

**MACHINISTS FITTERS AND
HELPERS UNION
LOCAL #3 C.L.C.
WELFARE PLAN**



**ON BEHALF OF MEMBERS OF:
MACHINISTS LOCAL 3
LABOURERS LOCAL 1204
RIGGERS LOCAL 643**

**GROUP BENEFIT
PLAN BOOKLET**

MAY 2007

INTRODUCTION

This booklet contains information about your Group Benefits. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Group Contract/Policy and by the Trustees of the Plan.

Both British Columbia and Alberta have passed legislation affecting the use of self-insured funding for providing benefit plans. In each case, the legislation allows for the use of self-insured funding, subject to disclosing this information to the covered Members in writing.

The Trustees are constantly attempting to provide benefits under the Plan to the Members in the most cost-effective manner. For some benefits it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act.

Coverage is provided through:

The Co-operators # G419

- Life Insurance
- Long Term Disability

The Machinists, Fitters and Helpers Union

Local #3 C.L.C. Welfare Plan #11244

- Extended Health Care
- Dental
- Wage Indemnity

American Home Assurance Company

#25721100

- Accidental Death & Dismemberment

Royal Sun Alliance Insurance Company

#32446514

- VIATOR Out of Province/Canada Group
Travel Medical Emergency Benefit

PRIVACY POLICY

We, the Trustees of the Machinists Fitters and Helpers Union Local #3 C.L.C. Welfare Plan have adopted the following *Privacy Principles*, which reflect our commitment to safeguarding our Members' personal information:

- Information about you and your communications with the Plan are kept confidential.
- Neither the Administrator nor the Plan will sell your personal information.
- Information about you is gathered lawfully and fairly.
- Information about you is gathered, used, or disclosed only to provide you with benefits and services as outlined in your plan documents.
- We maintain appropriate procedures to ensure that personal information in our possession is accurate and, where necessary, kept up to date. You are entitled to seek a correction of your personal information if you believe that the information held by the Plan is not accurate.
- You may access your personal information, subject to limited exceptions and conditions.
- Personal information is not disclosed without Member's permission except in limited circumstances as permitted or required by law. However, the Administrator, may share personal information with the Plan's actuaries, agents, consultants or service providers in connection with providing, administering, adjudicating, costing, financially managing and servicing Member's plans and benefits programs.
- Where we choose to have certain services, such as actuarial valuation, provided by third parties, we take all reasonable precautions regarding the practices employed by the service provider to protect your personal information. We ask that they, in turn, undertake to honour the Plan's privacy policy and applicable legislation.
- To protect your personal information against unauthorized access, disclosure, copying, use or modification, or theft or accidental loss, the Plan will maintain appropriate security mechanisms.

– The Trustees

TABLE OF CONTENTS

Introduction	1
Privacy Policy	2
General Information	5
Definitions	5
Effective Date of Coverage and Enrolment	6
Late Applicants	6
Identification (ID) Cards	7
Claims	7
Duplicate Coverage	7
Coordination of Benefits	8
General Exclusions	8
Termination of Coverage	9
To Answer Your Questions	9
Basic Life Insurance	10
Living Assistance Benefit	10
Total Disability Waiver of Premium	11
Conversion Privilege	11
Submitting a Claim	11
Termination Age	11
Accidental Death And Dismemberment	11
Who is Covered	12
Schedule of Losses	12
Repatriation Benefit	14
Rehabilitation Benefit	14
Family Transportation Benefit	14
Conversion Privilege Benefit	15
Continuance of Coverage Benefit	15
Waiver of Premium Benefit	15
Seat Belt Rider Benefit	16
Home Alteration and Vehicle Modification Benefit	16
Educational Benefit	16
Day Care Benefit	17
In-Hospital Indemnity Benefit	17
Permanent Total Disability Indemnity	18
Exclusions	19

Extended Health Care	19
Definitions	20
In-Province Eligible Expenses	21
Vision Care	23
Out-of-Province Non-Emergency Eligible Expenses	23
Out-of-Province Emergency Eligible Expenses	23
Benefit Summary	24
Exclusions	28
General Provisions and Limitations	30
International Assistance Service	33
Claims	38
Exclusions	39
Claims	41
Dental Care	42
Definitions	42
Payment of Benefits	42
Plan A – Basic Preventative & Restorative Services	43
Plan B – Major Restorative Services	44
Plan C – Orthodontics	45
Emergency Treatment Outside Your Province of Residence ...	46
Exclusions	46
Claims	46
Wage Indemnity	48
Recurrent Disability	49
Extended Benefit	49
Coordination with other Income Sources	50
Third Party Liability	50
Are Benefits Taxable?	50
Termination of Benefit	50
Exclusions	51
Claims	51
Long Term Disability	52
Benefit Adjustment	53
Rehabilitation Program	53
Third Party Liability	54
Total Disability Waiver of Premium	54
Submitting a Claim	55
Termination Age	55
Notes	56

GENERAL INFORMATION

Definitions

Allowable Enrolment Period

means,

- 1) within 4 months (for Extended Health & Dental benefits), or
- 2) within 31 days (for the Wage Indemnity benefit)

from the Coverage Effective Date.

Coverage Effective Date

means the date coverage becomes effective based on

- 1) your date of hire, and
- 2) the average number of hours you work each week or each year, and,
- 3) the waiting period, and
- 4) the Allowable Enrolment Period.

Deductible

means the initial portion of the Eligible expenses, which you must pay before the Plan will reimburse charges for any Eligible expense.

Dentist

means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, dentist may also mean dental specialist, or denturist.

Dependent

means, subject to any age limitations included in the benefit description, any of the following persons for whom coverage is provided under this Plan:

- 1) one Spouse, and
- 2) any child, stepchild, legally adopted child, or legal ward who is unmarried, living with you, and dependent upon you up to the age of 21 or 25 if attending school on a full-time basis. Coverage will terminate at the earliest of age 25 or the end of the school year (August 31st) in which the student graduates. A dependent child will be covered to any age if such dependent is handicapped.

Duplicate coverage

means that you (and your Dependents) are eligible to claim certain benefits under more than one plan.

Spouse

means your legal spouse or a person who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your spouse.

Effective Date of Coverage and Enrolment

If you are eligible for coverage, you must complete an enrolment card within the Allowable Enrolment Period to ensure that your coverage starts on the correct effective date.

You should apply for Dependent coverage (when applicable):

- 1) on the same date you apply for your own coverage, or
- 2) within the Allowable Enrolment Period if you have a new Dependent.

Limitations:

- 1) If you are not actively at work on your Coverage Effective Date, your Coverage Effective Date will be delayed until you return to active full-time employment.
- 2) If the Plan Administrator does not receive your enrolment card within the required time limits, please refer to the Late Applicants section.

Coverage begins on the Coverage Effective Date shown on your identification (ID) card(s), provided that you have complied with the Plan's enrolment rules.

Should you require additional information about when your coverage starts, please contact the Plan Administrator.

Late Applicants

If you did not apply during the Allowable Enrolment Period but request coverage later (for yourself and/or your Dependents), ask the Plan Administrator to explain the requirements for late enrolment under the Plan. Note: Different benefits may have different requirements – health evidence or retroactive premium payment. In some instances, coverage may be denied.

Identification (ID) Cards

You will be issued identification (ID) cards by the Plan Administrator.

Only you and your enrolled Dependents are entitled to use this card. Should you (or your Dependent) allow an ineligible person to use this card, your coverage may be suspended without notice.

You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent under the Plan.

Claims

- 1) All claims must be submitted in either English or French.
- 2) The Plan will pay eligible claims when all the required information is received within the required **time limits**. You are encouraged to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, the claiming deadlines are fully described for each benefit. No payment will be made if your claim is received after the time limits described in this booklet.
- 3) Your claim may be rejected if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled.
- 4) The necessary claim forms are available from the Plan Administrator or the Union Hall.
- 5) The exchange rate on foreign currency is payable at the rate quoted by selected financial institutions in Vancouver, British Columbia, for the date on which the expense was paid. Fluctuations in exchange rates are not the responsibility of the Plan.

Duplicate Coverage

If you and your Spouse are both employed and you are both enrolled for similar benefits, Duplicate coverage is allowed.

If you are eligible for Duplicate coverage, you and your family should discuss both plans (and what portion of the benefits you pay) to determine whether it is to your advantage to enroll under more than one plan.

Coordination of Benefits

The Plan will pay claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

- 1) Dependent 00 is always the primary claimant. Dependent 01 (or 90 to 99) is always the secondary claimant.
- 2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
- 3) In situations of separation or divorce, the following order applies:
 - a) the plan of the parent with custody of the child
 - b) the plan of the Spouse of the parent with custody of the child
 - c) the plan of the parent not having custody of the child
 - d) the plan of the Spouse of the parent in c) above
- 4) Total reimbursement shall never exceed 100% of the Eligible expenses.

General Exclusions

- 1) The Plan will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
 - a) under any other group or individual benefit plan or insurance policy, or
 - b) due to the legal liability of any other party.
- 2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
 - a) Intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion.
 - b) Active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat.
 - c) A direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country.
 - d) Any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Termination of Coverage

Generally, your coverage (and your Dependent coverage) terminates if you cease to be eligible due to leave of absence, age limitation or retirement, or if you terminate your employment, etc. For further details on termination of coverage, please contact the Plan Administrator.

