- prescription safety glasses (employees only) ......................... $150

Dental Care for Employees & Dependents ................................page 36
- basic services ................................................................ 80%
- major services ................................................................ 50%
- maximum for basic & major services combined .................. $2,500 per calendar year
- orthodontic services .......................................................... 50%
  - participants under age 19
- maximum for orthodontic services .................................... $2,500 lifetime
- fee guide .......................................................................... Current general practitioner or specialist

*with the exception of out-of-country Non-Emergency Care which is covered at 50%
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• monthly benefit $2,500 for first 24 months, then $3,000

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Please refer to the benefit description pages for complete details regarding expenses, benefit maximums and other limitations. If you have any questions, please call Mercon Benefit Services at 780.455.5845 or toll-free at 1.877.263.7266.

This booklet outlines your plan in general terms. In the case of inconsistencies between this booklet and the contracts issued by Great-West Life or ACE INA Life Insurance, the terms in the master contracts will prevail.

GENERAL INFORMATION

Benefit Plan Administrator
Mercon Benefit Services is the administrator of your benefit plan. Mercon Benefit Services' staff can assist you in a variety of ways, including answering questions about your eligibility for benefits, answering questions about the benefits provided by the plan and helping you complete claim forms.

Mercon Benefit Services will also record any changes to your address, send you claim forms, help you with any claim problem and tell you the status of your claims.

For assistance or claim forms contact:

Mercon Benefit Services
780.455.5845 or toll free at 1.877.263.7266
7:30 am to 4:30 pm (MST/MDT)
104 - 13025 St. Albert Trail
Edmonton AB T5L 4H5
mercon@merconbenefits.com

In addition, you can find valuable information about the benefit plan through the Mercon Benefit Services' website at www.merconbenefits.com. You can find out your benefit status, find information about the benefits covered under the plan, obtain copies of claim forms, check on the status of your extended health and dental claims and send an email message to Mercon Benefit Services, to name a few. Please note that you will need your Member Identification Number to access your personal information.

Locating Your Plan and Member Identification Numbers
Submission of claims, enquiries regarding your benefits, and registration on Great-West Life’s GroupNet for Plan Members all require that you provide your Plan and Member Identification Numbers.

Your Plan Number is 55400. Your Member Identification Number can be found on your Merit Prescription Drug Benefits card, which you will receive shortly after your benefits commence. It is the third set of numbers shown on the card as indicated in the illustration on page 4.
About This Booklet and Plan
This booklet contains important information about your eligibility for benefits and the levels of coverage provided under your benefit plan. The types of benefits you are covered for, the percentage amounts that will be paid by the plan and the plan maximums are summarized in the Schedule of Benefits.

As you read through the various sections of this booklet, there are a few key points to remember. First, this booklet outlines your plan in general terms. If there are any inconsistencies between what is contained in this booklet and the contracts issued by Great-West Life and ACE INA Life Insurance, the terms of the contracts will prevail. Second, life and disability benefits, and accidental death and dismemberment benefits are insured by Great-West Life and ACE INA Life Insurance, respectively, who are solely responsible for these insured portions of the benefit plan. Great-West Life adjudicates claims on behalf of the Merit plan, for the extended health and dental portions of the benefit plan, which are self-insured. Finally, if any of the insurance providers change, the terms of this booklet will remain the same, unless you are notified otherwise.

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

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

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

Benefit Limitation for Overpayment
If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days 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.

Enrolment Card
It is your responsibility, and in your own interest, to fully complete an enrolment card and ensure the information is kept up-to-date. You can obtain an enrolment card from your supervisor or payroll administrator, or Mercon Benefit Services. You should complete the enrolment card legibly and in black ink and return it immediately to your supervisor. Failure to do so can result in the payment of your claims being delayed or declined. The enrolment card contains information vitally important to both you and the plan administrator, Mercon Benefit Services. For example, if your current address is not on record, you may not receive notice informing you when benefit coverage begins or advising you that your eligibility for benefit coverage has terminated.

As well, the information on your enrolment card is used in order for Great-West Life to provide you with your pay-direct drug card. If you have not completed the enrolment card in full (including indicating the names and dates of birth for your dependents who will be covered under the extended health and dental portions of the benefit plan) you will not be issued a pay direct drug card, or the card you are issued may not cover all of your dependents.

If you have not provided Mercon Benefit Services with a current correct address, a pay-direct drug card will not be issued and you will not be able to submit any extended health care claims. You must also advise Mercon Benefit Services each time your address changes, in order to ensure continuing coverage.

The enrolment card is also used to designate your beneficiaries and for payment of any death benefits under the benefit plan. If the enrolment card is not completed properly, or you have not designated any beneficiary, death benefits will be paid to your estate.

Initial Eligibility
Your employer has agreed to report hours worked and remit payments for all hourly paid field or shop employees in your company. The hours you work each month are reported to Mercon Benefit Services, who maintain the balance of hours in your hour bank account. Initial coverage under the benefit plan takes effect on the first day of the second month after your hour
bank account has accumulated 300 hours (e.g. if your employer has reported 150 hours for each of July and August, you would have accumulated 300 hours at the end of August and would be eligible for benefits October 1 — the first day of the second month after you had accumulated 300 hours). So long as you work for a company participating in the Merit benefit plan, hours will accumulate in your account. You have up to nine months to accumulate 300 hours. Once your account reaches 300 hours, a letter will be sent to you by Mercon Benefit Services, advising you of the date your coverage under the benefit plan takes effect. If you fail to reach 300 hours in the nine-month period, your hours will be forfeited. For more details on how the hour bank operates, please see question #2 in Questions & Answers section.

Continuation of Coverage
In order to be eligible for a month of benefit coverage, 150 hours are deducted from your hour bank account. The maximum number of hours that can be left in your account, after the most recent input of hours and monthly deductions, is 1,200 hours. Hours in excess of 1,200 are forfeited.

Termination of Coverage
Your coverage under the benefit plan (except coverage for disability benefits) will terminate the last day of the month following the month the balance in your account falls below 150 hours, subject to the self-pay option outlined in the following section. Your coverage for disability benefits will terminate on the last day on which you are at work for a Merit company. You cannot receive a refund for any hours that have been reported by your employer, when you terminate employment. All hours reported will remain to your credit and will continue to provide coverage so long as you have a minimum of 150 hours in your hour bank account.

Self-Pay Option
Whenever your hour bank account balance falls below 150 hours, a letter will be sent to your last recorded address advising you of the date your benefits terminate. You may, however, elect to have your benefits, except disability benefits, extended for up to six consecutive months under the self-pay option. The amount of payment required, and the deadlines for submitting payments, will be outlined in the letter. Any period of self-pay will not accumulate hours in your hour bank account.

Extension of Benefits While Disabled
Should you become disabled while eligible for benefits under this plan, you may continue your benefits (except disability benefits), on a contribution basis, for up to 24 months from the date you become disabled. To be eligible for this 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. Please contact Mercon Benefit Services if you wish to continue benefits while you are disabled.

Extension of Benefits While on a Maternity/Parental Leave of Absence
You may continue your benefits under this plan (including disability benefits), on a contribution basis, for up to 52 weeks during a scheduled Maternity or Parental Leave of Absence. However, coverage cannot be continued for more than 52 weeks, including any period during which you elected the Self-Pay Option. Please contact Mercon Benefit Services regarding the continuation of your benefits during a Maternity or Parental Leave of Absence. They will provide you with a letter outlining the amount of payment required, and the deadline for submitting payment.

