CANADIAN MERCHANT SERVICE GUILD

WESTERN BRANCH BENEFITS PLAN

Effective: February 2017

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TO: MEMBERS OF THE CANADIAN MERCHANT SERVICE GUILD (CMSG) WESTERN BRANCH BENEFIT PLAN

Dear Member:

We are pleased to provide you with this booklet that outlines the group benefits available to you and your family as a member of the Canadian Merchant Service Guild. The booklet provides you with an outline of the coverage and benefits as well as various other aspects of the plan such as administrative and claims procedures.

We encourage you to read the booklet carefully and familiarize yourself with the benefits. Any questions regarding the benefits, administration or claims should be directed to your plan administrator:

Plan administrator
Coughlin & Associates Ltd.

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

Telephone: 613-231-2266
Fax: 613-231-2345
Toll Free: 1-888-613-1234
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211-3823 Henning Drive
Burnaby, BC V5C 6P3

604-298-7752, Ext. 113
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don@icbabenefits.ca

Fraternally yours,

The Trustees

IMPORTANT

This document contains important information concerning your group coverage and therefore should be kept in a safe place. It supersedes and replaces all previous communication material.

The extended health care and dental benefits are underwritten on a self-insured basis where all risks are carried by the Canadian Merchant Service Guild Western Branch benefit plan. Standard Life's services for the weekly indemnity benefit are provided on an administrative basis only. Standard Life underwrites and insures the life and long-term disability benefits. The accidental death and dismemberment benefit is underwritten and insured by the ACE INA Life Insurance Company while the out-of-country policy was issued by the Group Explorer Medical Emergency Insurance (Global Excel).

This information summarizes the benefits and provisions of your group plan. It does not constitute the group contracts, nor does it create or confer any contractual or other rights. Every effort has been made to ensure that the information is accurate. However, if there is any question of interpretation, all rights with respect to a covered person will be governed solely by the group contracts issued by the respective insurance companies to the Canadian Merchant Service Guild.

CHANGE OF ADDRESS:

This booklet has been sent to every member for whom a current address is available. It is important to inform the plan administrator and the Guild of any address changes.

PROTECTING YOUR PERSONAL INFORMATION

The administrator of your group benefit plans 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 benefits 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.

Table of contents

1. Benefit summary

A) INSURANCE BENEFITS FOR YOU

LIFE INSURANCE

If you die, Standard Life will pay the following amounts, based on your age and employment status:

Benefit:

- $200,000 active member.
- $ 50,000 retired member under age 65.
- $ 25,000 retired member at age 65 and over.

Coverage for retired members terminates at age 70.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If you die in an accident while insured, ACE INA will pay the amount specified to your beneficiary or estate, based on your age and employment status.

Benefit:

Equal to your life insurance.

WEEKLY INDEMNITY

Benefit:

- 65 per cent of weekly earnings to a maximum of $2,000 per week.
- the benefit is taxable;
- benefits are payable on a calendar day basis.

Elimination period:

- hospitalization: Nil;
- accident: 14 days;
- sickness: 14 days.

EI "carve-out": Weekly benefits of a disabled member will not be payable from the third to the 17th week inclusive when the disabled employee is eligible for EI sickness benefits. A disabled employee must show proof of application to and response from EI. During this 15-week period, the trust fund will "top up" the weekly benefit to a maximum of $2,000 per week.

If the member does not qualify for EI benefits during this period, the trust fund will pay the full weekly benefit to a maximum of $2,000 per week.

Note:

The 14-day elimination period will commence on the first date you receive medical attention after your last day at work. Please note that you cannot draw any income from lay days, banked leave or otherwise during the two week waiting period and the subsequent 15 weeks of EI benefits. Drawing any income from other sources will likely result in your EI benefits being reduced or clawed back.

Hospitalization means confinement of 24 hours, provided with a bed on the day ward, or given a general anaesthetic in a hospital.

Maximum benefit period: 52 weeks. This benefit ends on the date you terminate your employment or retire.

LONG-TERM DISABILITY

Benefit:

- equal to 65 per cent of your monthly basic earnings up to a maximum benefit of $5,000, reduced by direct and indirect offsets as specified in the group policy;
- the benefits paid under the long-term disability benefit are subject to an overall maximum inclusive of income from other sources. Income from all sources may not exceed 85 per cent of your basic pre-disability earnings. The benefit is taxable;
- income from other sources includes income from government or private pension plans or other government plans, as detailed under the long-term disability wording later in this booklet;
- during a period of less than a full month, 1/30 of the monthly benefit is payable for each day of total disability.

Elimination period:

- the later of 52 weeks or the expiry of the weekly indemnity benefit.

Maximum benefit period:

- the earlier of your termination, your retirement or attainment of age 65.

WORKERS' COMPENSATION/DISABLED MEMBERS' BENEFITS

Benefit:

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 until age 65 for disabilities that commenced on or after June 1, 2001; age 62 for disabilities that began prior to June 1, 2001 or on or after November 1, 2009. At that point, he/she will be treated the same as a retiree under the plan.

There is no AD&D coverage for retirees and as a result, AD&D coverage will terminate at age 65 for disabilities that commenced on or after June 1, 2001 or before January 25, 1993; age 62 for disabilities that began prior to June 1, 2001 or after January 25, 1993 as well as disabilities that began after November 1, 2009.

The dependant life coverage will also terminate at age 65 for disabilities that commenced on or after June 1, 2001 or before January 25, 1993; age 62 for disabilities that began prior to June 1, 2001 but after January 25, 1993 as well as disabilities that began on or after November1, 2009

The member's extended health care and dental care coverage as well as out-of-country coverage will continue until age 65 for disabilities that commenced on or after June 1, 2001 or before January 25, 1993; age 62 for disabilities that began prior to June 1, 2001 but after January 25, 1993 as well as disabilities that began on or after November 1, 2009.

Please refer to the section titled *Benefits after retirement/disability* later in this booklet or contact the plan administrator for information on the premiums and benefits after retirement.

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

B) LIFE, HEALTH AND DENTAL INSURANCE BENEFITS FOR YOU AND YOUR DEPENDANTS

LIFE INSURANCE

Benefit:

- $50,000 Spouse.
- $10,000 Child.

This benefit is available to dependants of an active member. It ends on the member's retirement or termination.

EXTENDED HEALTH CARE

Insured percentages

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 per cent 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.

Deductibles for seniors, those born in 1939 or earlier, will range from zero to two per cent of family income. Those born after 1939 will face deductibles ranging from zero to three per cent, depending on their income. Out-of-pocket pocket maximums also range from 1.25 to three per cent of family income for seniors, compared to two to four per cent for other residents.

MEMBERS AGE 65 OR OLDER WILL RECEIVE THE FOLLOWING FAIR PHARMACARE BENEFITS:

Seniors' Fair PharmaCare program

Net annual family income	Family deductible	Portion PharmaCare pays (once deductible is reached)	Family maximum (after which 100% of costs are covered)
Less than $33,000	None – Government assists with drug costs immediately	75% of prescription drug costs	Equal to 1.25% of net income
Between $33,000 and $50,000	Equal to 1% of net income	75% of prescription drug costs	Equal to 2% of net income
Over $50,000	Equal to 2% of net income	75% of prescription drug costs	Equal to 3% of net income

MEMBERS UNDER AGE 65 WILL RECEIVE THE FOLLOWING FAIR PHARMACARE ASSISTANCE:

Fair PharmaCare program

Net annual family income	Family deductible	Portion PharmaCare pays (once deductible is reached)	Family maximum (after which 100% of costs are covered)
Less than $15,000	None – Government assists with drug costs immediately	70% of prescription drug costs	Equal to 2% of net income
Between $15,000 and $30,000	Equal to 2% of net income	70% of prescription drug costs	Equal to 3% of net income
Over $30,000	Equal to 3% of net income	70% of prescription drug costs	Equal to 4% of net income

An important note: Plan members in BC are reminded that they must register for the new Fair PharmaCare program. To register, or for more information, call toll-free 1-800-387-4977. If proof of registration is not submitted to Coughlin & Associates Ltd., the plan administrator, your drug claim coverage will be *limited to $1,000 per individual per calendar year*. Failure to register may result in some CMSG drug claims not being reimbursed by the province of British Columbia.

Out-of-province charges for hospital care and services not available in your province of residence, but in Canada, will be reimbursed at 80 per cent.

VISION CARE

You, your spouse and eligible dependant children are covered to a maximum of $400 per person in any 24 consecutive month period, for charges relating to the purchase of lenses and frames and contact lenses when prescribed by a legally qualified practitioner.

Lenses and frames, or contact lenses required as a result of cataract surgery are reimbursed to a maximum of $400 within the 24 consecutive month period.

