

**Maximum Benefit
Firm Nos.**

**48598
48606
48607**

**IUPAT Local 177
Welfare Trust Fund**

Retirees

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. 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

Eligibility Rules

Provided by:

IUPAT Local 177 Welfare Trust Fund
Firm Nos. 48598, 48606 & 48607

Extended Health Care & Dental Care

Provided by:

IUPAT Local 177 Welfare Trust Fund
Firm Nos. 48598, 48606 & 48607

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
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Administered by:

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

Toll Free: (800) 893-7587
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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

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Booklet Effective Date: August 1, 2016
Effective Date of Plan: January 1, 2008
Date Issued: August 2016

**ELIGIBILITY RULES OF THE EARLY RETIREE HEALTH BENEFIT PROGRAM
(the "Program") OF THE IUPAT LOCAL 177 WELFARE TRUST FUND (the "Trust
Fund") MADE EFFECTIVE AS OF JANUARY 1, 2008
(Updated as of July 1, 2008)**

Effective January 1, 2008, the Trust Fund will offer to eligible Members of the Benefit Plan (the "Plan") of the Trust Fund and Early Retiree Health Benefit Program (the "Program"). The Board of Trustees expressly reserve the right to amend these Eligibility Rules from time to time and expressly reserve the right, as set out in the Trust Agreement, to change the benefits provided by the Program and to terminate the Program. Subject to the foregoing, the Eligibility Rules are as follows:

1. If at the time that a Member's Hour Bank with the Plan ends, or a Member's eligibility to make self payments to the Plan (such date being referred to as the "End of Plan Eligibility"), the Member is (a) under the age of 65 years; and (b) is in receipt of a Pension, or will be entitled to be in receipt of a Pension within 3 months from the End of Eligibility, from the IUPAT Local 177 Pension Plan, such Member is eligible to join the Program subject to the other provisions of these Eligibility Rules;
2. At the End of Plan Eligibility, the Member must be in good standing with IUPAT Local 177, and must remain in good standing on an uninterrupted basis with IUPAT Local 177 from the End of Eligibility and while such Member participates in the Program;
3. Within prescribed time period from the End of Eligibility (as such prescribed period is determined by the Board of Trustees from time to time), a Member must elect to participate in the Program by delivering to the Administrator of the Plan the required election form to participate in the Program and must complete such other documents as may be required by the Trustees from time to time. Currently, the time period to make such an election is 14 days from the End of Eligibility;
4. To be eligible for the Program, the Member must also have been either working or available for work within the jurisdiction of IUPAT Local 177, during the 12 months immediately preceding the End of Eligibility;
5. To be eligible for the Program, the Member must have been covered for benefits as an active Member of the Plan without interruption during the 12 months immediately preceding the End of Eligibility;
6. The Member must make the required monthly contributions required for the Program to the Administrator's office on an uninterrupted basis. The monthly contributions must be paid by way of post dated cheques or automatic credit card payments, with the first payment having been received by the Administrator with 14 days of the End of Eligibility;
7. Continued Eligibility for the Program is subject to IUPAT Local 177's verification of eligibility based on the Local's Retiree Member rules.
8. The benefits to be provided under the Program, and the contribution rates for such Program, shall be determined by the Board of Trustees from time to time. A summary of the benefits (Appendix "A") and the contribution rates (Appendix "B") is attached.

**ELIGIBILITY RULES OF THE EARLY RETIREE HEALTH BENEFIT PROGRAM
(the “Program”) OF THE IUPAT LOCAL 177 WELFARE TRUST FUND (the “Trust
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(Updated as of July 1, 2008)**

9. A Member of the Program, subject to the other conditions of these Eligibility Rules, will remain eligible for coverage until the last day of the month in which the Member reaches the age 65 years. A Member will cease to be eligible for continuing coverage of the Program if:
 - a) The Member does not remain in good standing with IUPAT Local 177 as a retired Member for a period of more than 30 days;
 - b) The Member fails to pay a contribution when due, and such default continues for a period of 14 days from the due date;
 - c) The Member gives written notice to the Administrator that the Member does not wish to continue to participate in the Program, in which case such coverage will end at the later of:
 - i. The end of the month in which such notice was received by the Administrator; and
 - ii. The date under which the eligibility in the Program ends under any of the other provisions of these Eligibility Rules or under any of the provisions of the Group Insurance Policy for the Program;
 - d) Upon the Member regaining eligibility for benefits in the Plan as an active Member of the Plan.
10. Except for a Member who becomes an active Member of the Plan subsequent to joining the Program, a Member whose participation in the Program ends by reason of any of the provision of these Eligibility Rules is not eligible to rejoin the Program or to commence to receive benefits in the Program for a second time.

These Eligibility Rules have been made and passed by the Board of Trustees this 11th day of April, 2008, with effect as of January 1, 2008. These Eligibility Rules were subsequently updated as of July 1, 2008.