Reinstatement
If your benefits terminate because you do not have sufficient hours in your hour bank plan, your benefits may be reinstated without having to again satisfy the initial 300-hour eligibility requirement. In order for your benefits to be reinstated, your hour bank account must reach at least 150 hours (including hours on hand at the time your benefits terminated) within eight months. When you have accumulated 150 hours within the eligible eight-month period, your benefits will be reinstated the first day of the second month after the 150th hour is recorded in your account. A letter will be sent to you advising the date your coverage is reinstated.

If you do not satisfy the 150-hour reinstatement provision within eight months, then any remaining hours in your hour bank account will be forfeited and the initial eligibility requirement of accumulating 300 hours within nine months will apply.

Apprenticeship Training Hours
Your employer may, at their discretion, continue to remit hours during a period of apprenticeship training, provided that the apprenticeship training commences within 30 days after the day you last worked for that employer. In this case, you will continue to be credited with hours in your hour bank account during your period of apprenticeship training.

Alternatively, you may self-pay in order to continue coverage during a period of apprenticeship training, as provided for under the Self-Pay Option.

Please contact Mercon Benefit Services regarding the continuation of coverage during your apprenticeship training.
Eligible Dependents
Certain benefits are available to your eligible dependents while you are covered for benefits under this plan. To be covered, your eligible dependents must live in Canada and must be listed on your enrolment card.

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 under this plan, and will be as indicated by you on your enrolment card.

A dependent child is eligible if he or she is a natural child, stepchild, or legally adopted child of you or your covered spouse. To be eligible, the dependent child must also be unmarried and fully dependent on you for support. If you are living in a common-law relationship, the child of the common-law spouse will be eligible for benefits so long as he/she is in the care and custody of both you and your spouse and living with you.

Where you are in possession of legal guardianship papers, a dependent child, under the age of 18 for which you are the legally appointed guardian, will also be eligible for dependent benefits.

Dependent children are covered only until age 21. However, coverage may be extended to the 25th birthday when the child is a full-time student and satisfactory proof of attendance is provided.

Unmarried and unemployed children 21 years of age or older can be covered if they are dependent upon you by reason of mental or physical disability, became totally disabled prior to attaining age 21, and have been continuously disabled since that time provided the dependent was insured as a dependent under this plan at the time of the accident or the onset of the illness causing the incapacitation. Unmarried and unemployed children who become totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to their attaining age 25, and have been continuously so disabled since that time shall also qualify as a dependent. Proof of the disability from the dependent’s physician must be provided.

Residency Requirement
You and your dependents will not be covered under this plan if you are residing outside Canada, unless an exception is requested by the employer and approved by Merit Contractors Association and the Insurers of the benefit plan.

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**Claims Instructions**

**Benefit Claim Submissions**

*Life, Disability, Accidental Death and Dismemberment and Out-of Province/Canada Claims:*

Paper claim forms must be completed and may be obtained by contacting Mercon Benefit Services. Completed forms should be returned to the appropriate insurer.

*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.*

**i) Prescription Drugs:**

All claims for eligible drugs can be made directly by your pharmacist at the time that you fill your prescription, if you present your pay-direct drug card issued by Great-West 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.

**ii) Extended Health and Dental:**

All eligible claims may be submitted online or by completing paper claim forms and mailing them to Great-West Life. Claim payments are expedited when online claim submission is utilized. 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.merconbenefits.com**, or by contacting Mercon Benefit Services. **Send completed paper claim forms directly to:**

**GREAT-WEST LIFE**

Winnipeg Benefit Payments
PO Box 3050
Winnipeg, MB
R3C 0E6
If your Health or Dental claim is sent to Mercon Benefit Services or one of the Merit offices, it will be forwarded to Great-West Life by regular mail. This will increase the time you will have to wait for reimbursement.

Be sure that you indicate your Plan Number 55400, Member Identification Number (see the General Information section for assistance in locating your Member Identification Number), full name and complete address on all claim forms or other correspondence sent to Great-West Life.

If you are unsure how to complete your claim form, contact Mercon Benefit Services for assistance.

**Online Health and Dental Claim Submissions**

To submit Health and Dental claims online, you must register on Great-West Life’s website, GroupNet for Plan Members. You will require your Plan Number – 55400, and your Member Identification Number which is the third set of numbers on your Prescription Drug Benefits card. See the General Information section for assistance in locating your Member Identification Number.

To register, go to [www.merconbenefits.com](http://www.merconbenefits.com) and select the Employee Portal. Next, click on “Great-West Life” on the navigational menu on the left side of the page and select the Great-West Life logo. Once you have done so, follow these steps:

1. Click on “Register Now”, then enter your Plan Number, Member Identification Number and any other requested information.
2. Once you have registered, follow the onscreen instructions for Direct Deposit, enabling Great-West Life to deposit claim payments directly to your bank account.
3. Sign up for eDetails, enabling Great-West Life to notify you by email when claims are adjudicated.

Once registration is completed, online claims processing will be enabled. 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. Claims are normally processed within one to three business days, at which time payment for approved claims will be deposited into your bank account.

Great-West Life has extensive safeguards in place to protect you and the Merit Benefit Plan from fraud or misuse. Online claims will be selected randomly for audit, requiring you to submit receipts for expenses being claimed. 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**

The following is a step-by-step outline of the procedure you should follow for all paper extended health and dental claims:

**Extended Health Care Expenses:**

- obtain a “Healthcare Expenses Statement”;
- itemize the expenses for covered services and supplies for each family member (which can all be put on the same form);
- keep a copy of the statement and receipts for your records;
- attach original paid-in-full receipts and send to Great-West Life;
- Great-West Life will mail a cheque for the eligible expenses to you.
- If you have made a claim under another plan first (e.g. through your spouse) you should 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. Please see Question #8 under the Questions and Answers section of this booklet for an explanation of how to file a claim in the event that you have coverage under your spouse’s plan.

**Out of Province/Canada Expenses:**

- obtain a “Statement of Claim Out-of-Country Expenses” and the appropriate form that allows Great-West Life to co-ordinate your benefits with the applicable provincial medical plan (available by calling Mercon Benefit Services or from the Mercon Benefit Services website);
- itemize the expenses for covered services and supplies on the form;
- keep a copy of the statement and receipts for your records;
- attach original paid-in-full receipts and send to Great-West Life;
- Great-West Life will either mail a cheque for the eligible expenses to you, or will pay the health care provider(s) directly, if you have so authorized;
- Great-West 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 should 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. Please see Question #8 under the Questions and Answers section of this booklet for an explanation of how to file a claim in the event that you have coverage under your spouse’s plan.

**Dental Expenses:**

- 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;
- complete your portion of the form and send directly to Great-West Life;
- Great-West 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).
- If you have made a claim under another plan first (e.g. through your spouse) you should 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. Please see Question #8 under the Questions and Answers section of this booklet for an explanation of how to file a claim in the event that you have coverage under your spouse’s plan.

