IUPAT Local 177 Welfare Trust Fund

Group Insurance Benefit Plan Booklet

All Active Employees

Maximum Benefit
Firm Nos.

48598
48606
48607

IUPAT Local 177
Welfare Trust Fund

All Employees

Important:
To avoid delays, always include your Full Name and Identification Number, your Employer Name and your Group Number on any claim forms or correspondence submitted.

Changing your Records:
To ensure that coverage is kept up to date for yourself, it is vital that you advise Funds Administrative Service Inc. (FAS) of any changes such as a change of name, change in marital status or change of beneficiary. Changes reported more than 31 days after the date of change may require evidence of insurability.

Disclaimer:
This booklet outlines the benefits that are available under your employer's Group Policy and/or Plan Document. In the event of a discrepancy between this document and the Group Master Policy or Plan Document, the latter will govern.

IUPAT Local 177 Welfare Trust Fund

Life, Dependent Life & Short-Term Disability
Underwritten by:
Sun-Life Financial
Group Policy No. 22394

Extended Health Care & Dental Care
Provided by:
IUPAT Local 177 Welfare Trust Fund
Firm Nos. 48598, 48606 & 48607

Emergency Medical Travel Assistance
Underwritten by:
Co-operators Life
Group Policy No. 7949

Member and Family Assistance Program
Administered by:
Homewood Health Inc.

IUPAT Plan Administrator
Funds Administrative Service Inc. (FAS)
10154 – 108 Street NW
Edmonton, AB T5J 1L3

Local: (780) 452-5161
Toll Free: (800) 770-2998
Fax: (780) 452-5388
Email: info@fasadmin.com

Administered by:
Maximum Benefit
582 King Edward Street
Winnipeg, MB R3H 0P1

Toll Free: (800) 893-7587
Fax: (877) 526-2515

Benefits Arranged by:
Phil Rivard, FSA FCIA
Vice President
Segal Consulting
10215 – 178 Street NW
Edmonton, AB T5S 1M3

***All Paper Claims must be sent to:**
Maximum Benefit
582 King Edward Street
Winnipeg, MB R3H 0P1

Electronic Submission of Dental Claims is accepted

INTRODUCTION

ABOUT THIS PLAN

The IUPAT Local 177 Welfare Trust Fund is controlled by the Board of Trustees of the IUPAT Local 177 Benefit Trust Funds.

Contributions are made to the Fund by the employers who are signatory to the Collective Agreement with the International Union of Painters and Allied Trades. Such employers are called "Contributing Employers" in this Booklet.

An account is kept by the IUPAT Plan Administrator for each member, showing the hours reported monthly by the Contributing Employer. This account is called the Hour Bank Account.

This Booklet is for your reference and general information only, and is not the original contract nor does it grant or confer any contractual rights. In the following pages you will find a brief description of the benefits to which you are entitled, the rules governing eligibility for these benefits and the procedures to follow when making a claim.

All rights and benefits are determined in accordance with the Plan Document or, where applicable, the Master Policy. The Trustees have full authority to make decisions on issues that arise regarding any portion of the Plan.

In order to enroll in the Plan, you must fully complete the IUPAT Local 177 Welfare Trust Fund Registration/Change Form. This form can be obtained from Funds Administrative Service Inc. (FAS). The information contained on this form provides the Administrator with a record of your personal data, which forms a very important basis of your file. You must report changes to your marital status, dependent information and/or your beneficiary designation by completing the appropriate form, which can be obtained from FAS or the Local Union office.

ABOUT THE HOUR BANK

When You Become Covered Initially

You and your eligible dependents will become covered on the first day of the second month following accumulation of 300 hours in your Hour Bank Account, provided you are actively at work or available for work on the day you would ordinarily become covered.

Should you not be working, or available for work, on the day your coverage would ordinarily start, insurance for you and your dependents will be delayed until you return to work or are available for work. A member must accumulate these 300 hours in the six month period from the date of the first contribution. If the 300 hours are not accumulated within the specified six month period, all hours are forfeited.

Reinstatement

If your coverage has previously terminated, you will again be covered on the first day of the second month in which you have accumulated 200 hours in your Hour Bank Account, provided your period of termination did not exceed six months. If you were not covered through the Plan for more than six months, you must meet the initial eligibility rule of 300 hours prior to becoming eligible for coverage.

Should you not be working, or available for work, on the day your coverage would ordinarily become reinstated, coverage for you and your dependents will be delayed until you return to or are available for work.

INTRODUCTION

Maximum Accumulation
The number of hours in your Hour Bank Account may never exceed 1,200 hours (enough to provide 12 months of coverage, even if you acquire no hours during that period). Hours in excess of 1,200 will be credited to the reserves of the Welfare Trust Fund.

Monthly Deduction
Each month, 100 hours will be deducted from your Hour Bank Account to provide benefit coverage.

Self-Pay Option
If you have less than 100 hours in your Hour Bank Account, you can make direct payments to the Fund to maintain your coverage, provided you are a member in good standing with the Union and are registered with the Union and available for work and are not working or employed by any employer who carries out any work that falls within the jurisdiction of the Union and who does not contribute to the Benefit Trust Fund under the terms of a Collective Agreement.

Once your Hour Bank Account is exhausted, the Trustees have initiated a provision enabling members to make self-payments to continue their benefit coverage for up to three (3) months.

Funds Administrative Service Inc. (FAS) will send you a Self-Pay Notice. The amount of this Self-Pay Notice is determined by the Board of Trustees and may change from time to time.

Any member making a claim under the Benefit Plan while working or employed on any work that falls within the jurisdiction of the Union shall be limited to reimbursement of premiums only.

Apprentices While Attending Required Schooling
Coverage will be maintained while a member is attending required schooling. No deductions will be made from the member's Hour Bank Account (Hour Bank is frozen) during this period. The period will commence on the first of the month coinciding with or immediately following the date of the required schooling, and end with the month that the schooling ends. You must complete a Request for Freezing of Hours Form and provide the necessary proof of attendance to FAS in order to qualify for this extension of coverage.

Continuation of Coverage While Disabled
No deductions will be made from a member's Hour Bank Account (Hour Bank is frozen) in any calendar month while the member is disabled and in receipt of Workers' Compensation Benefits (WCB), Employment Insurance Sickness Benefits (EI) or Short-Term Disability Benefits through the IUPAT Local 177 Welfare Trust Fund. The maximum period an Hour Bank Account may be frozen for a disabled member is twelve (12) months. The period will commence as of the date FAS receives a completed Request for Freezing of Hours Form and submits satisfactory proof of disability.

Booklet Effective Date: August 1, 2016
Effective Date of Plan: July 1, 2002

If you require any additional information, contact Funds Administrative Service Inc.

Date Issued: August 2016

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Section I

Life
Dependent Life
Short-Term Disability

GENERAL INFORMATION

The information contained in this section applies only to benefits insured by Sun Life of Canada.

About this booklet

The information in this employee booklet is important to you. It provides the information you need about the group benefits available through your employer's group contract with Sun Life Assurance Company of Canada (Sun Life), a member of the Fun Life Financial group of companies.

Your group benefits may be modified after the effective date of this booklet. You will receive written notification of changes to your group plan. The notification will supplement your group benefits booklet and should be kept in a safe place together with this booklet.

If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority.

If you have any questions about the information in this employee benefits booklet, or you need additional information about your group benefits, please contact Funds Administrative Service Inc. (FAS).

Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are a permanent employee.
- you must qualify under the hour bank, and have accumulated at least 300 hours in a 6 month period from the date of the first contribution.
- you have completed the waiting period.

The waiting period for your group plan ends on the last day of the month following the month in which you have completed 300 hours of service within a 6 month period.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3 months if you were actively working on the last scheduled working day. We consider you to be actively working for as long as there are hours remaining in your hour bank and you are in good standing with the union. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

You must be registered with and in good standing with the union and have accumulated hours in your hour bank to be eligible for coverage. You can accumulate up to 1200 hours in the hour bank which provides 12 months of coverage. You will continue to accumulate hours while working.

If you have less than 100 hours banked and are in good standing, registered with the union and are available for work, you can self pay up to a maximum of 3 months for benefits. You must not be working or employed by any employer who carries out any work that falls within the jurisdiction of the union and who does not contribute to the benefit trust fund under the terms of a collective agreement.

Once your Hour Bank Account is exhausted, the Trustees have initiated a provision enabling you to make self-payments to continue your benefit coverage for up to 3 months.

Coverage of an employee who was previously covered under this contract and who is re-employed by the employer within 6 months of terminating employment will again be eligible for coverage on the first day of the second month in which the employee has accumulated 200 hours in the employee's hour bank.

Who qualifies as your dependent

Your dependent must be your spouse or your child and a resident of Canada.

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who is publicly represented as your spouse, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 18.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 25 as long as the child is entirely dependent on you for financial support.

If a child becomes handicapped before the limiting age, we will continue coverage as long as:

- the child is incapable of financial self-support because of a physical or mental disability, and
- the child depends on you for financial support, and is not married nor in any other formal union recognized by law.

In these cases, you must notify Sun Life within 31 days of the date the child attains the limiting age. Funds Administrative Service Inc. (FAS) can give you more information about this.

Enrolment

You have to enrol to receive coverage. To enrol, you must complete the IUPAT Local 177 Welfare Trust Fund Registration/Change Form and mail it to FAS. For a dependent to receive coverage, you must complete the IUPAT Local 177 Welfare Trust Fund Request for Over-Age Dependent Coverage and forward the necessary proof of attendance or proof of disability documents to FAS.

When coverage begins

Your coverage begins on the date you become eligible for coverage.

If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work.

Dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

However, for a dependent, other than a newborn child, who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities.

Once you have dependent coverage, any subsequent dependents will be covered automatically.

If there are additional conditions for a particular benefit, these conditions will appear in the appropriate benefit section later in this booklet.

Changes affecting your coverage

From time to time, there may be circumstances that change your coverage.

For example, your employment status may change, or your employer may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

The following exceptions apply if the result of the change is an increase in coverage:

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

Updating your records

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to FAS:

- change of dependents.
- change of name.
- change of beneficiary.

When coverage ends

As an employee, your coverage will end on the earlier of the following dates:

- the date your employment ends or you retire.
- the date you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

A dependent’s coverage terminates on the earlier of the following dates:

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.
- the end of the period for which premiums have been paid for dependent coverage.

The termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the appropriate section of this employee benefits booklet.

However, if you die while covered by this plan, coverage for your dependents will continue until the earlier of the following dates:

- the date the person would no longer be considered your dependent if you were still alive.
- the last day of the third month following the month in which you die.
- the end of the period for which premiums have been paid for dependent coverage.
- the date the benefit provision under which the dependent is covered terminates.

GENERAL INFORMATION

Replacement coverage

The group contract will be interpreted and administered according to all applicable legislation and the guidelines of the Canadian Life and Health Insurance Association concerning the continuation of insurance following contract termination and the replacement of group insurance.

Sun Life will not be responsible for paying benefits if an insurer under a previous group contract is responsible for paying similar benefits.

If such legislation or guidelines require that Sun Life resume paying certain benefits because of a recurrence of an employee's total disability, Sun Life will resume payment at the same amount and for the remainder of the maximum benefit period.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact FAS to get the proper form to make a claim.

There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

All claims must be made in writing on forms approved by Sun Life.

For the assessment of a claim, Sun Life may require medical records or reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

Legal actions

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against Sun Life:

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or
- regarding claims for disability benefits that have been paid by Sun Life for some period of time, more than one year after the last date for which disability benefits have been paid, or

- regarding all other claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim, or
- regarding claims for *Coverage during total disability* which are initially approved, more than one year after the date you cease to be covered or your premiums cease to be waived.

Proof of disability

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

Medical examination

We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, we will not pay any benefit.

Recovering overpayments

We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.

Definitions

Here is a list of definitions of some terms that appear in this employee benefits booklet. Other definitions appear in the benefit sections.

Accident

An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.

Appropriate treatment

Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.

Basic earnings

Basic earnings are the salary you receive from your employer excluding any bonus, overtime or incentive pay.

Doctor

A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.

Illness

An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

Retirement date

If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

We, our and us

We, our and us mean Sun Life Assurance Company of Canada.

SHORT-TERM DISABILITY (WEEKLY INDEMNITY)

Insurer

This benefit is insured by Sun Life of Canada.

General description of the coverage

Short-Term Disability coverage provides a benefit if you become totally disabled. You qualify for this benefit if you present proof of claim acceptable to Sun Life that:

- you became totally disabled while covered, and
- you have been following appropriate treatment for the disability since its onset.

For the purposes of your Short-Term Disability coverage, you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation

Your benefits will be based on your coverage on the date you became totally disabled. Benefits are paid at the end of each week for which you are entitled to payments.

When disability payments begin

If you become totally disabled, you will be eligible for Short-Term Disability payments after 119 days of uninterrupted total disability or the first day you consult a doctor, whichever is later.

This period, which must be completed before disability benefits become payable, is the **elimination period**.

If you are totally disabled for part of any week, we will pay 1/7 of the weekly benefit for each day you are totally disabled.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for at least 119 uninterrupted days and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

Interrupted periods of disability

If you had a total disability for which we paid Short-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous total disability if it occurs within 2 weeks of the end of your previous disability. You must be covered when the total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability and will be paid for no longer than the rest of the maximum benefit period.