Dependant children under age 18 will be allowed prescription lenses required as a result of a new prescription within the 24 consecutive month period.

The plan will reimburse insured members age 19 to 65 for up to one eye examination per 24 consecutive month period to a maximum of $50 per insured individual.

HEARING AIDS

You, your spouse and your eligible dependants will be covered to a maximum of $1,000 per hearing aid per ear every three years, to an overall maximum of $2,000, when prescribed by a certified ear, nose and throat specialist.

MAXIMUM BENEFITS PER INSURED INDIVIDUAL

Individual limit	Maximums
• Private duty nursing	$10,000 lifetime
• Hospital charges (including convalescent home care, chronic care and detox facilities)	$10,000 lifetime
• Drugs & medication	$10,000 yearly
• **Overall limit**	**$150,000 lifetime***
*Reinstatement limit	$1,000 annually

The overall lifetime limit of $150,000 is subject to a reinstatement of $1,000 annually. As a result, individuals whose claims do not exceed $1,000 annually will have their lifetime maximum restored each year.

This benefit ends on the date you terminate or retire, except as provided for in the *Benefits after* retirement section.

DENTAL CARE

Deductible:

Nil.

Insured percentages

• Plan "A"	Basic services	100 per cent
• Plan "B"	Prosthetic appliances, crown and bridge procedures, and implantology	80 per cent
• Plan "C"	Orthodontics	50 per cent

Maximums

• Plans "A" and "B"	Combined calendar year maximum per insured person	$3,500
• Plan "C"	Lifetime maximum per insured	$2,500

Pre-determination of dental claims exceeding $500

See the *Dental care* section for procedures to follow when you have a claim expected to exceed $500.

Fee guide

Reimbursement based on the current fee guide for general practitioners of the College of Dental Surgeons of British Columbia. An additional 10 per cent of the general practitioners' fee guide is eligible for services rendered by a specialist.

This benefit ends on the date you terminate or retire, except as outlined in the *Benefits after retirement/disability* section.

OUT-OF-COUNTRY COVERAGE

The CMSG Western Branch benefit plan also provides out-of-country coverage. The plan covers an extensive list of expenses incurred while travelling outside Canada, anywhere in the world. Eligible expenses and maximums are listed under the *Out-of-country coverage* section. This benefit is available as long as you are a Canadian resident and your extended health care insurance with the CMSG Western Branch benefit plan is in effect.

CHANGE IN COVERAGE

Any change in coverage will become effective immediately on the date your status changes. However, if you acquire a common-law spouse, coverage for the spouse will be effective on the first of the month following receipt of the *Change of dependant coverage* form available from the plan administrator. Any such change because of a change in your basic earnings will be made on the first day of the month in which the change occurred.

Note:

If you are not actively at work on the date an increase would otherwise take effect or on the date the group policy is amended to provide additional or increased benefits, any increase will only take effect on the first day you are actively at work.

Similarly, any increase in coverage for a dependant who is confined to a hospital or similar institution will be delayed until he/she is discharged.

If you are totally disabled, you will be entitled to an increase in benefit due to a retroactive salary increase that results from the signing of a new collective agreement, provided the previous collective agreement expired before the date you became totally disabled.

BENEFITS AFTER RETIREMENT/DISABILITY

Arrangements can be made to maintain certain benefits after retirement. Benefits for members who retire before October 1, 2006 require a monthly premium while members who retire on or after October 1, 2006 may be eligible for benefits without premium payments.

- **Retirement prior to age 65**

Members can elect any or all of the following coverages:

Benefit	Coverage
-Life insurance	$50,000
-Extended health care	
-Dental care	

- **Members attaining age 65**

Members can elect any or all of the following coverages:

Benefit	Coverage
-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 age 65 for disabilities that commenced prior to January 25, 1993 on or after June 1, 2001; age 65 for disabilities that began after January 25, 1993 but before to June 1, 2001, as well as disabilities that began on or after November 1, 2009.

Members who are disabled and in receipt of long-term disability benefits will continue to have extended health care and dental care coverage until age 65 for disabilities that commenced prior to

January 25, 1993 or on or after June 1, 2001; age 65 for disabilities that began after January 25, 1993 or prior to June 1, 2001 or began on or after November 1, 2009. 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.

2. General information

PLAN EFFECTIVE DATE

The plan described in this booklet is up-to-date as of December 1, 2013.

ELIGIBLE MEMBERS

Full-time employees* of the employers party to collective agreements or participation agreements with the Canadian Merchant Service Guild will be eligible for coverage providing they:

- are members of the Canadian Merchant Service Guild;
- have completed 90 days employment with any one employer;
- are residents of Canada. **

All eligible employees participate in the plan.

* To be considered a full-time employee, you must be scheduled to work at least 30 hours a week, or, alternatively, you must be considered a permanent part-time employee eligible for benefits under the terms of the collective bargaining agreement.

** Participating employees who choose to live outside of Canada will receive the same coverage as that provided to members who reside in British Columbia or elsewhere in Canada. Non-Canadian residents will not be able to claim coverages that would not otherwise have been available to residents of Canada making claims in Canada.

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 between the officer and the company.

ELIGIBLE DEPENDANTS

Eligible dependants include your spouse and your unmarried children (including adopted, foster and step-children) who are less than 21 years of age. Unmarried children up to the age of 25, will also be covered, providing they are full-time students and dependent upon you for support. Your dependants must reside in Canada.

Your *spouse* is the person whom you have legally married or have publicly represented as your spouse and with whom you have resided for a period of at least 12 consecutive months.

Any mentally or physically handicapped child may remain covered past the maximum age provided that upon reaching maximum age, he/she is still incapable of self-sustaining employment and is wholly dependent on you for support and maintenance. The maximum age for out-of-country coverage for a mentally or physically handicapped child is 25.

Supporting documentation from a medical doctor will be required if he/she is suffering from a severe, incurable and chronic physical or mental disability.

NO MEDICAL EXAMINATION

No medical examination or other evidence of insurability is required for you to join the plan. New bargaining groups added to the plan may be required to submit evidence of insurability.

HOW TO JOIN

Complete the enrolment form supplied by your employer and return it to your employer upon completion.

EFFECTIVE DATE OF COVERAGE

All eligible full-time employees will be covered following the completion of three months of continuous employment with any one employer.

If you are absent due to disability, temporary lay-off or leave of absence on the date coverage would normally commence, your coverage will begin on the date return to active full-time employment.

Dependants shall be covered on the same date as you or on the date they meet the definition of eligible dependant.

TERMINATION DATE OF COVERAGE

Coverage will be terminated on the last day of the calendar month in which your employment terminates. However, lay-days shall constitute continuation of employment. For example, if employment terminates and you have lay-days to your credit, your coverage will terminate on the last day of the calendar month in which the credit is exhausted.

Dependants' coverage will terminate on the same day as that of the employee or upon their ceasing to be a dependant. An exception to the previous paragraph is the provincial medical coverage. You can continue to be covered by the MSPBC by making appropriate arrangements with that organization.

Eligibility for long-term disability coverage will terminate on the last day of the calendar month in which you attain age 64. If you are in receipt of long-term disability benefits, the last benefit payment will cease in the month in which you attain age 65.

CHANGE IN DEPENDANTS' STATUS

You must advise your employer of any change in the status of your dependants or you may be deprived of benefit payments.

REINSTATEMENT

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 employee and will be covered on the completion of 90 days continuous employment with any one participating employer.

The above applies to all benefits except the provincial medical coverage provided by the MSPBC.

TEMPORARY LAY-OFF AND LEAVE OF ABSENCE

Arrangements may be made through the plan administrator for the continuation of coverage for up to three months from the end of the month in which lay-off or leave of absence commences. This provision does not apply in cases when an employee 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 employee and the employer. The time limit shall be extended to the end of the maternity leave, subject to payment of premiums.

Effective April 1, 1999, employees 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 the following benefits:

Life insurance:	Member	$50,000
Dependant life:	Spouse	$10,000
	Child	$ 5,000

Extended health care: Full coverage for individual and family.

The plan does not include dental coverage, 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. Please contact the plan administrator or your employer for an application form.

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.

BENEFICIARY

Upon enrolment in the plan, you must designate the beneficiary to whom the death benefits will be payable. Subject to any legal restrictions, you may change your beneficiary by completing a new enrolment card.

CHANGE IN INFORMATION

To ensure that all correspondence records are up-to-date, it is important that you contact the plan administrator as soon as any change occurs, such as the addition of a new dependant, beneficiary or address.

PORTABILITY FEATURE

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 employer participating in this plan, 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.

TOTAL DISABILITY DEFINITION

For weekly indemnity coverage: 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.

For long-term disability and other benefits:

- During the elimination period and the initial disability period specified 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;
- 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 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 per cent or more of your gross monthly income determined at the onset of disability, as deemed by Standard Life.

