Plan Document - Appendix A

City of Surrey ***Employer***

G0086901H ***Plan Number***

January 1, 2012 ***Plan Effective Date***

Table of Contents ***Table of Contents***

The Extended Health Care and Dental Care Benefits are being provided directly by City of Surrey which has contracted with the Administrator to adjudicate and administer the claims for these benefits following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this Plan Document and the City of Surrey's Benefit Plan.

This Plan Document produced May 7, 2012.

2 Group Benefits Schedule

Employer	City of Surrey
Plan Number	G0086901H
Plan Effective Date	January 1, 2012

Class Numbers

Class Numbers

002 CUPE Local 402-02 (Plans H, I1 and J2)

Plan Numbers

Plan Numbers

H Full-time Employees of CUPE Local 402-02

I1 Part-time Employees of CUPE Local 402-02

J2 Timed Duration Employees of CUPE Local 402-02

Effective Date for Increases in Plan Benefits

Effective Date for Increases in Plan Benefits

When first eligible for the increase

Extended Health Care

Drug Benefit for Covered Persons who Reside in Quebec

In accordance with the requirements of the prescription drug insurance legislation in Quebec, An Act Respecting Prescription Drug (R.S.Q. c., A-29-01) and the regulations enacted under this act (hereinafter collectively the "Legislation"), the drug benefit provided under this Plan Document to covered persons who reside in Quebec will be administered as outlined in the Plan Document Addendum - Drug Benefit For Covered Persons Who Reside In Quebec.

Classifications Eligible for Plan Benefits

Employees in Class 002

Dependents of Employees in Class 002 are also covered for this Benefit.

Overall Plan Maximum

$500,000 per lifetime

Deductible

Individual - $100 per calendar year
Family - $100 per calendar year

Not applicable to:
- Hospital Care
- Vision
- Professional Services
- Medical Services and Supplies
- Out-of-Province/Canada Emergency Medical Treatment
- Out-of-Canada - Referrals

Note: The deductible is not applicable to Emergency Travel Assistance.

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Drugs
- Vision
- Professional Services
- Medical Services and Supplies

4 Group Benefits Schedule - Plan H

Note: The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 100%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

- Termination Age

Termination Age

last day of the month following the month in which the Employee retires

- Survivor Extended Benefit

Survivor Extended Benefit

subject to the Survivor Extended Benefit provisions

- Participation Basis

Participation Basis

non-mandatory

- Waiting Period

Waiting Period

3 months of continuous employment

Covered Expenses and Maximums (per covered person)

Covered Expenses and Maximums (per covered person)

The maximums shown below for Covered Expenses are subject to the Overall Plan Maximum.

- Hospital

Hospital

Private: Unlimited

- Convalescent Care

Convalescent Care

Semi-private: $20 per day for up to 180 days for all periods of treatment of an illness due to the same or related causes

- Direct Drugs - Plan 3

Direct Drugs - Plan 3

Prescription Drugs:

Fertility Drugs: $3,000 per lifetime

All other Covered Drug Expenses: Unlimited

- Professional Services

Professional Services

Chiropractor: $200 per calendar year for single coverage, $500 per calendar year for family coverage

Podiatrist/Chiropodist: $200 per calendar year for single coverage, $500 per calendar year for family coverage

Massage Therapist: Unlimited

Naturopath: $300 per calendar year for single coverage, $600 per calendar year for family coverage

Speech Therapist: $100 per calendar year

Physiotherapist: Unlimited

Acupuncturist: $100 per calendar year

Vision Care *- Vision Care*

Prescription Glasses: $400 per 24 months

Medical Services and Supplies *- Medical Services and Supplies*

Private Duty Nursing: Unlimited

Stock-Item Orthopaedic Shoes or Sandals: 1 pair per lifetime combined with Custom-Made Orthotics

Custom-Made Orthotics: 1 pair per lifetime combined with Stock-Item Orthopaedic Shoes or Sandals

Referral outside Canada for medical treatment available in Canada: Included in Overall Benefit Maximum

Out-of-Canada Maximum: Included in Overall Benefit Maximum

Hearing Aids: $800 per 5 calendar years for Dependent children, and $400 per 5 calendar years for any other person

Surgical Stockings: 2 pairs per calendar year

Stump Socks: $250 per calendar year

Surgical Brassieres: 2 per calendar year

Wigs and Hairpieces: $500 per lifetime

All other Medical Services and Supplies: Unlimited

Emergency Travel Assistance *- Emergency Travel Assistance*

Emergency Travel Assistance, a Travel Assist Benefit, is provided up to the maximum shown in the description of this Covered Expense under the Extended Health Care Benefit.

6 Group Benefits Schedule - Plan H

Dental Care

Dental Care

Classifications Eligible for Plan Benefits

Classifications Eligible for Plan Benefits

Employees in Class 002

Dependents of Employees in Class 002 are also covered for this Benefit.

Deductible

Deductible

Nil

Benefit Percentage (Co-insurance)

Benefit Percentage (Co-insurance)

80% for Level I - Basic Services

80% for Level II - Supplementary Basic Services

50% for Level III - Dentures

50% for Level IV - Major Restorative Services

Maximums

Maximums

unlimited for Level I, Level II, Level III and Level IV

- Dental Fee Guide

Dental Fee Guide

Current Fee Guide for General Practitioners and Specialists approved by the Provincial Dental Association in the Province in which the services are rendered

If the services are rendered in Alberta, the Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners and Specialists plus inflationary adjustment as determined by the Administrator.

- Termination Age

Termination Age

last day of the month following the month in which the Employee retires

- Survivor Extended Benefit

Survivor Extended Benefit

subject to the Survivor Extended Benefit provisions

- Participation Basis

Participation Basis

non-mandatory

- Waiting Period

Waiting Period

3 months of continuous employment

Extended Health Care

Drug Benefit for Covered Persons who Reside in Quebec

In accordance with the requirements of the prescription drug insurance legislation in Quebec, An Act Respecting Prescription Drug (R.S.Q. c., A-29-01) and the regulations enacted under this act (hereinafter collectively the “Legislation”), the drug benefit provided under this Plan Document to covered persons who reside in Quebec will be administered as outlined in the Plan Document Addendum - Drug Benefit For Covered Persons Who Reside In Quebec.

Classifications Eligible for Plan Benefits

Employees in Class 002

Dependents of Employees in Class 002 are also covered for this Benefit.

Overall Plan Maximum

$500,000 per lifetime

Deductible

Individual - $100 per calendar year
Family - $100 per calendar year

Not applicable to:
- Hospital Care
- Vision
- Professional Services
- Medical Services and Supplies
- Out-of-Province/Canada Emergency Medical Treatment
- Out-of-Canada - Referrals

Note: The deductible is not applicable to Emergency Travel Assistance.

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Drugs
- Vision
- Professional Services
- Medical Services and Supplies

8 Group Benefits Schedule - Plan I1

Note: The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 100%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

- Termination Age

Termination Age

last day of the month following the month in which the Employee retires

- Survivor Extended Benefit

Survivor Extended Benefit

subject to the Survivor Extended Benefit provisions

- Participation Basis

Participation Basis

non-mandatory

- Waiting Period

Waiting Period

6 months of continuous employment

Covered Expenses and Maximums (per covered person)

Covered Expenses and Maximums (per covered person)

The maximums shown below for Covered Expenses are subject to the Overall Plan Maximum.

- Hospital

Hospital

Private: Unlimited

- Convalescent Care

Convalescent Care

Semi-private: $20 per day for up to 180 days for all periods of treatment of an illness due to the same or related causes

- Direct Drugs - Plan 3

Direct Drugs - Plan 3

Prescription Drugs:

Fertility Drugs: $3,000 per lifetime

All other Covered Drug Expenses: Unlimited

- Professional Services

Professional Services

Chiropractor: $200 per calendar year for single coverage, $500 per calendar year for family coverage

Podiatrist/Chiropodist: $200 per calendar year for single coverage, $500 per calendar year for family coverage

Massage Therapist: Unlimited

Naturopath: $300 per calendar year for single coverage, $600 per calendar year for family coverage

Speech Therapist: $100 per calendar year

Physiotherapist: Unlimited

Acupuncturist: $100 per calendar year

Vision Care *- Vision Care*

Prescription Glasses: $400 per 24 months

Medical Services and Supplies *- Medical Services and Supplies*

Private Duty Nursing: Unlimited

Stock-Item Orthopaedic Shoes or Sandals: 1 pair per lifetime combined with Custom-Made Orthotics

Custom-Made Orthotics: 1 pair per lifetime combined with Stock-Item Orthopaedic Shoes or Sandals

Referral outside Canada for medical treatment available in Canada: Included in Overall Benefit Maximum

Out-of-Canada Maximum: Included in Overall Benefit Maximum

Hearing Aids: $800 per 5 calendar years for Dependent children, and $400 per 5 calendar years for any other person

Surgical Stockings: 2 pairs per calendar year

Stump Socks: $250 per calendar year

Surgical Brassieres: 2 per calendar year

Wigs and Hairpieces: $500 per lifetime

All other Medical Services and Supplies: Unlimited

Emergency Travel Assistance *- Emergency Travel Assistance*

Emergency Travel Assistance, a Travel Assist Benefit, is provided up to the maximum shown in the description of this Covered Expense under the Extended Health Care Benefit.

