ALBERTA SHEET METAL WORKERS

HEALTH & WELFARE PLAN

May 2024

To All Plan Participants
Alberta Sheet Metal Workers
Health & Welfare Plan

This information booklet has been prepared to give you an informal summary of the main features of your group insurance program. Please note that this information is in reference to the governing documents of the Plan: Life, Dependent Life and Long Term Disability (Group Policy #901743) and Supplementary Health, Dental and Weekly Income (Group Policy ##903044) of The Manufacturers Life Insurance Company, Accidental Death & Dismemberment (Policy #GPA 9429839) and Travel Medical Emergency (Policy #CMG 9428933) through AIG Insurance Company, Member Family Assistance Program (Company Code #646) through Homewood Human Solutions, while the pay direct prescription drug card is coordinated with Telus eClaims (Group # 58839) issued to the Trustees of the Alberta Sheet Metal Workers' Health & Welfare Plan.

Finally, please note that the Healthcare Spending Account (H.S.A.) allocations are self-insured and subject to the discretion of the Trustees from time to time given the financial stability of the Trust Fund and in compliance with CRA Tax Regulations.

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

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

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Notice Regarding Personal Information

When applying for coverage under the Group Benefit Plan, The Manufacturers Life Insurance Company, AIG Insurance Company, Homewood Human Solutions, and the Plan Administrator, Coughlin & Associates Ltd., set up a file with personal information relevant to your benefit coverage under the Plan.

The purpose of this file is to permit the insurance companies listed above and Coughlin & Associates to administer all financial services provided to you and to keep information specific to their business relationship with you. This includes the following:

1) Underwriting and financial reporting.
2) Claims adjudication and management.
3) Internal and external audits.
4) Preparation of regulatory and statutory reports.
5) Assistance in planning for financial security.

The files are kept in the offices of the Plan Administrator. The Employees of Coughlin & Associates have access to these files when required for insurance purposes.

You have certain rights of access and correction with respect to the information in your file. A request for access or correction must be placed in writing and may be sent to the office of the Plan Administrator Coughlin & Associates Ltd., P.O. Box 764, Winnipeg, Manitoba, R3C 2L4.

Privacy

Effective January 1, 2004, the federal Personal Information Protection and Electronic Documents Act (PIPEDA) governs the collection, use and disclosure of all personal data by all Canadian commercial organizations. Thus, every transaction involving the handling of personal data (collection, use, transfer, disclosure, storage, accessing, processing, etc.) has to be conducted in accordance with the Act.

In conjunction with the Insurers, Coughlin & Associates Ltd. is committed to respecting your right to privacy and safeguarding your personal information. For more information regarding the Insurers' privacy policies or Coughlin's Privacy Policy, please contact Coughlin & Associates Ltd. directly or via the website www.coughlin.ca for Coughlin's Privacy Policy.

Access to Plan Documents with respect to Benefits underwritten by Manulife Financial

You or your covered dependents have the right to request a copy of any or all of the following items:

- the sections of the Group Policy and/or Plan Document that apply to you and your dependents; and
- your application for group benefits; and
- any Evidence of Insurability you submitted as part of your application for benefits.

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

Summary of Benefits

Life Insurance

You are eligible for an amount of insurance equal to $40,000. The amount of insurance reduces to $4,000 at age 65 and terminates at age 70 or retirement, whichever occurs first.

Termination of coverage is as outlined under "Termination of Insurance" in the "Eligibility" section.

Accidental Death and Dismemberment

(underwritten by AIG)

You are eligible for an amount of insurance equal to $80,000. The amount of insurance reduces to $4,000 at age 65 and terminates at age 70 or retirement, whichever occurs first.

Termination of coverage is outlined under "Termination of Insurance" in the "Eligibility" section.

Dependent Life Insurance

Spouse:	$10,000
Each Child:	$ 5,000

Termination of coverage is as outlined under "Termination of Insurance" in the "Eligibility" section.

Weekly Disability Income

From $650 to $668 per week effective January 1, 2024 for all new disabilities. Benefits begin on the 1st day of a disability due to an accident and on the 1st day of a disability due to sickness or surgery. The maximum duration of benefits is 52 weeks. This Benefit is integrated with Employment Insurance benefits.

Note: This Plan pays benefits during the post-natal recovery period of maternity leave.

This benefit is taxable.

Termination of coverage is outlined under "Termination of Insurance" in the "Eligibility" section.

Long Term Disability

Your benefit is $1,500 per month. Your monthly benefit may be reduced subject to the 75% All Source Maximum described under Offsets in the Long Term Disability section later in this booklet.

The qualifying disability period starts when you first become totally disabled and ends after 365 days or the expiration of the Weekly Disability Income Benefit provided under Policy No. 903044 if greater, provided your disability is continuous and **you are under age 60.** If the disability is not continuous, the days you are disabled will be accumulated to satisfy the qualifying disability period provided:

- no interruption is longer than 2 weeks; and
- the disabilities arise from the same or related disease or injury.

