

International Association of HEAT and FROST INSULATORS & ASBESTOS WORKERS, No. 118



Health and Welfare Trust Fund

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Revised January 2007

www.hfbenefits.org

INTRODUCTION

On the following pages, you will find a brief description of the benefits provided by the Plan. We are certain the Plan will bring a greater peace of mind and an increased feeling of security to you and your family. Although it is intended to summarize the principal features of your Plan, all rights to benefits are governed by the Group Contract/Policy.

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

The Trustees are constantly attempting to provide benefits under the Plan to Members/Employees in the most cost-effective manner. For some benefits, such as Dental, Short Term Disability and some portions of the Extended Health Care, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act.

PRIVACY POLICY

We have a Privacy Policy which governs our collection, use and disclosure of personal information (including personal health information) about individuals who are Members or Dependents. The Privacy Policy requires us to keep such personal information confidential, but does permit use and disclosure of personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of our current Privacy Policy can be obtained from us on request and is also available on our website. By participating in the group benefit and insurance plans, and submitting claims under those plans, you are consenting to the collection, use and disclosure of your personal information pursuant to the terms of our Privacy Policy.

TO ALL MEMBERS:

This Plan is an Hour Bank system designed for Members of Local Union 118. Effective May 1, 2005 D.A. Townley & Associates Ltd. has been appointed to arrange the benefits and administer the International Association of Heat and Frost Insulators & Asbestos Workers, No. 118 Health and Welfare Trust Fund.

This booklet outlines benefits to which eligible Members and their covered Dependents may be entitled and outlines the procedures to be followed when making claims.

The employers contribute for each hour worked under the Collective Agreement. These hours are accumulated in the Hour Bank to provide you with coverage when you meet the eligibility requirements as outlined further along in this booklet.

Details of how you self-pay and the coverage available to you are also included in this booklet.

You are asked to read this booklet carefully so that you will have a clear understanding of how your Plan operates for the benefit of you and your family. It is your responsibility to maintain your coverage during periods of unemployment should your Hour Bank drop below the required amount of hours to provide monthly coverage.

We welcome your interest and suggestions in the hope that the Plan will always reflect the desire of the majority of the people it serves.

For any additional information or assistance, feel free to contact the Administrator's Office.

FROM THE TRUSTEES,

INTERNATIONAL ASSOCIATION OF HEAT AND FROST
INSULATORS & ASBESTOS WORKERS, NO. 118
HEALTH AND WELFARE TRUST FUND

BENEFITS PROVIDED BY:

**INTERNATIONAL ASSOCIATION OF HEAT AND FROST
INSULATORS & ASBESTOS WORKERS, No 118
HEALTH AND WELFARE TRUST FUND**

Dental

Extended Health Care*

Short Term Disability

(Group No. 903118, 903119, 903211 or 903120 (See booklet))

MEDICAL SERVICES PLAN OF BC

Basic Medical Coverage

(Group No. 3131182)

MANULIFE FINANCIAL

Life Insurance

Long Term Disability

(Group No. 961442)

RBC LIFE INSURANCE COMPANY

Accidental Death & Dismemberment

(Group No. GSR 16853)

*Expert Travel Financial Security (ETFS) insures a
\$10,000 Stop-Loss on the Extended Health Care Benefit.

ADDRESS INQUIRIES

to the Administrator's Office:

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PLAN SUMMARY TABLE

	Industrial/Institutional Plans			Commercial Plans	
	Active (Hour Bank)	Long-Term Disabled	Retired	Active (Hour Bank)	Active (Monthly)
MSP-BC	Yes	Yes	No	Yes	No
STD	Yes	N/A	No	No	No
LTD	Yes	N/A	No	Yes	Yes
Life Insurance	Yes	Yes	Yes	Yes	Yes
AD&D	Yes	Yes	No	Yes	Yes
Dental	Yes	Yes	Yes	Yes	Yes
EHC	Yes	Yes	Yes	Yes	Yes
Continued coverage on LTD	Yes	N/A	N/A	No	No
Eligible for Retirees Plan	Yes	Yes	N/A	No	No

GENERAL INFORMATION

Hour Bank System

	Industrial/ Institutional	Commercial
Hours to qualify for coverage	250	300
... worked within	10	9
Monthly cover charge	125	150
Hour Bank maximum	1,125	750
Self-Pay limit	9 months	6 months

How do I establish coverage?

- 1) You must be a Member in good standing of the Heat & Frost Workers' Local Union 118. (For H&W Plan purposes, Members working for non-union contractors who refuse to co-operate in Local 118 organizing efforts are not in good standing.)
- 2) You must be enrolled in the Plan by completing the Life Insurance beneficiary designation and the enrolment forms for MSP-BC.
- 3) You must have earned, and your employer(s) must have reported and paid into the Plan, the number of hours required to qualify for coverage according to the Hour Bank table above.
Hours worked but not reported or paid by your employers do not qualify you for coverage.

Associate Members

Associate Members are owners, estimators, office personnel and other employees of a participating employer, for which permission has been applied for and granted by the Union. The Union reserves the right to approve or reject a request for Associate Member coverage.

How do employer reports come in?

Your Collective Agreement requires that employers report, prior to the 15th day of each month, all hours worked by you up to the close of the employer's payroll ending closest to the last day of the pre-

ceding month. It is advisable that you keep your own pay slips as errors may occur in reporting or tabulating.

Reporting Month

The Administrator's Office needs a reporting month to operate the Hour Bank system. Employers send their reports and contributions for the hours Members work each month to the Administrator's Office in the following month. The Administrator's Office posts the hours to your Hour Bank.

When does coverage begin?

If you have filled out the application forms, your coverage will start on the first day of the month following the month in which enough hours are reported to the Plan by your employer(s).

EXAMPLE:

Month Worked:	Hours Reported:
June	0
July	150
August	150
September	Lag Month
October	Coverage Starts

How does coverage continue?

Once you are covered, the hours your employers report for you are added to your Hour Bank. Each month, a fixed number of hours are deducted to "pay" for your coverage (the "cover charge") and you will continue to be covered as long as your Hour Bank contains sufficient hours.

You may accumulate hours in your Hour Bank to carry you through periods of poor employment or vacation. Any hours in excess of the "Hour Bank maximum" go into the general fund of the Plan.

What if the Hour Bank falls short?

When your Hour Bank has too few hours to pay the cover charge, you are no longer covered by the Plan. However, you have the option of paying for the coverage yourself.

When do not have enough hours to continue coverage, the Administrator sends you a shortage notice telling you how many hours you are short and the amount required to maintain coverage. If you make payment of the amount requested by the deadline specified on the Notice, your coverage will be continuous.

Do not ignore the shortage notice! You could lose your coverage if you fail to respond. If you make a self-payment and late hours are reported or other adjustments are received later, all hours will be credited to your Hour Bank for future coverage.