10 Group Benefits Schedule - Plan I1

Dental Care

Dental Care

Classifications Eligible for Plan Benefits

Classifications Eligible for Plan Benefits

Employees in Class 002

Dependents of Employees in Class 002 are also covered for this Benefit.

Deductible

Deductible

Nil

Benefit Percentage (Co-insurance)

Benefit Percentage (Co-insurance)

80% for Level I - Basic Services

80% for Level II - Supplementary Basic Services

50% for Level III - Dentures

50% for Level IV - Major Restorative Services

Maximums

Maximums

unlimited for Level I, Level II, Level III and Level IV

- Dental Fee Guide

Dental Fee Guide

Current Fee Guide for General Practitioners and Specialists approved by the Provincial Dental Association in the Province in which the services are rendered

If the services are rendered in Alberta, the Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners and Specialists plus inflationary adjustment as determined by the Administrator.

- Termination Age

Termination Age

last day of the month following the month in which the Employee retires

- Survivor Extended Benefit

Survivor Extended Benefit

subject to the Survivor Extended Benefit provisions

- Participation Basis

Participation Basis

non-mandatory

- Waiting Period

Waiting Period

6 months of continuous employment

Extended Health Care

Drug Benefit for Covered Persons who Reside in Quebec

In accordance with the requirements of the prescription drug insurance legislation in Quebec, An Act Respecting Prescription Drug (R.S.Q. c., A-29-01) and the regulations enacted under this act (hereinafter collectively the “Legislation”), the drug benefit provided under this Plan Document to covered persons who reside in Quebec will be administered as outlined in the Plan Document Addendum - Drug Benefit For Covered Persons Who Reside In Quebec.

Classifications Eligible for Plan Benefits

Employees in Class 002

Dependents of Employees in Class 002 are also covered for this Benefit.

Overall Plan Maximum

$500,000 per lifetime

Deductible

Individual - $100 per calendar year
Family - $100 per calendar year

Not applicable to:
- Hospital Care
- Vision
- Professional Services
- Medical Services and Supplies
- Out-of-Province/Canada Emergency Medical Treatment
- Out-of-Canada - Referrals

Note: The deductible is not applicable to Emergency Travel Assistance.

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Drugs
- Vision
- Professional Services
- Medical Services and Supplies

12 Group Benefits Schedule - Plan J2

Note: The Benefit Percentage for Out-of-Province/Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 100%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

- Termination Age

Termination Age

last day of the month following the month in which the Employee retires

- Survivor Extended Benefit

Survivor Extended Benefit

subject to the Survivor Extended Benefit provisions

- Participation Basis

Participation Basis

non-mandatory

- Waiting Period

Waiting Period

12 months of continuous employment

Covered Expenses and Maximums (per covered person)

Covered Expenses and Maximums (per covered person)

The maximums shown below for Covered Expenses are subject to the Overall Plan Maximum.

- Hospital

Hospital

Private: Unlimited

- Convalescent Care

Convalescent Care

Semi-private: $20 per day for up to 180 days for all periods of treatment of an illness due to the same or related causes

- Direct Drugs - Plan 3

Direct Drugs - Plan 3

Prescription Drugs:

Fertility Drugs: $3,000 per lifetime

All other Covered Drug Expenses: Unlimited

- Professional Services

Professional Services

Chiropractor: $200 per calendar year for single coverage, $500 per calendar year for family coverage

Podiatrist/Chiropodist: $200 per calendar year for single coverage, $500 per calendar year for family coverage

Massage Therapist: Unlimited

Naturopath: $300 per calendar year for single coverage, $600 per calendar year for family coverage

Speech Therapist: $100 per calendar year

Physiotherapist: Unlimited

Acupuncturist: $100 per calendar year

Vision Care *- Vision Care*

Prescription Glasses: $400 per 24 months

Medical Services and Supplies *- Medical Services and Supplies*

Private Duty Nursing: Unlimited

Stock-Item Orthopaedic Shoes or Sandals: 1 pair per lifetime combined with Custom-Made Orthotics

Custom-Made Orthotics: 1 pair per lifetime combined with Stock-Item Orthopaedic Shoes or Sandals

Referral outside Canada for medical treatment available in Canada: Included in Overall Benefit Maximum

Out-of-Canada Maximum: Included in Overall Benefit Maximum

Hearing Aids: $800 per 5 calendar years for Dependent children, and $400 per 5 calendar years for any other person

Surgical Stockings: 2 pairs per calendar year

Stump Socks: $250 per calendar year

Surgical Brassieres: 2 per calendar year

Wigs and Hairpieces: $500 per lifetime

All other Medical Services and Supplies: Unlimited

Emergency Travel Assistance *- Emergency Travel Assistance*

Emergency Travel Assistance, a Travel Assist Benefit, is provided up to the maximum shown in the description of this Covered Expense under the Extended Health Care Benefit.

14 Group Benefits Schedule - Plan J2

Dental Care

Dental Care

Classifications Eligible for Plan Benefits

Classifications Eligible for Plan Benefits

Employees in Class 002

Dependents of Employees in Class 002 are also covered for this Benefit.

Deductible

Deductible

Nil

Benefit Percentage (Co-insurance)

Benefit Percentage (Co-insurance)

80% for Level I - Basic Services

80% for Level II - Supplementary Basic Services

50% for Level III - Dentures

50% for Level IV - Major Restorative Services

Maximums

Maximums

unlimited for Level I, Level II, Level III and Level IV

- Dental Fee Guide

Dental Fee Guide

Current Fee Guide for General Practitioners and Specialists approved by the Provincial Dental Association in the Province in which the services are rendered

If the services are rendered in Alberta, the Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners and Specialists plus inflationary adjustment as determined by the Administrator.

- Termination Age

Termination Age

last day of the month following the month in which the Employee retires

- Survivor Extended Benefit

Survivor Extended Benefit

subject to the Survivor Extended Benefit provisions

- Participation Basis

Participation Basis

non-mandatory

- Waiting Period

Waiting Period

12 months of continuous employment

Actively at Work

Actively at Work

at work for the Employer on a Full-time basis at the Employee's usual place of work.

On weekends or holidays, or when on vacation, an Employee is deemed to be Actively at Work if he was Actively at Work on his last normal working day or on his last scheduled shift.

Administrator

Administrator

the organization which the Employer may from time to time appoint for purposes of performing services for the Plan.

Benefit Percentage (Co-insurance)

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by the Employer.

Convalescent Hospital

Convalescent Hospital

a facility licensed to provide Convalescent Care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

Dentist

Dentist

a doctor of dentistry, licensed to practice dentistry in the place where the services are provided.

Dependent

Dependent

an Employee's Spouse or Child who is covered under the Provincial Plan.

- Spouse

Spouse

the Employee's legal Spouse, or the person who has, for at least 12 months, been continuously living with the Employee in a role like that of a marriage partner

The Employee's Spouse must be a resident of Canada or the United States.

Only one Spouse will be eligible for benefits under this Plan, and will be as indicated by the Employee on his application for benefits under this Plan. Where this information is not contained on the Employee's application, the person who qualifies last under this Plan's definition of Spouse will be the eligible Spouse.

- Child

Child

an Employee's natural or adopted child, legal ward, foster child or stepchild, who

a) is unmarried;

b) is not employed on a full-time basis;

c) is not eligible for plan benefits as an employee under this or any other group plan; and

d) is either under 21 years of age, or, is a full-time student at an accredited school, college or university.

A child of a female Dependent of the Employee or the Employee's Spouse who is unmarried and under 21 years of age, or who is a full-time student at an accredited school, college or university, and is entirely dependent upon the Employee for financial support, will also be considered to have satisfied the conditions of this Definition.

