CMSG Western Branch Benefit Plan

Group Benefit Plan
Active and Retired Members

Effective Date: **September 1, 2022**
Publication Date: **August 3, 2022**

Keep This Booklet in a Safe Place

Your group benefits provide an important supplement to your income and valuable protection to you and your family.

This booklet outlines the specific terms of your group benefits program as well as the coverage levels of each benefit. Be sure to keep this booklet in a safe place for future reference.

The coverage for these benefits is underwritten as follows:

Benefit	Insurer/Administrator	Policy Number	Appendix
Basic Life, Dependant Life and Long-Term Disability Insurance	Manulife Financial	G0633162	Appendix A
Weekly Indemnity (WI) and Long Term Disability (LTD) insurance	CMSG Western Branch Benefit Plan/Manulife	G0633163 (WI) G0633162 (LTD)	Appendix A
Accidental Death and Dismemberment (AD&D)	AIG Insurance Company of Canada	GPA 9427644	Appendix B
Out-of-province/Canada medical emergency insurance	AIG Insurance Company of Canada	9429026	Appendix C
Extended Health Care and Dental Care	CMSG Western Branch Benefit Plan/ Coughlin & Associates Ltd.	9006	See Section 2 and Section 3 of this booklet

If you have questions about your group benefits that are not covered in this booklet, please contact Coughlin & Associates Ltd., your plan administrator, at 613-231-2266, or toll-free 1-888-613-1234, or fax 613-231-2345, or email at info@coughlin.ca or your plan consultant, Weitzel & Associates Inc., at 604-428-2655, or toll-free 1-800-663-2865, or fax 604-879-6562 or email at don@weitzelassociates.ca.

If there are any discrepancies between the group contract and the benefits booklet, your coverage will be determined by the terms and conditions of the group contract.

Important

This document contains important information about your member benefits coverage and should be kept in a safe place. It supersedes and replaces all previous communications material and is the plan document in respect to the benefits described herein.

The Canadian Merchant Service Guild Western Branch, the plan sponsor, underwrites certain benefits on a self-insured basis as indicated in the table on the previous page. All risks in respect to these benefits are borne by the Canadian Merchant Service Guild Western Branch Trust.

As sponsor of the plan, the Canadian Merchant Service Guild Western Branch or its trustees or designates may establish rules or regulations for the administration or governance of the benefits plan and any transactions associated with it.

The Canadian Merchant Service Guild Western Branch Benefits Plan, or its trustees or designates, have the right to interpret the self-funded coverage of the plan and decide any and all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the self-funded benefits described in this booklet.

Reasonable and customary means that the treatment provided is accepted by the appropriate Canadian medical profession as being proven scientifically and effective medically and of a form, intensity, frequency and duration essential to the diagnosis and management of the disease or injury.

In respect to these benefits, no payment will be made for expenses that are related to services, treatments or supplies payable by or covered by a government plan.

The interpretations or decisions of the Canadian Merchant Service Guild Western Branch Benefits Plan, its trustees or designates with respect to the self-insured coverage, will be final and binding on all parties.

Protecting Your Personal Information

The plan administrator of your group benefit plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefit plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

Errors or Omissions

Every effort has been made to ensure that this booklet is accurate and complete. Should error, omission or dispute occur, the terms of the policies issued to the Canadian Merchant Service Guild Western Branch Trust will prevail. Clerical errors made by the trustees and the plan administrator will not invalidate benefits otherwise in force or continue benefits otherwise terminated.

Any fraud or willfully false statement in making a claim may invalidate your claim. You are not entitled to the claimed benefit. Sometimes, an overpayment situation may occur through no fault of yours. This means you received a greater benefit payment than you were entitled to receive. If you receive a benefit to which you are not entitled, you must immediately repay that amount to the plan sponsor, to Coughlin & Associates Ltd., which administers your group benefit plan on behalf of the plan sponsor, or to the insurer. If you receive benefits to which you are not entitled and do not repay them, any one or more of the following may occur:

a) any benefit payments to which you are entitled may be withheld to recover the amount you owe; and
b) criminal or other legal action may be brought against you.

Mission Statement

Background

The Canadian Merchant Service Guild (CMSG) Western Branch established a group health and benefit program for active and retired members of the CMSG Western Branch, their eligible dependants and survivors.

Objectives

The purpose of this program is to reimburse eligible participants for all or part of costs incurred for health care and dental care services and supplies not covered by the provincial health care plan. The CMSG Western Branch Benefit Plan is also designed to provide financial protection in the event of death or disability by providing group and optional life insurance coverage as well as accidental death and dismemberment and long-term disability insurance coverage.

The Benefit Plan will:

- provide effective group health care, dental care, life insurance and long-term disability coverage for all eligible plan members and beneficiaries;
- provide high quality, cost-effective and efficient service to members and beneficiaries; and
- operate in a way that promotes the objectives of CSMG Western Branch participants and plan members while supporting the principles of good governance and fiduciary responsibility.

The Benefit Plan document describes the coverage and provisions in detail. The benefit program may be amended at any time thereafter. Claims will be administered in accordance with any amendments and their effective dates. Members can consult the Benefit Plan document at any time through the CMSG Western Branch office.

Coughlin & Associates Ltd., the plan administrator, has been contracted to adjudicate and pay claims in accordance with the plan document.

Weitzel & Associates Underwriting Analysts Inc. is the consultant and has been contracted to provide consulting services and advice to the Trustees and members.

Table of Contents

Benefit Summary

The following is a summary of your benefit plan. For further details on each benefit, please refer to the appropriate section of this booklet.

Basic Member Life Insurance

COVERAGE PROVIDED BY MANULIFE FINANCIAL

Members Qualifying Criteria	Amount
• actively at work.	$200,000
• retired member under age 65.	$50,000
• retired member at age 65 or over.	$25,000

Life insurance coverage will continue into retirement, provided the required premiums are paid.

Termination - active member:	Retirement
Termination - retired member:	Age 70

Dependant Life Insurance

COVERAGE PROVIDED BY MANULIFE FINANCIAL

Benefit amount:	$50,000 spouse. $10,000 child.
Termination:	Member's retirement.

Active Member Accidental Death & Dismemberment (AD&D) Insurance

COVERAGE PROVIDED BY AIG INSURANCE COMPANY OF CANADA

Members Qualifying Criteria	Amount
• member under age 65:	$200,000
• retired member age 65 to 70:	$100,000

Weekly Indemnity Insurance

COVERAGE PROVIDED BY MANULIFE FINANCIAL

Benefit amount:	65% of weekly earnings.
Maximum amount	$2,000 weekly
Elimination period:	14 days accidental injury or illness, 0 days hospitalization
Maximum benefit period:	52 weeks.
Termination of coverage:	At retirement

Long-Term Disability Insurance

COVERAGE PROVIDED BY MANULIFE FINANCIAL

Benefit amount:	65% of monthly earnings.
Maximum amount:	$5,000 monthly.
Elimination period:	52 weeks.

Maximum benefit period for disabilities commencing:	
• Before January 25, 1993	To age 65
• Between January 25, 1993 and May 31, 2001	To age 62
• Between June 1, 2001 and October 31, 2009	To age 65
• Between November 1, 2009 and August 31, 2015	To age 62
• On or after September 1, 2015	To age 65

Termination of coverage:	Maximum benefit period less the elimination period; or at retirement, whichever occurs first.

The maximum amount may be reduced by benefits and payments provided from other sources as described in the *Long-Term Disability (LTD) Benefit* section of this booklet.

Out-of-Province/Canada Medical Emergency Insurance

COVERAGE PROVIDED BY AIG INSURANCE COMPANY OF CANADA

Deductible:	Nil.
Eligibility:	Class I: Active employees under age 75 Class II: Retired employees under age 75 Class III: Active employees age 75 to 80
Reimbursement level:	100% of eligible expenses.
Maximum amount:	Under age 70: Lifetime maximum of $5,000,000 per insured person. Age 70 and over: Lifetime maximum of $2,000,000 per insured person.
Coverage period:	60 consecutive days per trip.
Termination:	When you reach age 80 or earlier retirement.

Extended Health Care

REFER TO SECTION 2

Deductible:	Nil.
Reimbursement level:	100% of all eligible expenses (unless otherwise specified).
Maximum benefit:	$150,000 lifetime per insured person. The overall lifetime limit is subject to a reinstatement of $1,000 annually. Individuals whose claims do not exceed $1,000 annually will have their lifetime maximum restored each year.
Termination:	No termination date if actively working. To age 75 for retired members.

Note: Some individual benefits are subject to monthly, yearly or lifetime maximums.

Prescription drugs:

The following parameters are based on enrolment in the Fair PharmaCare Program. Refer to Section 2 – Extended Health Care for details on registration and program coverage.

• Deductible:	Nil.
• Reimbursement level:	100%, except as noted elsewhere in this booklet.
• Maximum benefit:	$10,000 per insured person per calendar year, however failure to submit proof of registration in the Fair PharmaCare program will result in a maximum $1,500 per insured person per calendar year. The $10,000 annual maximum may be waived for an insured person who is prescribed a life sustaining drug which exceeds this maximum, however the overall lifetime maximum of $150,000 remains in effect. Prior authorization is required from the plan administrator.
• Eligible drugs:	Drugs, serums, vaccines and injectables, only available by prescription with a valid drug identification number (DIN), when prescribed by a licensed health care practitioner or dentist dispensed by a pharmacist, dentist or a physician.
• Generic substitutions:	Mandatory.
• Drug card:	Yes.
• **Maximums and exclusions:**	
• Drugs:	Limited to a 34-day supply for prescription drugs or medicines and a 100-day supply for maintenance drugs.
• Viscosupplementation:	Excluded.
• Smoking cessation aids (products only):	$250 per lifetime per insured person
• Sexual dysfunction drugs:	$500 per insured person per calendar year.
• Fertility treatment:	12 treatment cycles lifetime.

Prior authorization may be required by the plan administrator for certain medications.