IN ANSWER TO YOUR QUESTIONS

Who is eligible to enroll?

All full-time Members who work a minimum number of hours per week as defined in the Trust Agreement, who are actively at work, and are under the age of 65.

How do I apply?

You must complete the enrolment card provided by the Plan Administrator, within one month of becoming eligible.

Are my Dependents covered?

Yes, some benefit plans include family benefits, provided that your Dependents meet the definition of a Dependent defined in General Information.

Who is a Dependent?

Your Spouse or common-law Spouse (provided the common-law Spouse has resided with you for a minimum of 12 months).

Your unmarried Dependent Children who are not working full-time:

- from birth to attainment of their 21st birthday, or
- up to attainment of their 25th birthday provided they are in full-time attendance at an accredited educational institute, or
- of any age and are suffering from a permanent mental or physical infirmity and are wholly financially dependent upon you and residing with you and who became disabled while otherwise eligible under either of the above two.

* No person will be considered a dependent if they reside outside of Canada on a permanent or temporary basis.

When do my benefits terminate?

Your benefits terminate automatically at the age specified in each benefit explanation, retirement date or your retirement on pension. Other reasons for termination of insurance are termination of your service as a Member, or wind up of the Plan.

How do I submit a claim?

Claim forms are available from your employer, the Union Hall or the Plan Administrator. Upon completion, all claims should be sent to:

Machinists Fitters and Helpers Union
Local #3 C.L.C. Welfare Plan
101- 4190 Lougheed Highway
Burnaby BC V5C 6A8

THE INFORMATION CONTAINED IN THIS BOOKLET IS FOR GUIDANCE ONLY. PLEASE KEEP THIS IMPORTANT DOCUMENT IN A SAFE PLACE FOR FUTURE REFERENCE.

BASIC LIFE INSURANCE

The amount of insurance below will be payable to your beneficiary upon your death.

Each Member	\$60,000
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Living Assistance Benefit

The Living Assistance Benefit is available as an advance payment of your Basic Life Insurance to help meet the medical or other health and welfare expenses of terminally ill Members under age 63.

Application for this benefit must be approved by the Plan and the Co-operators will confirm that medical evidence meets the Plan's requirements before approving payment.

The amount of money available as a Living Assistance Benefit payment is 50% of your Basic Life Insurance Benefit, to a maximum of \$20,000.

Total Disability Waiver of Premium

Should you become Totally Disabled (as that term is defined in the Policy) for more than six (6) months prior to age 65, the amount of Life Insurance will continue without payment of premiums while you remain Totally Disabled. Satisfactory proof of Total Disability must be submitted to The Co-operators within 12 months from the date of Total Disability and thereafter, upon request by The Co-operators. Your Life Insurance coverage and Waiver will terminate when you reach age 65 or recover, whichever occurs first.

Conversion Privilege

Upon termination of your Life Insurance, prior to age 65, you may obtain an individual policy with the Co-operators Life Insurance Company without evidence of good health on the Ordinary Life Plan, Limited Payment Life, Term to Age 65, or One Year Term Plan (non-renewable) at the lesser of \$200,000 or the difference between the amount of insurance at the time of your termination and the amount of insurance for which you are eligible under a new group contract at the time you are exercising your right to convert. The individual policy will be issued only if application is made within 31 days after your termination. Your life will continue to be insured during the 31-day conversion period whether or not you apply for conversion.

Submitting a Claim

The time limit within which a Life Insurance claim must be made is 180 days from the date of loss.

Termination Age

Your Basic Life Insurance Benefit terminates at age 65.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Basic Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed below in the schedule of losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is Covered?

All Employees/Members who
are under age 65

All Spouses under age 70.

All eligible dependent Children.
(see General Information)

Amount of Coverage

An amount equal to the group
life insurance amount, but not to
exceed \$5,000,000.00.

\$20,000.00

\$ 5,000.00

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot.	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye .	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye .	The Principal Sum
Loss of One Arm	Three-Quarters of The Principal Sum
Loss of One Leg.	Three-Quarters of The Principal Sum
Loss of One Hand.	Two-Thirds of The Principal Sum
Loss of One Foot	Two-Thirds of The Principal Sum
Loss of The Entire Sight of One Eye .	Two-Thirds of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Third of The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Speech or Hearing.	Two-Thirds of The Principal Sum
Loss of Hearing in One Ear	One-Third of The Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	Two Times The Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two Times The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body	Two Times The Principal Sum
Loss of Use of Both Arms or Both Hands.	The Principal Sum
Loss of Use of One Hand or One Foot.	Two-Thirds of The Principal Sum
Loss of Use of One Arm or One Leg	Three-Quarters of The Principal Sum

Loss of Four Fingers of One Hand One-Third of The Principal Sum
Loss of All Toes of One Foot One-Quarter of The Principal Sum

“Loss as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means, complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

“Loss” as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing in both ears.

“Loss” as used with reference to “Loss of Use” means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

All claims submitted under this policy for Loss of Use must be verified by agreement between a licensed practicing physician appointed by the Policyholder and a licensed practicing physician appointed by the Company, or in the event that the two physicians so appointed cannot arrive at an agreement, a third licensed practicing physician shall be selected by the first two physicians and the majority decision of three physicians shall be binding on the Policyholder and the Company. This procedure may be waived by the Company at its sole discretion.

Exposure & Disappearance

If by reason of an accident covered by the policy an Insured Person is unavoidably exposed to the elements and, as a result of such exposure suffers a loss for which indemnity is otherwise payable hereunder, such loss will be covered under the terms of the policy.

If the body of an Insured Person has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that such Insured Person shall have suffered loss of life within the meaning of the policy.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Person under the Policyholder's current basic group life insurance policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Person.

All other benefits shall be payable to the Insured Person.

ADDITIONAL BENEFITS**Repatriation Benefit**

When injuries covered by this policy result in loss of life of an Insured Person outside 50 Km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of \$15,000.00.

Rehabilitation Benefit

When injuries shall result in a payment being made by the Company under the Accidental Death and Dismemberment Indemnity section of this policy, the Company shall pay in addition:

The reasonable and necessary expenses actually incurred up to a limit of \$15,000.00 for special training of the Insured Person provided:

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

Family Transportation

When injuries covered by the policy result in an Insured Person being confined to a hospital, outside 100 Km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the actual expenses incurred by the immediate family member for transportation by the most direct route by

a licensed common carrier to the confined Insured Person but not to exceed the amount of \$15,000.00.

The term “member of the immediate family” means the spouse (or common-law spouse) parents, grandparents, children age 18 and over, brother or sister of the Insured Person.

Conversion Privilege

On the date of termination of employment or during the 60-day period following termination of employment, the employee may change his/her insurance to the American Home Assurance Company's individual insurance policy. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the policy ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of the American Home Assurance Company. The amount of insurance benefit converted to shall not exceed that amount issued during employment.

Continuance of Coverage

In the case of employees of the Policyholder who are (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of twelve (12) months, subject to payment of premium.

If an employee of the Policyholder assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Waiver of Premium

In the event an Insured Person becomes totally and permanently disabled and his/her waiver of premium claim is accepted and approved under the Policyholder's current group life policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier;

- a) The date the Insured Person attains age 65.
- b) The date of the death or recovery of the Insured Person.
- c) The date the Master Policy is terminated.

Seat Belt Rider

Benefits under the policy shall be increased by 10% if the insured person's injury or death results while he/she is a passenger or driver of a private passenger type automobile and his/her seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Home Alteration and Vehicle Modification

If an Insured Person received a payment under Section III – Coverage herein and was subsequently required (due to the cause for which payment under Section III – Coverage was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

- a) The one-time cost of alterations to the injured person's residence to make it wheelchair accessible and habitable; and
- b) The one-time cost of modifications necessary to a motor vehicle, owned by the injured person, to make the vehicle accessible or driveable for the Insured Person.

Benefit payments herein will not be paid unless:

- i) Home alterations are made on behalf of the Insured Person and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
- ii) Vehicle modifications are made on behalf of the Insured Person and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both Items (a) and (b) combined will not exceed \$15,000.00.

Educational Benefit Rider

If indemnity becomes payable for the accidental loss of life of an Insured Employee of the Policyholder, under the policy, the Company shall:

- 1) Pay the lesser of the following amounts to or on behalf of any dependent child who, at the date of accident, was enrolled as a full time student in any institution of higher learning beyond the 12th grade level:
 - a) The actual annual tuition, exclusive of room and board, charged by such institution per school year.

- b) \$10,000.00 per school year.
- c) 5% of the Insured Employee's Principal Sum.

Such amount will be payable annually for a maximum of four consecutive annual payments, only if the dependent child continues his or her education.

“Dependent Child” as used herein means any unmarried child under 25 years of age who was dependent upon the Insured Employee for at least 50% of his or her maintenance and support.

“Institution of higher learning” as used herein includes, but is not limited to, any University, Private College, or Trade School.

- 2) Pay to or on behalf of the surviving spouse the actual cost incurred within 30 months from the date of death of the insured Employee as payment for any professional or trades training program in which such spouse has enrolled for the purpose of obtaining an independent source of support and maintenance, but not to exceed a maximum total payment of \$10,000.00.