SHORT-TERM DISABILITY (WEEKLY INDEMNITY)

What we will pay

Here is how we calculate your Short-Term Disability payments. All references to income in this disability provision are to the gross amounts before any deductions.

Step 1: We take the maximum sickness benefit under the Employment Insurance Act.

Step 2: We subtract any income provided to you:

- under a motor vehicle insurance plan which provides disability benefits as long as any benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the motor vehicle insurance plan, and as long as the law does not prohibit such a deduction.
- under a group plan, including a multiple-employer group plan.
- as part of a salary continuance received from your employer during your disability.
- under the Québec Parental Insurance Plan.

After the first 17 weeks of total disability, when the maximum benefit period is more than 17 weeks, we also subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases that occur after benefits begin.
- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- under any coverage resulting from your membership in an association of any kind.

The result from Step 2 is the amount you would normally receive as a Short-Term Disability payment. However, if the amount calculated under Step 2, plus the above sources of income, exceeds 85% of your pre-disability basic earnings (after income tax, if the benefit is non-taxable), your Short-Term Disability payment is reduced by the excess.

If you are eligible for any of the income amounts above and do not apply for them, we will still consider them part of your income. We can estimate those benefits and use those amounts when we calculate your payments.

If you receive any of the income amounts above in a lump sum, we will determine the equivalent compensation this represents on a weekly basis using generally accepted accounting principles.

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

We have the right to adjust your benefit payments when necessary.

Maternity / parental leave of absence

Maternity leave agreed to with your employer will begin on the date you and your employer have agreed will be the start of your leave or the date the child is born, whichever is earlier. The leave will end on the date you and your employer have agreed that you will return to active, full-time work or the actual date you return to active, full-time work, whichever is earlier.

Parental leave is the period of time that you and your employer have agreed on.

Sun Life will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth.

Short-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for 119 uninterrupted days, provided your coverage has been continued.

However, if your employer has a Supplemental Unemployment Benefit (SUB) plan as defined in the Employment Insurance regulations covering the health-related portion of the maternity or parental leave, Sun Life will not pay any benefits under this plan during any period benefits are payable to you under your employer's SUB plan.

If you recover damages from another person

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

If you recover money, you must pay us 75% of your net recovery or the total disability income benefits paid or payable to you under this plan, whichever is less. Your net recovery does not include your legal costs. Seventy-five percent of your net recovery must be held in trust for us.

SHORT-TERM DISABILITY (WEEKLY INDEMNITY)

We have the right to withhold or discontinue disability income payments if you refuse or fail to comply with any of these terms.

When payments end

Your Short-Term Disability payments end on the earlier of the following dates:

- the date you are no longer totally disabled.
- the end of a maximum benefit period of 35 weeks of payment.
- the date you retire on pension.
- the date you die.

When coverage ends

Your Short-Term Disability coverage will end on the day you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

If the Short-Term Disability benefit terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the benefit were still in effect.

What is not covered

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence*. However, if you become totally disabled before a notice of separation is given, payments continue while you are totally disabled, but not beyond the end of the maximum benefit period.
- you are absent from Canada longer than 4 weeks due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

We will not consider you totally disabled if your disability results from drug or alcohol abuse. However, this limitation will not apply while you are participating in a Sun Life approved treatment program or you have an organic disease which would cause total disability even if drug and alcohol abuse ended.

We will not pay for total disability resulting from:

- a bodily injury sustained while doing any act or thing pertaining to any occupation or employment for wage or profit.
- any cause for which benefits are payable to you under any Workers' Compensation Act or similar legislation.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.

- intentionally self-inflicted injuries or attempted suicide, while sane or insane.
- participation in a criminal offence.

When and how to make a claim

To make a claim, claim forms that are available from FAS must be completed. You, the attending doctor and the Plan Sponsor will all have to complete claim forms.

In order for you to receive benefits, we must receive these forms no later than 30 days after the end of the elimination period. In any event, we must receive notice of claim within 30 days of the termination of this Short-Term Disability benefit.

We will assess the claim and send you or the Plan Sponsor a letter outlining our decision.

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

LIFE COVERAGE

Insurer

This benefit is insured by Sun Life of Canada.

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your dependents' Life coverage provides a benefit if one of your dependents dies while covered.

Life coverage for you

Amount

Your Life benefit is $75,000.

Reduction

Your benefit will reduce to 50% when you reach age 65.

Coverage ends

Your coverage will end when you retire or reach age 70 or the date on which you exhaust your hour bank, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Life coverage for your dependents

Amount

Your spouse’s benefit is $15,000. Your children's benefit is $7,500 per child.

Coverage ends

Coverage for your dependents will end when you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Who we will pay

If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

If a dependent dies, Sun Life will pay you the benefit for that dependent.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and desire to designate a minor as your beneficiary, you may wish to designate someone else to receive the death benefit in trust for the minor. If a trustee is not designated, applicable legislation may require that a death benefit payable to a minor be paid instead to a court, or guardian or public trustee. If you reside in Québec and have designated a minor as beneficiary, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor’s behalf. Alternatively (and regardless of whether you reside outside or in Québec), you may wish to consider designating your estate as beneficiary and provide the executor(s) with directions in your will as to the entitlement of the minor. You are encouraged to consult a legal advisor.

LIFE COVERAGE

Coverage during total disability

If you become totally disabled before you retire or reach age 65, whichever is earlier, Life coverage may continue without the payment of premiums as long as you are totally disabled. This continued coverage is subject to the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

Sun Life must receive proof of your total disability within 12 months of the date the disability begins. After that, we can require ongoing proof that you are still totally disabled.

If proof of total disability is approved after an individual insurance policy becomes effective as a result of converting the group Life coverage, the group Life coverage will be reduced by the amount of the individual insurance policy, unless the individual insurance policy is exchanged for a refund of premiums.

Total disability must continue for at least an uninterrupted period of 119 days.

This coverage will continue without payment of premiums, from the date total disability begins, until the date you cease to be totally disabled or the date you fail to give Sun Life proof of your continued total disability, whichever is earlier.

Dependent Life coverage will also continue without payment of premiums, as long as your Life coverage is continued without payment of premiums, but not after the Dependent Life benefit is terminated.

For the purposes of your Life coverage, you will be considered totally disabled if you are prevented by illness from performing any occupation you are or may become reasonably qualified for by education, training or experience.

Converting Life coverage

If your Life coverage ends or reduces for any reason other than your request, you may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

If your spouse's Life coverage ends for any reason other than your request, your spouse may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

Where necessary in order to comply with applicable legislation: If your child's Life coverage ends due to the termination of your Life coverage, you may apply to convert the group Life coverage for your child to an individual Life policy with Sun Life without providing proof of good health.

The request must be made within 31 days of the reduction or end of the Life coverage.

There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact FAS for details.

When and how to make a claim

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from FAS.

RESPECTING YOUR PRIVACY

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Section II

Extended Health Care
Dental Care

BENEFIT SCHEDULE – EXTENDED HEALTH CARE

Class 1 & 2	**All Employees**
Co-Insurance	Maximum Benefit will pay the percentages of Eligible Expenses, which are in Excess of the Deductible Amount, as follows: • In Province Hospital Eligible Expense – 100% • Prescription Drugs: – 1st Tier, Plan 49/AB* (Alberta Formulary) with generic – 90% – 2nd Tier, Plan 88G* – 75% *Drug Plan Formulary as defined by Telus Health Solutions • Vision Care Eligible Expense – 100% • Accidental Dental – 100% • All Other Eligible Expenses – 90%
Age Limit	Earlier of age 70 or retirement

Prescription Drug Coverage

Deductible	Dispensing Fee
Formulary and Maximums	• Drug Formulary 49/AB (Alberta Formulary) with generic and 88G, as defined by Telus Health Solutions • Drug coverage includes: ➢ All Eligible Prescription Drugs, including Oral Contraceptives, bearing a Drug Identification Number – Unlimited ➢ Preventative immunization vaccines and toxoids are covered • This plan includes the Prior Authorization Drug Program.

Other Coverages

Deductible	Nil
In-Province Hospital	The difference between the ward and semi-private rate, unlimited maximum
Nursing Care Maximum	$25,000 for a maximum of 12 months per condition
Ambulance Maximum	Unlimited
Paramedical Practitioners Maximum	$500 per person, per practitioner each calendar year
Convalescent / Rehabilitation Hospital Maximum	$25 per day for up to 180 days of confinement for all periods of treatment of an illness due to the same or related cases
Hearing Aid Maximum	$600 per person every 36 consecutive months
Eye Examinations Maximum	One per adult and overage dependent, maximum $100 per 24 months (12 month period for a Dependent Child under age 18)
Vision Care Maximum	Prescription Glasses & Contact Lenses – $500 per individual, once in any 24 month period - Contact Lenses for Special Conditions – $400 per individual, once in any 24 month period. Laser Eye Surgery - $300 per individual, once every 24 month period.

BENEFIT SCHEDULE – DENTAL CARE

Class 1	**All Employees with less than 1 year of service**
Deductible Amount	Nil
Co-Insurance	Maximum Benefit will pay the percentages of eligible expenses, which are in excess of the deductible amount, as follows: • Basic and Preventative Treatment – 90% • Endodontics, Periodontics – 90% for the first 6 units of scaling/root planing and 50% for any subsequent units • Major Restorative Treatment – 60% • Orthodontic Treatment (Dependent Child under 18 only) – 50%
Maximum Benefit	• Basic and Major Services combined – $1,500 • Endodontics, Periodontics combined with Basic • Orthodontic Treatment – $1,000 Lifetime
Dental Fee Guide Year	Fixed 2016 Fee Guide, General Practitioner
Dental Fee Guide Province	Province of Residence
Age Limit	Earlier of age 70 or retirement

BENEFIT SCHEDULE – DENTAL CARE

Class 2	**All Employees with more than 1 year of service.**
Deductible Amount	Nil
Co-Insurance	Maximum Benefit will pay the percentages of eligible expenses, which are in excess of the deductible amount, as follows: • Basic and Preventative Treatment – 90% • Endodontics, Periodontics – 90% for the first 6 units of scaling/root planing and 50% for any subsequent units • Major Restorative Treatment – 75% • Orthodontic Treatment (Dependent Child under 18 only) – 50%
Maximum Benefit	• Basic and Major Services combined – $2,500 • Endodontics, Periodontics combined with Basic • Orthodontic Treatment – $2,000 Lifetime
Dental Fee Guide Year	Fixed 2016 Fee Guide, General Practitioner
Dental Fee Guide Province	Province of Residence
Age Limit	Earlier of age 70 or retirement

GENERAL INFORMATION

ACCESS TO DOCUMENTS

Where provincial legislation permits, you may obtain copies of the application, evidence of insurability, plan and booklet.

LEGAL ACTIONS

Every action or proceeding against Maximum Benefit for the recovery of money payable under the benefit program is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

APPEALS

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

BENEFIT LIMITATION FOR OVERPAYMENT

If benefits are paid that were not payable under the benefit plan, you are responsible for repayment within 30 days after Maximum Benefit sends you a notice of the overpayment, or within a longer period if agreed to in writing by Maximum Benefit. If you fail to fulfill this responsibility, further benefit payments will be withheld until the overpayment is recovered. This does not limit Maximum Benefit's right to use other legal means to recover the overpayment.

DEFINITIONS

Allowable Expense Any item which is a covered expense under this plan document.

Child An unmarried child of the Employee or the Employee's spouse (excluding a foster child or a ward), who is wholly dependent on the Employee for support and:

a) is less than 18 years old.
b) is less than 25 years old, and is in full-time attendance* at an accredited institute of learning**. **[Proof of attendance is required by FAS for each child student on an annual basis.]**
c) is 18 years of age or over and is financially dependent upon the Employee because of mental or physical infirmity provided such child was financially dependent on the Employee and such infirmity has existed continuously from a time when the child was otherwise insured as a dependent under this policy. Proof of incapacity must be received by FAS within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

*Full-time attendance means at least 60% of a full course load for the academic year. It does not mean short-term courses (i.e., summer school) of less than 13 weeks duration, evening classes or minor course loads.

**Accredited institutes of learning include high school and post secondary schools (i.e., colleges, universities, technical and vocational schools) and where the student is registered for the complete year in a program leading to a degree or certificate.

Children under 18 are not covered if they are working more than 30 hours per week, unless they are full-time students.

Chronic Care Facility A legally licensed institution, including the chronic care beds of a hospital, which is eligible to receive payments under a provincial hospital plan, and which:

a) operates primarily to provide care for the chronically ill;
b) requires that every patient be under the care of a physician;
c) provides 24-hour nursing services by registered nurses;
d) is not primarily operated as a maternity home, a nursing home or a place for rest, or for the care and treatment of the aged, the blind, the deaf, the mentally ill, drug addicts, or alcoholics; and,
e) is not primarily providing custodial care.

Contributing Employer Employers who are signatory to the Collective Agreement with the International Union of Painters and Allied Trades.

Convalescent Care Facility / Rehabilitation Hospital A legally licensed institution, including the convalescent care beds of a hospital, which is eligible to receive payments under a provincial hospital plan, and which:

a) operates primarily to provide recuperative care;
b) requires that every patient be under the care of a physician;
c) provides 24-hour nursing services by registered nurses;
d) is not primarily operated as a maternity home, a nursing home or a place for rest, or for the care and treatment of the aged, the blind, the deaf, the mentally ill, drug addicts, or alcoholics; and,
e) is not operated as a chronic care facility.