**Direct Deposit of Extended Health Care and Dental Claims:**

Rather than having Great-West Life mail a cheque to you for health and dental claims, you can expedite payment by having claim proceeds deposited directly to your bank account. Direct Deposit is mandatory for online claim submission, but may also be set up if you elect to submit paper health and dental claims. You can sign up for Direct Deposit on the Great-West Life website (accessed by going to [www.merconbenefits.com](http://www.merconbenefits.com) and clicking on the Great-West Life logo and registering on GroupNet for Plan Members).

Once you have authorized Great-West Life to electronically deposit your claim payments, all future health and dental claim payments will be deposited into your bank account. You will also receive an email notice when claims have been processed.

**Life Insurance, Life Waiver, Accidental Death and Dismemberment, and Disability Claims**

Life, Life Waiver, Accidental Death and Dismemberment and Disability claim forms should be returned to Mercon Benefit Services, who will submit them to the appropriate Insurer. Great-West Life is the Insurer for Employee and Dependent Life Insurance, Short Term Disability, and Long Term Disability. ACE INA Life Insurance is the Insurer for Accidental Death and Dismemberment.

The following is a step-by-step outline of the procedure you should follow for all life and disability claims:

**Employee and Dependent Life Insurance**

- immediately notify Mercon Benefit Services, who will provide you with the necessary claim forms;
- obtain an original death certificate or funeral directors statement;
- send the completed forms and documents to Mercon Benefit Services;
- the benefit will be paid as soon as satisfactory proof of death and beneficiary designations have been verified by Great-West Life.

**Waiver of Premium for Life Insurance Benefits Due to Disability**

- notify Mercon Benefit Services of your disability as soon as possible;
- notice of all waiver of premium claims must be provided to Great-West Life within 300 days of the onset of your disability;
- Mercon Benefit Services will provide the necessary forms for completion by you, your employer and your doctor;
- waiver of premium will be approved as soon as satisfactory proof of your disability has been provided to Great-West Life.

**Accidental Death and Dismemberment Insurance**

- within 30 days of the accident, notify Mercon Benefit Services, who will provide you with the necessary claim forms;
- obtain an original death certificate, medical examiner’s report or other proof of loss;
- send the completed forms and documents to Mercon Benefit Services no later than 90 days from the date of the accident; Mercon will send the forms to ACE INA Life Insurance;
- failure to furnish proof of claim within the time prescribed will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed; in no event
will the Insurer accept notice of claim beyond one year;
• the accidental death and dismemberment benefits will be paid as soon as proof of death or loss has been verified by ACE INA Life Insurance

Long Term Disability (LTD)
• notify Mercon Benefit Services of your disability as soon as possible;
• notice of all Long Term Disability claims must be provided to Great-West Life within 180 days after the end of the Qualifying Period;
• Mercon Benefit Services will provide the necessary forms for completion by you, your employer and your doctor;
• the LTD benefit will be paid as soon as satisfactory proof of your disability claim has been provided to Great-West Life.

**Employee Life Insurance**

**Benefit**
You are eligible for $100,000 of Employee Life Insurance. The life insurance benefit insures you for death from any cause.

**Beneficiary**
Should you die while insured, the Employee Life Insurance benefit is payable to your beneficiary. You designated a beneficiary at the time that you completed your original enrolment card. If a beneficiary has not been properly appointed, then the Employee Life Insurance benefit will be payable to your estate. If you wish to change your beneficiary designation at any time, complete a new enrolment card and forward it to Mercon Benefit Services.

**Waiver of Premium Due to Disability**
If you become disabled, you may be eligible for a waiver of Employee Life Insurance premiums. You must apply for the waiver of premiums within 300 days of the onset of your disability. The appropriate form can be obtained by contacting Mercon Benefit Services. The Insurer will advise you if you have been approved for waiver of premium, which will apply so long as you remain disabled, or to age 65. The Insurer may ask for proof of continuing disability from time to time.

**Conversion of Benefit**
Should your Employee Life Insurance terminate, you may convert the amount of insurance that you had prior to termination to an individual policy. Your application for an individual policy must be made, and you must pay the premium, within 31 days after your insurance coverage terminates. Should 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 designated beneficiary, or estate (if a beneficiary has not been designated). For complete details of the conversion option, contact Mercon Benefit Services.
Coverage
The Accidental Death and Dismemberment coverage provides you with 24-hour protection against on or off-the-job accidents, whether on business, vacation or at home.

Benefit Amount
The amount of Accidental Death and Dismemberment Insurance for which you are covered (the Principal Sum) is $100,000

Critical Disease Benefit
The Insurer will pay you an amount equal to 10% of the Benefit Amount to a maximum of $50,000, provided that you:
• have been medically diagnosed with one of the covered Critical Diseases after the effective date of your coverage under this benefit and prior to age 65; and
• have been Totally Disabled (from any and all occupations as defined in the policy) from that Critical Disease for at least nine months.

Benefits are limited to the first covered Critical Disease in your lifetime. Covered Critical Diseases are: Poliomyelitis, Parkinson’s Disease, Huntington’s Chorea, Multiple Sclerosis, Alzheimer’s Disease, Type 1 Diabetes (insulin dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease and Necrotizing Fasciitis.

Schedule of Losses
If any of the following losses take place within one year from the date of the accident, the Insurer will pay the percentage of the Benefit Amount, based on the amount stated in the Benefit Amount section. Not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

An amount equal to 200% of the Benefit Amount for:
Paraplegia (total paralysis of both lower limbs);
Quadriplegia (total paralysis of all four limbs);
Hemiplegia (total paralysis of one side of the body);
Loss of both arms, both hands, both legs or both feet;
Loss of use of both arms, both hands, both legs or both feet;
Loss of use of one arm and one leg on same side of the body.

An amount equal to 100% of the Benefit Amount for:
Loss of life;
Loss of entire sight of both eyes;
Loss of one hand and one foot;
Loss of use of one hand and one foot;
Loss of use of one hand or one arm and one leg;
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;
Brain death.

An amount equal to 75% of the Benefit Amount for:
Loss of one arm or one leg;
Loss of use of one arm or one leg;
Loss of one hand and one foot;
Loss of use of one hand and one foot;
Loss of entire sight of one eye;
Loss of speech or hearing in both ears.

An amount equal to 33 1/3% of the Benefit Amount for:
Loss of thumb and index finger of same hand;
Loss of four fingers of same hand;
Loss of hearing in one ear.

An amount equal to 25% of the Benefit Amount for:
Loss of all toes of one foot.

Surgical Reattachment
If you suffer a complete severance of a hand, foot, arm, leg, or thumb and index finger, the Insurer will pay the amount specified in the Schedule of Losses, even if the severed limb is surgically reattached, whether the reattachment is successful or not.

Seat Belt Benefit
If you sustain an injury resulting in payment being made under the Schedule of Losses while driving or riding in a vehicle and are wearing a properly fastened seat belt, the Principal Sum will be increased by 10%, to a maximum of $25,000. Proof of seat belt use must be provided at the time of claim.
Day Care Benefit
If you suffer a loss of life in a covered accident, the Insurer will pay a Day Care Benefit equal to the reasonable and necessary expenses incurred, subject to:

- The lesser of 5% of the Principal Sum; or
- A maximum of $5,000 per year

The benefit is payable for any dependent child who is 12 years of age or younger and are enrolled in a legally licensed day care centre on the date of the accident, or must be enrolled in one within 365 days following the date of the accident.