The Employee's Child must be a resident of Canada or the United States.

A child covered under this Plan, who is incapacitated due to a mental or physical disability on the date he reaches the age when he would otherwise cease to be an eligible Dependent, will continue to be an eligible Dependent under this Plan.

A child is considered incapacitated if he is incapable of engaging in any substantially gainful activity and is dependent on the Employee for support, maintenance and care, due to a mental or physical disability.

The Employer may require written proof of the Dependent's condition as often as may reasonably be necessary.

A stepchild must be living with the Employee to be an eligible Dependent.

Disability or Disabled

Disability or Disabled

the state of being Totally Disabled.

Drug

Drug

a medication that has been approved for use by the Federal Government of Canada and has a Drug Identification Number

Employee

Employee

a person who:

a) is directly employed by the Employer on a Full-time basis;

b) *for Plan J2,* is directly employed by the Employer on a special project of limited duration;

c) is compensated for services by the Employer; and

d) is residing in Canada.

Employer

Employer

City of Surrey.

Experimental or Investigational

Experimental or Investigational

not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards.

Full-time basis

Full-time basis

For Employees in Plan H: permanent Employee

For Employees in Plan I1: regular Employee

For Employees in Plan J2: normal work schedule as determined by the Employer.

Hospital

Hospital

a legally licensed institution which is operated for the care and treatment of sick and injured persons as in-patients, and which:

a) is eligible to receive payments under a provincial hospital plan;

b) provides organized facilities for diagnosis, major surgery, or rehabilitation;

c) provides 24-hour nursing service by registered nurses, and has a Physician in regular attendance;

d) is not primarily operated as a nursing home or a place for rest, or for the care and treatment of the aged, the blind or deaf; and

e) is not primarily operated as a place for the care and treatment of alcoholics, drug addicts, or the mentally ill, unless the institution is eligible to receive payments under a provincial hospital plan.

For the purpose of this Plan, the chronic beds of a Hospital are not considered to be part of that Hospital.

Immediate Family Member

Immediate Family Member

a person who is:

a) the Employee;

b) the Employee's Spouse or Child;

c) the Employee's or Spouse's parent; or

d) the Employee's or Spouse's brother or sister.

Indefinite Lay-Off

Indefinite Lay-Off

a period during which the Employee is laid off work and for which there is no fixed recall date.

18 Definitions

Leave of Absence

Leave of Absence

a period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Employer and the Employee. Leave of absence includes Maternity and Parental Leave of Absence.

Licensed, Certified, Registered

Licensed, Certified, Registered

the status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority, in the place where the service is provided.

Life-Sustaining Drugs

Life-Sustaining Drugs

Drugs which are necessary for the survival of the patient.

Maternity Leave of Absence

Maternity Leave of Absence

the period of formal maternity leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

For the purposes of this Plan, Maternity Leave of Absence will be deemed to commence on the earlier of:

a) the date fixed by mutual agreement between the Employee and the Employer; and

b) the date the child is born.

Medically Necessary

Medically Necessary

broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Parental Leave of Absence

Parental Leave of Absence

the period of formal child care leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

Physician

Physician

a doctor of medicine, licensed to practice medicine in the place where the services are provided.

Prior Plan

Prior Plan

a previous Group Plan which covered all or some of the persons covered under this Plan, and which terminated within 31 days prior to the Effective Date of this Plan.

Provincial Plan

Provincial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

Reasonable and Customary

Reasonable and Customary

the lowest of:

a) the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as agreed upon by Manulife Financial and the Employer;

b) the amount shown in the applicable professional association fee guide; or

c) the maximum price established by law.

Retirement Date for Totally Disabled Employees

Retirement Date for Totally Disabled Employees

a Totally Disabled Employee's Retirement Date is the Employee's 65th birthday, unless he has retired prior to this.

Temporary Lay-Off

Temporary Lay-Off

a period during which the Employee is laid off work and for which there is a fixed recall date.

Waiting Period

Waiting Period

a period of continuous active employment with the Employer, as shown in the Benefit Schedule, following which the Employee becomes eligible for plan benefits.

Ward

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

20 Eligibility for Plan Benefits

Eligibility for Plan Benefits

Eligibility for Plan Benefits

- Employee

Employee

An Employee is eligible for plan benefits under this Plan if he:

a) is a member of a Classification which is eligible for plan benefits, as set out in the Benefit Schedule;

b) is younger than the Termination Age shown in the Benefit Schedule; and

c) has continuously been an Employee, as defined, for a period as long as the Waiting Period shown in the Benefit Schedule.

- Dependent

Dependent

An Employee's Dependent becomes eligible for plan benefits at the same time that the Employee does. However, the Employee must apply for the Employee coverage in order for the Dependent to be eligible. A person who becomes a Dependent after the Employee becomes covered is eligible on the date that person becomes a Dependent.

Amount of Plan Benefit Coverage

Amount of Plan Benefit Coverage

The amount of plan benefit coverage for which a person is eligible under any Benefit will be determined in accordance with the Benefit Schedule.

How to Become Covered

How to Become Covered

To become covered under this Plan, an eligible Employee must apply in writing on approved forms. Coverage for Dependents must also be applied for on approved forms.

Evidence of Good Health

When Evidence of Good Health is Required

For all benefits, except Dental Care, evidence of good health is required whenever an Employee makes a Late Application for coverage on any person.

In this case, the Employee will bear the cost of supplying evidence which conforms to the Administrator's rules.

Late Application ***- Late Application***

For non-mandatory benefits, an application is considered late when an Employee:

a) applies for coverage on any person after having been eligible for more than 31 days ; or

b) re-applies for coverage on any person whose coverage had earlier been cancelled.

For mandatory and non-mandatory benefits, an application is considered late when, after having previously waived benefits under this Plan because he was covered for similar benefits under his Spouse's plan, an Employee:

a) applies for coverage more than 31 days after his benefits terminated under the Spouse's plan; or

b) if he applies for coverage, and benefits under his Spouse's plan have not terminated.

22 Effective Date of Plan Benefits

Effective Date of Plan Benefits

Effective Date of Plan Benefits

Once an application for Employee or Dependent plan benefits has been completed, coverage becomes effective as follows, if the Employee is then Actively at Work:

a) for all plan benefit coverage which does not require evidence of good health, on the date the Employee or Dependent becomes eligible for this coverage; and

b) for all plan benefit coverage which does require evidence of good health, on the date this evidence is approved by the Employer or the Administrator.

If the Employee is not Actively at Work when plan benefit coverage would otherwise take effect, this coverage will take effect on the next day on which he is again Actively at Work.

An Employee who is not Actively at Work on the Effective Date may still be eligible for plan benefits under this Plan through a Transfer of Benefits from the Prior Plan.

Dependent plan benefits will not take effect prior to the Effective Date of the Employee's plan benefits.

Increases in Plan Benefits

Increases in Plan Benefits

An increase in plan benefits on an Employee or Dependent will take effect as follows, if the Employee is then Actively at Work:

a) if evidence of good health is not required, on the Effective Date for Increases in Plan Benefits shown in the Benefit Schedule; and

b) if evidence of good health is required, on the date this evidence is approved by the Employer or the Administrator.

If the Employee is not Actively at Work when an increase in plan benefits would otherwise take effect, this increase in plan benefits will take effect on the next day on which he is again Actively at Work.

Decreases in Plan Benefits

Decreases in Plan Benefits

A decrease in the amount for which any person is covered takes effect when the person is first eligible for the decreased amount.

This Section applies only if this Plan replaces a Prior Plan.

Concessions Granted

Concessions Granted

The Employer grants the following concessions to persons who were covered under the Prior Plan when it terminated:

a) a Transfer of Coverage for Employees not Actively at Work; and

b) the Carry-Forward of any Deductible.

These concessions are as described below.

Transfer of Coverage

Transfer of Coverage

An Employee who is not Actively at Work on the Effective Date is still eligible under this Plan if he:

- Eligibility

a) was covered under the Prior Plan when that Plan terminated; and

b) would be eligible for plan benefits under this Plan if Actively at Work on its Effective Date.

- Amount Transferred

An Employee eligible to transfer benefits will be eligible under this Plan for the lesser of:

a) the amount for which he was covered under the Prior Plan when it terminated; and

b) the amount of plan benefits for which he would be eligible under the Plan if Actively at Work on its Effective Date.

- Effective Date of Transfer

Plan benefits under a transferred benefit will become effective on the later of:

a) the date plan benefits provided under the Prior Plan would terminate in the absence of this provision; and

b) the Effective Date of this Plan.