Deductible An amount of eligible expenses for which no benefits are payable.

DEFINITIONS

Dental Hygienist	A person who has taken and passed a course in dental hygiene under a recognized dental faculty, and has received a diploma as a qualified dental hygienist.
Dentist	A person who is duly licensed to practice dentistry.
Denturist	A person who is duly qualified to perform the services defined by the scope of his license. This includes any other practitioner practicing under a similar license.
Dependent	A spouse or child who is domiciled in Canada. For the purposes of Extended Health Care, an eligible dependent must also be insured under a provincial health plan.
Drugs	Medication contained in federal or provincial schedules and bearing a drug identification number on their labels.
Employee	A person who is domiciled in Canada and who is employed by the Employer on a permanent full-time basis for not less than 100 hours per month. For the purposes of Extended Health Care, an eligible Employee must also be insured under a provincial health plan.
Employee Contribution	The amount which the Employer requires an Employee to pay toward the coverage under this Plan.
Fee Guide	Means the dental association fee guide published for the calendar year identified in the **BENEFIT SCHEDULE**.
Government Health Care	Means the body of federally or provincially enacted laws, as amended from time to time, governing provincial health insurance plans, provincial hospital insurance plans, provincial medicare plans, provincial dental care plans, federal or provincial medical or dental care and services acts, the Hospital Insurance and Diagnostic Services Act (Canada) and any other federal or provincial government sponsored hospitalization, Medicare, drug or dental insurance plan which provides health insurance to residents of Canada.
He/His/Him	Applies to both sexes unless the context clearly indicates otherwise.
Hospital	Any hospital that is designated as such by law and is for the care and treatment of sick and injured individuals and which has organized facilities for diagnosis and 24-hour nursing service but does not include a nursing home, home for the aged or chronically ill, rest home, convalescent hospital or a place for the care and treatment of alcoholism or drug abuse other than incidentally.
Hospitalized	Being confined in a hospital for more than 18 consecutive hours.
Temporary Lay-Off	A period during which the Employee is laid off work with an expectation of returning to work.
Leave of Absence	A period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Employer and the Employee. Leave of absence includes maternity and parental leave of absence.

DEFINITIONS

Licensed, Certified, Registered

The status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority.

Maternity Leave of Absence

The period of formal maternity leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits. For the purposes of this Plan Document, maternity leave of absence will be deemed to commence on the earlier of:

a) the date fixed by mutual agreement between the Employee and the Employer; or
b) the date the child is born.

Medically Necessary

Broadly accepted by the medical profession as effective, appropriate and essential in the diagnosis or treatment of a sickness or injury, and based on generally recognized and accepted standards of health care.

Parental Leave of Absence

The period of formal child care leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

Nursing Home

A health care facility licensed to provide skilled nursing care and medical supervision for up to 2½ hours each day, together with 24-hour personal care service.

Physician

A Doctor of Medicine (MD), duly licensed to practice medicine, or any other practitioner recognized by the College of Physicians and Surgeons in the province in which the treatment is rendered.

Plan

This plan document and any policy, contract or arrangement providing group benefits for similar allowable expenses, whether on an insured or uninsured basis. This includes, but is not limited to:

a) group plans,
b) franchise plans,
c) service plans, capitation plans or prepayment plans, which can be arranged through any employer, Employee benefit organization, union, trusteed group, or professional organization.

Plan Administrator

A person, firm or corporation appointed for the purposes of providing administrative services in respect of the insurance provided under this policy.

Reasonable and Customary

Within the usual range of charges being made by others of similar standing in the area in which the charge is incurred when providing the same or comparable services or supplies.

Remarriage

Either of the following arrangements that a surviving spouse enters into subsequent to the Employee's death:

a) a marriage through an ecclesiastical or civil ceremony, or
b) a common-law marriage in which the surviving spouse, who although not legally married to the person, cohabits with the Employee in a conjugal relationship which has been represented as such in the community in which they reside.

DEFINITIONS

Spouse

A person who:

a) is married through an ecclesiastical or civil ceremony to an Employee, or
b) although not legally married to the Employee, cohabits with the Employee in a conjugal relationship which has been represented as such in the community in which they reside for at least 12 months at the time of application.
c) a divorced or ex-common-law spouse of the Employee for whom insurance protection for some of the benefits under the Employer's benefit program is mandated by court order.

At any one time, only one person may be insured as an Employee's spouse.

Total Disability or Totally Disabled

The complete inability of an Employee, as a result of sickness or accident, to perform substantially the whole of the duties of his regular occupation.

ELIGIBILITY

Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are a permanent employee.
- you must qualify under the hour bank, and have accumulated at least 300 hours in a 6 month period from the date of the first contribution.
- you have completed the waiting period.

The waiting period for your group plan ends on the last day of the month following the month in which you have completed 300 hours of service within a 6 month period

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3 months if you were actively working on the last scheduled working day. We consider you to be actively working for as long as there are hours remaining in your hour bank and you are in good standing with the union. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

You must be registered with and in good standing with the union and have accumulated hours in your hour bank to be eligible for coverage. You can accumulate up to 1200 hours in the hour bank which provides 12 months of coverage. You will continue to accumulate hours while working.

If you have less than 100 hours banked and are in good standing, registered with the union and are available for work, you can self pay up to a maximum of 3 months for benefits. You must not be working or employed by any employer who carries out any work that falls within the jurisdiction of the union and who does not contribute to the benefit trust fund under the terms of a collective agreement. Once your Hour Bank Account is exhausted, the Trustees have initiated a provision enabling you to make self-payments to continue your benefit coverage for up to 3 months.

Coverage of an employee who was previously covered under this contract and who is re-employed by the employer within 6 months of terminating employment will again be eligible for coverage on the first day of the second month in which the employee has accumulated 200 hours in the employee's hour bank.

Dual Insurance

An Employee may not be insured as a dependent except that if both husband and wife are Employees, one Employee may be insured as a dependent of the other. However, the Employee insured as a dependent must be insured as an Employee for any benefits which are provided for Employees only.

COMMENCEMENT OF INSURANCE

Commencement of Employee Insurance

The insurance of any Employee will become effective on the date on which he first becomes eligible provided that Employee is actively at work on such date.

Funds Administrative Service Inc. (FAS) will obtain on, or prior to the date an Employee becomes insured, a IUPAT Local 177 Welfare Trust Fund Registration/Change Form that is signed by the Employee.

If an Employee is not actively at work on the date his insurance would otherwise commence, such insurance will commence on the first day he is subsequently actively at work. If the Employee is not actively at work on such date due solely to a paid vacation or general holiday, then he will be considered actively at work on such date.

With respect to the Dental Care Benefit, if the Employee applies more than 31 days after the date of his eligibility, his dental coverage will be limited as set forth in the **BENEFIT SCHEDULE** under the Dental Care portion.

Commencement of Dependent Insurance

The dependent insurance of an Employee will become effective on the latest of the following dates:

a) the date on which the insurance of an Employee first becomes effective under this policy,
b) the date on which the dependent insurance of an Employee is reinstated under this policy,
c) the date on which an Employee insured under this policy first becomes eligible for dependent insurance provided written application is made within 31 days of the date of such eligibility,
d) the date on which the insurability of the dependent is approved by Maximum Benefit, if the Employee's application for dependent insurance is made more than 31 days after the Employee first became eligible for such insurance.

The insurance for any individual becoming an eligible dependent of an Employee insured with dependent insurance will become effective on the date that such individual becomes a dependent as defined in this policy.

If a dependent (other than a new-born child) is confined to a hospital on the date his insurance would otherwise become effective, his insurance will not become effective until the first day immediately following his discharge from the hospital.

CHANGE OF INSURANCE

Change of Insurance

Any change of the amount of insurance or change in benefit will become effective on the later of the following dates provided the Employee is actively at work on such date:

a) the date on which the Employee first became eligible for such change.
b) if applicable, the date on which the insurability of the Employee is approved by Maximum Benefit, if the change of the amount of insurance requested is for an amount which is in excess of the amount the policy will provide without evidence of insurability as shown in the **BENEFIT SCHEDULE**.

If an Employee is not actively at work on the date his insurance would otherwise change, such insurance will change on the first day he is subsequently actively at work. If the Employee is not actively at work on such date due solely to a paid vacation or general holiday, then he will be considered actively at work on such date.

TERMINATION OF COVERAGE

Termination of Employee Insurance

Except as specifically provided to the contrary elsewhere in the policy, all insurance of an Employee will terminate on the earlier of:

a) the last day of the month in which an Employee has less than 100 hours in the Hour Bank Account and does not make direct payments to maintain coverage,
b) the date on which the Employees ceases to be a member in good standing with the Union,
c) the date on which the age of the Employee equals the applicable age limit shown in the **BENEFIT SCHEDULE**,
d) the end of the period for which required premiums on behalf of an Employee have been paid,
e) the date on which the Employee becomes a full-time member of the armed forces of any country,
f) the date on which this policy is terminated,
g) the date on which the Employee discontinues any required contributions or reach the maximum number of direct payments allowed under the Plan,
h) the date on which the Employee ceases to be actively at work, which includes but is not restricted to, the date on which the Employee is pensioned or retired (with less than 100 hours in the Hour Bank Account), unless otherwise stated in the **BENEFIT SCHEDULE**.

However, if the Employee ceases to be actively at work

- due to maternity and/or parental leave and premiums continue to be remitted, such Employee will be considered to be actively at work if the Employer, acting on a basis precluding individual selection, continues the Employee's insurance, for any period not exceeding the period required under the relevant provincial or federal legislation.
- due to lay-off, coverage may be continued during the period an employee is temporarily laid off. An employee with current union dues and with hours remaining in the Health & Welfare Hour Bank will remain covered until such time as their hour bank is exhausted.
- due to leave of absence, coverage may be continued during the period an employee is temporarily granted a leave of absence, but only until the last day of the month following the month in which the leave starts. The leave of absence cannot be because of illness, paid vacation or maternity/paternity leave.

If federal or provincial legislation requires the Employer to continue an Employee's insurance beyond the date it would otherwise terminate, then subject to continued premium payment, his insurance will be continued to the end of the period required by law but not beyond the date on which this policy is terminated.

Termination of Dependent Insurance

Except as specifically provided to the contrary elsewhere in the policy, the dependent insurance of an Employee will terminate on the earliest of

a) the date on which the insurance of the relevant Employee terminates,
b) the date on which the Employee no longer has any dependents,
c) the end of the period for which required premiums for dependent insurance, on behalf of the Employee, have been paid,
d) the date on which dependent coverage under this policy is terminated.

The insurance of any dependent of an Employee will terminate the date the dependent is no longer a dependent as defined in this policy.

TERMINATION OF COVERAGE

Benefit Extension After Termination

If an Employee is totally disabled or a dependent is confined to a hospital on the date the Employee's insurance terminates for any reason other than policy termination, reimbursements will be made, as if insurance had not ended for such individual, for any eligible expenses incurred as a result of such disability or confinement until the earliest of:

a) the date the Employee ceases to be totally disabled,
b) the date the dependent is no longer confined in a hospital,
c) the 91st day after the date the Employee's insurance terminated,
d) the date this benefit terminates.

CLAIMS

Notice and Proof of Claim

Notice and proof of any claim must be received by Maximum Benefit within the time limit, if any, specified in each benefit. However, if this policy terminates, benefit payments will cease immediately, regardless of the date the expense(s) was (were) incurred.

Payment of Benefit

A benefit payable during the lifetime of the Employee will be made to the Employee unless otherwise indicated elsewhere in the policy.

If an Employee dies before payments to which he is entitled are made or if an Employee is not competent to give a valid release for payments to which he is entitled, Maximum Benefit may in its discretion pay, to the extent permitted by law, to a relative by blood or connection by marriage of the Employee or to any person appearing to Maximum Benefit to be entitled to such payment. Such payment will fully discharge Maximum Benefit to the extent of the amount paid if made in good faith.

Medical Examination

From time to time, Maximum Benefit will be entitled to have a claimant examined by a physician or physicians of its choice.

Subrogation

Conditional payments shall be made to an Employee with a potential loss of income claim against a party who caused or contributed to the disability. Any such payments are subject to the company's subrogation right to reimbursement when the Employee is indemnified through a judgment or settlement.

Misstatement of Age

If the age of any individual has been misstated, the benefits payable under this policy will be based upon the actual age of the individual concerned, at the relevant time.

Amount of Insurance

The amount of insurance in force for each Employee is determined by classification as shown in the **BENEFIT SCHEDULE**. The Policyholder must notify Maximum Benefit in writing, on a regular monthly basis, of any change in the amount of insurance of any individual. If Maximum Benefit is not notified of such change within 31 days, payment of a claim relating to such individual will be abased on the amount which is the lesser of the amount of insurance prior the change and amount of insurance after the change.

Assignment

The rights or interest of an Employee under this policy are not assignable.

Co-ordination of Benefits

If an individual is insured under two different plans, they may be subject to co-ordination of benefits. The amount of any benefits payable during any calendar year will be coordinated, as per insurance industry guidelines, and the amount payable cannot exceed 100% of the actual eligible expenses incurred.

