IBEW 2166 Health and Welfare Plan

Class B - Active Apprentices under 70

Policy / Contract #:
NexgenRx IBEW2166

Contract Effective Date: 01Jul18
Booklet Production Date: 01Jul18

CONTACT INFORMATION

The following Benefits are provided by or administered by:

NexgenRx Inc. administers your Dental, Drug, and Extended Health Care Benefits

Member Support is available from 8:30am to 10:00pm E.S.T.	866-424-0257
Pharmacy and Dental Office support for electronic submission is available from 8:30am to 10:00pm E.S.T.	866-394-3648

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Introduction

Your Plan sponsor, IBEW Local 2166 Health, Welfare and Pension Trust, and NexgenRx have worked together to develop a package of benefits to meet your needs. These benefits are an important part of your financial security provided by your plan sponsor.

The goal is to make it easy for you and your family to have your questions answered. If you have any questions about your benefits, you can ask your plan sponsor, or call NexgenRx on our toll-free at line 1-866-424-0257or if calling in the Toronto area 647-722-3046.

Why is this booklet important?

This booklet outlines the benefits that are available under your plan sponsor's contract with NexgenRx. The section called "General Terms" includes facts about eligibility and enrolment. This is followed by a section on each of your benefits, containing benefit descriptions and the coverage that each benefit provides and what you are not covered for.

Please remember that this booklet is a summary of your benefit details effective July 1, 2018.

If you have any questions about the details in this booklet or about your group health benefits, please contact your IBEW Local 2166 or call NexgenRx.

If there are variations between the information contained in the booklet and the provisions of the contract and plan document, the contract and plan document will prevail.

Definitions

Here are definitions for some of the terms in this booklet. You will find more definitions included in each section.

Co-Insurance

Co-insurance is the rate at which benefits are payable.

Spouse

A spouse is a person to whom you are legally married or with whom you have a common-law spouse relationship. Common-law spouse means a partner whom you have lived with for at least 12 months

The maximum number of spouses that can be covered at one time is 1.

Child

A child is your unmarried natural born, legally adopted, step-child, foster child and/or common-law child. Common-law child means a child of your common-law spouse and another person. This child must be dependent on you and your common-law spouse for support and maintenance.

- A child must be under age 22, and dependent on you for support and maintenance
- Coverage is continued while the child is under age 26 and attending an accredited college or university on a full-time basis. Upon request you must provide confirmation that the child is a full-time student and remains dependent on you for support and maintenance
- Coverage is continued beyond the maximum ages indicated above for a child who is physically or mentally handicapped as long as the child became handicapped before reaching the applicable maximum age stated above, and you provide proof satisfactory to us that the child is not capable of self-support due to the handicap

Dependent

A dependent is your spouse or child. Anyone who is in the armed forces full-time is not eligible to be a dependent.

Emergency

An emergency means any sudden, unexpected illness or injury for which the insured person needs immediate treatment.

Family

A family is you and all your dependents that are covered under the same contract.

Covered Person

Covered person means you or any one of your dependents who are covered under the contract.

General Terms

The terms that are defined in this provision are used throughout the plan.

Union

The International Brotherhood of Electrical Workers, Local 2166

Member

A person that belongs to the International Brotherhood of Electrical Workers, IBEW Local 2166 who is in good standing. Whose dues are not more than three months in arrears and is not in violation of the IBEW constitution.

Employer

An Employer who contributes to the IBEW Local 2166 Health & Welfare Trust Fund

Member's Monthly Earnings

1. Regular and overtime rates of pay for Journeymen and rates of pay for Apprentices shall be as shown in the appropriate table of the current Collective Agreement of IBEW Local 2166.
2. The regular work week shall be five (5) days, Monday – Friday, of eight (8) consecutive hours each. The regular hours of work shall be 8:00am to 12:00 noon and 12:30pm to 4:30pm but these may be varied by the employer when required by job conditions.

Credited Hours

Each union member will receive one credit for each hour worked for which contributions have been made and reported in such member's name, by his employer. These credits are termed "credited hours" and are deposited in the member's hour bank.

Active Premium

The cost of a member's benefits coverage, including income replacement coverages.

Self-Pay Premium

The premium paid by the member to maintain benefit coverage. Any time a member is at risk of losing coverage due to lay-off, shortage of work, illness and/or injury at the time your coverage is set to terminate you may elect to pay the total premiums to maintain your benefit coverage to a maximum of 18 months. Whenever a member has elected to self-pay to maintain benefit coverage please note that Income Replacement is not included in the Benefit package.

Hour Bank

Employers contribute to the plan for every hour that a member works, one (1) hour worked equals one (1) credit to the members hour bank for the purpose of determining the commencement, continuation and termination of a member's coverage under the plan. The maximum number of hours that can accumulate in a Members Hour Bank will be 2,520 hours the equivalent to 18 months of premium contributions. A member's Hour Bank is subject to the following conditions.

1. A minimum number of 420 hours must be in the Hour bank before a new Member will be eligible for coverage under this plan.
2. An amount representing the cost of the Member's coverage will be deducted from his Hour Bank at the end of each month for coverage to be continued for the following month. The current monthly deduction is 140 hours per month. There will be an 18-month termination cycle. This

means that should a member be nonactive, their Hour Bank will go to zero after a period of 18 months.

3. A member who does not have sufficient “Credited Hours” in his Hour Bank at the end of the month to continue coverage for the following month may elect to pay the Self-Pay Premium to maintain coverage during lay-off, illness or injury up to a maximum of 18 consecutive months. This election can only be made at the time coverage lapses. A member who is working within the trade but outside Union Jurisdiction is not eligible to self-pay any premium.
4. If a member has not paid his monthly dues for a period of 6 months his hour bank will be forfeited to the reserve.
5. When a member retires their coverage will terminate and any remaining hours in their bank will be transferred to the reserve.

The number of hours that apply to each of the above conditions will be as agreed to by us.

Eligibility

To be eligible for group coverage under the plan you must:

- Be a member in good standing of IBEW 2166 that has not been suspended or removed for unpaid dues.
- Must be working the minimum required number of hours or have at least 140 hours in your hour bank to maintain coverage per month. Your hours will be credited to your hour bank when they are reported by the employer and contributions have been remitted. If an Employer is late with contributions this may delay your coverage.
- Be a permanent resident of Canada and covered under your provincial health care plan.

Confirming Your Coverage

When your coverage begins, you will receive a NexgenRx Benefit Card outlining your coverage. Upon receipt, please check the card to make sure the information is correct.

What Changes to Report to Your IBEW Local 2166/NexgenRx?

You must report the following changes immediately to your Union Office:

- changes in dependent coverage, including the birth of a child
- change of spouse
- change of name
- change from single or family status
- change of banking information (if NexgenRx is depositing your claim expenses directly into your bank account)

Your Coverage Ends

On the earliest of the following dates:

- The last day of the month in which the Member reaches age 70 or retires, whichever is earlier.
- The last day of the month in which your hour bank has insufficient hours to maintain coverage.
- The date you cease to be a member.

- The date this contract terminates

A dependent's coverage will end on the earliest of the following dates:

- The date your coverage ends
- The date you request termination of dependent coverage
- The date your dependent no longer satisfies the definition of dependent

Reinstatement

If coverage has been terminated due to insufficient hours in your hour bank, your coverage will become active again on the first day of the second month following the accumulation of 240 hours in your hour bank.

Members who are laid off or otherwise cease to actively participate in the plan will be treated as new Members after a period of 24 months has elapsed.

Legal Action

No legal action may be taken until 60 days after proof of claim is given to NexgenRx or more than one year after the deadline for providing proof of claim. If you have received benefit payments but the payments end, no legal action may be taken more than one year after the last payment was made.

Submitting Claims

All claims should be submitted immediately after the expense is incurred but not more than 12 months from the date of service.

Co-ordination of Benefits with Your Spouse's Plan

Co-ordination with your spouse's plan is one of the advantages of group coverage. It allows you to receive up to 100% of Health Care costs, if both you and your spouse have similar coverage.

Claiming Your Spouse's Expenses

If you are claiming an expense for your spouse, the claim will always go to their plan first and your plan second. Your spouse's plan will assess and pay the portion of the claim that is covered by them and send your spouse an explanation of benefit along with payment. Once you receive the explanation of benefit you can then send a copy of the explanation of benefit and a copy of the expense receipts, along with a completed claim form for the unpaid portion, to NexgenRx Inc. for assessment.

Claiming Your Child's Expenses

If you are claiming an expense for your child, you send the claim to the plan of the parent with the earliest birthday (month and day) in the calendar year first. For example, if your birthday is May 19th and your spouse's birthday is June 11th, your child/children's claims will always go to your plan first. Once you receive the explanation of benefits you can then send a copy of the receipts along with a copy of the explanation of benefits to your spouse's plan.

If you are separated or divorced, claims for your child's benefit must be co-ordinate based on the standard industry guidelines. Please refer to CLHIA – Co-ordination of Benefits guide… http://www.clhia.ca/domino/html/clhia/clhia_lp4w_lnd_webstation.nsf/resources/Consumer+Brochures/$file/Brochure_Guide_To_CoOrdinationBenefits_ENG.pdf

Claiming Your Expenses

If you are claiming your expenses, the claim must be sent to NexgenRx Inc. first. NexgenRx Inc. will pay for the portion of the claim that is covered by your plan and send you an explanation of payment. Your spouse can then send a copy of the explanation and a copy of the receipts, along with a claim form for the unpaid portion, to his/her group carrier.

Should you or your Union terminate your coverage and your Union's contract is still in effect, you have 1 year from the date of service to submit any claims incurred during the period you were covered under the plan

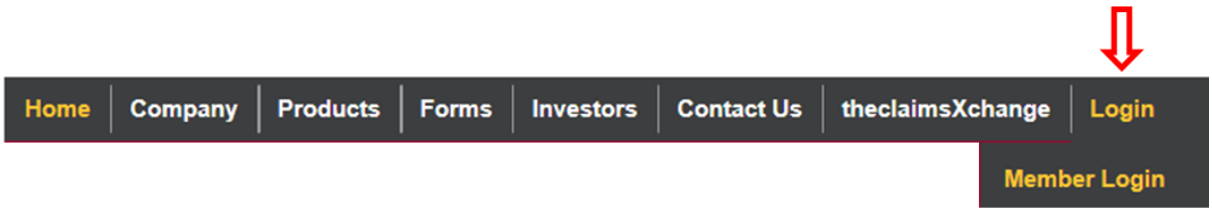
Submitting Your Claims on the Web

Members have the option to submit claims on our secure website. Please note when using the web claims submission, you must be set up on our system for Direct Deposit for your claims reimbursement. You must also keep the original copies of your receipts for 18 months from the time you submit your claim on line for audit purposes.

As a plan member, NexgenRx Inc. provides you with access to our claims processing website to look-up the status of your claims anytime you wish. In order to access our secure, online administration and information website please follow these instructions:

FIRST TIME USERS

1. Go to the following Web address: www.nexgenrx.com
2. Click on **MEMBER LOGIN** at the top right-hand side of screen as show below:



Please note that **FIRST TIME USERS** must complete all steps in order to use their account and subsequently logon to the website.