Hospital care:

• Reimbursement level:	100% of eligible expenses to a combined maximum of $10,000 per insured per lifetime, unless specified otherwise.
• Coverage:	Cost of a private or semi-private room for each day of hospitalization.
• Palliative care:	Covered under the hospital care coverage as indicated above.
• Convalescent care:	Covered under the hospital care coverage as indicated above.
• Chronic care:	Covered under the hospital care coverage as indicated above.
• Detoxification:	60% per member to a lifetime maximum of $15,000 per maximum 42 day confinement. 100% per dependant to a lifetime maximum of $10,000 per maximum 42-day confinement.
• Room referral care outside province of residence but in Canada:	80% of eligible expenses to a combined maximum of $10,000 per insured per lifetime for all hospital expenses

Vision care (eyeglasses, contact lenses and laser eye surgery):

• Reimbursement level:	100% of eligible expenses.
• Maximum:	$400 per insured person once in any 24 month period.
• Laser eye surgery:	Included up to the maximum listed above on an ongoing basis.
• Glasses or contact lenses following cataract surgery:	$400 per insured person within the 24 consecutive month period.
• Artificial crystalline lenses, also known as intraocular lenses (IOL) for cataracts:	Reasonable and customary charges.

• Eye examinations, including eye refraction:	Up to a maximum of $50 per insured person for any period of 24 consecutive months for members and dependents age 19 to 65.

Professional and paramedical services:

• Reimbursement level:	100% of eligible expenses
• Maximum per practitioner:	
• Acupuncturist*:	$200 per insured person each calendar year.
• Audiologist*:	$200 per insured person each calendar year.
• Chiropractor:	$35 per visit and up to $50 for x-rays to a maximum of $500 per insured person per calendar year.
• Christian Science Healer*:	$200 per insured person per calendar year, doctor's referral required.
• Inhalation Technician*:	$200 per insured person per calendar year, doctor's referral required.
• Occupational therapist*:	$200 per insured person per calendar year.
• Massage therapist or Orthotherapist*:	Combined maximum of $1000 per insured person per calendar year.
• Naturopath:	$200 per insured person per calendar year.
• Orthoptic Technician*:	$200 per insured person per calendar year, doctor's referral required.
• Osteopath:	$200 per insured person per calendar year.
• Podiatrist or Chiropodist:	Combined maximum of $200 per insured person per calendar year.
• Psychologist, social worker or counsellor	$1,000 per insured person per calendar year. Services of a social worker or counsellor can be accepted if proof is provided that registered psychologist is not available.
• Speech therapist*:	$200 per insured person per calendar year.
• Physiotherapist*:	$1,000 per insured person per calendar year.

***** Physician's referral required. Medical recommendation to be renewed every 12 months.

Medical supplies and services:

• Reimbursement level:	100% of eligible expenses.
• Maximum per service and/or supply:	
• Surgical brassieres:	Purchase of 4 surgical brassieres per insured person per calendar year.
• Private duty nurse:	$10,000 lifetime maximum per insured person.
• Artificial eye:	Purchase, including reimbursement for polishing or rebuilding of the artificial eye per insured person up to reasonable and customary charges.
• Stump socks:	Reasonable and customary charges.
• Orthopaedic shoes:	Purchase of one pair (custom made), up to maximum of $400 per insured person each calendar year.
• Custom made orthotics or arch support:	Purchase, $200 per insured person each calendar year.
• Elastic Support stockings:	Purchase, 4 pairs to a maximum of $100 per insured person each calendar year.
• Conventional wheelchair:	Reasonable and customary charges.
• Hearing aids:	Purchase, $1,000 per hearing aid per insured person to an overall maximum of $2,000 for any period of 36 consecutive months. A written prescription by a licensed otolaryngologist is required.
• Diagnostic services:	Reasonable and customary charges.
• Wigs as result of chemotherapy:	Purchase, lifetime maximum of $300 per insured person, doctor's referral required.
• Glucometer:	Reasonable and customary charges to a maximum of one device for any period of 36 consecutive months.

• TENS nerve stimulators:	Reasonable and customary charges, doctor's referral required.
• Out-of-province referral treatment:	Excluded.

Dental Care

REFER TO SECTION 4

Deductible:	Nil.
Fee guide:	Based on the current British Columbia Dental Association fee guide for general practitioners. An additional 10% of the general practitioner's fee schedule can be added for specialist's claims.
Reimbursement amount:	
• Basic services:	100% of eligible expenses.
• Maximum:	• Combined maximum with major services to a maximum of $3,500 per insured person each calendar year.
• Major Services	80% of eligible expenses.
• Maximum:	• Combined maximum with basic services to a maximum of $3,500 per insured person each calendar year.
• Orthodontic services:	50% of eligible expenses.
• Maximum:	• Lifetime maximum of $2,500 per insured person.
Treatment frequency:	
• Complete oral examination:	Once every 3 years.
• Recall oral examination:	Once every 6 consecutive months.
• Specific oral examination:	Unlimited.
• Emergency oral examination:	Unlimited.
• Complete series of periapical films or panoramic radiographs:	Complete series are eligible once per year. Panoramic radiographs are eligible once every 3 years.
• Polishing:	Once every 6 consecutive months.
• Bitewing radiographs:	Unlimited.
• Scaling:	8 units combined with root planning per calendar year.
• Root planning:	8 units combined with scaling per calendar year.
• Fluoride treatment:	Once every 6 consecutive months.
• Replacement fillings	Once every 12 consecutive months.
• Tooth coloured (composite) filling:	Eligible on all teeth.
• Special periodontal appliances, including occlusal guards and bruxism appliances:	Reasonable and customary charges.
• Adjustments to periodontal appliance to control bruxism:	One adjustment up to 2 units of time after the date of insertion.
• Pit and fissure sealants:	For children under age 18.
• Occlusal equilibration:	4 units per calendar year.
• Space maintainers:	Initial provision and installation.
• Oral hygiene instruction:	Excluded.
• Anaesthetic:	Eligible in relation to dental surgery only.
• Denture adjustments including minor adjustments:	Reasonable and customary charges.
• Denture rebase/reline:	Reasonable and customary charges.
• Preformed stainless steel and polycarbonate crowns:	Reasonable and customary charges.
• Crowns, inlays and onlays:	Once every 5 years. Excludes porcelain crowns for molar teeth.
• Veneers:	Once every 5 years.
• Implant services and supplies	Included.

• Laboratory fees:	Limited to the reasonable and customary fees specified for the dental treatment or service.
Termination:	No termination date if actively working. To age 75 for retired members

For orthodontic services only, members who remain insured for prolonged periods are allowed to reclaim benefits previously exceeding the limit applicable when the claim was first submitted.

If coverage is terminated and reinstated within a 6 month period, the applicable maximum at termination is carried forward. If coverage is reinstated after 6 months from the date of termination, the maximum will reset to the amount eligible during the first year of coverage.

General Information

This Plan Supplements Provincial Plans

This group benefit plan is designed to supplement protection, not duplicate or take the place of, the benefits available under provincial hospital and medical care plans. Therefore, this benefit plan excludes care and services that can be provided under a provincial plan. The group plan cannot provide any benefits where care or treatment by private insurance is prohibited.

Who is Eligible

Full-time members of an employer party to collective agreements or participation agreements with the Canadian Merchant Service Guild Western Branch will be eligible for coverage provided they:

- are members of the Canadian Merchant Service Guild Western Branch;
- have completed 90 days of employment with any one employer;
- are residents of Canada. Participating members who choose to live outside of Canada will receive the same coverage as that provided to members who reside in Canada. Non-Canadian residents will not be able to claim coverages that would not otherwise have been available to Canadian residents making claims in Canada.

Waiting Period

An eligible member will be covered following the completion of three months of continuous employment with any one employer.

When Coverage Begins

Active member:
- when the eligibility and waiting period requirements have been satisfied.

Inactive member:
- upon return to active work (absence due solely to a paid vacation or general holiday will not delay coverage.

Dependants:
- the date member coverage begins (if a dependant has been identified) or,
- the date a dependant becomes eligible for coverage; or
- the dependant coverage application date, provided the application is made within 31 days initial eligibility for dependant coverage otherwise; or,
- the date the plan administrator approves the evidence of insurability submitted for the dependant.

IMPORTANT: 31 days after the effective date of coverage, evidence of insurability must be submitted for each dependant.
Dependant coverage will be effective as of the date the plan administrator approves the evidence.

Complete a new Enrolment form to add or change a legally married or common-law spouse, or add or remove a child.

Definitions

Active work member or member actively at work: an employed and working member who performs all of usual customary duties of the occupation.

Collective agreement: the agreement in accordance with which contributions are made to the fund by the employer on behalf of a member.

Dependant child:

- an unmarried person who is a natural or adopted child; or
- a child of a common-law spouse, who resides with you and is dependent on you for support; and
  (i) younger than 21 years of age; or
  (ii) 21 years but younger than 25 years of age and in full-time attendance at an accredited institute of learning, and dependent on you for support; or
  (iii) 21 years or older and incapable of self-sustaining employment due to a mental or physical handicap. The child's coverage will be continued under the policy, provided the child's handicap has existed continuously from a time when he/she was otherwise insured as a dependant under this policy. Supporting documentation by a physician will be required.

To avoid delays or processing problems, contact the plan administrator when any change in dependant status occurs.

Disability:

- **Weekly Indemnity:** You are considered totally disabled if you are in a state of complete and continuous incapacity resulting from illness, or accidental injury, which wholly prevents you from performing the substantial duties of your own occupation.

- **Long Term and other benefits:**
  i) During the elimination period and the initial disability period specific in the Benefit Summary, you are in a state of complete and continuous incapacity resulting from illness, or accidental injury, which wholly prevents you from performing the substantial duties of your own occupation;
  ii) Following the initial disability period, you are in a state of complete and continuous incapacity resulting from illness, or accidental injury, which wholly prevents you from performing the substantial duties of any occupation for which you are or may become reasonably qualified by training, education or experience. Furthermore, you must not be able to earn 60% or more of your gross monthly income determined at the onset of disability by the insurer.