Day Care Benefit

If indemnity becomes payable under the policy for accidental loss of life of an Insured Employee, the Company will pay an amount equal to the lesser of the following amounts:

- 1) The actual cost charged by such day care center per year, or
- 2) 3% of the Insured's Principal Sum, or
- 3) \$5,000.00 per year,

On behalf of any child who was an Insured's dependent at the time of such loss and is under age 13 and is currently enrolled or subsequently enrolled in an accredited day care center within 90 days following such loss.

The benefit is payable annually for a maximum of four consecutive payments but only if the dependent child continues his or her enrollment in an accredited day care center.

In-Hospital Indemnity Benefit

If an Insured suffers a loss under the Table of Losses as a result of a covered accident and requires that an Insured be confined to a hospital for more than five (5) consecutive days, the Company will pay:

- a) a monthly benefit of one (1) percent of the Insured's applicable Principal Sum; or
- b) for periods of less than one (1) month, one thirtieth (1/30) of the above monthly benefit per day.

Benefits are retroactive to the first (1st) day of hospital confinement.

This benefit is limited to:

- a) a monthly amount not to exceed \$1,000.00; and
- b) a total of twelve (12) months for any covered accident.

Successive periods of hospital confinement for loss from the same covered accident separated by a period of less than three (3) months will be considered as one (1) period of hospital confinement.

The term "**Hospital**" is defined as an establishment which meets all of the following requirements:

- 1) holds a licence as a hospital (if licensing is required in the province);
- 2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- 3) provides 24-hour a day nursing service by registered or graduate nurses;
- 4) has a staff of one or more licensed physicians available at all times;
- 5) provides organized facilities for diagnosis, and major medical surgical facilities; and
- 6) is not primarily a clinic, nursing, rest of convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

When, as the result of injury and commencing within 365 days of the date of the accident, an Insured Person is totally and permanently disabled and prevented from engaging in each and every occupation or employment for compensation or profit for which he or she is reasonably qualified by reason of his or her education, training or experience, the Company shall pay, provided such disability has continued for a period of twelve consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any other amount paid or payable under the Accidental Death and Dismemberment Indemnity Coverage of the policy as the result of the same accident.

Exclusions

The accident insurance plan does not cover any loss resulting from:

- Suicide or self-inflicted injuries;
- Full-time service in the Armed Forces;
- Declared or undeclared war or any act thereof;
- Injuries received during aircraft travel except for the purposes of transportation where the Member is travelling as a passenger.

EXTENDED HEALTH CARE

The Extended Health Care (EHC) Benefit is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax-supported agency.

All dollar maximums outlined in this booklet are **claimable** unless specifically identified as a **payable** maximum.

Deductible \$100 per person or family each calendar year.

If in any calendar year the Eligible Expenses do not exceed the Deductible, the Eligible Expenses incurred during the last 3 months of the calendar year may be applied against the Deductible for the next year.

Reimbursement

In-Province

Eligible Expenses
and

Out-of-Province

Non-emergency
Eligible Expenses: 100%

Out-of-Province

Emergency
Eligible Expenses: 100%

<i>Plan Maximum</i>	The maximum amount of benefits payable for a Member or Dependent is \$25,000 in a 24-month period. <hr/> With respect to Out of Country/Canada Emergency expenses, there is an overall maximum of \$5,000,000. <hr/>
<i>Dependent Children</i>	Covered from birth to age 21 or to age 25 if in full-time attendance at a school or university, or to any age if handicapped. See General Information for more details.

Definitions

Eligible Expense

means a charge for any service and/or supply included in this booklet as a benefit that:

- 1) is assessed as a customary charge, medically necessary for health care and maintenance, or to maintain or restore teeth, and
- 2) was ordered or referred by a physician or dentist, unless otherwise specified in the benefit description, and
- 3) is not a cost normally paid (in whole or part) or provided by a government plan or any other provider of health coverage, and
- 4) is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received.

It does not include any payment to a pharmacy or a practitioner (demanded or received by balanced billing, extra billing, or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan. Pharmacare's low cost alternative and reference based pricing will not be applied unless specified in this booklet.

Physician

means an individual who is duly qualified and licensed to practice medicine or surgery, or both, in the area where the service is provided, but excludes a physician residing with or related to you or your Dependents.

Practitioner

means an individual who is currently licensed, certified, or registered to practice a profession in the area where the care or service is provided.

Accidental injury

means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth.

In-Province Eligible Expenses

The EHC benefit covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a physician. Unless otherwise indicated, the maximums included here are on a per person basis.

Hospital

The additional charge for a semi-private or private room accommodation in a hospital or the extended care unit of a hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

Emergency Ambulance

- a) charges for a licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient;
- b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport;
- c) emergency transport from one hospital to another, only when the original hospital has inadequate facilities; and
- d) charges for an attendant when medically necessary.

Prescription Drugs

Prescription drugs and medicines dispensed by a licensed pharmacist or a physician, in a quantity we consider reasonable:

- a) drugs and medicines which legally require a prescription from a physician or dentist;
- b) insulin preparations for diabetics;
- c) vitamin B12 for the treatment of pernicious anemia; and
- d) allergy serums when administered by a physician.

Practitioners

Professional services of the following practitioners to the maximum amounts indicated per calendar year, but excluding x-rays (unless indicated below), appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician.*

- a) acupuncturist \$300
- b) chiropractor \$300
- c) massage practitioner \$300
- d) naturopath \$300
- e) physiotherapist \$300
- f) podiatrist \$300
- g) psychologist \$300
- h) speech language pathologist \$300
- i) private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence.

Dental Accident

Dental treatment by a dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. Payment will be based on Fee Schedule. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Eye Examinations

Charges for eye examinations up to \$65 per covered person every 24 months.

Medical Aids and Supplies

Charges for the following services and supplies:

- a) testing supplies, needles, and syringes for diabetics;
- b) oxygen, blood, and blood plasma;
- c) ostomy and ileostomy supplies;
- d) surgical stockings to a maximum of 2 pair per calendar year;
- e) walkers, canes and cane tips, crutches, splints, casts, collars, and trusset, but not elastic or foam supports;
- f) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but the Plan will pay the equivalent of a standard prostheses;
- g) stump socks;
- h) one mastectomy brassiere per breast prosthesis to a maximum of 2 per lifetime;
- i) wigs and hairpieces required as a result of medical treatment or injury to a lifetime maximum of \$500;
- j) one pair of custom fitted orthopedic shoes or orthotics per person prescribed by a physician or podiatrist and replacements thereof when necessitated by normal wear and tear; and
- k) hearing aids and repairs to a maximum of \$400 in a 60-month period for adults and \$800 in a 60-month period for Dependent Children up to 21 years of age. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

Standard Durable Medical Equipment

Preauthorization is required from the Plan for expenses in excess of \$5,000

- a) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.
- b) Repairs to purchased items. The Plan will replace the item when it

- can no longer be made functional. Request may be made for trade-in or return of replaced equipment.
- c) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
 - d) Standard durable equipment includes:
 - i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchair and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise the Plan will pay the manual equivalent;
 - ii) medical monitors including heart and blood glucose monitors, and cardiac screeners;
 - iii) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems;
 - iv) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators;
 - v) insulin infusion pumps for diabetics – when basic methods are not feasible;
 - vi) transcutaneous electric nerve stimulators (TENS), when prescribed for intractable pain; and
 - vii) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

Vision Care

Charges for the purchase and/or repair of eye wear when prescribed by a physician or optometrist to a maximum of \$300 in a 12-month period. Charges for non-prescription eye wear are not covered.

Out-of-Province Non-Emergency Eligible Expenses

The Plan will reimburse you for non-emergency Eligible Expenses incurred by you and your eligible Dependents while travelling outside your province of residence subject to the Deductible, in-province reimbursement percentage, and maximums. The Plan will not reimburse any expenses payable or provided under a government plan.

Out-of-Province Emergency Eligible Expenses

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances occurring while you are temporarily outside your province or territory of residence. It is important that you read and understand your plan before you travel. In the event of any

discrepancy between the provisions of a booklet or other document you hold and the provisions of the Policy, the provisions of the Policy shall govern. The Insurer has contracted Global Excel Management Inc. (called "Global Excel") to provide medical assistance and claims services under the Policy.

**Coverage Period: 60 days per trip
IN THE EVENT OF AN EMERGENCY,
YOU MUST CALL GLOBAL EXCEL IMMEDIATELY:
From Canada & USA: 1-866-870-1898
From Anywhere: +(819) 566-1898**

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the Policy expressly requires the prior approval or authorization of Global Excel, on the basis of the Reasonable and Customary Costs that would have been payable for such expenses by the Insurer in accordance with the terms and conditions of the Policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the Reasonable and Customary Costs reimbursed by the Insurer.