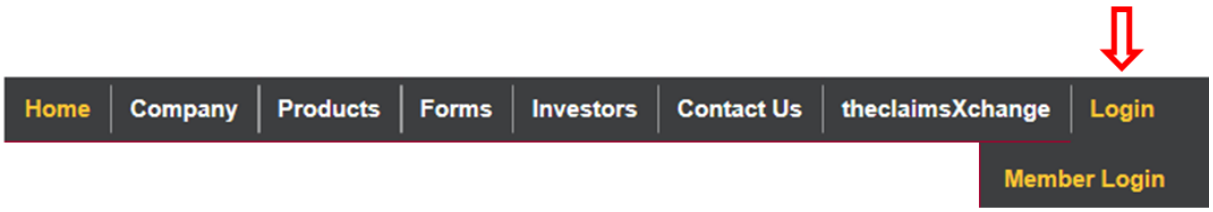
Your **USERNAME** and **TEMPORARY pass phrase** are automatically generated by our system and included in your welcome kit.

- After clicking on the **ACTIVATE ACCOUNT** button under the **Activate Your Account** section, the system will take you to the Account Activation Screen.
- Read the information and click **NEXT.**
- Review the Terms of use and click the checkbox at the bottom of the screen to accept the terms.
- Click **NEXT**
- This will take you to the **VERIFICATION OF IDENTITY** screen.
- Fill in the fields on this screen that are noted with an asterisk, i.e. **USER NAME** and temporary **PASS PHRASE**; click **NEXT**.
- The system will take you to the **ACCOUNT SETUP** screen.
- Complete all fields. Select a **NEW** password of your choosing **(it must be at least 8 characters in length**) and confirm your newly selected password by entering it again. Complete the challenge question, challenge answer section and enter your email address. Click **NEXT**.
- The system will now confirm that your account has been activated. **The next time you log in, enter your user name and pass phrase under the SIGN IN heading.**
- Click **FINISH**. This will take you back to the main login screen.
- You may now login using your username and the **NEW** password that you have selected.
- Once you have signed in, click on the **PLAN MEMBER** tab on the right near the top.
- Then click on the **SUBMIT A CLAIM** option and proceed through the steps.

EXISTING USERS

3. Go to the following Web address: www.nexgenrx.com

4. Click on **MEMBER LOGIN** at the top right-hand side of screen as show below:



5. Enter your pre-assigned user name and *personal* secure pass phrase under the **SIGN IN** heading.
6. Once you have signed in, click on the **PLAN MEMBER** tab on the right near the top.
7. Then click on the **SUBMIT A CLAIM** option and proceed through the steps.

How to submit a paper claim

Complete the claim form that is available from your Employer or on NexgenRx Inc.'s web site, www.nexgenrx.com

Make sure that your receipts include:

- the name of the person who received the service or supply (referred to as "the patient")
- the date the service or supply was received
- the type of service or supply received and
- the cost paid

Mail your claim to: NexgenRx Inc.
185 The West Mall, Suite 600
Toronto, ON M9C 5L5

Your Health Care Coverage

Your plan will pay for the usual cost of covered services and supplies that are medically necessary to treat an illness, injury or pregnancy and incurred in Canada by a recognized practitioner / provider.

It will cover:

- The amount that is usually charged for the service or supplies in the area in which the charge is made
- Services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Association as effective and appropriate and based on accepted standards of Canadian health care and the Canada Revenue Agency
- Services and supplies that private plans are legally allowed by the government to cover. The plan will not cover services or supplies that are covered by the government plan in your home province
- Charges for services and supplies that are incurred while the person is covered under this plan

Your Health Care Coverage (Summary)

Extended Health Care	
Deductible	None
Maximum Dispensing Fee Allowed	Dispensing Fees are payable at 70%
Coinsurance	
Hospital	100% Semi-Private to a maximum of 7 days per incident.
Drugs	70% with Generic equivalent Overall maximum of $10,000 per person per calendar year
Convalescent Care	$20 per person per day up to 120 days per incident
Ambulance Services	80% Maximum 3 trips per person per calendar year
Diagnostic Tests	80%
Paramedical Practitioners	80% to a maximum of $500 per person per calendar year
Vision Care Maximum	50% One exam per person 21 and over every 2 calendar years One exam per person per calendar year for individuals under 21 Combined maximum of $250 per person per 2 calendar years for frames, lenses, contact lenses and laser eye surgery $200 per person per lifetime for Contact lenses required to correct visual acuity to 20/40 level if not possible with regular prescription eyeglasses.

Extended Health Care (continued…)	
Nursing Care Maximum (at home)	$10,000 per person every 3 calendar years
	One pair per person per calendar year for custom made orthopedic shoes (Doctor referral required)
Orthopedic Shoes and Custom-Made Orthotics Maximum	$300 per person every 2 calendar years for custom made foot orthotics (Doctor referral required)
	$100 per person every 2 calendar years for adjustments/modifications
Hearing Aids and Hearing Aid Repair Maximum	$700 per person every 5 calendar years
	80%
Medical Supplies (medically necessary services and supplies)	Medically necessary braces other than cervical collars, Artificial limbs, eyes and other prosthetic devices, Walkers, crutches and canes ($100 per person every 2 calendar years), Post surgery frames/lens, contact lens or prosthetic lens one per lifetime per eye, Breast prostheses (1 per person every 2 calendar years), Surgical bras (2 every calendar year), Oxygen equipment, Compression garments including gradient support and elastic support stocking (2 pairs per person every calendar year), Wigs following chemotherapy or radiation or underlying pathology ($100 per person's lifetime if a result of chemotherapy, $250 if a result of total hair loss from Alopecia Totalis), Hearing aids and repairs not including batteries ($700 per person every 5 calendar years), Wheelchairs, hospital beds and other temporary therapeutic equipment (rental only unless it is more economical to purchase such equipment), Aero Chambers ($100 per two calendar years), CPAP Machine ($1,000 per person every 3 calendar years), Ostomy/Ileostomy/Colostomy supplies ($1000 per person per calendar year), Compressors (100 per person every 3 calendar years), Nebulizers to administer asthma medication ($100 per person every 3 calendar years), T.E.N.S. machine ($200 per person every 5 calendar year),
Accidental Dental	80% to a maximum of $2,500
Termination	Retirement or end of the calendar year in which you turn age 70

Dental	
Deductible	None
Coinsurance	
Basic	80%
Major Restorative	60%
Maximums	
Basic & Major Restorative	Combined maximum of $1,500 per person every calendar year
Recall Exams	2 per calendar year
Fee Guide	Prior Year Provincial General Practitioners for New Brunswick
Termination	Retirement or end of the calendar year in which you turn age 70

Drug Benefit

What You Are Covered for and How Much the Plan Will Pay

The plan has no deductible.

Eligible expenses under the plan include the ingredient cost and the dispensing fee. The plan pays 70% toward the ingredient cost and dispensing fee while the patient pays 30% (co-pay) of the eligible ingredient cost and the dispensing fee. The co-pay is the amount you must pay to the pharmacist for each eligible drug. The plan has an overall maximum of $10,000 per person per calendar year.

Immunizations and Vaccines are covered for members only when it is medically required.

Your plan pays for most drugs that legally require a written prescription. If a generic drug can be substituted for a brand name drug, the plan will only cover the cost of the generic substitute with the lowest price.

The plan covers up to a 34-day supply of acute drugs, and up to a 100-day supply for maintenance drugs.

Prior Authorization Program

Your policy contains a provision that provides coverage for certain drugs requiring prior authorization approval.

Please visit our NexgenRx website for a list of drugs requiring prior authorization* at www.nexgenrx.com under the FORMS section.

If you or a member of your family are currently taking any of the listed drugs, please contact the NexgenRx Call Center right away at 1-866-394-3648 to avoid any delays at the pharmacy.

Prior Authorization helps ensure that services and supplies are reasonable treatments and medically necessary. Your doctor may be required to provide medical evidence that a lower cost alternative service or supply cannot be used before coverage may be considered and/or that the treatment is for approved medical reasons.

A Prior Authorization form must be submitted to NexgenRx for claims approval. The applicable forms can be found on our website as stated above.

*The NexgenRx Prior Authorization list is subject to change at NexgenRx's discretion.

You and your dependents can use the NexgenRx drug card to purchase eligible drugs. Use of the NexgenRx drug card authorizes NexgenRx or their authorized agent, to inform pharmacists and physicians on patient safety issues for you and your dependents. NexgenRx, or our authorized agent, is not legally liable for this information.

You and your dependants may not be able to use the NexgenRx drug card to buy drugs from a physician, dentist, clinic, hospital, or some pharmacies, but you can make a claim for the cost of eligible medicines by using a claim form and attaching the receipts. A receipt must show the prescription number and the name of the drug or Drug Identification Number (DIN).

If your NexgenRx drug card is lost or stolen, it must be reported immediately to IBEW Local 2166.

You and your dependents cannot use the drug card to purchase the following items:

- alcohol swabs
- appliances
- atomizers
- certain equipment
- ostomy supplies
- devices for giving inhaled medications (for example, an aero chamber) blood glucose monitor and prosthetic devices
- Non-disposable Insulin delivery devices

We will **not** pay for the following:

- hair growth stimulants
- products used to quit smoking
- anti-obesity drugs
- alcohol
- bandages
- contraceptives other than birth control pills
- cosmetic items
- sunscreens
- cotton
- vitamins (except some injectables), minerals, dietary supplements food substitutes, infant food or formula
- disinfectants
- homeopathic medicines
- non-disposable insulin delivery devices
- products which can be bought without a prescription, other than some life supporting products
- spring loaded devices used to hold lancets

Extended Health Care (EHC) benefits

For your extended health care benefits:

The plan has no deductible.

The plan pays 100% for in province hospital services, 50% for Vision and 80% for Paramedical.

Hospital Accommodation

For “in province” hospital services, the plan will cover the cost of a semi-private room in a hospital for a maximum of 7 days per incident. Room charges for outpatient treatment will not be covered.

The hospital stay must be because of illness, injury or pregnancy and the patient must be confined on an in-patient basis.

Vision Care

The plan will pay for one eye exam per person 21 and over every 2 calendar years* and one eye exam per person under 21 every 1 calendar year.

The plan will pay $200 per person per lifetime for contact lenses prescribed by an optometrist or ophthalmologist to correct visual acuity to the 20/40 level when prescribed by an ophthalmologist provided sight can be restored to at least 20/40 level by contact lenses but cannot be improved to that level by eyeglasses*.

The plan will pay for prescription eyeglasses or contact lenses to a maximum of $250 per person every 2 calendar years.

Paramedical Practitioner Services

The plan will pay 80% of reasonable and customary fees to a maximum of $500 per person per practitioner per calendar year for the following Practitioners:

- Speech Therapists
- Clinical Psychologists

The plan will pay 80% of reasonable and customary fees to a combined maximum of $500 per person per calendar year.

The plan will pay for the following:

- Chiropractors
- Osteopaths
- Podiatrists/Chiropodists
- Naturopaths
- Physiotherapists/Athletic Therapists
- Speech Therapists
- Christian Science Practitioners

These practitioners must be registered in the province where the service is provided, be performing a service for which their registration applies and cannot be a person who normally lives with you nor be a person related to nor a member of your immediate family. Christian Science Practitioners must be listed in the Christian Science Journal.

The plan will cover the cost of laboratory test(s) or x-ray(s) recommended by a licensed chiropractor, osteopath, chiropodist or podiatrist in any one calendar year included in the $500 maximum for paramedical practitioners.