The insurance industry standards determine where a claim should be sent first for payment:

a) a person considered an insured Employee, under either plan, must submit their claims to their plan first. After their plan issues a payment, a copy of the claim and payment may be submitted to the other plan for payment of any unpaid balance,
b) dependent children's claims must be submitted through the group insurance plan of the parent with the earlier birthday and month in the calendar year. Any unpaid balance would then be submitted to the other plan, along with a copy of what was already paid.

CLAIMS

Facility of Payment

When payments, which should have been made under this Plan in accordance with the **Co-ordination of Benefits** provision, have been made under any other Plans, Maximum Benefit shall have the right, exercisable alone and in its sole discretion, to pay over to any other insurance company or other organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision, and such amounts will be deemed to be benefits paid under this Plan and, to the extent of such payments, Maximum Benefit will be fully discharged from liability under this Plan.

Right to Receive and Release Information

Maximum Benefit may, with proper authorization, release to or obtain from any other insurance company or other organization or person any information, with respect to any individual, which Maximum Benefit deems to be necessary for the purpose of determining the applicability of and implementing the terms of the **Co-ordination of Benefits** provision or any provisions of similar purpose of any other Plan. Any individual claiming benefits under this policy will furnish to Maximum Benefit such information as may be necessary to implement the **Co-ordination of Benefits** provision.

Right to Recovery

Whenever payments have been made by Maximum Benefit under this plan, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of the **Co-ordination of Benefits** provision, Maximum Benefit will have the right to recover such excess of payment from any persons to or for whom such payments were made.

CLAIMS PROCEDURES

Claim Payments

Upon acceptance of proof, benefits will be determined as specified under **Eligible Expenses.**

Claim payments for Extended Health Care and Dental Care are made payable to the Employee unless he has authorized payment to be made to a person and/or corporation which has rendered services, treatments or supplies.

Claim payments which are authorized to be made to a hospital will be sent directly to the hospital.

EXTENDED HEALTH CARE BENEFIT

Co-Insurance

Any co-insurance amount shown in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible Amount which will be reimbursed by Maximum Benefit subject to any limitations shown in the Benefit Schedule.

Eligible Expenses – In Province

Eligible Expenses in the Member's normal province of residence include charges for the following:

Hospital

Accommodation while in a Hospital as an In-patient, up to the amount specified in the Benefit Schedule, provided that the confinement starts while the covered person is covered under this benefit.

A legally licensed institution which is operated for the care and treatment of sick and injured persons as In-patients, and which:

a) Is eligible to receive payments under a provincial hospital plan;
b) Provides organized facilities for diagnosis and major surgery;
c) Provides 24-hour nursing service by registered nurses, and has a Physician in regular attendance;
d) Is not primarily operated as a nursing home or a place for rest, or for the care and treatment of the aged, the blind or deaf; and
e) Is not primarily operated as a place for the care and treatment of alcoholics, drug addicts, or the mentally ill.

For the purpose of this Plan, Chronic Care and Convalescent/ Rehabilitation Facilities/beds are not considered under the Hospital coverage.

Convalescent / Rehabilitation Hospital

Semi-private accommodation in a licensed Convalescent or Rehabilitation Hospital provided the person was admitted within 14 days following a period as an In-patient in a Hospital - to the maximum specified in the Benefit Schedule.

Eligible Expenses – In Canada

Eligible Expenses within Canada include charges for the following:

Nursing Care

Nursing care (not custodial care) provided in the covered person's home by a registered nurse or a licensed practical nurse or a registered nursing assistant none of whom is related by blood or marriage or normally live with you or any of your dependents - to the maximum shown in the Benefit Schedule.

Prior approval from Maximum Benefit is required, for which a written recommendation from the Physician must be submitted.

Ambulance

a) A licensed ground ambulance when used to transport the person in any of the following circumstances because of either emergency or In-patient treatment:
   - from the place where the person suffers the accident or sickness to the nearest Hospital where adequate medical treatment is available;
   - from one Hospital to another Hospital, where specialized treatment is to be provided.

b) A licensed air ambulance when used to transport the person because of an emergency to the nearest Hospital where adequate treatment is available or to another Hospital when certified as essential by the attending Physician.

EXTENDED HEALTH CARE BENEFIT

Pay-Direct Drugs (Generic Substitution)

Subject to the Deductible, Co-insurance and Drug Formulary as specified in the Benefit Schedule, and provided through the Pay-Direct Drug card, all Generic* drugs are eligible if they:

- Bear a Drug Identification Number and are dispensed by a licensed pharmacist, and
- Can only be obtained by a written prescription from a Physician or Dentist for use in respect of an illness or injury, or by a qualified health professional if legislation permits them to prescribe those drugs, and
- Are not in excess of a 34-day supply (100 day supply for maintenance drugs).

*Generic drug means a less expensive drug that has been substituted, with the approval of the attending physician, for the original prescribed drug yet it provides the same effective treatment.

If the physician does not permit the drug to be substituted, the eligible expense will include the cost of the brand name product.

Prior Authorization Drug Program

The plan covers drugs that are medically necessary. The Prior Authorization Drug (PA) program applies to a small number of drugs for which prior approval is required before being covered by the plan. For a drug to be approved for coverage, the employee and doctor will need to complete a PA kit providing some medical information.

If the information provided meets the plan's medical criteria, then the prescription drug will be approved for coverage. A list of drugs requiring pre-authorization can be found on my-benefits and the Maximum Benefit website.

If claims are submitted for a listed drug that has not received prior authorization, the claim will be declined. If the drug card is used to purchase a listed prescription drug, the purchaser will be notified that the drug needs prior authorization.

PA kits are obtained by called RESOLVE at 1-800-663-8637.

Drug Limitations

The following are not eligible, unless otherwise stated in the Benefit Schedule:

- Proprietary or patent medicines,
- Experimental drugs,
- Obesity drugs,
- Fertility drugs,
- Erectile Dysfunction drugs,
- Dietary or health foods, vitamins, nutritional products, and
- Smoking cessation aids (which include, but are not limited to, nicotine patches and nicotine gum),
- Drugs that are administered intravenously,
- Drugs that are normally only administered in a hospital.

Eligible drugs that are covered under a provincially funded drug program, are limited to the provincial deductible and applicable co-insurance.

Medical Equipment and Supplies

a) Purchase but not the repair of a spinal brace or an artificial limb or eye where the loss of the limb or eye occurs while the person is covered under this Benefit; replacement is included when required due to physiological change.
b) Purchase or rental but not the repair or replacement of a crutch or a custom made (rigid support) brace (not prescribed specifically for sporting activities).
c) Rental or purchase, of a wheelchair or hospital bed, to lifetime maximum of $2,000 each. Prior approval from Maximum Benefit is required, for which a written recommendation from the Physician must be submitted, stating the medical necessity for the item.
d) Purchase of colostomy, ileostomy or uretherostomy supplies.
e) Purchase of one glucometer per lifetime.
f) Purchase of Diabetic supplies, including disposable needles and reagent strips.
g) Injectable drugs and serums.
h) Purchase of a breast prosthesis when required because of total or radical mastectomy which has been performed while the person is covered under this Benefit - to a maximum of $400 per person every 60 consecutive months.
i) Purchase of two surgical brassieres each calendar year when required because of a total or radical mastectomy.
j) Purchase of two pairs of surgical stockings per person each calendar year.

Paramedical Practitioners

Up to the maximum specified in the **BENEFIT SCHEDULE** for each type of practitioner listed below, provided such practitioner is operating within the scope of his license and is not related by blood or connected by marriage to either the Employee or any of his dependents or normally resides with the Employee or any of his dependents:

- Massage Therapist
- Osteopath
- Podiatrist/Chiropodist (includes 1 x-ray per calendar year)
- Speech Therapist
- Chiropractor (includes 1 x-ray per calendar year)
- Naturopath/Homeopath
- Physiotherapist
- Psychologist

Provincial Paramedical Limitations:

In the Province of Alberta:

For services of a podiatrist
Reimbursement will only be provided for Eligible Expenses incurred after the annual maximum allowance under the provincial health plan has been exhausted. Proof that the relevant allowance has been exhausted will be required.

Orthopedic Supplies

a) Purchase but not repair of one pair of orthopedic shoes each calendar year which have been specifically designed for the individual and which are purchased from a recognized orthopedic supplier. This does not include off-the-shelf shoes that have been modified.
b) Purchase of customized orthesis or arch support.

Combined maximum of $300 per calendar year.

EXTENDED HEALTH CARE BENEFIT

Hearing Aids

Purchase but not the repair of hearing aids on the written prescription of a licensed otolaryngologist - to the maximum specified in the **BENEFIT SCHEDULE** for each individual.

Other Eligible Expenses

a) Oxygen, plasma, blood or blood substitutes and their administration.
b) X-ray and diagnostic laboratory procedures and x-ray or radium therapy; such procedures do not include services received in a hospital.
c) Purchase of wigs required as a result of chemotherapy - to a lifetime maximum of $100 per individual.

Eye Examinations

Eye examinations (including eye refractions) performed by a qualified ophthalmologist or licensed optometrist - to the maximum specified in the **BENEFIT SCHEDULE.**

Dental Treatment Due to Accident

Services of a dentist required for the repair and replacement of sound natural teeth because of an accidental blow to the mouth while insured under this benefit but not by an object wittingly or unwittingly placed in the mouth. This dental treatment must commence or a detailed treatment plan satisfactory to Maximum Benefit must be submitted to Maximum Benefit, within 90 days of such injury. No reimbursement will be provided for treatment performed more than 2 years after the date of the accident.

If there is a less expensive course of treatment that will give a professionally adequate result, the amount payable under this Plan is equal to the cost of the less expense treatment. If the Employee chooses to proceed with the more expensive treatment, they will be responsible for the additional costs.

Vision Care

Contact lenses, eyeglasses, sunglasses and safety glasses, which require a prescription and are dispensed by an ophthalmologist, a licensed optometrist or a qualified optician - to the maximum specified in the **BENEFIT SCHEDULE**.

Vision Care Limitation

Off the shelf sunglasses or safety glasses are excluded.

Medically Necessary Contact Lenses

Coverage for contact lenses is subject to Medical Necessity and will be paid according to the following:

- To correct extreme visual acuity problems that cannot be corrected to 20/40 in the better eye with spectacle lenses;
- Following cataract surgery resulting in Aphakia
- Keratoconus or other corneal irregularities.

Limitations and Exclusions

No reimbursement will be made under this benefit for the following:

a) services or treatment which in whole or in part a government health plan prohibits from being paid, except to the extent that it permits excess reimbursement;
b) services, treatment or supplies which the individual received without charge;
c) services, treatment or supplies which are experimental in nature;
d) drugs, services, treatment or supplies for the treatment of sexual dysfunction;
e) drugs, hormones, products and injections for the treatment of obesity;
f) services, treatment or supplies provided to the Employee by the Employer;
g) services, treatment or supplies not included in the list of eligible expenses;
h) any services, treatment or supplies which are required as the result of a motor vehicle accident.

Eligible expenses which result directly or indirectly from the following:

a) intentionally self-inflicted injuries while sane or insane,
b) cosmetic treatment other than due to an accidental bodily injury which is caused solely by external, violent and accidental means, independently of all other causes and which is sustained while the individual is insured under this benefit,
c) committing or attempting to commit a criminal offence,
d) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan,
e) war, whether war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion.

Co-ordination of Benefits

This benefit is subject to the **Co-ordination of Benefits** provision of this policy.

Proof of Claim

Written proof of a claim must be submitted to Maximum Benefit within 365 days of the date the expense was incurred.

Subsequent written proof satisfactory to Maximum Benefit of a continuing total disability must be submitted to Maximum Benefit in accordance with any request made by Maximum Benefit.

Survivor Benefit

A Dependent, whose coverage under this plan would otherwise have ended because of the death of the Member, will continue to be covered under this benefit in accordance with the other provisions of this plan until the earliest of the following dates:

a) The end of the period of 12 months following the date of the death of the Member,
b) The exhaustion of the deceased member’s hour bank,
c) The date on which the Spouse remarries,
d) The date on which this Benefit terminates.

DENTAL CARE BENEFIT

Payment of Benefit

Upon receipt of proof of claim satisfactory to Maximum Benefit that an Employee or dependent while insured under this benefit incurred eligible expenses which were necessary and which were for services recommended by a dentist, and

a) performed by a dentist; or
b) performed by a dental hygienist under the supervision of a dentist; or,
c) performed by a licensed denturist where such services are within the scope of his license.

Maximum Benefit will provide reimbursement for such expenses in excess of the deductible (if any), subject to the co-insurance and maximums specified in the **BENEFIT SCHEDULE**, and in accordance with other applicable provisions of this policy.

Eligible expenses will be considered to have been incurred on the date the service or supply was provided. However with respect to a bridge, crown or denture, the date of insertion of such appliance will be the date such expense was incurred and with respect to root canal therapy, the date of the final treatment shall be the date that expense was incurred.

Treatment Plan

A treatment plan is a plan of dental treatment (including radiographs if required) showing the patient's dental needs, a written description of the proposed treatment necessary in the professional judgment of the dentist, and the cost of the proposed treatment. It is recommended that one is obtained when the total cost associated with the proposed treatment is over $500.

Upon receipt of the treatment plan, the Employee will be provided with an estimate of the benefits payable under this Plan. The course of treatment must commence within 90 days of the date of the estimate.

Alternate Treatment

If there is a less expensive course of treatment that will give a professionally adequate result, the amount payable under this Plan is equal to the cost of the less expense treatment. If the Employee chooses to proceed with the more expensive treatment, they will be responsible for the additional costs.