Self-Pay limit

The "self-pay limit" is the number of consecutive months you may continue your coverage by self-payment, provided you remain a Member in good standing of the Heat & Frost Workers' Local Union 118. If you return to work for an employer then the count of your self-payments will reset to zero, if the employer remits enough hours to the Plan to provide a month of coverage.

While making full self-payments, you will have full benefits except for Short Term Disability and Long Term Disability. Associate Members are not entitled to self-pay.

When a Member is collecting under the Short Term Disability Plan/E.I. Sick Pay or Workers' Compensation, will they receive assistance with their Hour Bank?

Yes. For each day that he/she is disabled and provided that the claim for the Short Term Disability Plan/E.I. Sick Pay or Workers' Compensation has been accepted for payment, the Hour Bank will be credited with contributions of 4 hours per day subject to a maximum of the monthly Hour Bank charge each month for up to 12 months. If the claim is for STD this will be done automatically, but for Workers' Compensation or E.I. Sick Pay, a special form should be requested from the Administrator's office. To qualify for these Disability Credits the Member must be eligible for benefits when the disability commences.

When does coverage end?

Coverage is always provided on a whole month basis only, and will be terminated for you and your Dependents when:

- Your Hour Bank falls below the cover charge and you do not pay your shortage notice by the specified date, OR

- When you cease to be a Member in good standing of the Union.

If coverage ends, when will coverage start again?

If your coverage ends, you must re-qualify as described previously under “HOW DO I ESTABLISH COVERAGE?”, i.e. when enough hours have been worked and reported to the Plan. **You may not requalify by self-payment.**

However, if your coverage is terminated because you accidentally fail to pay a shortage notice, and you contact the Administrator’s office immediately, you may be allowed to reinstate coverage by paying the actual number of hours you were short, plus a full payment to ensure continued coverage for the following month.

Hour Bank Freeze

The regulations of the Heat & Frost Welfare Plan allow you, as a Member of Local 118, if temporarily working out of any other Local in Canada, to “suspend” or “freeze” hours submitted by your employer and your existing Hour Bank. Please contact your Union office or Administrator for the rules regarding freezing your Hour Bank.

Reciprocal Agreement

If you are working in the jurisdiction of another Local Union on a temporary basis for up to 12 consecutive months, and the other Local has a Welfare Plan which has entered into a Reciprocal Agreement with this Plan, then the hours remitted on your behalf may be transferred back to this Plan to help you maintain coverage.

Before any hours can be transferred, a Benefits Transfer Form must be completed and returned to the Heat & Frost Local Union 118 Business Office.

Coverage options at time of termination

When your benefits under the International Association of Heat and Frost Insulators & Asbestos Workers No. 118 Health and Welfare Trust Fund terminate, you may want to continue your coverage.

Conversion Privilege

Your Life Insurance continues for 31 days following either the termination of your employment, or your classification changing to one

in which you are not insured. During this 31-day period you may convert the amount of your Group Life Insurance, provided you are under 65 years of age, to any individual whole life or convertible one-year term or term to age 65 plan without submitting evidence of health.

The amount of the individual policy shall not exceed the amount of insurance for which you were insured when coverage was discontinued, subject to a maximum of \$200,000 less any amount you become eligible for under a replacing contract of group life insurance.

The premium rate will be determined from your age and class of risk at the time of conversion.

Note: The conversion privilege does not apply for loss of insurance as a result of:

- i) any age reduction specified in the Summary of Benefits; or
- ii) if insurance terminates when you reach the age specified in the Summary of Benefits section or upon your retirement.

All Terminating Members – Basic Medical

You should take basic medical coverage through the Medical Services Plan of BC.

Long-service retirees from the Industrial/Institutional Plan – Local 118 Retirees Benefit Plan

If you are retiring from the Industrial/Institutional plan with at least 10 years of Local 118 Membership, and are taking a pension from the Heat and Frost Local Union 118 Pension Plan, you may be eligible for the Local 118 Retirees Benefit Plan.

For further information, please contact the Plan office.

If I die, do my Dependents remain covered?

Yes, the Plan will continue their coverage for 10 months, whether or not there are hours remaining in your Hour Bank at the time of your death.

Dependent Coverage

Your eligible Dependents will be covered for Extended Health Care and Dental Benefits and for Basic Medical (MSP-BC), but you must register them in the Plan for this coverage to take effect. Your eligible Dependents are:

- your Spouse; and

- your Dependent children to age 21 (age 19 for MSP-BC); and
- your Dependent children to any age (age 25 for MSP-BC) who are attending a recognized school or college full time (you must be prepared to prove dependency); and
- your Dependent children to any age who are physically or mentally disabled who are dependent on you for support and for whom you are entitled to an income tax exemption, provided each child was covered by the Plan immediately prior to his or her 21st birthday.

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

Dependents are **not** covered for Short Term Disability, Life Insurance, and Accidental Death & Dismemberment coverage.

New Dependents are not covered until you register them.

BASIC MEDICAL – MSP-BC COVERAGE

When you qualify you will be covered with the Medical Services Plan of BC, provided you have completed the required application form. The Medical Services Plan of BC pamphlet provides a detailed outline of the medical coverage under the Government Plan. **Your MSP-BC Group Number is: 3131182**

DEFINITIONS

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

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

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

Fee guide means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed. For Alberta, the Fee guide means the current Canadian Life and Health Insurance Association fee guide.

Fee schedule means the Plan's schedule that contains eligible Dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Integration with Government Plans

Extended Health Care benefits are intended to supplement and not overlap benefits under government plans such as the Medical Services Plan and Fair Pharmacare Program of British Columbia. You are required, as a condition of coverage, to take all reasonable steps to qualify and obtain the fullest extent of coverage, benefits, contribution, or reimbursement available under all applicable government plans. We will also make payment only where permitted by provincial legislation or other applicable law.

Effective Date of Coverage and Enrolment

If you are eligible for coverage, you must complete an application card to ensure that your coverage starts on the correct effective date.

You should apply for Dependent coverage (when applicable):

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

Coverage begins on the coverage effective date shown on your identification (ID) card(s), provided you have complied with our enrolment rules.

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

Coverage effective date – Retired Members means the day after your coverage terminates under the Industrial/Institutional Hour Bank or Disabled Plan for active employees, provided you apply for Benefits within the Allowable enrolment periods.

Identification (ID) Cards

Identification (ID) cards will be issued for distribution, by your Plan Administrator.

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

You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent for your group.

Claims

- 1) All claims must be submitted to us in English.
- 2) We pay eligible claims when we receive all the required information within the required time limits. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.
- 3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled.

- 4) The necessary claim forms are available from your Plan Administrator.
- 5) The exchange rate on foreign currency is payable at the rate quoted by selected financial institutions in Vancouver, British Columbia, for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

Duplicate Coverage

If you and your Spouse have coverage under the Heat & Frost Local Union 118 Health and Welfare Plan, please check with your Plan Administrator to see if Duplicate coverage is allowed for Dental and Extended Health Care benefits.

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

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

Your Plan Administrator will advise you if you are eligible to waive certain benefits under this group plan.