Registered Nurses

The plan will cover these services to a maximum of $10,000 every 3 calendar years.

Services provided by a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse must be approved by NexgenRx in advance. These services must be provided in the insured person's home by a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse who does not normally live with, is not related to, nor is a member of the insured person's immediate family.

The plan will not cover the cost of a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse if the care they provide is not the skilled duties that only they can provide. We will also not cover the cost of care from a Registered Nurse, Registered Nursing Assistant, or Registered Practical Nurse that is provided in a nursing home, rest home, home for the aged, hospital, or any facility that provides similar care.

Ambulance Services

The plan will cover the cost of a licensed ambulance or other emergency service, (including air ambulance), that transports the insured person to and from the nearest hospital that is able to give the necessary treatment. This covers travel between hospitals to a maximum of 3 trips per person per calendar year.

Convalescent Care

The plan will pay for active treatment or convalescent care in a Rehabilitative, Convalescent Institute when prescribed by a physician, up to $20 per day for semi-private accommodation to a maximum of 120 days per incident. At the age of 65 a maximum of $500.00 applies.

Miscellaneous Services

The plan will pay for out-patient services from a licensed hospital and for certain diagnostic tests, radium treatments and x-rays from a licensed facility in your home province up to $1,000 per person every calendar year. Diagnostic imaging is covered only in Quebec.

Medical Equipment

The plan covers the cost of out-patient supplies obtained from a hospital or surgical supply company in your home province. It will also cover the cost of rental charges for wheelchairs, hospital beds and other temporary therapeutic equipment that is deemed medically necessary. It may cover the cost of purchasing this equipment if NexgenRx determines that it is more economical than renting. NexgenRx must approve the purchase before it is made. The plan will pay a reasonable and customary fee for the least expensive device that is medically adequate.

The following is a list of examples of items that the plan will cover if prescribed by a physician and approved by NexgenRx:

- Breast prostheses after a mastectomy, including replacement(s), one every 2 calendar years, and 2 surgical bras every calendar year
- Custom made orthopedic shoes prescribed by a physician providing the diagnosis and deemed necessary for everyday living and not just for sports and recreation, and dispensed by a Podiatrist/Chiropodist, Orthotist, or Pedorthist to a maximum of 1 pair every calendar year. Proof of a biomechanical assessment/gait analysis performed by a licensed practitioner is required.
- Note: supporting documentation is required. Please contact your Union Office or NexgenRx Inc. to find out how to submit claims.
- Orthopedic shoes prescribed or dispensed by a Chiropractor or Physiotherapist are not eligible under the plan.
- Custom made foot orthotics prescribed by a physician providing the diagnosis and deemed necessary for everyday living and not just for sports and recreation, and dispensed by a Podiatrist/Chiropodist, Orthotist, or Pedorthist. The plan covers a maximum of $300 per person every 2 calendar years and $100 every 2 calendar years for the cost of adjustments and modifications. Proof of a biomechanical assessment/gait analysis performed by a licensed practitioner is required
- Note: supporting documentation is required. Please contact your Union Office or NexgenRx Inc. to find out how to submit claims.
- Orthotics prescribed or dispensed by a Chiropractor or Physiotherapist are not eligible under the plan.
- Hearing aids and repairs (not including batteries) up to a maximum of $700 per person every 5 calendar years
- Ostomy/Ileostomy/Colostomy and incontinence supplies to a maximum of $1,000 per person per calendar year.
- Oxygen equipment rental.
- Continuous Positive Airway Pressure (CPAP) Machine and supplies to a maximum of $1,000 per person every 3 calendar years.
- T.E.N.S. machine for chronic pain up to $200 per person every 5 calendar years
- Braces with physician’s approval
- Artificial limbs and eyes and other approved prosthetic devices up to one prosthetic appliance per limb per lifetime.
- Walkers, crutches and canes to a maximum of $100 per person every 2 calendar years.
- Wigs and hairpieces to a maximum of $100 per person per lifetime if resulting from chemotherapy, radiation $250 per person per lifetime if a result of total hair loss from Alopecia Totalis. (excludes wigs for male pattern baldness)
- Surgical or Support Stockings or Compression Hose 2 pair per person every calendar year

- Wheelchair or hospital-type bed rental (including mattress and safety side rails) or if needed for long term illness or disability. Rental only unless it is more economical to purchase such equipment.
- Aero chambers to a maximum of $100 per person every 2 calendar years.
- Compressors to a maximum of $100 per person every 3 calendar years.
- Nebulizers to a maximum of $100 per person every 3 calendar years.

The following is a list of examples of items that are **not** covered even if prescribed by a physician:

- Air conditioners or purifiers
- Blood pressure kits
- Breast pumps
- Craftmatic, Ultramatic or other lifestyle beds
- Exercise equipment, machines or programs
- Home or car modifications (for example, ramps or lifts)
- Humidifiers
- Mattresses (except for standard mattresses with approved hospital beds)
- Obus For
- me or orthopedic pillows
- Non-disposable Insulin delivery devices

Accidental Dental

If healthy, natural teeth are damaged or lost due to a sudden impact, the plan will cover the cost of the dental services required to repair or replace the teeth if the impact that caused the damage or loss happened while you or your dependent are covered under this provision. This does not include damage or loss caused by objects or food placed in the mouth.

The amount payable is based on the least expensive treatment that is adequate to correct the damage. No more than the fee stated in the current Dental Association General Practitioner's Fee Guide will be covered. This treatment must be completed within 12 months of the impact. If treatment is scheduled to occur more than 90 days after the impact, NexgenRx must be given a treatment plan before the end of the 90-day period.

Orthodontic care must be for relocating teeth that are accidentally forced out of position or for splinting damaged teeth for stability. Dental procedures to correct existing cross bites, alignment of rotated teeth, closing of spaces, and up righting teeth are not covered. Implants and treatment related to implants are also not covered.

Your Dental Coverage

When Your Dental Treatment Will Cost More Than $600

If the cost of any dental treatment will be more than $600, NexgenRx Inc. recommends that you submit a "pre-determination" before the treatment is started. A pre-determination is a report describing the proposed treatment and cost. NexgenRx Inc. will determine how much of the treatment is covered before the treatment begins and give you a written estimate of how much you will be responsible to pay before the treatment begins.

If you do not submit a pre-determination prior to the treatment being performed and submit the claim post treatment, your claim may be delayed in processing. In order to assess whether the treatment will be allowed, NexgenRx Inc. may need to obtain x-rays and/or study models from your dentist. This process may also delay your claim assessment.

What You Are Covered for and How Much the Plan Will Pay

The plan has no deductible.

The plan does have co-insurance as described in the following section.

The plan has an annual combined maximum of $1,500 per person per calendar year for eligible basic and major services. This maximum applies to the following:

- Diagnostic services
- Preventative services
- Basic Restorative services
- Endodontic services
- Periodontic services
- Basic Surgical services
- Major Restorative Services
- Major Surgical Services

The amount payable is a percentage (as outlined below) of the prior year's Dental Association Suggested Schedule of Fees for General Practitioners in New Brunswick.

Alternate Benefits Clause

Coverage is based on the cost of the least expensive treatment that could be used to treat or prevent the dental problem. If the cost of the dental work given is more than the cost of the least expensive treatment, the plan will only cover the cost of the least expensive treatment.

Diagnostic Coverage (covered at 80%)

Diagnostic services include items such as oral exams and x-rays

Preventive Coverage (covered at 80%)

Preventive services include items such as scaling and polishing

Basic Restorative Coverage (covered at 80%)

Restorative services include items such as fillings (lowest cost alternative treatment will not apply to composite fillings)

Endodontic Coverage (covered at 80%)

Endodontic services include items such as root canal therapy

Periodontic Coverage (covered at 80%)

Periodontic services include items such as treatment of the gums

Basic Surgical Coverage (covered at 80%)

Basic surgical services include items such as tooth extractions

Major Restorative Services (covered at 60%)

Major Restorative Services include items such as crowns, dentures and bridges

Major Surgical Services (covered at 60%)

Major Surgical Services includes items such as extensive surgical procedures

Limitations

- Complete exams are covered to once every 6 months.
- Recall exams and polishing are limited to 2 every 24 months.
- Specific exams are covered to one every 6 months.
- Bite-wing X-rays are limited to 8 films per calendar year.
- Periodontal scaling is limited to 12 units per calendar year.
- Fluoride treatments are limited to one every 12 months.
- Oral hygiene instructions are limited to once every 6 months.
- Panoramic x-rays are limited to once every 6 months.
- Space maintainers are covered for dependent children under age 15 only.
- Occlusal Equilibration are covered to 8 units per calendar year.
- Stainless Steel, Plastic and Polycarbonate Restorations are covered for dependent children under age 15 only and subject to an allowance of once per tooth every 36 months.
- Additional Covered Services: Anesthesia in conjunction with an eligible dental expense/procedure, professional visits and Therapeutic Injections.
- Inlay/Onlay restorations and Crowns are covered to once per tooth every 5 calendar years. Repairs thereto are also covered benefits.
- White fillings are allowable on all teeth. Alternate Benefits Clause will not apply to white fillings (plan will not reduce white fillings to silver fillings)

Replacement of removable dentures and bridgework are eligible only:

- if a natural tooth is extracted and the existing appliance cannot be made serviceable
- when it is 5 years old and cannot be made serviceable
- if the existing appliance is temporary and is replaced with the permanent denture within 12 months of its installation

What You Are Not Covered For

The plan will not pay for:

- Dental services or supplies that the insured person is eligible to claim under the Workers' Compensation legislation
- Any dental charges not included in the current Dental Association Suggested Schedule of Fees for General Practitioners
- Dental Implants
- Cosmetic procedures
- Charges for appointments that are not kept
- Charges for completing claim forms
- Treatment to correct temporomandibular joint dysfunction (t
- he hinge joint of the jaw is called the temporomandibular joint)
- Any endodontic treatment which was started before the effective date of coverage
- The replacement of dental appliances that are lost, misplaced or stolen
- Any treatment related to orthognathic surgery (remodeling or reconstruction of your jaw)

To make a claim, complete the claim form that is available from the plan sponsor or from the NexgenRx website at www.nexgenrx.com under the “Forms” tab.

If you have questions, please contact your plan sponsor or call NexgenRx toll free at 1-866-424-0257 or, if you are in the Toronto area, 647-722-3046.

I.B.E.W. Local 2166 Health & Welfare Trust

Group Policy Number: G0112474
Class: Journeymen under age 70

A message from your plan sponsor

I.B.E.W. Local 2166 Health & Welfare Trust is pleased to be able to offer you medical and financial security by sponsoring your group benefits program. We have selected Manulife Financial as a partner to help us deliver the program. They are committed to providing excellent service for us.

At this point, you will have received some basic information about how you can connect with Manulife Financial and how to submit claims. Now, I would encourage you to spend a few moments reviewing our plan's coverage so you can better understand what's available. You'll learn about not only the more routine things, but also about some of the benefits available that you may need to draw on in a time of crisis. Your plan is here to offer you some support in the event you encounter unforeseen circumstances in the future.

After reviewing the coverage, if you have any questions, check in with our plan administrator.

