BCTC

BENEFITS PACKAGE

FOR COPE 378 MEMBERS

2006

(BCTC IBEW/OPEIU BOOKLET)

INTRODUCTION

This information booklet has been prepared to give you an informal summary of the main features of your group coverage program.

This booklet is not an insurance policy, and does not grant or confer any contractual rights. All rights under this program shall be governed by the provisions of the Master Contract and by applicable law.

This booklet is for your reference. Please read it carefully and keep it for future use.

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British Columbia Transmission Corporation

Plan Effective Date: October 1, 2003

ELIGIBILITY

You are eligible for coverage if you are covered under a provincial health insurance plan, you are registered for Fair Pharmacare, and you are:

- a full-time regular employee;
- a part-time regular employee; or
- a full-time temporary OPEIU employee.

Waiting Period

- Extended Health Care coverage commences on the date employment commences for all full-time and part-time regular employees, and all eligible full-time temporary employees.
- Dental coverage will commence on the date employment commences for all full-time and part-time regular employees. Temporary OPEIU employees will become eligible after completion of 12 months of employment.

Changing Your Records

To ensure that coverage is kept up to date for yourself and your dependents, it is vital that you advise your Benefits Administrator within 31 days of any changes such as a change of name, change in marital status or dependents, or loss of spousal benefit coverage.

Please refer to the General Provisions section in the back of this booklet for further information, including:

WHEN YOUR COVERAGE STARTS;
WHEN YOUR COVERAGE TERMINATES; and
HOW TO CLAIM.

EXTENDED HEALTH CARE

Features	LEVEL 1	LEVEL 2	LEVEL 3
Annual Deductible (per family) *	$100	None	None
Reimbursement of Eligible Expenses:			
Hospital (semi-private or private)	80% **	100%	100%
Drugs	80%**	100%	100%
Vision Care	80%**	100%	100%
Paramedicals ***	80%**	100%	100%
Supplies: Hearing Aids Orthotics	80%*	100%	100%
Out-of-Province: Hospital/Physician's charges/Lab & X-ray	100%	100%	100%
Other eligible expenses	80%**	100%	100%
Remote Area Medical Travel	100%	100%	100%
Drugs	Managed Formulary	Managed Formulary	Managed Formulary
Vision Care *Employee & Spouse*	n/a	$250 every 24 months	$300 every 24 months
Dependent children	$100 every 12 months	$100 every 12 months	$200 every 12 months
Lifetime Maximum	$100,000	$500,000	Unlimited

* The Annual Deductible (Level 1) does not apply to Remote Area Medical Travel expenses.

** After $1,000 has been paid for an individual in a calendar year, further eligible expenses incurred in that year for that individual will be reimbursed at 100%.

*** Psychologists are covered under Level 3 only.

DENTAL EXPENSE

Features	**LEVEL 1**	**LEVEL 2**	**LEVEL 3**
Deductible	None	None	None
Basic Services Major Services Orthodontics	90% n/a n/a	95% 65% 50%	100% 80% 50%
Basic & Major Yearly Maximum	Unlimited	Unlimited	Unlimited
Orthodontic Maximum	n/a	$2,500 lifetime	$3,000 lifetime

CONSIDERATION IN CHOOSING YOUR OPTIONS

When making your choice selection, you should consider:

1) Your present and anticipated usage of covered expenses, such as prescription drugs, paramedical practitioners (i.e., chiropractor, physiotherapist, etc.) and dental expenses.

2) The coverage available under your provincial health care plan or through your spouse's employer.

3) If you and your spouse both work for BCTC, you may not cover an OPEIU or IBEW or M&P spouse as a dependent for extended health care if that spouse is also covered as a member in an extended health care group under BCTC.

4) If you and your spouse both work for BCTC, you may both apply for duplicate dental coverage.

5) Duplicate coverage for extended health care and dental coverage is permitted if your spouse is not an employee of BCTC.

EXTENDED HEALTH CARE

In the event you incur in a calendar year any of the Eligible Expenses listed below, you will be paid a percentage of such expenses in excess of the Deductible for that year, as outlined in the Benefit Selection.

Deductible

The Deductible is that portion of the Eligible Expenses which you are required to pay in any year before you receive benefits. The Deductible is specified in the Benefit Selection.

