Maximum Benefit
Firm Nos.

48598
48606
48607

IUPAT Local 177
Welfare Trust Fund

All Active Employees aged 70-74

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

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)
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Edmonton, AB T5J 1L3

Local: (780) 452-5161
Toll Free: (800) 770-2998
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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

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 and/or dependent information 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.

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: January 1, 2008

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

Date Issued: August 2016

TABLE OF CONTENTS

Section I

Extended Health Care
Dental Care

BENEFIT SCHEDULE – EXTENDED HEALTH CARE

Class 4	**All Active Employees aged 70 - 74**
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	Terminates at age 75

<u>Prescription Drug Coverage</u>

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 • $8,000 overall maximum per person, per calendar year • Preventative immunization vaccines and toxoids are covered • This plan includes the Prior Authorization Drug Program.

<u>Other Coverages</u>

Deductible	Nil
Overall Maximum	$2,000 per person, per calendar year
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
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 4	**All Active Employees aged 70 - 74**
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%
Maximum Benefit	• 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	Terminates at age 75

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	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.
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.

DEFINITIONS

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.

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.
- 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.
- 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 for Disabled Employees

If an Employee is disabled or becomes disabled, Extended Health Care and Dental benefits will terminate at the earlier of:

a) 24 months from the initial date of disability (first day not actively at work),
b) The date the Plan Sponsor or Maximum Benefit terminates this plan,
c) The date the Employee requests termination of the coverage,
d) The date the Plan Sponsor requests termination of the Employee, due to the Employee's non-payment of any required contribution, if applicable.

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. 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

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.

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, and
- Are not in excess of a 34-day supply (100 day supply for maintenance drugs).

EXTENDED HEALTH CARE BENEFIT

Prior Authorization Drug program

The plan covers drugs that are medically necessary. The Prior Authorization (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 orthesis 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 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.

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.

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.

EXTENDED HEALTH CARE BENEFIT

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.

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

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;

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.