Employer: (can be any of the following)

- the Policy holder;
- employers party to collective agreements or participation agreements with the Canadian Merchant Service Guild Western Branch.

Full-time member/employee: Regularly scheduled work of at least 30 hours per week, or permanent part-time member/employee eligible for benefits under the terms of the collective bargaining agreement.

Insured person: (can be any of the following) member with coverage, spouse and dependant child.

Part-time member/employee: See full-time member/employee.

Policy holder: The Canadian Merchant Service Guild Western Branch Benefit Plan.

Retiree: is a member in good standing who:

- has or is retired and has not returned to work for a participating employer;
- participated in the benefit plan for the preceding five years, has attained age 55 and whose benefits were in force at the time of retirement;
- completed the application for retirement benefits within 31 days of retirement.

Spouse: can be:
- an individual to whom the member is legally married; or
- a common-law partner with whom the member has co-habited with for a period of at least 12 months and who is publicly represented as the member's spouse/partner.

Members must state the name of the person to be considered a spouse for the purposes of the policy. Only one spouse will be covered under the policy at any time.

Temporary lay-off: a member who has not reported to work for a participating employer.

Change in Information

To ensure that you receive all correspondence and that the proper information is stored in your file, contact the plan administrator as soon as a change (i.e. new dependant, beneficiary or address) occurs.

Termination of Coverage

Member Coverage will terminate as follows:
- For members, on the last day of the calendar month in which your employment terminates;
- For employment termination with lay-days to your credit, coverage terminates on the last day of the calendar month in which the credit is exhausted.
- For LTD benefits, coverage terminates on the last day of the calendar month in which you attain age 64. If you are in receipt of LTD benefits, the last benefit payment will cease in the month in which you attain age 65.
- the member ceases to be a member of any eligible class;
- the date the member class is terminated;
- the date the member becomes a full-time member of the armed forces of any country;
- the date the policy terminates; or
- the date the member begins working for a non-union or non-participating employer.

Dependant coverage will terminate on the earliest of the following:
- the date the member's coverage terminates;
- the date the dependant ceases to be a qualified dependant;
- the date dependant coverage under the policy is terminated;
- the date contributions cease to be made for dependant coverage.

Reinstatement of Coverage

If you return to active full-time employment within six months of the date your coverage terminates, your coverage will be reinstated immediately upon your return. If you do not return to active full-time employment within the six months and have not continued benefits under the special lay-off package, you will be considered a new member and will be covered on the completion of 90 days continuous employment with any one participating employer. This does not apply to the provincial medical coverage provided by the MSPBC.

Continuation of Coverage

If a member is absent from work due to temporary lay-off or leave of absence, arrangements can be made through the plan administrator for the continuation of coverage for up to three months from the end of the month in which the lay-off or leave of absence commences. This provision does not apply in cases when an member is absent from work during any period of formal maternity or parental leave taken pursuant to provincial or federal law or mutual agreement between the member and the employer. The time limit shall be extended to the end of the maternity leave, subject to payment of premiums.

Members who have been covered under the plan for 12 consecutive months and who are working on a full-time basis will be covered for three months consisting of life, AD&D, dependant life, health and dental benefits only. These premiums will be paid by the CMSG Western Branch Benefit Plan.

Members on lay-off extending beyond three months may make arrangements with the plan administrator to continue benefits under a special lay-off package. This package is available for up to 18 months following lay-off and includes:

Member Life insurance: $50,000;
Dependant Life insurance: $10,000 spouse and $5,000 child;
Extended Health Care: Full coverage for member and eligible dependants.

The plan does not include dental care, disability insurance or MSPBC coverage. The monthly cost of the lay-off package must be funded by the member and payments directed to the plan administrator. Members who opt for the extended lay-off package will be eligible for immediate reinstatement of all benefits immediately upon return to active full-time employment with any participating employer within the 18-month period. For the purposes of this plan, lay-days constitute days of employment.

Health and dental benefits for dependants following death: If you die prior to retirement, the health and dental benefits for your dependants may be continued for one year following the date of your death.

Workers' Compensation/Disabled Members' Benefits

A member who is in receipt of Workers' Compensation Board (WCB) benefits will continue to be insured under the CMSG Western Branch Benefit Plan. Claims involving re-training and/or partial WCB pensions will be reviewed by the plan trustees on an individual basis. The plan administrator will periodically request copies of the member's most recent WCB cheque stubs and related correspondence.

A disabled member will begin to receive waiver of premium benefits for his/her group life insurance and AD&D coverage to the maximum benefit period indicated for Long-Term Disability Insurance in the *Benefit Summary*. Coverage for AD&D, dependant life and member's extended health care, dental and out-of-country will continue to the maximums indicated in the *Benefit Summary.*

WCB claims involving retraining or partial payment will be reviewed by the plan trustees on an individual basis

Benefits After Retirement/Disability

Arrangements can be made to maintain certain benefits after retirement. Benefits for members who retire require a monthly premium to be determined annually.

Retirement prior to age 65
Members can elect any or all of the following coverages:

Member Life insurance: $50,000
Extended Health Care
Dental Care

Members attaining age 65
Members can elect any or all of the following coverages:

Member Life insurance: $25,000
Extended Health Care
Dental Care

Members cannot add additional benefits at a later date. Application must be made within 31 days of retirement. Members who are disabled will be treated as retirees for the benefits beyond the maximum benefit period for Long-Term Disability Insurance indicated in the *Benefit Summary*.

Members who are disabled and in receipt of long-term disability benefits will continue to have extended health care and dental care coverage until the maximum benefit period for Long-Term Disability

Insurance indicated in the *Benefit Summary*. In addition, members are eligible for a life insurance waiver of premium benefit.

Retiree benefits continue to a maximum age 70 in respect to life insurance, and age 75 in respect to extended health, dental care and out-of-country coverages.

Contact the plan administrator for information on premiums and benefits following retirement or disability.

Portability Feature Rules

Your coverage will continue until the end of the calendar month in which your employment terminates. If you return to full-time employment with a participating employer within six months of the date your coverage terminates, you will be reinstated immediately and will not have to complete the waiting period.

If you transfer to another participating employer, you will be eligible for insurance as of the date of the transfer or from the day immediately following the completion of the waiting period, whichever is later.

Beneficiary Rules

Beneficiary means the person designated in writing to receive the benefits. Upon enrolment in the plan, a member must designate the beneficiary to whom the death benefits will be payable. Subject to any legal restrictions, you may change your beneficiary by contacting the plan administrator.

Phased-in Work Reduction

The collective agreement provides for phased-in work reduction for members who attain age 60 with 20 years of service. Members electing to work under the phased-in work reduction terms will continue to receive benefits, subject to some reductions identified separately to affected members. The work/leave of absence arrangement shall be as mutually agreed upon between the officer and the company.

Co-ordination of Benefits

If you or your dependants are also covered under another health insurance program or contract, the payment of your benefits will be coordinated so that the total benefit you will receive will not exceed 100% of allowable expenses.

Subject to the consent of the covered person, the plan administrator may release to any person or corporation any data necessary to implement this provision.

Order of Benefit Determination

If you or your dependants are eligible to receive a payment under this contract and a similar payment under another benefits plan, the payment of benefits to you will follow this order:

- if the other plan does not have a COB provision, the benefits of the other plan will be paid first;
- if the other plan contains a COB provision, its benefits will be coordinated with those under this agreement so that priority will be given to the plan under which the person is eligible to receive benefits as follows:
    - other than as a dependant;
    - as a dependent child of the parent with the earlier month and day of birth in the calendar year;
    - as a dependent child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

In cases of separation or divorce:

- the plan of the parent with custody of the child;
- the plan of the spouse-partner of the parent with custody of the child;
- the plan of the parent not having custody of the child;
- the plan of the spouse-partner of the parent not having custody of the child.

If the person is covered under another plan, priority will go to:

- the plan where the member is an active, full-time member;
- the plan where the member is an active, part-time member;
- the plan where the member is a retiree.

If priority cannot be established according to the above, the benefits shall be paid under both plans in a ratio proportionate to the amounts that would have been paid under each plan had there been coverage under just that plan.

Extended Health Care

Payment of Benefits

If you or your dependants incur any eligible expenses for medically necessary services or supplies the benefit plan will pay a benefit subject to limitations and exclusions. The benefit payable will be based on the amount shown in the *Benefit Summary* following the payment of the annual deductible if applicable. All covered services and supplies must be considered reasonable and acceptable by the Canadian medical profession and proven to be effective and in a form, intensity, frequency and duration essential to the diagnosis and treatment of the illness or injury. Certain drugs may require prior authorization from the plan administrator.

Fair Pharmacare Program

With the exception of out-of-province charges for hospital care and services not available in your province of residence, charges for the services and supplies outlined in the book are covered at 100% after Fair PharmaCare's contribution.

Effective May 1, 2003, the universal drug and seniors drug care plans were merged to form the Fair PharmaCare program. Under the plan, deductibles and out-of-pocket maximums are based on annual reported income rather than a flat annual fee.

Members under age 65 will receive the following Fair PharmaCare assistance:

Net Annual Family Income	Family Deductible	Portion of Prescription Drug Costs paid by PharmaCare (once deductible is reached)	Family Maximum (after which 100% of costs are covered)
Less than $15,000	None Government paid	70%	2% of net income
Between $15,000 and $30,000	2% of net income	70%	3% of net income
Over $30,000	3% of net income	70%	4% of net income

Members age 65 and over will receive the following Seniors Fair PharmaCare assistance

Net Annual Family Income	Family Deductible	Portion of Prescription Drug Costs paid by PharmaCare (once deductible is reached)	Family Maximum (after which 100% of costs are covered)
Less than $33,000	None Government paid	75%	1.25% of net income
Between $33,000 and $50,000	1% of net income	75%	2% of net income
Over $50,000	2% of net income	75%	3% of net income

Plan members in British Columbia must register for the BC Fair PharmaCare program. If proof of registration is not submitted to Coughlin & Associates Ltd., the plan administrator, your drug claim coverage will be limited as outlined in the *Benefit Summary*. To register, or for more information, call toll-free 1-800-387-4977. Registration and submission of proof is a one-time occurrence.