3. Benefit provisions

I) LIFE INSURANCE

A) LIFE INSURANCE FOR YOU

The amount of your life insurance is outlined in the *Benefit summary*.

If you die while insured, Standard Life will pay the amount of your life insurance benefit to your last beneficiary on file. In the absence of a named beneficiary, payment will be made to your estate.

You may name the beneficiary of your choice or your estate. All nominations you make are revocable, unless you or the law stipulate otherwise.

Due to the complications that might arise upon settlement of the estate, it is not advisable to appoint a minor child as beneficiary. If a minor child is appointed, the funds should be left "in trust" and the member's last will and testament should be amended to include a trustee who will handle the minor child's affairs.

B) LIFE INSURANCE FOR YOUR DEPENDANTS

The amount of your dependants' life insurance can be determined from the *Benefit summary*.

If one of your insured dependants dies, Standard Life will pay the amount of insurance to you.

DISABILITY WAIVER OF PREMIUM BENEFIT

If a claim for the long-term disability benefit has been approved, the premiums under this benefit will be waived for the period during which the participant is eligible to receive a monthly disability benefit. The waiver of premiums period commences as of the end of the elimination period and terminates as of the end of the maximum period specified under the *Long-term disability* section of the *Benefit summary*.

At all times, the amount of insurance for which waiver of premiums is granted will not be greater than that which was in force on the participant's life at the onset of disability and will be subject to the same reduction and termination as if the participant was actively at work.

If a claim under the long-term disability benefit has been declined or if the participant ceases to be eligible to receive the monthly disability benefit, the participant will be eligible for waiver of premiums under this benefit, subject to the following terms and conditions.

A participant not insured under the long-term disability benefit will be eligible for waiver of premiums under this benefit, subject to the following terms and conditions:

ELIGIBILITY

If a participant becomes disabled, the premiums under this benefit will be waived if each of the following conditions is satisfied:

1. The participant is acknowledged as disabled as defined under *Definition of disability* specified hereinafter.
2. The participant is less than 65 years of age at the onset of disability.
3. The participant became disabled prior to termination of employment while insured under this benefit.

The preceding applies to disabilities occurring on or after September 1, 2011 and provided under the Standard Life group insurance policy.

In respect to disabilities that occurred prior to September 1, 2011, if you were disabled prior to June 1, 1998 or on or after November 1, 2009 the waiver of premium benefit will continue until your 62nd birthday, after which, you will be treated as a retiree for life benefit purposes. For disabilities occurring on or after June 1, 1998 but before November 1, 2009 the waiver of

premium benefit will continue only as long as the benefit plan operates, and will terminate upon your attainment of age 65.

If the benefit plan terminates or winds-up, members disabled on or after June 1, 1998 will be treated the same as active members and will be able to exercise the conversion option described below.

CONVERSION

If your insurance ends prior to age 65, you are entitled to purchase an individual life insurance policy from Standard Life within 31 days of coverage termination, without evidence of insurability. Your written request and first premium must be received by Standard Life within the 31-day period. A similar conversion is available to your spouse.

This conversion privilege terminates on your attainment of age 65.

BENEFITS AFTER DISABILITY/RETIREMENT

Arrangements can be made to maintain some plan coverage after retirement. Application must be made within 31 days of retirement.

Please contact the plan administrator for information on premiums and benefits after retirement.

MAKING A CLAIM

If you or one of your insured dependants dies, a claim should be made as soon as reasonably possible.

If you become totally disabled, a claim for waiver of premium must be made no later than 12 months after you stopped being actively at work. Each year, Standard Life may require proof of your continued total disability.

II) ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) COVERAGE

This benefit provides a lump sum cash benefit in the event of your accidental death or dismemberment anywhere in the world, 24 hours per day, 365 days a year including while travelling (passenger only) in commercial or chartered aircraft, provided the aircraft has a current and valid airworthiness certificate.

ELIGIBILITY

If you are an active, permanent, full-time member of the Canadian Merchant Service Guild, you will be covered for a benefit amount stated below.

BENEFIT

You are insured for the amount as specified in the *Benefit summary.*

In the event of your death, the benefit amount is payable to the beneficiary you have named under your group life insurance plan or in the absence of such designation, to your estate.

LOSS SCHEDULE

If injuries result in any one of the following specific losses within one year from the date of accident, ACE INA will pay the benefit specified below, based on the principal sum that is equal to the benefit amount stated in the policy schedule. No more than one (the largest) benefit shall be paid for injuries resulting from one accident.

For loss of:	Percentage of principal sum
Life	100 per cent
Both hands, both feet, entire sight of both eyes, one hand and one foot, one hand or one foot and entire sight of one eye	100 per cent
Speech and hearing	100 per cent
Use of both arms or both hands	100 per cent
Quadriplegia, paraplegia, hemiplegia	200 per cent
One arm or one leg or use of one arm or one leg	75 per cent
One hand or one foot or use of one hand	66 2/3 per cent
Entire sight of one eye	66 2/3 per cent
Speech or hearing	66 2/3 per cent
Thumb and index finger of the same hand	33 1/3 per cent
Four fingers of the same hand	33 1/3 per cent
Hearing in one ear	25 per cent
All toes of the same foot	12 1/2 per cent

Loss shall mean, with respect to hand or foot, actual severance through or above the wrist or ankle joint; with respect to arm or leg, actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect

to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger, actual severance through or above the first phalange; with respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand; with regard to toes, the actual severance of both phalanges of all toes of the same foot.

Loss as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs) and hemiplegia (paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs. Paralysis benefit is subject to a maximum of $1 million.

Loss of use shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined to be permanent on evidence satisfactory to ACE INA.

Additional benefits covered in this policy include the following:

Repatriation benefit	$10,000
Rehabilitation benefit	$10,000
Family transportation benefit	$10,000
Spousal occupational training benefit	$10,000
Home alteration and vehicle modification benefit	$10,000
Seatbelt benefit	10 per cent

Please refer to the plan administrator for a complete description of these benefits and the exact provisions as described in the master policy.

EXCLUSIONS

The plan does not cover any loss that is the result of:

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. war or any act thereof;
3. flying in aircraft being used for any test or experimental purpose, fire fighting, power line inspection, pipeline inspection, aerial photography or exploration;
4. flying as pilot or crew member in any aircraft or device for aerial navigation;
5. full-time, active duty in the armed forces;
6. the commission or attempted commission of any act which if adjudicated by a court would be illegal under the laws of the jurisdiction where the act was committed;
7. an injury sustained where the insured person consumed, used, or hand administered any drug, medication, narcotic, toxic substance or any other substance, except for any drug or medication prescribed by a licensed medical practitioner or dentist.

EXPOSURE AND DISAPPEARANCE

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the benefits afforded you.

If your body has not been found within one year of the disappearance, stranding, sinking, or wrecking of the conveyance in which you were riding at the time of the accident it shall be presumed, subject to all other conditions of the policy, that you suffered a loss of life resulting from bodily injuries sustained in the accident and covered under the policy.

AGGREGATE LIMIT OF LIABILITY

Aggregate limit of liability is $1,500,000 per accident. ACE INA will not be liable for any amount in excess of the above stated aggregate limit of liability.

IMPORTANT

This booklet contains a summary of the principal features of the AD&D plan. This information is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Master AD&D policy ABT 102077.

III) WEEKLY INDEMNITY

PAYMENT OF BENEFITS

If you become totally disabled while insured, the plan will pay, subject to limitations and exclusions, a weekly indemnity benefit for each week you remain totally disabled after completion of the elimination period until the earliest of the following:

- the date you cease to be totally disabled;
- the date you are no longer under the care of a medical doctor;
- the date the maximum benefit period is reached; or,
- when you refuse to be examined by a medical doctor appointed by the plan administrator.

Weekly benefits of a disabled member will not be payable from the third to the 17th week inclusive when the disabled employee is eligible for EI sickness benefits. A disabled employee must show proof of application to and response from EI. During this 15-week period, the trust fund will "top up" the weekly benefit to a maximum of $2,000 per week.

If the member does not qualify for EI benefits during this period, the trust fund will pay the full weekly maximum of $2,000 per week.

TOTAL DISABILITY DEFINITION

You are considered totally disabled if you are prevented by illness or injury from performing the duties of your own occupation and do not engage in any occupation or employment for wage or profit.

COVERAGE DURING PERIODS OF EXTENDED LAY-OFF

The weekly income benefit is not available to members during periods of extended lay-off.

COVERAGE WHILE ON VACATION

The benefit for illness and accident will commence at the later of the expiration of the 14-day waiting period (from the date you first visited a physician) or the date you were scheduled to return to work. Claims relating to hospitalization will commence on the date of your scheduled to return to work.