The benefit is paid each year for up to four consecutive years.

If none of your dependent children satisfy the above requirements, a benefit of $2,500 will be paid to the designated beneficiary.

Family Transportation Benefit
If you are confined as an in-patient in a hospital at least 150 kilometers from your city of permanent residence or outside of Canada and require personal attendance by some or all members of your immediate family as recommended in writing by your physician, the Insurer will pay for the expenses incurred by immediate family members for accommodation and return transportation via the most direct route.

The amount payable under this benefit will not exceed $15,000.

Home Alteration and Vehicle Modification Benefit
If you sustain an injury which results in payment being made under the Schedule of Losses (excluding the Loss of Life Benefit), and you subsequently require the use of a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of the accident for:

- the one-time cost of alterations to your principal residence to make it wheelchair accessible and habitable; and
- the one-time cost of modifications necessary to a motor vehicle utilized by you to make the vehicle accessible or drivable for you.

Benefit payments herein will not be paid unless:

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

The expenses must be incurred within three years from the date of the Covered Loss and are subject to a lifetime maximum of $15,000.

Spousal Occupational Training Benefit
If you suffer a loss of life in a covered accident, the Insurer will pay the expenses actually incurred for your spouse to participate in a formal occupational training program to become qualified for active employment in an occupation for which your spouse would otherwise not be qualified.

Expenses must be incurred within three years from the date of the accident and are subject to a maximum lifetime payment of $15,000.

Rehabilitation Benefit
If within three years from the date of your injury you participate in a rehabilitation program, the Insurer will pay the reasonable and necessary expenses actually incurred up to $15,000. Training must be required because of your injuries and for you to become qualified for an occupation in which you would not have been engaged except for your injuries.

Payment is not made for ordinary living, travelling or clothing expenses.

Repatriation Benefit
If you suffer a loss of life in a covered accident outside of Canada, or in Canada at least 150 kilometers from your normal place of residence, and the loss of life occurs within 365 days of the date of an accident the Insurer will pay the actual expense incurred for the preparation of the body and its transportation to the funeral home or the place of interment in proximity to your normal place of residence. Benefits will not exceed $15,000.

Special Education Benefit
If you suffer a loss of life in a covered accident, the Insurer will pay up to 5% of the Principal Sum to a maximum of $5,000 per year, on behalf of any dependent child who, on the date of the accident is:

- enrolled as a full-time student in any post-secondary institution of higher learning; or
• is enrolled at the secondary school level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The Special Education Benefit is payable annually for a maximum of four consecutive annual payments if the dependent child continues the education as a full-time student.

If none of your dependent children satisfy the above requirements, a benefit of $2,500 will be paid to the designated beneficiary.

Bereavement Benefit
If you suffer a loss of life within 365 days of a covered accident, your dependent spouse and children may receive up to six sessions of grief counselling by a Professional Counsellor. The Insurer will pay for reasonable and customary expenses, up to $1,000.

A “Professional Counsellor” means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income
If you are hospitalized as an in-patient and are under the care of a physician for an injury that results in payment being made under the Schedule of Losses (other than for Loss of Life), the Insurer will pay:
• one percent of the Principal Sum for each full month; or
• one-thirtieth of the monthly benefit for each day of a partial month.

The benefit is retroactive to the first full day of confinement, not to exceed 365 days aggregate payment for each period of confinement. The maximum benefit payable is $2,500 per month.

"In-patient" means you are admitted to a hospital as a resident or bed-patient and are provided at least one day’s room and board by the hospital.

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

Cosmetic Disfigurement Benefit
If you suffer a third degree burn in a non-occupational accident, the Insurer will pay a percentage of the Principal Sum, depending on the area of your body which was burned according to the following table:

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Area Classification (A)</th>
<th>Maximum Allowable percentage for Area Burned (B)</th>
<th>Maximum Percentage of Principle Sum Payment (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face, Neck, Head</td>
<td>11</td>
<td>9%</td>
<td>99%</td>
</tr>
<tr>
<td>Hand and Forearm</td>
<td>5</td>
<td>4.5%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Upper Arm</td>
<td>3</td>
<td>4.5%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Torso (front or back)</td>
<td>2</td>
<td>18%</td>
<td>36%</td>
</tr>
<tr>
<td>Thigh</td>
<td>1</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Lower Leg (below knee)</td>
<td>3</td>
<td>9%</td>
<td>27%</td>
</tr>
</tbody>
</table>

The Maximum Percentage of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the Maximum Allowable Percentage for Area Burned (B). In the event of a 50% surface burn, the Maximum Allowable Percentage for Area Burned (B) is reduced by 50%. This table only represents the maximum percentage of the Principal Sum payable for any one accident. 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

Identification Benefit
If you suffer a loss of life in a covered accident at least 150 kilometers from your normal place of residence and identification of the body by a member of the immediate family is necessary, the Insurer will reimburse the reasonable expenses incurred by the immediate family member for:
• transportation by the most direct route to the place where the body is located; and
• hotel accommodation for a maximum duration of three days.

Expenses up to $15,000 may be reimbursed, and are subject to the Loss of Life benefit subsequently being paid following identification of the body. Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.
**Exposure & Disappearance**

Loss resulting from unavoidable exposure to the elements shall be covered to a maximum of the Benefit Amount. If your body has not been found within 1 year of disappearance, forced landing, stranding, sinking or wrecking of the conveyance in which you were riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that you suffered a loss of life resulting from bodily injuries sustained in the accident covered under this benefit.

**Total Disability Waiver of Premium**

If premiums for your basic life insurance coverage are being waived, then premiums for the Accidental Death and Dismemberment benefit will also be waived, but only so long as the policy remains in force.

**Conversion**

During the 31-day period immediately following termination of coverage, you may convert this insurance to an individual Accidental Death and Dismemberment-only insurance policy (excluding the Critical Disease Benefit). Details of converted coverage are subject to rules in effect as of the date of the conversion.

**AD&D Definitions**

- Loss of a hand or foot will mean actual severance through or above the wrist or ankle joint
- Loss of an arm or leg will mean the actual severance through or above the elbow or knee joint
- Loss of sight of will mean the total and irrecoverable loss of sight
- Loss of speech will mean the total and irrecoverable loss of speech which does not allow audible communication in any degree
- Loss of hearing will mean the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device
- Loss of thumb and index finger of same hand or loss of four fingers of same hand will mean the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand)
- Loss of toes will mean the severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot
- Loss referring to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs) and hemiplegia (total paralysis of upper and lower limbs of one side of the body) means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 180 consecutive days and determined by the Insurer to be permanent
- Loss of use shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand, provided the loss of function is continuous for 12 consecutive months and is determined by the Insurer to be permanent
- Brain death means irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain, even though the heart is still beating

**Exclusions**

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

- Intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
- Declared or undeclared war or any act thereof;
- Travel or flying in an aircraft owned or leased by the Employer, you or a member of your household, or aircraft being used for any test or experimental purpose, firefighting, powerline inspection, pipeline inspection, aerial photography or exploration;
- Losses occurring while you are serving on full-time active duty in the Armed Forces of any country or international authority;
- Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the “Hazards Insured Against” section of the Accidental Death & Dismemberment portion of the policy.
DEPENDENT LIFE INSURANCE

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 card.