If in any calendar year the eligible expenses incurred do not exceed the deductible, any portion incurred during the last three months of that calendar year may be applied to the deductible for the next calendar year.

Lifetime Maximum Benefit

The total lifetime benefit payable in respect of you or your dependents is limited to the Lifetime Maximum Benefit specified in the Benefit Selection.

Eligible Expenses

Preferred Accommodation in Canadian Hospitals

The difference between the charges made for ward and semi-private or private room and board in a licensed Canadian hospital or an extended care unit of a hospital, including the coinsurance charge of the extended care unit.

Drug Expenses - Managed Health Care

Reasonable and customary charges incurred for medically necessary drugs and medicines which:

1) are dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines, and prescribed by a physician for the treatment of an illness or injury;

2) are based on the provincial formulary. The provincial formulary is a defined list of the most cost-effective, medically accepted medicines in each therapeutic drug class; or

3) when dispensed by a pharmacist or physician, include insulin preparations and supplies, oral contraceptives, smoking cessation aids (maximum of $150 per calendar year), fertility drugs, vitamins, Vitamin B12 for treatment of pernicious anemia, and allergy serums when administered by a physician.

No benefit shall be payable for:

1) drugs which do not appear on the formulary list, with the exception of those drugs identified in 3) above unless the delisted drug has no lower cost generic equivalent or you received reimbursement for the brand name drug or medicine under this plan during the last 24 month period;

2) brand name drugs if a lower priced generic equivalent is also listed on the formulary; or

3) any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

Out of Province Emergency Expenses

Note:

- Only covered individuals under age 65 are eligible for emergency expenses outside Canada.
- Coverage is limited to the first 180 days of travel outside Canada.
- Students attending school outside Canada are covered for 365 days.

If, while travelling outside your province of residence, hospitalization or medical treatment is required due to emergency and nonelective reasons, the following expenses in excess of any provincial government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by any provincial government plan:

1. Reasonable and customary charges for semi-private or private accommodation within Canada and semi-private accommodation outside Canada.

2. Reasonable and customary charges for the services of a physician.

3. Reasonable and customary charges for hospital services and supplies furnished during hospitalization, and for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

4. Ambulance and prescription drugs in sufficient quantity to alleviate an acute medical condition.

Note:

1. If you should require medical treatment while travelling, contact World Access as soon as possible, so they can ensure that you get the care you need without incurring unnecessary expenses (if possible, before seeking treatment).

2. Hospital charges will continue to be covered where transportation would endanger the health of the patient. When the patient's condition has stabilized, and with the approval of the attending physician, the patient will be moved by licensed ambulance which is equipped and has space available to provide further medical treatment.

Out of Province Non-Emergency Expenses

Non-emergency eligible expenses incurred while travelling outside your province of residence will be eligible for reimbursement as if these expenses were incurred in the province of residence, subject to the deductible, in-province reimbursement percentage and maximums. There will be no reimbursement for any expenses payable or provided under any provincial government plan.

Travel Assistance Services:

The following benefits are covered in the event of an emergency which occurs while you or your dependents are travelling for non-medical reasons outside your province of residence:

- Multilingual assistance by toll-free telephone, 24 hours a day, 365 days a year, for covered individuals and providers of medical services to obtain aid and assistance.
- Referral to a legally qualified physician, dentist, legal advisor or an appropriate medical care facility.
- Assistance in arranging a cash advance from credit cards or family and friends to post bail and pay legal fees.
- Assistance in replacement (but not cost) of necessary travel documents or tickets in the event of theft or loss.
- Multilingual telephone interpretation services in the event of an emergency.

- A centre for communication of messages between you and your family, friends or business associates. Messages are held for 15 days.

- Medical consultation and monitoring of medical care and services if you or your dependents are hospitalized, and arrangement for contact with the patient, the attending physician and the patient's personal physician and family if necessary.

- **Emergency transportation**: Emergency transportation to the nearest appropriate medical care facility and if medically necessary from the medical care facility to a hospital in Canada. Upon written recommendation of a physician, such charges shall include a medical attendant if necessary who is neither a resident in the employee's home nor a relative of the employee or the employee's spouse.