Section II

Extended Health Care Dental Care

BENEFIT SCHEDULE – EXTENDED HEALTH CARE

Class 3	Retirees
Co-Insurance	<p>Maximum Benefit will pay the percentages of Eligible Expenses, which are in Excess of the Deductible Amount, as follows:</p> <ul style="list-style-type: none"> • In Province Hospital Eligible Expense – 100% • Prescription Drugs: <ul style="list-style-type: none"> – 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	Coverage terminates the last day of the month in which the Retiree reaches Age 65

Prescription Drug Coverage

Deductible	Dispensing Fee
Formulary and Maximums	<ul style="list-style-type: none"> • Drug Formulary 49/AB (Alberta Formulary) with generic and 88G, as defined by Telus Health Solutions • Drug coverage includes: <ul style="list-style-type: none"> • All Eligible Prescription Drugs, bearing a Drug Identification Number - \$8,000 annual maximum • Preventative immunization vaccines and toxoids are covered • This plan includes the Prior Authorization Drug Program.

Other Coverages

Deductible	Nil
Overall Maximum	\$2,000 per person, per calendar year
Maximum	Combined Extended Health Care coverage - \$2,000 annual maximum
In-Province Hospital	The difference between the ward and semi-private rate, unlimited maximum
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

BENEFIT SCHEDULE – EXTENDED HEALTH CARE

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 in any 24 month period.

BENEFIT SCHEDULE – DENTAL CARE BENEFIT

Class 3	Retirees
Deductible Amount	Nil
Co-Insurance	Maximum Benefit will pay the percentages of eligible expenses, which are in excess of the deductible amount, as follows: <ul style="list-style-type: none">• 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%
Maximum Benefit	<ul style="list-style-type: none">• Basic and Major Services combined – \$2,500 per calendar year• Endodontics, Periodontics combined with Basic
Dental Fee Guide Year	Fixed 2016 Fee Guide, General Practitioner
Dental Fee Guide Province	Province of Residence
Age Limit	Coverage terminates the last day of the month in which the Retiree reaches Age 65

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.

DEFINITIONS

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.
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.

DEFINITIONS

Hospital	<p>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.</p> <p>A legally licensed institution which is operated for the care and treatment of sick and injured persons as In-patients, and which:</p> <ol style="list-style-type: none">Is eligible to receive payments under a provincial hospital plan;Provides organized facilities for diagnosis and major surgery;Provides 24-hour nursing service by registered nurses, and has a Physician in regular attendance;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; andIs not primarily operated as a place for the care and treatment of alcoholics, drug addicts, or the mentally ill. <p>For the purpose of this Plan, Chronic Care and Convalescent/ Rehabilitation Facilities/beds are not considered under the Hospital coverage.</p>
Hospitalized	<p>Being confined in a hospital for more than 18 consecutive hours.</p>
Temporary Lay-Off	<p>A period during which the Employee is laid off work with an expectation of returning to work.</p>
Leave of Absence	<p>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.</p>
Licensed, Certified, Registered	<p>The status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority.</p>
Maternity Leave of Absence	<p>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:</p> <ol style="list-style-type: none">the date fixed by mutual agreement between the Employee and the Employer;orthe date the child is born.
Medically Necessary	<p>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.</p>
Parental Leave of Absence	<p>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.</p>
Nursing Home	<p>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.</p>

DEFINITIONS

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: <ul style="list-style-type: none">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, trustee 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: <ul style="list-style-type: none">a) a marriage through an ecclesiastical or civil ceremony, orb) 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.
Spouse	A person who: <ul style="list-style-type: none">a) is married through an ecclesiastical or civil ceremony to an Employee, orb) 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. <p>At any one time, only one person may be insured as an Employee's spouse.</p>
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.

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	<p>A benefit payable during the lifetime of the Employee will be made to the Employee unless otherwise indicated elsewhere in the policy.</p> <p>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.</p>
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 based 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	<p>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.</p> <p>The insurance industry standards determine where a claim should be sent first for payment:</p> <ol style="list-style-type: none">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. If the covered person is confined in a hospital as of the effective date of their coverage, they will not become eligible for the hospital benefit until they are discharged from the hospital.
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:
Ambulance	<ol style="list-style-type: none">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:<ul style="list-style-type: none">• 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.
Pay-Direct Drugs (Generic Substitution)	<p>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:</p> <ul style="list-style-type: none">• 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). <p>*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.</p> <p>If the physician does not permit the drug to be substituted, the eligible expense will include the cost of the brand name product.</p>

EXTENDED HEALTH CARE BENEFIT

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.

EXTENDED HEALTH CARE BENEFIT

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 orthosis or arch support.

Combined maximum of \$300 per calendar year.

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**

EXTENDED HEALTH CARE BENEFIT

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 expensive 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.

EXTENDED HEALTH CARE BENEFIT

Co-ordination of Benefits	This benefit is subject to the Co-ordination of Benefits provision of this policy.
Proof of Claim	<p>Written proof of a claim must be submitted to Maximum Benefit within 365 days of the date the expense was incurred.</p> <p>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.</p>
Survivor Benefit	<p>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:</p> <ol style="list-style-type: none">The end of the period of 12 months following the date of the death of the Member,The exhaustion of the deceased member's hour bank,The date on which the Spouse remarries,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 expensive 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.

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;

DENTAL CARE BENEFIT

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.

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.