IBEW Local 1555 Health and Welfare Plan

Class 5 - Retirees

Group Number: 91079-002

Updated Effective Date: September 1, 2016

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PRIVACY PROTECTION PRACTICES

In the course of providing customers with quality health and life coverage, the Company acquires and stores certain personal information about its clients and their dependents. The purpose of this document is to keep you informed about the Company's privacy protection practices.

Protecting personal information is not new to the Company. Ensuring the confidentiality of client information has always been fundamental to the way we do business and our staff understand that the privacy policies and procedures we have in place to ensure confidentiality are to be taken very seriously.

What is personal information?
Personal information includes details about an identifiable individual and may include name, age, identification numbers, income, employment data, marital and dependent status, medical records, and financial information.

How is your personal information used?
Your personal information is necessary to allow the Company to process your application for coverage under its health plan. Your personal information is used:

- to provide the services outlined in your policy or the group policy of which you are an eligible member,
- to understand your needs so that we can recommend suitable products and services, and
- to manage our business.

To whom could this personal information be disclosed?
Depending on the type of coverage you carry with us, release of selected personal information to the following may be necessary in order to provide the services outlined in your policy:

- other Canadian Blue Cross organizations in order to administer your benefit plan if you reside outside the Atlantic Provinces, Quebec or Ontario,
- specialized health care professionals when necessary to assess benefit or product eligibility,
- government and regulatory authorities in an emergency situation or where required by law, other third parties, on a confidential basis, when required to administer the benefits outlined in your contract or your group's policy, and
- the plan member of any policy under which you are a participant.

We do not provide or sell personal information about you to any outside company for use in marketing and solicitation. Personal information about you or your dependents is not released to a third party without permission unless necessary to fulfill the services the Company is contracted to provide to you.

To ensure the Company is able to provide you with the best possible service, it is important that the personal information we use is accurate and up to date. You can help by keeping us informed of changes of address, marital status and the addition or deletion of dependents. Should you become aware of errors in our information about you, please contact our customer service personnel and we will ensure the data is corrected.

PRIVACY PROTECTION PRACTICES

By becoming a customer or filing a claim for benefits, you are agreeing to allow your personal information to be used and disclosed in the manner outlined above. If you prefer that we not use or disclose your personal information in those situations where it is not necessary to administer your benefit plan, please visit our website or write to us at the address provided.

Please note that not allowing the Company to use information about you may mean we may not be able to provide you with certain products or services that may be of use to you.

For more information on the Company's privacy policy, contact us using one of the following:

www.medavie.bluecross.ca

Atlantic Provinces: 1-800-667-4511
Ontario: 1-800-355-9133
Quebec: 1-888-588-1212
From anywhere in Canada: 1-888-873-9200

Chief Privacy Officer
Medavie Blue Cross
Risk Management Group
644 Main Street
PO Box 220
Moncton, NB E1C 8L3

or

privacyofficer@medavie.bluecross.ca

If the issue is not resolved to your satisfaction, you may file a complaint in writing to:

Office of the Privacy
Commissioner of Canada
112 Kent Street
Ottawa, ON K1A 1H3

PLAN MEMBER WEBSITE

INSTRUCTION FOR MEMBERS

Medavie Blue Cross is continually developing its Web technology to respond to the needs of our customers. One such innovation, the Plan Member Website, will help you better understand, manage and co-ordinate your benefit plan.

The Plan Member Website is simple to use and is delivered in a secure environment. Now, when you want to access general information about your plan, view your claims and payment history, or print generic claim forms, you just have to click your mouse. The Plan Member Website is available 24 hours a day, seven days a week from home or work, all you need is an Internet connection. The Plan Member Website makes life easier for you.

ON THE PLAN MEMBER WEBSITE

There are a variety of options available to you on the Plan Member Website.

Coverage Inquiry: Detailed information about the Medavie Blue Cross benefit plan
Forms: Printable versions of generic Medavie Blue Cross claim forms

Member Information

- Members can view and/or update address information (where access is available)
- Request new identification cards
- Add/update banking information for direct deposit of claim payments (where applicable)

Member Statements

- Members can view claims history for member and dependents
- View record of payments issued to member and/or the service provider
- View Health Spending Account balances (where applicable)

FIRST-TIME ACCESS TO THE PLAN MEMBER WEBSITE

To register for the Plan Member Website, visit **www.medavie.bluecross.ca** and log in.

Please ensure you make note of your user ID and password for future reference.

PLEASE NOTE

For security reasons, the Plan Member Website is for use of the plan member only.

We look forward to helping you take advantage of our online technology. For further information on the Plan Member Website, or for any questions about your Medavie Blue Cross benefit plan, please contact our Customer Information Center toll free at the number on the back of your identification card or e-mail *inquiry@medavie.bluecross.ca.*

AN OVERVIEW OF YOUR GROUP COVERAGE

A group coverage program covering your medical and financial security has been made available to you by your employer. This program is offered to you through Medavie Inc. and Blue Cross Life Insurance Company of Canada, hereafter called the Company.

The information contained in this booklet is an overview of the provisions of the policy between your employer and the Company. Included is a summary of your benefits and pertinent information that you will require to optimize the coverage available to you and your family.

This booklet together with your identification card contains important information and must therefore be kept in a safe place.

BLUE ADVANTAGE ®

To access a wealth of savings on medical, vision care and many other products and services, visit www.blueadvantage.ca.

Where legislated:
You have the right to request a copy of the group policy details pertaining to your insured coverage, a copy of your application for benefits, and any written statements or other records provided to the Company as evidence of your health. You may also request, with reasonable notice, a copy of the contract for insured benefits. The first copy will be provided at no cost to you. A fee may be charged for subsequent copies. All requests for copies of documents should be directed to Medavie Blue Cross. Medavie Blue Cross will only provide you with a copy of the contract for insured benefits in circumstances where it is a legislated requirement.

Finally, please note that the masculine gender has been used indiscriminately throughout this document in order to facilitate its reading.