Coordination of Benefits

If Duplicate coverage is allowed, we pay claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

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

General Exclusions

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

Termination of Coverage

Generally, your coverage (and any Dependent coverage) terminates based on the Hour Bank rules described in the Plan booklet, or if the group plan terminates. If you have questions about coverage, please contact your Plan Administrator.

Pre-Existing Condition

Means any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12-month period before you apply for the Plan.

EXTENDED HEALTH CARE

Industrial and Institutional:

Active (Hour Bank) #903118

Retirees #903119

Disabled/Associate #903211

Commercial:

Active (Hour Bank) #903120

Deductible –
All groups

\$50 per person or family each calendar year. If in any calendar year the Eligible expenses do not exceed the Deductible, the Eligible expenses incurred during the last 3 months of the calendar year may be applied against the Deductible for the next year.

*Reimbursement
Group 903118*

**In-Province Eligible Expenses and
Out-of-Province non-Emergency
Eligible Expenses:** 100%
**Out-of-Province Emergency Eligible
Expenses:** 100%

*Reimbursement
Group 903119*

**In-Province Eligible Expenses and
Out-of-Province non-Emergency
Eligible Expenses:** 70%
**Out-of-Province Emergency
Eligible Expenses:** 100%

*Reimbursement
Group 903211*

**In-Province Eligible Expenses and
Out-of-Province non-Emergency
Eligible Expenses:**
- Hearing Aids and Vision Care 100%
- Other 80%
**Out-of-Province Emergency Eligible
Expenses:** 100%

*Reimbursement
Group 903120*

**In-Province Eligible Expenses and
Out-of-Province Non-Emergency
Eligible Expenses:** 80%
**Out-of-Province Emergency
Eligible Expenses:** 100%

<i>Reimbursement Note Groups 903119, 903211 and 903120</i>	After \$1,000 has been paid for a person or family in a calendar year, further Eligible expenses for that person or family within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.
<i>Plan Maximum Groups 903118, 903211 and 903120</i>	The lifetime maximum amount of benefits payable for a Member or Dependent is unlimited, subject to the terms and conditions of the Group Contract.
<i>Plan Maximum Group 903119</i>	The lifetime maximum amount of benefits payable for a Member or Dependent is \$25,000.
<i>Dependent Children All groups</i>	Eligible until reaching age 21, or reaching any age if in full-time attendance at a school or university, or to any age if handicapped.

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

All dollar limits included in the benefit descriptions are claimable unless specifically defined as payable.

To determine the benefit amount claimable, the claim is assessed as follows:

- the total Eligible expense is calculated
- the claimable limits are applied
- the Deductible, when applicable, is subtracted
- the reimbursement percentage is applied, then
- the EHC plan maximum (if applicable) is applied.

To determine the benefit amount payable, the claim is assessed as follows:

- the total Eligible expense is calculated
- the Deductible, when applicable, is subtracted
- the reimbursement percentage is applied
- the payment limits are applied, then
- the EHC plan maximum (if applicable), is applied.

DEFINITIONS

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

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

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing, or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan. PharmaCare’s Low Cost Alternative and Reference Based Pricing will not be applied unless specified in this booklet.

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

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

In-Province Eligible Expenses

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

1) Hospital

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

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

- 3) Prescription Drugs

Drugs and medicines dispensed by a licensed pharmacist or a Physician, in a quantity we consider reasonable:

 - a) drugs and medicines which legally require a prescription from a Physician or Dentist, and included with the above:
 - b) insulin preparations for diabetics
 - c) vitamin B12 for the treatment of pernicious anemia
 - d) allergy serums when administered by a Physician.

- 4) Practitioners

Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician.*

Group 903118 and 903211:

- a) acupuncturist.....\$400
- b) chiropractor\$400
- c) massage practitioner.....no Calendar year limit
- d) naturopath\$400
- e) physiotherapist.....no Calendar year limit
- f) podiatrist.....\$400
- g) psychologist\$400
- h) speech language pathologist\$400
- i) private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence.

Group 903119:

- a) acupuncturist.....\$400
- b) chiropractor\$400
- c) massage practitioner.....no Calendar year limit
- d) naturopath\$400
- e) physiotherapist.....no Calendar year limit
- f) podiatrist.....\$400
- g) psychologist\$400
- h) speech language pathologist\$400
- i) private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence.

Group 903120:

- a) acupuncturist.....\$400
- b) chiropractor\$400
- c) massage practitioner.....no Calendar year limit
- d) naturopath\$400
- e) physiotherapist.....no Calendar year limit
- f) podiatrist.....\$400
- g) psychologist\$400
- h) speech language pathologist\$400
- i) private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence.

5) Dental Accident

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

Accidental

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

We pay benefits based on eligible Dental services and financial limits in our current Fee schedule, and we pay the fees in our current Fee schedule or, if applicable, the Fee guide in the province/territory of service.

6) Medical aids and supplies

Charges for the following services and supplies:

- a) testing supplies, needles, and syringes for diabetics
- b) oxygen, blood, and blood plasma
- c) ostomy and ileostomy supplies
- d) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports
- e) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prostheses
- f) mastectomy brassieres to a maximum of 1 brassiere per breast prosthesis to a maximum of 2 per lifetime
- g) charges for the following items to the maximum amounts indicated per calendar year:
 - i) stump socksno limit
 - ii) surgical stocking2 pairs
- h) wigs and hairpieces required as a result of medical treatment or injury to a lifetime payable maximum of \$500
- i) when prescribed by a Physician or podiatrist as medically necessary, charges for one pair of custom fitted orthopedic shoes or orthotics and replacements when necessitated by normal wear and tear
- j) hearing aids and repairs to the maximum shown below. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.
 - i) For groups 903118 and 903211, a lifetime maximum of \$500. Dependent children are covered for an additional benefit of \$400 per 60-month period.
 - ii) For group 903120, a maximum of \$300 in a 60-month period.
 - iii) **Hearing aids are not an Eligible expense for group 903119.**

- 7) Standard durable medical equipment
- a) Preauthorization is required from us for expenses in excess of \$5,000
 - b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.
 - c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.
 - d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
 - e) Standard durable equipment includes:
 - i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent
 - ii) medical monitors including heart and blood glucose monitors, and cardiac screeners
 - iii) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems
 - iv) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
 - v) insulin infusion pumps for diabetics – when basic methods are not feasible
 - vi) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
 - vii) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.
- 8) Vision Care
- Charges for non-prescription eyewear are not covered.
- a) Groups 903118 and 903211: Charges for the purchase and/or repair of eyewear when prescribed by a Physician or optometrist to a maximum of \$150 in a 12-month period.

- b) Group 903119: Not covered.
 - c) Group 903120: Charges for the purchase and/or repair of eye-wear when prescribed by a Physician or optometrist to a maximum of:
 - i) \$175 in a 24-month period for adults.
 - ii) \$175 in a 12-month period for children.
- 9) Medical Examinations
- Charges of a Physician for medical examinations required by government statute or regulation for employment purposes provided such charges are not payable by your employer under a collective agreement.