INTEGRATION WITH FEDERAL AND PROVINCIAL PLANS

Any disability income benefits which an employee becomes eligible to receive under the Canada/Quebec Pension Plan or any other disability income benefits under any other federal or provincial plan, shall reduce the amount payable under this benefit to the extent that the total amount which the employee is eligible to receive from all such sources shall not exceed 85 per cent of pre-disability basic earnings.

RECURRENT DISABILITIES

Periods of disability for same or related causes will be considered one continuous absence unless you return to work for at least two weeks between absences.

FUNDING WHILE DISABLED

When an officer is disabled and becomes eligible for weekly indemnity or Workers' Compensation Board benefits, the employer will pay the full premium, including the life insurance premium, for up to 52 weeks.

REHABILITATION BENEFIT

For disabilities that have an indefinite or prolonged prognosis and appear to extend beyond the maximum weekly indemnity benefit period, the plan administrator reserves the right to recommend that you consider engaging in a rehabilitation program as soon as possible after commencement of your total disability.

DISPUTED WORKERS' COMPENSATION BOARD CLAIM

If an officer covered by the benefit plan suffers a disability and payment is in dispute with the Workers' Compensation Board, weekly indemnity payments will be paid retroactively, if requested by the officer, provided he/she has been off work for at least two weeks due to the disability and the WCB has not accepted the claim.

If the WCB claim is subsequently approved, the officer will be required to repay the weekly indemnity payment he/she received to the appropriate underwriter

SUBROGATION

If you are entitled to recover damages for loss of income from another person as a result of personal injuries sustained by you while you are entitled to receive benefits under the insurance benefits provisions, the plan will be subrogated to all your rights of recovery for loss of income to the extent of the sum of the benefits paid or payable to you under that provision.

The plan sponsor may require you to complete a reimbursement questionnaire and execute a reimbursement agreement. If you do not complete and return the reimbursement agreement to the plan administrator the within 30 days after a request, the benefits which you would otherwise be entitled to receive under the weekly indemnity benefit provision will not be paid until you do so.

BENEFITS AFTER COVERAGE ENDS

If this insurance coverage ends while you are totally disabled, you will continue to receive benefits as if the coverage were still in effect.

LIMITATIONS

Payment is not made for:

1. maternity and/or parental leave as provided under the relevant legislation;

2. maternity leave commencing with the earlier of:
   (a) the elected date of leave, mutually agreed to by you and your employer; and
   (b) the date of birth of the child and ending with the earlier of:
      i) the elected date of return to active full-time work with the employer, mutually agreed upon by you and your employer and;
      ii) the actual date you again actively work with the employer;
3. parental leave mutually agreed to by you and your employer;
4. any period you are not under the care of a medical doctor;
5. total disability due to abuse of drugs or alcohol unless;
   (a) you are confined in a hospital or participate satisfactorily in a program approved by the plan administrator; or,
   (b) there is organic disease present that would cause total disability even if the use of drugs or alcohol ceased.

EXCLUSIONS

A benefit will not be paid for a total disability resulting from:

1. the hostile action of any armed forces, insurrection or participation in any riot or civil commotion;
2. commission or attempted commission of a criminal offence by you;
3. intentionally self-inflicted injuries or attempted suicide (while sane or insane);
4. bodily injury sustained while doing any act or thing pertaining to any occupation or employment for wage or profit when Workers' Compensation benefits are payable;

5. any cause for which indemnity or compensation is provided under any Workers' Compensation Act or similar legislation.

TAX DEDUCTION FROM SOURCE

The weekly indemnity benefit is taxable as income. However, taxes are not deducted at source.

On your instruction, a tax deduction from source (tax withholding from the benefits payable) can be arranged so that you avoid a large tax obligation during normal tax time.

Contact the plan administrator for information on deducting tax at source.

UNDERWRITING

The plan is self-insured by the CMSG Western Branch Benefit Trust Fund.

Coughlin & Associates Ltd. and Standard Life of Canada administer and adjudicate the weekly indemnity benefit.

IV) LONG-TERM DISABILITY

If you become totally disabled while insured, Standard Life will pay, subject to limitations, exclusions and subrogation, a long-term disability benefit for each month you remain totally disabled after completion of the elimination period until the earliest of the following:

- the date you cease to be totally disabled;
- the date you are no longer under the care of a medical doctor;
- when you are no longer a member in good standing of the Canadian Merchant Service Guild and paying the appropriate rate of union dues;
- your attainment of age 65;
- the date the maximum benefit period is reached; and/or
- when you refuse to be examined by a medical doctor appointed by Standard Life.

TOTAL DISABILITY DEFINITION

- **During the elimination period and the initial disability period specified 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;
- **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 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 per cent or more of your gross monthly income determined at the onset of disability, as deemed by Standard Life.

CONTINUED PROFICIENCY CERTIFICATION

The long-term disability benefit has been modified to include disability income protection for up to two years in the event you fail to revalidate your certificate due to a medical condition.

RECURRENT DISABILITIES

Successive periods of disability separated by less than six consecutive months of continuous active work shall be considered one period of total disability, provided the nature of the illness or injury is related to the initial disability.

INTEGRATION WITH FEDERAL AND PROVINCIAL PLANS

The long-term disability benefit is first reduced by income benefits payable under any Workers' Compensation or occupational disease laws or similar legislation and by *primary* income benefits payable under the Canada/Quebec Pension Plans, and by benefits payable under any other government plan, excluding Employment Insurance. Thereafter, any benefits received from employment-related plans of insurance will reduce the long-term disability benefit to the extent that your total income from all sources will not exceed 85 per cent of your pre-disability basic earnings.

COVERAGE DURING PERIODS OF LAY-OFF

Long-term disability coverage is not available during a period of lay-off.

PREMIUMS AND BENEFITS DURING DISABILITY

Premiums for weekly indemnity and long-term disability benefits are not applicable while you receive long-term disability benefits. You shall continue to be covered under the dental, extended health care, out-of-country coverage and the Medical Services Plan of B.C. without payment of premiums while you receive long-term disability benefits.

REHABILITATION BENEFIT

If you become totally disabled, you will be encouraged to participate in a program of retraining, such as a part-time work. During this period, you may qualify for rehabilitation income. This benefit is available for a maximum of 24 months following the elimination period. The program must first be approved in writing by Standard Life.

It is recommended that you consider engaging in a rehabilitative program as soon as possible after commencement of your total disability, including the period before your monthly payments commence. Contact Standard Life's rehabilitation section via its nearest claims office.

SUBROGATION

If you are entitled to recover damages for loss of income from another person as a result of personal injuries sustained by you and for which you are entitled to receive benefits under the insurance benefits provisions, Standard Life will be subrogated to all your rights of recovery for loss of income to the extent of the sum of the benefits paid or payable to you under that provision.

Standard Life may require you to complete a reimbursement questionnaire and execute a reimbursement agreement. If you do not complete and return the reimbursement questionnaire or execute the reimbursement agreement within 30 days after request, your LTD benefits will not be paid until you do so.

BENEFITS AFTER COVERAGE ENDS

If this insurance coverage ends while you are totally disabled, you will continue to receive benefits as if the coverage was still in effect.

LIMITATIONS

Payment is not made for:

1. a period during which you engage in any employment or occupation for wage or profit (other than in a rehabilitative program);
2. a total disability due to abuse of drugs or alcohol unless;
   (a) you are confined in a hospital or are satisfactorily participating in a program approved by the plan administrator; or,
   (b) there is organic disease present that would cause total disability even if the use of drugs or alcohol ceased.
3. maternity and/or parental leave taken by the member as provided under the relevant legislation;
4. maternity leave commencing with the earlier of:
   (a) the elected date of leave, mutually agreed to by you and your employer; and,
   (b) the date of birth of the child, and ending with the earlier of:

i) the elected date of your return to active full-time work, mutually agreed to by you and your employer; and;

ii) the actual date the member is again actively at work with the employer;

(c) the parental leave mutually agreed to by you and your employer.

EXCLUSIONS

A benefit is not paid for a total disability that is due to or results from:

1. the hostile action of any armed forces, insurrection or participation in any riot or civil commotion;
2. intentionally self-inflicted injuries or attempted suicide (while sane or insane);
3. commission or attempted commission of a criminal offence by you;
4. bodily injury sustained while doing any act or thing pertaining to any occupation or employment for wage or profit;
5. any cause for which indemnity or compensation is provided under any Workers' Compensation Act or similar legislation.

TAXATION OF BENEFIT

The long-term disability benefit is a taxable income to members.

V) EXTENDED HEALTH CARE

If, while insured, you or your dependants incur any of the eligible expenses for medically necessary services or supplies in the treatment of an illness or injury, the benefit plan will pay a benefit, subject to limitations and exclusions. The amount payable is determined by using the insured percentage shown in the *Benefit summary*.