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
Dependent Life Insurance premiums will be waived if you become disabled and have been approved for waiver of your Employee Life Insurance premiums.

Conversion of Benefit
Should your Employee Life Insurance terminate, your spouse may convert the amount of his/her Dependent Life Insurance to an individual policy. 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 Mercon Benefit Services.

EXTENDED HEALTH CARE BENEFITS

The extended health care benefits are self-insured under the Merit Benefit Plan. Great-West Life adjudicates extended health claims for the Merit Benefit Plan.

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.

Prescription Drug Benefit
The Merit plan will provide coverage for 80% of the Eligible Drugs and 80% of the Eligible Dispensing Fee. 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 drug card. You will not have to pay any amount of the prescription that is covered by the plan, but you will have to pay the remaining 20% (or 10% if coverage has increased to 90%) and any other 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 Merit 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;
- charges for serums and vaccines, whether obtained with a prescription, or supplied directly by a physician or health unit;
- charges for insulin, whether or not obtained with a prescription;
- injectable drugs and vaccines administered in a doctor’s office or health unit whether supplied on the prescription of a doctor or not, excluding the charge for the doctor to administer the drug.

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.

Some specific drugs may require prior authorization by Great-West Life 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, so it is recommended that you shop around when filling your prescriptions.

**Diabetic Supplies:** The following diabetic supplies are covered at 80%:

- needles, syringes, lancets, lancing devices, infusion sets, urine and blood glucose testing strips for the monitoring and treatment of diabetes (these items may be billed directly using your pay-direct drug card.)

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

- drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy;
- drugs dispensed during treatment as an in-patient or as an out-patient in a hospital;
- any drugs not approved for sale in Canada;
- any drugs that have not been assigned a Drug Identification Number;
- any drugs administered in a manner that is considered investigational or experimental;
- most over-the-counter drugs;
- charges for the administration of drugs, serums or vaccines;
- vitamins;
- proteins and dietary or food supplements;
- erectile dysfunction drugs;
- hair growth stimulants;
- drugs that are considered cosmetic, whether or not prescribed for a medical reason;
- any portion of an Eligible Drug charge that is covered by another insurance plan or benefit.

**Medical Services and Supplies**
The Merit 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.

**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:** This plan will pay for ambulance services for transportation to and from the nearest hospital where essential treatment is available in the event of illness or injury. The plan will pay the reasonable and customary charges of the ambulance services. Air ambulance transportation will only be covered if normal ground ambulance is not available or is not in the best medical interests of the patient. Response fees are covered only when treatment is provided. Ambulance charges for job related accidents are not covered.
**Paramedical Practitioners:** Charges for the following services are covered, 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; and
- must be provided in the province where the practitioner is registered/licensed in that specialty.

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncturist</td>
<td>Maximum of $500 per calendar year</td>
</tr>
<tr>
<td>Chiropodist or Podiatrist*</td>
<td>Maximum of $500 per calendar year</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Maximum of $500 per calendar year</td>
</tr>
<tr>
<td>Dietician</td>
<td>Maximum of $500 per calendar year</td>
</tr>
<tr>
<td>Massage Therapist</td>
<td>Maximum of $500 per calendar year</td>
</tr>
<tr>
<td>Naturopath</td>
<td>Maximum of $500 per calendar year</td>
</tr>
<tr>
<td>Osteopath</td>
<td>Maximum of $500 per calendar year</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Maximum of $500 per calendar year</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>Maximum of $600 per calendar year</td>
</tr>
<tr>
<td>Speech Language Pathologist</td>
<td>Maximum of $500 per calendar year</td>
</tr>
</tbody>
</table>
| 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 Mercon to verify amounts.

**Hearing Aids:** Up to $1,000 in any five consecutive calendar years for the purchase or repair of hearing aids (excluding batteries), prescribed by a physician, audiologist or otolaryngologist. The repair of hearing aids does not require a prescription.

**Orthopedic Footwear and Orthotics:**
- the cost of custom made orthopedic footwear, including orthopedic alteration to standard footwear (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 or sandalthotics prescribed by a physician, podiatrist or chiropodist, up to a maximum of $350 per person per calendar year.

**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,
- charges for artificial limbs, artificial eyes, artificial nose or artificial larynx. Myoelectric arms including repairs to a maximum of $10,000 per prosthesis (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:** Where prescribed by a physician, charges for the following medical aids, subject to reasonable and customary pricing and any maximums indicated. It is recommended that you verify the reasonable and customary maximum allowed prior to purchasing covered items:
- 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 tents;
- 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 procedures, diagnostic services, radiology, blood and blood plasma, blood radium treatment, coagulotherapy, 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;
- burn pressure gradient garments to a maximum of two pairs per person per calendar year;
- 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;
• Continuous or Automatic Positive Airway Pressure (CPAP/APAP) machines.

Vision Care Expenses:
• 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, to a maximum of $350 every two calendar years for participants age 19 and over, and $350 each calendar year for participants who have not attained their 19th birthday;
• 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; this benefit is in addition to the $350 benefit every two calendar years outlined above;
• 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;
• eye exams for you and your dependents by a licensed ophthalmologist or optometrist where not covered by a provincial medical plan, to a maximum of $75 every two calendar years or $75 every calendar year for participants who have not attained their 19th birthday (no payment will be made for eye examinations which are medically required).

Out of Province/Canada Medical Emergency Benefits
The Merit 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.

Note: Claim forms must be completed for any out-of-country expenses.

Emergency Outside Canada Medical Treatment: 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;
• diagnostic services;
• medical supplies provided out-of-hospital if they would have been covered in Canada;
• out-of-hospital services of a professional nurse;
• prescription drugs;
• ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available;
• paramedical services 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.

Benefit 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 Outside Canada: 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 Great-West Life before you leave Canada for treatment.

No benefits will be paid for:
• investigational or experimental treatment; or
• transportation or accommodation charges.

Non-Emergency Care Outside Canada benefits are reimbursed at a rate of 50%.

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

• On-site hospital payment when required for admission, to a maximum of $1,000.
• If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment.
• 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
Toll Free in Canada and USA 1.855.222.4051
Toll Free in the United Kingdom 0.800.252.074
Toll free in Mexico 0.1.800.522.0029
Call direct from Cuba 1.204.946.2946
In all other countries call collect 1.204.946.2577

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.

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.
The dental care benefits are self-insured under the Merit Benefit Plan. Great-West Life adjudicates dental claims for the Merit Benefit Plan.

Benefit Coverage
This section outlines the details of your dental care benefits. To make sure your dentist or denturist is informed of the details of your dental benefits, you should take your booklet with you whenever you or your dependents require dental care or treatment. You should be aware that there are no specific guidelines for what dentists are permitted to charge for dental services. Some dentists may charge more while other dentists may charge less than what will be paid by the Merit 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 Merit dental plan. The payment of any dental expenses is subject to any benefit levels and maximum benefit amounts indicated.

Eligible Expenses
Eligible expenses are defined 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.

Fee Guide
The Merit 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, or the amount charged by your dentist/denturist. For dental services provided by a dentist in Alberta, the coverage is based on the current Great-West Life representative price. If dental services are provided by a specialist, then the applicable specialist fee guide will be used.