Out-of-Province Non-Emergency Eligible Expenses

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

Out-of-Province Emergency Eligible Expenses

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances occurring while you are temporarily travelling outside your province or territory of residence. It is important that you read and understand your Plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provisions of the Policy, the provisions of the Policy shall govern. The insurer has contracted Viator/Global Excel Management Inc. (called Global Excel™) to provide medical assistance and claims services under the Policy.

IN THE EVENT OF AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY:

The emergency telephone numbers are listed on the back of the Medical Assistance Card provided.

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. It remains

your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.

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

The Policy covers expenses that are:

- incurred outside the province or territory of residence of the insured person;
- medically necessary;
- Reasonable and customary costs;
- incurred as a result of an emergency due to sudden and unforeseen sickness and/or injury occurring during the coverage period;
- in excess of those covered by the Government Health Insurance Plan or other insurance under which you may have coverage; and
- legally insurable;

subject to the overall maximum per insured person of \$5,000,000.

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

1. **Hospital Accommodation:** Reasonable and customary room and board costs up to the semi-private room rate charged by the hospital. If medically necessary, expenses for treatment in an intensive or coronary care unit are also covered. If coverage terminates for any reason during your hospital stay, benefits continue until discharge, to a maximum of one year. In no case will expenses for In-patient stays be covered for a period greater than 365 days per insured person.
2. **Physician Charges:** Reasonable and customary charges for treatment by a physician.
3. **Diagnostic Services:** Reasonable and customary charges for laboratory tests and x-rays prescribed by the attending physi-

cian and that are part of the emergency treatment. The policy does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel.

4. **Paramedical Services:** The services (including x-rays) of a licensed chiropractor, physiotherapist, podiatrist or osteopath, to the maximum of \$250 per insured person, per profession listed above, when approved in advance by Global Excel.
5. **Prescriptions:** Drugs, including injectable drugs, and sera that can only be obtained upon medical prescription, that are prescribed by a physician and that are supplied by a licensed pharmacist when medically necessary for emergency treatment, except when needed to stabilize a chronic condition or a medical condition which you had before your trip. This benefit is limited to a 30-day supply per prescription, unless you are hospitalized.
6. **Ambulance Services:** Reasonable and customary costs when reasonable and medically necessary, for licensed ground ambulance service to the nearest medical facility.
7. **Medical Appliances:** When approved in advance by Global Excel, reasonable and customary costs for minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and/or the temporary rental of a wheelchair when prescribed by the attending physician, obtained outside your province or territory of residence and medically necessary.
8. **Private Duty Nurse:** The professional services of a registered private nurse, when medically necessary and while hospitalized, to the maximum of \$5,000 per insured person, when approved in advance by Global Excel.
9. **Emergency Air Transportation:** When approved and arranged in advance by Global Excel, the reasonable and customary costs for:
 - a) air ambulance to the nearest appropriate medical facility or to a Canadian hospital for immediate emergency treatment;
 - b) transport on a licensed airline with an attendant (where required) to return you to your a province or territory of residence for immediate emergency treatment.

10. **Transportation to Bedside:** When approved in advance by Global Excel, a single round-trip economy airfare from Canada plus up to \$150 per day up to a maximum of \$3,000 for the cost of meals and commercial accommodation for one of the following: Spouse, parent, child, brother, sister or business partner, to:
- a) be with you if you are travelling alone and have been hospitalized as the result of an emergency. To be payable, this benefit requires that you eventually be hospitalized as an in-patient for at least three (3) consecutive days outside your province or territory of residence and that the attending physician provide written certification that the situation was serious enough to warrant the visit; or
 - b) identify the deceased insured person prior to the release of the body, where necessary.

The insurer will only reimburse covered expenses evidenced by original receipts.

11. **Return of Travelling Companion:** If you are returned to your province or territory of residence under the Emergency Air Transportation benefit or the Return of Deceased benefit, the insurer will reimburse the cost of a single one-way economy airfare for a travelling companion to return to Canada, when approved in advance by Global Excel.
12. **Treatment of Dental Accidents:** Up to \$2,000 per insured person for emergency Dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth provided the Injury was caused by an external, accidental blow to the mouth or face. you must consult a physician or Dentist immediately following the Injury. Treatment must begin during the coverage period and be completed prior to returning to your province or territory of residence. An accident report is required from a physician or Dentist for claims purposes.
13. **Meals and Accommodation:** Up to \$150 per day to a maximum of \$3,000 per trip per participant, for the cost of commercial accommodation and meals for the participant and/or any of his/her dependents when their trip is extended beyond the last day of the coverage period due to the sickness and/or Injury suffered by an insured person. This benefit must be authorized in advance by Global Excel. The fact that you are unable to trav-

el must be certified by the attending physician and supported with original receipts from commercial organizations.

14. **Vehicle Return:** Up to \$5,000 if neither you, nor someone travelling with you, are able to operate your vehicle, whether owned or rented, during your trip due to sickness and/or injury. Arrangements and payment will be made for the return of the vehicle to your home in your province or territory of residence or the nearest appropriate rental agency. Benefits will only be payable for a single person to return the vehicle when approved and/or arranged in advance by Global Excel. This benefit does not cover wages lost by the person driving your vehicle. The insurer will only reimburse covered expenses evidenced by original receipts.
15. **Return of Deceased:** Up to \$5,000 towards the cost of preparation and transportation of the deceased insured person to their province or territory of residence in the event of death due to a sickness and/or injury.

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

The cost of the casket or urn is not covered.

16. **Incidental Expenses:** Up to \$250 for your out-of-pocket expenses such as telephone charges, television rental and parking while you are hospitalized for an emergency and the expenses are incurred, as a direct result of such hospitalization. The insurer will only reimburse covered expenses evidenced by original receipts.

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

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

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

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

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

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

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

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

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

Claims Procedures

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

- a) include the policy number, the patient’s name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
- b) submit all original itemized bills from the medical provider(s) stating the patient’s name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or physician;
- c) provide the original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;
- d) provide proof of the departure date(s) and return date(s);
- e) provide written proof of claim within ninety (90) days of the date of receipt of services covered under the Policy;
- f) provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;

- g) sign and return the authorization form, provided by Global Excel, allowing the insurer to recover payment from the Canadian provincial or territorial Government Health Insurance Plan. The insurer will coordinate and pay your claim to the participating medical providers and where permitted, coordinate claims directly with the Canadian provincial or territorial Government Health Insurance Plan on your behalf; and
- h) return the unused portion of your air ticket to Global Excel if the Emergency Air Transportation benefit is used.