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What you need to know about your plan

Who and what your plan covers

We are Manulife Financial, your plan sponsor's partner in supporting the group insurance benefits you receive at work. We know how important your coverage is and that you count on us to give you great tools to help you understand what you have.

You become eligible initially on the 1st day of the 2nd month following the accumulation of 420 hours.
Monthly hour bank deduction - 140 hours
Maximum hour bank accumulation - 2520 hours
Excess hour bank hours are contributed to general reserves of the Trust Fund

Reinstatement - You become eligible on the 1st day of the 2nd month following the accumulation of 240 hours.

Coverage/increases in coverage, reinstatement of coverage are effective only if you are actively at work or available for work. (Available for work is determined by your name appearing on the out-of-work list of the union.)

Your dependants - your spouse, child or children who are insured under the Provincial Health Plan - may also be eligible for some of the coverage provided through this benefits program. Your plan sponsor's plan must be in effect and you and your dependants must have satisfied all of the participation requirements first, for your coverage to be active.

In the event that a provincial plan or government-sponsored program or plan or legally mandated program discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, your group benefits plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

The information provided here is an overview of the coverage and services your plan sponsor has chosen to offer as part of your group benefits program. It doesn't include reference to all of the plan details, limitations and exclusions or terms and conditions your employer has arranged. Those are set out in your plan sponsor's group benefits plan documents (for example, the policy or plan document and any plan amendments). Manulife's administrative team will refer to those plan documents when evaluating claims, your eligibility for coverage, and for the general administration of the program. In the event of a discrepancy between this coverage overview and the plan documents, the terms outlined in the plan documents will apply.

Where required by law, you or any claimant under the Policy have the right to request a copy of any or all of the following items:

- the Policy
- your application for group benefits and

Your plan sponsor is I.B.E.W. Local 2166 Health & Welfare Trust

This booklet produced: July 17, 2018

Your plan number is G0112474
This is the main number you should provide as a reference when contacting Manulife Financial. Be sure to record this number and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

Your coverage class is Journeymen under age 70

The plan effective date is July 01, 2018

This is the official day when all of the coverage and services your plan sponsor has arranged with us begins. Coverage starts once you have fulfilled any waiting period requirements set for your plan.

Your plan may include a waiting period for some benefits.

The day after the waiting period has finished is the earliest date you can use this coverage.

- any Evidence of Insurability you submitted as part of your application for benefits

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the policy.

Manulife Financial reserves the right to charge you for such documentation after your first request.

Time Limit on Legal Action
Every action or proceeding against Manulife Financial for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.

Enhanced information is also available on the Internet
There may be times when you may not have coverage details with you, but you need to find out about some portion of your coverage quickly. Know that you can always find the most up-to-date plan information - including an electronic version of this document - on the Plan Member Secure Site. Once registered, you can log-in any time from any Internet connection. Go to **www.manulife.ca/groupbenefits** and input your plan number and plan member certificate number. The site will tell you everything else you need to do to finish the registration process.

The electronic version also includes links to definitions, forms, and enhanced information that may help you understand how your benefits program can support you.

HOW LONG COULD IT TAKE TO HAVE MY CLAIM PROCESSED?

This will depend largely on how you submit your claim and how you choose to receive payment. Send paper claims to the address printed on the claim form. Be sure to record your plan contract number and plan member certificate number on all correspondence and claim forms.

USE MORE THAN ONE PLAN TO GET MORE MONEY BACK
Did you know that you can recover up to 100% of your expenses if you coordinate claims with your spouse's group plan? This is called coordination of benefits and here's how it works.

Manulife Financial does not accept beneficiary appointments for any benefits other than Life Insurance and Accidental Death and Dismemberment under this Plan.

This Policy contains a provision removing or restricting the right of the group life insured to designate persons to whom or for whose benefit insurance money is to be payable.

Core Coverage and Services

Your plan sponsor has chosen to offer the following benefits to form the coverage in this program.

Short-Term Disability

Benefit Details	Your Plan's Coverage
Waiting Period	1st day of the 2nd month following the accumulation of 420 hours
Benefit Amount	$350
Qualifying Period	none, if the disability is due to an accident 7 calendar days, if the disability is due to a sickness
	If hospitalized due to sickness prior to the end of the Qualifying Period, benefits are payable from the first day of hospitalization.
Definition of Disability	Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation.
	The availability of work will not be considered by Manulife Financial in assessing your disability. *If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.*
Maximum Benefit Period	52 weeks
Termination	age 70, or your retirement, whichever is earlier
Tax Status	The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit. If your employer pays any portion of the premium for this benefit, then any payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.
Entitlement	To be entitled to disability benefits, you must meet the following criteria: • you must be continuously Totally Disabled throughout the Qualifying Period • Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability,

	such that you are prevented from performing the essential duties of your own occupation • you must be receiving from a physician, regular, ongoing care and treatment for your disabling condition
Exclusions	*No benefits are payable for any disability related to:* • any illness or injury which arises out of or in the course of employment, unless Workers' Compensation denies your claim • self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness • war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion • medical or surgical care which is performed solely for cosmetic purposes, except if due to an illness or injury • the committing of a criminal offence • injuries sustained while operating a motor vehicle under the influence of drugs or alcohol as prohibited by law • abuse of drugs or alcohol, unless you are participating in an in-patient medical treatment program for substance abuse
Periods for which you are not entitled to benefits *(Unless your employer is required to provide coverage because of legislation, regulation, or by law)*	When you are: • not receiving from a physician, regular, ongoing care and treatment for your disabling condition • not supplying Manulife Financial with medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of your own occupation • failing to participate and cooperate in an examination by an examiner selected by Manulife Financial • receiving EI (Employment Insurance) maternity, parental, compassionate care or critically ill child benefits • on lay off • on leave of absence • engaging in employment for wage or profit,

	except as provided for under the Rehabilitation Assistance provision • incarcerated
Amount of Disability Benefit Payable	The amount of disability benefit payable to you is the Benefit Amount shown above, less any amount you receive: a) for the same or related disability: • from Workers' Compensation or similar coverage • from any provincial motor vehicle plan or motor vehicle insurance policy that does not take into account disability benefits payable under the Employment Insurance Program • from an employer sponsored salary continuance plan b) as earnings from your employer, including severance payments and vacation pay as set out in the Employment Insurance Program
Rules we use to calculate your benefit	Manulife Financial will apply the following rules in determining your disability benefit: • benefits payable from other sources which began before the commencement of your current Disability will not be taken into account • benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Manulife Financial • for benefits payable other than on a weekly basis, a weekly equivalent of such benefit will be estimated by Manulife Financial
Employment Insurance (E.I.) Integration	Short-Term Disability benefits commence following the Qualifying Period and are payable until Employment Insurance Sickness (E.I.) benefits are normally scheduled to begin. During the 15 week period that E.I. benefits are normally paid, Short-Term Disability benefits will be discontinued. However, if you are not entitled to E.I. benefits because you have not met the necessary service requirements, and if you continue to be totally disabled, Short-Term Disability benefits will be payable during the period you would normally receive E.I. benefits. If you are still totally disabled after the 15 week

	period usually covered by E.I. concludes, your Short-Term Disability benefits will recommence and continue up to the Maximum Benefit Period. The Benefit Period includes the 15 week period during which E.I. benefits are normally payable.
Subrogation	If your disability is caused by another person and you have a legal right to recover damages, Manulife Financial will request that you complete a subrogation reimbursement agreement when you submit your Short-Term Disability claim. *On settlement or judgment of your legal action, you will be required to reimburse Manulife Financial those amounts you recover which, when added to the disability benefits that Manulife Financial paid to you, exceed 100% of your lost income.*
Termination of Payments	Your disability benefit payments will cease on the earliest of: • the date you cease to be Totally Disabled, as defined under this benefit • the date on which benefits have been paid up to the Maximum Benefit Period for this benefit • the date you retire • the date of your death
Recurrent Disability	If you become Totally Disabled again from the same or related causes within 2 weeks from the end of the period for which benefits were paid, Manulife Financial will treat the disability as a continuation of your previous disability. You will not be required to satisfy any applicable Qualifying Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit. If the same disability recurs more than 2 weeks after the end of the period for which benefits were paid, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.
Submitting Claims: *Complete the Short-Term Disability Claim form (which is available from your Plan*	

Administrator). Your attending physician must also complete a portion of this form. A completed claim form must be submitted to Manulife Financial within 180 days from the end of the Qualifying Period.

Payments: *Payments will be made weekly in arrears. Any payment for a period of less than one week will be made at a daily rate of one-seventh of your weekly benefit amount.*

Rehabilitation Assistance

Once Manulife Financial determines that you are Totally Disabled, if appropriate, and at Manulife Financial's discretion, you may be offered rehabilitation to assist you in returning to work.

In considering whether Rehabilitation Assistance is appropriate for you, Manulife Financial will take into account:

- the nature, extent and expected duration of your disability
- your level of education, training or experience
- the nature, scope, objectives and cost of a Vocational Plan

Vocational Plan

A Vocational Plan is a training or job placement program that is expected to facilitate your return to work. If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you and your employer, Manulife Financial will provide a structured Vocational Plan that will prepare you for a return to work.

Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan. Your Disability Benefit will be reduced by earnings received from any employment only if your total income from all sources exceeds:

- 100% of your pre-disability Earnings, if this Benefit is taxable; or
- 100% of your pre-disability Net Earnings, if this Benefit is non-taxable.

If you cease to participate in the Vocational Plan because of a change in your medical status, Manulife Financial will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan. If you are not available or do not co-operate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

Life Insurance

You may also wish to consider supplementing this coverage by purchasing any available Optional or Personal Benefits coverage available for your plan.	
Benefit Details	Your Plan's Coverage
For you as the employee	
Waiting Period	1st day of the 2nd month following the accumulation of 420 hours
Benefit Amount	$50,000
Non-Evidence Limit	$50,000
Reduction and Termination Age	Your benefit amount reduces by 50% at age 65 and terminates at age 70 or retirement, whichever is earlier
Qualifying Period for Waiver of Premium	365 days
Waiver of Premium	If you become Totally Disabled while insured and prior to age 65 and meet the Waiver of Premium Entitlement Criteria, your Life Insurance will continue without payment of premium. Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of: • your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period • any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above The availability of work will not be considered by Manulife Financial in assessing your disability. If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.
Conversion Privilege	If your Group Benefits terminate or reduce, you may be eligible to convert your Life Insurance to an individual policy, without needing to provide medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial

	within 31 days of the termination or reduction of your Life Insurance. If you die during this 31-day period, the amount of Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion. See the **conversion option** details in the Individual plan options section.
For your spouse and your dependants	
Waiting Period	1st day of the 2nd month following the accumulation of 420 hours
Benefit Amount	$10,000 for your spouse and $5,000 for each dependant child
Termination Age	The earlier of Plan member's age 70 or retirement
Qualifying Period for Waiver of Premium	365 days
Waiver of Premium	If you become Totally Disabled while insured and prior to age 65 and meet the Waiver of Premium Entitlement Criteria, your Life Insurance will continue without payment of premium.
Conversion Privilege	If your spouse's Life insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by Manulife Financial within 31 days of the termination date. See the **conversion option** details in the Individual plan options section.

Your beneficiary or estate must **submit a claim** within 90 days of the date of death. He or she can obtain the necessary paperwork from your plan sponsor. Claims for Waiver of Premium must be submitted within 180 days of the end of the qualifying period.