- **Return of Deceased**: Charges incurred for the return of a deceased employee or dependent to the place of former residence in Canada, subject to a maximum benefit of $5,000 per individual.

- * **Return of Dependent Children**: Charges incurred for the return of dependent children to their residence in Canada in the event you or your spouse is hospitalized and the children are left unattended. The children must be under 16 years of age. Arrangements for an escort to accompany the children will be made if necessary.

- * **Return Trip Delay**: Transportation - Charges incurred for delay of the return trip of a covered individual due to the hospitalization of that individual or another covered individual with whom the individual is travelling, limited to the cost of one way economy class transportation.

- * **Visit of Family Member**: Charges incurred for transportation of an immediate family member to visit a hospitalized covered individual. Such individual must have been travelling alone and confined to a hospital for more than 7 days. The cost of transportation is limited to return economy fare for one family member. An immediate family member is defined as a spouse, parent, child, brother or sister or a person with whom the covered individual normally resides.

  * ***The above charges are subject to a combined maximum benefit of $5,000 per emergency.***

- **Return of Vehicle**: Charges incurred in connection with the return of a covered individual's vehicle in the event the covered individual is unable to return it due to illness, injury or death, subject to a maximum benefit of $500 per trip. The vehicle will be returned to the covered individual's residence or nearest appropriate rental agency. Such charges shall not include commercial transport vehicles.

- **Return Trip Delay**: Accommodation - Charges incurred for commercial accommodation and meals for covered individuals while staying with a hospitalized covered family member when their return trip is delayed due to an illness or accident. Such charges are subject to a maximum benefit of $700 per family.

- **Convalescent Benefit**: Charges incurred for accommodation for covered individuals requiring convalescence following hospitalization, subject to a maximum benefit of $75 per day for not more than 5 days for each covered individual.

Extended Health Expenses

Paramedical Services

Charges, when not covered under any provincial plan allowance, for treatment (excluding x-rays) by a certified, registered or licensed practitioner up to the maximum amounts indicated per calendar year.

a) Speech Therapist (for dependent children up to age 16) $500
b) Acupuncturist $500
c) Massage Therapist .... no calendar year maximum
d) Physiotherapist .... no calendar year maximum
e) Chiropractor $500
f) Naturopath $500
g) Podiatrist $500
h) Licensed & Registered Psychologist ***(Level 3 only)*** $500

Note: For Chiropractors, Massage Therapists, Naturopaths, Physiotherapists and Podiatrists, there will be a per visit fee maximum of:

- $10 per visit for the first 12 visits (if under age 65); and
- $10 per visit for the first 15 visits (if age 65 and over).

Private Duty Nursing

Reasonable and customary charges for the medical services (excluding custodial care, psychological or personal counselling) of a Registered Nurse (R.N.), which are rendered in the hospital or in the home, provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and if medically necessary to treat an acute condition which results from a sudden occurrence with severe symptoms and lasts less than 60 consecutive days from the date of diagnosis by a Physician. Conditions due mainly to chronic illness or infirmity or palliative care are not covered.

Ambulance *(in province)*

Charges for professional ambulance service, other than airline, to and from the nearest hospital qualified to provide the necessary treatment.

Emergency transportation (except while travelling outside your province of residence) by airline to and from the nearest hospital qualified to provide the necessary treatment is covered when time is critical and the patient's physical condition prevents the use of another means of transport. Such emergency transportation is also provided for an attendant, if medically required, who is neither a resident in your home nor a relative of your family.

Accidental Dental

Charges for necessary dental treatment required as the result of an accidental injury to natural teeth provided the accident occurred while covered under this plan. As determined by Maritime Life, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within 12 months of the accident to be considered a covered medical expense.

Hearing Aids

Charges for purchase and repair of hearing aids (excluding batteries, recharging devices or other such accessories), subject to a maximum benefit of $400 per person in any 5 calendar years. Replacements will only be covered when the existing hearing aid cannot be repaired satisfactorily.

Medical Examinations

Charges for medical examinations, *for employees only,* when required by government regulations for employment purposes.

Durable Medical Equipment

Charges for rental (or purchase, if unavailable on a rental basis or required for a long term disability and as pre-approved by Maritime Life) of durable medical or surgical equipment required for therapeutic purposes and as approved by Maritime Life, for use in the home but designed primarily for use in a hospital:

1) Preauthorization is required for expenses in excess of $5,000.