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

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

All pertinent documents should be sent to:

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

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

EXCLUSIONS

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

- 1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, contraceptives, fertility drugs, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians or any person who renders a professional health service in the patient's province of residence
- 2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
- 3) any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
- 4) allergy testing unless rendered by a naturopath
- 5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures
- 6) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English
- 7) any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan

- 8) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits
- 9) expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
- 10) expenses incurred, outside your province of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 21 days of the expected delivery date
- 11) charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence
- 12) expenses of a Dependent hospitalized at the time of enrolment
- 13) services performed by a Physician who is related to or resident with you or your Spouse
- 14) fees for ambulance services when an ambulance is called but not used
- 15) ambulance charges for work-related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
- 16) retroactive coverage and payment of any expense, including expenses that receive special authorization from Pharmacare
- 17) any other item not specifically included as a benefit.

Claims

- 1) Because we do not return receipts after the claim is processed, we recommend that you keep a photocopy of the receipts that you submit. We will send you a remittance statement for your records each time you submit a claim.
- 2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.
- 3) Certain medical expenses are covered under the government plan. If you submit your claim to us before you submit your claim

to the government plan, we will deduct what the government plan would normally pay (e.g. Pharmacare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer. Information for claiming Pharmacare expenses may be obtained from your pharmacist.

- 4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
 - a) Obtain a claim form from your Plan Administrator.
 - b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
 - c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **June 30th** of the year following the calendar year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.

Example: **We must receive your receipts for 2005 before June 30, 2006.**

DENTAL CARE

<i>Deductible</i>	No Deductible		
<i>Reimbursement Groups 903118, 903211 and 903120</i>	Basic Services	Major Services	Orthodontic Services
	80%	50%	50%
<i>Group 903119</i>	70%	50%	None
<i>Frequency Plan Limits</i>	Each Calendar Year	Each Calendar Year	Lifetime
<i>Financial Limit Per Member or Dependent Groups 903118, 903211, and 903120</i>	\$3,000 Combined with Major Services	\$3,000 Combined with Basic Services	\$3,000
<i>Financial Limit Per Member or Dependent Group 903119</i>	\$1,000 Combined with Major Services	\$1,000 Combined with Basic Services	None
<i>Financial Limit for Late Applicants All groups</i>	<p>\$250 per person for all Dental services for first 12 months of coverage</p>		
<i>Dependent Children All groups</i>	<p>Eligible until reaching age 21, or reaching any age if in full-time attendance at a school or university, or to any age if handicapped.</p>		

Payment of Benefits

- 1) We pay benefits based on Dental services, financial limits and treatment frequencies in the Fee schedule.
- 2) We apply the reimbursement percentage shown above to the fees shown in the Fee schedule/Fee guide as follows:
 - a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia: the fees in the Fee schedule

- b) for services performed in Canada but outside British Columbia: the fees in the Fee guide in the province/territory of service
 - c) for services performed outside Canada if your province of residence is not British Columbia: the fees in the Fee guide in your province/territory of residence.
- 3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

Basic Services

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

1) Diagnostic services

a) examinations:

- i) complete – provided we have not paid for any other exam by the same Dentist in the past 6 months –1 per 3-year period
- ii) recall – 2 per calendar year
- iii) specific – 2 per calendar year
- iv) consultations (as a separate appointment).

b) x-rays

- i) diagnostic
- ii) panoramic – 1 per 2-year period
- iii) complete mouth series – 1 per 3-year period

All x-rays combined shall not exceed the dollar limit for a complete mouth series.

c) diagnostic models – 1 set per calendar year.

2) Preventive services

a) scaling

b) polishing – 2 per calendar year

c) topical application of fluoride – 2 per calendar year

d) fixed space maintainers

e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2-year period. No age limit.

- 3) Restorative services
 - a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2-year period:
 - i) amalgam (silver coloured) fillings
 - ii) composite (tooth coloured) fillings on permanent front (anterior and bicuspid) teeth only

On permanent posterior (molar) teeth and all primary teeth, we pay the bonded amalgam rate for composite fillings.
 - b) stainless steel crowns on primary and permanent teeth – once per tooth in a 2-year period.
 - c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5-year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.
- 4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals – 1 per tooth in a 5-year period.
- 5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
 - a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
 - b) root planing
 - c) gingival curettage – 1 per sextant in a 5-year period
 - d) osseous surgery – 1 per sextant in a 5-year period
- 6) Prosthetic repairs
 - a) removal, repairs, and recementation of fixed appliances
 - b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2-year period
 - c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5-year period
 - d) gold foil – only when used to repair existing gold restorations.
- 7) Surgical services
 - a) extractions
 - b) other routine oral surgical procedures

- c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule.

Major Services

You are eligible for Major Services when your Dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

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

Major Services include, but are not limited to, the following:

- 1) Prosthodontic Services
 - a) removable
 - i) complete upper and lower dentures
 - ii) partial upper and lower dentures
 - b) fixed bridges (does not apply to Group 903119).
- 2) Restorative Services (does not apply to Group 903119)
 - a) inlays or onlays involved in bridgework
 - b) veneers
 - c) crowns and related services.
- 3) Periodontal Appliances
bruxing guards – 2 appliances in a 5-year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

Limitations

- 1) Only 1 major restorative service involving the same tooth will be covered in a 5-year period.
- 2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.
- 3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5-year period.
- 4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Basic Services.
- 5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our Fee schedule. Where other material

would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Orthodontic Services

Groups 903118, 903211 and 903120 only: Benefits are payable for Orthodontic Services performed after you have been enrolled under this Dental Plan for a 6-consecutive-month period. This benefit is designed to cover Orthodontic Services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations

- 1) The lifetime benefit maximum under Orthodontic Services is \$3,000.00 per member or dependent.
- 2) No benefit is payable for the replacement of appliances which are lost or stolen.
- 3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
- 4) Treatment performed solely for splinting is not covered.

Emergency Treatment Outside Your Province of Residence

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

EXCLUSIONS

The following are not Eligible expenses under your Dental plan:

- 1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
- 2) any item not specifically included as a benefit
- 3) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
- 4) procedures performed for congenital malformations or for purely cosmetic reasons
- 5) charges for drugs, pantographic tracings, and grafts

- 6) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule
- 7) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
- 8) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
- 9) incomplete or temporary procedures
- 10) recent duplication of services by the same or different Dentist
- 11) any extra procedure which would normally be included in the basic service performed
- 12) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
- 13) travel expenses incurred to obtain Dental treatment.