Deductible

The individual deductible amount is the amount of eligible expenses which must be paid by or on behalf of an individual in any calendar year before reimbursement will be made under this benefit. Once an Employee and his dependents have satisfied the family deductible amount during any calendar year, no further deductible will be applied against eligible expenses incurred by any member of such family during the balance of that calendar year.

Co-Insurance

Any co-insurance amount shown in the **BENEFIT SCHEDULE** is the percentage of eligible expenses in excess of the deductible amount which will be reimbursed by Maximum Benefit subject to any limitations shown in the **BENEFIT SCHEDULE**.

Benefit Outside Canada

Payment will be made for dental treatment rendered while travelling outside Canada, but only to the extent that payment would have been made under this benefit if such treatment had been rendered in the Employee's normal province of residence and provided that such treatment was rendered for emergency purposes only.

DENTAL CARE BENEFIT

Basic Treatment (Eligible Expenses)

Basic treatment excludes any services that are primarily for orthodontic treatment

1. Oral Examinations:
   - complete oral examinations - limited to one in any 24 month period;
   - specific and recall oral examinations - limited to one in any 6 month period;
   - emergency examinations for evaluating acute pain and/or infection.
2. X-rays:
   - complete series of periapical films and panoramic film - each limited to one in any 24 month period;
   - bitewing films and x-rays to diagnose a symptom or examine progress of a particular course of treatment other than temporomandibular joint film.
3. Laboratory examinations
4. Consultations
5. Preventative:
   - prophylaxis (light scaling and polishing for preventive purposes rather than therapeutic) limited to once in any 6 month period;
   - topical application of fluoride and anti-cariogenic substances - limited to once in any 6 month period and for dependents under age 18 only;
   - pit and fissure sealants covered on primary and adult teeth under age 18;
   - space maintainers for missing primary teeth; not designed specifically for sporting activities;
   - temporary dressing for the emergency relief of pain;
   - occlusal equilibration;
   - night guards.
6. Minor Restorative Services:
   - non-bonded amalgam,
   - acrylic, silicate or composite restorations, (composite fillings apply to all teeth);
   - pre-formed stainless steel and polycarbonate crowns.
7. Removal of erupted teeth and surgical removal of impacted teeth and residual roots.
8. Repair, rebasing and relining of partial or complete dentures, not including the replacement of teeth on a denture.
9. Local anesthesia and anesthesia required in relation to dental surgery.

Endodontics (Eligible Expenses)

Endodontics is root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.

- root canal therapy
- apexification
- apicoectomy
- retro filling
- root amputation
- hemisection
- vital pulpotomy

DENTAL CARE BENEFIT

Periodontics (Eligible Expenses)

Periodontics is the treatment of bone and gum disease.

- periodontal scaling/root planing (not exceeding 6 units of time per calendar year; subsequent units covered at 50%).
- definitive periodontal surgery:
  Definitive periodontal surgery includes local anesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post surgical care. A surgical site is considered a sextant. The mouth is divided in 6 sextants. The allowance for fewer teeth may be prorated. Definitive periodontal surgery includes the following procedures:
  - gingival curettage
  - gingivoplasty
  - gingivectomy
  - flap approach
  - grafts – pedicle; free soft tissue; lateral sliding; and rotated

Related Periodontal Services:

- provisional splinting
- occlusal adjustment (8 Units per Calendar Year)
- periodontal appliance
- periodontal appliance adjustment or reline

Oral Surgery (Eligible Expenses)

Oral surgery includes local anesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation. A surgical site will be considered a sextant unless specified as a quadrant.

1. Extraction of Erupted Tooth (Uncomplicated) – limited if additional teeth extracted in the same quadrant.
2. Extraction of Erupted Tooth (Complicated) – limited if additional teeth extracted in the same quadrant. Surgery requires surgical flap or sectioning of the tooth.
3. Extraction of Impacted Tooth (Soft Tissue Impaction) – limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue and extraction of impacted tooth.
4. Extraction of Impacted Tooth (Partial Bone Impaction) – limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and either removal of bone and tooth or sectioning and removal of tooth.
5. Extraction of Impacted Tooth (Complete Bone Impaction) – limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and removal of bone and sectioning and removal of tooth.
6. Extraction of Residual Root – limited if additional teeth extracted in the same quadrant.
7. Surgical Exposure of Impacted Tooth – limited if additional teeth exposed in the same quadrant.
8. Alveoloplasty – includes remodeling, excision, removal and reduction of bone.
9. Other procedures.

DENTAL CARE BENEFIT

Major Treatment (Eligible Expenses)

1. Metal inlay/onlay restorations.
2. Retentive pins in inlays and crowns.
3. Crowns (single restorations only), other than preformed stainless steel and polycarbonate crowns, for a tooth that is broken by caries or traumatic injury and cannot be filled by amalgam or composite. Replacement of an existing crown is included if such crown is at least 5 years old.
4. Prosthodontic Appliances (e.g. fixed bridgework, removable partial or complete dentures) other than dentures with precision or stress breaker attachments or precision attachments and telescoping crown unit for fixed bridgework as follows:
   - construction and insertion of an initial permanent prosthodontic appliance if such appliance was necessary because of the extraction of at least one natural tooth while insured under this Benefit;
   - replacement of an existing prosthodontic appliance with a permanent prosthodontic appliance
     - if such appliance was necessary because of the extraction of at least one natural tooth while insured under this Benefit, or
     - if the existing appliance is at least 5 years old, or
     - if the existing appliance is temporary and being replaced by a permanent appliance within 12 months of the date the temporary one was installed;
   - denture adjustments with minor adjustments limited to once in a six month period
   - repair of fixed bridgework.

Orthodontic Treatment

If an individual, while insured under this benefit, incurs eligible expenses which are for necessary dental treatment which has as its objective the correction of malocclusion of the teeth, Maximum Benefit will provide reimbursement for such expenses, in accordance with the provisions of this policy and subject to any limitations of amount shown in the **BENEFIT SCHEDULE**.

Limitations and Exclusions

Reimbursement will not be made for any portion of the charge that is over the suggested charge in the appropriate fee guide.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the locality where the services are provided. However, in no event will the total reimbursement of lab fees exceed 60% of the suggested fee in the appropriate fee guide for the particular dental treatment requiring the lab services.

No reimbursement will be made under this benefit for the following:

1. any dental treatment which is for cosmetic purposes when the form and function of the teeth are satisfactory and no pathological condition exists;
2. expenses incurred for nutritional counselling, oral hygiene and dental plaque control programs;
3. any dental treatment rendered for full mouth reconstructions, for vertical dimension correction, for the restoration of occlusion, for the correction of temporomandibular joint (TMJ) dysfunction or for permanent splinting of teeth;
4. expenses incurred for implants;
5. charges levied by a dentist for broken appointments, completion of claim forms or advice by telephone;

6. expenses incurred for the replacement of dentures and appliances that are lost, mislaid or stolen;
7. any dental treatment which is not yet approved by the Canadian Dental Association or which is clearly experimental in nature;
8. dental services, treatment or supplies which the individual received without charge or which a government health plan prohibits from being paid;
9. any dental treatment rendered outside Canada except as specifically provided under the **Benefit Outside Canada** provision;
10. any services, treatment or supplies provided to the Employee by the Employer;
11. dental services and supplies not included in the list of eligible expenses;
12. eligible expenses which result directly or indirectly from the following:
    a) intentionally self-inflicted injuries while sane or insane,
    b) committing or attempting to commit a criminal offence,
    c) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan,
    d) war, whether war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion.
13. any services and supplies rendered for the treatment or correction of any congenital or developmental malformation.
14. any services, treatment or supplies which are required as the result of a motor vehicle accident

Co-ordination of Benefits

This benefit is subject to the **Co-ordination of Benefits** provision of this policy.

Pre-Determination of Benefit

When the total cost of any proposed dental treatment is expected to exceed $500, the Employee or dependent should submit a detailed treatment plan within seven days after the plan is prepared by the dentist, to Maximum Benefit before commencement of treatment. Maximum Benefit will then advise the Employee of the amount of reimbursement for which the Employee or dependent is eligible in accordance with the provisions of this policy. The treatment plan should outline the type of treatment to be provided, the anticipated dates of treatment, and the amounts to be charged for such treatment.

The treatment plan submitted must be performed by the dentist who first presented the treatment, otherwise the Employee or dependent will be required to submit a new treatment plan to Maximum Benefit for re-assessment.

Proof of Claim

Written proof of a dental claim must be submitted to Maximum Benefit within 365 days of the date the expense was incurred.

Maximum Benefit reserves the right to require radiographs and other types of diagnostics such as specialist reports, periodontal charts and study models.

DENTAL CARE BENEFIT

Payment of Orthodontic Claims

Notwithstanding anything to the contrary under the **CLAIMS** section (provision) of this policy, the payment of orthodontic claims will be made on one of the following bases:

1. If a single charge is estimated for the entire course of treatment and the Employee pays this charge to the orthodontist in prearranged installments over an estimated period of treatment, Maximum Benefit will reimburse the Employee each time he submits a bill or receipt to Maximum Benefit for any prearranged installment.
2. If a single charge is estimated for the entire course of treatment and the Employee pays this charge to the orthodontist in one lump sum, Maximum Benefit will reimburse the Employee on a quarterly basis as follows:
   - the first amount of reimbursement will be made 3 months after treatment commences, and subsequent amounts of reimbursement will be made every 3 months thereafter;
   - the quarterly amount of reimbursement will be determined by multiplying the average monthly amount of benefit by the numeral three;
   - the average monthly amount of benefit will be determined by dividing the estimated single charge by the period of months over which the entire course of treatment is estimated to extend.
3. If in lieu of a single charge, a charge is made for each treatment as it is performed, Maximum Benefit will reimburse the Employee as each charge is incurred.

Survivor Benefit

A Dependent, whose coverage under this plan would otherwise have ended because of the death of the Member, will continue to be covered under this benefit in accordance with the other provisions of this plan until the earliest of the following dates:

a) The end of the period of 12 months following the date of the death of the Member,
b) The exhaustion of the deceased member's hour bank,
c) The date on which the Spouse remarries,
d) The date on which this Benefit terminates.

MEMBER AND FAMILY ASSISTANCE PROGRAM (MFAP)

Effective July 1, 2005, Homewood Health Inc. is the provider of your **Member and Family Assistance Program (MFAP)**. The **MFAP** provides members, their spouses and eligible dependents with direct, confidential, professional counselling and preventative health services. Program features include:

Up to a maximum of 4 sessions per individual per calendar year that can be utilized by the member and their eligible dependents. These services can be used as needed and in any combination that includes all of the following choices:

Counselling for a full range of personal & family difficulties such as:

• relationship and family problems	• work related stress or conflict
• separation/divorce/custody	• anger management
• difficulties with children	• eating disorders
• childcare and eldercare resources	• aging parents
• alcohol and drug dependencies	• sexual harassment and abuse
• gambling and other addictions	• grief and bereavement
• depression, stress, anxiety & other psychological disorders	• retirement planning

Referral to Legal and Financial Advisory Services – up to two hours in total per calendar year is available for certain legal and financial difficulties through the MFAP.

Web site services available by Member registration at www.homewoodhealth.com include:

- **Child Care, Elder Care and Self Care Service** provides information about personal and family care providers in Canada.
- **The Health and Wellness Companion** is a program that allows you to store personal and family health information for secure and confidential access – anywhere, at anytime; a comprehensive health library including a searchable drug database, answers to questions about diagnostic medical tests, medical terms, diseases and conditions and a health risk assessment that allows you to evaluate your current health and uncover potential health risks through a series of interactive health risk assessments.
- **Interactive eLearning Courses** that offer you the convenience of self-paced, private and personalized learning experiences designed to improve your personal health and well-being and/or workplace effectiveness.

Immediate Help for any personal crisis or any urgent concern.

Call Homewood Health Inc. Toll Free, within North America:

English	1 800 663 1142
French	1 866 398 9505
Hearing Impaired	1 888 384 1152
International (call collect)	1-604-689-1717

24 hours a day, 7 days a week

***VERY IMPORTANT**: When registering for any of these services online or when contacting Homewood Health Inc. by telephone, please indicate your company name as **IUPAT Local 177 Welfare Trust Fund**.

Section III

Emergency Medical Travel Assistance

SCHEDULE OF BENEFITS

This booklet contains further clauses which may limit coverage. Please read all the benefit description pages carefully. Please note that all dollar amounts are expressed in Canadian currency.

Policy Number	7949
Calendar Year Deductible	Nil
Co-insurance Level	100%
Overall Maximum per Insured Person	$5,000,000 per Coverage Period
Description of Classes	All eligible members
Work Hours Required	100 hours per month
Eligibility Period	300 hours within 6 months
Common Law Spouse Cohabitation Period	Continuous cohabitation: Last 12 months
Age Limits for Dependent Children	Under age 18, or under age 25 if a full-time student at a recognized educational institution
Pre-Existing Condition Stability Period – Active Members	None
Coverage Period	90 days per trip
Survivor Benefit	None
Termination Age	70 or earlier retirement

SCHEDULE OF BENEFITS

The Benefit

Travel health coverage is provided under the Johnston Group Inc. Emergency Out of Province/Out of Canada Group Policy. This plan covers medical emergencies that take place outside your province or country of residence. The Co-operators, through TIC, provides all emergency medical assistance services.