Group Insurance Eligibility
To be eligible for group coverage, you must be a retired Member who is a resident of Canada, covered under your provincial government plan. Coverage is effective on the date of retirement.

To participate in your group plan, you must complete the coverage forms that are provided to you upon your eligibility to the various plans.

Your dependents are covered on the date you become covered, or on the date they become your dependents.

To be eligible the Member must also meet the following criteria:

a) Member must be in good standing of IBEW Local 1555;

b) Member must be retired and receiving an IBEW Local 1555 pension

c) Member must not be working with an employer that is governed by the collective agreement,

d) Member must be under 75 years of age for Health and Dental benefits;

IBEW Local 1555 Collective Agreement **Member Eligibility Quick Reference Guide** This table is intended to be used as a reference only. For more information about your eligibility for benefits, see the applicable sections in this booklet. For questions about the cost of your benefits, contact your Plan Administrator at IBEW Local 1555.	Basic Life: $60,000	Dependent Life: Spouse: $15,000 / Child: $10,000	Weekly Indemnity: $400 / week	Long Term Disability: $1,200 per month	Health	Dental
Class 1: (Working)						
Active (To age 65 – Cost of 140 Hrs.)	✓	✓	✓	✓	✓	✓
Active (65 and over, under 75 – Cost of 130 Hrs.)	✓	✓			✓	✓
Active Members in receipt of Disability benefits (Class 4 – See notes below)						
Disabled Member on LTD (To age 65 – Cost of 100 Hrs.)	*	*			**	**
Class 2: (with Hour-Bank – Cost 125 Hrs.)						
Non-Active (To age 65)	✓	✓			✓	✓
Non-Active (65 and over, under 75)	✓	✓			✓	✓
Class 3: (without Hour Bank; self-pay – Cost of 115 Hrs.)						
Non-Active (To age 65)	✓	✓			✓	✓
Non-Active (65 and over, under 75)	✓	✓			✓	✓
Class 5: (Retired Members)						
Retired Members (To age 75 – Cost of 100 Hrs.)					✓	✓

Class 4: Important information for Members in Receipt of Disability benefits under age 65
This Overview does not cover all possible instances of disability, such as a disability claim under Worker's Compensation or other instances where waiver of premium may be applied.

Short Term Disability:
During the period that you are eligible for Short Term Disability benefits, the cost for your benefits will be determined by the Class 2 and Class 3 rates. That is, the cost to maintain coverage will be deducted from your Hour Bank at the Class 2 rate until it is exhausted, following which time you will be required to self-pay at the Class 3 rate to maintain coverage.

Long Term Disability:
If you are totally disabled and receiving Long Term Disability benefits, your Basic Life and Disability premiums are waived and the cost for your Health and Dental benefits is 100 Hours per month.

*Basic Life and Disability benefits continue while you are disabled and premiums may be waived following a period of total disability. Definitions of total disability and waiver of premium are included in this booklet and are subject to the terms of the contract.

**Health and Dental benefits are optional if member has spousal coverage.

IBEW Local 1555 Health and Welfare Plan Eligibility Definitions

Member in Good Standing
A member whose dues are not more than three (3) months in arrears and who is not in violation of the IBEW constitution.

***Active* (Working greater than 40 hours)**
A member who is paying IBEW Local 1555 monthly dues and is working locally for an ECANB contractor or who is dispatched from Local 1555 to another IBEW jurisdiction and is paying Local 1555 dues and travel dues.

***Non-Active* (Non-working)**
A member who is paying IBEW Local 1555 monthly dues and is NOT working and whose name is on the work list for local and/or travel jobs.

Disabled*
A member who is paying IBEW Local 1555 monthly dues and is in receipt of Disability benefits from Medavie Blue Cross, and is self-paying monthly premiums for Health and Dental benefits*.

Retired
A member who is not paying IBEW Local 1555 dues and is receiving “Retirement Benefits” under Article 11 of the IBEW constitution.

Retirement Eligibility
A Member who meets the requirements under Article 11 of the IBEW constitution and also meets the Local 1555 vesting formula. Two years of uninterrupted IBEW membership will equal one year of eligibility. Twenty continuous years of uninterrupted membership at date of retirement qualifies a member to be fully vested.

*You are enrolled for all eligible benefits on a Mandatory basis and cannot choose which benefits to enrol in. The exception to this rule is that you may decline Health and Dental coverage if eligible under another similar plan, such as a spouse’s plan. If you lose your other coverage, you must notify the IBEW Local 1555 Plan Administrator within 31 days in order to have your Health and Dental benefits reinstated.

Definition of Dependents
Your dependents are:

a) Your spouse, who is the person to whom you are married, or the person that you introduce as your spouse and with whom you have been living in a conjugal relationship for at least one year.

b) Your unmarried children who are your financial dependents and
   - are under 21 years of age, or
   - are under 26 years of age if full-time students attending an institution providing instruction at a secondary, college or university level, as a duly registered student, or
   - regardless of their age, if they live with you and have become totally and permanently disabled before age 21 (or age 26 if a student).

Termination of Insurance

Insurance will terminate on the earliest of the following dates:

a) the date on which you are no longer a Member in good standing with IBEW Local 1555,

b) the date on which the master Group Insurance contract is cancelled.

Conversion Privilege
If you should terminate your coverage, you may convert to an Individual plan currently issued by Blue Cross provided that application is made within 31 days following your date of termination. This conversion privilege is also available to the spouse, or where required by provincial legislation, dependent child.

Filing a Claim

Hospital Benefit
If you or one of your dependents are hospitalized, simply show your identification card at the time you are being admitted. The claim will be forwarded to our office by the hospital.

Drug Benefit

Pay direct plan - simply show your identification card and the provider will arrange to bill the Company.

Extended Health Benefit
Complete the claim form, if applicable, attach the original receipts and forward to the Company (See contact information).

The duly completed claim form must be sent to the Company no later than 24 months after the date expenses are incurred or within a time agreed upon by the Company when contract terminates.