This is a taxable benefit for Union Members and a Non-Taxable benefit for Associate Employees.

Termination of coverage is as outlined under "Termination of Insurance" in the "Eligibility" section.

Supplementary Health Expense

Deductibles	⇒	$25 per individual, $50 per family per year
Coinsurance	⇒	80% of Out of Province and Canada Expenses when incurred on a referral basis
	⇒	80% of Prescription Drug expenses
	⇒	80% of all other eligible expenses, subject to Reasonable and Customary limits in excess of the deductible are paid by Manulife Financial
	⇒	Note Plan maximums will apply

Plan Maximums

Prescription Drug	⇒	$25,000 per family per benefit year
	⇒	$1,000 per benefit year per insured individual for Viagra and all other erectile dysfunction drugs
	⇒	$2,500 lifetime maximum per individual for fertility drugs and treatment

The Plan is partnering with Pocket Pills, a digital pharmacy, to offer home delivery of prescription drugs. Access to this service can be obtained through https://app.pocketpills.com/coughlin or can be obtained on the Coughlin website at www.coughlin.ca.

Paramedical Services (excluding Physiotherapy)	⇒	$500 per person per benefit year per practitioner
Physiotherapy	⇒	$700 per person per benefit year
Other Eligible Expenses	⇒	Unlimited (note maximums will apply)
Vision Care	⇒	$300 per person in any period of 24 consecutive months (12 consecutive months for individuals under age 18 years of age) are covered. Eye examinations to a maximum benefit of $70 per person in any period of 24 consecutive months are covered
	⇒	$1,500 every 10 years for Laser Eye Surgery
Smoking Cessation Aids	⇒	$500 per person per lifetime

The following expenses are not subject to the deductible:

- hospitalization in Canada; and
- hospitalization or medical treatment required due to emergency non-elective reasons when incurred outside your province of residence.

Benefit Year means the period starting July 1st and ending June 30th.

Termination of coverage is as outlined under "Termination of Insurance" in the "Eligibility" section.

People Connect – Mental Health Resource

Maximum (per person) ..... included under Psychology benefit in Supplementary Health Expense, Paramedical Services, plus eligible under H.S.A.

People Connect provides members and their family members with educational tools, an online assessment, and access to immediate care

through virtual therapy. The first virtual counselling session is free, and each additional session is $75.00 per hour or $37.50 per 30 minutes and payable via credit card. For reimbursement from the Health and Welfare Trust Fund, please submit the receipt and claim form to Coughlin & Associates for processing.
To get started, please visit pcpeopleconnect.com. For additional information, please contact peopleconnect@peoplecorporation.ca.

Coverage Ceases ..... upon cessation of Supplementary Health Expense benefit coverage

Dental Expense

Deductibles ⇒ Nil

Coinsurance ⇒ 80% for Minor Services
50% for Major Services
50% for Orthodontics

Fee Guide

The current Fee Guide is considered to be the Current Alberta Dental Association Fee Guide for General Practitioners or Specialists.

Maximum Benefit per Individual

Orthodontics ⇒ $2,000 Lifetime Maximum

All Other Expenses ⇒ $2,500 per Benefit Year

Benefit Year means the period starting July 1st and ending June 30th.

Termination of coverage is as outlined under "Termination of Insurance" in the "Eligibility" section.

Travel Medical Emergency

Policy Number ..... CMG 9428933

Deductible ..... Nil

Benefit Maximum ..... Under 70: $5 Million/per person/lifetime
..... 70 to 74: $2 Million/per person/lifetime

Maximum Duration .....90 days

Coverage ceases ..... Earlier of age 75 or depletion of
.....Hour Bank account and/or self-pay period

Contact Number..... Canada/US: 1-877-207-5018
.....Outside Canada/US: 1-819-566-3940

Please see the Travel Medical Emergency section for how to make a claim. Or refer to the Travel Medical Emergency Booklet provided by AIG for further information.

Member Family Assistance Program (EFAP)

Benefit.....12 sessions (1 hour)/individual/
calendar year via Homewood Human Solutions

Please refer to **Member Family Assistance Program** section for complete details or call Homewood Health at 1-800-663-1142.

Healthcare Spending Account

Reimbursement.....100% of eligible expenses
limited to H.S.A. account balance
Eligibility ..... All Members provided they are in continuous
Good standing with the Union

Please refer to **Healthcare Spending Account** section for complete details.

Retiree Health Benefit Program
(Supplementary Health, Vision, Dental, EFAP, and TME)

Eligibility .....Retired Members (and Spouses) in good standing
who have been insured in the Plan
for 15 consecutive years prior to retirement
(subject to monthly self-payments, also TME coverage
subject to 90 day duration and pre-existing
90 day treatment free stability clause)
Coverage Ceases .....Upon the "Retired Member" attaining age 75

Please refer to **Provision for Self-Pay by a Member** in the **Eligibility** section for more details.