If you are terminally ill and not expected to live more than 24 months, and you require financial assistance, you may qualify for a Compassionate Assistance loan.

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your Plan Administrator.

You should review your beneficiary designation to be sure that it reflects your current intent.

Survivor Benefit

Benefit Details	Your Plan's Coverage
If you die while your dependants are insured under the program, Manulife Financial will continue coverage for some benefits without payment of premium: • Dependant Life	Coverage will continue until the earliest of: • the date your dependant is no longer a dependant • the date similar coverage is obtained elsewhere • the date which is 2 years from your death or • the date the Group Policy terminates

Accidental Death and Dismemberment Insurance

The amount payable for each loss is a percentage of the Accidental Death and Dismemberment benefit amount which was in effect for you on the date of your injury.

You may also wish to consider supplementing this coverage by purchasing: Optional Accidental Death and Dismemberment Insurance

Benefit Details	Your Plan's Coverage
Waiting Period	1st day of the 2nd month following the accumulation of 420 hours
Benefit Amount	$50,000
Non-Evidence Limit	$50,000
Reduction and Termination Age	Your benefit amount reduces by 50% at age 65 and terminates at age 70 or retirement, whichever is earlier
Covered losses must: • be as a direct result of the accidental injury • have occurred within 365 days from the date of the accidental injury • be total and irreversible or irrecoverable Exclusions: No Accidental Death & Dismemberment benefits will be payable if the loss results from any of the following: • suicide or self-inflicted injuries • war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion • an infection (except **pyogenic infections** from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity • riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew • riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf	• Loss of Life - 100% • Loss of or Loss of Use of Both Hands or Both Feet - 100% • Loss of Sight of Both Eyes - 100% • Loss of One Hand and One Foot - 100% • Loss of One Hand and Sight of One Eye - 100% • Loss of One Foot and Sight of One Eye - 100% • Loss of Hearing in Both Ears and Speech - 100% • Loss of or Loss of Use of One Arm or One Leg - 75% • Loss of or Loss of Use of One Hand or One Foot- 66 2/3% • Loss of sight of One Eye - 66 2/3% • Loss of Speech or Hearing in Both Ears - 66 2/3% • Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33 1/3% • Loss of All Toes of One Foot - 25% • Loss of Hearing in each Ear - 25% • Hemiplegia, Paraplegia or Quadriplegia - 200%

of your employer • committing or attempting to commit an assault or criminal offence • injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol	*In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.* *Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident. No more than 100% will be paid for all losses due to any one accidental injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while you are living).*
Exposure and Disappearance	If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the covered loss list. If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.
Waiver of Premium	If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. Accidental Death and Dismemberment Waiver of Premium ends if this plan terminates.
Non-Duplication of Expenses	Expenses which are eligible under this benefit and for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid under any other coverage will then be considered under this benefit, subject to any stated maximum. The total combined amount of payments from all coverage combined will not exceed 100% of the eligible expenses incurred.
Additional benefits related to covered losses or accidental death	
Rehabilitation	$10,000 maximum payment for reasonable and necessary expenses incurred within 3 years from the date of the loss listed above for a rehabilitation program in order to return to gainful employment.
Repatriation	$10,000 maximum payment for expenses to prepare and return your body to your residence if your

	death, which resulted directly from an accidental injury, occurs 150 kilometres or more from your residence.
Family Transportation	$1,500 per accident maximum payment for the hotel and travel expense incurred by a direct family member if you are confined to a hospital which is 150 kilometres or more from your residence. If travelling by a method of transportation not licensed to transport fare-paying passengers expenses are reimbursed at a rate of $0.20 per kilometre.
Spousal Occupational Training	$10,000 maximum payment for reasonable and necessary expenses incurred by your spouse within 3 years from the date of your loss listed above for an occupational training program to become qualified for employment for which he or she would not otherwise have sufficient qualifications.
Dependant Education	$5,000 or 5% of your Accidental Death and Dismemberment benefit whichever is less is the yearly maximum for a maximum of 4 years, for the payment of tuition for each child who is enrolled as a full-time student: • in a school for higher learning above the secondary school level at the time of your death, or • at the secondary school level, but who enrols as a full-time student in a school for higher learning within 365 days after your death if you die as a direct result of an accidental injury
Seat Belt Benefit	10% of your Accidental Death and Dismemberment benefit paid as an additional amount if you die as a direct result of an accidental injury sustained while driving or riding in an automobile, provided you were wearing your seat belt and it was properly fastened at the time of the accidental injury.
Day Care	$5,000 or 5% of your Accidental Death and Dismemberment benefit whichever is less is the yearly maximum for a maximum of 4 years, for the payment of day care expenses for each child under 13 years of age who is enrolled in a legally licensed day-care centre at the time of the accidental injury, or who becomes enrolled within 365 days from the date of your death, if you die as a direct result of an accidental injury.
Home Alteration and Vehicle Modification	$10,000 maximum payment for reasonable and necessary expenses incurred within 3 years of the accidental injury where you:

	• suffer a loss of, or loss of use of, both feet or both legs, or • become a hemiplegic, paraplegic, or quadriplegic and require the use of a wheelchair to be ambulatory The benefit covers: • alterations to your home for the purpose of making it wheelchair accessible • modifications to one motor vehicle for the purpose of making it wheelchair accessible
Claims *must be submitted within 90 days of the date of injury or death. Necessary paperwork is available from your plan sponsor. Claims for Waiver of Premium must be submitted within 180 days of the end of the qualifying period.* *You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your Plan Administrator.* *You should review your beneficiary designation to be sure that it reflects your current intent.*	

Additional coverage and services available for you to purchase

Your plan sponsor has also included options for you to consider purchasing to provide additional coverage for yourself and your family in addition to what is provided as part of your core coverage and services.

Optional Life Insurance

Benefit Details	Your Plan's Coverage
For you as the employee	
Waiting Period	1st day of the 2nd month following the accumulation of 420 hours
Amount	increments of $10,000 to a maximum of $250,000
Non-Evidence Limit	All amounts are subject to Evidence of Insurability.
Reduction and Termination Age	age 65 or retirement, whichever is earlier
Qualifying Period for Waiver of Premium	365 days
Waiver of Premium	If you become Totally Disabled while insured and prior to age 65 and meet the Waiver of Premium Entitlement Criteria, your Life Insurance will continue without payment of premium as long as you remain Totally Disabled and otherwise eligible up to the Termination Age. Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of: • your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period • any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above The availability of work will not be considered by Manulife Financial in assessing your disability. If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.
Conversion Privilege	If your Group Benefits terminate or reduce, you may be eligible to convert your Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Optional Employee Life Insurance. See the **conversion option** details in the Individual plan options section.

Exclusions	If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.
For your spouse	
Waiting Period	1st day of the 2nd month following the accumulation of 420 hours
Amount	increments of $10,000 to a maximum of $250,000
Non-Evidence Limit	All amounts are subject to Evidence of Insurability.
Termination Age	employee's age 65 or retirement, or your spouse's age 65, whichever is earlier
Waiver of Premium	If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived as long as you remain Totally Disabled and otherwise eligible up to the employee's age 65.
Conversion Privilege	If your spouse's Optional Life insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by Manulife Financial within 31 days of the termination date. See the **conversion option** details in the Individual plan options section.
Exclusions	If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.
You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your Plan Administrator. You should review your beneficiary designation to be sure that it reflects your current intent.	

Optional Accidental Death and Dismemberment Insurance

The amount payable for each loss is a percentage of the Accidental Death and Dismemberment benefit amount which was in effect for you as on the date of your injury.

Benefit Details	*Your Plan's Coverage*
For you as the employee	
Waiting Period	1st day of the 2nd month following the accumulation of 420 hours
Benefit Amount	increments of $10,000 to a maximum of $250,000
Non-Evidence Limit	$250,000
Termination Age	age 65 or retirement, whichever is earlier
Covered losses must: • be as a direct result of the accidental injury • have occurred within 365 days from the date of the accidental injury • be total and irreversible or irrecoverable Exclusions: No Accidental Death & Dismemberment benefits will be payable if the loss results from any of the following: • suicide or self-inflicted injuries • war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion • an infection (except **pyogenic infections** from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity • riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew • riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer	• Loss of Life - 100% • Loss of or Loss of Use of Both Hands or Both Feet - 100% • Loss of Sight of Both Eyes - 100% • Loss of One Hand and One Foot - 100% • Loss of One Hand and Sight of One Eye - 100% • Loss of One Foot and Sight of One Eye - 100% • Loss of Hearing in Both Ears and Speech - 100% • Loss of or Loss of Use of One Arm or One Leg - 75% • Loss of or Loss of Use of One Hand or One Foot- 66 2/3% • Loss of sight of One Eye - 66 2/3% • Loss of Speech or Hearing in Both Ears - 66 2/3% • Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33 1/3% • Loss of All Toes of One Foot - 25% • Loss of Hearing in each Ear - 25% • Hemiplegia, Paraplegia or Quadriplegia - 200%

• committing or attempting to commit an assault or criminal offence • injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol	*In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable. Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident. No more than 100% will be paid for all losses due to any one accidental injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while you are living).*
Exposure and Disappearance	If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which the insured person was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the covered loss list. If the insured person disappears after a conveyance in which he/she was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if the insured person's body is not found within 365 days after the incident occurred.
Waiver of Premium	If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. Accidental Death and Dismemberment Waiver of Premium ends if this plan terminates.
Non-Duplication of Expenses	Expenses which are eligible under this benefit and for which the insured person is also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid under any other coverage will then be considered under this benefit, subject to any stated maximum. The total combined amount of payments from all coverage combined will not exceed 100% of the eligible expenses incurred.
Additional benefits related to covered losses or accidental death	
Rehabilitation	$10,000 maximum payment for reasonable and necessary expenses incurred within 3 years from the date of the loss listed above for a rehabilitation program in order to return to gainful employment. (Applicable only to Employee Optional Accidental Death and Dismemberment Coverage)

Repatriation	$10,000 maximum payment for expenses to prepare and return the insured person's body to their residence if their death, which resulted directly from an accidental injury, occurs 150 kilometres or more from their residence.
Family Transportation	$1,500 per accident maximum payment for the hotel and travel expense incurred by a direct family member if the insured person is confined to a hospital which is 150 kilometres or more from their residence. If travelling by a method of transportation not licensed to transport fare-paying passengers expenses are reimbursed at a rate of $0.20 per kilometre.
Spousal Occupational Training	$10,000 maximum payment for reasonable and necessary expenses incurred by your spouse within 3 years from the date of your loss listed above for an occupational training program to become qualified for employment for which he or she would not otherwise have sufficient qualifications. (Applicable only to Employee Optional Accidental Death and Dismemberment Coverage)
Dependant Education	$5,000 or 5% of your Accidental Death and Dismemberment benefit whichever is less is the yearly maximum for a maximum of 4 years, for the payment of tuition for each child who is enrolled as a full-time student: • in a school for higher learning above the secondary school level at the time of your death, or • at the secondary school level, but who enrols as a full-time student in a school for higher learning within 365 days after your death • if you die as a direct result of an accidental injury (Applicable only to Employee Optional Accidental Death and Dismemberment Coverage)
Seat Belt Benefit	10% of your Accidental Death and Dismemberment benefit paid as an additional amount if the insured person dies as a direct result of an accidental injury sustained while driving or riding in an automobile, provided he/she was wearing his/her seat belt and it was properly fastened at the time of the accidental injury.
Day Care	$5,000 or 5% of your Accidental Death and Dismemberment benefit whichever is less is the

	yearly maximum for a maximum of 4 years, for the payment of day care expenses for each child under 13 years of age who is enrolled in a legally licensed day-care centre at the time of the accidental injury, or who becomes enrolled within 365 days from the date of your death, if you die as a direct result of an accidental injury. (Applicable only to Employee Optional Accidental Death and Dismemberment Coverage)
Home Alteration and Vehicle Modification	$10,000 maximum payment for reasonable and necessary expenses incurred within 3 years of the accidental injury where the insured person: • suffers a loss of, or loss of use of, both feet or both legs, or • become a hemiplegic, paraplegic, or quadriplegic and require the use of a wheelchair to be ambulatory The benefit covers: • alterations to the insured person's home for the purpose of making it wheelchair accessible • modifications to one motor vehicle for the purpose of making it wheelchair accessible
Claims *must be submitted within 90 days of the date of injury or death. Necessary paperwork is available from your plan sponsor. Claims for Waiver of Premium must be submitted within 180 days of the end of the qualifying period.* *You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your Plan Administrator.* *You should review your beneficiary designation to be sure that it reflects your current intent.*	

Individual plan options available to purchase if you are leaving the plan

When your group coverage ends, your relationship with Manulife doesn't have to stop there. You have the option to purchase your own personal plans.