Dental Benefit
Reimbursement can be made electronically through the CDA Net; you must present your identification card to your dentist at every visit. Two reimbursement options are possible depending on your dentist's preference:

a) You only have to pay for your deductible (if applicable) and the excess expenses not covered by coinsurance. The coinsurance amount is paid directly to the dentist by the Company; or
b) You pay the total amount requested by your dentist and you will receive in the next few days the portion of the expenses refundable by your plan.

If, however, your dentist cannot use the electronic transaction network, complete and submit a dental claim form with original receipts to the Company (See contact information). The duly completed claim form must be sent to the Company no later than 24 months after the date on which expenses were incurred or within a time agreed upon by the Company when contract terminates.

Note: For coverage purposes, you and your dependents are deemed covered under the Hospital and Health Insurance Act in your province of residence.

Hospital, Drug, Extended Health Benefit and Dental Benefits
Claims will be administered by the Blue Cross plan in the covered Member's province of residence.

Limitation Periods for Legal Action

Every action or proceeding against an insurer (i.e. the Company) for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act

Coordination of Benefits

If you or one of your dependents is covered under another health plan, the benefits payable under this plan and any other plan will be coordinated so that payments from all sources do not exceed the expenses actually incurred. Coordination of benefits will be done in accordance with the guidelines of the Canadian Life and Health Insurance Association (CLHIA).

The benefit payable to you or one of your dependents follows the order described below:

a) The benefits payable under a plan that does not include a co-ordination of benefits clause are payable before those which would otherwise be payable under this plan.

b) The benefits of any plan that includes a co-ordination of benefits clause are payable in the following order:
   - the plan where you qualify as an member
   - the plan where you qualify as a dependent

If you or one of your dependents qualifies as a member, benefits are payable in the following order:

- an active full-time member,
- an active part-time member,
- a retiree.

For the co-ordination of benefits for dependent children priority will go to the plan of:

- the parent with the earlier birth date in the calendar year,
- the parent whose first name begins with the letter that comes first in the alphabet, if both parents have the same birth date.

Dependent children whose parents are separated or divorced; priority will go to the plan of:

- the parent with custody of the child,
- the spouse of the parent with custody of the child,
- the parent who does not have custody of the child,
- the spouse of the parent who does not have custody of the child.

Dependent children whose parents are separated or divorced with joint custody; priority will go to the plan of:

- the policy of the parent with the earlier birth month in the calendar year,
- the policy of the other parent,
- the policy of the new spouse of the parent who is first payor,
- The policy of the other spouse who is second payor.

Coordination of Benefits (Cont'd)

When the benefits due under this policy are payable after any other plan, the benefits payable are equal to the lesser of the following amount:

a) The total benefits that would have been payable in the absence of the Coordination of Benefits provision,
b) The total eligible expenses under your current plan less the benefits payable under any other plan. The benefits payable under any plan include those which you or one of your dependents would have been entitled had you duly submitted a claim.

"Plan" shall mean any coverage providing payment for medical treatment, services or supplies under any group, family, creditor or savings insurance coverage, and/or any government-sponsored plan providing coverage for similar care.

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BLUE CROSS CONTACT INFORMATION

Blue Cross has offices at the following locations to answer any inquiries you may have relating to your group coverage or to allow you to submit claims.

ATLANTIC CANADA	P.O. Box 220, 644 Main St. Moncton, NB E1C 8L3
QUEBEC	550 Sherbrooke Street West Suite B9 Montreal, PQ H3A 6T6
ONTARIO	P.O. Box 2000 185 The West Mall, Suite 1200 Etobicoke, ON M9C 5P1
Customer Inquiry	**Toll Free 1-800-355-9133**
MANITOBA	599 Empress Street P.O. Box 1046 Station Main Winnipeg, MB R3C 2X7
SASKATCHEWAN	P.O. Box 4030 516 Second Avenue N Saskatoon, SK S7K 3T2
ALBERTA	10009 - 108th Street NW Edmonton, AB T5J 3C5
BRITISH COLUMBIA	Pacific Blue Cross 4250 Canada Way P.O. Box 7000 Burnaby, BC V6B 4E1
Customer Inquiry	**Toll Free 1-888-873-9200**

SUMMARY OF BENEFITS

HOSPITAL BENEFIT

	% Co-insurance	Accommodation	Maximum duration
Active Care	100%	Semi-private	Unlimited
Convalescence	100%		$50 per day to a maximum of 120 days per calendar year
Rehabilitation	100%		$50 per day to a maximum of 120 days per calendar year

GENERAL INFORMATION

Deductible	Nil
Survivor Benefit	24 months, without dues
Termination	The end of the calendar year in which the age 75 is reached

DRUG BENEFIT

	Co-payment	Maximum
Drug Benefit	15% to a maximum of $30 per prescription	Unlimited
Diabetic Supplies	15% to a maximum of $30 per prescription	Unlimited
Fertility Benefits	15% to a maximum of $30 per prescription	$1,500 per calendar year up to a lifetime maximum of $3,000
Erectile Dysfunction Benefits	15% to a maximum of $30 per prescription	$250 per calendar year

GENERAL INFORMATION

Deductible	Nil
Dispensing Fee	The participant pays dispensing fee for each eligible drug on the prescription
Payment Type	Drug card - direct payment
Lowest Cost Substitution	Yes, even if the prescriber indicates no substitution
Survivor Benefit	24 months, without dues
Termination	The end of the calendar year in which the age 75 is reached

SUMMARY OF BENEFITS

EXTENDED HEALTH BENEFIT

PARAMEDICAL PRACTITIONERS

	% Co-insurance	Eligible maximum per visit	Maximum per calendar year
Psychologist/Social Worker	85%	U & C	$500
Chiropractor	85%	U & C	$750*
X-rays (Chiropractor, Osteopath, Naturopath, Chiropodist/Podiatrist)	85%		$50
Naturopath	85%	U & C	$750*
Acupuncturist	85%	U & C	$750*
Homeopath	85%	U & C	$750*
Dietician	85%	U & C	$750*
Osteopath	85%	U & C	$750*
Chiropodist/Podiatrist	85%	U & C	$750*
Audiologist	85%	U & C	$750*
Speech Therapist	85%	U & C	$750*
Occupational Therapist	85%	U & C	$750*
Physiotherapist/ Athletic Therapist	85%	U & C	$750*
Massage Therapist**	85%	U & C	$750*