Deductible Carry-Forward

Deductible Carry-Forward

For persons covered under this provision, expenses incurred during the current calendar year while covered under the Prior Plan will be counted in satisfying the Deductible as if they were incurred while covered under this Plan.

24 Termination of Plan Benefits

Termination of Employee Plan Benefits

Termination of Employee Plan Benefits

An Employee's plan benefit coverage terminates on the earliest of:

a) the date the Employee no longer satisfies the definition of Employee;

b) the date the Employee ceases to be Actively at Work;

c) the date the Employer terminates the Employee's coverage;

d) the date the Employee enters the armed forces of any country on a full-time basis;

e) the date this Plan terminates or coverage on the classification to which the Employee belongs terminates;

f) the date the Employee reaches the Termination Age, as shown under each Benefit in the Benefit Schedule; or

g) the date the Employee dies.

Termination of Employment Exceptions

Termination of Employment Exceptions

If an Employee ceases to be Actively at Work, his coverage will normally terminate as specified under the Termination of Employee Plan Benefits provision. However, the Employer will waive this rule and continue plan benefit coverage under the conditions set out below. An Employee's plan benefit coverage can only be continued on a basis that does not discriminate against another Employee.

- Due to Illness or Injury

Due to Illness or Injury

If an Employee ceases to be Actively at Work due to illness or injury, all plan benefit coverage may continue until the Employer terminates the coverage.

- Due to Maternity or Parental Leave of Absence

Due to Maternity or Parental Leave of Absence

If an Employee ceases to be Actively at Work due to Maternity or Parental leave of absence, all plan benefit coverage may continue for the period of leave to which the Employee is entitled by legislation governing the Employer.

In jurisdictions where the continuation of plan benefit coverage is mandated by legislation, a copy of the Employee's written and signed notice to discontinue any required contribution must also accompany the request for termination.

- Due to Other Leave of Absence or Lay-Off

Due to Other Leave of Absence or Lay-Off

If an Employee ceases to be Actively at Work due to a leave of absence other than Maternity or Parental leave, or due to Temporary or Indefinite Lay-off, all plan benefit coverage may continue until the Employer terminates it.

- Due to Legal Strike or Lockout

Due to Legal Strike or Lockout

If an Employee ceases to be Actively at Work due to a Legal Strike or Lockout, plan benefit coverage may continue only if the Employer informs the Administrator that this is the case, but in no event for more than the duration of the Strike or Lockout.

- Due to Involuntary Severance

Due to Involuntary Severance

If an Employee ceases to be Actively at Work due to an Involuntary Severance, plan benefit coverage may continue only if the Employer informs the Administrator that this is the case, but in no event for more than the duration of the Severance.

Legislated Benefit Extensions

Legislated Benefit Extensions

If legislation mandates that employee benefits continue for a limited period after an Employee's employment terminates, the Employer will extend each plan benefit for the minimum period required by law.

Termination of Dependent Plan Benefits

Termination of Dependent Plan Benefits

Plan benefit coverage on an Employee's Dependent terminates on the earliest of:

a) the date the Employee's plan benefit coverage terminates subject to the Survivor Extended Benefit provisions;

b) the date the Dependent is no longer eligible for coverage under the provisions of this Plan;

c) the date written notification is received from the Employee to cease his Dependent coverage because his Dependents are covered under another benefit plan for benefits similar to the ones in this Plan; or

d) the date a required contribution is due but not paid.

26 Extended Health Care Benefit

The Benefit

The Benefit

The Employer will pay the Benefit Percentage of all Covered Expenses incurred for the care of a covered person once he has satisfied the Deductible.

Payment is subject to an overall Maximum Benefit and to any maximum amount shown in the Benefit Schedule and in the Covered Expenses section below. Lifetime maximums apply to all periods combined in which a covered person is covered by the Employer.

- Claim Amounts Applied To The Maximum

Claim Amounts Applied To The Maximum

Claim amounts that will be applied to the maximum are the amounts paid by the Employer for Covered Expenses after applying the Deductible, Benefit Percentage and any other applicable Plan Document provisions.

Satisfying the Deductible

Satisfying the Deductible

The Deductible is satisfied:

a) when Covered Expenses incurred for the care of a covered person exceed the Individual Deductible; or

b) when expenses applied to Individual Deductibles for a covered person's family exceed the Family Deductible.

- Deductible Carry-Forward

Deductible Carry-Forward

Covered Expenses used to satisfy a Deductible in the last 3 months of a calendar year may also be used to satisfy the Deductible in the following calendar year.

Covered Expenses

Covered Expenses

Expenses shown below are covered if they:

a) are Medically Necessary for the treatment of an illness or injury of a covered person and are recommended by a Physician; and

b) are incurred for the care of a person while he is covered under this Benefit; and

c) are reasonable taking all factors into account.

These Expenses are covered to the extent that:

a) they are Reasonable and Customary, as determined by the Administrator or the Employer; and

b) they are not covered under the Provincial Plan or any other government-sponsored program; and

c) they can legally be covered.

All Extended Health Care Benefits are paid as if the person were covered under the Provincial Plan.

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, this 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.

Advance Supply Limitation

Advance Supply Limitation

Payment of any Covered Expenses under this Benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time, except for covered Drug expenses.

- Drug Expenses

- Drug Expenses

The maximum quantity of Drugs that will be payable for each prescription will be limited to the lesser of:

a) the quantity prescribed by the Physician or Dentist; or

b) a 34 day supply.

A quantity of up to a 100 day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by the Physician and the Pharmacist.

Hospital Services in Canada

Hospital Services in Canada

- Hospital Care

- Hospital Care

Hospital charges in excess of the charges for standard Ward accommodation, up to the Hospital maximum shown in the Benefit Schedule, provided:

a) the covered person was confined to Hospital on an in-patient basis; and

b) the accommodation was specifically elected in writing by the covered person.

- Convalescent Care

- Convalescent Care

Charges for convalescent care and the cost of room and board if this care has been ordered by a doctor, up to the Convalescent Care Maximum shown in the Benefit Schedule provided:

a) confinement follows at least 5 consecutive days of in-patient hospitalization,

b) confinement begins within 14 days of release from the hospital, and

c) confinement is primarily for rehabilitation and not for custodial care.

- Expenses Not Covered

- Expenses Not Covered

Charges for any portion of the cost of Ward accommodation, utilization or copayment fees (or similar charges).

Direct Drugs - Plan 3

Direct Drugs - Plan 3

Charges incurred for the following when prescribed in writing by a Physician or Dentist and dispensed by a licensed Pharmacist, up to the maximum for this Covered Expense shown in the Benefit Schedule.

- Drugs For Treatment of an Illness or Injury

- Drugs For Treatment of an Illness or Injury

Charges for any Drug which by law or convention requires the written prescription of a Physician or Dentist.

Charges for life-sustaining Drugs.

Charges for injectable medications.

Charges for Vitamin B12, if prescribed for the treatment of pernicious anemia.

Charges for Sclerotherapy if medically necessary.

Charges for the following expenses are not covered:

a) the administration of injectable medications;

b) Drugs, biologicals and related preparations which are intended to be administered in Hospital on an in-patient or out-patient basis and are not intended for a patient's use at home;

c) intrauterine devices and diaphragms;

d) anti-smoking Drugs;

e) anti-obesity Drugs unless with a prescription; and

f) Drugs used in the treatment of a sexual dysfunction.

- Preventive Drugs

- Preventive Drugs

Charges for oral contraceptives, when prescribed for reasons other than contraception. When prescribed for the purpose of contraception, this Drug will be subject to the limitation of $200 per family per calendar year.

Charges for preventive vaccines and medicines (oral or injected).

- Diabetic Supplies

- Diabetic Supplies

Charges for standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered).

- Direct Claims Payment

- Direct Claims Payment

The Employer will provide a Pay Direct Drug Card for each Employee covered for this Benefit. The Pay Direct Drug Card is honoured by participating Pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered Drug expenses the covered Employee must:

a) present the Pay Direct Drug Card to the Pharmacist; and

b) pay any amounts that are not covered under this Benefit.

Reimbursement of covered Drug expenses will be payable directly to the Pharmacist. Prescriptions for covered drug expenses purchased without the Pay Direct Drug Card will be reimbursed directly to the Employee.

Vision Care

Vision Care

Charges for the following Vision Care expenses when prescribed by an ophthalmologist or optometrist:

a) eye exams including refractions, up to $75 per 2 calendar years; and

b) purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, up to the Prescription Glasses maximum shown in the Benefit Schedule. Charges for sunglasses or safety glasses are not covered.