Work-related Injuries/Expenses

Extended health care expenses for work-related injuries that are recoverable from the WCB will be refunded to the plan as they are recovered from the WCB.

Covered Expenses

The plan will pay for the following services and supplies, providing they are not covered by your provincial health care plan to the limits specified in the *Benefit Summary*:

Prescription Drugs and Medication

- Drugs, serums, compound mixtures, vaccines and injectables, including oral contraceptives, only available by prescription, are covered when prescribed by a medical doctor, or dentist.
- Brand name drugs are eligible up to the price of the generic drug equivalent.
- Diabetic supplies such as diabetic needles, syringes, test strips, lancets, alcohol swabs and glucometers (excluding batteries).
- Certain eligible medications may require the prior authorization of the plan administrator.
- Compound mixtures, when at least one ingredient is a prescription requiring medication, are eligible under the plan

Hospital Care

The plan will cover the costs for hospital care in the province where you live, up to the cost of accommodation listed in the *Benefit Summary.*

A hospital is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing 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, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

The plan will also cover accommodations in a convalescent hospital if this care has been ordered by a doctor, up to the maximum listed in the *Benefit Summary.*

For the purposes of this plan, a convalescent hospital is 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.

A chronic care hospital is a licensed hospital that provides chronic care for patients who are chronically ill, whose chronic care needs cannot be provided at home. The patient requires a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. It does not include a nursing home, rest home, home for the aged, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse. If the plan member is confined in a chronic hospital or chronic care unit of a public general hospital, reimbursement will be made up to the maximum indicated in the *Benefit Summary.*

Palliative care establishment means any establishment in Canada designated as such by law that provides, under the supervision of a physician, care and treatment to patients, mainly during the terminal phase of their illness, and that provides nursing care 24 hours a day by a registered nurse and maintains daily records of each patient under the care of a physician. An active treatment hospital designated as such by law, extended care facility, rest home, convalescent or rehabilitation centre, home for the aged or the chronically ill, home for the mentally ill, sanatorium, convalescent hospital, or institution for the care and treatment of alcoholism or drug addiction is not considered a palliative care establishment.

Medical Supplies

The plan will cover the costs after provincial plan coverage (if applicable) for the medical services listed below when ordered by a doctor, up to the maximums indicated in the *Benefit Summary.* If no maximum is indicated, reimbursement will be based on the reasonable and customary costs in the locality where the services and supplies were provided. Reimbursement of eligible items is based on the date the items are paid in full.

- Hearing aids, or repairs to existing hearing aids plus initial batteries. Hearing aid evaluation tests, ear examinations and replacement batteries are not eligible.
- Custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist (must indicate medical diagnosis).

- Custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist (must indicate medical diagnosis).
- Private duty nursing services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. A pre-care assessment must be provided and prior authorization by the plan administrator is required.
- External breast prosthesis (following mastectomies) and surgical brassieres.
- Elastic support stockings, including compression hose, showing the brand name and compression ratio.
- Wigs for patients who have undergone special treatment, such as chemotherapy. A doctor's referral indicating the condition being treated is required.
- Transcutaneous electric stimulators (TENS) machines. A doctor's referral indicating the condition being treated is required.
- Transportation in a licensed ground or air ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- Rental or at the administrator's discretion, purchase of durable equipment including but not limited to standard-type wheelchair, wheelchair repairs, hospital bed (with or without mattresses), hospital bed rails, respirator/ventilator, oxygen and its administration, apnea monitors. In lieu of rental, the plan may, at its discretion, substitute charges for the purchase of such articles where applicable rental charges will be applied to the purchase price.
- Rental or at the administrator's discretion, purchase of braces, trusses, casts, canes, crutches, walkers, splints (excluding dental splints), cryocuffs, cervical collars, standard-type artificial limb or eye. Braces must be constructed with rigid or semi-rigid material, required for normal activities of daily living, and not solely for sports-related activities, with the written prescription of a physician.
- Diabetic supplies such as diabetic needles, syringes, test strips, lancets, alcohol swabs and glucometers (excluding batteries). Purchase of continuous glucose monitors (Dexcom G5) subject to medical requirements/criteria.
- Purchase of colostomy and ileostomy supplies (where surgical stoma exists), payable after incurred expenses exceed the provincial health plan.
- Laboratory tests performed by a commercial laboratory for the diagnosis of an illness.
- Medical services and supplies including bandages, surgical dressings, blood transfusions, plasma, radium and radioactive isotope treatments when authorized by the patient's attending physician.
- Certain diagnostic laboratory services and X-rays, except for those provided by a doctor in the course of treatment and not normally covered by the provincial health care plan.
- Fees charged by a medical practitioner for the completion of documentation related to WI and LTD cases.
- The costs of treatment for the repair or replacement of natural teeth, which require treatment as a result of accidental blow to the mouth. Damage must be caused by a direct blow to the mouth, not from an object wittingly or unwittingly placed in the mouth. The accident must have occurred after the effective date of the plan. Treatment must be completed within 6 months of the date of the accident. Reimbursement will be based on the current Dental Association fee guide for general practitioners, in the province of British Columbia.

Vision Care

Reimbursement of eligible eye wear is based on the date the items are paid in full. A written prescription by a licensed or registered optometrist or ophthalmologist is required. Reimbursement for eye exams is based on the date of the eye exam.

Paramedical Services

Medically necessary services, including X-rays, of licensed, certified or registered (in the province where treatment is given) paramedical practitioners up to reasonable and customary fees per visit when operating within their recognized fields of expertise to the maximums specified in the *Benefit Summary.* Reimbursement is based on the dates the services were rendered. All receipts must clearly indicate the names of those attending the sessions.

Expenses Not Covered

- Services covered by any provincial government plan or any workers' compensation board.
- Any care, services or supplies that are not medically necessary, as determined by the plan administrator.
- Services or supplies to the extent that their costs exceed the reasonable and customary rates in the locality where the services or supplies are provided.
- Care, services or supplies utilized as treatment of lifestyle choices, as determined by the plan administrator.
- Services or supplies that are primarily for cosmetic purposes.
- Drugs or medicines, services or supplies that have been self-prescribed, or prescribed by or for family members.
- Drugs, injectables, supplies or appliances that are experimental or that are not approved by Health Canada.
- Vitamins unless they are injected, vitamin preparations, food supplements, and drugs not approved for sale in Canada.
- Charges incurred as a result of conditions arising from war, whether or not war was declared, from participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
- Vision care expenses for magnifying glasses or safety glasses of any kind.
- Additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear, or as the result of a pathological change, unless prior approval in writing is obtained from the plan administrator.
- Vaporizers, breast pumps and nebulizers.
- Hearing aid evaluation tests, maintenance and recharging devices.
- Charges incurred as a result of self-inflicted injury or while committing, or attempting to commit, a criminal offence.
- Services or supplies purchased outside Canada except as provided under the out-of-country care provision.
- The plan will not pay for the following, even when prescribed:
    - the cost of giving injections, serums and vaccines
    - medicines obtained from a doctor or dentist
    - treatments for weight loss, proteins and food or dietary supplements
    - hair growth stimulants
    - contact lens care products and eye lubricant
    - dietary supplement, diet foods, vitamins, vitamin supplements, minerals other than hematinics, and anorexiants
    - food and food products including infant formula, infant foods, salt and sugar substitutes
    - skin and hair care products, including protectives, soaps, cleansers, emollients, lubricants, suntan lotions and deodorants
    - personal hygiene products, contraceptive preparations and devices
    - dental and oral hygiene products, including toothpastes, mouthwashes, and prophylaxis treatments
    - lozenges and cough suppressants or antacids, anti-flatulents and absorbents
    - medications for pets
    - laxatives, anti-diarrheals and hemorrhoidals
    - drugs listed as excluded in the *Benefit Summary*

Dental Care

If, while insured, you or your dependants incur any of the eligible expenses for dental services, the plan will pay a benefit subject to the dental care limitations. The amount payable will be determined based on the percentage shown in the *Benefit Summary*.

Benefits are based on the edition of the Dental Association Fee Guide for General Practitioners indicated in the *Benefit Summary*.

Dental treatments are considered eligible, if performed by a dentist, denturist, or independent dental hygienist who practices within the scope of their license.

Pre-determination of Benefits

Where a course of treatment is expected to cost $300 or more or will involve the use of crowns, inlays, onlays, bridges, dentures or orthodontic treatment, it is recommended that the insured person obtain a written estimate outlining the procedures and itemized charges, including X-rays, from the attending dentist. The estimate should be submitted to the plan administrator prior to commencement of the treatment. The plan administrator will review the estimate and advise the insured person on the amount of benefit payable.

Alternate Benefit Provision

Situations may arise where alternative methods of treatment may be available. It is solely for the member and his/her dentist to decide which method will be employed. As the basis for determining liability under the benefit plan, the plan administrator reserves the right to use the least expensive method of treatment that would provide a professionally adequate result.

This provision cannot be applied on excluded provisions, services or devices. Only those treatments listed are eligible.

Basic Services

The following services will be eligible for payment to the limits outlined in the *Benefit Summary*:

- Recall oral examinations;
- Bite-wing X-rays;
- Prophylaxis (light scaling and polishing of teeth) at time of tooth application of an anti-cariogenic agent;
- Oral hygiene instruction;
- Fluoride treatment;
- Complete oral examinations;
- Panoramic X-rays, full mouth series of X-rays;
- Simple alveolectomy (incision into tooth socket) at time of tooth extraction;
- Surgical extractions including extractions of impacted teeth;
- Surgical removal of tumours, cysts, neoplasms, plus the incision and drainage of an abscess;
- Amalgam, silicate, acrylic, and composite filings, including the inlay or onlay of one or two tooth surfaces;
- Pit and fissure sealants for children up to the age of 18;
- Therapeutic scaling;
- Provision of space maintainers for missing primary teeth, bruxism appliances and habit breaking appliances;
- Diagnostic X-ray and laboratory procedures required in relation to dental surgery;
- General anaesthetic required in relation to eligible dental treatment;
- Consultation required by the attending dentist;
- Re-lining, re-basing, adjustments or repairing of an existing denture;

- Endodontic treatment (i.e. those basic procedures necessary for pulp therapy and root canal therapy) and the bleaching of endodontically treated teeth. Root canal therapy will be limited as outlined in the *Benefit Summary*;
- Periodontic treatment (i.e. those basic procedures necessary for the treatment of tissues supporting the teeth). Occlusal equilibration is limited as outlined in the *Benefit Summary*;
- Injection of antibiotic drugs when prescribed by a dentist.