GENERAL INFORMATION

Deductible	Nil
Survivor Benefit	24 months, without dues
Termination	The end of the calendar year in which the age 75 is reached

*** To a total combined maximum of $750 for all practitioners per calendar year.**
****Massage Therapist has a prescription requirement (valid for one year).**

U & C - Usual, Customary and Reasonable: Usual, Customary and Reasonable means the normal charges for similar services made by other providers of the same standing in the locality or geographical area where the charge is incurred, as determined by Medavie Blue Cross, or in accordance with a payment schedule established by Medavie Blue Cross.

SUMMARY OF BENEFITS

EXTENDED HEALTH BENEFIT

MEDICAL EXPENSES

	% Co-insurance	Maximum
Nursing Care	100%	$10,000/calendar year
Ambulance Transportation	100%	$1,000/calendar year
Orthopedic Shoes	100%	$200/calendar year
Molded Arch Orthotics	100%	$400/calendar year
Compression Garments	100%	$200/calendar year
Prosthetics (limbs, eyes)	100%	Up to U & C (see Annex A)
Mobility Aids (cast, canes, crutches)	100%	Up to U & C (see Annex A)
Medical Equipment	100%	Up to U & C (see Annex A)
Diabetic Equipment	100%	$200/calendar year
Ostomy Supplies	100%	Up to U & C
Hearing Aids	100%	$1,000/2 calendar years
Intrauterine Contraceptive Device	100%	$75/2 calendar years
Other Medical Services and Supplies**	100%	Up to U & C (see Annex A)
TENS	100%	$300/5 calendar years
Diagnostic Tests***	100%	$1,000/calendar year
Accidental Dental Care*	100%	Subject to authorization

GENERAL INFORMATION

Deductible	Nil
Survivor Benefit	24 months, without dues
Termination	The end of the calendar year in which the age 75 is reached

*** Benefits subject to pre-authorization**
**** Other medical expenses are listed in Annex A**
***** Diagnostic imaging services coverage in Quebec only**

SUMMARY OF BENEFITS

EXTENDED HEALTH BENEFIT

VISION CARE

	% Co-insurance	Maximum
Eye Examination	100%	One eye examination (up to U & C)/2 calendar years*
Contact Lenses Due to Disease	100%	$500/2 calendar years*
Visual Training	100%	$150 per lifetime
Lenses/Frames/Contact Lenses/Laser Eye Surgery	100%	$500/2 calendar years*

GENERAL INFORMATION

Deductible	Nil
Survivor Benefit	24 months, without dues
Termination	The end of the calendar year in which the age 75 is reached

*** To a total combined maximum of $500 per two calendar years.**

SUMMARY OF BENEFITS

DENTAL BENEFIT

	% Co-insurance	Maximum per calendar year
Preventive Care	85%	$1,500*
Basic Plan	85%	$1,500*
Major Plan	80%	$1,500*
Fee Guide Schedule	Current year	
Number of Recall Examinations, Polishing and Topical Application of Fluoride	Twice per calendar year	

GENERAL INFORMATION

Deductible	Nil
Payment Type	Reimbursement**
Survivor Benefit	24 months, without dues
Termination	The end of the calendar year in which the age 75 is reached

*** Preventive Care, Basic Plan and Major Plan are subject to a combined maximum of $1,500**

**** Reimbursement can be made electronically through the Canadian Dental Association (CDA Net); depending on your dentist's preference.**

Prosthetics are subject to a frequency of one per lifetime. If due to physiological/pathological change to the residual limb, medical documentation of such will be considered.

Repairs and/or adjustments are provided to a maximum of $300 per calendar year.

Wigs: $300 per lifetime

Durable medical equipment is subject to pre-authorization and purchase at the discretion of Medavie Blue Cross.

Other medical services and supplies as prescribed:

- Oxygen and rental of equipment for the administration thereof are subject to pre-authorization and purchase at the discretion of Medavie Blue Cross,
- Wheelchair/scooter cushions and inserts (as approved up to usual, customary and reasonable charges),
- Ostomy supplies and incontinence supplies up to usual, customary and reasonable charges,
- Artificial larynx subject to a frequency of one per lifetime up to usual, customary and reasonable charges,
- Charges for the repair of artificial larynx: $300 per calendar year,
- Burn pressure garments: $500 per calendar year,
- Surgical brassieres: limited to two per calendar year,
- Speech aids: $500 per lifetime,
- Spacing devices up to usual, customary and reasonable charges,
- Allergy testing materials: $50 per calendar year,
- Sleeves for lymphedema: two per calendar year.

HOSPITAL BENEFIT

This benefit covers eligible expenses incurred by you or your dependents subject to the deductible (if applicable) and the percentage of reimbursement specified in the Summary of Benefits.

Eligible Expenses

The usual and necessary expenses from a medical point of view and recommended by a physician are reimbursed at the percentages and up to the maximums specified in the Summary of Benefits. Reimbursement will be considered only when the services are provided by an approved provider as identified by the Company.

HOSPITALIZATION

Hospital Room Benefit

Hospitalization charges when you are admitted as an inpatient in a hospital for active care after the effective date of your coverage and for as long as you are entitled to covered services, subject to the maximum reimbursement specified in the Summary of Benefits. The preferred accommodation is specified in the Summary of Benefits.

Convalescent Care

Charges for convalescent care, if you have been admitted less than 14 days after obtaining your discharge from a hospital where you have been receiving active treatment, subject to the daily maximum and maximum number of days specified in the Summary of Benefits.