Claims

- 1) Present your ID card to your Dentist's office. It is important to ask if your Dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment**. This is important especially when your Dentist is recommending extensive Dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.
- 2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90-day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment submitted later than 1 year from the date the service is performed.
- 3) We require a separate claim form for each member of your family who has received Dental services. Be sure to include the following information on the claim form:
 - a) name of the Dentist
 - b) name and birthdate of the person receiving the Dental care
 - c) your group and Social Insurance Numbers (this information is on your ID card)

- d) your home mailing address
 - e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate Dental claim forms (one for each plan). Incomplete claims will be returned for clarification.
- 4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:
- a) We will pay the Dentist directly for services provided under this Dental plan when we receive a claim form signed by the Dentist, certifying these services were performed and the fee charged.
 - b) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive a claim form or receipts signed by your Dentist. We will send you a cheque when the claim is processed.
- 5) Orthodontic Claims Procedures (Groups 903118, 903211 and 903120 only)
- a) Receipts
Because we do not return original receipts, we will accept photocopies. Do not hold receipts until the completion of treatment.
 - b) Claiming deadlines
 - i) We suggest that you submit Orthodontic claims within **90 days** of the date the payment was due to your Orthodontist (the due date).
 - ii) Reimbursement is made if the complete and correct claims information is received within 1 year of the due date. However, no benefit is payable for claims not received within 1 year of the due date.
 - c) Treatment plan
 - i) Have your Orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts.
 - ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.
 - iii) We will retain your treatment plan on file. If we do not have your treatment plan on file we are unable to pay:

- your initial fee/down payment
 - your monthly/quarterly fees
 - one time appliance fees
 - Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.
- d) Monthly or quarterly fees
- i) Submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses.
 - ii) The amount paid will be pro-rated over the estimated months of active treatment. For example, when braces are on the teeth, the estimated length of treatment will be on the treatment plan.
 - iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

SHORT TERM DISABILITY (STD)

This Section applies to Group 903118 only.

Weekly Benefit Amount \$423

<i>Elimination Period</i>	Injury	Hospital	Sickness
	0 days	0 days	7 days

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

- a) we will provide benefits for the first 8 weeks of disability, and
- b) EI will provide benefits from the 9th to the 23rd week of disability, and
- c) we will provide benefits for an additional 29 weeks of disability.

Maximum Benefit Period 52 weeks

DEFINITIONS

Recurrent Disability means a disability that is related to or due to the same cause(s) as a prior disability for which you received benefit payments.

Benefit

We will pay short term disability (STD) benefits when you are totally disabled and prevented from working as a result of an accident or sickness for which Workers' Compensation benefits are not payable.

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

The weekly benefit amount, the elimination period, and the maximum benefit period are shown in the Schedule of Benefits.

Recurrent Disability

A Recurrent disability will be considered part of the prior disability if, after receiving STD benefits, you returned to work on a full-time basis and were able to perform all the essential duties of your occupation for less than 2 weeks. Once you have resumed work on a full-time basis and have been at work for 2 consecutive weeks, any subsequent injury or sickness will be considered a new disability.

Extended Benefit

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

Coordination with other Income Sources

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

Third Party Liability

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

Are Benefits Taxable?

Yes. Benefits are taxable because your employer pays the cost of your STD Plan.

Termination of Benefit

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

- 1) you are no longer disabled

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

EXCLUSIONS

Benefits are not payable for any period of disability:

- 1) arising from any of the following:
 - a) self-inflicted injury or sickness
 - b) participation in a criminal offense
 - c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation
 - d) a pregnancy related sickness
 - i) during any period of formal maternity leave and/or parental leave
 - ii) during any period in which Employment Insurance (EI) benefits are being paid
 - e) substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your Physician

- f) medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness
- 2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing
- 3) while you are
 - a) in a jail or penitentiary
 - b) on leave of absence or paid vacation
 - c) receiving benefits for the same or related disability from WCB or similar legislation
- 4) if you become disabled during a strike or lockout at your place of employment; however, your right to benefits will be reinstated when the strike or lockout ends.

Claims

- 1) Obtain a claim form from your Plan Administrator, as soon as possible after you become totally disabled.
- 2) Complete the employee's statement and sign the form on both sides.
- 3) Return the form to your Plan Administrator for completion of the employer's portion.
- 4) Have your Physician complete and sign the medical portions of the form.
- 5) We must receive satisfactory proof of claim within **30 days** following the end of the Elimination period. Failure to submit a claim within the 30-day limit will not invalidate the claim if special circumstances prevail.
- 6) We may request supplementary reports to update the medical information on file. Any cost for completion of medical reports will be your responsibility.
- 7) Incomplete claim forms will cause a delay in the payment of your benefits.

LIFE INSURANCE

Industrial and Institutional:

Active (Hour Bank) and Disabled/Associate (Class 001)

Honourary or Exempt (Class 002)

Commercial:

Active (Hour Bank) (Class 003)

Active (Monthly) (Class 004)

SUMMARY OF BENEFITS

Class 001 –

Amount of Basic Life Insurance: \$35,000.

Coverage terminates on the date you no longer have hours in your Hour Bank Account.

Class 002 -

Amount of Basic Life Insurance:

- retired before October 1, 2002 – \$10,000
- retired before April 1, 2004 – \$5,000
- retired on or after April 1, 2004 – not applicable.

Coverage terminates on the date you cease to be an Honourary or Exempt Member.

Class 003 & 004 –

Amount of Basic Life Insurance: \$35,000.

Waiver of Premium Benefit: to age 65 (note Definition of Disability is to match that of Long Term Disability if you are on LTD, otherwise, it is our standard “any occupation”).

Termination of Insurance for Class 003:

Coverage terminates on the date you no longer have hours in your Hour Bank Account.

Termination of Insurance for Class 004:

Coverage terminates on the end of the month in which employment ceases.

EMPLOYEE LIFE INSURANCE

In the event of your death while insured, the amount of your Life Insurance is payable to your beneficiary. You may change your beneficiary at any time by written notice to your Plan Administrator, subject to any policy or legal limitations.

Waiver of Premium for disability

If you become totally disabled for 6 consecutive months before age 65, your Life Insurance will be continued free of charge until you cease to be totally disabled or you reach age 65, whichever occurs first. To qualify, you must be unable to work for compensation or profit or to engage in any business or occupation, and you must submit proof of your continuing disability as may be required by the Insurer.

Note: In order to qualify for the Waiver of Premium benefit you must notify Manulife Financial of your disability within one (1) year of your last active day at work, and must furnish proof of your disability satisfactory to the Insurer within 18 months of that last active working day.

Conversion Privilege

Your Life Insurance continues for 31 days following either the termination of your employment, or your classification changing to one in which you are not insured. During this 31-day period you may convert the amount of your Group Life Insurance, provided you are under 65 years of age, to any individual whole life or convertible one-year term or term to age 65 plan without submitting evidence of health.

The amount of the individual policy shall not exceed the amount of insurance for which you were insured when coverage was discontinued, subject to a maximum of \$200,000 less any amount you become eligible for under a replacing contract of group life insurance.

The premium rate will be determined from your age and class of risk at the time of conversion.

Note: The conversion privilege does not apply for loss of insurance as a result of:

- i) any age reduction specified in the Summary of Benefits; or
- ii) if insurance terminates when you reach the age specified in the Summary of Benefits section or upon your retirement.