MAXIMUM

The benefit plan carries both individual yearly or lifetime limits as well as an overall lifetime limit as specified in the *Benefit summary*. As outlined in the *Benefit summary*, up to $1,000 may be re-invested annually in your lifetime coverage maximum.

WORK-RELATED INJURIES/EXPENSES

Expenses from worked-related injuries will be recoverable from the WCB when they involve payments first made through the extended health care plan.

INSURED PERCENTAGES

The eligible expenses will be reimbursed in accordance with the percentages outlined in the *Benefit summary*.

Special rules apply to prescription drugs and charges for out-of-province hospital care as well as services available in Canada but not available your province of residence.

ELIGIBLE EXPENSES

The following is a list of the items currently eligible for payment under your benefit plan. Eligible expenses must be reasonable, customary, and recommended by a physician:

A. Services of a physician

A benefit is payable for physicians' services that are medically necessary as a result of illness or injury, and which are provided out-

of-province while you or an eligible dependant are travelling or on vacation. (Excludes any treatment rendered for cosmetic purposes.)

B. Dental expenses

Dental treatment for the repair of damage resulting directly from an accidental injury to natural sound teeth, provided the treatment is rendered within six months of the accident and your coverage is still in force. Payment will be based on the amount for the least expensive procedure that will provide a professionally adequate result to a maximum of $5,000 per accident.

C. Ambulance services

Charges for emergency transportation to and from a hospital, provided the trip is in a professional ambulance, a scheduled airline, railroad, ship, boat or air ambulance to the nearest hospital qualified to provide the necessary treatment.

D. Medical supplies, aids, and appliances

Charges for the following supplies, aids, and appliances when provided upon the recommendation or approval of the attending physician, or, if it is legal to do so, by the attending osteopath or podiatrist:

1. casts, bandages and surgical dressings;
2. radium or cobalt or radioactive isotopes;
3. blood or blood plasma;
4. rental for therapeutic use of wheelchairs, hospital beds, iron lungs, artificial kidney, oxygen or respiratory equipment, etc. Replacement appliances are eligible once every five consecutive years, which includes existing appliances that cannot be made serviceable;
5. surgical supplies;
6. diabetic supplies including glucometers (except for batteries); glucometers are limited to once every five consecutive years;

7. drugs and supplies of a non-prescription nature required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis and Parkinsonism;
8. mastectomy bras to a maximum of four per calendar year;
9. wigs, subject to a lifetime maximum of $300 for patients who have undergone chemotherapy treatment;
10. custom-made arch supports to a maximum of $200 per insured per calendar year (must be accompanied by a medical doctor's referral indicating the medical diagnosis);
11. support stockings up to four pairs to a maximum of $100 per calendar year, a prescription showing the brand name and compression ratio is required;
12. custom moulded orthopedic shoes prescribed by an orthopedic surgeon for the proper management of unusual, congenital or post-traumatic foot problems; one pair per calendar year to a maximum of $400 per insured per calendar year (must be accompanied by a medical doctor's referral indicating the medical diagnosis);
13. hearing aids when prescribed by the attending certified ear, nose and throat specialist, the maximum benefit during a three-year period is $1,000 per hearing aid per ear and does not include payment for repairs and maintenance, batteries or recharging devices, or other such accessories;
14. aids and appliances, subject to prescribed limits, required on account of bodily injury to physical organs, or parts, such as eye glasses, contact lenses, hearing aids, dental appliances, splints, trusses, braces (must be constructed with rigid or semi-rigid materials, required for normal activities of daily living (not solely for sports-related activities) and on the written prescription of a physician), and crutches, provided such injury is sustained in an accident occurring while the individual is insured;

15. other surgical supplies, aids and appliances to replace lost physical organs or parts, or to aid in their functions when impaired;

16. purchase of TNS (transcutaneous nerve stimulator) machine upon written prescription by an attending physician.

E. Vision care

Vision care is provided for the purchase of lenses and frames, including safety lenses and contact lenses, when prescribed by a person legally qualified to make such prescription, to a maximum of $400 per person in any 24 consecutive month period. For lenses and frames and/or contact lenses required as a result of cataract surgery, a maximum of $400 within the 24 consecutive month period.

Dependant children under age 18 will be allowed prescription lenses, required as a result of a new prescription within the 24-month period. Reimbursement of eligible eyewear is based on the date the item is paid in full.

For members and eligible dependants age 19 to 65: One eye examination per 24 consecutive months to a maximum $50 per insured individual. Eye exams are reimbursed based on the date of the eye exam. Fees that are in addition to the standard eye exam are not eligible for reimbursement.

F. Drugs and medication

Maximum: $10,000 annually.

Plan members in British Columbia must register for the BC Fair Pharmacare Program. If proof of registration is not provided to the plan administrator, drug claims will be limited to $1,500 per person per calendar year. To register, call, toll-free, 1-800-387-4977. (Registration and submission of proof is a one-time occurrence.)

The CMSG benefits program covers drug that are available only on the written prescription of a physician and are dispensed by a licensed pharmacist to a maximum of a three months supply at one time. Oral

contraceptives are eligible to a maximum of 13 months supply (one year) at one time. Drugs, injectables, allergy serum and inoculations are included. Compound mixtures are eligible when at least one ingredient is a prescription-requiring medication and is eligible under the plan.

Fertility drugs are covered subject to a combined lifetime maximum of 12 treatment cycles.

Viagra®, Cialis®, Levitra®, up to $500 per calendar year.

Nicorette gum/patches and other smoke cessation products are covered, subject to a lifetime maximum of $250 per person.

Certain eligible medications may require prior authorization of the plan administrator.

Pay direct drug card

CMSG Western Branch members may pay for prescription drugs directly through the drug plan using the pay direct drug card from ESI Canada and Coughlin & Associates Ltd.

With the pay direct drug card, prescription drug claims are processed on-the-spot. There are no forms to complete, no payment required outside of any deductible or co-payment charges. Simply present the card to the pharmacist at time of purchase. The drug claim payment will be processed immediately.

The member as well as his/her eligible spouse and dependants, may use the card. The pay direct drug card is designed to cover only prescription drug costs.

Present the pay direct drug card to the pharmacist at the time of purchase. The prescription data will be submitted electronically to ESI Canada and the drug claim will be assessed in seconds. When the claim is approved, the pharmacist will return the card to the card holder.

The card may be used at any pharmacy in Canada.

G. Services of paramedical practitioners

The following expenses are covered when rendered by a licensed, certified or registered (in the province where the treatment is given) paramedical practitioner, up to the reasonable and customary fees per visit, when operating within their recognized fields of expertise to the levels specified to a maximum of $200 per individual (except chiropractor, physiotherapy, psychology and massage therapy), each calendar year after the patient has received the maximum benefit payable under the provincial health care plan:

1. osteopaths;
2. Christian Science healer, when certified as medically necessary by the attending physician;
3. naturopath services, excluding supplements;
4. podiatrist;
5. orthoptic technicians, when certified as medically necessary by the attending physician;
6. audiologists, when certified as medically necessary by the attending physician;
7. speech therapists, when certified as medically necessary by the attending physician;
8. occupational therapists, when certified as medically necessary by the attending physician;
9. inhalation therapists are covered when certified as medically necessary by the attending physician;
10. approved services of a clinical psychologist who is licensed, certified or registered, provided that if such services are for psychiatric testing they are rendered in conjunction with medically necessary psychotherapeutic treatment to a maximum $1,000 per person per calendar year. Services of a registered counsellor or a social worker can be accepted when a registered psychologist is not available;

11. acupuncture by licensed physician or dentist, or other licensed, certified or registered technicians in an approved institution and when prescribed by a physician or dentist. If the service is wholly or partially provided under a hospital plan, any co-insurance factor or other charges to the individual including charges for outpatient services will be covered;
12. services by a chiropractor are limited to $35 per visit and $50 for X-rays to a maximum of $500 per calendar year after provincial health plan benefits have been exhausted;
13. physiotherapy, excluding occupational or recreational, when certified as medically necessary will be reimbursed up to $1,000 per calendar year with recommendation from your attending physician;
14. massage therapy will be reimbursed up to $1,000 per calendar year with recommendation from your attending physician.

Receipts must clearly indicate the names of those people attending the sessions. Reimbursement is based on the dates the services were rendered. If you choose to enter into a block or annual payment plan for services, reimbursement will be made at the end of the contract period, upon submission of all receipts and a copy of the contract.

No payment will be made for duplication of services.