Physical Rehabilitation

Charges for rehabilitative care after the effective date of your coverage, subject to the daily maximum and maximum number of days specified in the Summary of Benefits.

Termination of Benefit

The Hospital Benefit ends at the age noted in the Summary of Benefits, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

Survivor Benefit

After your death, your dependents continue to be covered without cost and up to the earliest of the following dates:

a) 24 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another insurer, or
d) The termination date of the group policy.

DRUG BENEFIT

This benefit covers expenses for eligible drugs as defined by the Company and is subject to any co-pay, co-insurance or maximum listed in the Summary of Benefits.

The Company may, on an ongoing basis, add, delete or amend the list of eligible drugs on any list hereinafter mentioned. Certain drugs may require prior authorization to be eligible for payment as identified by the Company.

Drugs must be dispensed by a provider approved by the Company.

If the Summary of Benefits specifies Lowest Cost Substitution applies, and an interchangeable drug has been prescribed, the Company will reimburse to the lowest ingredient cost interchangeable drug.

You may request a higher cost interchangeable drug; however, you will be responsible for paying the difference in cost between the interchangeable drugs.

Regardless of whether your physician indicates the prescribed interchangeable drug cannot be substituted, the Company will only reimburse to the lowest ingredient cost interchangeable drug.

For participants with an adverse reaction to the interchangeable drug dispensed, the Company will consider reimbursement to another interchangeable drug on a case by case basis only, through the defined exception process.

Eligible expenses are considered to have been incurred on the date the services are rendered or the product is supplied.

Eligible Expenses

The plan refunds the following expenses, according to the percentage of reimbursement specified in the Summary of Benefits:

Expenses for drugs which require a prescription by law, approved by the Company, and prescribed by a doctor or dentist are eligible. In addition, certain drugs prescribed by other qualified health professionals will be considered if the applicable provincial legislations permit the professional to prescribe those drugs.

Expenses not Reimbursed by the Plan
Incurred expenses for the following products or drugs are excluded, unless specified in the Summary of Benefits:

- products not approved by the Company,
- products for the care of contact lenses,
- proteins or dietary supplements, amino acids, essential fatty acids,
- processed food for infants,
- hygiene products, including soaps and emollients,
- softeners and protective substances for the skin,
- minerals, vitamins,
- homeopathic/naturopathic products,
- drugs or drug formats or preparations with no therapeutic indication,
- herbal remedies,
- traditional medicines,
- probiotics,
- vaccines,
- weight loss treatments.

Applicable to Quebec Residents

Act Respecting Prescription Drug Insurance
This policy must be administered in accordance with the Act Respecting Prescription Drug Insurance ("the Act") in relation to Quebec participants, including the Act's provisions with respect to maximum coinsurance, out-of-pocket maximums, eligible drugs and exception drugs.

Under no circumstances will the expenses not reimbursed by the plan provision of this benefit render Drug Benefits for Quebec participants less generous than the basic prescription drug insurance plan established by the Act.

Out-of-pocket Maximum per Calendar Year
If, in any calendar year, a Quebec participant spends more on eligible drugs than the maximum contribution amount established by the RAMQ, the amounts in excess of the maximum contribution amount will be reimbursed by the Company at a rate of 100%. The Quebec participant's contribution amount includes the deductible and co-payment, if applicable, for you and your dependents.

Participants Age 65 Years and Over
When you and your spouse reach the age of sixty-five (65), you have a decision to make regarding your drug coverage.

Decision to join the RAMQ plan at age 65
When you or your spouse reaches the age of sixty-five (65) you may choose to be insured under the basic prescription drug insurance plan provided by the Act Respecting Prescription Drug Insurance (RAMQ's plan) rather than to maintain complete drug coverage under the group insurance plan. Such choice is then irrevocable.

If, at age sixty-five (65), you choose to be insured under the RAMQ's plan, you and your dependents, regardless of their age, will no longer be eligible for coverage under the group insurance plan (except for supplementary coverage, as mentioned in items a) and b) below).

If, at age sixty-five (65), your spouse chooses to be covered under the RAMQ's plan, then he will no longer be eligible for coverage under the group insurance plan (except for supplementary coverage, as mentioned in items a) and b) below).

However, you and your dependents who have joined the RAMQ's plan remain covered under the group insurance plan for the expenses indicated below (by paying the increase in premium, if applicable, according to the premium rates schedule of the contract):

a) the deductible and the coinsurance paid by the insured under the RAMQ's plan; and
b) subject to the deductible and the percentage of reimbursement mentioned in the benefit summary for drug coverage: the reimbursement of any prescription drug which does not appear on the list provided by the RAMQ, but which is covered under the insurer's list of drugs.

Decision to cancel registration with the RAMQ at age 65

When a Quebec resident reaches the age of sixty-five (65), he is automatically registered by the RAMQ as a beneficiary of its prescription drug coverage. When you or your spouse reaches the age of sixty-five (65) you must therefore cancel your automatic registration with the RAMQ plan in order to continue full drug coverage under the group insurance plan. Provisions relating to the increase in premium (if applicable) are mentioned in the premium schedule of the contract or, after the effective date of the contract, in the contract renewal provisions issued by the Insurer.

If a Quebec resident decides to maintain coverage under this benefit, the Company reserves the right to modify the premium rates applicable to this benefit for any Quebec resident age 65 and over.

Termination of Coverage

The Drug Benefit ends at the age noted in the Summary of Benefits, whichever occurs first. The coverage for eligible dependents ends when your Drug Benefit terminates or on the date they no longer meet the definition of dependent, whichever occurs first.

Survivor Benefit

After your death, your dependents continue to be covered without cost and up to the earliest of the following dates:

a) 24 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another insurer, or
d) The termination date of the group policy.

EXTENDED HEALTH BENEFIT

This benefit covers eligible expenses incurred by you or your dependents subject to the deductible (if applicable) and the percentage of reimbursement specified in the Summary of Benefits.