Professional Services

Professional Services

Services of a licensed chiropractor, podiatrist/chiropodist, massage therapist, naturopath, speech therapist, physiotherapist, and acupuncturist, up to the Professional Services maximum shown in the Benefit Schedule.

The recommendation of a Physician is not required for Professional Services, except for services of a massage therapist. A Physician's recommendation for these services is required on an annual basis.

Expenses for some of these Professional Services may be payable in part by Provincial Plans. In those provinces, expenses under this Benefit are payable only after the Provincial Plan's maximum for the calendar year has been paid.

Medical Services and Supplies

Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

- Private Duty Nursing

- Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

a) a registered nurse; or

b) a registered nursing assistant (or equivalent designation) who has completed an approved medications training program.

Covered Expenses are subject to the Private Duty Nursing maximum shown in the Benefit Schedule.

Charges for the following services are not covered:

a) service provided primarily for custodial care, homemaking duties, or supervision;

b) service performed by a nursing practitioner who is an Immediate Family Member or who lives with the patient;

c) service performed while the patient is confined in a hospital, nursing home, or any similar institution; and

d) service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household.

The Employer suggests that a detailed treatment plan be submitted with cost estimates before Private Duty Nursing services begin. The Administrator will then advise the Employee of any benefit that will be provided.

- Major Medical Equipment

- Rental of Major Medical Equipment

The rental or, when approved by the Administrator or the Employer, purchase of:

a) Mobility Equipment: crutches, canes, walkers, and wheelchairs; and

b) Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals.

- Non-Dental Prostheses, Supports and Hearing Aids

- Non-Dental Prostheses, Supports and Hearing Aids

Charges for external prostheses (other than myoelectric appliances).

Charges for braces (other than foot braces), trusses, collars, leg orthosis, casts and splints.

Charges for the following expenses, when recommended by a Physician or podiatrist:

a) stock-item orthopaedic shoes or sandals; and

b) modifications or adjustments to stock-item orthopaedic shoes, regular footwear or sandals.

Charges for replacements are covered if medically necessary due to wear or prescription change and are recommended by a Physician or podiatrist.

Charges will be subject to the Stock-Item Orthopaedic Shoes maximum shown in the Benefit Schedule.

Charges for casted, custom-made orthotics which are recommended by a Physician or podiatrist, up to the Custom-Made Orthotics maximum shown in the Benefit Schedule. Charges for replacements are covered if medically necessary due to wear or prescription change and are recommended by a Physician or podiatrist.

Charges for cost, installation, repair, and maintenance of a hearing aid or aids (including charges for batteries), up to the Hearing Aids maximum shown in the Benefit Schedule.

Charges for surgical stockings up to the Surgical Stockings maximum shown in the Benefit Schedule.

Charges for surgical brassieres up to the Surgical Brassieres maximum shown in the Benefit Schedule.

- Other Services and Supplies

- Other Services and Supplies

The cost of ileostomy, colostomy and incontinence supplies.

The cost of oxygen.

The cost of medicated dressings and burn garments.

The cost of a heart rate monitor.

The cost of a cardiac screener.

The cost of an insulin pump.

The cost of plasma and blood transfusions.

The cost of medical examinations, if required for employment purposes due to government statute or regulations, unless such costs are payable by the Employee under a collective agreement.

The cost of laboratory tests rendered outside of a Hospital, unless prohibited by the Provincial Plan.

The cost of stump socks, up to the Stump Socks maximum shown in the Benefit Schedule.

The cost of wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to the Wigs and Hairpieces maximum shown in the Benefit Schedule. The recommendation of a Physician is not required.

The cost of glucometers, up to a maximum of $700 per lifetime.

The cost of Synvisc.

- Diagnostic Procedures

- Diagnostic Procedures

Charges for microscopic and other similar diagnostic tests and services, rendered in a licensed laboratory.

- Ambulance

- Ambulance

Charges for licensed ambulance service provided in the covered person's province of residence, including air ambulance, to transfer the patient to and from the nearest hospital where adequate treatment is available.

- Dental Treatment

- Dental Treatment

Charges for a General Practitioner's treatment of accidental injuries to the natural teeth or jaw. The accident must be due to a force or blow external to the mouth and have occurred while the person was covered for this Benefit. The treatment must be received and approved for payment within 12 months of the accident.

Injuries due to biting or chewing are not covered.

Dental Treatment after Coverage under this Plan ends

Dental Treatment after Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan, the Employer will pay for expenses for the treatment of accidental injuries to the natural teeth, provided the accident is due to a force or blow external to the mouth and occurred while the person was covered for this Benefit. The treatment must be received and approved for payment within 6 months of the accident.

- Out-of-Province or Out-of-Canada

- Out-of-Province or Out-of-Canada

Charges incurred for the following medical treatment given outside the covered person's province of residence:

a) treatment required as a result of a Medical Emergency arising during the first 60 days while temporarily outside the province of residence provided that the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

   An Emergency is an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.

   Emergency services are any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives.

b) referral out of Canada for medical treatment which is available in Canada, up to the Referral outside Canada maximum shown in the Benefit Schedule.

   If, while outside Canada on referral for medical treatment, the covered person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the Referral outside Canada maximum shown in the Benefit Schedule.

These charges are subject to the Out-of-Canada Maximum shown in the Benefit Schedule.

For all treatment given out of Canada, other than emergency medical treatment, the Employer:

a) requires that it be recommended as necessary by a Physician practicing in Canada, and

b) suggests that a detailed treatment plan be submitted with cost estimates before treatment begins.

The Administrator will then advise the Employee of any benefit that will be provided.

Charges for the following are payable under this Covered Expense:

a) Physician's services;

b) Hospital room and board at standard Ward rates. Charges in excess of Ward rates are payable if this Benefit covers Hospital Services in Canada. In such case, the amount payable under this expense is limited to the cost of semi-private accommodation;

c) the cost of special Hospital services;

d) Hospital charges for out-patient treatment;

e) licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or Hospital where adequate treatment is available; and

f) medical evacuation for admission to a Hospital or medical facility in the province where the patient normally resides.

Covered Expenses will be limited to Reasonable and Customary charges less the amount payable by the Provincial Plan, or which would have been payable had proper application been made.

All other charges incurred while outside the province of residence are payable under the appropriate Covered Expense on the same basis as if they were incurred in the province of residence.

Emergency Travel Assistance

Emergency Travel Assistance

Travel Assistance

The following assistance services are provided for a covered person when required as a result of a Medical Emergency during the first 60 days while travelling outside such person's province of residence.

Medical Emergency Assistance

Medical Emergency Assistance

An Emergency is an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.

Emergency services are any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives.

a) **24-Hour Access**

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), telex or fax.

b) **Medical Referral**

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of coverage, is provided.

c) **Claims Payment Service**

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed $200 (Canadian), payment of such expenses will be arranged and claims co-ordinated on behalf of the covered person.

Payment and co-ordination of expenses will take into account the coverage that the covered person is eligible for under a Provincial Plan and this Plan. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered person is entitled, the Administrator shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from the Employee.

d) **Medical Care Monitoring**

Medical care and services rendered to the covered person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the covered person, the attending physician, the covered person's personal physician and family.

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Out-of-Province or Out-of-Canada.

If medically necessary for a qualified medical attendant to accompany the covered person, expenses incurred for round-trip transportation will be paid.

f) **Return of Dependent Children**

If dependent children are left unattended due to the hospitalization of a covered person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

g) **Trip Interruption/Delay**

If a trip is interrupted or delayed due to an illness or injury of a covered person, one-way economy transportation will be arranged to enable each covered person and a Travelling Companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

A Travelling Companion is any one person travelling with the covered person, and whose fare for transportation and accommodation was pre-paid at the same time as the covered person's fare.

If the covered person chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same illness or injury, will not be paid.

If a covered person must return home due to the hospitalization or death of an Immediate Family Member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will be paid.

h) **After Hospital Convalescence**

If a covered person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum shown in part I) of this provision.

i) **Visit of Family Member**

Expenses incurred for round-trip economy transportation will be paid for an immediate family member to visit a covered person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by the Administrator.

j) **Vehicle Return**

If a covered person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the covered person's home or nearest appropriate rental agency will be paid, up to a maximum of $1,000 (Canadian).

k) **Identification of Deceased**

If a covered person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

l) **Meals and Accommodation**

Under the circumstances described in parts f),g),h),i), and k) of this provision, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of $2,000 (Canadian) per medical emergency.