Major Services

- Inlays and onlays when three or more tooth surfaces are involved if the existing materials cannot be made serviceable and to the limits outlined in the *Benefit Summary*;
- Crowns, including gold and porcelain veneer restorations where other material is not suitable;
- The creation of an initial bridge or initial denture, once coverage is in force for at least 12 months;
- Repairs to an existing bridge, crown, inlay, onlay or veneer;
- The replacement of an existing bridge, crown, inlay, onlay, veneer or denture, only under the circumstances set out below:
    i) if the existing appliance is at least five years old and cannot be made serviceable; and
    ii) if the existing appliance is temporary and is replaced with a permanent appliance within 12 months of the date the temporary appliance was installed.

Orthodontic Services

All necessary dental treatment, which has as its objective the correction of malocclusion of the teeth. Reimbursement for the initial orthodontic fee must not exceed 35% of the total treatment plan. The balance of the orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, outlined in the orthodontic treatment plan.

Reimbursement of the monthly fees will be based on the amount or date of payment, if different from the treatment plan.

General Exclusions

No payment will be made for expenses resulting from:

- self-inflicted injuries or illness while sane or insane;
- any injury or illness for which the covered person is entitled to indemnity or compensation under any workers' compensation board;
- charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication;
- cosmetic surgery or treatment (when so classified by the plan administrator) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident;
- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot;
- services, treatments or supplies, eligible under this plan and payable under any government plan, whether or not the claimant is covered under such a plan; the plan administrator will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan;
- examinations required for the use of a third party;
- travel for health reasons;
- dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union;
- any charges for services, treatment or supplies for which there would be no charge except for the existence of coverage;
- the replacement of an existing appliance that has been lost, mislaid or stolen;
- services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for a correction to temporomandibular joint dysfunction;
- drugs, sera, injectables and supplies that are not approved by Health Canada (Food and Drugs) or are experimental or limited in use whether or not so approved;
- experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society;
- any dental services or supplies relating to dental implants and TMJ;
- expenses required for recreation or sports;
- services or supplies received during a period of hospital confinement that began before your insurance became effective;
- transportation and delivery charges;
- hospital charges except detoxification facility charges as specified by the plan;
- services not listed as covered expenses;

How to Claim Benefits

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 12 months of the date of purchase or service. You have 90 days following the termination of your coverage to submit claims for reimbursement.

Life Insurance Claim

In the event of a death, your beneficiary should immediately contact Coughlin & Associates Ltd. who will provide the necessary information.

Life waiver of premium claims: Manulife Financial will not be liable for life insurance waiver of premium claims for which initial notice of the qualifying disability is submitted more than 6 months after the earlier of:

i) the end of the period following the date the member was last actively at work equal to the waiver of premium waiting period; and
ii) the date the policy terminates.

Accidental Death and Dismemberment (AD&D) Insurance Claim

In the event of a claim, immediately contact Coughlin & Associates Ltd. who will provide the necessary information.

Notice of claim must be given to Chubb Life Insurance within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life Insurance within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonable possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event will Chubb Life Insurance accept notice of claim beyond one year.

Weekly Indemnity

In the event of a disability claim, immediately contact your employer who will provide the necessary information.

A claim must be made immediately and not later than 60 days after the commencement of your total disability. It is important that you promptly report to your employer any disability that may result in a weekly indemnity claim in order that the appropriate form can be completed.

The claim form must be completed in the following order:

1. the officer completes the member's portion;
2. the employer completes the employer's portion;
3. the doctor completes the attending physician's portion of the form before it is submitted for assessment.

Any fees charged by the attending physician for the completion of forms will be covered by the benefit plan.

Long-Term Disability Insurance Claim

In the event of a disability claim, immediately contact your employer who will provide the necessary information.

The initial notice of disability income claim should be submitted to Manulife Financial no later than 10 days after disability starts.

Manulife Financial will not be liable for long term disability income claims for which initial notice is submitted more than 3 months after the earlier of:

i) the end of the waiting period; and
ii) the date the policy terminates.

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

In the event of a claim, immediately contact RSA Travel/Global Excel who will provide the necessary information.

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

i) give written notice of claim by delivery thereof or by sending it by registered mail to Global Excel not later than 30 days from the date the claim arises under the policy;
ii) within 90 days from the date a claim arises under the *policy*, furnish Global Excel such proof of claim as is reasonably possible in the circumstances of the *emergency* giving rise to the claim and the loss occasioned thereby, the right of the claimant to receive payment, his age and the age of the beneficiary, if relevant; and
iii) if required by Global Excel, provide a satisfactory certificate stating the cause for which the claim is made and the duration of the disability, if applicable.

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

Extended Health and Dental Care Claims Reimbursement

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 12 months of the date of purchase or service. You have 90 days following the termination of your coverage to submit claims for reimbursement.

Interest shall not be payable on any reimbursement under this plan.

All expenses incurred and paid by the participants shall be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement shall be made for expenses incurred and paid by a participant for any of the eligible services, substances and appliances set out in and in accordance with, the provisions set forth in the plan group agreement, provided such expenses:

i) are incurred and paid for services, substances and appliances prescribed by, and given under the direction of a physician, subject to the conditions of this agreement; and
ii) are in the opinion of the plan administrator reasonable and customary in the area in which they are rendered or supplied.

Reimbursement shall not be made for of any eligible expense unless the benefit premiums were paid when due for the months in which the service, substance or appliance was rendered or supplied.

Extended Health Care Claims

If you incur eligible extended health care expenses, complete the appropriate claim form and return it, along with any original receipts, to Coughlin & Associates Ltd. In coordination of benefits situations where Coughlin & Associates Ltd. is the secondary payer, the original explanation of benefits form of the primary insurer and copies of the relevant receipts or health claim forms must be submitted.

Claim forms may be obtained from the Coughlin & Associates Ltd. website at www.coughlin.ca.

Note: Original claims receipts will be retained by Coughlin & Associates Ltd. It is recommended that you photocopy receipts prior to submitting claims.

Dental Claims

Coughlin will process your dental claim using the electronic data interchange (EDI) claims processing service. With EDI, your dental claim can be sent directly from your dental office to Coughlin's claims department for adjudication.

Coughlin's EDI service uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association. With Telus, you can be assured that the information contained in your dental claim will be transmitted to Coughlin quickly, safely and confidentially right from your dentist's office.

To take advantage of Coughlin's EDI service, inform your dentist that Coughlin is your plan administrator and present them with the following security codes:

- the Coughlin Telus carrier identification number (also known as the BIN number) is 610105 on the Telus network;
- your unique member identification number; and
- the policy number of your group benefit plan.

Coughlin can provide you with your member identification number.

When your dental care claim is submitted electronically, it will be processed within two to four business days.

Pay-Direct Drug Card / Drug Claims

You can pay for your prescription drugs directly through your drug plan using the pay-direct drug card from Express Scripts Canada (ESC) and Coughlin & Associates Ltd.

With the pay-direct drug card, your prescription drug claims will be processed on-the-spot. There are no forms to complete. Simply present the drug card to your pharmacist when you purchase prescription drugs. Your claim payment will be processed immediately.

The card can be used by you as well as your spouse and eligible dependants. The pay-direct drug card is designed to cover only prescription drug costs.

The drug card can be used at any pharmacy in Canada.

Pre-Authorized Deposit (PAD)

Members and employees of benefit plans administered by Coughlin & Associates Ltd. can have their claim reimbursements deposited directly to their bank accounts.

With Coughlin's Pre-Authorized Deposit (PAD) reimbursement program, members can receive your reimbursement within two to five days following the approval of their medical or dental claims. You will not have to wait for the arrival of a cheque and a trip to the bank before depositing your reimbursement.

To enrol in Coughlin's PAD program, just log on to the Coughlin website at www.coughlin.ca or contact the CMSG Western Branch office.

Coughlin Member Portal

You can log-in to the Coughlin member portal at www.coughlin.ca and view your personal benefits and claims account. You can:

- Manage your profile, including updating your mailing address, telephone number, email address, updating your language of preference and viewing your dependant information.
- View your claims history and the status of claims, print explanation of benefits statements, view your benefit accumulations/maximums and view your booklet (where applicable).

- Download and print claim submission and administrative forms.

Claims Appeals Process

In the event a claim is denied and the member is not in agreement, an appeal may be submitted in writing by the member to Coughlin & Associates Ltd., identifying the basis of the appeal and including supporting medical information justifying the expense as medically necessary.

These appeals will be reviewed in conjunction with our medical/dental consultants and the decision of the Board of Trustees will be communicated in writing to the member.

Contact Us

Questions?

Claims department:
Tel: 613-231-8540
Toll-free 1-877-768-3378
Email: ottclaims@coughlin.ca

All other inquiries:
Tel: 613-231-2266
Toll-free 1-888-613-1234
Fax: 613-231-2345
Email: info@coughlin.ca
Website: www.coughlin.ca

Mailing address:
P.O. Box 3517, Station C
Ottawa, ON K1Y 4H5

Business hours:
Monday to Friday: 8:30 a.m. to 4:30 p.m. EST

Appendix A – Basic Member Life, Member Life, Weekly Indemnity and Long Term Disability Insurance

Underwritten by MANULIFE FINANCIAL (**no carrier document available at this time)**

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to these benefits.