Benefit Summary

Hospital Accommodation	
Physician Charges	
Diagnostic Services	
Ambulance Services	
Medical Appliances	
Emergency Air Transportation	<i>Reasonable & Customary Costs</i>
Paramedical Services	<i>\$250 per Profession</i>
Prescription Drugs	<i>30 day supply per Prescription</i>
Private Duty Nurse	
Vehicle Return	
Return of Deceased	<i>up to \$5,000</i>
Transportation to Bedside	<i>Economy Round-trip Airfare Plus up to \$150 per day to \$3,000</i>
Return of Travelling Companion	<i>One-way Airfare</i>

Treatment of Dental Accidents	<i>up to \$2,000</i>
Meals and Accommodation	<i>up to \$150 per day, to \$3,000 per Trip</i>
Incidental Expenses	<i>up to \$250</i>

The Policy covers expenses that are:

- incurred outside the province or territory of residence of the Insured Person;
- Medically Necessary;
- Reasonable and Customary Costs;
- incurred as a result of an Emergency due to sudden and unforeseen Sickness and/or Injury occurring during the Coverage Period;
- in excess of those covered by the Government Health Insurance Plan or other insurance under which you may have coverage; and
- legally insurable;

subject to the Overall Maximum per Insured Person specified in the Schedule of Benefits.

In the event of an Emergency, the following benefits are payable under the Policy. However, certain expenses, as specified below, are covered only if you obtain the prior approval of Global Excel.

- 1) **Hospital Accommodation:** Room and board costs up to the semi-private room rate charged by the Hospital. If Medically Necessary, expenses for treatment in an intensive or coronary care unit are also covered. If coverage terminates for any reason during your Hospital stay, benefits continue until discharge, to a maximum of one year. In no case will expenses for In-patient stays be covered for a period greater than 365 days per Insured Person.
- 2) **Physician Charges:** Charges for treatment by a Physician.
- 3) **Diagnostic Services:** Laboratory tests and x-rays prescribed by the attending Physician and that are part of the Emergency treatment. The Policy does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel.
- 4) **Paramedical Services:** The services (including x-rays) of a licensed chiropractor, physiotherapist, podiatrist or osteopath, to the maximum specified in the Benefit Summary section of the Schedule of Benefits, per Insured Person, per profession listed above, when approved in advance by Global Excel.
- 5) **Prescriptions:** Drugs, including injectable drugs, and sera that can only be obtained upon medical prescription, that are prescribed by a Physician and that are supplied by a licensed

- pharmacist when Medically Necessary for Emergency treatment, except when needed to stabilize a chronic condition or a medical condition which you had before your Trip. This benefit is limited to a 30-day supply per prescription, unless you are hospitalized.
- 6) **Ambulance Services:** When reasonable and Medically Necessary, licensed ground ambulance service to the nearest medical facility.
 - 7) **Medical Appliances:** When approved in advance by Global Excel, minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and/or the temporary rental of a wheelchair when prescribed by the attending Physician, obtained outside your province or territory of residence and Medically Necessary.
 - 8) **Private Duty Nurse:** The professional services of a registered private nurse, when Medically Necessary and while hospitalized, to the maximum specified in the Benefit Summary section of the Schedule of Benefits, per Insured Person, when approved in advance by Global Excel.
 - 9) **Emergency Air Transportation:** When approved and arranged in advance by Global Excel:
 - a) air ambulance to the nearest appropriate medical facility or to a Canadian Hospital for immediate Emergency treatment;
 - b) transport on a licensed airline with an attendant (where required) to return you to your province or territory of residence for immediate Emergency treatment.
 - 10) **Transportation to Bedside:** When approved in advance by Global Excel, a single round-trip economy airfare from Canada plus up to the amounts specified in the Benefit Summary section of Schedule of Benefits for the cost of meals and commercial accommodation for one of the following: Spouse, parent, child, brother, sister or business partner, to:
 - a) be with you if you are travelling alone and have been hospitalized as the result of an Emergency. To be payable, this benefits requires that you eventually be hospitalized as an In-patient for at least three (3) consecutive days outside your province or territory of residence and that the attending Physician provide written certification that the situation was serious enough to warrant the visit, or
 - b) identify the deceased Insured Person prior to the release of the body, where necessary.The Insurer will only reimburse covered expenses evidenced by original receipts.
 - 11) **Return of Travelling Companion:** If you are returned to your province or territory of residence under the Emergency Air Transportation benefit or the Return of Deceased benefit, the Insurer will reimburse the cost of a single one-way economy airfare for a travelling companion to return to Canada, when approved in advance by Global Excel.

- 12) **Treatment of Dental Accidents:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits per Insured Person for Emergency dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth provided the Injury was caused by an external, accidental blow to the mouth or face. You must consult a Physician or dentist immediately following the Injury. Treatment must begin during the Coverage Period and be completed prior to returning to your province or territory of residence. An accident report is required from a Physician or dentist for claims purposes.
- 13) **Meals and Accommodation:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits per Participant, for the cost of commercial accommodation and meals for the Participant and/or any of his/her Dependents when their Trip is extended beyond the last day of the scheduled Trip due to the Sickness and/or Injury suffered by an Insured Person. This benefit must be authorized in advance by Global Excel. The fact that you are unable to travel must be certified by the attending Physician and supported with original receipts from commercial organizations.
- 14) **Vehicle Return:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits if neither you, nor someone travelling with you, are able to operate your Vehicle, whether owned or rented, during your Trip due to Sickness and/or Injury. Arrangements and payment will be made for the return of the Vehicle to your home in your province or territory of residence or the nearest appropriate rental agency. Benefits will only be payable for a single person to return the Vehicle when approved and/or arranged in advance by Global Excel. This benefit does not cover wages lost by the person driving your Vehicle. The Insurer will only reimburse covered expenses evidenced by original receipts.
- 15) **Return of Deceased:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits towards the cost of preparation and transportation of the deceased Insured Person to their province or territory of residence in the event of death due to Sickness and/or Injury.

In the case of cremation and/or burial at the place of death of the Insured Person, this benefit is limited to \$2,500.

The cost of the casket or urn is not covered.

- 16) **Incidental Expenses:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits for your out-of-pocket expenses such as telephone charges, television rental and parking while you are hospitalized for an Emergency and the expenses are incurred as a direct result of such hospitalization. The Insurer will only reimburse covered expenses evidenced by original receipts.

Exclusions

The Policy does not cover losses or expenses related in whole or in part, directly or indirectly, to any of the following:

- 1) Treatment or services normally covered or reimbursable under a Government Health Insurance Plan or under other insurance you might have.
- 2) Any condition that existed prior to departure unless such pre-existing medical condition has been stable (i.e. no change in symptoms, no hospitalization, no change in condition, no new prescription drugs or prescribed change in treatment or medication) immediately prior to departure for the Pre-existing Condition Stability Period specified in the Schedule of Benefits.
- 3) Any Trip booked or commenced contrary to medical advice or after you are diagnosed with Terminal illness.
- 4) Any medical condition for which, prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization could be required while travelling.
- 5) Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that you elect to have provided outside your province or territory of residence when medical evidence indicates that you could return to your province or territory of residence to receive such treatment. The delay to receive treatment in your province or territory of residence has no bearing on the application of this exclusion.
- 6) Treatment or surgery during a Trip when the Trip is undertaken for the purpose of securing or with the intent of receiving medical or Hospital services, whether or not such Trip is taken on the advice of a Physician.
- 7) Cardiac catheterization, angioplasty, and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by Global Excel prior to being performed, except in extreme circumstances where such surgery is performed on an Emergency basis immediately upon admission to Hospital.
- 8) Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel.
- 9) Hospitalization or services rendered in connection with general health examinations for “check-up” purposes, treatment of an Ongoing Condition, regular care of a chronic condition, home health care, investigative testing, rehabilitation or ongoing care or treatment in connection with drugs, alcohol or any other substance abuse or non-compliance with any prescribed medical therapy or treatment and medical treatment of an acute Sickness and/or Injury after the initial Emergency has ended (as determined by the Medical Director of Global Excel).

- 10) A disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless hospitalized.
- 11) Emergency air transportation and/or car rental unless approved and arranged in advance by Global Excel.
- 12) Treatment not performed by or under the supervision of a Physician or licensed dentist.
- 13) Treatment or hospitalization of mother or child as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the four (4) weeks before or after the expected delivery date.
- 14) War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, rebellion, revolution or military power.
- 15) Terrorism or by any activity or decision of a government agency or any other entity to prevent, respond to or terminate terrorism except for ensuing loss or damage which results directly from fire or explosion. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss or damage.
- 16) Committing or attempting to commit an illegal act or a criminal act.
- 17) Suicide (including any attempt thereat) or self-inflicted injury, whether or not you are sane.
- 18) Service in the armed forces.
- 19) Participation in any sport as a professional athlete (for which you are remunerated), or in motorized or mechanically-assisted racing or speed contests (defined as an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event).
- 20) Loss or damage to eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices and resulting prescription thereof.
- 21) The replacement of an existing prescription whether by reason of loss, unless otherwise specified elsewhere in the Policy, renewal or inadequate supply or the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada or which are not required as a result of an Emergency.
- 22) Upgrading charges and cancellation penalties for airline tickets, unless approved in advance by Global Excel.
- 23) The cost of any airline ticket covered under the Policy where your ticket may be exchanged or used for the same purpose.
- 24) Crowns and root canals.
- 25) Treatment or services received in the province where you attend school or work on a full-time basis or in your home country, if you are a foreign student studying in Canada or a non-resident working in Canada.