Non-Medical Assistance

Non-Medical Assistance

a) **Return of Deceased to Province of Residence**

In the event of the death of a covered person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of $5,000 (Canadian). Expenses related to the burial, such as a casket or an urn will not be paid.

b) **Lost Document and Ticket Replacement**

Assistance in contacting the local authorities is provided, to help a covered person in replacing lost or stolen passports, visas, tickets or other travel documents.

c) **Legal Referral**

Referral to a local legal advisor, and if necessary, arrangement for cash advances from the covered person's credit cards, family or friends, is provided.

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

Telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

f) **Pre-trip Assistance Service**

Up-to-date information is provided on passport and visa, vaccination and inoculation requirements for the country where the covered person plans to travel.

Health Advice and Assistance

Health Advice and Assistance

The following services are available for a covered person when required as a result of an illness or injury:

a) **After Hours Access to a Registered Nurse**

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family Physician is not readily accessible.

b) **Medical Advice**

Medical advice will be provided on:

i) whether the illness or injury can be safely treated at home or will require a visit to a Physician or hospital emergency room;

ii) the type of side effect to expect from a prescribed Drug; and

iii) other health related services that may be requested or required by the covered person.

c) **Link to 911**

If necessary, a covered person will be immediately linked to their local 911 emergency service for medical assistance.

d) **Follow-Up Call**

Where appropriate, to monitor the care of the covered person, the registered nurse will follow-up with the covered person within 24 hours after the medical advice is provided.

Exceptions

Exceptions

The Administrator, and the company contracted by the Administrator to provide the travel assistance services described in this Benefit, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of a covered person to obtain medical treatment or emergency assistance services for any reason.

Emergency assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances which interfere with or prevent the provision of any services.

Expenses Not Covered

Expenses Not Covered

No benefit is payable for any expense which is directly or indirectly related to:

a) any illness or injury arising out of or in the course of employment when the person is covered by or is eligible for coverage by workers' compensation;

b) any illness or injury for which benefits are payable under any government plan or legally mandated program;

c) self-inflicted injuries or illnesses, whether the person is sane or insane;

d) war, insurrection, the hostile action of any armed forces or participation in a riot or civil commotion;

e) the committing of or the attempt to commit an assault or criminal offence;

f) charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms;

g) charges for services or supplies:

   i) when there would have been no charge at all in the absence of plan benefit coverage;

   ii) when reimbursement would have been made under a government-sponsored plan in the absence of plan benefit coverage;

   iii) which are received from a medical or dental department maintained by an employer, association or trade union;

   iv) which are required for recreation or sports but which are not medically necessary for regular activities;

   v) which would have been payable by the Provincial Plan if proper application had been made;

   vi) which are performed or provided by the covered person, an Immediate Family Member or a person who lives with the covered person;

   vii) which are provided while confined in a Hospital on an in-patient basis;

   viii) which are not specified as a Covered Expense under this Benefit;

h) medical or surgical care which is cosmetic; or

i) medical treatment which is not usual and customary, or which is Experimental or Investigational in nature.

j) equipment used to treat seasonal affective disorder.

40 Dental Care Benefit

The Benefit

The Benefit

The Employer will pay the Benefit Percentage of all Covered Expenses incurred for the dental care of a covered person.

Payment is subject to any maximum amounts shown in the Benefit Schedule and to any limit on benefits shown in the Covered Expenses section below. Lifetime Maximums apply to all periods combined in which a person is covered by the Employer.

In determining if an expense is covered, the Employer may require the following information:

a) x-rays and a complete dental chart showing any extractions, fillings, or other work performed prior to the date of the incurred expenses for which claim is being made;

b) itemized bills from the dentist or other sources, of services or treatments; and

c) laboratory or hospital reports, casts, molds or study models, or other similar evidence of the condition or treatment of the teeth or mouth.

- Claim Amounts Applied To The Maximum

- Claim Amounts Applied To The Maximum

Claim amounts that will be applied to the maximum are the amounts paid by the Employer for Covered Expenses after applying the Deductible, Benefit Percentage and any other applicable Plan Document provisions.

Covered Expenses

Covered Expenses

Expenses shown below are covered if they:

a) are incurred for the necessary dental care of a covered person;

b) are incurred for the care of a person while he is covered under this Benefit;

c) are incurred for services provided by a Dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license;

d) are reasonable as determined by the Employer or the Administrator, taking all factors into account; and

e) do not exceed:

   i) the fees recommended in the Dental Fee Guide shown in the Benefit Schedule, or

   ii) reasonable and customary charges, as determined by the Employer or the Administrator, if such expenses are not included in the Dental Fee Guide shown in the Benefit Schedule.

Alternate Benefits

Alternate Benefits

Where any two or more courses of treatment covered under this Benefit would produce professionally adequate results for a given condition, the Employer will pay Benefits as if the least expensive course of treatment were used. The Administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Level I - Basic Services

Level I - Basic Services

a) complete oral examinations, one per 36 months

b) specific examinations, twice per calendar year

c) full mouth x-rays, one per 36 months

d) panoramic x-rays, one per 24 months

e) recall examinations, twice per calendar year

f) bitewing x-rays, twice per calendar year

g) routine diagnostic and laboratory procedures

h) one unit of light scaling and one unit of polishing, twice per calendar year, when the service is performed outside Quebec, or prophylaxis (polishing), twice per calendar year, when the service is performed in Quebec

i) fluoride treatment, twice per calendar year

j) oral hygiene instruction, twice per calendar year

k) space maintainers (excluding appliances placed for orthodontic purposes), for Dependent children under age 18 only

l) pit and fissure sealants, 1 per tooth per 24 months

m) fillings, (amalgam, silicate, acrylic and composite) and retentive pins. Replacement fillings are covered only if

   i) the existing filling is at least 12 months old and required due to significant breakdown of the existing filling or recurrent decay; or

   ii) the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam

n) pre-fabricated full-coverage restorations (metal and plastic). Pre-fabricated metal restorations will be subject to a limitation of 1 per tooth per 24 months.

o) minor surgical procedures, simple extractions, and post surgical care

p) complicated extractions including impacted and residual roots

q) consultation, anaesthesia, and conscious sedation

r) denture repairs, once per 5 calendar years

s) relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture

t) injection of antibiotic Drugs when administered by a Dentist in conjunction with dental surgery

Level II - Supplementary Basic Services

Level II - Supplementary Basic Services

a) surgical procedures not included in Level I (excluding implant surgery)

b) periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

   i) scaling not covered under Level I, and root planing

   ii) provisional splinting

c) endodontic services (which include root canals and therapy, root amputation, apexifications and periapical services).

d) onlays, one every 60 months

e) inlays (covering at least 3 surfaces, provided the tooth cusp is missing), one every 60 months

Work in Progress when Coverage under this Plan ends

Work in Progress when Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan for reasons other than termination of this Plan or this Dental Care Benefit, and endodontic treatment had begun exposing a tooth, the Employer will pay for expenses related to such treatment provided the expense is incurred within 31 days after the plan benefits terminate.

Level III - Dentures

Level III - Dentures

a) initial provision of full or partial removable dentures

b) replacement of removable dentures, provided the new dentures are necessary due to one of the following:

   i) a natural tooth is extracted and the existing appliance cannot be made serviceable

   ii) the existing appliance is at least 60 months old and cannot be made serviceable

iii) the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent denture. The total amount payable for both the temporary and permanent dentures is the amount which would have been allowed for permanent dentures.

- Open Space Limitation

Open Space Limitation

No benefit will be payable if dentures are required solely to replace a natural tooth which was missing prior to the date the person became covered for this Covered Expense under this Plan.

Work in Progress when Coverage under this Plan ends

Work in Progress when Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan for reasons other than termination of this Plan or this Dental Care Benefit, and an impression for a denture had been taken prior to the termination, the Employer will pay for expenses related to the installation of the denture provided the expense is incurred within 31 days after the plan benefits terminate.