Conversion Option

Some core coverage benefits (Life, Optional Life, Critical Illness, Optional Critical Illness) give you the option to purchase individual coverage when your group benefits terminate or reduce, without needing to provide medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your coverage. Other specific conditions for coverage may be noted in each benefit information section of this document.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Definitions

Explanation of some of the terms used in this document

Co-insurance

The way the cost of a service is shared between you and your plan. It exists in addition to any deductibles. So for example, an 80% co-insurance means that after the deductible has been satisfied, your plan will cover up to 80% of the bill and you would pay the rest.

Co-payment

The fixed amount that you must pay towards the cost of a service each time you use your plan. Most often, co-payments exist in situations where a claim is settled at point of sale. For instance, you might see a drug benefit with a $2.00 co-pay amount. Regardless of the cost of the prescription being filled, you are required to pay $2.00.

Dependant

Your Spouse or Child who is insured under the Provincial Plan.

Spouse

- your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

Child

- your natural or adopted child, or stepchild, who is:
    - unmarried
    - under the age stated below:

      for other coverages (if applicable) - under age 22, or under age 26 if a full-time student;
    - not employed on a full-time basis
    - not eligible for insurance as an employee under this or any other Group Benefit Program

- a child who is incapacitated on the date he or she reaches the age when insurance would normally terminate will continue to be an eligible dependant. However, the child must have been insured under this Benefit Program immediately prior to that date

- a child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependant on the employee for support, maintenance and care, due to a mental or physical disability. Manulife Financial may require written proof of the child's condition as often as may reasonably be necessary

- a stepchild must be living with you to be eligible

- a child must be at least 14 days old to be eligible (excluding Dental and Extended Health Care coverage)

Drugs

- must be prescribed in writing by a physician, dentist or other health care professional whose scope of practice within their province permits them to write a prescription;
- must be dispensed by a licensed pharmacist;
- must have been approved for use by Health Canada and have a drug identification number(DIN).

RAMQ - Drug Benefit and Pharmacy Services for persons who reside in Quebec
If you and your dependants reside in Quebec, the following provisions apply to your drug benefit coverage:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and
- covered pharmacy services that are to be paid when the drug is on the RAMQ List; and
- drugs that are listed as a covered expense under your drug plan but are not on the RAMQ List.

The following provisions apply to the coverage of drugs that are on the RAMQ List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act (R.S.Q. c., A-29-01). Coverage for all other drugs will be subject to the regular provisions included in your benefit plan.

a) Benefit Percentage
Prior to the annual out-of-pocket maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

i) For any drug on the RAMQ List which is not otherwise covered under the terms of this benefit, the percentage payable is the percentage as set out by legislation.

ii) For any Legislated pharmacy services which are not otherwise covered under the terms of the Policy, the percentage is as set out by the then applicable Legislation.

iii) For any drug on the RAMQ List which is covered under the terms of this benefit, the percentage payable is the greater of:

- the benefit percentage stated under the benefit; or
- the percentage as set out by the then applicable legislation.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

b) Annual Out-of-Pocket Maximum
The annual out-of-pocket maximum is a portion of covered drug expenses or covered pharmacy services which must be paid by you and your spouse in a calendar year, before the percentage payable under this benefit will be 100%. Amounts that will be applied to the annual out-of-pocket maximum are:

i) deductible amounts, and

ii) the portion of covered drug expenses that is paid by an insured person, when the percentage of covered expenses payable under this benefit is less than 100%; and

iii) covered pharmacy services that are performed by pharmacists for drugs on the RAMQ formulary.

The annual out-of-pocket maximum for you and your spouse is as stipulated in the legislation and includes

those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependant children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, those portions of covered drug expenses and covered pharmacy services paid for your dependant children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

c) Deductible
Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the deductible will not apply.

d) Lifetime Maximums
Lifetime maximums (if any) will not apply to drugs on the RAMQ List or covered pharmacy services. Drug and pharmacy service coverage provided after the lifetime maximum stated under this plan is reached is subject to the following conditions:
i) only drugs that are on the RAMQ List are covered, and
ii) covered pharmacy services that are performed for drugs on the RAMQ List, and
iii) the percentage payable by Manulife Financial for covered expenses is the percentage as set out by legislation.

e) Eligible Dependant Children
Your eligible dependant children who are in full-time attendance at an accredited educational institution will be covered until the later of:
i) the age specified in this Benefit Booklet or
ii) age 26.

Drug coverage and covered pharmacy services provided for dependant children after the age stated in this Benefit Booklet is subject to the following conditions:

- only drugs that are on the RAMQ List are covered, and
- covered pharmacy services performed for a drug on the RAMQ List, and
- the percentage payable by Manulife Financial for covered expenses is the percentage as set out by legislation.

f) Termination Age for Covered Drug and Pharmacy Service Expenses
Provided you are otherwise eligible for the drug benefit, the termination age (if any) for the drug benefit will not apply. Drug coverage provided after the termination age specified under The Benefit is subject to the following conditions:
i) only drugs that are on the RAMQ List are covered,
ii) only covered pharmacy services related to a drug on the RAMQ List,
iii) the percentage payable by Manulife Financial for covered expenses is the percentage as stipulated in the legislation
iv) the Annual Out-of-Pocket Maximum is as stipulated in the legislation

Coverage for drugs that are listed as a covered expense under this Benefit but not on the RAMQ List will be subject to all the standard provisions included in this Benefit Booklet.

Due Diligence

A process employed by Manulife Financial to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the plan. This process may use pharmacoeconomics, cost

effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an advisory body.

Earnings

Earnings are your regular rate of pay from your employer (prior to deductions)
- including regular bonuses
- including regular overtime pay

Earnings may include other income as agreed to in writing by your employer and Manulife Financial.

If you are being paid on a commission basis, your earnings will be as reported on your T4/T4A form for the previous year. If you have less than one year of service with your employer, your earnings will include an average of the total commissions paid over your actual period of employment.

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the lesser of:
- the amount reported on your claim form, or
- the amount reported by your employer to Manulife Financial and for which premiums have been paid.

Experimental or Investigational

Not approved as an effective, appropriate and essential treatment of an illness or injury.

Lower Cost Alternative

If two or more drugs, supplies or services result in therapeutically similar results, or prescribing guidelines recommend alternate drugs, supplies or services be tried first that are lower in cost, the lower cost alternative will be considered.

Medical and Non Medical Travel Emergencies

Sudden, unexpected injuries which occur or unforeseen illnesses which begin while travelling out-of-province or out-of-Canada for business or pleasure and for accidents or illnesses that were not previously diagnosed or treated in Canada.

Medically Necessary

Accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of a phase of an illness or injury. Manulife Financial has the right after due diligence has been completed to determine whether the drug, service or supply is eligible under the Plan.

Non-Evidence Limit

The amount of insurance benefits you can receive without needing to provide proof of good health. Anything over this figure means that Manulife must review medical evidence before you are approved for the higher amount.

Out-Of-Pocket Maximum

This is the maximum amount of money you will have to pay on your own before your insurance benefits begin to take over and pay. It includes things like deductibles, and co-insurance, but not things like co-payments or your monthly premium.

Prior Authorization

A claims management feature applied to a specific list of drugs, supplies or services to determine eligibility based on predefined clinical criteria and a pharmacoeconomic or cost effectiveness evaluation.

Pyogenic Infection

A bacterial infection or inflammation that produces a generally viscous, yellowish-white fluid formed in infected tissue. The fluid consists of white blood cells, dead tissue and cellular debris.

Reasonable and Customary Charges

The lowest of:

- the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial; or
- the amount shown in the applicable professional association fee guide; or
- the maximum price established by law

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RSA

Out-of-Province/Canada Group Travel Medical Emergency Insurance

IMPORTANT NOTICE - PLEASE READ CAREFULLY

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 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.

SECTION I — INDIVIDUAL COVERAGE - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

***Participant* Coverage**

To be covered under the *policy* as a *participant*, *you* must meet the following eligibility requirements:

1. be covered under the government health insurance plan of *your* province or territory of residence;
2. be covered under the basic group extended health care plan of the *policyholder*;
3. be younger than the *termination age* specified in the Schedule of Benefits;
4. have *your* place of employment in Canada;
5. have *your* permanent residence in Canada;

   and

6. a) if *you* are covered as an employee of the *policyholder*, *you* must also:
      i. work the minimum number of hours per week specified in the Schedule of Benefits; and
      ii. have satisfied the eligibility period specified in the Schedule of Benefits;

      or

   b) if *you* are covered as a member of the *policyholder* who is other than an employer, *you* must also:
      i. be a member in good standing of the *policyholder*; and
      ii. be on the monthly list of members entitled to coverage provided to the Insurer by the *policyholder*.

Participant coverage will become effective on the later of:

1. the date the *policy* becomes effective; or
2. the date the *participant*'s coverage becomes effective under the basic group extended health care plan of the *policyholder*.

Coverage for disabled employees or employees who are not actively at work on the date their coverage would normally become effective will become effective on the date the employee resumes active work.

Participant coverage will terminate immediately upon the first to occur of:

1. the date *you* cease to meet the above eligibility requirements for *participant* coverage;
2. the date the premium is due if the *policyholder* does not remit *your* premium to the Insurer, except where this is the result of clerical error; or
3. the date the *policy* is terminated.

Dependent Coverage

To be covered under the *policy* as a *dependent*, *you* must meet the following eligibility requirements:

1. be covered under the government health insurance plan of *your* province or territory of residence;
2. be covered as a *dependent* under the basic group extended health care plan of the *policyholder*; and
3. meet the definition of *dependent* in the *policy*.

***Dependent* coverage, if any, will become effective on the later of:**

1. the date the *policy* becomes effective; or

2. the date the *dependent*'s coverage becomes effective under the basic group extended health care plan of the *policyholder*,

but in no event prior to date the *participant*'s insurance becomes effective.