LONG TERM DISABILITY (LTD)

Industrial and Institutional:

Active (Hour Bank) and Disabled/Associate (Class 001)

Honourary or Exempt (Class 002)

Commercial:

Active (Hour Bank) (Class 003)

Active (Monthly) (Class 004)

SUMMARY OF BENEFITS

Class 001

This benefit is equal to 75% of monthly earnings, subject to the 85% All Source Maximum described under Offsets in the Long Term Disability section later in this booklet. The maximum benefit payable is \$1,700 per month.

The qualifying disability period starts when you first become totally disabled and ends after 365 days, provided your disability is continuous and you are under age 60. If the disability is not continuous, the days you are disabled will be accumulated to satisfy the qualifying disability period provided:

- 1) no interruption is longer than 2 weeks;
- 2) the disabilities arise from the same or related disease or injury.

No-Evidence Limit: \$1,700

Coverage terminates on the date you attain age 60 or retirement, whichever is earlier.

Class 002

No Long Term Disability coverage for retirees.

Classes 003 & 004

This benefit is equal to 66.67% of monthly earnings, subject to the 80% All Source Maximum described under Offsets in the Long Term Disability section later in this booklet. The maximum benefit payable is \$2,000 per month.

The qualifying disability period starts when you first become totally disabled and ends after 119 days, provided your disability is continuous and you are under age 60. If the disability is not continuous,

the days you are disabled will be accumulated to satisfy the qualifying disability period provided:

- 1) no interruption is longer than 2 weeks;
- 2) the disabilities arise from the same or related disease or injury.

No-Evidence Limit: \$2,000

Class 003

Coverage terminates on the date you attain age 60 or retirement, whichever is earlier.

Class 004

Coverage terminates on the date the Member ceases employment, retires or attains age 60, whichever is earlier.

EMPLOYEE LONG TERM DISABILITY BENEFITS

In the event you become totally disabled for the required period of time known as the Qualifying Disability Period and you are under the continual treatment of a legally qualified physician deemed appropriate by the Insurer, you will receive a monthly income benefit.

Qualifying Disability Period	>	As described in the Summary of Benefits.
Monthly Benefit	>	As described in the Summary of Benefits.
Maximum Disability Period	>	to age 60.

Benefits will not be payable beyond age 60, unless you satisfy the Qualifying Disability Period while age 59, in which case benefits will be payable for a maximum of 12 months.

Total Disability

You are considered totally disabled, **during the first 24 months (for Class 001) and for the first 12 months (for Classes 003 and 004)** in which you receive benefits, if you are unable to perform any and every duty of your occupation. **After this 24-month period (for Class 001) and 12-month period (for Classes 003 and 004)** you are considered totally disabled if you are unable to perform any and every duty of any occupation for which you are reasonably qualified by training, education or experience.

Recurrent Disability

If a disability recurs and it is due to the same or related causes, it will be considered as one continuous disability and will not be subject to the Qualifying Disability Period unless you have returned to active, full-time employment for a period of 6 consecutive months or longer.

If your new disability is due to causes unrelated to your prior disability you may be eligible for a new disability period, subject to the Qualifying Disability Period, if you have returned to active work for at least one full day.

Offsets

The amount payable under this benefit for total disability is calculated by deducting from your benefit any other sources of income. These are specified in the Master Policy and include the following:

- 1) wages or retirement benefits payable from your employer or employer's pension or retirement plan;
- 2) any payments on account of your disability from any Workers' Compensation law or similar law;
- 3) payments received from the Canada or Quebec Pension Plan, excluding payments made in respect of dependent children;
- 4) any income or benefit payable under any other plan or program of any government or of any subdivision or agency of the government, including any plan or program established pursuant to a provincial automobile insurance act.

All Source Maximum:

Your total monthly income while disabled (Long Term Disability benefit plus any income listed above and Canada or Quebec Pension Plan family benefits) cannot exceed 85% (classes 003 & 004 80%) of your gross monthly earnings as of the date your disability commenced. If your total income exceeds 85% (classes 003 & 004 80%), your Long Term Disability benefit will be reduced accordingly.

EXCLUSIONS AND LIMITATIONS

Benefits are not payable for the following:

- 1) for any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program recommended by said physician;
- 2) for any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;
- 3) for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addiction, unless you are participating in a recognized substance withdrawal program;
- 4) disabilities resulting from self-inflicted injuries or attempted suicide;
- 5) disabilities as a result of participation in a war, riot, insurrection or criminal act;
- 6) for the portion of a period of disability during which you are
 - a) imprisoned in a penal institution; or
 - b) confined in a hospital, or similar institution, as a result of criminal proceedings;
- 7) any period of disability, or portion thereof, during any leave of absence (including maternity leave) as defined in the General Provisions section of this booklet;
- 8) for a disability which commences on or after the date a strike begins, except as outlined in the Master Policy; however, an employee may commence to fulfill his/her qualifying disability period from the date of disability;
- 9) to an insured individual who refuses to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending physician or on the advice of independent medical opinion;
- 10) to employees of Classes 003 and 004 unless they have been actively working for a participating employer for a minimum of 24 hours per week at the date of disability.

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will be subrogated to all your rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You shall execute such documents as required by the Insurer.

In the event you provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the Insurer's right of subrogation will apply.

The term compensation shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

Disability Case Management Program

Manulife Financial has developed a disability case management program. The purpose of this program is to assist you, in the event you become totally disabled and qualify for benefits, to return to productive employment. Our disability case management team includes medical consultants, claim adjudicators and a field coordinator. This team will work with you, your employer and your physician to assist you to recover and return to the workplace.

Rehabilitative Employment

If you are disabled, the Insurer may recommend that you undergo some suitable rehabilitative training program which would take into account the nature and limitations of your disability. Further details on this aspect will be provided in the event you become disabled.

Canadian Residency Requirement

No benefits are payable if the Member resides outside Canada for any period exceeding 90 consecutive days or a total of 180 days in any 365-day period, unless:

- i) the Member has previously notified and received approval in writing from the Insurer, and;
- ii) the Member remains under the regular care of a licensed physician deemed appropriate by the Insurer, and;
- iii) proof of the ongoing disability can be determined on evidence satisfactory to the Insurer in English or French within 30 days of request.

ACCIDENTAL DEATH & DISMEMBERMENT

You are insured against the perils described in the Loss Schedule. Your protection is world-wide, 24 hours a day, on or off the job. Benefits are payable regardless of any other benefits that you may receive from any insurance company other than the Company, or any other organization. **"The Company"** means RBC Life Insurance Company.

Who is eligible?

You are eligible if you are a Member of the Policyholder in good standing and you are under age 80.

Principal Sum

Your amount of Principal Sum is equal to the amount of your Basic Life Insurance under the Plan.

Termination clause

All benefits terminate on the earlier of the day you reach age 80 or the day you retire, or the day you cease to be covered under the Hour Bank rules explained in the General Information Section of this booklet.

When is this plan effective?

Your insurance is effective as per the eligibility provisions established by the Plan Administrator, as explained in the General Information Section of this booklet.

Loss Schedule

If an accident causes a loss payable under this schedule within one year from the date of the accident, the Company pays the sum set opposite such loss, and not more than the aggregate of the Principal Sum is paid for injuries resulting from the same accident.