Maximum Benefit
The Merit dental plan has maximum amounts that will be paid for dental services. 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. The total maximum lifetime amount that will be paid for Orthodontic Dental Services for each participant under age 19 is $2,500.

Alternate Courses of Treatment
When two or more courses of dental treatment are available to correct a dental condition, the Merit 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.

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, by mail, of the amount that is payable by the Merit dental plan.

Basic Dental Services
Subject to the Fee Guide and Maximum Benefit provisions outlined earlier, the Merit 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 who have not attained their 19th birthday (see question #10 under the Questions & Answers section at the end of the booklet for an explanation of the coverage during the year that a participant turns age 19);
- emergency examinations;
- saliography;
- 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 who have not attained their 19th birthday (see question #10 under the Questions & Answers section at the end of the booklet for an explanation of the coverage during the year that a participant turns 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**
• one unit every calendar year for participants age 19 and over;
• one unit every six months for participants who have not attained their 19th birthday (see question #10 under the Questions & Answers section at the end of the booklet for an explanation of the coverage during the year that a participant turns age 19).

**Topical fluoride treatment**
• only for participants who have not attained their 19th birthday, once every six months (see question #10 under the Questions & Answers section at the end of the booklet for an explanation of the coverage during the year that a participant turns age 19).

**Habit breaking appliances**
• for the control of harmful dental habits.

**Pit and fissure sealants**
• for participants who have not attained their 19th birthday, for permanent teeth only.

**Space maintainers**
• for missing primary teeth, for participants who have not attained their 19th birthday;
• 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;
  - 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 who have not attained their 19th birthday;
• 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 who have not attained their 19th birthday (see question #10 under the Questions & Answers section at the end of the booklet for an explanation
of the coverage during the year that a participant turns age 19);
• non-surgical treatment of gum disorder;
• occlusal adjustments to a lifetime maximum of eight units;
• scaling and root planing, to a combined maximum of eight units in a calendar year;
• bruxism appliances;
• maintenance, adjustment and repair to appliances, twice in a calendar year;
• periodontal surgery;
• general anesthesia and facilities in conjunction with periodontal surgery;
• desensitization.

Denture services
• relines and rebasings, limited to once each calendar year;
• denture repairs limited to once each calendar year;
• resilient liner in relined or rebased dentures after the three-month post-insertion 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.

Major Dental Services
Subject to the Fee Guide and Maximum Benefit provisions outlined earlier, the Merit 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 post-insertion period including:
- Denture remakes, once every 3 calendar years.
- Denture adjustments, once every calendar year.
- Denture repairs and additions, tissue conditioning and resetting of denture teeth.
- Repairs to covered bridgework.
- Removal and recementation of bridgework.

Orthodontic Dental Services
Subject to the Maximum Benefit provisions outlined earlier, the Merit plan will provide coverage for 50% of the following orthodontic dental services. Only participants who have not attained their 19th birthday are eligible for this benefit, which includes coverage for:
- general orthodontic exam, once every five calendar years;
- diagnostic services;
- fixed and removable appliances;
- full banding and retention;
- appliance therapy.

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;
- 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 payment of contributions. This extension will terminate 24 months from the date of your death.

Extension of Benefits
Regardless of whether a treatment plan has been approved, your dental benefits will not extend beyond the date coverage terminates, unless dental treatment is rendered within 31 days of your termination of coverage for the following procedures:
- dental restoration in connection with Major Dental Services for which the tooth was prepared prior to the termination date;
- root canal therapy where the pulp chamber was opened prior to the termination of coverage;
- installation of a denture when an impression for dentures was taken prior to the termination date and the denture is installed after the termination date.

Dental Examinations of Information
In order to determine benefits payable, the plan is entitled to request and will pay reasonable charges for:
- an examination by a dentist of the plan’s choice;
- the submission of diagnostic/evaluative material such as x-rays;
- information required to make a payment involving Coordination of Benefits.

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 have been lost, stolen or broken;
- 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;
• 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;
• 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

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

- you are in benefit under the Hour Bank Benefit Program;
- you are actively at work for a Merit employer who is participating in the Merit LTD program.

You are in benefit if you have accumulated sufficient hours in your hour bank account in order to purchase the current month of coverage.

You are considered to be actively at work if you were working for your employer on your last scheduled shift prior to becoming disabled.

Coverage During Apprenticeship Training
You are also eligible for LTD coverage while on an approved apprenticeship training program so long as you remain in benefit and the training begins no more than 30 days after the last day worked as an employee with a company participating in the LTD plan. Please contact Mercon Benefit Services regarding the continuation of benefit coverage during your apprenticeship training.

Benefit
The LTD benefit is $2,500 per month for the first 24 months of payments and $3,000 per month thereafter. The LTD benefit is reduced by benefits paid under any Workers’ Compensation Act or similar law. The benefit is payable only so long as you remain disabled as provided under the Definition of Disability.

There is a further reduction of your LTD benefit 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.

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

If, while you are receiving benefits from the Insurer, a cost of living increase is introduced in any governmental plan as a result of an increase in the Consumer Price Index, your benefits are not decreased by the extra amount you receive. However, a decrease in your LTD benefit will occur in the case of other increases such as a change in the method of establishing the benefit level of the governmental plan.

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.

Qualifying Period
You become eligible for LTD benefits following 120 days of disability.

Payment Period
LTD payments will commence following the later 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 continue to be paid until the earlier of the date your disability ceases, or the attainment of age 65.

Definition of Disability
In order 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. Thereafter, 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.

Periods for Which 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 for under the Rehabilitation Assistance provision;

• 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 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):

• 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;

• benefits payable under any Workers’ Compensation Act or similar law.

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.

Rehabilitation
LTD benefits will continue to be paid during a period of approved rehabilitation employment. 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).

Survivor Benefits
A survivor benefit, equal to three times the last monthly disability benefit payment received by you, will be paid to your surviving spouse. If you do not have a 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:

• a work-related injury when you have not applied for benefits payable under any Workers’ Compensation Act or similar law;

• self-inflicted injuries or illnesses, whether sane or insane;

• 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;

• 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;

• a pre-existing condition which causes disability within the first 12 months from the date your coverage commences. A pre-existing condition is any injury or illness for which you received medical treatment during the 90 days immediately prior to the date you are eligible for benefits. This exclusion does not apply if, after becoming insured, you have been actively working for 90 days in a six consecutive month period from the date you are first eligible for benefits, with no absence related to the pre-existing condition.

(Should an Employee’s coverage terminate and is then reinstated within 120 days after termination, this pre-existing condition exclusion will be
applied based on the original date of coverage. Should the Employee’s coverage not be reinstated within 120 days, this exclusion will be applied based on the date the Employee’s coverage was reinstated.)

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:
- the date you are no longer totally disabled;
- the date you fail to supply the Insurer with appropriate medical evidence;
- the date you do not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by the Insurer;
- the date you refuse to participate in a vocational or functional capabilities assessment;
- the date you refuse to participate in a rehabilitation program approved by the Insurer;
- the date you reach age 65;
- the date you die.