Level IV - Major Restorative Services

Level IV - Major Restorative Services

a) crowns or veneers (only when function is impaired due to cuspal or incisal angle damage caused by trauma or decay), one every 60 months

b) crown repairs, once per 5 calendar years

c) bruxism appliance, two per 5 calendar years

d) initial provision of fixed bridgework

e) bridge repairs, once per 5 calendar years

f) replacement of fixed bridgework or the addition of teeth to bridgework, provided the replacement or addition is due to one of the following:

i) a natural tooth is extracted and the existing appliance cannot be made serviceable

ii) the existing appliance is at least 60 months old and cannot be made serviceable

iii) the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent bridge. The total amount payable for both the temporary and permanent bridge is the amount which would have been allowed for a permanent bridge.

iv) the existing appliance is less than 60 months old and is required to replace an existing appliance which has caused temporomandibular joint disturbances and which cannot economically be modified to correct the condition

- Open Space Limitation

Open Space Limitation

No benefit will be payable if fixed bridgework is required solely to replace a natural tooth which was missing prior to the date the person became covered for this Covered Expense under this Plan.

Work in Progress when Coverage under this Plan ends

Work in Progress when Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan for reasons other than termination of this Plan or this Dental Care Benefit, and an impression for a crown, onlay or bridgework had been taken prior to the termination, the Employer will pay for expenses related to the installation of the crown, onlay or bridgework provided the expense is incurred within 31 days after the plan benefits terminate.

Pre-Determination of Benefits

Pre-Determination of Benefits

When a proposed course of treatment is expected to cost more than $500, a treatment plan should be filed with the Administrator before treatment begins.

The Administrator will then advise the Employee of the amount, if any, that is payable.

Dental Treatment after Coverage under this Plan ends

Dental Treatment after Coverage under this Plan ends

If a person's plan benefit coverage terminates under this Plan, the Employer will pay for expenses for the treatment of accidental injuries to the natural teeth, provided the accident is due to a force or blow external to the mouth and occurred while the person was covered for this Benefit. The treatment must be received and approved for payment within 6 months of the accident.

Expenses not Covered

Expenses not Covered

No benefit is payable for any expense which is directly or indirectly related to:

a) a charge, or a portion of a charge, which is eligible for reimbursement under any other part of this Plan, or through a government plan or legally mandated program;

b) self-inflicted injuries or illnesses, whether the person is sane or insane;

c) war, insurrection, the hostile action of any armed forces or participation in a riot or civil commotion;

d) the committing of or the attempt to commit an assault or criminal offence;

e) charges for broken appointments, third party examinations, travel to and from appointments, or completion of claim forms;

f) charges for services or supplies:

   i) when there would have been no charge at all in the absence of plan benefit coverage;

   ii) which are received from a medical or dental department maintained by an employer, association or trade union; or

   iii) which are performed or provided by the covered person, an Immediate Family Member or a person who lives with the covered person;

   iv) which are not specified as a Covered Expense under this Benefit;

   v) which are usually intended for sport or home use, for example mouth guards, unless medically necessary;

g) treatment rendered for a full mouth reconstruction, for a vertical dimension, or for a correction of temporomandibular joint dysfunction;

h) cosmetic treatment, unless this is needed because of an accidental injury which occurred while the person was covered under this Plan;

i) implants, or any services rendered in conjunction with implants. However, if an implant is the treatment of choice and the implant is part of a bridge, crown or denture, then only the cost of the bridge, crown or denture will be considered eligible;

j) anti-snoring or sleep apnea devices;

k) treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition;

l) the replacement of removable appliances which are lost, mislaid or stolen; or

m) laboratory fees which exceed Reasonable and Customary charges, as determined by the Employer or the Administrator.

46 Survivor Extended Benefit

The Benefit

The Benefit

If an Employee dies while covered for this Benefit and while his Dependents are covered under this Plan, the Employer will continue the Dependent coverage for a period of up to 12 months. The Benefit Schedule shows which Dependent coverage will be continued under this Benefit.

- Plan Benefit Coverage Continued

Plan Benefit Coverage Continued

The coverage continued on a Dependent will be the same as that which was in effect on the date of the Employee's death. This coverage will be subject to any age reduction or termination shown in the Plan at that time.

- Termination of Plan Benefit Coverage

Termination of Plan Benefit Coverage

The maximum period for extended coverage is 12 months. Coverage on any Dependent ceases prior to this:

a) if the Dependent would cease to qualify as a Dependent, even if the Employee were still alive;

b) if the Dependent obtains similar coverage elsewhere; or

c) if this Plan terminates.

Payees

Payees

All benefits for an Employee and such Employee's Dependents are payable to the Employee, unless the Employee has previously authorized payment to be made to the person and/or corporation which has rendered services, treatment or supplies. If the Employee is not alive, these benefits are payable to such Employee's estate.

Payment of Small Amounts

- Payment of Small Amounts

If any amount up to $10,000 is payable to a person who is not alive or who cannot give a valid discharge for such payment, the Employer may pay the amount to:

a) any relative of that person; or

b) any person or institution incurring expenses for the care or maintenance of that person.

Requirement of Proof

Requirement of Proof

No claim for benefits will be paid until the Employer receives satisfactory proof in writing that such benefits are payable under the terms of this Plan.

The Employer or Administrator reserves the right to request any additional information necessary, as determined by the Employer or Administrator, to validate the eligibility of a claim for benefits under this Plan. The Employee is responsible for any expenses incurred for obtaining this additional information.

Submission of Proof

- Submission of Proof

Claims for drug benefits which were not handled on a credit-card basis must be submitted on forms provided by the administering company and forwarded to the address shown on the form. Proof that Extended Health Care and Dental Care benefits are payable must be submitted within the earlier of:

i) March 31st following the year in which the claim was incurred; or

ii) 90 days from the date of termination of plan benefit coverage.

Date Costs are Incurred

Date Costs are Incurred

The expense for a service or supply is deemed to have been incurred on the date the service was performed or the supply furnished. If a procedure involves multiple appointments, the expense is deemed to be incurred on the date the procedure is completed. For supplies that have to be ordered, the expense will be deemed to be incurred on the date the supplies were paid for. Proof of receipt of the supplies is required.

Continuing Proof

Continuing Proof

If benefits are being paid or coverage continued on a covered person because of disability, the Employer may require written proof that this person remains Disabled under the terms of this Plan. This proof will be required as often as may reasonably be necessary.

Examination by the Employer

Examination by the Employer

The Employer reserves the right to have any person in respect of whom a claim is being made under this Plan submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by the Administrator, as often as may reasonably be required. No benefits will be payable if, without reasonable cause, the covered person fails to undergo such examination.

Subrogation

Subrogation

If a covered person suffers personal injury or loss for which he has a right to bring action for damages against a third party, the Employer shall be subrogated to the covered person's rights to recover damages to the extent that it may be obligated to pay benefits to the covered person. In such case, the Employer will require the covered person to complete a subrogation reimbursement agreement. The Employer has the right to suspend payment of benefits until the completed agreement is received.

Upon judgement or settlement for damages, the covered person shall reimburse the Employer for benefits paid or payable. Unless notified to the contrary, the covered person's solicitor shall also represent the Employer's interests in such a recovery.

Time Limit on Legal Action

Time Limit on Legal Action

No legal action against the Employer or the Administrator may be commenced less than 60 days after proof has been filed in accordance with the above requirements. No such action may be brought more than two years after the last day on which proof of claim would be accepted under the terms of this Plan.

Co-ordination of Benefits

Co-ordination of Benefits

The Employer will co-ordinate its Extended Health Care and Dental Care Benefits payable under this Plan with other Plans which also cover a covered person for similar Benefits.

Plans Co-ordinated with this Plan

Plans Co-Ordinated with this Plan

For the purposes of the Co-ordination of Benefits, Plan means:

a) other Group Benefit programs;

b) any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, including any pre-payment coverage, capitation plan, franchise plan or services plan; and

c) individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

How Claims are Co-ordinated

How Claims are Co-ordinated

Benefits payable under this Plan will be reduced, when necessary, so that no more than 100% of eligible expenses incurred during a calendar year are jointly paid by this Plan and all Plans which come before it in the Order of Benefit Payment.

For the purposes of this provision, eligible expenses are as defined in each Policy or Plan document, before any applicable payment limitations, such as deductible, benefit percentage and maximums, are applied. An expense is eligible only to the extent that it is Reasonable and Customary.

Order of Benefit Payment

Order of Benefit Payment

The Order of Benefit Payment is established by applying the following rules to the various Plans which cover eligible expenses. The rules are applied from first to last until an order is established.

a) The Plan with no Co-ordination of Benefits provision in the Policy or Plan document is deemed to pay its benefits first (primary carrier).

b) If all Plans have a Co-ordination of Benefits provision, the following rules are applied to determine the Order of Benefit Payment. The rules depend on the basis on which the person is covered in the Plan.

   i) Employee/Member

      The Plan which covers the person as an employee/member is deemed to pay its benefits before a Plan which covers that person as a dependent.