Hospital Accommodation	Reasonable & Customary Costs
Physician Charges	Reasonable & Customary Costs
Diagnostic Services	Reasonable & Customary Costs
Paramedical Services	$250 per eligible Profession
Prescription Drugs	30-day supply per Prescription
Ambulance Services	Reasonable & Customary Costs
Medical Appliances	Reasonable & Customary Costs
Private Duty Nurse	Up to $5,000
Out of Canada Referral Benefit	$50,000 per Lifetime
Emergency Air Transportation	Reasonable & Customary Costs
Transportation to Bedside	Economy Round-trip Airfare plus up to $150 per day to $3,000
Return of Traveling Companion	One-way Airfare
Treatment of Dental Accidents	Up to $2,000
Meals and Accommodation	Up to $150 per day, to $3,000 per trip
Vehicle Return	Up to $5,000
Return of Deceased	Up to $5,000
Incidental Expenses	Up to $250

DEFINITIONS

"Actively At Work", "Actively Employed", "Active Work" or "Actively Working", means with respect to a Member, a person who is considered Actively at Work as defined under the Member's Maximum Benefit Extended Health Care plan.

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

"Acute Care" shall mean active intervention required to diagnose or manage a condition that would otherwise deteriorate.

"Allowable Expenses" means only the services and supplies set out in the Covered Services and Supplies section, when actually incurred by a Covered Person for treatment of a Medically Diagnosed Condition.

"Approved Hospital" is an institution designated by applicable legislation as a hospital and which fully meets every one of the following conditions:

- is legally licensed as a hospital where such licensing laws exist; and
- in Canada, is approved by the Province or Territory in which it is situated to provide insured hospital services in accordance with the Government Health Insurance Plan of the Province or Territory; where the hospital is located; and
- has medical, surgical and diagnostic facilities on the premises; and
- is open 24 hours per day and has a staff of one or more Physicians available at all times; and
- continuously provides 24 hour medial care by or under the supervision of resident professional Registered Nurses; and
- provides Acute, Convalescent, or Palliative Care.

"Approved Leave" is a temporary leave of absence approved by the Participating Company. Coverage can continue during an approved leave as long as the Covered Person remains covered under the Participating Company's basic group extended health care plan, provided premiums are paid.

"Auto Plan Benefits" means any benefits to replace income which are payable to a Member as a result of a motor Vehicle accident, whether payable by a:

- government run plan, or
- private insurer, and
- includes without limitation benefits which the Member has received or is entitled to receive under any provincial motor vehicle accident insurance plan and further specifically includes no-fault benefits payable under the Manitoba Public Insurance Corporation Act, the Saskatchewan Automobile Accident Insurance Act and the Automobile Insurance Act (Quebec) or any legislation which replaces any of the foregoing, provided that benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the provincial motor vehicle accident plan.

"Birth" means the complete expulsion or extraction from the mother of a fetus, irrespective of the duration of pregnancy, which, after complete separation from its mother, breathes or shows any sign of life.

"Convalescent Care" shall mean active treatment or rehabilitation for a condition that will significantly improve as a result of convalescent care and that immediately follows 3 or more days of confinement in an Approved Hospital for Acute Care.

DEFINITIONS

"Convalescent Hospital" is an institution (or a distinct part of an Acute Care hospital or Physical Rehabilitation Centre providing Convalescent Care) which:

- has a transfer arrangement with one or more hospitals and which is regularly engaged in providing, for compensation on an inpatient basis, skilled nursing care during the convalescent or physical rehabilitative stage of an Injury or Sickness;
- charges for ward care for the Covered Person involved are covered by the Government Health Insurance Plan. In no event shall the term Convalescent Hospital include any institution or part thereof which is used principally as a rest facility, a facility for the aged or a facility for Chronic Care.

"Coverage Period" means the number of consecutive days, as stated on your Certificate of Insurance. The coverage period is calculated as of the commencement date of the Trip.

"Covered Person" is an eligible Member or Dependent as defined under the Maximum Benefit Extended Health Care plan.

"Days" or "Day" means calendar days.

"Dentist" is a person who is legally licensed to practice dentistry in the Province or Territory or other jurisdiction in which the person is practicing.

"Denturist" is a person who is legally licensed to provide full denture service directly to a patient in the Province or Territory or other jurisdiction in which the person is practicing.

"Dependent" shall mean an eligible Spouse or eligible Child of the Member as defined under the Members Maximum Benefit Extended Health Care plan.

"Emergency" means the occurrence of a Sickness 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 the Covered Person's return to Canada.

"Member" is a person who is eligible for coverage under this Policy in accordance with the definition of a Member under the Maximum Benefit Extended Health Care plan.

"Fee" means the charges as set out in the Provincial Fee Guide for general practitioners as approved and published by the Provincial Dental Association in the Province or Territory in which the Member resides or the charge for services rendered by a Denturist as stated in the Schedule of Fees published by the appropriate organizations in the Province or Territory in which the Member resides.

"Government Health Insurance Plan" is the Provincial, Territorial or Federal legislation and the regulations pursuant to such legislation, as amended from time to time, which provide government sponsored Hospital, Drug, Dental or other Medical Care Benefits for residents of Canada, including but not limited to: provincial Dental Care Plans, provincial Health Insurance Plans, provincial Hospital Insurance Plans, provincial drug plans, provincial Medicare Plans, federal or provincial Medical or Dental Care and Services Acts, and the Hospital Insurance and Diagnostic Services Act (Canada).

"Government Plan Benefits" are any benefits which, as a result of Injury or Sickness, are payable to a Member from any government agency and includes without limitation any benefits which the Member has received or is entitled to receive under the Canada Pension Plan, Quebec Pension Plan (excluding any dependent benefits and cost of living increases), and/or any worker's compensation act or similar statute.

DEFINITIONS

"Injury" shall mean an unexpected and unforeseen harm to the body that is caused by an Accident, sustained by a Covered Person during the Coverage Period and that requires emergency treatment that is covered under this Policy.

"In-patient" means a patient who occupies an Approved Hospital bed for more than 24 hours for medical treatment and for which admission was recommended by a Physician when Medically Necessary.

"Immediate Family Member" means the 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 of the Covered Person.

"Maternity Leave" is the period of time allowed under the applicable Provincial Labour Standards Act or such period as agreed to by the Member and the Participating Company, commencing on the date as agreed to by the Member and Participating Company, or the date of delivery, whichever is earlier.

"Medical Assessment" shall mean independent medical examinations, assessments or tests performed by one or more Medical Practitioners and includes without limitation psychological assessments, neuro-psychological evaluations utilizing a generally accepted classification system, physiological examinations, and functional capacity assessments, psychometric assessments and neuro-psychological testing.

"Medical Care" shall mean Medically Necessary services, supplies or surgery, including hospitalization, provided, or ordered, by a Physician in the treatment of a Covered Person's Sickness or Injury.

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

- is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;
- is not experimental or investigative in nature;
- cannot be omitted without adversely affecting the Medically Diagnosed Condition of the covered Person or quality of Medical care;
- cannot be delayed until the Covered Person returns to his/her province of residence.

"Medical Practitioner" includes a Physician, Specialist, Psychiatrist, Psychologist, Physiotherapist and Occupational Therapist. The Physician, Specialist and Psychiatrist must be legally licensed to practice medicine in the Province or Territory where the service is rendered and be registered by the College of Physicians and Surgeons in the Province or Territory in which the person is practicing. The Psychologist, Physiotherapist and Occupational Therapist must be licensed, certified or registered to practice the profession by the appropriate authority or the Province or Territory in which care or services are rendered, or where no such authority exists, having a certificate of competency from the professional body which establishes standards of competency and conduct for such profession. The Medical Practitioner cannot be related to the Member.

"Medically Diagnosed Condition" or "Medically Diagnosed" shall mean a Sickness or an Injury which has been diagnosed according to a generally accepted classification system, including but not limited to, an x-ray, MRI, bone scan, biopsy, CT Scan, psychometric testing including MMPI-2, or a haematological or ultrasonic test.

"Ongoing Condition" means an Acute Medically Diagnosed Condition that requires continuing care and/or treatment after the initial Emergency has ended, as determined by the Insurance Company's Medical Director.

"Palliative Care" shall mean treatment for the relief of pain in the final stages of a terminal condition.

DEFINITIONS

"Parental Leave" is the period of time allowed under the applicable Provincial Labour Standards Act, commencing on the date as agreed to by the Member and Participating Company, or the date immediately following the completion of Maternity Leave, whichever first occurs.

"Participating Company" shall mean a Company who has agreed to participate in the Maximum Benefit Extended Health Care plan and whose participation has been approved by the Third Party Administrator acting on behalf of the Insurance Company.

"Participating Company's approved application" shall mean the signed application filed with the Third Party Administrator summarizing the Company's applicable benefits as specified in this Policy and under the Company's group benefit plan.

"Physician" means a medical practitioner whose legal and professional standing within his/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/she practices, who prescribes drugs and/or performs surgery and who gives medial care within the scope of his/her licensed authority. The Physician cannot be the Covered Person or related to the Covered Person.

"Practitioner" shall mean a person who is a member of a paramedical profession and is duly licensed, certified or registered to practice that profession in the Province or Territory in which the person is practicing. Licensed, certified or registered means licensed, certified or registered to practice the profession by the appropriate authority in the Province or Territory in which care or services are rendered, or where no such authority exists, having a certificate of competency from the professional body which establishes standards of competency and conduct for such profession. The Medical Practitioner cannot be related to the Member.

"Pre-existing Condition" shall mean any existing medical condition prior to departure.

"Pre-existing Condition Stability Period" shall mean the period of time indicated in the Schedule of Benefits, immediately prior to departure, during which any Pre-Existing Condition must remain stable (ie. no change in symptoms, no hospitalization, no change in condition, no new prescription drugs or prescribed change in treatment or medication).

"Previous Policy" shall mean the Group Policy issued to the Policyholder or Participating Company by any Insurance Company which provided benefits comparable to this Policy and which was terminated, and less than 31 Days later, replaced by this Policy.

"Province" or "the Province" shall mean the Covered Person's Province or Territory of residence.

"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 Illness or Sickness.

"Reasonable and Customary Treatment" shall mean systematic treatment that is:

- generally accepted and recognized by the Canadian medical profession as effective appropriate and essential in the treatment of the Medically Diagnosed Condition, and
- of a nature, intensity, frequency and duration essential to the diagnosis or management of the Medically Diagnosed Condition involved; and
- prescribed and rendered by a Physician, or where considered appropriate by Co-operators Life for the nature of the Medically Diagnosed Condition, the treatment must be prescribed and rendered by a Specialist.

DEFINITIONS

"Sickness" shall mean disease or illness 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 medial treatment.

"Specialist" shall mean a Physician who specializes in a particular study or work and is registered by the College of Physicians and Surgeons in the Province or Territory in which the person is practicing and has been recognized with a designation in his/her area of specialty. The Specialist cannot be related to the Member.

"Terminal Illness" means the Covered Person has a condition that is cause for the Physician to estimate that the Covered Person has less than 6 months to live.

"Termination Age" means the age stated in the Participating Company's application at which the Member's coverage terminates. Dependents beyond the Termination Age may be covered provided that the Member 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 groups, 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.

"Third Party Administrator" is the Johnston Group Inc.

"Third Party Benefits" means all benefits paid or to be paid under this Policy to a Covered Person or on behalf of a Covered Person to another Party.

"Trip" means a journey undertaken by a Covered Person which commences on the date of departure from his/her province or territory of residence and ends when he/she returns to their province or territory of residence. If a Member's Dependent attends school outside of Canada, the trip duration will be extended to allow for the length of time the Dependent is actually attending school. It will also allow for up to 1 week of travel time to and from home and school. However, coverage is not extended for any additional travel more than one week before school commences or one week after it is completed. The Dependent must be covered under the Government Health Insurance Plan in order to be eligible for Out of Country coverage under this policy.

"Vehicle" means a vehicle that is drawn, propelled or driven by any means other than muscular power and, without limiting the generality of the foregoing, specifically includes a boat and a snowmobile.

INSURING PROVISIONS

Eligibility of a Member

A Member is eligible for coverage under this Policy if he/she satisfies the eligibility criteria as indicated in the Maximum Benefit Extended Health Care plan.

Eligibility of a Dependent

Dependents are eligible for insurance on the later of:

- The date the Member is eligible, or
- The date the person becomes a Dependent.

Effective Date of a Member's Insurance

The insurance of an eligible Member shall take effect on the date the Member's coverage becomes effective as indicated in the Maximum Benefit Extended Health Care plan.

Effective Date of a Dependent's Insurance

Insurance for a Dependent shall take effect on the date the Member becomes insured under this Policy or the date the Dependent is insured under the Member's Maximum Benefit Extended Health Care plan, if later.

Termination of a Member's Insurance

The insurance of any Member under this Policy shall automatically terminate when coverage terminates under the Maximum Benefit Extended Health Care plan.

Termination of a Dependent's Insurance

Insurance with respect to a Dependent shall automatically terminate when coverage terminates under the Members Maximum Benefit Extended Health Care plan.