Termination of LTD Coverage
Your LTD coverage terminates on the earlier of the following:
- the date you are no longer in benefit under the Hour Bank Benefit Plan;
- the date you cease to be actively at work;
- the date your employer ceases to make any required premium contributions;
- the date you reach age 65 less 120 days (the Qualifying Period).

**EMPLOYEE & FAMILY ASSISTANCE PROGRAM**

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

The Shepell•fgi EFAP 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. Shepell•fgi offices are located in most major centres across Canada. In person, telephonic, online, video counselling and a variety of text based services are available.

Also available is Shepell•fgi’s comprehensive online wellness library: workhealthlife.com. Go online and discover practical solutions for managing career issues, handling life as a parent, making better food choices and much more. Logon at workhealthlife.com using “Merit Contractors Association” as the employer.

A Health Coaching service is also included in the EFAP Program providing information, advice and support for questions or concerns about specific health issues. Consultations are available by telephone and support is provided by Registered Nurses or Occupational Health Nurses.
Accessing the EFAP
The EFAP is available to you and your eligible dependents 24 hours, 7 days a week, 365 days a year through these simple access points:
• Call the Shepell•fgi Care Access Centre toll free at 1.877.916.9116;
• Online Access (Canada only) via workhealthlife.com;
• E-Counselling via workhealthlife.com; shepellfgi.com or My EAP*;
• First Chat, an online chat support service, via workhealthlife.com;
• For crisis situations requiring immediate attention call 911 or the Shepell•fgi Care Access Centre at 1.877.916.9116.

Note: When calling Shepell•fgi, tell them you are under the Merit Contractors Association Benefit Plan. You are not listed under your company name.

*My EAP is a free mobile application for Apple and Blackberry mobile devices that delivers interactive tools, support resources and access to EFAP services. Go to either Apple’s App Store or Blackberry’s App World to download the application.

Confidentiality
Confidentiality is the cornerstone of the EFAP 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.

Shepell•fgi has strict guidelines in place to ensure your privacy. When you access EFAP services, only you and your counsellor will know. No personal information is ever released to your spouse, your children, your employer, Mercon Benefit Services or Merit Contractors Association.

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. This means you will not run into one of your co-workers while at your counselling appointment.

Services Provided
Shepell•fgi 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
• Stress assessment and counselling
• Family issues including childcare and eldercare
• Stress
• 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
Shepell•fgi 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 behaviour 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 EFAP
There is no cost to you or your eligible dependents to access the services of the EFAP. The cost of any service not supplied by Shepell•fgi or covered by the Merit Benefit Plan is your responsibility.

Counselling Sessions Provided
The EFAP 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 and monitor your progress with the community resource. If your situation is recognized as highly specialized and out of the scope of the services normally provided by Shepell•fgi, you will also be referred to a resource in your community.

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

BEST DOCTORS

Diagnostic and Treatment Support Services
Best Doctors connects seriously ill 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. Four services are available to you and your eligible dependents.

InterConsultation: This service is designed to allow you, your dependents and your attending physician or specialist access to the expertise of world-class specialists, resources, information and clinical guidance.

When you or one of your dependents has been diagnosed with a serious medical condition for which there is objective evidence, or if it is suspected that a serious illness is present, this service can be accessed. It is made up of a unique step-by-step process that may help address questions or concerns about a medical condition.

How InterConsultation works:
• You and your dependents can access diagnostic and treatment support services by calling 1.877.419.BEST (2378) toll free.
• You will be connected with a Member Advocate, a Registered Nurse dedicated to your case who will provide support throughout the process. The Member Advocate will arrange to gather your medical records and answer any questions you may have. The information provided is not shared with your employer, Merit Contractors Association or Mercon Benefit Services.
• Best Doctors’ team of Harvard-trained physicians completes an in-depth analysis of your medical information and pathology is retested by a Centre of Excellence. The team identifies the best qualified expert(s) in your illness from a world-wide network of 50,000 specialists. The Best Doctors specialist will prepare a comprehensive report summarizing findings, and will confirm, clarify or change your diagnosis and treatment recommendations. Your Member Advocate will review the information with you and answer any questions you may have.
• You and your treating physician work together to choose the next steps.
**FindBestDoc**: Best Doctors will help locate a specialist if needed, providing details about each specialist’s preferred method of referral and information about travel and accommodations if out-of-town travel is necessary. Appointments and referrals must be made by your treating physician. Medical and travel expenses are not covered.

**FindBestCare**: Best Doctors will access discounts for hospitals and doctors if out-of-country care is necessary and will ensure vital information is sent to the medical specialists involved. Medical and travel expenses are not covered.

**Best Doctors 360°**: Helps individuals navigate the health care system and take control of their own health care. This service provides ongoing one-on-one support, customized health information and access to local resources. Best Doctors 360° is not only for serious illness, but can help all employees and their dependents with their health care questions.

**Ask the Expert**: This service enables individuals to ask questions about their health concerns and treatment options. Individuals calling Best Doctors will be connected with a Member Advocate to discuss their health concerns. An expert will be selected from Best Doctors’ global network of top-rated specialists to address the questions. Answers will be provided in a written report.

The following are some questions frequently asked about the benefits program that may assist you.

1. **How do I become enrolled under this plan?**
   (a) you must be employed by a participating employer;
   (b) an enrolment card must be completed and returned to your employer;
   (c) an hour bank account is established in your name once your employer has reported hours worked by you and remitted contributions for the hours worked.

2. **What is an hour bank account?**
   Mercon Benefit Services, the plan administrator, keeps a record of all hours worked for each employee and reported by an employer participating in this plan. Your hour bank account operates like a bank account except hours are recorded instead of dollars. As long as you are working for a participating employer, all hours worked by you are “deposited” into your account. To “pay” for benefits, 150 hours are deducted or withdrawn from the account for each month of coverage.

   Every hour you work in a month, including overtime, is reported to Mercon Benefit Services. These hours are reported at the end of the last pay period for that month and may not coincide with the last day of the calendar month. For example, if you worked 200 hours for the entire month but only 150 hours were worked and reported in the two pay periods for that month, you would be credited with 150 hours in your hour bank for that month and the remaining 50 hours would be reported and credited to your hour bank in the following month.

The following is an example of an employee’s hour bank account. Read each row from left to right.

<table>
<thead>
<tr>
<th>Hours Worked</th>
<th>Month Hours Worked</th>
<th>Updated Hourbank Balance</th>
<th>Hours Deducted</th>
<th>Coverage for Month</th>
<th>Closing Hour Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>150</td>
<td>Jan</td>
<td>150</td>
<td>0</td>
<td>n/a</td>
<td>150</td>
</tr>
<tr>
<td>180</td>
<td>Feb</td>
<td>330</td>
<td>150</td>
<td>Apr</td>
<td>180</td>
</tr>
<tr>
<td>170</td>
<td>Mar</td>
<td>350</td>
<td>150</td>
<td>May</td>
<td>200</td>
</tr>
<tr>
<td>90</td>
<td>Apr</td>
<td>290</td>
<td>150</td>
<td>June</td>
<td>140</td>
</tr>
<tr>
<td>0</td>
<td>May</td>
<td>140</td>
<td>150</td>
<td>n/a</td>
<td>140</td>
</tr>
</tbody>
</table>

In this example, because at least 300 hours are in this employee’s hour bank account at the end of February, and coverage begins the 1st day of the 2nd...
calendar month after accumulating 300 hours, coverage will begin on April 1st. 150 hours are deducted for each month of coverage — in this example, April, May and June. At the end of June, however, only 140 hours are left in the account. If no additional hours were worked in May, there are less than the 150 hours in this person’s hour bank account necessary to maintain coverage for July.