Eligible Expenses

The usual and necessary expenses from a medical point of view and recommended by a physician are reimbursed at the percentages and up to the maximums specified in the Summary of Benefits. Reimbursement will be considered only when the services are provided by an approved provider as identified by the Company.

MEDICAL SERVICES AND SUPPLIES

Nursing Care

Services of a registered nurse, registered nursing assistant or licensed practical nurse, who is not a member of the participant's family, whether residing with him or not, provided such services are rendered at the participant's home and are not primarily for custodial care, subject to the overall maximum amount payable noted in the Summary of Benefits.

Payment for eligible expenses will be based upon the payment schedule for private duty nurses established by the Company for the Participant's province of residence.

In addition, the participant may be eligible for services rendered by a personal care worker in the participant's home if under the active care of a nurse or if requiring home care during the recuperation period after a discharge from the hospital. Personal care workers offer essential services related to activities of daily living such as bathing, dressing, toileting, feeding and mobilization.

Charges for the following services are not covered:

a) Custodial care, homemaking duties, shopping, transportation, respite care, and services not related to providing support for the five activities of daily living listed above,

b) Services to those residing in a government funded facility or any other facility which provides similar care to its residents,

c) Service available through a government funded nursing or personal care program or community health program available to the general population at no cost.

Ambulance Transportation

Transportation in a licensed ambulance, including air ambulance, when medically necessary and when incurred in Canada, to and from the nearest hospital able to provide the necessary medical services, subject to a maximum amount payable noted in the Summary of Benefits.

Orthopedic Shoes

Charges for orthopedic shoes when the shoes have been customized with special features to accommodate, relieve or remedy some mechanical foot defect or abnormality. A prescription from an orthopedic surgeon, physiatrist, rheumatologist, chiropodist/podiatrist or the attending physician is required along with a copy of the biomechanical or gait analysis from the health care professional. Also, charges for shoe modifications, adjustments and supplies when prescribed by one of the health care professionals noted above to accommodate, relieve or remedy some mechanical foot defect or abnormality. Orthopedic shoes must be dispensed by an approved provider of orthopedic shoes. The combined maximum amount payable is noted in the Summary of Benefits.

Custom Made Orthotic Shoe Inserts

Charges for custom made orthotic shoe inserts when required to accommodate, relieve, or remedy some mechanical foot defect or abnormality, excluding their replacement (except for pathological change), on written authorization of an orthopedic surgeon, physiatrist, rheumatologist, podiatrist or the attending physician. Custom made orthotic shoe inserts must be dispensed by an approved provider of custom made orthotic shoe inserts. The maximum amount payable for this benefit is noted in the Summary of Benefits.

Compression Garments

Charges, including elastic support garments and gradient compression garments, (made to measure) on written authorization of the attending physician, to a maximum combined amount payable as noted in the Summary of Benefits.

Prostheses

Charges for the following remedial prosthetic appliances:

- artificial limbs (limited to one prosthetic appliance for each limb per lifetime),
- breasts (limited to a left and a right prosthesis every two (2) consecutive calendar years),
- artificial nose (limited to one (1) per lifetime),
- eyes (limited to one left and one right prosthesis per lifetime),
- casts and splints up to the usual, customary and reasonable amount,
- trusses (limited to one (1) truss per five (5) consecutive calendar years),
- braces (limited to one (1) cervical collar per calendar year. All other braces are limited to one (1) per lifetime),
- canes and crutches (limited to a combined maximum of two (2) per lifetime).

Replacement of these items will not be a benefit unless replacement is required due to pathological or physiological change.

Wigs, when loss is due to an underlying pathology or its treatment (i.e. chemotherapy), to a maximum amount payable as noted in the Summary of Benefits. Hair prosthetics, replacement therapy and other procedures for physiological hair loss are not eligible (i.e. male pattern baldness).

Prosthetic repairs and/or adjustments are provided to a maximum amount payable as noted in the Summary of Benefits.

Hearing Aids

Charges for hearing aids (excluding batteries and exams), when prescribed by an otolaryngologist, otologist and/or recommended by a registered audiologist. Eligible dependent children less than 21 years of age, requiring a hearing aid for each ear, are eligible for two (2) hearing aids (one for each ear). The maximum amount payable for this benefit is noted in the Summary of Benefits.

Intrauterine Contraceptive Device (IUD)
Purchase of an intrauterine contraceptive device (IUD), to the maximum amount payable noted in the Summary of Benefits.

TENS
Charges for the rental or purchase of a neuromuscular stimulation device (TENS) to the maximum amount payable noted in the Summary of Benefits.

Diabetic Equipment
Charges for the following equipment used for the treatment and control of diabetes: glucometer, pressurized insulin injector, blood glucose monitoring and insulin dosing systems, or equipment approved by the Company that performs similar functions. The overall maximum payable for this equipment is noted in the Summary of Benefits.

Medical Equipment
Charges for rental of a wheelchair, hospital-type bed (including mattress and safety side rails), and equipment for the administration of oxygen, when prescribed by a licensed physician. If, due to extended illness or disability, it is felt that the need for these items will be long-term, the Company, at its sole discretion, may approve the purchase of these items.

Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once every five consecutive calendar years.

Charges for the repair of a manual or electric wheelchair up to the usual, customary and reasonable amount.

You or your dependent must obtain the prior approval from the Company before any purchase, rental or repair otherwise the claim may be rejected.

Paramedical Services
Charges for treatment, except when performed in a hospital, by a licensed practitioner. The maximum payable amount for each eligible practitioner is mentioned in the Summary of Benefits. In addition the maximum payable amount for X-rays is mentioned in the Summary of Benefits.

Diagnostic Test
Charges for diagnostic laboratory and X-ray services, when carried out by an approved laboratory which, in the opinion of the Company, is qualified to render such services. These services will include:

- laboratory analyses, X-rays, electrocardiograms, CT scans, ultrasounds, and magnetic resonance imagery (MRI).

Services will be provided to a maximum combined amount payable as noted in the Summary of Benefits. Diagnostic imaging services coverage in Quebec only.