For Loss of:	Percentage of Principal Sum
Life.....	100%

For Loss of or Loss of Use of:

Both Hands or Both Feet	100%
Sight of Both Eyes.....	100%
One Hand and One Foot	100%
One Hand or Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Leg or One Arm	75%
Hearing in One Ear	50%
Either Hand or Foot.....	66 2/3%
Speech or Hearing in Both Ears	66 2/3%
Sight of One Eye	66 2/3%
Thumb and Index Finger of the Same Hand.....	33 1/3%
Four Fingers of the Same Hand.....	33 1/3%
All Toes of One Foot.....	12 1/2%

For Total and Irreversible Paralysis of:

All four limbs (Quadriplegia)	200%
Both lower limbs (Paraplegia).....	200%
One arm and one leg on the same side of the body (Hemiplegia).....	200%

“Loss” means, with regard to:

Hands and Feet:	Actual severance through or above the wrist or ankle joint;
Eyes:	Entire and irrecoverable loss of sight;
Leg or Arm:	Actual severance through or above the knee or elbow joint;
Thumb and Fingers:	Actual severance through or above the metacarpophalangeal joints;
Speech and Hearing:	Entire and irrecoverable loss;
Toes:	Actual severance through or above the metatarsophalangeal joints;

“Loss of Use of” means, with regard to:

Any Limb(s):	Must be total, irrecoverable and be continuous for 12 months after which the benefit is payable, provided the
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nerve damage is determined to be permanent.

Indemnity provided under this section for all losses you sustain as a result of any one accident does not exceed the following:

- a) With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum.
- b) With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum.

Exposure and Disappearance

If loss results from unavoidable exposure to the elements and indemnity is otherwise payable hereunder, such loss is payable under the terms of the policy.

If your body is not found within one year after the date of the disappearance, sinking or wrecking of the vehicle in which you are an occupant at the time of the accident and under such circumstances as would otherwise be covered hereunder, it is presumed that you suffered loss of life resulting from bodily injury caused by an accident at the time of such disappearance, sinking or wrecking.

Waiver of Premium

If you become totally disabled from an accident or sickness and waiver of premium is approved under your applicable Group Life Insurance Plan, premiums under this plan are waived while total disability continues, until the earlier of your attainment of age 65, your eligibility terminates or the policy is terminated.

Repatriation

If you lose your life as a result of a covered accident occurring at least 100 kilometres from your principal residence, the Company pays up to \$10,000 for the preparation and transportation of your body back to your principal residence.

If you receive benefits for a loss described in the Loss Schedule, the Company pays for the expenses actually incurred by your spouse within three years from the date of the accident, for an approved and mutually agreed upon formal occupational training program, specifically qualifying him to gain active employment in an occupation for which he would otherwise not have had sufficient qualifications. The maximum payable hereunder is **\$10,000**.

Spousal Retraining

“Spouse” means a person who is living with you and who is legally married to you; or if you are not married, is a person whom you have publicly represented as your Spouse and with whom you have resided continuously for at least 12 months in a conjugal-like relationship, civil union, adult interdependent relationship and who is:

- at least 18 years of age;
- competent to contract; and
- not related by blood closer than would legally bar marriage.

If more than one person meets this definition, the Insurance Company will only pay one benefit, which will be paid in equal shares to the persons meeting the definition.

Rehabilitation

If you receive benefits for a loss described in the Loss Schedule and you require special training to allow you to work in an occupation that you would not have engaged in except for the injuries you sustained, the Company pays for that training, considering the expenses are reasonable and necessary (other than travelling, clothing and ordinary living expenses), up to **\$10,000**, occurring within two years from the date of the accident.

Family Transportation

If while on a trip, you sustain an injury and as a result, are confined as an in-patient in a Hospital, are under the Regular Care and Attendance of a Physician and require the personal attendance of a Member of the Immediate Family as recommended by the attending Physician, the Company pays for the expense incurred by the family member for transportation to your bedside by the most direct route by a licensed common carrier, but not to exceed an amount of **\$3,500** as the result of any one accident.

“**Hospital**” means an institution licensed as a hospital, which is open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with twenty-four (24) hour nursing service. Hospital will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home or convalescent hospital.

“Member of the Immediate Family” means your Spouse or common-law Spouse, parents, grandparents, children over age 18, brother or sister.

“Regular Care and Attendance” means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

Education

The Company pays for tuition fees in the event of your accidental death. To qualify, eligible dependent children must be enrolled as full-time students in a post-secondary “institution of education” at the time of your death or must enroll within one year following your death.

The amount paid for tuition fees and textbook expenses is equal to the lesser of **3%** of your Principal Sum or **\$5,000**, per year per child, for a maximum of four consecutive years. The Company must receive proof of enrollment and attendance for each year that a payment is to be made for each child. If there are no dependent children eligible for this benefit, your Principal Sum is increased by **\$2,500**.

For the purpose of this benefit, “Dependent child” means your unmarried natural born child, legally adopted child, step-child or any common-law child (if you have his legal custody and control), who is under **25** years of age and is dependent upon you for support and maintenance. In addition, a child incapable of self-support by reason of mental or physical infirmity is covered beyond the maximum age.

“Institution of education” includes any University, CEGEP, Trade School or College, as defined where you live.

Home Alteration and Vehicle Modification

If you receive benefits for a loss described in the Loss Schedule and are subsequently required (due to the cause for which payment under the Loss Schedule is made) to use a wheelchair to be ambulatory, the Company pays, upon presentation of proof of payment, the one-time cost of (a) alterations to your residence to make it wheelchair accessible and habitable and (b) modifications necessary to your motor vehicle to make the vehicle accessible or driveable for you.

Benefits herein are not paid unless: (a) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization providing support and assistance to wheelchair users and (b) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the provincial vehicle licensing authorities.

The maximum payable under this benefit is **\$10,000**.

To whom are benefits paid?

Your accidental death benefit is paid to the beneficiary designated under your applicable Group Life Insurance Plan, or to your estate if no such designation is made. Any other benefits are paid to you (those described in the Loss Schedule are paid as a percentage of the Principal Sum).

EXCLUSIONS

The insurance does not cover losses caused in any way from suicide or any suicide attempt; self-inflicted injuries; war, declared or undeclared; full-time active service in the armed forces of any country; travelling as a pilot or crew member of any aircraft or travel in the Policyholder's owned or leased aircraft.

Claim Procedures

To make a claim under this plan, written notice of the accident must be given to the Company within 30 days of the date of the accident and written proof must be submitted within 90 days of the date of the accident. The Company provides the necessary claim forms as well as instructions covering other requirements that may aid in a prompt handling of the claim.

If the Company does not receive the required notice and proof of loss, the claim may not be considered after the 90 day period has expired, unless there is good reason for the delay. In no event is a claim considered after one year from the date of the accident if the Company was not notified and the necessary forms not completed and submitted to the Company.

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