Dependent Survivor Benefits

In the event of a Member's death, the coverage for an insured Dependent with respect to Out of Province/Out of Canada emergency coverage will continue for the number of years as indicated in the Schedule of Benefits from the date of the Member's death, provided this Policy and the Participating Company's coverage under this Policy remains in force and the Dependent does not become eligible for benefits under any other group insurance plan as either a Member or Dependent and the Dependent remains eligible as defined in this Policy. Premiums are required for the extension of the Dependent's coverage.

Reinstatement of a Member's Insurance

A Member's insurance under this Policy will be reinstated the date the Member coverage is reinstated under the Maximum Benefit Extended Health Care plan.

CLAIMS PROVISIONS

Proof of Claim

To be entitled to payment of benefits provided under this Policy, the Covered Person, on his/her own behalf and on behalf of his Dependents hereby authorizes any Physician, health professional, hospital, institution and any other organization to forward to Co-operators Life or its representatives, all information, reports or documents that they may require.

The Covered Person 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.

Each Member is required to prove his/her entitlement to benefits under this Policy and to provide notice of claim in accordance with this Policy. Any expenses incurred will be the Member's responsibility.

Claim Form

A Member must submit a claim for benefits under this Policy on the Insurance Company's claim form (the "Claim Form") provided to the Member by Maximum Benefit or the Participating Company, at the time of claim. The Claim Form shall be completed by the Member, the Participating Company and where necessary, a Physician.

Time to Submit Claim

Emergency Out of Province/Canada Claims

- In the event of a claim for Emergency services received out of province in Canada or out of Canada, the Covered Person must notify Co-operators Life immediately, failure to do so will limit the benefits payable under this Policy.
- If the Covered Person incurs any expenses without prior approval by Co-operators Life, such expenses will be covered except where the Policy expressly requires the prior approval or authorization of Co-operators Life, on the basis of 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 the Covered Person will be responsible for paying any difference between the amount the Covered Person incurred and the Reasonable and Customary Costs reimbursed by the Insurer.
- In the event that Co-operators Life is not contacted immediately, the Covered Person, or a beneficiary entitled to make a claim, or the agent of any of them, shall:
  - ⇨ give written notice of claim by delivery thereof or by sending it by registered mail to Co-operators Life not later than 30 Days from the date the claim arises under the Policy,
- Within 90 Days from the date a claim arises under the Policy, furnish Co-operators Life such proof of claim as is reasonably possible in the circumstances of the Medical Emergency.

Failure to Submit Claim or proof of ongoing claim – No Benefits payable

The Member will not be entitled to any Benefits where:

- In the case of Emergency out of province or out of Canada expenses, the Member submits a Claim Form or any other Proof of Claim more than 12 months after the services or supplies are provided.
- If this Policy terminates, or the Participating Company's coverage under this Policy terminates, the Member must submit claims incurred prior to the termination date no later than 90 Days after the termination date.

Proof Within A Reasonable Period
Whenever Co-operators Life requests information necessary for the initial adjudication and/or ongoing adjudication or approval of benefits or authorization on any claims, it must be submitted within the time period specified in the Insurance Company's letter of request. If not submitted in this time, Co-operators Life will not be liable to pay benefits.

Limitation of Action

No action or proceeding at law or in equity shall be brought against Co-operators Life to recover benefits payable under this Policy:

(i) Prior to the expiration of 60 Days after the Claim Form has been filed in accordance with the requirements of this Policy; or
(ii) Unless brought:
- Where no benefits have been paid to the Member, within one year from the expiration of the time within which the Claim Form is first required (Claims Provisions – Time to Submit a Claim) by the Policy or from the date on which Co-operators Life first denies the claim for benefits, whichever first occurs; or
- Where benefits have been paid under the Provision under which benefits are being claimed, within 1 year of the date on which Co-operators Life terminates the payment of benefits under the said Provision.

The time limit within which to commence an action shall expire on the date(s) as specifically provided for in this provision and in no event shall it be extended to each and every monthly payment accruing after the date(s).

Co-ordination of Benefits

Co-operators Life will co-ordinate benefits payable under this Policy with other Plans which also cover an insured person for similar benefits.

If a Member or Dependent who is covered for Extended Health Care benefits and/or Out of Province/Canada benefits under this Policy is also covered under any other Plan which provides similar benefits, the amount of benefits payable under this Policy for Allowable Expenses incurred during any benefit year shall be co-ordinated and/or reduced so that the benefits payable from all Plans shall not exceed 100% of the actual Allowable Expenses.

Plans Co-ordinated with this Policy
For the purpose of co-ordination of benefits, Plan means:
- Group insurance programs;
- Any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, including any pre-payment coverage, capitation plan, franchise plan or services plan; and
- Individual travel insurance plans.

When reimbursement is available under any government plan, each covered expense is reduced by the amount payable under that plan. The reduced covered expense is then considered to be the covered expense under all other co-ordination provisions. It is subject to any applicable deductible, co-insurance or co-payment level, and maximum under this Policy. Government plans are plans that are legislated, funded, or administered by a government.

The amount payable is reduced when this Policy is secondary to another group plan. The reduction is the amount by which total payments under all group plans would exceed eligible Allowable Expenses. An eligible Allowable Expense is that portion of a customary charge for Reasonable and Customary Treatment for which coverage is provided under this Policy.

When payments are reduced, each benefit is reduced proportionately. Only the reduced benefit amount is applied to any payment maximum. Group plans are plans that are available only to Members or members of particular groups and not to the general public.

Student accident plans are not considered group plans. A secondary plan is one that determines its benefits after another plan.

Order of Benefit Payment

1. The Plan with no Co-ordination of Benefits provision in the Policy or Plan document is deemed to pay its benefits first (primary carrier).
2. If all Plans have a Co-ordination of Benefits provision, the following rules are applied to determine the Order of Benefit Payment. The rules depend on the basis on which the person is covered in the Plan.

A plan determines its benefits first if it covers the person as a Member.
If the person is covered as a Member under more than one plan, the plans are prioritized in the following order:

(i) The plan covering the person as an Active, full-time Member;
(ii) The plan covering the person as an Active, part-time Member;
(iii) The plan covering the person as a retiree.

A plan is secondary if it covers the person as a Dependent:
If the Covered Person is covered as a Dependent of more than one person, the plans are prioritized in the following order:

(i) The plan covering the person as a Dependent Spouse;
(ii) The plan covering the person as a Dependent Child of the parent with the earlier birthday in the calendar year;
(iii) The plan covering the person as a Dependent Child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

If the parents are separated or divorced:
The plans under which benefits for the child are determined are prioritized in the following order:

(i) The plan of the parent with custody of the child;
(ii) The plan of the spouse of the parent with custody of the child;
(iii) The plan of the parent without custody of the child;
(iv) The plan of the spouse of the parent without custody of the child.

Dental Accidents
In case of *dental* accidents, dental plans are secondary to Extended Health Care Plans with dental accident coverage.

Out-of-Country/Province Health Care Expenses
Where a person is also covered under more than one policy (for example, from employment related group insurance policy, individual or group travel or health policies, credit card coverage or any other private insurance sources) coverage will be co-ordinated with other policies according to the Co-ordinating Coverage Guidelines for *Out-of-Country/Province Health Care Expenses* provided by the Canadian Life and Health Insurance Association.

Capitation Plans
If other coverage *is* available under a capitation plan, (a pre-paid plan) benefits will be co-ordinated according to guidelines prepared by the Canadian Life and Health Insurance Association.

General Information
If benefits *have* already been paid under another group plan, this Policy is automatically secondary.

If these rules do not establish an order of benefit determination, or another plan has different rules, benefits will be prorated between plans in proportion to the amounts available before co-ordination.

Co-ordination of benefits will also take place within this Policy if a person is covered as both a Member and a Dependent under this Policy; or a person is covered as a dependent of two Members under this Policy.

Other Sources
The amount payable is also reduced when this Policy is secondary to sources other than governments and group plans. The reduction is the amount by which total payments from all sources would exceed covered expenses. When payments are reduced, each benefit is reduced proportionately. Only the reduced benefit amount is applied to any payment maximum. This plan is considered secondary only if payment has already been made by the other source.

Right of Recovery
Whenever payments have been made by Co-operators Life with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Provision, Co-operators Life shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as Co-operators Life shall determine:

(i) Any persons to whom the payments were made, or
(ii) Any persons for whom the payments were made, or
(iii) Any other Insurance Companies, or
(iv) Any other organizations.

CLAIMS PROVISIONS

Third Party Liability

Notwithstanding any other Provision in this Policy where either:

(i) A Member becomes Totally Disabled as a result of an Injury or Sickness, or
(ii) A Covered Person becomes eligible for reimbursement of insured medical or dental expenses as a result of Injury or Sickness,

for which a Third Party is or may be, directly or indirectly, either in whole or in part, legally liable, then Co-operators Life will have no obligation to pay the Member or the Covered Persons any Benefits under this Policy, other than in accordance with this Provision.

Co-operators Life will pay Benefits under the Policy subject to the following conditions:

(i) That the Member or Covered Person repays to Co-operators Life the full amount of the Recoverable Benefits paid or to be paid under this Policy; and
(ii) The Member or Covered Person enters into a Reimbursement Agreement on the terms and conditions stipulated by Co-operators Life; and
(iii) The Member or Covered Person, as the case may be, takes all steps necessary to recover from the Third Party the loss of income and/or expenses advanced or to be advanced or reimbursed under this Policy and any other expenses covered under the Third Party Benefits, including without limitation, commencing and prosecuting an action against the Third Party and if required by Co-operators Life assigning the right to any damages awarded or funds received by way of settlement from the Third Party to Co-operators Life as security for any benefits paid under this Policy.

"Recoverable Benefits" means any Benefits which are paid under this Policy as a consequence of an Injury or Sickness for which a Third Party is, or may be, directly or indirectly, either in whole or in part, legally liable.

Consequences of Failure to Obtain Consent

The Member or Dependent must obtain the written consent of Co-operators Life before compromising or settling the action or cause of action, required in the Third Party Liability section, with the Third Party. Failure to obtain the consent of Co-operators Life will disentitle the Member or Dependent to future Benefits under this Policy and will relieve Co-operators Life of all of its obligations to the Member or Dependent under this Policy. Consent shall not be unreasonably withheld by Co-operators Life.

Age

Co-operators Life shall be entitled to proof of the age of a Covered Person before making payment of any claim under this Policy.

Assignment

The benefits payable under this Policy are assignable only to the Service Provider.

Payee

Benefits payable under this Policy are payable to the Member or, when authorized, the Service Provider.

CLAIMS PROVISIONS

Duty to Disclose

If Co-operators Life or the Third Party Administrator requests health evidence of insurability, the Member or Dependent must disclose at the time of application, every fact that the Member or Dependent is aware of that may be material to the insurance applied for under this Policy in:

- the health evidence application for insurance, and
- any medical examination, and
- any written statement or answers given as evidence of insurability.

Failure to Disclose

The entire coverage under this policy shall be voidable if the Insurer determines, whether before or after loss, that the Policyholder or the Covered Person has concealed, misrepresented or failed to disclose any material fact or circumstance concerning this policy or his interest therein, or if the Policyholder or the Covered Person refuses to disclose information or to permit the use of such information, pertaining to any of the Covered Persons under this policy. Consequently and following a loss, no claim shall be payable by the Insurer and the Covered Person shall be solely responsible for all expenses relating to his claim, including medical repatriation costs. Co-operators Life may contest the validity of the insurance coverage of a Covered Person if Co-operators Life learns of any failure to disclose, or any misrepresentation of fact, before the insurance for that Covered Person has been in force continuously for 2 years during the Covered Person's lifetime.

Exception to Two-Year Limitation

Notwithstanding the Failure to Disclose provision, where the Covered Person makes a claim for benefits under this Policy from a Sickness which began, or an Injury which occurred, before the insurance of the Covered Person under this Policy has been in force for 2 years then Co-operators Life may contest the validity of the insurance at anytime.

Out of Province/Canada Medical Emergency Benefits

Out of Province/Country Emergency Benefits for Members and Dependents

Assessment Standard

All Allowable Expenses covered under this provision must represent Reasonable and Customary Treatment of the Covered Person's Medically Diagnosed Condition.

Amount Payable

Co-operators Life will reimburse the Member for Allowable Expenses:

(i) That are incurred while the Member or Dependent is insured under this Provision; and
(ii) That exceed the deductible, for a Member who is required to pay a deductible.

Covered Expenses

Allowable Expenses are the lesser of the actual charges and the Reasonable and Customary Costs for covered services and supplies.

"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 or Injury.

Co-insurance Levels and Deductible Amounts

Allowable Expenses are reimbursed at the co-insurance level indicated in the Schedule of Benefits. Extended Health Care Benefits are subject to any maximums identified for the covered services or supplies.

The deductible amounts shown in the Schedule of Benefits are applied each calendar year. They are applied as Allowable Expenses are incurred. No more than the individual deductible will apply to an individual Member's expenses. No more than the family deductible will apply to expenses for a Member with Dependents.

The calendar year deductible amounts do not apply to certain coverages identified in the Schedule of Benefits.

Date Expenses are Incurred

For the purposes of all calculations made under this Provision, Allowable Expenses for services and supplies are considered to be incurred when the Covered Person receives them.