Other Medical Services and Supplies

a) Charges for the purchase of wheelchair/scooter cushions and inserts, limited to the usual, customary and reasonable amount.
b) Charges for artificial larynx, limited to one purchase per lifetime.
c) Charges for the repair of artificial larynx, subject to the maximum amount payable noted in the Summary of Benefits.
d) Charges for the purchase of burn pressure garments, subject to the maximum amount payable noted in the Summary of Benefits.
e) Charges for the purchase of surgical brassieres, limited to two (2) per calendar year.
f) Charges for the purchase of spacing devices up to the usual, customary and reasonable amount.
g) Charges for allergy testing materials, subject to the maximum amount payable noted in the Summary of Benefits.
h) Charges for sleeves for lymphedema, limited to two (2) per calendar year.

Ostomy Supplies

Charges for essential ostomy supplies, up to the usual, customary and reasonable amount.

Speech Aids

Charges for speech aid equipment, when approved by a qualified speech therapist and authorized by the attending physician, for persons who do not have oral communication ability, to a maximum payable amount noted in the Summary of Benefits.

Accidental Dental

Charges for dental treatment, when sound, natural teeth have been damaged by a direct accidental blow to the mouth, or a fractured or dislocated jaw required setting.

This dental treatment must be rendered or reported and approved for payment by the Company within 180 days of the accident and dental work must be completed within 24 months from the date of the accident. Eligible expense will be the dentists' usual and customary fee up to the "dental fee guide" for general practitioners in effect where services are rendered.

All deferred dental treatment must be completed and approved for payment by the Company no later than the last day of the month in which the person turns 21 years of age unless otherwise prescribed by statute, in which case the statutory provision applicable in the province where the participant resides shall apply.

When such dental treatment must be deferred because of the age of the patient, or other factors which are justified, in the opinion of the Company, the claim may be approved for later payment. To meet our payment criteria, the participant must have been covered by the Company for accidental dental at the time the accident occurred, and must still be covered by the Company at the time the services are rendered. The only exception to this criterion is when the participant is uninsured for dental benefits at the time the service is rendered, in which case the claim may be approved. The subscriber must submit to the Company within 180 days of the accident complete details of the required services from the dentist and reason for deferment.

VISION CARE

Eye Examination
Charge of a registered, licensed optometrist or ophthalmologist for eye examinations. Subject to the combined maximum amount payable mentioned in the Summary of Benefits.

Contact Lenses Due to Disease
Charges for contact lenses when prescribed by a licensed ophthalmologist for ulcerated keratitis; severe corneal scarring, keratoconus (conical cornea) or aphakia, provided sight can be improved to at least 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses. The total combined maximum payable amount is stated in the Summary of Benefits.

Visual Training
Charge of a registered, licensed optometrist or ophthalmologist for visual training and remedial eye exercises limited to the maximum payable amount stated in the Summary of Benefits.

Lenses/Frames/Contact Lenses/Laser Eye Surgery
Charges incurred for corrective lenses/frames or contact lenses or intraocular lenses used in cataract surgery or the cost of laser eye surgery when prescribed by an optometrist or ophthalmologist, up to the combined maximum amount payable stated in the Summary of Benefits.

Expenses not Reimbursed by the Plan
The following expenses are not reimbursed under the plan:

a) Medical examinations or routine general check-ups required for use by a third party,

b) Charges for rest cures, convalescent care, custodial care, rehabilitation services in a hospital for the chronically ill or a chronic care unit of a general hospital, or charges incurred by the participant when, in the opinion of the Company, proper treatment should be in a chronic care unit of an institution for the chronically ill,

c) Charges relating to elective services obtained by a participant outside his province of residence when his provincial government health care programs have not accepted liability for those items normally covered in the participant's province of residence,

d) Any services and supplies to which the participant is entitled under any workers compensation statute or any other legislation,

e) Charges which normally would not be made if the participant were not covered by this policy,

f) Services for cosmetic purposes or condition not detrimental to one's health,

g) Any services and supplies normally available without cost, or at nominal cost, under any government statute on the effective date of this policy, whether or not such services or supplies continue to be eligible under a government program,

h) Mileage and/or delivery charges to or from a hospital or health care professional,

i) Services in connection with an injury or disease resulting from riot, insurrection or war whether war be declared or not. This includes any condition caused directly or indirectly by any armed forces,

j) Medications restricted under federal or provincial legislation that are prescribed and/or dispensed despite such regulations,

k) Registration charges or non-residents surcharges in any hospital,

Expenses not Reimbursed by the Plan (Cont'd)

l) Services required as a result of attempting to commit a criminal act,

m) Service performed by an unqualified practitioner,

n) Charges for missed appointments or the completion of forms,

o) Services which are normally paid for directly or indirectly by the employer,

p) Any health care services and supplies which are not provided by a company approved provider,

q) Charges for experimental or investigative health care services or supplies,

r) Any health care service or supply that are not medically necessary nor proven effective,

s) Charges for health care planning assessments including, but not limited to physiotherapy assessments. Health care planning assessments will be excluded as eligible benefits, unless otherwise specified in this policy,

t) Any health care services and supplies administered in a hospital or by any agency or provider controlled by a hospital or by any agency or provider funded, in whole or in part, by government of any level, are not eligible for reimbursement under this policy, unless otherwise specified in this policy.

Limitation

For the purpose of the present benefit, all participants shall be deemed covered under the hospital and health insurance acts of their province of residence in Canada.

Termination of Benefit

The Extended Health Benefit ends at the age noted in the Summary of Benefits, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

Survivor Benefit

After your death, your dependents continue to be covered without cost and up to the earliest of the following dates:

a) 24 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another insurer, or
d) The termination date of the group policy.

DENTAL BENEFIT

This benefit covers eligible expenses incurred by you or one of your dependents for dental services recommended by a dentist and performed by:

- a dentist, or
- a dental hygienist under the supervision of a dentist, or
- a denturist.

Expenses are subject to the deductible (if applicable), percentages of reimbursement and maximums specified in the Summary of Benefits.