H. Private duty nursing

Services of a registered nurse or registered nursing assistant are provided in the covered person's home. Services must be approved in advance by the plan administrator. A *Request for nursing care services* form must be completed by the attending physician. When the services are required for more than 30 days, an updated authorization form must be submitted to the plan administrator on a monthly basis. Payment for nursing care services is limited to a lifetime maximum of $10,000.

I. Hospital expenses

Maximum: $10,000 lifetime

Hospital coverage includes the following:

1. standard charges for semi-private or private accommodation including any daily hospital co-insurance charge in your province of residence;

2. hospital expenses to cover the treatment of alcoholism and drug addiction in a residential treatment centre approved by the province of British Columbia for a maximum of 42 days at the usual and customary charge by such centre.

3. reasonable charges necessarily incurred for confinement in a chronic care facility, provided such confinement has been recommended by a physician, is medically necessary and the patient has a limited potential for rehabilitation. Such confinement must not have as its primary objective to provide 24-hour medical and professional nursing supervision for a person who has reached the apparent limit of his recovery;

4. standard charges for semi-private or private accommodation including any daily hospital co-insurance charge for out-of-province emergency hospital treatment within Canada;

5. 80 per cent of the cost of hospital treatment outside your province of residence, provided the services are not available in your home province and when referred by your attending physician. Pre-approval by the plan administrator is required;

6. the differential for semi-private or private room accommodation, including any daily hospital co-insurance charge, will be covered in extended care units of acute care general hospitals.

Note: the term *private accommodation* refers to a private single room.

EXTENSION OF BENEFITS WHILE DISABLED

If an insured individual is disabled and on the date of termination of his insurance requires the personal attendance of a licensed physician, he/she will be entitled to the same benefit to which he would have been entitled before the termination provided:

1. in the case of an individual who is not totally disabled, only expenses resulting solely from the disability and which were incurred within three months of the date of termination of insurance will be considered;

2. in the case of an employee who is totally disabled, only expenses resulting solely from the disability that were incurred within 12 months of the date of termination of insurance will be considered;

3. in the case of an individual who incurs expenses in connection with an extra-uterine pregnancy or pregnancy that existed prior to termination of insurance involving an intra-abdominal surgical procedure within nine months of the date of termination of insurance, only expenses incurred within 12 months of the date of termination of insurance will be considered.

CO-ORDINATION OF BENEFITS

When payment for benefits provided under this plan is available to a person insured under another pre-paid health service contract, insurance policy or plan benefits shall be co-ordinated and the amount payable pro-rated and limited to the extent that the total amount available does not exceed 100 per cent of all the eligible expenses.

The plan administrator may obtain from or release to any person or corporation, any information considered necessary to implement this provision and facilitate the payment of benefits under this agreement, subject to the consent of the covered member, if required by law.

In co-ordination of benefits situations where Coughlin & Associates Ltd. is the secondary payer, the original explanation of benefits form from the primary insurer and copies of the relevant receipts or dental claims forms must be submitted.

ORDER OF BENEFIT DETERMINATION

If a person is eligible to receive a benefit under this plan and the same or a similar benefit under any other plan, benefit payments will be decided in the following manner:

1. if another plan does not contain a co-ordination of benefits provision, its benefits will be payable prior to the application of benefits under this plan; or

2. if another plan contains a co-ordination of benefits provision, the benefits of that plan shall be co-ordinated with the benefits under this plan.. Priority shall be given to the plan under which the person is eligible to receive the benefits in the following order:

   A. other than as a dependant; or

   B. as a dependant of a covered person with the earlier month of birth and day in the calendar year.

If priority cannot be established in the above manner, the benefits shall be pro-rated among the plans in proportion to the amounts that would have been paid under each plan had there been coverage only by that plan.

LIMITATIONS AND EXCLUSIONS

No benefits are payable for any of the following charges:

1. charges for which an individual obtains or is entitled to obtain benefits under the terms of any government plan or for which no actual charge is made;
2. any service or supply for which the charge is incurred previous to the effective date of coverage;
3. those charges incurred on account of pregnancy, childbirth or miscarriage or any complications thereof, when incurred after the date of termination of insurance, except as indicated under *Extension of benefits;*
4. those charges due to intentionally self-inflicted sickness or injury while sane or insane, insurrection or war, whether war be declared or not, any act incident thereto, or participation in any riot;
5. charges in connection with general health examination or any service provided by telephone;
6. charges that are not reasonable, including those charges which are in excess of those which would have been made in the absence of insurance under this plan;
7. charges by any person who is a member of the immediate family of the insured individual or who ordinarily resides in the insured individual's home;
8. any charge excluded in the group policy; and
9. any charge for service, treatment or supplies for which there would be no charge except for the existence of insurance.

VI) DENTAL CARE

If, while insured, you or your dependants incur any of the eligible expenses listed below, the benefit plan will pay a benefit subject to limitations and exclusions. The amount payable is determined using the insured percentages shown in the *Benefit summary* and based on the lower of the actual charge or the amount in the fee guide for general practitioners of the College of Dental Surgeons of British Columbia. An additional 10 per cent of the general practitioners fee guide is eligible for services rendered by a specialist.

It is important to ask your dentist if the plan payment will cover the entire cost of your treatment. Your dentist's charges for services rendered may be different from the plan payment. Fees greater than the plan's payment limit will be your responsibility.

ELIGIBLE EXPENSES

The present dental care plan coverage is comprised of the following:

- Plan "A" Basic services;
- Plan "B" Major dental services;
- Plan "C" Orthodontics.

PLAN "A"

Basic services

Members and insured dependants are entitled to the following dental services when performed by a dentist.

Diagnostic services

The basic procedures necessary to help evaluate existing conditions and determine the required dental treatment including:

- oral examinations, once in any six-month period. Complete oral examinations will be covered once in any three-year period;

- X-rays, limited to the equivalent of one full-mouth series per year. Panoramic mouth X-rays will be covered once in any three-year period; and
- consultations (as a separate appointment).

Preventive services

The basic procedures necessary to prevent the occurrence of oral disease including:

- polishing, up to one unit, and topical application of fluoride and other anti-cariogenic substances - once in any six-month period;
- initial provision and installation of space maintainers; and
- diagnostic casts or study models.

Surgical services

The procedures necessary for extractions and other basic surgical procedures normally performed by a dentist.

Restorative services

Those basic procedures necessary for initially filling teeth with amalgam, silicate, acrylic or composite restorations and stainless steel crowns.

Replacement of amalgam, silicate, acrylic or composite restorations, provided that, unless an additional tooth surface is involved, a continuous period of at least 12 consecutive months has elapsed since the last date on which the restoration was provided or replaced for the individual by any person.

Pit and fissure sealants for children up to the age of 18.

Prosthetic repairs

Those basic procedures required to repair or re-line fixed or removable appliances. Repairs to complete upper and/or lower dentures may be performed by either a licensed dentist or a duly licensed dental mechanic.

Endodontics

Those basic procedures necessary for pulpal therapy and root canal therapy. Root canal therapy will be limited to once per tooth per lifetime of patient.

Periodontics

Those basic procedures necessary for the treatment of tissues supporting the teeth including:

- scaling/root planing to a combined maximum of eight units of time every calendar year; and
- occlusal equilibration to a maximum of four units of time every calendar year.

The plan does not pay for duplicate, incomplete or unsuccessful procedures. Any fees in excess of the fee schedule are your responsibility.

Anaesthesia

Covered expense when given in conjunction with dental surgery only.

The percentage of payment for services under Plan "A" is outlined in the *Benefit summary*.

PLAN "B": MAJOR DENTAL SERVICES

Benefits shall be payable for the following:

1. initial provision of crown (other than stainless steel crowns), metal inlays or onlays, if the tooth is broken down by decay or traumatic injury so that the tooth structure cannot be restored with an amalgam, silicate, acrylic or composite restoration;
2. replacement of crowns, other than stainless steel, if a five-year period has elapsed since the last date on which the crown was provided;
3. initial installation of full dentures, partial dentures, or fixed bridgework;

4. replacement or addition of teeth to existing full or partial dentures or fixed bridgework provided the existing denture or fixed bridgework was installed at least five years prior to its replacement and cannot be made serviceable; and

5. implants and implantology.

The percentage of payment for services under *Plan "B"* will be as outlined in the *Benefit summary* and in accordance with the schedule of fees. Any fees in excess of the fee schedule are your responsibility.

The combined maximum for *Plan "A"* and *Plan "B"* per calendar year per individual family member is identified in the *Benefit summary*.

PLAN "C": ORTHODONTICS

Orthodontic services as listed in the fee guide of the College of Dental Surgeons of British Columbia. Lost, broken or stolen appliances will not be replaced.

The maximum lifetime benefit is the amount stated in the *Benefit summary*.

The percentage of payment for services under *Plan "C"* is outlined in the *Benefit summary*.