***Dependent* coverage will terminate immediately upon the first to occur of:**

1. the date the *dependent* ceases to meet the above eligibility requirements for *dependent* coverage;
2. the date the *participant*'s coverage terminates, except if termination is due to the death of the *participant*, in which case *your* coverage will continue until the earlier of the expiry of two (2) years or the date *you* cease to meet the definition of *dependent* or reach the *termination age* specified in the Schedule of Benefits or remarry or die, provided the *policyholder* continues to make the required premium payments; or
3. the date the *policy* is terminated.

SECTION II — BENEFITS

Medical Referral

This *policy* covers expenses that are:

Reasonable and customary medical and transportation expenses for the *insured person* and an approved escort, to a lifetime maximum of $25,000 Cdn., for a pre-approved Medical Referral, subject to the following conditions:

a) The treatment must be unavailable where the insured person resides and located at least five hundred (500) kilometers from where the *insured person* resides.

b) The insured person's attending Canadian *physician* and a specialist from a related medical field must recommend the treatment.

c) Provided they are eligible for reimbursement in whole or in part, eligible medical expenses in excess of the *insured person's government health insurance plan* allowance are covered.

d) Medical services and travel must take place within thirty (30) days of receiving approval from the *insured person's* government health insurance plan, unless the earliest possible treatment date exceeds thirty (30) days from the date of approval.

e) All Medical Referrals must be submitted in writing to, and pre-approved by, *Global Excel*, along with supporting documentation.

Out-of-Province Medical Benefits

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* specified in the Schedule of Benefits. 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:** 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:** Charges for treatment by a *physician*.
3. **Diagnostic Services:** Laboratory tests and x-rays prescribed by the attending *physician* and that are part of the *emergency* treatment. The *policy* does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by *Global Excel*.
4. **Paramedical Services:** The services (including x-rays) of a licensed chiropractor, physiotherapist, podiatrist or osteopath, to the maximum specified in the Benefit Summary section of the Schedule of Benefits, 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:** When reasonable and *medically necessary*, licensed ground ambulance service to the nearest medical facility.
7. **Medical Appliances:** When approved in advance by *Global Excel*, 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 specified in the Benefit Summary section of the Schedule of Benefits, per *insured person*, when approved in advance by *Global Excel*.
9. **Emergency Air Transportation:** When approved and arranged in advance by Global Excel:
    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* 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 the amounts specified in the Benefit Summary section of Schedule of Benefits for the cost of meals and commercial accommodation for one of the following: *spouse*, parent, child, brother, sister or business partner, to:
    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*:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits 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:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits 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 scheduled *trip* 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 travel must be certified by the attending *physician* and supported with original receipts from commercial organizations.
14. ***Vehicle* Return:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits 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:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits 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 *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:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits 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.

SECTION III — EXCLUSIONS

The *policy* does not cover losses or expenses related in whole or in part, directly or indirectly, to any of the following:

1. Treatment or services normally covered or reimbursable under a government health insurance plan or under other insurance *you* might have.
2. Any condition that existed prior to departure unless such pre-existing medical condition has been stable (i.e. no change in symptoms, no hospitalization, no change in condition, no new prescription drugs or prescribed change in treatment or medication) immediately prior to departure for the Pre-existing Condition Stability Period specified in the Schedule of Benefits.
3. Any *trip* booked or commenced contrary to medical advice or after *you* are diagnosed with *terminal illness*.
4. Any medical condition for which, prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization could be required while travelling.
5. Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that *you* elect to have provided outside *your* province or territory of residence when medical evidence indicates that *you* could return to *your* province or territory of residence to receive such treatment. The delay to receive treatment in *your* province or territory of residence has no bearing on the application of this exclusion.
6. Treatment or surgery during a *trip* when the *trip* is undertaken for the purpose of securing or with the intent of receiving medical or *hospital* services, whether or not such *trip* is taken on the advice of a *physician*.
7. Cardiac catheterization, angioplasty, and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by *Global Excel* prior to being performed, except in extreme circumstances where such surgery is performed on an *emergency* basis immediately upon admission to *hospital*.
8. Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by *Global Excel*.
9. Hospitalization or services rendered in connection with general health examinations for “check-up” purposes, treatment of an *ongoing condition*, regular care of a chronic condition, home health care, investigative testing, rehabilitation or ongoing care or non-compliance with any prescribed medical therapy or treatment and medical treatment of an acute *sickness* and/or *injury* after the initial *emergency* has ended (as determined by the Medical Director of *Global Excel*).
10. A disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless hospitalized.
11. Emergency air transportation and/or car rental unless approved and arranged in advance by *Global Excel*.
12. Treatment not performed by or under the supervision of a *physician* or licensed dentist.
13. Treatment or hospitalization of mother or child as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the four (4) weeks before or after the expected delivery date.
14. War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, rebellion, revolution or military power.
15. Terrorism or by any activity or decision of a government agency or any other entity to prevent, respond to or terminate *terrorism* except for ensuing loss or damage which results directly from fire or explosion. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss or damage.
16. Committing or attempting to commit an illegal act or a criminal act.
17. Suicide (including any attempt thereat) or self-inflicted *injury*, whether or not *you* are sane.

18. Service in the armed forces.
19. Participation in any sport as a professional athlete (for which *you* are remunerated), or in motorized or mechanically-assisted racing or speed contests (defined as an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event).
20. Loss or damage to eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices and resulting prescription thereof.
21. The replacement of an existing prescription whether by reason of loss, unless otherwise specified elsewhere in the *policy*, renewal or inadequate supply or the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada or which are not required as a result of an *emergency*.
22. Upgrading charges and cancellation penalties for airline tickets, unless approved in advance by *Global Excel*.
23. The cost of any airline ticket covered under the *policy* where *your* ticket may be exchanged or used for the same purpose.
24. Crowns and root canals.
25. Treatment or services received in the province where *you* attend school or work on a full-time basis or in *your* home country, if *you* are a foreign student studying in Canada or a non-resident working in Canada.
26. Medication, drugs or toxic substance abuse or overdose (whether or not you are sane); alcohol abuse, alcoholism or an accident while being impaired by drugs or alcohol or having an alcohol concentration that exceeds 80 milligrams per 100 milliliters of blood.

SECTION IV — GENERAL PROVISIONS AND LIMITATIONS

1. **Notice to *Global Excel*:** In the event of a *sickness* and/or *injury* likely to give rise to an *emergency*, *you* must give immediate notice to *Global Excel*. Failure to do so may limit the benefits payable under the *policy*. 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.
2. **Transfer or Medical Repatriation:** During an *emergency* (whether prior to admission or during a covered hospitalization), the *insurer* reserves the right to:
   a) transfer *you* to one of *Global Excel*'s preferred health care providers, and/or
   b) return *you* to *your* province or territory of residence for the medical treatment of *your sickness* and/or *injury* where this poses no danger to *your* life or health. If *you* choose to decline the transfer or return when declared medically stable by the Medical Director of *Global Excel*, the Insurer will be released from any liability for expenses incurred for such *sickness* and/or *injury* after the proposed date of transfer or return. *Global Excel* will make every provision for *your* medical condition when choosing and arranging the mode of *your* transfer or return and, in the case of a transfer, when choosing the *hospital*.
3. **Limitation of Benefits:** Once *you* are deemed medically stable to return to Canada (with or without medical escort) either in the opinion of the Medical Director of *Global Excel* or by virtue of discharge from a medical facility, *your emergency* will be deemed to have ended, whereupon any further consultation, treatment, recurrence or complication related to the *emergency* will no longer be eligible for coverage under the *policy*.
4. **Misrepresentation and Non-Disclosure:** *Your* entire coverage under the *policy* shall be voidable if the Insurer determines, whether before or after loss, that *you* or the *policyholder* have concealed, misrepresented or failed to disclose any material fact or circumstance concerning the *policy* or *your* interest therein, or if *you* or the *policyholder* refuse to disclose information or to permit the use of such information, pertaining to any of the *insured persons* under the *policy*. Consequently and following a loss, no claim shall be payable by the Insurer and *you* shall be solely responsible for all expenses relating to *your* claim, including medical repatriation costs.
5. **Subrogation:** If *you* suffer a loss covered under the *policy*, the Insurer is granted the right from *you* to take action to enforce all *your* rights, powers, privileges, and remedies, to the extent of benefits paid under the *policy*, against any person, legal person or entity which caused such loss. Additionally, if "no fault" benefits or other collateral sources of payment of medical expenses are available to *you*, regardless of fault, the Insurer is granted the right to make demand for, and recover, those benefits. If the Insurer institutes an action it may do so at its own expense, in *your* name, and *you* will attend at the place of loss to assist in the action, in addition to providing the Insurer all information, cooperation and assistance the Insurer may reasonably require. If *you* institute a demand or action for a covered loss, *you* shall immediately notify the Insurer so that the Insurer may safeguard its rights.

   You shall take no action after a loss that will impair the rights of the Insurer set forth in this paragraph and shall do all such things as are necessary to secure such rights.
6. **Arbitration:** Notwithstanding any clause in the *policy*, the parties hereto undertake to submit to an arbitration procedure, to the exclusion of the courts, any present or future dispute relating to a claim.

   The arbitration proceedings shall be governed by the arbitration law in force in the Canadian province or territory of residence of the *participant*. The parties agree that any action will be referred to arbitration.
7. **Applicable Law:** The *policy* is governed by the law of the Canadian province or territory of residence of the

participant. Any legal proceeding by the *insured person*, his heirs or assigns shall be brought in the courts of the Canadian province or territory of residence of the *participant*.

8. **Other Insurance:** This insurance is a second payer plan. For any loss or damage insured by, or for any claim payable under any other liability, group or individual basic or extended health insurance plan, or contracts including any private or provincial or territorial auto insurance plan providing *hospital*, medical, or therapeutic coverage, or any other insurance in force concurrently herewith, amounts payable hereunder are limited to those covered benefits incurred outside the province of residence that are in excess of the amounts for which an *insured person* is insured under such other coverage. All coordination with employee related plans follows Canadian Life and Health Insurance Association Inc. guidelines. In no case will the *insurer* seek to recover against employment related plans if the lifetime maximum for all in-country and out-of-country benefits is $50,000 or less. If the lifetime maximum for all in-country and out-of-country benefits is over $50,000, the *insurer* will coordinate benefits only above this amount.
9. **Co-ordination and Order of Benefits:** If a person has coverage under another plan that does not provide for co-ordination of benefits, that plan will be considered primary carrier and will be responsible for making the initial payment. If the other plan does provide for co-ordination of benefits, the order of benefit will be as follows:

   Participant and Dependent Spouse

   The plan insuring the *participant* or the *participant*'s *dependent spouse* as an employee/member pays benefits before the plan insuring the *participant* or the *participant*'s *spouse* as a *dependent*.

   Dependent Child

   If the *dependent* child is insured as a *dependent* under the *participant*'s and the *spouse*'s plans, benefits will first be payable under the plan of the parent whose birthday comes first in the calendar year. The balance of eligible expenses can then be submitted to the plan of the other parent.