Appendix B – Accidental Death and Dismemberment Insurance

Underwritten by AIG INSURANCE COMPANY OF CANADA

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to this benefit.

Group Personal Accident Booklet
Policyholder: Canadian Merchant Service Guild Western Branch
Policy No.: GPA 9427644

Why You Need Accident Insurance

A serious accidental Injury or death can have tremendous consequences for your family that may prevent you or your Spouse from meeting your financial obligations. Your Employer has provided you with accident insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to your beneficiary to help ease any financial burden if you suffer a Loss of Life as a result of an accident. The policy also provides you with 'living benefits' should you suffer an accident that results in any of the Losses listed in the Table of Losses, such as Paralysis or Loss of Hearing.

Eligibility and Principal Sum

Your plan provides Accidental Death & Dismemberment benefits for Injuries as a result of covered accidents. You are automatically covered a Principal Sum amount of $200,000.

Definitions

The following is an explanation of the terms used in this benefit booklet.

Activities of Daily Living means the following six activities:

1. Maintaining continence: ability to control urination and bowel movements, including the use of ostomy supplies or other devices such as catheters if required;
2. Transferring: ability to move in and out of a bed, between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing including braces, artificial limbs or other surgical appliances;
4. Toileting: use of a lavatory including getting to and from and getting on and off, to manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Eating: ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower or washing satisfactorily by other means.

Annual Earnings means your annual salary from employment with your Employer immediately prior to the date of loss, exclusive of overtime, bonus, incentive payments, profit sharing or commission.

Carjacking means taking unlawful possession of a Private Passenger Type Automobile by means of force or threats against you then rightfully occupying such Private Passenger Type Automobile.

Company means AIG Insurance Company of Canada.

Dependent Child means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Dependent Parent means your parents, parents-in-law, grandparents, grandparents-in-law, great-grandparents or great-grandparents-in-law that are dependent upon the you for support, maintenance and care.

Employer means the Policyholder or an affiliate or subsidiary thereof, for which you are employed.

Hospital means an establishment which:

(a) holds a licence as a hospital (if licencing is required in the jurisdiction);

(b) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

(c) provides 24 hour a day nursing service by registered or graduate nurses;

(d) has a staff of one or more licenced Physicians available at all times;

(e) provides organized facilities for diagnosis, and major medical surgical facilities;

(f) is not primarily a clinic, nursing, rest or convalescent home or similar establishment; and

(g) is not, other than incidentally, a place for the treatment of alcohol or drug addiction.

Immediate Family means a person who is related to you in any of the following ways: a spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (including legally adopted or stepchild).

Injury or ***Injuries*** means bodily injury which is sustained by you as a direct result of an unintended unanticipated accident, provided such accident is external to the body and occurs while your insurance under this policy is in force.

Insured Employee means an individual who belongs to an eligible class of Insured Employees specified in the Policy Schedule Declarations provided such individual's name is on file with the Policyholder as being insured under this policy.

Loss when used with reference to:

(a) ***Quadriplegia***, ***Paraplegia***, and ***Hemiplegia*** means the complete and irreversible paralysis of such limbs;

(b) ***Hand or Foot*** means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;

(c) ***Arm or Leg*** means the complete severance through or above the elbow or knee joint;

(d) ***Thumb and Index Finger*** means the complete severance through or above the first phalange;

(e) ***Fingers*** means the complete severance through or above the first phalange of all four Fingers of one Hand;

(f) ***Toes*** means the complete severance of both phalanges of all the toes of one foot;

(g) ***The Entire Sight of One Eye*** means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye;

(h) ***The Entire Sight of Both Eyes*** means the total and irrecoverable loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in ophthalmology must clinically confirm the diagnosis in writing;

(i) ***Hearing in One Ear*** means the diagnosis of permanent loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in otolaryngology must confirm the diagnosis in writing;

(j) ***Hearing*** means the diagnosis of permanent loss of Hearing in both ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in otolaryngology must confirm the diagnosis in writing;

(k) ***Speech*** means complete and irrecoverable loss of the ability to utter intelligible sounds; and

(l) ***Loss of Use*** means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

Loss when used herein may also include ***Loss of Life.***

Permanent and Total Disability means Injury which prevents you from performing at least two of the six Activities of Daily Living, without assistance from another person and you have been determined on evidence satisfactory to the

Company, to be and remain, as of 12 months after the date of the Injury, incapable of performing at least two of the six Activities of Daily Living without assistance from another for the remainder of your life. The disability must be determined to be total, permanent, and irreversible and certified to be such by a Physician acceptable to the Company. Your inability to actually obtain employment is not a criteria to qualify for the Permanent and Total Disability benefit.

Physician means a medical doctor, other than you or your Immediate Family, who is licenced to administer medical treatment and prescribe drugs in the place where he or she provides medical services. The following are not considered to be Physicians: naturopath, herbalist and homeopath.

Private Passenger Type Automobile means any means of transportation not operated for commercial purposes, designed to carry passengers and that is pulled, propelled or fuelled in any way, including cars, trucks, motorcycles, mopeds, snowmobiles or boats.

Spouse means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

General Policy Provisions

Effective Date
Your coverage begins on the date you satisfy the eligibility requirements to become an Insured Employee.

Termination Date
Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee; or
4. the first day of the month following the date you no longer belong to an eligible class of employees as set out in the policy.

Continuance of Coverage
If you are no longer employed or actively working, your coverage shall continue in the following circumstances: (1) during a statutory leave, as set out in applicable provincial, territorial or federal employment standards legislation or equivalent, but not more than the period required under such legislation, or (2) during the notice period for termination of employment as required by law, provided premiums continue to be paid.

Conversion Privilege Benefit
If you leave your job for any reason, you have 90 days to convert your coverage to an individual insurance policy that provides comparable coverage. The amount of insurance benefit provided for the new policy shall not exceed the lesser of $500,000 or your Principal Sum in force at the time you convert your policy. The premium due will be based on the rates in force for individual policies at time of application.

Aggregate Limit Per Accident
The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy schedule, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered Loss occurs within 365 days after the date of the accident causing the Loss, the Company will pay the indicated percentage of the Principal Sum as set out in the following Table of Losses. If you sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

Table of Losses	Percentage Principal Sum Payable
Loss	
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Brain Death	100%
Loss of One Arm or One Leg	80%
Loss of One Hand or One Foot	75%
Loss of The Entire Sight of One Eye	75%
Loss of Thumb and Index Finger of the Same Hand	33.3%
Loss of Speech and Hearing	100%
Loss of Speech or Hearing	75%
Loss of Hearing in One Ear	66.7%
Loss of Four Fingers of One Hand	33.3%
Loss of All Toes of One Foot	25%
Loss of Use	
Loss of Use of Both Arms or Both Hands	100%
Loss of Use of One Hand or One Foot	75%
Loss of Use of One Arm or One Leg	80%
Paralysis	
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the Principal Sum up to a maximum of $1 million
Paraplegia (total paralysis of both lower limbs)	Two times the Principal Sum up to a maximum of $1 million
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times the Principal Sum up to a maximum of $1 million

Additional Benefits

These benefits shall only apply if selected by your Employer and the appropriate premium paid. The Benefit Description is a summary only and does not include all of the provisions, sub-limits, conditions and exclusions.

Benefit	Maximum	Benefit Description
DISAPPEARANCE	Principal Sum	Pays the Loss of Life Principal Sum if your body has not been found within one year of a forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant.
REHABILITATION BENEFIT	$15,000	Pays the expenses incurred for occupational training up to the Maximum if such expenses are incurred within three years of the accident and are as a result of an Injury for which you receive a benefit under the policy.
HOME ALTERATION AND VEHICLE MODIFICATION	$15,000	Pays a one-time benefit up to the Maximum for covered home alternation and vehicle modification expenses if you suffer an Injury for which you receive a benefit under the policy and require a wheelchair to be ambulatory.
WORKPLACE MODIFICATION AND ACCOMMODATION	$5,000	Pays a one-time benefit to your Employer up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require special adaptive equipment or workplace modification in order for you to return to work full-time for the Policyholder.
PSYCHOLOGICAL THERAPY	$5,000	Pays a benefit up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require psychological therapy within two years of the Injury.
IN-HOSPTIAL BENEFIT	$2,500/month	Pays a benefit of (i) 1% of the Principal Sum up to the Maximum for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than five but less than 30 nights, if you suffer an Injury for which you receive a benefit under the policy and are confined to hospital as a result of such Injury, for a maximum of twelve months.
FAMILY TRANSPORATION	$15,000	Pays a benefit up to the Maximum for the expenses incurred for the transportation of an Immediate Family member to your hospital if you suffer an Injury for which you receive a benefit under the policy and as a result are confined to a hospital more than 100 kilometres from home.
REPATRIATION BENEFIT	$15,000	Pays a benefit up to the Maximum to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.
IDENTIFICATION BENEFIT	$5,000	Pays a benefit up to the Maximum for the transportation and commercial lodging of an Immediate Family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.
DAY CARE BENEFIT	$5,000/year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.
DEPENDENT CHILD EDUCATIONAL BENEFIT	$5,000/school year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the tuition costs of each Dependent Child who is enrolled as a full-time student in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.
SPOUSAL EDUCATIONAL BENEFIT	$15,000	Pays a benefit up to the Maximum for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 36 months of your death.