Any fees in excess of the fee guide are your responsibility.

A letter from your doctor may be required before any orthodontic expenses are reimbursed. Reimbursement for the initial orthodontic fee must not exceed 35 per cent 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.

SERVICES NOT COVERED

No amount shall be payable under this benefit for charges:

- in connection with general health examinations;
- which an individual is entitled under any government plan;
- for benefit which an individual is entitled to obtain without charge;
- for injuries resulting from any act related to war, insurrection or participation in a riot;
- which are not medically necessary;
- incurred as a result of any dental disease, defect or injury arising out of or in the course of any employment of an insured individual; and/or
- for education or training in, and supplies used for dietary or nutritional counselling, personal oral hygiene or dental plaque control.

EMERGENCY DENTAL CARE ANYWHERE IN THE WORLD

If you require emergency dental care while travelling or on vacation outside British Columbia, you are entitled to the services of a duly qualified dentist and will be reimbursed up to the amount that would have been paid had the services been rendered in British Columbia.

PRE-DETERMINATION

If the expected cost exceeds the pre-determination limit shown in the *Benefit summary*, send the dentist's proposed treatment plan (completed dental claim form) to the administrator before treatment commences. The administrator will advise you of the amount payable for the treatment, taking into account possible

alternate procedures or courses of treatment based on accepted dental practice. This will make you aware of the amounts payable before the dental work is done.

BENEFIT AFTER PROVISION TERMINATION

If a procedure is performed after this provision terminates, a benefit is payable as if this provision had not terminated for the repair of damage to natural teeth resulting from an accidental blow to the mouth, provided:

- the accident occurred while the person was insured and this provision was in force; and
- the procedure is performed within six months after the date of the accident.

LIMITATIONS

No payment is made for:

- dental services payable in whole or in part under any legislation, except to the extent that it permits excess payment; or
- any portion of the charge over the usual, customary and reasonable charge of the least expensive alternate service or material consistent with adequate dental services when such alternate service or material is customarily provided.

EXCLUSIONS

No benefits are payable for any of the following charges:

1. dental services provided primarily for cosmetic purposes;
2. charges for dentures lost, misplaced or stolen;
3. charges for appointments not kept or completion of claim forms;

4. expenses related to services or supplies of the type normally intended for sport or home use, such as, but not limited to, mouthguards;

5. charges for services or supplies rendered for full mouth reconstructions, vertical dimension corrections, correction to temporomandibular joint dysfunction (TMJ), or for the purpose of splinting;

6. charges by any person who is a member of the immediate family of the insured individual or who ordinarily resides in the insured individual's home;

7. any charges for service treatment or supplies for which there would be no charge except for the existence of insurance;

8. charges for dental services due to or resulting from:

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

    b) any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation, or;

    c) commission or attempted commission of a criminal offence by the insured person.

VII) OUT-OF-COUNTRY COVERAGE

This coverage protects members and their eligible dependants against the wide variety of expenses while travelling outside your province of residence, anywhere in the world. As long as you and/or your dependants are Canadian residents and your extended health care insurance with the CMSG Western Branch benefit plan is in effect, you will be protected by the Global Excel travel assistance program.

Dependants include your spouse, under age 75, as well as your dependant children who are dependent upon you for support and are under 21 years of age. Dependant children who are pursuing education at a university or college may continue to be covered from ages 21 to 25, provided they are attending a school located in Canada.

TRAVEL PERIOD LIMITATION

Coverage for any trips outside of the country is limited to a 60-day per trip maximum. Coverage beyond 60 days is not provided by this plan. Individuals should make their own arrangements for travel coverage extending beyond the 60-day maximum.

TRAVEL PLAN

The Global Excel plan is arranged through ETFS Incorporated by Coughlin & Associates Ltd., the plan administrator.

CERTIFICATE

A Global Excel card is issued to each member. This card bears no termination date, however, should your coverage terminate at any time, the card will be null and void.

24-HOUR ACCESS

The coverages are provided 24 hours a day and seven days a week. In case of emergency, the worldwide Global Excel network

may be called so that the hospital or attending physician may confirm that insurance coverage is in force and make any necessary arrangements.

ELIGIBLE EXPENSES

If you or your dependants incur an eligible expense, the insurer will reimburse the following expenses, subject to the provisions and limitations of the policy:

NOTE: The following is for summary information purposes. For complete details, see the Global Excel brochure.

A. Hospital expenses

1. reasonable and customary hospital, room and board charges, up to and including the semi-private accommodation level, subject to a maximum duration of 365 days per person.

2. reasonable and customary hospital charges for out-patient services when medically required.

B. Services of a physician

Reasonable and customary fees for medical care and treatment or surgical procedures performed by a legally qualified physician or surgeon.

C. Services of private duty nurse

On the recommendation of an attending physician, the services of a private duty nurse required as a result of the emergency during hospitalisation to a maximum of $5,000 per accident or sickness. Prior approval of the plan administrator is required.

D. Emergency dental treatment benefit

Expenses of a legally qualified dentist or dental surgeon for loss resulting from injury to natural teeth, including replacements of such teeth provided the injury was caused by an external accidental blow to the mouth or face. Treatment must be completed prior to

your return to your province of residence subject to a maximum of $2,000 for any one accident.

E. Drugs and medication

Charges for drugs, medicines, serums and vaccines, obtainable only upon a written prescription and dispensed by a pharmacist, physician or surgeon, but excluding any charges made for the administration of injectable drugs, serums and vaccines subject to a dispensing maximum of 30-day supply.

F. Ambulance service

Expenses for a licensed ambulance service to the nearest qualified medical facility.

G. Medical supplies, aids and appliances

Casts, splints, crutches, trusses or braces (must be constructed with rigid or semi-rigid material, required for normal activities of daily living, not sports-related activities), walkers and/or temporary rental of a wheelchair, when prescribed by a licensed physician.

H. Paramedical services

Expenses for the services of any of the following licensed practitioners to a maximum of $250 per specialty per calendar year:

- chiropractor;
- osteopath;
- podiatrist;
- physiotherapist.

I. Return of deceased

In the event of death, the insurer will reimburse the insured person up to $5,000 for the cost of preparation and homeward transportation of remains to his/her point of departure. The policy provides up to $2,500 for burial or cremation at the place of death, excluding casket or urn.

J. Return of vehicle benefit

If, as a result of injury or sickness, the insured person has become totally disabled and is unable to continue the trip by driving the motorized vehicle used as a conveyance during such trip, the insurer will pay, up to a maximum amount of $5,000, the expenses incurred for the return of such vehicle by a commercial agency to the insured person's normal place of residence or the rental agency.

K. Diagnostic services

Laboratory tests and X-rays prescribed by the attending physician that are part of the emergency. This policy does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel.

L. After hospital convalescence

You are covered for after hospitalisation medical care until Global Excel determines that you are able to resume your trip, or you are deemed stable by Global Excel and eligible for repatriation.

M. Emergency air transportation

1. Air ambulance to the nearest appropriate medical facility or to a Canadian hospital for immediate medical attention.
2. Transport on a licensed airline with an attendant (where required) for emergency return to your province or territory of residence for immediate medical attention.

N. Transportation to bedside

Transportation of one of the following by single roundtrip economy airfare from Canada and up to $150 per policy, per day to a maximum of $3,000 to be with you if you have been travelling and are confined to a hospital for at least three days: spouse, parent, child, brother, sister or business partner.

O. Return of travelling companion

The insurer will reimburse the cost of a single one way economy airfare for a travelling companion to return to Canada under the return of deceased Emergency Air Transportation provision.

P. Return to trip destination

If you are returned to your province or territory of residence under the Emergency Air Transportation benefit, the insurer will reimburse the cost of a single one way economy airfare for you to be returned to your trip destination, when approved in advance by the Medical Director of Global Excel and provided that your attending physician determines that you require no further treatment for your emergency.

Q. Meals and accommodations

Up to $150 per policy, per day to a maximum of $3,000 for the cost of commercial accommodations and meals when your trip is delayed beyond your last day of coverage due to an illness or injury suffered by you or another person covered under this policy. Original receipts are required. This benefit must be authorized in advance by Global Excel.

R. Incidental expenses

Up to $250 per policy will be reimbursed for your out of pocket expenses such as telephone charges, television and parking while you are hospitalised for a covered medical emergency.

S. Private hospital accommodations

Room and board charges up to the private room rate charged by the hospital. If medically required, expenses for treatment in an intensive or coronary care unit are also covered. If coverage expires during your hospital stay, benefits continue until discharge, to a maximum of one year.

T. Lost medication prescriptions

The replacement of an existing prescription for medication in the event of loss, to a maximum of $100.