2) When rented from a medical supplier, charges for standard durable medical equipment are covered. If unavailable on a rental basis or required for a long term disability, purchase of these items may be considered at the discretion of Maritime Life. Reimbursement on rental equipment is paid monthly but will in no event exceed the purchase price of the equipment.

3) Maritime Life may request trade-in or return of replaced equipment. Repairs to purchased items are covered. Replacement is covered only when the item can no longer be made functional.

4) Electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating the manual equivalent, otherwise the manual equivalent will be paid.

5) Medical monitors including heart and blood glucose monitors, and cardiac screeners.

6) Bio-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems.

7) Breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators.

8) Insulin infusion pumps for diabetics – when basic methods are not feasible.

9) Transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain.

10) Transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

Medical Supplies

Charges for purchase (or rental where indicated*) of the following items:

- testing supplies, needles, and syringes for diabetics;
- oxygen, blood, and blood plasma;
- ostomy and ileostomy supplies;
- elastic support stockings;
- synovial fluid injections when administered by a Physician;
- walkers*, canes* and cane tips, crutches*, splints, casts, collars, and trusses, but not elastic or foam supports;
- rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectric limbs are excluded, but the equivalent cost of a standard prosthesis will be paid;
- wigs or hairpieces required as a result of hair loss sustained in a cancer treatment program to a maximum of $500 in a 12 month period; or
- charges for the following items to the maximum amounts indicated per calendar year:
  a) $150 for mastectomy brassieres; and
  b) $200 for stump socks.

Orthopedic Shoes & Orthotics

Charges for orthopedic shoes and orthotics which have been specially designed and molded for the covered individual and are prescribed by a physician or podiatrist to correct a diagnosed physical impairment. Expenses are subject to:

- one pair of custom fitted orthopedic shoes, foot orthotics or arch supports;
- repairs to custom fitted orthopedic shoes; or
- modifications to stock item footwear.

Replacement will be covered only when due to a change in prescription or normal wear and tear (but not more than once in a calendar year).

Vision Care Expenses

Lenses and frames for eyeglasses or contact lenses are subject to the maximum benefit specified in Level 1, Level 2 and Level 3 in the Benefit Selection. Repair to eyewear is covered. Non-prescription eyewear is not covered.

In-Province Medical Travel Benefit

Medical Travel for Remote Areas

If you select Level 3 coverage or live in a remote area (Atlin, Bella Coola, Burns Lake, Chetwynd, Clowhorn, Dawson Creek, Dease Lake, Duncan Dam, Falls River, Fort Nelson, Fort St. James, Fort St. John, Fraser Lake, Hazelton, Houston, Hudson's Hope, Kitimat, McBride, McKenzie, Masset, Mica Creek, Pemberton, Prince Rupert, Queen Charlotte City, Sandspit, Shalath, Smithers, Stewart, Terrace, Tofino, Valemont and Vanderhoof), you are eligible for the following coverage.

Note: Remote area medical travel under this section is not subject to any deductible or lifetime maximum specified in the Benefit Selection.

When ordered by your attending Physician, Dentist or Oral Surgeon because adequate medical or dental treatment is not available locally, the following are included as eligible expenses:

- Transportation to and from the nearest locale within British Columbia or Alberta equipped to provide the required treatment:

  1) Transportation for a patient by: automobile (to a maximum of $0.30 per kilometer), scheduled air, rail, bus or boat (ferry).

  2) Transportation of an attendant as follows:

     - if the patient is the employee or spouse – one medical attendant; or

     - if the patient is a dependent child – one medical attendant or one parent.

  Where transportation has been provided by automobile, gasoline receipts are not required.

- Accommodation: Where transportation has been provided under the remote area medical travel, accommodation in a commercial facility, Easter Seal House, Heather House, Vancouver Lodge, Ronald McDonald House, or similar institution approved by your employer, for the patient and attendant, before and after medical and dental treatment, to a combined maximum of $50 per day for a total of 7 days.

Conditions:

1) Transportation must take place within 2 months of the Physician's or Dentist's referral.
2) Each claim form must be pre-authorized by your employer.