Pre-determination of Allowable Expenses

Co-operators Life must be contacted before a Covered Person seeks any medical treatment. If the Covered Person's Medically Diagnosed Condition renders him/her unable to do so, then someone else must contact Co-operators Life. It is the Covered Person's responsibility to ensure that Co-operators Life has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If this pre-determination is not obtained, Co-operators Life's only obligation will be to reimburse the Covered Person for the claim on the basis of the recommendations that would have been made if the pre-determination request had been submitted and the Covered Person will be responsible for paying any difference between the amount actually incurred and the Reasonable and Customary Costs reimbursed by Co-operators Life.

Availability or Quality of Care – Limitation

Co-operators Life shall not take any responsibility for the availability or quality of any medical treatment (including the results thereof) or transportation at the vacation destination, or the Covered Person's failure to obtain medical treatment during the Coverage Period.

Covered Services and Supplies:

To qualify for coverage the Covered Person must be covered by the Government Health Insurance Plan in the Covered Person's province of residence.

Any benefit otherwise payable under this Policy will be reduced by any amount the Covered Person received or is eligible to receive from:

(i) Any Government Health Insurance Plan, or
(ii) Worker's compensation act or any similar statute, or
(iii) Any government hospital, medical, dental or health care Plan, whether payable or not, or
(iv) Any other insurance under which the Covered Person may have coverage.

Where the Government Health Insurance Plan provides a grant in lieu of actual reimbursement for medical services and supplies, Covered Persons will be deemed to have received the maximum grant available unless their "grant notification" states otherwise. The Covered Person must submit a copy of the grant notification together with all receipts to Co-operators Life.

Benefits will be payable as stated under this Policy once an amount equal to the grant has been spent on the Covered Expenses for which the grant was intended. Where payment is available under a charitable organization or other plan, it will be made as per the Co-ordination of Benefits Provision.

Out-of-Province/Country Emergency Care

Out-of-Province or Out-of-Country Emergency care is provided for Covered Persons under the age indicated in the Schedule of Benefits for the Coverage Period indicated in the Schedule of Benefits if:

(i) It is required as a result of a Medical Emergency arising while the Covered Person is traveling outside their province or territory of residence for vacation, business or education; and
(ii) The Covered Person is covered by the Government Health Insurance Plan in their Province of residence.

A Medical Emergency or Emergency means the occurrence of a Sickness 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 the Covered Person returns to Canada and does not include medical attention for the monitoring of a stabilized condition.

During an Emergency (whether prior to admission or during a covered hospitalization), Co-operators Life reserves the right to:

- Transfer the Covered Person to one of Co-operators Life's preferred health care providers, and/or
- Return the Covered Person to his/her province or territory of residence

for the medical treatment of a Sickness and/or Injury where this poses no danger to the life or health of the Covered Person. If the Covered Person chooses to decline the transfer or return when declared medically stable by the Medical Director of Co-operators Life, 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. Co-operators Life will make every provision for the Medically Diagnosed Condition of the Covered Person when choosing and arranging the mode of the transfer or return and, in the case of a transfer, when choosing the Approved Hospital.

Once the Covered Person is deemed medically stable to return to Canada (with or without medical escort) either in the opinion of the Medical Director of Co-operators Life or by virtue of discharge from a medical facility, the 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 this Policy.

Co-operators Life covers the Reasonable and Customary Costs, in excess of the coverage provided by the Covered Person's provincial Government Health Insurance Plan, for the following services and supplies when related to the initial Emergency medical treatment:

(i) Treatment by a Physician.

(ii) Diagnostic x-ray and laboratory 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 Co-operators Life.

(iii) Approved Hospital accommodation in a standard or semi-private ward or coronary care or intensive care unit (if Medically Necessary), if the confinement begins while the Covered Person is insured under this benefit provision. If coverage terminates for any reason during the Covered Person's Approved 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 Covered Person.

(iv) Medical supplies provided during a covered hospital confinement, when approved in advance by Co-operators Life, 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 the Covered Person's province or territory of residence and deemed Medically Necessary.

(v) Paramedical services when authorized in advance by Co-operators Life, to the maximum specified in the Schedule of Benefits.

(vi) Prescription 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 the Covered Person had before the Trip. This benefit is limited to a 30 day supply unless the Covered Person is hospitalized.

(vii) Ambulance services, when reasonable and Medically Necessary, by a licensed ambulance company to the nearest centre where essential treatment is available.

(viii) Emergency Air Transportation when approved in advance by Co-operators Life. Air ambulance to the nearest appropriate medical facility or to a Canadian Hospital for immediate Emergency treatment. Transport on a licensed airline with an attendant (where required) to return to the Covered Person's province or territory of residence.

(ix) Dental accident treatment to the maximum indicated in the Schedule of Benefits per Covered Person for emergency dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth provided the Injury was cased by an external, accidental blow to the mouth or face. The Covered Person must consult a Physician or dentist immediately following the Injury. Treatment must begin during the Coverage period and be completed prior to returning to the Covered Person's home province or territory of residence. An accident report is required from a Physician or dentist for claims purposes.

(x) Private Duty Nurse, the professional services of a registered private nurse, when Medically Necessary and while hospitalized, to the maximum specified in the Schedule of Benefits, per Covered Person, when approved in advance by Co-operators Life.

(xi) Emergency Medical Transportation – when approved and arranged by Co-operators Life, coverage is provided for emergency medical transportation to return the Covered Person to their home province or territory for Emergency medical treatment. If the Covered Person is traveling outside Canada, coverage is also provided for the cost of emergency medical transportation to a hospital in Canada when the Covered Person is assessed as medically transportable, provided transportation has been pre-approved and arranged by Co-operators Life.

(xii) Transportation to Bedside – when approved in advance by Co-operators Life, reimbursement for a single round-trip economy airfare from Canada plus up to the amount specified in the 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:

- be with the Covered Person if the Covered Person was traveling alone and was hospitalized as an in-patient in an Approved Hospital for at least 3 consecutive Days outside of the Covered Person's home province or territory of residence and that the attending Physician provides written certification that the situation was serious enough to warrant the visit; or
- identify the deceased Covered Person prior to the release of the body, where necessary.

Co-operators Life will only reimburse covered expenses evidenced by original receipts.

(xiii) Return Transportation for Traveling Companion – If the Covered Person is returned to their home province or territory of residence under the Medical Emergency Medical Transportation benefit or the Return of Deceased benefit, Co-operators Life will reimburse the cost of a single one-way economy airfare for a traveling companion to return to Canada, when approved in advance by Co-operators Life.

(xiv) Meals and Accommodation – to the maximum specified in the Schedule of Benefits per Covered Person, for the cost of commercial accommodation and meals for the Covered Person 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 the Covered Person. This benefit must be authorized in advance by Co-operators Life. The fact that the Covered Person is unable to travel must be certified by the attending Physician and supported with original receipts from commercial organizations.

(xv) Vehicle Return – to the maximum specified in the Schedule of Benefits if neither the Covered Person nor someone traveling with the Covered Person is able to operate the Covered Person's vehicle, whether owned or rented, during the Trip due to Sickness and/or Injury. Arrangements and payment will be made for the return of the Vehicle to the Covered Person's home province or territory or residence to 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 Co-operators Life. This benefit does not cover wages lost by the person driving the Vehicle. Co-operators Life will only reimburse covered expenses evidenced by original receipts.

(xvi) Return of Deceased – to the maximum specified in the Schedule of Benefits towards the cost of preparation and transportation of the deceased Covered 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 Covered Person, this benefit is limited to $2,500. The cost of the casket or urn is not covered.

(xvii) Incidental Expenses – to the maximum indicated in the Schedule of Benefits for the Covered Person's out-of-pocket expenses such as telephone charges, television rental and parking while the Covered Person is hospitalized for an Emergency and the expenses are incurred as a direct result of such hospitalization. Co-operators Life will only reimburse covered expenses evidenced by original receipts.

Out of Canada Referral Benefit

Referral out of Province of residence or Canada for medical treatment which is unavailable in Canada, up to the Out-of-Province/Canada Referral maximum indicated in the Schedule of Benefits. The purpose of this benefit is not intended to be a relief from treatment waiting lists or to expedite treatment otherwise available in Canada or the Covered Person's Province of residence.

For Referred treatment given outside the Province of residence/Canada, Co-operators Life:

- Requires that it be recommended as necessary by a Physician practicing in Canada, and
- Requires that the Covered Person be covered by the Government Health Insurance Plan in their Province of residence, and
- Treatment be approved and covered in whole or part by the Covered Person's Government Health Insurance Plan in their Province of residence, and
- That a detailed treatment plan be submitted with cost estimates before treatment begins.

Co-operators Life will then advise the Member of any benefit that will be provided.

Co-operators Life covers the Reasonable and Customary Charges, in excess of the coverage provided by the Covered Person's provincial Government Health Insurance Plan, or which would have been payable had proper application been made, for the following services and supplies when related to the referred medical treatment:

- Physicians services;
- Hospital room and board at standard Ward rates;
- The cost of Hospital services;
- Hospital charges for out patient treatment;
- Licensed ambulance services, including air ambulance to transfer the patient to the nearest medical facility or Hospital where adequate treatment is available; and
- Medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides.

All other charges incurred while outside the Province of residence are payable under the appropriate covered Expense on the same basis as if they were incurred in the Province of residence.

General Limitations and Exclusions

No benefits will be paid for:

1. Expenses that private insurers are not permitted to cover by law.
2. Services or supplies payable by worker's compensation or similar statute or a Third Party or where the Covered Person is entitled to without charge or for which a charge is made only because the Covered Person has insurance coverage.
3. Services or supplies that do not represent Reasonable and Customary Treatment of the Covered Person's Medically Diagnosed Condition.
4. Services or supplies associated with:
   - treatment performed for cosmetic purposes only;
   - recreation or sports rather than with other regular daily living activities;
   - services or supplies in connection with a change in gender;
   - anti-obesity treatment, including drugs, protein and dietary or food supplements whether or not prescribed for a medical reason;
   - the diagnosis or treatment of infertility; or
   - contraception, other than contraceptive drugs.
5. Services or supplies:
   - not specifically listed as a covered expense; or
   - associated with covered items, unless specifically listed as a covered expense.
6. Services or supplies received outside Canada except as specifically listed as covered under the Emergency Out-of-Province or Canada provision.
7. Expenses incurred for:
   - the completion of claim forms;
   - obtaining further medical information regarding claims for covered expenses;
   - medical screening or examinations for the use of a Third Party, or
   - broken appointments, travel expenses or communication costs by a Medical Practitioner.
8. Expenses arising from:
   - war, revolution or military power, insurrection, civil commotion, acts of terrorism or voluntary participation in a riot, or
   - active duty as a member of any branch of the armed forces of any government.

9. Extra charges which may result due to the Medical Practitioner or any other health practitioner opting-out of the provincial Government Health Insurance Plan. Coverage will be provided on the same basis as if the Medical Practitioner or any other health practitioner was a member of the provincial Government Health Insurance Plan.
10. Medical Care or expenses which are provided or covered by a Government Health Insurance Plan, a Third Party, any worker's compensation act or similar statute or a charitable organization, even if the Covered Person has opted-out of the Plan.
11. Medical Care that was necessitated either wholly or partly, directly or indirectly as the result of committing, attempting or provoking an assault or criminal offence.
12. Medical Expenses incurred as a result of a situation from Injuries sustained in, or directly or indirectly from, a Vehicle accident where the Covered Person was driving a Vehicle involved in the accident and had either:
    - alcohol in his or her blood in excess of 80 milligrams of alcohol per hundred milliliters of blood; or
    - his or her capacity impaired as a result of drug or alcohol usage.
13. Treatment or services normally covered or reimbursable under a Government Health Insurance Plan or under other insurance the Covered Person might have.
14. 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.
15. Any Trip booked or commenced contrary to medical advice or after being diagnosed with a Terminal Illness.
16. Any medical condition for which, prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization could be required while traveling.
17. Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that the Covered Person elects to have provided outside his province or territory of residence when medical evidence indicates that the Covered Person could return to his province or territory of residence to receive such treatment. The delay to receive treatment in the province or territory of residence has no bearing on the application of this exclusion.
18. 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. This exclusion does not apply to the Out of Canada Referral Benefit.
19. Cardiac catheterization, angioplasty, and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by Co-operators Life prior to being performed, except in extreme circumstances where such surgery is performed on an Emergency basis immediately upon admission to Hospital.
20. Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Co-operators Life.
21. 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 drug, 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 Co-operators Life).
22. A disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless the Covered Person is hospitalized.

23. Emergency air transportation and/or car rental, unless approved and arranged in advance by Co-operators Life.
24. Treatment not performed by or under the supervision of a Physician or licensed dentist.
25. Treatment or hospitalization of mother or child as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the 4 weeks before or after the expected delivery date.
26. 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.
27. Suicide (including any attempt thereat) or self-inflicted injury, whether or not the Covered Person is sane.
28. Participation in any sport as a professional athlete (for which the Covered Person is 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).
29. Loss or damage to hearing devices, eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices and resulting prescription thereof.
30. The replacement of an existing prescription whether by reason of loss, unless otherwise specified elsewhere in this 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.
31. Upgrading charges and cancellation penalties for airline tickets, unless approved in advance by Co-operators Life.
32. The cost of any airline ticket covered under this policy where the Covered Person's ticket may be exchanged or used for the same purpose.
33. Crowns and root canals.
34. Treatment or services received in the province where a Covered Person attends school or works on a full-time basis or in his home country, if such Covered Person is a foreign student studying in Canada or a non-resident working in Canada.