Should this employee work more than 10 hours in the next eight months, he/she will again become eligible for the benefits program without the initial eligibility requirement of 300 hours in his/her bank account. If he/she does not work 10 hours or more in the next eight months, any hours left in the hour bank account are forfeited. He/she will then have to accumulate an initial 300 hours in order to obtain benefit coverage.

3. How do I know if I am covered on an on-going basis?
If you have access to a computer and the Internet, you can access Mercon Benefit Services’ website at www.merconbenefits.com. You must create a profile under the Employee Portal to access your personal information. To do this you will need your Member Identification Number, which can be found on your pay-direct drug card. You can also call Mercon Benefit Services to obtain information concerning your eligibility. Provided you have filled out an enrolment card with your correct address and it is on file with Mercon Benefit Services, you will receive a letter advising you if your coverage terminates.

4. Can I pay the premium myself in order to maintain my coverage?
Yes. Mercon Benefit Services will write to you in advance of your coverage terminating. If you comply with the scheduled payment deadlines, you can purchase coverage for all benefits, except disability benefits, for a period of up to six consecutive months (or up to 24 months from the date of disability if you are in receipt of Workers’ Compensation or Long Term Disability benefits, or have been approved for Waiver of Premium under the Employee Life Insurance benefit).

5. Are my hours portable?
Mercon Benefit Services keeps records based on your Member Identification Number. Your hour bank account is kept in your name regardless of which participating employer you work for. Participating employers are required to make contributions to this plan for all hourly paid employees so that if you work for another participating employer your hours will be credited to your individual hour bank account.

6. When do my dependents get coverage under this plan and what benefits do they qualify for?
Your eligible dependents are covered for dependent life insurance, extended health care and dental care benefits at the same time you become eligible for coverage, provided that you have indicated them as eligible dependents on your completed enrolment card.

7. Who are my eligible dependents?
Your eligible dependents are:
(a) your spouse; and/or
(b) your dependent children under the age of 21 years or up to the age of 25 if your child is a full-time student.

8. Whose plan should pay for any medical or dental claims related to our children when my spouse has a plan through his/her employer?
Because you and your spouse have benefit plans available, you can claim reimbursement of medical or dental expenses from both plans. Any expenses you incur on behalf of yourself should be sent to the Merit plan for reimbursement first. You then submit the balance to your spouse’s plan -- attach a copy of your receipts and the Explanation of Benefits from the Merit plan to a fully completed claim form from your spouse’s plan.

Any expenses incurred on behalf of your spouse must be submitted to his/her plan first. Any remaining balance can then be submitted to the Merit plan (remember to attach a copy of the receipts and the Explanation of Benefits from your spouse’s plan).

Claims for dependent children should be submitted first to the plan of the parent whose birth date occurs first in the calendar year. Once that plan has provided reimbursement, any remaining balance can then be submitted to the other plan together with a copy of the receipts and the Explanation of Benefits provided by the first payer.

Under the coordination of benefit provision, the maximum reimbursement from both plans combined is 100% of the eligible claim amount.

9. How does this plan fit in with provincial government health plans?
Your provincial government health plan will cover you for many basic health related expenses such as physician’s fees and standard ward accommodation in a hospital. This plan is intended to provide coverage for many expenses not covered through provincial government health plans.
From time to time, provincial government health plans may change the coverage they provide or the coverage companies can provide for extended health care benefits. When that happens, you will be advised of how the change may impact the Merit benefit plan. Please do not assume that when a provincial government health plan changes its coverage that the Merit plan will make up the difference.

10. My child turns age 19 on May 9th of this year. How will this impact dental and vision care coverage?

The Merit dental plan provides coverage for recall examinations, bitewing x-rays, polishing of teeth and topical fluoride treatment once every six months for participants under the age of 19. Once a participant turns 19, however, coverage is provided for recall examinations, bitewing x-rays and polishing of teeth only once each calendar year. Topical fluoride treatment coverage is not provided at all beyond age 18. Similarly, participants under the age of 19 are provided coverage for eyeglasses once each calendar year, while participants age 19 and older are provided coverage for eyeglasses once every two calendar years.

It should be noted that, in the calendar year in which a participant turns age 19, coverage for recall examinations, bitewing x-rays and polishing of teeth would only be allowed once. For example, if your child had a recall exam in January and then turned 19 on May 9th, coverage for another recall exam would only be provided during the following calendar year. If your child made a claim for eyeglasses in January and turned 19 on May 9th, then coverage for another set of eyeglasses would only be provided two calendar years after the calendar year in which the dependent turned 19.

11. Who should I contact if I change my residence?
Contact Mercon Benefit Services and request that your file be updated with your new address.

12. Can I change my designated beneficiary for my life insurance?
Yes, you can change the beneficiary for your life insurance by completing a new enrolment card. Obtain a new enrolment card from your employer or Mercon Benefit Services. Remember, if you identify a child under age 18 as the beneficiary, ensure that you write “in trust” beside the named beneficiary and include the name of the Trustee. Also ensure that the enrolment card is completed legibly, in black ink.

13. When should I expect to receive a reimbursement after submitting a claim for medical or dental services?
If you wish to expedite payment, you have the option of processing your claims online and having payments deposited directly into your bank account. You can expect to receive reimbursement of eligible claims within one to three days after processing them online. For assistance with online claims, refer to the Claims Instructions section of this booklet. Alternatively, you can call Mercon Benefit Services.

If you have submitted a paper claim and have mailed it to Great-West Life (and all relevant information was included), you should receive a cheque following a period of ten days to two weeks. There are two periods each year, June and December, when claim processing might take a little longer. June represents a peak period in the insurance industry when a large number of medical and dental claims are being processed. Responses in December are often delayed due to the Christmas break. Call Mercon Benefit Services if you have a question regarding the status of your claim.

14. If I participate in the Christian Labour Association of Canada (CLAC) benefit plan, can I consolidate my accounts in the CLAC and Merit plans?
Yes, there is an agreement in place between Merit and CLAC in Alberta that permits consolidation, either through a transfer to the CLAC plan or to the Merit plan. Please contact Mercon Benefit Services if you wish to do so.

15. Can I get a refund if I go to work for a non-Merit company?
No, Merit Plan does not permit a refund for any hours that have been submitted by your employer to the Hour Bank plan. Your benefits under the Hour Bank plan will continue so long as you have a minimum of 150 hours in your Hour Bank account.

16. Will any maximum benefit amounts that apply for the health and dental benefits start over if I stop working for one Merit member company and start working for another Merit member company, or if I stop working and later get rehired by the same company?
No, the same maximum benefit amounts will continue to apply. For example, you will only be eligible for one $600 annual physiotherapy maximum while a member of the Merit Benefit Plan, regardless of how many Merit member companies you may work for during the course of a year. Similarly, any lifetime maximums will only apply once while a member of the Merit Benefit Plan (e.g. you will have only one lifetime maximum of $500 for smoking cessation products).