Benefit	Maximum	Benefit Description
FUNERAL EXPENSE	$5,000	Pays a benefit up to the Maximum to reimburse funeral expenses if you suffer a covered accidental death.
BEREAVEMENT BENEFIT	$1,000	Pays up to the Maximum if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of your loss of life.
SEAT BELT AND AIR BAG BENEFIT	$50,000	Pays a benefit of 10% of the Principal Sum up to the Maximum if you suffer a covered accidental death while operating or riding as a passenger in a Private Passenger Type Automobile in which your seatbelt was properly fastened. If the seat belt benefit is payable and you were in a seat protected by a properly functioning supplemental restraint system which inflated on impact, an additional benefit of 10% of the Principal Sum will be paid. The Seat Belt and Air Bag Benefit is payable up to the Maximum combined.
DISABILITY FITNESS BENEFIT	$5,000	Pays a benefit up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require specially designed fitness training or athletic equipment for disabled persons, which would not have been required except for such Injury. Only such expenses incurred within the first two years from the date of Injury are eligible. Only one benefit shall be payable, the largest, under the policies issued by the Company and shall not duplicate benefits payable under any other insurance.
PARENTAL CARE BENEFIT	$10,000	Pays a benefit of an additional 10% of the Principal Sum up to the Maximum for any Dependent Parents, if you suffer a covered accidental death. The benefit is payable if at the time of accident, your Dependent Parent is in a licensed nursing care facility, enrolled in a home health care program, living with you or receiving financial support and care by you. Only one Parental Care Benefit will be payable regardless of the number of eligible Dependent Parents.
CARJACKING BENEFIT	$25,000	Pays an additional benefit of 10% of the Principal Sum up the Maximum if you suffer a covered accidental Injury and the Injury which caused the Loss is a result of a Carjacking while you were operating or riding in, or getting in or out of, a Private Passenger Type Automobile.
FELONIOUS ASSAULT BENEFIT	10% of Principal Sum	Pays an additional benefit of 10% of the Principal Sum if you suffer an Injury for which you receive a benefit under the policy as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, unless such an act was committed by a fellow employee or a member of your family or household.
COSMETIC DISFIGUREMENT BENEFIT	$25,000	Pays a percentage of the Principal Sum up to the Maximum if you suffer a third degree burn by means of exposure to fire, heat, caustics, electricity or radiation. Please see the policy for details including the percentage payable.

Policy Exclusions

The policy will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by you while sane;

(b) self inflicted Injury or any attempt thereat by you while sane or insane;

(c) declared or undeclared war or any act thereof;

(d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

(f) Injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;

(h) travel or flight in or on (including getting in or out of, or on or off of) any aircraft, if you are:

  (i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

  (ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

  (iii) riding as a passenger in an aircraft owned, leased or chartered by the Policyholder;

(i) travel or flight in or on (including getting in or out of, or on or off of) any aircraft or craft designed to fly or glide above the Earth's surface:

  (i) except as a passenger on a regularly scheduled commercial airline; or

  (ii) being used for crop dusting, spraying or seeding, fire-fighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or

  (iii) operating to or from off-shore landing sites; or

  (iv) used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

(j) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

(k) Injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority;

(l) Injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;

(m) Injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;

(n) the commission or attempted commission by you or Injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

(o) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and

(p) natural causes.

Claims Process

Beneficiary Designation

You have the option to designate a beneficiary, should you choose not to, in the event of accidental Loss of Life, the benefit will be paid to the beneficiary you have designated in writing under your Employer's current group life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

How to Make a Claim

In the event of claim, claim forms can be obtained from your Employer.

Written notice of claim to the Company must be given no later than 30 days from the date of accident. Within 90 days from the date of the accident, proof of claim must be submitted to the Company. Proof may include a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed above will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and in no event later than one year from the date of the accident or the Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

Important Notes

This booklet, as may be amended, provides only a summary of the provisions for the Group Personal Accident coverage and the Additional Benefits. The full coverage details are contained in the policy including eligibility, limitations, exclusions and termination provisions. In the event of a discrepancy between this booklet and policy, the terms of the policy shall govern.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations. Possession of this booklet alone does not mean that you or your dependents are covered. The policy must be in effect and you must satisfy all the requirements.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), The Limitations Act (for actions or proceedings governed by the laws of Saskatchewan) or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Insurance is underwritten by AIG Insurance Company of Canada.

Appendix C – Out-of-Province/Canada Medical Emergency Insurance

Underwritten by AIG INSURANCE COMPANY OF CANADA

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to this benefit.

EMERGENCY OUT OF PROVINCE MEDICAL

For all in benefit Members of

Canadian Merchant Service Guild
Western Branch Benefit Plan

POLICY NUMBER
CMG 9429026

September 2022

EMERGENCY OUT-OF-PROVINCE MEDICAL COVERAGE

Each Canadian province provides a provincial medical plan with comprehensive benefits for hospital confinement, the service of medical doctors and other health practitioners, ambulance services, etc. In many cases, the benefits provided by these plans will pay all, or almost all, of the expenses you incur in your home province. (Note: In this Plan, "province" also refers to a "territory" of Canada, where applicable; "you" and "your" includes the Insured Members and their eligible dependents.)

When you are outside your province of residence and require these services, your provincial medical plan will usually make a payment towards your expenses; but that payment is usually limited to the amount that would have been paid for the same service in the province in which you reside. Unfortunately, there is often a considerable difference between the cost of these services outside your province of residence and the amount allowed by your provincial medical plan, which you would have to pay yourself were it not for this valuable benefit.

This Plan provides extensive coverage for many services rendered outside your province of residence. It is important to note that such expenses are covered provided that they were unexpected and of an emergency nature.

ELIGIBILITY

All in benefit Members and Retirees under the Canadian Merchant Service Guild Western Branch Benefit Plan and their eligible dependents whose names are on file with the Policyholder are insured under this Plan.

Class I: All eligible active Employees under age 75.
Class II: All eligible retired Employees under age 75.
Class III: All eligible active Employees ages 75 to 80.

PERIOD OF COVERAGE

You and your dependents are covered while outside your province of residence for such reasons as business or vacation. Expenses incurred by you are not covered in the event that you had left the province for the purpose of obtaining medical treatment, (except as indicated under the Referral Services benefit).

Trips are limited to a maximum of 60 consecutive days.

EMERGENCY COVERAGE FOR HOSPITAL, MEDICAL AND THERAPEUTIC SERVICES OUTSIDE PROVINCE OF RESIDENCE

When injuries or sickness result in emergency hospitalization, medical or therapeutic services, the Company will pay benefits for the period this contract is in force, not to exceed the maximum benefit amount shown below for the actual expenses incurred outside your province of residence that exceed the amount which is payable with respect to such expenses under any government hospitalization or medical care plan in your province of residence (GHIP), or if you are not covered under any such plan, to the extent that they exceed any amount which would be payable with respect to such expenses under the provincial medical plan if you were covered under any such plan.

Benefit Maximum amount reduces as follows:

Under age 70 - $5,000,000.00 lifetime maximum
Age 70 and over - $2,000,000.00 lifetime maximum

HOSPITAL CONFINEMENT

Benefits are payable for confinement as a resident in-patient in a hospital, including semi-private accommodation and charges made by the hospital for services and supplies rendered by such hospital and provided for use during such confinement.

In the event that you are confined to hospital at the end of your trip outside Canada and thus prevented from returning to Canada, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first insured expense was incurred.

MEDICAL AND THERAPEUTIC SERVICES:

Benefits are payable for:

a) the services of a legally qualified physician or surgeon (other than an insured person);

b) laboratory tests and X-ray examination by a legally qualified doctor of medicine for the purpose of diagnosis;

c) the services of a registered graduate nurse (other than a relative by blood or marriage), up to a maximum of 50 nursing shifts at the usual and customary fee, but not more than $100 per shift;

d) rental of crutches or hospital type bed, or the cost of splints, canes, slings, trusses, braces or other approved prosthetic appliances;

e) the services of a legally qualified anaesthetist;

f) drugs or medicines that require a legally qualified physician's written prescription;

g) services of a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist (other than a relative) up to a maximum of $300 per practitioner;

h) expenses for accidental injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires treatment by a legally qualified dentist or dental surgeon within 30 days from the date of the accident, not to exceed in the aggregate the amount of $2,000 as the result of any one accident;

i) expenses for the relief of dental pain, other than pain caused by an accident, initiated within 48 hours of the onset and completed no later than 90 days after initial treatment, not to exceed $500; and

j) out-patient services provided by a hospital.

AUTOMOBILE RETURN

If you become totally disabled and you are unable to continue your trip or vacation, the Company will pay the actual charges of a commercial agency for the return of your private or rental vehicle used for the trip, to your place of residence or nearest rental agency, up to a maximum of $4,000.

"Totally Disabled" means your complete inability, on medical evidence, to continue your duties or activities and to continue your trip or vacation.

REPATRIATION BENEFIT

When injuries or sickness covered by this Plan result in your loss of life in a province or country other than your place of residence and within 365 days after the date of the incident, the Company will pay the actual expense incurred for preparing your body for burial or cremation and shipment of your body to your place of residence in Canada, the amount not to exceed $15,000.

IDENTIFICATION BENEFIT

If your body requires identification following your loss of life for which a benefit is paid or payable hereunder, the Company will pay to one of your Immediate Family members, the reasonable and necessary expenses actually incurred by such Immediate Family member for:

a) commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of 3 consecutive nights); and

b) transportation by the most direct route to such location.

This benefit is payable by the Company only if the body is located outside the Immediate Family member's normal province of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.40 per kilometre travelled.

The maximum amount payable for this benefit is $5,000 per Insured Person.

TRIP INTERRUPTION BENEFIT

If your scheduled departure is delayed for at least 12 hours due to sickness or hospitalization as provided by the Plan, or due to sickness or hospitalization of your covered travelling companion, the Company will reimburse you up to a maximum of $500 for the extra cost of your one-way economy/charter air fare via the most cost-effective itinerary to your next scheduled travel destination or original departure point of the same trip.

The Company will also reimburse the additional and unplanned hotel and meal expenses, telephone calls and taxi fares up to a combined maximum of $300 per day to a maximum of 5 days.

In order to claim any of the above outlined expenses, original itemized invoices must be provided at time of claim. The combined maximum amount payable for this benefit is $2.000 per Insured Person per incident.

FAMILY TRANSPORTATION BENEFIT

If you suffer injury or sickness, resulting in being confined to a hospital located outside your province of residence, the Company shall pay the reasonable and necessary expenses actually incurred for the transportation of an Immediate Family member to the hospital.