Medical Travel for Cancer Treatment

If you do not live in one of the aforementioned remote areas, you are eligible for transportation charges, for the patient only, to and from the nearest cancer clinic within British Columbia or Alberta equipped to provide the required treatment.

Transportation shall be by automobile (to a maximum of $0.30 per kilometer), schedule air, rail, bus or boat (ferry).

Where transportation has been provided by automobile, the mileage allowance applies when the round trip (from your city of residence) exceeds 300 kilometres. Gasoline receipts are not required.

Reimbursement will be in accordance with the deductible and level of co-insurance for the benefit level selected.

Exclusions

The foregoing list of eligible expenses shall not include any of the following:

- charges which are considered a covered service of any provincial government plan;
- charges for general health examinations, and examinations required for use of third party;
- charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
- charges for medical treatment or surgical procedure by a physician other than as provided under Out of Province Expenses;
- charges for transport or travel, other than as specifically provided under eligible expenses;
- charges not specified in the foregoing list of eligible medical expenses;
- charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his license;
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;
- charges which are from an occupational injury or disease covered by any Workers' Compensation law or similar legislation;

- charges which would not normally have been incurred but for the presence of this coverage or for which you are not legally obligated to pay;
- charges which Maritime Life is not permitted, by any law or regulation, to cover;
- charges for dental work where a third party is responsible for payment for such charges;
- charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
- charges for services or supplies resulting from any intentionally self-inflicted wound;
- charges for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare - Canada or are experimental or limited in use whether or not so approved;
- charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
- charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies; and
- expenses incurred outside your province of residence due to therapeutic abortion, childbirth or complications of pregnancy occurring within 2 months of the expected delivery date.

DENTAL EXPENSE BENEFIT

As the wording of this dental coverage is technically oriented Maritime Life suggests you take this booklet with you when you visit your dentist.

In the event you incur any of the eligible expenses listed below, you will be paid a percentage of such expenses as outlined in the Benefit Selection.

Maximum Benefit

The total benefits payable are subject to the maximums specified in the Benefit Selection.

Extension of Benefits

Eligible expenses for endodontic treatment, dentures or crown and bridgework that commenced prior to the termination date of your coverage will be considered work in progress and will be reviewed for payment if completed within 30 days of your date of termination. Filing of treatment forms will not constitute acceptance as work in progress.

Dental Claim Form Required

Paper claims must be submitted to Maritime Life's claim office, on a form satisfactory to Maritime Life. Your dentist can also submit claims electronically to Maritime Life via Electronic Data Input (EDI).

Alternate Benefit

Where there are two or more courses of treatment available to adequately correct a dental condition, Maritime Life will determine reimbursement based on the least expensive treatment.

Submission of Treatment Plan

As a service to you, Maritime Life will advise you in advance of the amount of its liability when a proposed course of treatment includes major restorative dentistry or orthodontics. To use this service, simply have your dentist complete a treatment plan, including pretreatment x-rays if the proposed treatment involves crowns or bridgework.

Fee Schedule

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the Fee Guide for General Practitioners or Specialists in effect in the province where you receive treatment on the date the expense is incurred. If no specialist's guide exists, fees will be based on the General Practitioner's fee guide plus 10%.

BASIC SERVICES

Diagnostics & Preventive Therapy

Procedures required to assist the dentist in evaluating existing conditions and eliminate or reduce the need for future dental treatment:

- diagnostic services include standard recall examinations, specific oral examinations and x-rays; and
- preventive services include polishing, topical fluoride, scaling and passive space maintainers (those that do not move the teeth).

Note: The following limits will apply:

- recall examinations: two exams in any calendar year;
- x-rays: complete series or equivalent in a 3 year period;
- topical fluoride & polishing: twice in any calendar year; and
- scaling and/or root planing: 16 units in any calendar year.

(One unit of time = 15 minutes)

Basic Restorative Dentistry

The basic procedures used to restore the natural teeth to their normal functions by the use of:

- silver fillings;
- amalgam fillings;
- composite (white) fillings on anterior and bicuspid teeth only (white fillings on molar teeth will be reimbursed based on the cost of amalgam fillings);
- stainless steel crowns; or
- inlays and onlays limited to one per tooth in a 5 year period.