      If the person is an employee/member under more than one Plan, the following order applies:

      1) the Plan where the person is an active full-time employee, then

      2) the Plan where the person is an active part-time employee, then

      3) the Plan where the person is a retiree.

ii) Dependent - Spouse

If a dependent spouse is also covered as an employee/member under another Plan, the Plan which covers the spouse as an employee/member is deemed to pay its benefits before the Plan which covers the spouse as a dependent.

If the spouse is an employee/member under more than one Plan, the order of benefit payment is as outlined under “Employee/Member” above.

iii) Dependent - Child

If a dependent child is covered under more than one Plan, benefits are deemed to be paid first under the Plan of the parent with the earlier birthdate (month/day) in the calendar year. If both parents have the same birthdate, the Plan of the parent whose first name begins with the earlier letter in the alphabet is deemed to pay benefits first.

However, in situations where the parents of the dependent child are separated or divorced, the following order applies:

1) the Plan of the parent with custody of the child, then

2) the Plan of the spouse of the parent with custody of the child, then

3) the Plan of the parent not having custody of the child, then

4) the Plan of the spouse of the parent not having custody of the child.

Where divorced or separated parents share joint custody of the dependent child, benefits are deemed to be paid first under the Plan of the parent with the earlier birthdate (month/day) in the calendar year. If both parents have the same birthdate, the Plan of the parent whose first name begins with the earlier letter in the alphabet is deemed to pay benefits first.

c) For dental accidents, Extended Health Care Plans with accidental dental coverage determine benefits before Dental Plans.

d) If the Order of Benefit Payment cannot be established by the preceding rules, benefits will be pro-rated between or among the Plans in proportion to the amounts that would have been paid under each Plan had there been coverage by only that Plan.

Special Rules Applied

Special Rules Applied

The Employer will apply the following rules in co-ordinating benefits under this Plan:

a) if a person does not apply for a benefit for which he is eligible under another Plan, the amount of such benefit will be estimated by the Employer and assumed to be paid;

b) if only part of a Plan provides for the co-ordination of benefits, this part will be considered a separate Plan from the part which does not provide for co-ordination;

c) this Plan is considered to be a Plan in applying the rules which establish an Order of Benefit Payment;

d) when a Plan provides benefits in the form of service rather than cash payments, the Reasonable and Customary value of the service rendered is deemed to be both an Allowable Expense and a benefit paid; and

e) if a person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Administration of the Provision

Administration of the Provision

The Employer has the right to release to or obtain from any other insurer, person or institution, information needed to administer the Co-ordination of Benefits provision in this Plan. The Employer has the right to recover any payments in excess of the amount determined to be payable in accordance with this provision.

Method of Administration

Method of Administration

This Plan must be administered in accordance with the Employer's instructions.

Notice of New Employees

Notice of New Employees

The Employer must supply enrolment material to eligible Employees and inform the Administrator of the addition of new Employees as they become eligible for plan benefit coverage.

Notice of Terminated Employees

Notice of Terminated Employees

The Employer must inform the Administrator of the termination of plan benefit coverage on Employees on or before the date on which this coverage terminates. The Employer is also responsible for the retrieval of every prescription drug credit-card issued under this Plan. Payments made or the cost of drugs dispensed with respect to ineligible persons because of the late receipt of termination notice or the Employer's failure to retrieve drug credit-cards will be recovered from the Employer if they cannot be recovered from the Employee on whose behalf they were paid.

Uniform Practices

Uniform Practices

Options available to the Employer must be chosen and administered by the Employer on a uniform basis without prejudice to any Employee.

Clerical Error and Misstatement

Clerical Error and Misstatement

A clerical error is a mistake in writing or copying data. A clerical error made by the Employer or the Administrator will not invalidate plan benefit coverage otherwise in force, or continue plan benefit coverage otherwise terminated under the terms of this Plan.

If a covered person's age has been misstated, his true age will be used to determine:

a) the effective date or termination date of plan benefit coverage;

b) the amount of plan benefits; and

c) any other rights or benefits under this Plan.

The Employer will adjust the plan benefits in force where these are affected by a clerical error or a misstatement of age.

Employee Contributions

Employee Contributions

The Administrator is not responsible for the collection of any employee contributions required for plan benefits under this Plan.

Termination of the Plan

Termination of the Plan

The Employer may refer to the Discontinuance of Agreement provision of the Administrative Agreement between the Employer and the Administrator for further information on terminating the Plan.

Gender

Gender

In this Plan Document, unless the context requires otherwise, reference to the masculine gender will also include the feminine gender.

Currency of Payment

Currency of Payment

All amounts payable under this Plan, to or by the Employer, are payable in Canadian currency.

Conformity with the Law

Conformity with the Law

If a provision of this Plan Document is contrary to any law to which it is subject, this provision will be deemed to conform to the minimum requirements of such law.

Drug Benefit for Covered Persons who Reside in Quebec

In accordance with the requirements of the prescription drug insurance legislation in Quebec, An Act Respecting Prescription Drug (R.S.Q. c., A-29-01) and the regulations enacted under this act (hereinafter collectively the "Legislation"), the drug benefit provided under the Plan Document to covered persons who reside in Quebec will be administered as outlined in this Addendum.

If a provision of the Plan Document or this Addendum is, in full or in part, contrary to the Legislation or any other law or regulation replacing it, that provision, or the part that is deemed to be contrary will be presumed to be amended to comply with the minimum requirements of the then applicable laws and regulations.

Covered Drug Expenses

The following expenses are covered:

a) 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

b) drugs that are listed as a covered expense in the Plan Document but are not on the RAMQ List.

Coverage for drugs on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List)

The following provisions apply only to the coverage of drugs that are on the RAMQ List. For all other covered drug expenses, the provisions stated in the Plan Document will apply.

a) **Percentage Payable By the Administrator**

Prior to the Annual Out-of-Pocket Maximum being reached, the percentage of covered expenses payable under the Plan Document will be:

i) For any drugs on the RAMQ List which are not otherwise covered under the terms of the Plan Document, the percentage payable is as set out by the then applicable Legislation.

ii) For any drug on the RAMQ List which is covered under the terms of the Plan Document, the percentage payable is the greater of:

- the benefit percentage stated in the Plan Document, 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 expenses payable under the Plan Document will be 100%.

b) **Annual Out-of-Pocket Maximum**

The Annual Out-of-Pocket Maximum is the portion of covered drug expenses which must be paid by a covered person in a calendar year, before the percentage payable under the Plan Document will be 100%. Amounts that will be applied to the Annual Out-of-Pocket Maximum are:

i) the deductible amounts, and

ii) the portion of covered drug expenses that is payable by the covered person, when the benefit percentage under the Plan Document is less than 100%.

The Annual Out-of-Pocket Maximum for the Employee and his Spouse is as stipulated in the Legislation and includes those portions of covered drug expenses paid for dependent children.

For the purposes of calculating the Out-of-Pocket Maximum for the Employee and His Spouse, those portions of covered drug expenses paid for dependent children will be applied to the person who is closest to reaching the Annual Out-of-Pocket Maximum.

c) **Deductible**

Deductible amounts, if any, stated in the Plan Document will apply, up to the Annual Out-of-Pocket Maximum. Thereafter, the deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums, if any, stated in the Plan Document will not apply to drugs on the RAMQ List. Drug coverage provided after the lifetime maximum amount stated in the Plan Document is reached is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered, and

ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

Eligible Dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of attainment of:

i) the age specified in the Plan Document, and

ii) age 26

Drug coverage provided for Dependent Children after the age stated in the Plan Document is subject to the following conditions:

- only drugs that are on the RAMQ List are covered, and

- the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age for covered Drug Expenses**

Provided the person is otherwise eligible for the drug benefit under the Plan Document, the Termination Age, if any, specified in the Plan Document will not apply. Drug coverage provided after the Termination Age specified in the Plan Document is subject to the following conditions:

i) only drugs that are on the RAMQ List are covered,

ii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation,

iii) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and

iv) the premium required for the drug coverage is the premium for the Extended Health Care Benefit.

g) **Continuation of Coverage - Concerted Work Stoppages**

In the event of a strike, lock-out or other concerted work stoppages, coverage will continue until the later of:

i) the length of time, if any, specified in the Plan Document, and

ii) 30 days

Coverage for drugs that are listed as a covered expense in the Plan Document, but are not on the RAMQ List

With respect to drugs that are covered under the Plan Document but are not on the RAMQ List, all the provisions stated in the Plan Document will apply.

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