U. Trip interruption

The cost of a one-way economy airfare to return to your province or territory of residence or the fees charged to change your ticket (whichever is less) and reimbursement of the non-refundable portion of unused land arrangements, to a maximum of $500 in the event of:

1. unexpected illness, injury or death of your immediate family member, business partner, key employee or travelling companion, or
2. a disaster which renders your principal residence uninhabitable, or
3. hospitalisation of the person caring for your dependants necessitating an early or delayed return, provided no evidence of said events was made apparent in the 90 days preceding your trip.

V. Incidental business expenses

Up to $250 will be reimbursed for your out-of-pocket expenses for the temporary use or rental of a computer or portable phone in the event of theft. Original receipts and police report or statement are required.

W. Flight accident insurance

Death or dismemberment as a result of injury sustained during the trip while you are travelling as a passenger, not as a pilot or crew member, aboard a fixed wing multi-engine transport aircraft with an authorized takeoff weight greater than 35,000 lbs. (15,900 kg) operated between licensed airports by a scheduled or charter airline.

Aggregate limit of liability

An aggregate limit of $5 million per insured for accident or sickness will be paid.

Exclusions

This insurance does not cover expenses resulting from any of the following:

1. any expenses payable or reimbursable under a private or government insurance plan;
2. any travel booked or commenced contrary to medical advice or after receipt of a terminal prognosis;
3. cardiac catheterisation, angioplasty, and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by Global Excel prior to being performed, except in extreme circumstances where such surgery is performed on an emergency basis immediately upon admission to a hospital;
4. treatment, surgery or medication that is not required for the immediate relief of acute pain or suffering or that you elect to have provided outside Canada when medical evidence indicates that you could return to Canada to receive such treatment;
5. treatment or surgery when the trip is undertaken for the purpose of medical or hospital services;
6. hospitalisation or services rendered in connection with general health examinations for "check-up" purposes, treatment of an ongoing condition, regular care or a chronic condition, home health care, investigative testing, rehabilitation or ongoing care or treatment in connection with drugs, alcohol or any other substance abuse or non-compliance with any prescribed medical therapy or treatment;
7. upgrading charges and cancellation penalties for airline tickets, unless approved in advance by Global Excel;

8. loss or damage to eyeglasses, contact lenses, prosthetic devices or hearing aids;
9. the failure (or fear of failure) or inability of any equipment or computer program to recognize or correctly interpret or process any date as its true calendar date, or to continue to function correctly beyond that date;
10. emergency air transportation and/or car rental not approved in advance by Global Excel;
11. crowns and root canals;
12. the replacement of an existing prescription whether by reason of renewal or inadequate supply except to the extent set forth in Benefit "T" or the purchase of drugs and medication (including vitamins) commonly available without a prescription or which are not legally registered and approved in Canada or which are not required as a result of a medical emergency;
13. participation in professional sports, motorized or mechanically assisted racing or speed contests;
14. mental, psychological or emotional disorders, unless hospitalised;
15. treatment not performed by or under the supervision of a licensed physician or dentist;
16. treatment of hospital confinement of mother or child(ren) as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the nine weeks before and/or after the expected delivery date;
17. war, whether declared or undeclared, riot or civil disorder, rebellion, revolution, hijacking or terrorism, and service in the armed forces;
18. committing or attempting to commit a legally negligent act, criminal offence, suicide, attempted suicide or self-inflicted injury, whether sane or insane;

19. expenses incurred as the result of the abuse of medication, drugs, alcohol or other toxic substances;

20. expenses incurred in your province of residence, or in a province where you attend school on a full-time basis, or in your home country if you are a foreign student studying in Canada, or a non-resident working in Canada.

GENERAL PROVISIONS

Written notice of injury or sickness on which claim may be based must be given to the insurer within 30 days after the date of the accident causing such injury or sickness.

In case of claim for loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible. In no event will a claim be considered later than one year after the date of the accident.

4. How to make a claim

When you have a claim, please obtain the necessary forms from your employer, the Guild or the plan administrator. All completed claim forms must be forwarded to the plan administrator:

Coughlin & Associates Ltd.

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

Telephone:	613-231-2266
Fax:	613-231-2345
Toll Free:	1-888-613-1234
E-mail:	webmaster@coughlin.ca

It is only reasonable for you to expect prompt payment of claims when they arise. The administrator wants to provide prompt service but needs your help. Make sure that all the information is complete and that all questions have been answered. **It is important that you identify that you are a member of the CMSG Western Branch benefit plan.**

Following are the claims procedures for the various benefits:

LIFE INSURANCE

If you or one of your dependants dies, a claim form should be completed as soon as reasonably possible. Contact the administrator for the necessary forms.

If you become totally disabled, a claim for waiver of premium from the trust fund must be made not later than 12 months after you stopped being "actively at work" and not earlier than six months.

ACCIDENTAL DEATH AND DISMEMBERMENT

In the event of a claim, notice of claim must be given to ACE INA Insurance within 30 days from the date of accident and subsequent proof-of-claim within 90 days from the date of the accident. Contact the administrator for the necessary forms.

WEEKLY INDEMNITY

If you become totally disabled, 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

If you become totally disabled, notify Standard Life of your condition at least 30 days before the end of your elimination period. A formal claim must be made not later than 90 days after you complete the 52-week elimination period.

While you are receiving the short-term disability benefit (WI) leading up to the long-term disability benefit, the insurer, Standard Life, will forward the necessary forms to be completed long enough in advance so that no interruption in payment results.

EXTENDED HEALTH CARE

When you or any of your registered dependants have accumulated eligible expenses in excess of the required deductible, obtain a claim form from your employer, the Guild or the administrator.

Please submit the original bills and/or receipts no later than 24 months after the date the expense was incurred to substantiate the claim. Be sure that the receipts are itemized on the claim form, i.e. sufficient information should be included to identify the insured person, the date each expense was incurred and the type of service provided.

A completed claim form, together with all the bills and/or receipts, should be mailed to the administrator.

DENTAL CARE

When you or a member of your family receive a bill for eligible dental services, ask your dentist to provide a completed claim form with sufficient details so that the claim can be processed for payment. A separate claim must be completed for each eligible dependant who has received dental care services.

Mail or fax the completed claim form to the administrator. Be sure to include the name of the dentist, the name of the person receiving the dental care, the date of birth, the group policy number, your personal identification number and your home address.

The administrator will send you a cheque as soon as the claim is processed.

Alternatively, at the member's request, assignment of benefits to the dentist can be made.

Note:

Claims should be submitted as soon as possible after the dental treatment has been completed. No action may be brought against the plan for any claim unless presented to the plan administrator within 60 days of treatment completion date.

OUR EDI SERVICE

Coughlin & Associates Ltd. can process your dental claim using our electronic data interchange (EDI) claims processing service.

With EDI, ***your dental claim can be sent directly from your dental office*** to our claims department for adjudication.

Our 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 & Associates Ltd. quickly, safely and confidentially right from your dentist's office.

To take advantage of Coughlin's EDI service, just tell your dentist that Coughlin & Associates Ltd. is your claims administrator and present him/her with the following security codes:

- the Coughlin & Associates Ltd. Telus identification number (also known as the BIN number), which is **610105**;
- your unique employee identification; and
- the policy number of your group benefit plan, **9006**.

Your human resources department or plan administrator will be able to provide you with your employee identification and group benefit plan policy numbers.

PRE-AUTHORIZED DEPOSIT (PAD) AVAILABLE

Members and employees of benefit plans administered by Coughlin & Associates Ltd. can now have their health and dental 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** and follow the instructions at the bottom of the home page.

CHECK YOUR CLAIMS ELECTRONICALLY

You can also check the status of your claims electronically. But first, you have to register with Coughlin & Associates Ltd.'s claims administration system. Just follow these steps:

1. Go to **www.coughlin.ca**.
2. To access the portal, click the *"Log on"* menu item at the upper right of the Coughlin & Associates Ltd. website.
3. Using the drop down menu located there, select *"Member portal"* link. Then, click the *"Go"* button.
4. First-time users must then click the Haven't registered yet? button and complete the registration form. (Note: your temporary password, which is needed to register, should have been provided on previous claim assessments.)
5. A user identification number and password will then be assigned.
6. After that, just click on *Claims history* to review the status of your recent claims.

OUT-OF-COUNTRY COVERAGE

Should a claim arise, written notice of any loss, damage, injury, expenses or payments shall be given to the company within 30 days. The insured must provide proof of loss within 90 days.

All claims and enquiries should be directed to the plan administrator.

5. Contract/policy numbers

Benefits	Insurers	Policy numbers
Life, LTD	Standard Life	33162
WI	Self-insured/Standard Life	33162
AD&D	ACE INA	ABT 102077
EHC, dental,	Self-insured	9006
Out-of-country	Global Excel	1057324