Extractions and Oral Surgery

- uncomplicated removal of teeth; or
- routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.

Endodontics

- endodontic procedures and root canal therapy.

Periodontics

- adjunctive services as follows: acute infections, occlusal adjustment, provisional splinting;
- surgical services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery; and
- special periodontal appliances.

Anaesthesia

- anaesthesia where reasonably and customarily required in connection with other covered procedures.

Prosthetic Repairs

- repair or relining and rebasing of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication;
- removal, repairs and recementation of bridgework; or
- tissue conditioning.

MAJOR SERVICES

Only one major restorative service involving the same tooth will be covered in a 5 year period.

Extensive Restorative Dentistry

Those procedures, including crowns and veneers, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive decay or fracture, cannot be restored with a filling. When a tooth can be restored with amalgam or composite restorations, benefits will be determined based on the usual costs of such a restoration.

Dentures and Fixed Bridgework:

- initial installation of partial dentures, full dentures or fixed bridgework;
- inlays or onlays involved in bridgework; or
- replacement of an existing denture or bridge.

Note: Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

ORTHODONTICS

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of the teeth". These include active space retainers, or orthodontic appliances, for the purpose of repositioning or moving of the teeth. No benefit is payable for replacement of appliances which are lost or stolen.

To claim orthodontic benefits, a treatment plan must be submitted before treatment starts and photocopies of receipts monthly, as treatment progresses.

Benefits will be paid on a monthly basis, (prorated over the course of the treatment if the patient pays the full amount to the dentist in advance of completed treatment).

Exclusions

No benefit is payable for the following:

- services or supplies that are primarily for cosmetic dentistry;
- services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
- any charge for an injury resulting from war, riot, insurrection, participation in a criminal act or hostilities of any kind;
- any miscellaneous charges such as counseling; oral hygiene or nutritional instruction, travel, broken appointments, communication costs, filling in of forms, written reports or charges for translating documents into English;
- any charge resulting from any intentionally self-inflicted injury;
- any services covered in whole or in part by any government plan, services for which no charge is made, or services which Maritime Life is not permitted by law to cover;
- any charge for services which would not normally have been incurred, but for the presence of this coverage, or for which you are not required to pay;
- any hospital charges for board and room and related services and supplies;
- any dental examinations required by a third party;
- services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease;
- diagnostic procedures in connection with any benefit categories excluded as eligible expenses; and
- services or supplies for implantology.

GENERAL PROVISIONS

WHEN YOUR COVERAGE STARTS

Your coverage comes into effect on your eligibility date if you are actively at work on that date. If you are not actively at work on your coverage effective date, your effective date will be delayed until you return to active employment.

WHEN YOUR COVERAGE TERMINATES

Your coverage terminates in the event of:

- non-payment of premium;
- a change in your classification to one not covered;
- termination or amendment of the Plan;
- your commencing active duty in any armed forces;
- the date a covered individual attains age 65 with respect to emergency outside Canada expenses; or
- for all other eligible expenses, the last day of the month in which your employment terminates or you retire, whichever is earlier.

Note: In the event you are absent from work due to sickness, injury, layoff or leave of absence, your coverage may continue for a period as determined by your Employer.

Leave of absence is defined as a period of time away from work mutually agreed to by you and your Employer. In the case of maternity leave of absence, the leave shall begin and finish on dates agreed to by you and your Employer or as required by Provincial or Federal Law.

COORDINATION OF BENEFITS

Payment of extended health care, emergency travel assistance and dental benefits shall be coordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, Maritime Life has a right to receive and release information on benefits and if necessary, collect any overpayments made by it. Benefit payments will be determined as follows:

1) The plan which does not contain a Coordination of Benefits provision will pay before the plan which does.

2) Where both plans contain a Coordination of Benefits provision, priority is given as follows:

   a) The plan where the person is covered as an employee.
   b) The plan where the person is covered as a dependent spouse.
   c) The plan where the person is covered as a dependent child.

3) Where a dependent child is under two or more plans, priority is given as follows:

   a) The plan of the parent with the earlier date of birth (month/day) in the calendar year.
   b) The plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same date of birth.