General Provisions and Limitations

- 1) **Notice to Global Excel:** In the event of a Sickness and/or Injury likely to give rise to an Emergency, you must give immediate notice to Global Excel. Failure to do so may limit the benefits payable under the Policy. If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the Policy expressly requires the prior approval or authorization of Global Excel, on the basis of the Reasonable and Customary Costs that would have been payable for such expenses by the Insurer in accordance with the terms and conditions of the Policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the Reasonable and Customary Costs reimbursed by the Insurer.
- 2) **Transfer or Medical Repatriation:** During an Emergency (whether prior to admission or during covered hospitalization), the Insurer reserves the right to:
 - a) transfer you to one of Global Excel's preferred health care providers, and/or
 - b) return you to your province or territory of residence for the medical treatment of your Sickness and/or Injury where this poses no danger to your life or health. If you choose to decline the transfer or return when declared medically stable by the Medical Director of Global Excel, the Insurer will be released from any liability for expenses incurred for such Sickness and/or Injury after the proposed date of transfer or return. Global Excel will make every provision for your medical condition when choosing and arranging the mode of your transfer or return and, in the case of a transfer, when choosing the Hospital.
- 3) **Limitation of Benefits:** Once you are deemed medically stable to return to Canada (with or without medical escort) either in the opinion of the Medical Director of Global Excel or by virtue of discharge from a medical facility, your Emergency will be deemed to have ended, whereupon any further consultation, treatment, recurrence or complication related to the Emergency will no longer be eligible for coverage under the Policy.
- 4) **Misrepresentation and Non-Disclosure:** Your entire coverage under the Policy shall be voidable if the Insurer determines, whether before or after loss, that you or the Policyholder have concealed, misrepresented or failed to disclose any material fact or circumstance concerning the Policy or your interest therein, or if you or the Policyholder refuse to disclose information or to permit the use of such information, pertaining to any of the Insured Persons under the Policy. Consequently and following a loss, no

claim shall be payable by the Insurer and you shall be solely responsible for all expenses relating to your claim, including medical repatriation costs.

- 5) **Subrogation:** If you suffer a loss covered under the Policy, the Insurer is granted the right from you to take action to enforce all your rights, powers, privileges, and remedies, to the extent of benefits paid under the Policy, against any person, legal person or entity which caused such loss. Additionally, if “no fault” benefits or other collateral sources of payment of medical expenses are available to you, regardless of fault, the Insurer is granted the right to make demand for, and recover, those benefits. If the Insurer institutes an action it may do so at its own expense, in your name, and you will attend at the place of loss to assist in the action, in addition to providing the Insurer all information, cooperation and assistance the Insurer may reasonably require. If you institute a demand or action for a covered loss, you shall immediately notify the Insurer so that the Insurer may safeguard its rights.

Notwithstanding any provisions in the Policy to the contrary, the Insurer’s rights under this paragraph shall be governed by the laws of the state, province, or district where the loss occurs, or where benefits under the Policy are paid.

You shall take no action after a loss that will impair the rights of the Insurer set forth in this paragraph and shall do all such things as are necessary to secure such rights.

- 6) **Arbitration:** Notwithstanding any clause in the Policy, the parties hereto undertake to submit to an arbitration procedure, to the exclusion of the courts, any present or future dispute relating to a claim.

The arbitration proceedings shall be governed by the arbitration law in force in the Canadian province or territory of residence of the Participant. The parties agree that any action will be referred to arbitration.

- 7) **Applicable Law:** The Policy is governed by the law of the Canadian province or territory of residence of the Participant. Any legal proceeding by the Insured Person, his heirs or assigns shall be brought in the courts of the Canadian province or territory of residence of the Participant.
- 8) **Other Insurance:** If, at the time of loss, you have insurance from another source, or if there is any other party responsible for benefits provided under the Policy, the Insurer will pay covered expenses only in excess of those covered by that other insurer or other responsible party, including credit cards, private or public health plans, private or provincial auto plans, or any other insurance, whether collectable or not, which provides the Insured Person with some or all of the benefits and coverage provided

under the Policy. If, however, that other insurance is also “excess only”, the Insurer will co-ordinate payment of all eligible claims with that other insurer. All co-ordination follows the Canadian Life and Health Insurance Association guidelines. In no case, will the Insurer seek to recover against employment related plans if the lifetime maximum for all in country and out-of-country benefits is \$50,000 or less.

- 9) **Co-ordination and Order of Benefits:** If a person has coverage under another plan that does not provide for co-ordination of benefits, that plan will be considered primary carrier and will be responsible for making the initial payment. If the other plan does provide for co-ordination of benefits, the order of benefit will be as follows:

Participant and Dependent Spouse

The plan insuring the Participant or the Participant’s dependent Spouse as an employee/member pays benefits before the plan insuring the Participant or the Participant’s Spouse as a Dependent.

Dependent Child

If the dependent child is insured as a Dependent under the Participant’s and the Spouse’s plans, benefits will first be payable under the plan of the parent whose birthday comes first in the calendar year. The balance of eligible expenses can then be submitted to the plan of the other parent.

If both parents have the same birthday (month/day), the claims for children must be submitted to the plan in the alphabetical order of the parents’ first names.

When a person is insured under other group or individual policies or government plans, the benefits payable from all sources cannot exceed one hundred percent of expenses incurred.

- 10) **Rights of Examination:** To be entitled to payment of benefits provided under the Policy, the Participant, on his or her own behalf and on behalf of his or her Dependents hereby authorizes any physician, health professional, hospital, institution and any other organization to forward to the Insurer or its representatives, all information, reports or documents that they may require.

The Participant hereby authorizes the Insurer to communicate directly with any physician, health professional, hospital, institution or other organization to obtain any information required for the assessment of claims and hereby relieves the persons concerned of all legal responsibility which could arise from the disclosure of such information.

- In the event of death, the Insurer will require that a death certificate be filed with the claim. Furthermore, the Insurer has the right to request an autopsy and review any autopsy report, if not prohibited by law.
- 11) **Limitation of Actions:** An action or proceeding against the Insurer for the recovery of a claim under the Policy shall not be commenced more than one (1) year (two (2) years in the Northwest Territories, three (3) years in the province of Quebec) after the date the insurance money became payable or would have become payable if it had been a valid claim.
 - 12) **Availability and Quality of Care:** Neither the Insurer nor Global Excel shall be responsible for the availability or quality of any medical treatment (including the results thereof) or transportation at the vacation destination, or your failure to obtain medical treatment during the Coverage Period.
 - 13) **Evidence of Age:** The Insurer reserves the right to request proof of age of any Insured Person.
 - 14) **Assignment:** Benefits under the Policy may not be assigned.
 - 15) **When Money Payable:** All money payable under the Policy shall be paid by the Insurer within sixty (60) days after it has received proof of claim.
 - 16) **Continuance of Individual Coverage during Absence from Work:** If a Participant is absent from work due to disability, temporary lay-off, authorized leave of absence, strike or any other work stoppage, the insurance will be continued as long as the Participant remains covered under the Policyholder's basic group extended health care plan.
 - 17) **Examination of the Policy:** The Policy, including any endorsements, will be kept at the office of the Policyholder. You may consult the Policy during the regular business hours of the Policyholder.

International Assistance Service

Global Excel is available to take your calls 24 hours a day, 7 days a week.

Emergency Call Centre – No matter where you travel, professional assistance personnel are ready to take your call. Global Excel can also provide you with Canada Direct instructions and codes so that you only deal with Canadian telephone operators.

Referrals – Global Excel can refer you to the preferred medical providers (Hospitals, clinics and Physicians) that are closest to where you are staying. With a referral, it is less likely that you will have to pay for services out of pocket.

Benefit Information – Explanation of your coverage is available to you and to the medical providers who are treating you.

Medical Consultants – Global Excel’s team of medical professionals, available 24 hours a day, will monitor the services given in the event of a serious Emergency. If necessary, Global Excel will help you return to Canada for the care you need.

Urgent Message Relay – In the event of a medical Emergency, Global Excel will contact your travelling companion to keep him/her advised of your medical situation and will help you exchange important messages with your family.

Interpretation Service – Global Excel can connect you to a foreign language interpreter when required for Emergency services in foreign countries.

Direct Billing – Whenever possible, Global Excel will instruct the Hospital or clinic to bill the Insurer directly.

Claims Information – Global Excel will answer any questions you have about the eligibility of your claim, standard verification procedures and the way that the benefits under the Policy are administered.

Definitions

“Accident” means a fortuitous, sudden, unforeseen and unintentional event exclusively attributable to an external cause resulting in bodily Injury.

“Actively at Work” means the employee is physically and mentally capable of doing each and every function of his/her occupation, on the basis of the minimum number of hours worked per week specified in the Schedule of Benefits. If an employee is not actively at work due to vacation, holidays, a non-scheduled working day, maternity or parental leave, then actively at work means the capability to perform the employee’s normal duties at the employee’s normal place of employment on the same basis as the employee who is actively at work.

“Coverage Period” means the number of consecutive days specified in the Schedule of Benefits during which you are covered under the Policy when you take a Trip and which is calculated as of the commencement date of your Trip.