However, if you or your dependents become covered more than 31 days after your date of eligibility, the maximum amount reimbursed under this benefit for all eligible services is limited to $250 during the first 12 months of coverage.

Calculation of Eligible Expenses
The eligible amount for covered benefits is the amount indicated in the suggested fee guide for dental services approved by the province of provider (current year edition).

Eligible Expenses
After payment of the deductible (if applicable), the following expenses are reimbursed, according to the percentage of reimbursement and maximum specified in the Summary of Benefits.

Preventive Care

a) Oral examinations and diagnosis
   - Complete oral examination (once per two consecutive calendar years)
   - Recall oral examination (as mentioned in the Summary of Benefits)
   - Emergency oral examination and specific oral examination (once per calendar year)

b) X-rays
   - Complete series films (once per two consecutive calendar years)
   - Panoramic film (once per two consecutive calendar years)
   - Intra-oral films – periapical
   - Intra-oral films – occlusal
   - Intra-oral films – bitewings (once per calendar year)
   - Extra-oral films
   - Sialography
   - Radiopaque dyes

Preventive Care (Cont'd)

c) Laboratory tests and examinations
- Bacterial culture
- Biopsy of soft oral tissue
- Biopsy of hard oral tissue
- Cytological examination

d) Preventive treatment
- Polishing of coronal portion of teeth (as mentioned in the Summary of Benefits)
- Topical application of fluoride (as mentioned in the Summary of Benefits)
- Oral hygiene instruction (lifetime maximum of one instruction)
- Pit and fissure sealants (for participants under age 18)
- Scaling (8 units* per calendar year in combination with root planing)

e) Space maintainers

Basic Care

a) Restorations
- Amalgam, acrylic, silicate or composite on posterior and anterior teeth
- Retentive pins
- Full coverage prefabricated restorations

b) Endodontic services
- Pulp capping
- Pulpotomy
- Emergency pulpectomy
- Root-canal therapy
- Endodontic surgery
- Bleaching (endodontically treated teeth)
- Apexification

c) Periodontics
- Periodontal surgery
- Provisional splinting
- Management of acute infections
- Desensitizations
- Other adjunctive periodontal services
- Root planing (8 units* per calendar year in combination with scaling)
- Periodontal curettage
- Occlusal adjustments (three units* per calendar year)
- Periodontal appliances (one per two consecutive calendar years)
- Adjustments to appliances (three units* per calendar year)

d) Removable denture adjustments
- Minor adjustments
- Rebasing and relining (one per two consecutive calendar years)

* A unit of time is equal to 15 minutes of service

Basic Care (Cont'd)

e) Oral surgery
- Removal of erupted teeth
- Surgical exposure and movement of teeth
- Surgical excision of cysts and neoplasms

f) General adjunctive services
- Anaesthesia (related to surgery)

Major Restoration

The following charges are eligible if major restorations are included in the Summary of Benefits:

a) Extensive Restorations
- Inlays/onlays/crowns (once per tooth every five consecutive calendar years)

b) Prosthodontic Services
- Complete and partial dentures (once every five consecutive calendar years)
- Bridgework (once every five consecutive calendar years)
- Implants (once per tooth every 10 consecutive calendar years)
- Restorations over implants (i.e. crowns, bridgework and dentures) (once per tooth every 10 consecutive calendar years)

This program excludes replacement of the denture unless it is at least 5 years old and cannot be made serviceable, and the replacement of dentures that may have been lost, mislaid or stolen.

Proposed Dental Treatment in Excess of $500

If the cost of the proposed dental treatment exceeds $500, have your dentist complete the predetermination section of the claim form and forward it to the Company before the start of treatment. You will thus know, beforehand, the exact amount of the reimbursement. If you change dentist in the course of treatment, you will be required to submit a new treatment plan to the Company.

Expenses not Covered by the Plan
The following expenses are not covered:

a) Treatment or appliance, related directly or indirectly to full mouth reconstruction, or to correct vertical dimension and temporomandibular joint dysfunction, unless specified otherwise in your Summary of Benefits.

b) Services rendered by a dental hygienist but not administered under the supervision of a dentist, except in those provinces where it is no longer a legal requirement.

c) Services and supplies relating to any appliance worn in the practice of a sport.

d) Expenses that are payable or reimbursable under a public or private plan or that would normally be so if a claim had been submitted.

e) Charges payable under an occupational health and safety board or by an automobile insurance bureau, or any other similar law or public plan, if applicable.

f) Expenses resulting from any suicide attempt or self-inflicted injury, whether the participant is sane or not.

g) Expenses due to any injury or illness resulting from the participant's active participation in civil unrest, riot or insurrection, unless while performing work related functions, or injury sustained in a war.

h) Services that are not medically required, that are given for cosmetic purposes (this exclusion does not apply to composite restoration).

i) Services that exceed the ordinary services given in accordance with current therapeutic practice.

j) Care or services rendered free of charge, or that would be if there were no benefit coverage, or that are not chargeable to the participant.

k) Expenses incurred for veneers.

l) Splinting for periodontal reasons, where cast crowns or inlays are used for this purpose, with or without onlays.

Restriction
No reimbursement will be made for any portion of the charge that is over the suggested fee in the appropriate fee guide for the least expensive treatment that will provide a professionally adequate result.

Reimbursement of laboratory fees will be limited to the reasonable and customary charges for such services in the area where the services are provided.

Alternate Benefits
When one or more form of alternative treatment exists, the Company, in consultation with its health care consultants, reserves the right to make payment for eligible services and supplies based on an alternate procedure with a lower cost, when deemed appropriate and consistent with good health management.

Termination of Benefit
The Dental Care benefit ends at the age noted in the Summary of Benefits, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered (but not upon your death) or on the date they no longer meet the definition of dependent, whichever occurs first.

Survivor Benefit
After your death, your dependents continue to be insured without cost and up to the earliest of the following dates:

a) 24 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another Insurer, or
d) The termination date of the group policy.