   The following order of benefit payment will apply if the parents are separated or divorced:

   a) The plan of the parent with custody of the child.
   b) The plan of the spouse of the parent with custody of the child.
   c) The plan of the parent not having custody of the child.
   d) The plan of the spouse of the parent in (c) above.

ELIGIBLE DEPENDENTS

Eligible dependents under this plan shall include:

- Unmarried children who are dependent on you for support and not employed at a regular, full-time job, and are:

  1) under age 21;

  2) students to any age if attending an accredited school, college, or university on a full time basis (i.e., minimum 10 classroom hours per week);

  3) functionally impaired children to any age (For the purposes of this plan, functionally impaired shall mean an unmarried person who was covered as a dependent prior to becoming functionally impaired, or was born physically or mentally disabled); or

  4) an eligible dependent child of your spouse provided:
     i) he/she is also your biological child; or
     ii) your spouse is living with you and has custody of the child.

- Your spouse as the result of a valid civil or religious ceremony, or a person whose relationship with you has existed for a minimum period of 12 consecutive months immediately prior to the date on which a claim arose. A common-law relationship must include continuous cohabitation and public representation of married status.

  Divorced spouses (with or without a court order or separation agreement) are not eligible for coverage as a dependent.

CHANGE IN GOVERNMENT SPONSORED PROGRAMS

The medical, dental and hospital benefits under this group plan are provided in conjunction with government sponsored provincial programs. In the event coverage under any provincial program is modified, suspended or discontinued, the group plan will not automatically assume responsibility for any services or products previously covered under the provincial programs.

MEDICAL INFORMATION BUREAU (MIB)

MIB Group, Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Maritime Life may periodically report information to the MIB. If you apply to receive health insurance coverage from another MIB member company or submit a claim for benefits for such a company, the MIB upon request will supply the other insurer with the information on file.

Maritime Life may also release information in its file to other health insurance companies to whom you may submit a claim for benefits. All information obtained will be treated as confidential.

Upon request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek a correction. Their address is:
MIB, 330 University Ave, Suite 501, Toronto, Ontario, M5G 1R7.
Telephone: (416) 597-0590.

HOW TO CLAIM

In order to quickly process a claim, the following information is required:

- your full name and address;
- the name of your Employer;
- your Certificate (Identification) Number;
- your Provincial Medical Insurance Plan Number (Emergency Travel Assistance coverage only); and
- your Group Plan Number:
  903135 for Extended Health Care; and
  903235 for Dental Expense.

For Emergency Travel Assistance claims
Dial the number on the back of your identification card and you will be connected with the World Access Operation Centre. Be sure to carry your identification card (supplied by your employer) with you when you travel. The card contains the information you are required to give to World Access in the event you need assistance.

If your claim is for payment of $200 or less, you will be asked to make the payment and keep the receipts. Your provincial health plan and Maritime Life will reimburse you for the eligible expenses upon your return.

For Drug claims
The pay-direct drug card program provides on-the-spot processing of your prescription drug claims. Your pharmacist sends your claim electronically to Maritime Life's service provider, ESI Canada, and immediately receives a message back advising how much of your drug purchase is covered. This means, in most cases, there are no claim forms for you to complete, and you will only have to pay the pharmacist for the portion of your purchase that your plan does not cover.

The **Maritime*Script*** drug card must be presented each time a claim is made at any pharmacy in Canada. The card is not eligible outside Canada and, if any drugs are required while outside Canada, or for any reason if there is a problem using the card at any pharmacy within Canada, those drugs should be purchased. To arrange for payment for an eligible expense under this Plan, please contact Maritime Life. The card is valuable and should be protected like a credit card. If it is lost or stolen you should report the fact to your Benefits Administrator.

For all other claims:
Contact your Benefits Administrator who will supply you with the proper forms with instructions for completion.

TIME LIMITATIONS

Extended Health Care:

We suggest you submit your claims within 90 days from the date the expense was incurred. However, you must submit the claim form by December 31st of the year following the calendar year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances. For example, Maritime Life must receive your receipts for 2003 before December 31, 2004.

Dental:

We suggest you submit your claims within 90 days of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will Maritime Life pay any claim or adjustment submitted later than one year from the date the service is performed.