“Dependent” means the Spouse and the unmarried child of the Participant or Spouse, who is under the age limit specified under General Information, is dependent on the Participant for support and is not employed on a full-time basis. A dependent child who is physically or mentally disabled and totally dependent on the Participant for support will continue to be eligible provided he/she was covered as a Dependent under the Policy before attaining such age limit.

“Emergency” means the occurrence of a Sickness and/or Injury during the Coverage Period that requires immediate Medically Necessary treatment for the relief of acute pain or suffering, other than experimental or alternative treatment, and such treatment cannot be delayed until your return to Canada.

“Global Excel” and **“Global Excel Management Inc.”** mean the company appointed by the Insurer to provide medical assistance and claims services under the Policy.

“Government Health Insurance Plan” means the health care coverage provided by Canadian provincial and territorial governments to their residents.

“Hospital” means an institution which is designated as a hospital by law; which is continuously staffed by one or more Physicians at all times; which continuously provides nursing services by graduate registered nurses; which is primarily engaged in providing diagnostic services and medical and surgical treatment of a Sickness and/or Injury in the acute phase, or active treatment of a chronic condition; which has facilities for diagnosis, major surgery and in-patient care. The term Hospital does not include convalescent, nursing, rest or skilled nursing facilities, whether separate from or part of a regular general hospital, nor a facility operated exclusively for the treatment of persons who are mentally ill, aged, or drug or alcohol abusers.

“Immediate Family Member” means your Spouse, son, daughter, father, mother, brother, sister, stepson, stepdaughter, stepfather, stepmother, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother.

“Injury” means any unexpected and unforeseen harm to the body that is caused by an Accident, that you sustained during the Coverage Period and that requires Emergency treatment that is covered by the Policy.

“In-patient” means a patient who occupies a Hospital bed for more than twenty-four (24) hours for medical treatment and for which admission was recommended by a Physician when Medically Necessary.

“Insurer” means Royal & Sun Alliance Insurance Company of Canada.

“Medical Assistance Card” means the card provided to the Participant and on which the following information is shown: name of the Policyholder, Policy Number, Coverage Period per Trip and emergency telephone numbers.

“Medically Necessary”, in reference to a given service or supply, means such service or supply:

- a) is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;
- b) is not experimental or investigative in nature;
- c) cannot be omitted without adversely affecting the condition of the Insured Person or quality of medical care;
- d) cannot be delayed until the Insured Person returns to his or her province or territory of residence.

“Ongoing Condition” means an acute Sickness and/or Injury that requires continuing care and/or treatment after the initial Emergency has ended as determined by the Medical Director of Global Excel.

“Participant” means an employee or a member whom the Policyholder identifies as being entitled to coverage under the Policy and for whom the Policyholder has paid the required premium.

“Physician” means a medical practitioner whose legal and professional standing within his or her jurisdiction is equivalent to that of a doctor of medicine (M.D.) licensed in Canada, who is duly licensed in the jurisdiction in which he or she practices, who prescribes drugs and/or performs surgery and who gives medical care within the scope of his or her licensed authority. A Physician must be a person other than you or your Immediate Family Member.

“Policy” means the group travel emergency medical insurance contract issued to, and on file with, the Policyholder, bearing the policy number specified in the Schedule of Benefits.

“Policyholder” means the company or organization specified in the Schedule of Benefits and to which the Policy is issued.

“Reasonable and Customary Costs” means costs that are incurred for approved, covered medical services or supplies that do not exceed the standard fee of other providers of similar standing in the same geographical area, for the same treatment of a similar Sickness and/or Injury.

“Sickness” means a disease or disorder of the body that results in loss while this coverage is in effect. The sickness must be sufficiently serious to prompt a reasonably prudent person to consult a physician for the purpose of medical treatment.

“Spouse” means the person to whom the Participant is legally married or with whom he or she has been residing for the cohabitation period specified in the Schedule of Benefits.

“Terminal Illness” means you have a condition that is cause for the Physician to estimate that you have less than six (6) months to live.

“Termination Age” means the age specified in the Schedule of Benefits at which the Participant’s coverage terminates. Dependents beyond the Termination Age may be covered provided that the Participant has not yet reached the Termination Age.

“Terrorism” means an ideologically motivated unlawful act or acts, including but not limited to the use of violence or force or threat of violence or force, committed by or on behalf of any group(s), organization(s) or government(s) for the purpose of influencing any government and/or instilling fear in the public or a section of the public.

“Trip” means a journey that you undertake which commences on the date of your departure from your province or territory of residence and ends when you return to your province or territory of residence.

“Vehicle” means any automobile, station wagon, mini-van, sports utility vehicle (for on-road use), motorcycle, pick-up truck or a mobile home, camper truck or trailer home under 11 meters (36 feet in length), used exclusively for the transportation of passengers other than for hire, in which the Insured Person is a passenger or driver during the Trip.

“You”, “Your” and “Insured Person” means any one of the Participant or the Participant’s Dependents covered under the Policy.

Claims

Notice and Proof of Claim

In the event that Global Excel is not contacted immediately, the Insured Person, or a beneficiary entitled to make a claim, or the agent of any of them, shall:

- a) give written notice of claim by delivery thereof or by sending it by registered mail to Global Excel not later than thirty (30) days from the date the claim arises under the Policy;
- b) within ninety (90) days from the date a claim arises under the Policy, furnish Global Excel such proof of claim as is reasonably possible in the circumstances of the Emergency giving rise to the claim and the loss occasioned thereby, the right of the claimant to receive payment, his or her age and the age of the beneficiary, if relevant; and
- c) if required by Global Excel, provide a satisfactory certificate stating the cause for which the claim is made and the duration of the disability, if applicable.

Failure to Give Notice of Proof

Failure to give notice of claim or furnish proof of claim within the prescribed period above does not invalidate the claim if the notice or proof is given or furnished as soon as is reasonably possible, and in no event later than one (1) year from the date of Injury or the date a claim arises under the Policy on account of Sickness if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Insurer to Furnish Forms for Proof of Claim

Global Excel, on behalf of the Insurer, shall furnish forms for proof of claim within fifteen (15) days after receiving notice of claim, but where the claimant has not received the forms within that time he or she may submit his or her proof of claim in the form of a written statement of the cause or nature of the Emergency giving rise to the claim.

Claims Procedure

You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim, you must:

- a) include the Policy number, the patient's name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
- b) submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or Physician;
- c) provide the original prescription drug receipts (not cash receipts) from the pharmacist, Physician or Hospital showing the name of

- the prescribing Physician, prescription number, name of preparation, date, quantity and total cost;
- d) provide proof of the departure date(s) and return date(s);
 - e) provide written proof of claim within ninety (90) days of the date of receipt of services covered under the Policy;
 - f) provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;
 - g) sign and return the authorization form, provided by Global Excel, allowing the Insurer to recover payment from the Canadian provincial or territorial Government Health Insurance Plan. The Insurer will coordinate and pay your claim to the participating medical providers and where permitted, co-ordinate claims directly with the Canadian provincial or territorial Government Health Insurance Plan on your behalf; and
 - h) return the unused portion of your air ticket to Global Excel if the Emergency Air Transportation benefit is used.

All sums in the plan are in Canadian currency unless otherwise indicated. If you have paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Any information not provided may result in a delay in processing your claim.

All pertinent documents should be sent to:



Global Excel Management Inc
73 Queen St.
Sherbrooke, Quebec
J1M 1J3

Tel: 1-866-870-1898 (toll free) or (819) 566-1898 (collect)
during business hours (EST)

Exclusions

The following are not included as Eligible Expenses under your EHC plan:

- 1) any other item not specifically included as a benefit;
- 2) except as specifically included in this booklet: dentures or dental treatments, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamin preparations, contraceptives, fertility drugs, erectile dysfunction drugs, medications used to treat or replace an

- addiction or habituation, support stockings, orthotics, arch supports, and professional services of physicians or any person who renders a professional health service in the patient's province of residence;
- 3) general anaesthetic, medications used to prevent baldness or promote hair growth, food and mineral replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription;
 - 4) any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury;
 - 5) allergy testing unless rendered by a naturopath;
 - 6) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures;
 - 7) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English;
 - 8) any payment to a pharmacy, a practitioner, or a physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan;
 - 9) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits;
 - 10) expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications due to such treatment;
 - 11) expenses incurred outside your province of residence, due to therapeutic abortion, childbirth, or complication of pregnancy occurring within 2 months of the expected delivery date;
 - 12) charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence;
 - 13) transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind;
 - 14) expenses of a Dependent hospitalized at the time of enrolment;
 - 15) services performed by a physician who is related to or residing with you or your Spouse;
 - 16) fees for ambulance services when an ambulance is called but not used;

- 17) ambulance charges for work-related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility; or
- 18) retroactive coverage and payment of any expense, including expenses that receive special authorization from Pharmacare.

Claims

- 1) Because the Plan does not return receipts after the claim is processed, it is recommended that you keep a photocopy of the receipts that you submit to the Plan. You will receive a remittance statement for your records each time you submit a claim.
- 2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained by the Plan, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.
- 3) Certain medical expenses are covered under the government plan. If you submit your claim to the Plan before you submit your claim to the government plan, the Plan will deduct any amounts the government plan would normally pay (e.g. Pharmacare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design.
- 4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
 - a) Obtain a claim form from the Plan Administrator or the Union Hall
 - b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
 - c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, you must submit the claim form by **June 30th** of the year following the calendar year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances. **Example:** Your claim must be received for your receipts for 2003 before June 30, 2004.