   If both parents have the same birthday (month/day), the claims for children must be submitted to the plan in the alphabetical order of the parents' first names. When a person is insured under other group or individual policies or government plans, the benefits payable from all sources cannot exceed one hundred percent of expenses incurred.
10. **Rights of Examination:** To be entitled to payment of benefits provided under the *policy*, the *participant*, on his own behalf and on behalf of his dependents hereby authorizes any *physician*, health professional, *hospital*, institution and any other organization to forward to the *insurer* or its representatives, all information, reports or documents that they may require.

    The *participant* hereby authorizes the Insurer to communicate directly with any *physician*, health professional, *hospital*, institution or other organization to obtain any information required for the assessment of claims and hereby relieves the persons concerned of all legal responsibility which could arise from the disclosure of such information.

    In the event of death, the Insurer will require that a death certificate be filed with the claim. Furthermore, the *insurer* has the right to request an autopsy and review any autopsy report, if not prohibited by law.
11. **Limitation of Actions:** An action or proceeding against the Insurer for the recovery of a claim under the *policy* shall not be commenced more than one (1) year (two (2) years in the Northwest Territories, three (3) years in the province of Quebec) after the date the insurance money became payable or would have become payable if it had been a valid claim.
12. **Availability and Quality of Care:** Neither the Insurer nor *Global Excel* shall be responsible for the availability or quality of any medical treatment (including the results thereof) or transportation at the vacation destination, or *your* failure to obtain medical treatment during the *coverage period*.
13. **Evidence of Age:** The Insurer reserves the right to request proof of age of any *insured person*.
14. **Assignment:** Benefits under the *policy* may not be assigned.
15. **When Money Payable:** All money payable under the *policy* shall be paid by the Insurer within sixty (60) days after it

has received proof of claim.

16. **Continuance of Individual Coverage During Absence from Work:** If a *participant* is absent from work due to disability, temporary lay-off, authorized leave of absence, strike or any other work stoppage, the insurance will be continued as long as the *participant* remains covered under the *policyholder*'s basic group extended health care plan.
17. **Examination of the *policy*:** The *policy*, including any endorsements, will be kept at the office of the *policyholder*. *You* may consult the *policy* during the regular business hours of the *policyholder*.

SECTION V — AUTOMATIC EXTENSION OF COVERAGE PERIOD

The *coverage period* per *trip* will automatically be extended up to 72 hours, provided the *participant* has not reached the *termination age*, if:

a) *You* are hospitalized due to a medical *emergency* on the last day of coverage. *Your* coverage will remain in force for as long as *you* are hospitalized and the 72-hour extension commences upon release from *hospital*;

b) a late train, boat, bus, plane, or other *vehicle* in which *you* are a passenger causes *you* to miss *your* scheduled return to *your* province or territory of residence (including by reason of weather);

c) the *vehicle* in which *you* are travelling is involved in a traffic *accident* or mechanical breakdown that prevents *you* from returning to *your* province or territory of residence on or before *your* return date;

d) *You* must delay *your* scheduled return to *your* province or territory of residence due to a medical *emergency*.

All claims incurred after *your* original scheduled return date must be supported by documented proof of the event resulting in *your* delayed return.

SECTION VI — INTERNATIONAL ASSISTANCE SERVICE

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 are 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.

SECTION VII — DEFINITIONS

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

"Actively at Work" means the employee is physically and mentally capable of doing each and every function of his/her occupation, on the basis of the minimum number of hours worked per week specified in the Schedule of Benefits. If an employee is not *actively at work* due to vacation, holidays, a non-scheduled working day, maternity or parental leave, then *actively at work* means the capability to perform the employee's normal duties at the employee's normal place of employment on the same basis as the employee who is *actively at work*.

"Coverage Period" means the number of consecutive days specified in the Schedule of Benefits during which *you* are covered under the *policy* when *you* take a *trip* and which is calculated as of the commencement date of *your trip*.

"Dependent" means the *spouse* and the unmarried child of the *participant* or *spouse*, who is under the age limit specified in the Schedule of Benefits, is *dependent* on the *participant* for support and is not employed on a full-time basis. A *dependent* child who is physically or mentally disabled and totally *dependent* on the *participant* for support will continue to be eligible provided he/she was covered as a *dependent* under the *policy* before attaining such age limit.

"Emergency" means the occurrence of a *sickness* and/or *injury* during the *coverage period* that requires immediate *medically necessary* treatment for the relief of acute pain or suffering, other than experimental or alternative treatment, and such treatment cannot be delayed until *your* return to Canada.

"Global Excel" and **"Global Excel Management Inc."** mean the company appointed by the *insurer* to provide medical assistance and claims services under the *policy*.

"Government Health Insurance Plan" means the health care coverage provided by Canadian provincial and territorial governments to their residents.

"Hospital" means an institution which is designated as a *hospital* by law; which is continuously staffed by one or more *physicians* at all times; which continuously provides nursing services by graduate registered nurses; which is primarily engaged in providing diagnostic services and medical and surgical treatment of a *sickness* and/or *injury* in the acute phase, or active treatment of a chronic condition; which has facilities for diagnosis, major surgery and *in-patient* care. The term *hospital* does not include convalescent, nursing, rest or skilled nursing facilities, whether separate from or part of a regular general *hospital*, nor a facility operated exclusively for the treatment of persons who are mentally ill, aged, or drug or alcohol abusers.

"Immediate Family Member" means *your spouse*, son, daughter, father, mother, brother, sister, stepson, stepdaughter, stepfather, stepmother, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother.

"Injury" means any unexpected and unforeseen harm to the body that is caused by an *accident*, that *you* sustained during the *coverage period* and that requires *emergency* treatment that is covered by the *policy*.

"In-patient" means a patient who occupies a *hospital* bed for more than twenty-four (24) hours for medical treatment and for which admission was recommended by a *physician* when *medically necessary* .

"Insurer" means Royal & Sun Alliance Insurance Company of Canada.

"Medical Assistance Card" means the card provided to the *participant* and on which the following information is shown: name of the *policyholder*, *policy* number, *coverage period* per *trip* and *emergency* telephone numbers.

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

a) is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;

b) is not experimental or investigative in nature;

c) cannot be omitted without adversely affecting the condition of the *insured person* or quality of medical care;

d) cannot be delayed until the *insured person* returns to his province or territory of residence.

"Ongoing Condition" means an acute *sickness* and/or *injury* that requires continuing care and/or treatment after the initial *emergency* has ended as determined by the Medical Director of *Global Excel*.

"Participant" means an employee or a member whom the *policyholder* identifies as being entitled to coverage under the *policy* and for whom the *policyholder* has paid the required premium.

"Physician" means a medical practitioner whose legal and professional standing within his or her jurisdiction is equivalent to that of a doctor of medicine (M.D.) licensed in Canada, who is duly licensed in the jurisdiction in which he or she practices, who prescribes drugs and/or performs surgery and who gives medical care within the scope of his or her licensed authority. A *physician* must be a person other than *you* or *your immediate family member*.

"Policy" means the group travel *emergency* medical insurance contract issued to, and on file with, the *policyholder*, bearing the *policy* number specified in the Schedule of Benefits.

"Policyholder" means the company or organization specified in the Schedule of Benefits and to which the *policy* is issued.

"Reasonable and Customary Costs" means costs that are incurred for approved, covered medical services or supplies that do not exceed the standard fee of other providers of similar standing in the same geographical area, for the same treatment of a similar *sickness* and/or *injury*.

"Sickness" means a disease or disorder of the body that results in loss while this coverage is in effect. The *sickness* must be sufficiently serious to prompt a reasonably prudent person to consult a *physician* for the purpose of medical treatment.

"Spouse" means the person to whom the *participant* is legally married or with whom he has been residing for the cohabitation period specified in the Schedule of Benefits.

"Terminal Illness" means *you* have a condition that is cause for the *physician* to estimate that *you* have less than six (6) months to live.

"Termination Age" means the age specified in the Schedule of Benefits at which the *participant*'s coverage terminates. Dependents beyond the *termination age* may be covered provided that the *participant* has not yet reached the *termination age*.

"Terrorism" means an ideologically motivated unlawful act or acts, including but not limited to the use of violence or force or threat of violence or force, committed by or on behalf of any group(s), organization(s) or government(s) for the purpose of influencing any government and/or instilling fear in the public or a section of the public.

"Trip" means a journey that *you* undertake which commences on the date of *your* departure from *your* province or territory of residence and ends when *you* return to *your* province or territory of residence.

"Vehicle" means any automobile, station wagon, mini-van, sports utility *vehicle* (for on-road use), motorcycle, pick-up truck or a mobile home, camper truck or trailer home under 11 meters (36 feet in length), used exclusively for the transportation of passengers other than for hire, in which the *insured person* is a passenger or driver during the *trip*.

"You", **"Your"** and **"Insured Person"** mean any one of the *participant* or the *participant*'s dependents covered under the *policy*.

SECTION VIII — CLAIMS

Notice and Proof of Claim

In the event that *Global Excel* is not contacted immediately, the *insured person*, or a beneficiary entitled to make a claim, or the agent of any of them, shall:

a) give written notice of claim by delivery thereof or by sending it by registered mail to *Global Excel* not later than thirty (30) days from the date the claim arises under the *policy*;

b) within ninety (90) days from the date a claim arises under the *policy*, furnish *Global Excel* such proof of claim as is reasonably possible in the circumstances of the *emergency* giving rise to the claim and the loss occasioned thereby, the right of the claimant to receive payment, his age and the age of the beneficiary, if relevant; and

c) if required by *Global Excel*, provide a satisfactory certificate stating the cause for which the claim is made and the duration of the disability, if applicable.

Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the prescribed period above does not invalidate the claim if the notice or proof is given or furnished as soon as is reasonably possible, and in no event later than one (1) year from the date of *injury* or the date a claim arises under the *policy* on account of *sickness* if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Insurer to Furnish Forms For Proof of Claim

Global Excel, on behalf of the *insurer*, shall furnish forms for proof of claim within fifteen (15) days after receiving notice of claim, but where the claimant has not received the forms within that time he may submit his proof of claim in the form of a written statement of the cause or nature of the *emergency* giving rise to the claim.

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 amounts 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:

Global Excel Management Inc.

73 Queen St.

Sherbrooke, Québec

J1M 0C9

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

PROTECTING YOUR PRIVACY

For privacy information, please see www.rsagroup.ca, or call 1-800-716-4339.

We at RSA recognize and respect every individual's right to privacy. When *you* apply for benefits, we establish a confidential file of *your* personal information. We use the information to administer the benefit plan under which *you* are covered. This includes many tasks, such as:

- Determining *your* eligibility for coverage under the plan;
- Assessing *your* claims and providing *you* with payment;
- Managing *your* claims;
- Verifying and auditing eligibility and claims; and
- Underwriting activities, such as determining the cost of the plan and analyzing the design options of the plan.

We limit access to information in *your* file to staff, to persons authorized by us who require it to perform their duties, to persons to whom *you* have granted access, and to persons authorized by law. We may also exchange information, when necessary to administer the benefit plan, with *your* health care provider, other insurance and reinsurance companies, and *your* plan administrator.

IDENTIFICATION OF INSURER

Viator™ Group Out-of-Province/Canada Travel Medical Emergency Insurance is underwritten by Royal & Sun Alliance Insurance Company of Canada.

In the event of an occurrence likely to result in a claim under this insurance, immediate notice should be given to *Global Excel*.