This benefit is only payable if:

a) confinement to hospital occurs within 365 days of the sickness or the accident causing the injury; and

b) reimbursement of expenses are limited to the cost of one economy class return air fare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such immediate family member.

The maximum amount payable for this benefit for any one sickness, or for all injuries resulting from any one accident, is $15,000 and incidental travel expenses up to a maximum of $200 per day to a maximum of $800 per Insured Person.

RETURN TRANSPORTATION FOR TRAVELLING COMPANION

If you are repatriated to Canada in accordance with the Repatriation Benefit, or return to Canada in accordance with the Ground or Air Transportation benefit, the Company will pay a benefit to you (or your estate) for the extra cost of a one-way economy air fare transportation on a commercial flight or charter via the most cost effective itinerary to transport your Travel Companion to Canada.

The maximum amount payable for this benefit for any one trip is $5,000 per Insured Person for the transport of one Travel Companion.

RETURN AND ESCORT OF DEPENDENT CHILDREN UNDER AGE

If you are repatriated to Canada in accordance with the Repatriation Benefit, or return to Canada in accordance with the Ground or Air Transportation benefit, the Company will pay a benefit to you (or your estate) for the cost of a one-way economy air fare transportation on a commercial flight or charter via the most cost effective itinerary to transport your Dependent Children travelling with you on a trip to their home, plus reasonable overnight hotel accommodation and meal expenses and for the services of an attendant to escort your Dependent Children under age 16, if required.

The maximum amount payable for this benefit for any one trip is $5,000 per repatriated or returned Insured Person.

REFERRAL SERVICES

In the event you are referred to a hospital outside your province of residence as a resident in-patient, the Company will pay benefits for reasonable and customary charges for standard ward accommodation and for charges made by the hospital for services and supplies to the extent that such are medically necessary. Coverage shall also include the reasonable and customary services of a physician or legally qualified surgeon.

Prior to the commencement of any referral treatment, written pre-authorization from your provincial medical plan and the Company must be obtained. The government hospitalization or medical care plan in your province of residence (GHIP) may cover most, or all, of these costs. Any referral requires written recommendation from the physician or legally qualified surgeon stating the reason for the referral, and a letter from GHIP outlining their liability. Failure to comply in obtaining pre-authorization will result in non-payment.

The maximum amount payable for this benefit in any consecutive 12 month period is $50,000 per Insured Person.

It is understood and agreed that expenses incurred under the Referral Services provision are not due to an emergency. It is further understood and agreed that exclusion h) is not in effect for expenses incurred under the Referral Services provision.

EMERGENCY TRAVEL ASSISTANCE OFFERS THE FOLLOWING FEATURES:

Travel assistance is provided by Global Excel Management Inc. With centres worldwide they will:

- help locate the most appropriate medical facility for you;
- confirm coverage with AIG Insurance Company of Canada and assure the hospital that you are covered;
- guarantee payment for hospitalization, if necessary;
- arrange for admission to a hospital;
- provide translation services;
- contact your own doctor for recommendations, when required;
- contact your family and employer, when required;
- arrange for/co-ordinate emergency medical evacuation; and
- co-ordinate your return home.

HOW TO CLAIM

If you require emergency medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately. If circumstances prevent you from calling Global Excel Management Inc. right away, you should contact them as soon as you can. Global Excel Management Inc. will help ensure that you receive the medical care you need and, if possible, will make claims payment arrangements directly with the hospital or service provider.

If you contact GLOBAL EXCEL MANAGEMENT INC. right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

If you are not able to contact Global Excel Management Inc. before being billed for the charges, or if your medical needs are minor in nature (i.e., costing less than $500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip. In any case, your claim should be submitted no later than 90 days after the expense was incurred. Global Excel Management Inc. and the insurance company are not responsible for dealing with any payment reminders or collection notices that you receive from medical providers.

To make a claim for out-of-pocket expenses, contact a Global Excel Management Inc. operator at:

From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

Give the operator your name and your Policy Number: CMG 9429026.

The operator will send you a claim form. When you complete the form, provide the patient's name and provincial health plan number and your certificate number. Be sure to attach detailed statements and original receipts showing the services rendered and the charges for each service.

Mail your completed claim form and attachments to:

Global Excel Management Inc.
73 Queen Street
Lennoxville, QC, J1M 1J3

Please make sure you obtain your medical records, statements or detailed receipts at the time of treatment and/or discharge, to submit with your claim. All claims must be submitted to Global Excel Management Inc. as soon as possible, and no later than 90 days after the expense was incurred.

COORDINATION OF BENEFITS

Global Excel Management Inc. will co-ordinate coverages with other policies according to the CLHIA's Coordinating Coverage Guidelines for Out-of- Country/Province Health Care Expenses. The total amount payable from all sources may not exceed the expenses you incurred.

IN AN EMERGENCY, HERE'S WHAT TO DO

Call Global Excel Management Inc. immediately in the event of a serious medical emergency.

Their operators are backed by a team of emergency care professionals - physicians and nurses who work closely with the doctor looking after you, and if necessary, your family or company doctor, to help ensure that you receive the medical care you need.

An operator will ask you the following:

Your name, location and the details or your emergency.
Your Policy Number: CMG 9429026
Service Support Telephone Numbers:

Telephone:
From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

GROUND TRANSPORTATION

The use of a licensed ground ambulance to a maximum of $5,000 any one accident or sickness.

AIR TRANSPORTATION

a) If an injury or sickness commencing during the course of your trip results in a medically necessary Air Transportation, the Company will pay benefits for covered expenses up to a maximum of $500,000. An Air Transportation must first be approved by the Company and it must be ordered by a legally licensed physician or surgeon who certifies that the severity of your injury or sickness warrants your Air Transportation and that such is medically necessary.

b) If, due to the geographical area at the onset of your medical emergency an air ambulance is deemed necessary, the Company will pay the cost of a licensed air ambulance for your transport to the nearest hospital or medical facility where appropriate medical treatment can be obtained.

Air Transportation means:

a) your medical condition warrants immediate transportation from the place where you suffered the injury or sickness to the nearest hospital where appropriate medical treatment can be obtained; or

b) after being treated at a local hospital, your medical condition warrants transportation to the place where you reside (provided such residence is located in Canada) to obtain further medical treatment or to recover; or

c) both **a)** and **b)** above.

Covered expenses are only those reasonable and customary expenses, up to the maximum, for transportation, medical services and medical supplies which are medically necessary and incurred in connection with your Air Transportation. All transportation arrangements made for transporting you must be by the most direct and economical route. Expenses for special transportation must be recommended by the attending physician or surgeon or required by the standard regulations of the conveyance transporting you.

Expenses for medical supplies and services must be recommended by the attending physician or surgeon. Air Transportation means any land, water or air conveyance required in connection to transport you during an Air Transportation. Special Transportation includes, but is not limited to, air ambulance, land ambulances, commercial airlines and private motor vehicles.

Charges for use of a local ambulance and/or the use of a scheduled air carrier on physician's advice, up to the cost of a one-way economy air fare for you and $250 for incidental travel expenses; if return by stretcher is required, the cost of such additional economy class seating as is necessary; if a medical attendant is required to accompany you, the Company will pay the fee of such attendant plus one return economy air fare and reasonable incidental travel expenses.

EXCLUSIONS AND LIMITATIONS

Benefits are not payable for:

a) injuries received while you are participating in any maneuvers or training exercises of the armed forces;

b) pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of a pregnancy, complications which occur before the end of the seventh month will be covered if they occur while insured hereunder;

c) sickness or injury where the trip is undertaken for the purpose of securing medical treatment or advice for such sickness or injury;

d) dental surgery or cosmetic surgery unless such surgery is a result of a covered injury;

e) emotional or mental disorders unless you are hospitalized;

f) sickness or injury due to participation in professional sports;

g) treatment or services that contravene any government hospital or medical plan in Canada;

h) expenses incurred on an elective (non-emergency) basis;

i) loss or injury as a result of suicide or any attempt thereat or self-inflicted injuries while sane or insane;

j) an act of declared or undeclared war, civil war, rebellion, revolution; insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority;

k) any services or supplies provided by an Insured Person;

l) any treatment or surgery not required for the immediate relief of acute pain or suffering;

m) any treatment or surgery which reasonably could be delayed until you return to your province of residence; and

n) anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to you prior to departure.

o) a medical condition that had deteriorated, or had to be treated or investigated in the three (3) months immediately preceding the Insured Person's departure from Canada. Applicable to Class III only.

All expenses must be incurred on a non-elective emergency basis and are in excess of any individual, group or provincial medical plan.

EXTENDED COVERAGE AFTER TERMINATION

In the event of the delayed arrival of your common carrier hospitalization this Plan will automatically be extended at no charge:

1) 24 hours in the event of a delayed common carrier;
2) the period of hospitalization plus 24 hours after you are released from hospital.

TERMINATION OF COVERAGE

Coverage will terminate on the earliest of:

1) the date you cease to meet the eligibility requirements of the Plan;
2) the date any required premium is unpaid; or
3) the date the Master Policy terminates or in accordance with any other terms and conditions stated in the Master Policy.

WHAT TO DO IN A MEDICAL EMERGENCY

You or someone acting on your behalf should call Global Excel Management Inc. immediately, before you get medical assistance. If you can't call right away, contact Global Excel Management Inc. as soon as you are able to do so.

Call:

U.S. & Canada 1-877-207-5018
Outside U.S. & Canada 1-819-566-3940 collect

The operator will ask you for:

Your name, location and the details of your emergency
Your Policy Number: CMG 9429026

The operators are backed by a team of emergency care professionals - physicians and nurses who work closely with the doctor looking after you, and if necessary, your family or company doctor, to help ensure that you receive the medical care you need.

This brochure has been prepared to help you understand your coverage and, as such, does not create or confer any contractual or other rights. The terms and conditions governing the insurance are set out in the group Master Policy issued by AIG Insurance Company of Canada. In the event of any variation between information in this brochure and the provisions of the policy, the latter will prevail.

AIG