DENTAL CARE

<i>Deductible</i>	No Deductible		
<i>Reimbursement</i>	Plan A	Plan B	Plan C
	Basic Services	Major Restorative Services	Orthodontic
	100%	75%	75%
<i>Frequency</i>	Each Calendar Year	Each Calendar Year	Lifetime
<i>Financial Limit Per Dependent Child</i>	Not Applicable	Not Applicable	\$2,500
<i>Financial Limit Per Member of Spouse</i>	Not Applicable	Not Applicable	\$2,500
<i>Dependent Children</i>	Covered from birth to age 21, or age 25 if in full-time attendance at a school or university, or any age if handicapped. See General Information for more details.		

Definitions

Fee Guide

means the Canadian Provincial/Territorial Dental Fee Guide that contains Dental services and fees in effect on the date the Dental services are performed.

Fee Schedule

means Schedule 2 of the Fee Schedule that contains eligible Dental services, financial limits, treatment frequencies, and fees in effect on the date the Dental services are performed.

Payment of Benefit

- 1) The Plan will pay benefits based on Dental services, financial limits and treatment frequencies in the Fee Schedule.

- 2) The Plan will apply the reimbursement percentage shown on the previous page to the fees shown in the Fee Schedule/Fee Guide as follows:
 - a) For services performed in British Columbia or outside Canada, if your province of residence is British Columbia – the fees in the Fee Schedule.
 - b) For services performed in Canada but outside British Columbia – the fees in the Fee Guide in the province/territory of service.
 - c) For services performed outside Canada if your province of residence is not British Columbia – the fees in the Fee Guide in your province/territory of residence.
- 3) Fees in excess of the amount shown in the applicable Fee Schedule/Fee Guide will be your responsibility.

Plan A - Basic Preventive & Restorative Services

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible Expenses per person include, but are not limited to, the Basic Services shown below.

Diagnostic Services

- a) examinations:
 - i) complete – provided the Plan has not paid for any other exam by the same dentist in the past 6 months – 1 per 3-year period;
 - ii) recall – 2 per calendar year;
 - iii) specific – provided the Plan has not paid for any other exam by the same dentist in the past 60 days; and
 - iv) consultations (as a separate appointment) – 2 per calendar year.
- b) x-rays
 - i) diagnostic;
 - ii) panoramic – 1 per 2-year period; and
 - iii) complete mouth series – 1 per 3-year period.

All x-rays combined shall not exceed the dollar limit for a complete mouth series.
- c) diagnostic models – 1 set per calendar year

Preventive Services

- a) scaling;
- b) polishing – 2 per calendar year
- c) topical application of fluoride – 2 per calendar year;
- d) fixed space maintainers; and
- e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2-year period. No age limit.

Restorative Services

- a) Fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2-year period for amalgam (silver coloured) fillings and or composite (tooth coloured) fillings.
- b) Stainless steel crowns on primary and permanent teeth – once per tooth in a 2-year period.
- c) Inlays on onlays – only 1 inlay, onlay, or another major restorative service on the same tooth will be covered in a 5-year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including but not limited to root canals – 1 per tooth in a 5-year period.

Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:

- a) occlusal adjustment and recontouring – a combined yearly limit shown in Fee Schedule;
- b) root planing;
- c) gingival curettage – 1 per sextant in a 5-year period; and
- d) osseous surgery – 1 per sextant in a 5-year period

Prosthetic Repairs

- a) removal, repairs and recementation of fixed appliances;
- b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2-year period;
- c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5-year period; and
- d) gold foil – only when used to repair existing gold restorations.

Surgical Services

- a) extractions;
- b) other routine oral surgical procedures; and
- c) anaesthesia in conjunction with surgery shall not exceed the dollar limit shown in Fee Schedule.

Plan B – Major Restorative Services

You are eligible for Plan B Services when your dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where Basic Restorative methods cannot be used satisfactorily).

Mounted x-rays and/or diagnostic casts may be required for approval.

Only 1 Major Restorative Service involving the same tooth will be covered in a 5-year period.

Plan B Services include, but are not limited to, the following:

Prosthetic Services

- a) removable:
 - i) complete upper and lower dentures;
 - ii) partial upper and lower dentures;
- b) fixed bridges.

Restorative Services

- a) veneers;
- b) crowns and related services; and
- c) inlays and onlays involved in bridgework.

Periodontal Appliances

Bruxing guards – 2 appliances in a 5-year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

Limitations

- 1) Only 1 inlay, onlay, or another Major Restorative Service on the same tooth will be covered in a 5-year period.
- 2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.
- 3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
- 4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
- 5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in the Fee Schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of the alternative material.

Plan C – Orthodontics

Benefits are payable for Orthodontic Services performed on or after the effective date of your coverage.

Limitations:

- 1) The lifetime benefit maximum under Plan C is \$2,500.
- 2) No benefit is payable for the replacement of appliances which are lost or stolen.
- 3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.

Emergency Treatment Outside Your Province of Residence

You are entitled to the services of a dentist if, while travelling or on vacation outside your province of residence, you require emergency Dental care. You will be reimbursed according to the Fee Schedule.

Exclusions

The following are not Eligible Expenses under the Dental Plan:

- 1) Items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- 2) Any item not specifically included as a benefit;
- 3) Charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English;
- 4) Procedures performed for congenital malformations or for purely cosmetic reasons;
- 5) Charges for drugs, pantographic tracings, and grafts;
- 6) Charges for implants and/or services performed in conjunction with implants, except as indicated in the Fee Schedule;
- 7) Anaesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- 8) Charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint;
- 9) Incomplete or temporary procedures;
- 10) Recent duplication of services by the same or different dentist;
- 11) Any extra procedure which would normally be included in the Basic Service performed;
- 12) Services or items which would not normally be provided, or for which no charge would be made, in the absence of Dental benefits; and
- 13) Travel expenses incurred to obtain Dental treatment.

Claims

- 1) Present your ID card to your dentist's office. It is important to ask if your Dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your dentist submit an outline of the proposed services to the Plan **before your start treatment**. This is important especially when your dentist is recommending extensive Dental work. This will help you understand what portion of the dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your dentist.

- 2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will the Plan pay any claim or adjustment submitted later than 1 year from the date the service is performed.
- 3) the Plan requires a separate claim form for each member of your family who has received Dental services. Be sure to include the following information on the claim form:
 - a) Name of the dentist;
 - b) Name and birthdate of the person receiving the Dental care
 - c) Your group, social insurance, and Dependent(s) numbers (this information is on your ID card;
 - d) Your home mailing address; and
 - e) Whether you have coverage through another plan. Claims information regarding the other carrier is not retained on file. If you or your Dependents are covered by two plans, your dentist must complete two separate Dental claim forms (one for each plan). Incomplete claims will be returned for clarification.
- 4) Before your dentist starts treatment, please ask how billing is made. The Plan may pay in either of two ways:
 - a) The Plan will pay the dentist directly for services provided under this Dental Plan when a claim form signed by the dentist is received by the Plan, certifying these services were performed and the fee charged.
 - b) If you have paid your dentist directly, the Plan will reimburse you the benefit amount when a claim form or receipts signed by your dentist are received. You will receive a cheque when the claim is processed.
- 5) Orthodontic Claims Procedures
 - a) Receipts:

Because the Plan does not return original receipts, photocopies will be accepted. Do not hold receipts until the completion of treatment.
 - b) Claiming Deadlines:
 - i) It is suggested that you submit Orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
 - ii) Reimbursement is made if the complete and correct claims information is received within 1 year of the due date. However, no benefit is payable for claims not received within **1 year** of the due date.

- c) Treatment Plan:
 - i) Have your orthodontist complete the “Certified Specialist in Orthodontics Standard Information Form” (the treatment plan) before treatment starts.
 - ii) If the payment schedule or treatment changes, the Plan requires a revised treatment plan for review.
 - iii) The Plan will retain your treatment plan on file. If your treatment plan is not on file the Plan is unable to pay:
 - your initial fee/down payment;
 - your monthly/quarterly fees; or
 - one time appliance fees;
 - iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.
- d) Monthly or Quarterly Fees:
 - i) Submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses.
 - ii) The amount paid will be pro-rated over the estimated months of active treatment. For example, when braces are on the teeth, the estimated length of treatment will be on the treatment plan.
 - iii) As long as your coverage is in effect, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

WAGE INDEMNITY

The Plan

The Plan will pay Wage Indemnity (WI) benefits when you are Totally Disabled and prevented from working as a result of an accident or sickness for which Workers’ Compensation benefits are not payable.

<i>Weekly Benefit Amount</i>	The current Employment Insurance (EI) maximum		
<hr/>			
<i>Elimination Period</i>	Injury	Hospital	Sickness
	0 days	0 days	3 days
<hr/>			

Employment Insurance (EI) Carve-Out If you are eligible for Employment Insurance benefits:

- a) we will provide benefits for the first 2 weeks of disability, and
- b) EI will provide benefits from the 3rd to the 17th week of disability, and
- c) we will provide benefits for an additional 9 weeks of disability.

Maximum Benefit Period 26 weeks with the following exception: if you reach termination age while receiving benefits and have then received payments for less than 15 weeks, benefit payments will continue during disability until you receive 15 weeks of benefits.

Termination Age 65 or earlier retirement

The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a physician or chiropractor – whichever is later – and will be paid only during periods of disability when you are under his or her regular care and following the treatment prescribed. Certification of disability beyond a 6 week period must be made by a physician.

Recurrent Disability

A recurrent disability means a disability that is related to or due to the same cause(s) as a prior disability for which you received benefit payments. A recurrent disability will be considered part of the prior disability if, after receiving WI benefits, you returned to work on a full-time basis and were able to perform all the essential duties of your occupation for less than 2 weeks. Once you have resumed work on a full-time basis and have been at work for 2 consecutive weeks, any subsequent injury or sickness will be considered a new disability.

Extended Benefit

If you are Totally Disabled when this insurance terminates, your WI benefits will continue as though your insurance had not terminated, up to the maximum benefit period, provided you remain Totally Disabled.

Coordination with other Income Sources

Your WI payment will be coordinated with benefits received from other sources so that the total benefits received, for the same disability, will not exceed your normal take home pay on the date you became Totally Disabled.

Third Party Liability

Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse the Plan when you receive payment from the third party.

Are Benefits Taxable?

Benefits are taxable as your employer contributes to the cost of your WI Plan.

Termination of Benefit

Your benefit payments will cease on the earliest date one or more of the following occurs:

- 1) you are no longer disabled;
- 2) you are no longer receiving continuing medical care and treatment from your physician;
- 3) you fail to submit satisfactory proof of continuing disability as required by the Plan;
- 4) you refuse a medical examination by a physician chosen by the Plan;
- 5) you are no longer following the treatment recommended for your disability;
- 6) you leave the province, state or country where you normally work and live, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by the Plan.
- 7) you perform any work for compensation or profit;
- 8) the end of the maximum benefit period indicated in the Schedule of Benefits;
- 9) you retire; or
- 10) you die.

Exclusions

Benefits are not payable for any period of disability:

- 1) arising from any of the following:
 - a) self-inflicted injury or sickness;
 - b) participation in a criminal offense;
 - c) civil commotion, insurrections, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation;
 - d) pregnancy related sickness
 - i) during any period of formal maternity leave and/or parental leave;
 - ii) during any period in which Employment Insurance (EI) benefits are being paid;
 - e) substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician; or
 - g) medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness.
- 2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless the plan has agreed in writing;
- 3) while you are
 - a) in a jail or penitentiary;
 - b) on leave of absence or paid vacation;
 - c) receiving benefits for the same or related disability from WCB or similar legislation; or
- 4) if you become disabled during a strike or lockout at your place of employment; however, your right to benefits will be reinstated when the strike or lockout ends.

Claims

The following steps must be taken as soon as possible after becoming "disabled" (unable to work):

- a) Obtain an E.I. Claims Kit from a post office or the Employment Office. **The physician's report must be completed and a copy sent to the Administrator's office.**
- b) If the Member is **not** eligible for EI Sick benefits, he/she must obtain the *2-page Machinists Fitters and Helpers Union Local #3 CLC Welfare Plan Wage Indemnity Benefits Claim form* from the Administrator's office, as he/she is entitled to submit a claim to the Wage Indemnity Plan, provided that a copy of the EI rejection letter accompanies the claim. **Claimants must be under the care of a physician and be treated in person during the period claimed for.**
- c) Complete Section 1 of the claim form.

- d) The attending physician must complete Section 2 of the claim form. If there is any charge for completing this form, it is the claimant's responsibility.
- e) Send the second page of the claim form to the employer to complete Section 3.
- f) All pages of the claim form must be completed and presented to the Administrator's office within 30 days unless specified circumstances prevent such.

LONG TERM DISABILITY

The purpose of this benefit is to provide coverage should you become Totally Disabled as a result of an accidental injury or sickness and are unable to work at any occupation, for wage or profit.

Your taxable benefit is determined as follows:

<i>Monthly Benefit Amount</i>	Flat \$1,000 or 85% of your pre-disability gross salary, whichever is less.
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<i>Elimination Period</i>	Benefits commence on the 181st day of continuous/consecutive disability
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<i>Definition of Total Disability</i>	Shall mean disability as a result of Injury or Sickness, to the extent that the Member is under the regular care and following the prescribed treatment of a physician and is prevented from engaging in any occupation or performing any work of any sort for wage, remuneration or profit or for which the Member is able or may reasonably become able by means of education, training or experience.
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If you become Totally Disabled while you are on a lay-off, you will not be eligible for benefits until the date you are recalled to work. Your benefits will start on that date provided you have served the 180 day qualifying period. If you have not served the qualifying period on the date you are recalled to work, your benefits will start at the end of the 180 days after your recall date.

In no case shall a benefit be paid beyond:

- the attainment of your 65th birthday, or
- retirement or normal retirement date, or the date you withdraw pension funds, or

- the date you engage in any work for wage or profit, or
- the date you are no longer disabled, or fail to furnish satisfactory evidence of continuance of disability, or
- the date you refuse to submit to a medical examination by a physician chosen by the insurance company, or
- your date of death,

whichever first occurs.

Successive periods of disability arising from the same or related cause and separated by less than six months will be treated as one period of continuous Total Disability.

Benefit Adjustment

At the time of a claim, your Long Term Disability Benefit will be reduced by any disability benefits you are entitled to receive from the Workers' Compensation Act, Canada Pension Plan or Quebec Pension Plan, any criminal injuries compensation legislation and any automobile insurance act. The reduction will also include any CPP or QPP retirement benefits, however, will not include any additional amounts payable for dependents or cost of living increases.

If necessary, your Long Term Disability will be further adjusted so that your **total income** will not exceed 85% of your pre-disability gross salary (net salary if your benefit is non-taxable). This applies to disability benefits from any other source including: pension plan; employer funded salary replacement/ other insurance plan whether group or association; damages for loss of income which are payable from any legal action; employment income other than from an approved rehabilitation program; and severance.

Rehabilitation Program

Based on a determination made by The Co-operators, a rehabilitation program may be provided to you which could include: assessment (medical, psychological, vocational evaluation), treatment (medical, psychological, vocational intervention, including various programs of therapy), employment (work trial, modified/full or part-time work), services (training strategies and work related activities expected to enhance your ability to return to work or secure employment) and a rehabilitation benefit.

The Co-operators will have the sole right and discretion in determining whether a rehabilitation program will be provided to you and the

services provided as part of that program. If you do not participate in a rehabilitation program provided either by The Co-operators or by another party approved by The Co-operators (i.e. any worker's compensation act or similar statute, auto plan benefits, Canada/Quebec Pension Plan) or The Co-operators withdraws approval of your program, then your disability/rehabilitation benefits under this policy will cease.

While you participate in the rehabilitation program your disability benefits will continue, but will be reduced by 50% of any rehabilitative earnings (total earnings from your rehabilitation employment if your benefit is taxable, total earnings less income tax, EI, CPP/QPP if your benefit is non-taxable). Your benefit may be further reduced so that your rehabilitative earnings plus your disability benefit do not exceed 100% of your pre-disability income (gross if your benefit is taxable, net if your benefit is non-taxable).

Any rehabilitation program will not extend beyond the end of your own occupation period. Nothing in the rehabilitation program or provision will create any basis for any extension of the own occupation period.

Third Party Liability

If you become Totally Disabled due to an injury or disease for which a third party is or may be legally liable, benefits will be paid when you sign (and submit to The Co-operators) a Reimbursement Agreement.

You will be required to reimburse The Co-operators for benefits received in accordance with the terms and conditions stated in the Reimbursement Agreement.

You must obtain the written consent of The Co-operators before compromising or settling the action or cause of action with the third party. Failure to do so may disentitle you to any future benefits under this policy.

Total Disability Waiver of Premium

Premiums will be waived while you are receiving disability benefits commencing with the first premium that falls due after the first benefit payment is eligible to be made.

Exclusions

No benefit will be payable for any disability resulting from or caused by:

- intentionally self-inflicted injury, while sane or insane, or
- insurrections, war or hostilities of any kind, or
- riot or civil commotion regardless of whether you were participating, or
- injury occurring while committing or attempting to commit a criminal offense, or
- medical or surgical care which is cosmetic in nature or medical care or surgery that is not medically necessary. However, periods of disability due to the donation of an organ or tissue will be covered, or
- use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment from a rehabilitation centre or an institution provincially recognized for that treatment, or
- injury or sickness for which a third party is liable, except as provided for in the third party liability section.

No benefit will be payable for any disability if you are imprisoned or if you are not under continuous care and treatment by a physician who is certified by the Royal College of Physicians and Surgeons in a speciality appropriate to your sickness or injury.

No benefits will be payable during any period that you are on maternity leave, parental leave or any other leave of absence.

No further benefits will be payable from the date you refuse to participate in any rehabilitation program approved by The Co-operators.

Submitting a Claim

The time limit within which a Long Term Disability claim must be made is 90 days from the date The Co-operators is liable.

Termination Age

Your Long Term Disability coverage terminates at age 65.

ADMINISTRATOR

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