General Information

The Group Insurance is administered by a Board of Trustees representing the Alberta Sheet Metal Workers' Health and Welfare Plan and employers participating in the Plan. Such employers are called "Contributing Employers" in this handbook.

An account is kept by the Administrator of the Fund for each member which shows hours worked for a Contributing Employer for which contributions have been made for the purchase of group insurance. This account is called an Hour Bank Account.

Each month 140 hours will be deducted from your Hour Bank Account. The number of hours in your Hour Bank Account may never exceed 1,680 hours (enough to provide 12 months of coverage even though you acquire no hours during that period). Excess hours over this amount will be credited to the general reserves of the Fund.

Changes in Insurance

If a Member's benefit coverage changes because of an amendment to the Plan, or because of a change in their age, class, dependent status, etc., the new benefits become effective on the date the change affecting the benefits occurs.

When a change results in increased benefits, the Member must be actively at work (for an eligible Employer) to be eligible for the new benefits. If he/she is not actively at work for an eligible Employer on the date the new benefits would otherwise become effective, the change will not become effective until he/she returns to work for an eligible Employer. Increased benefits for a dependent confined in hospital on the dates the new benefits would otherwise become effective do not become effective until he or she is released from the hospital. In any case, payment for services and supplies received before the date of an increase in benefits will always be based on plan benefits in effect before the change.

Eligibility

Who May Be Insured

This Plan is for members of the Alberta Sheet Metal Workers' Health and Welfare Plan who work for Contributing Employers, **noting all Participants must be declared residents of Canada, and insured under the prospective Provincial Medicare Plan,** and includes the following:

1) Union Members

   Union Members are members of Local Union 8 participating in the Alberta Sheet Metal Workers' Health and Welfare Plan and for whom an employer is obligated to make contributions to the Fund.

2) Associate Employees *

   Associate Employees are:

   (a) Any salaried office or employees of the Local for whom coverage under this Plan has been approved by the Trustees.

   (b) Any employee of the Trustee for whom coverage under this Plan has been approved by them.

   (c) Any other employee of certain employers for whom coverage under this Plan has been approved by the Trustees.

   (d) Employees of the Sheet Metal Workers Retirement Trust Fund

   * *Only Associate Employees who work a minimum of 20 hours per week may become eligible for benefits.*

3) Trustees of the Alberta Sheet Metal Workers' Health and Welfare Plan may also become eligible for benefits.

When Union Members Become Insured Initially

Union Member

You and your eligible dependents will become insured for Health, Vision, Dental, Weekly Income, MFAP, and Travel Medical Emergency on the first day of the month following receipt of 260 hours in your Hour Bank Account, provided you are actively at work or available for work on the

day you would ordinarily become insured. Should you not be working or available for work on the day your insurance would ordinarily start, the insurance for you and your dependents will be delayed until you return to work or are available for work.

* You will become insured for Life, Dependent Life, AD&D, and Long Term Disability on the first day following 260 hours have been worked

Associate Employee

Provided you work at least 20 hours per week, you and your eligible dependents will become insured on the first day of the month following receipt of 2 months of contributions from a Contributing Employer on your behalf.

Provision for Self-Pay by a Member

If at the end of any given month, a member insured under this policy fails to meet the required monthly coverage cost as determined by the rules of the Trust Fund, such member will be notified by the Administrator before his insurance is terminated and given the opportunity of contributing the necessary amount of money so that he may continue to be insured.

Provided the member continues to be in good standing with the Union, self-payments may be made on the following basis:

1) Active Union Members may make monthly payments equal to the coverage costs at which point coverage ceases for the following insurance benefits:

    - for Life Insurance and AD&D – amount of coverage reduces at age 65, and upon retirement coverage is limited to the depletion of Hour Bank (if any), but in no event does coverage go beyond attainment of age 70.
    - For Dependent Life Insurance – coverage can be extended to the earlier of attaining age 65, retirement or maximum self-pay duration (up to 24 consecutive months).

2) Active Union Members may make monthly payments equal to the coverage costs for a maximum of 6 consecutive months for Long Term Disability and Weekly Disability Income benefits, but not beyond age 60 for Long Term Disability only.

3) Disabled Union Members who have been declined for Waiver of Life and Accidental Death & Dismemberment insurance premiums may self-pay their Life Insurance to attainment of age 70, their Dependent Life Insurance to the earlier of attainment of age 65, retirement, or 24 consecutive months, and their Accidental Death and Dismemberment to the earlier of attainment of age 70, retirement, or 24 consecutive months, provided they continue to be disabled.

4) Active and retired Union members may make monthly payments equal to the coverage costs to the earlier of attainment of age 65 or 24 consecutive months with respect to the Supplementary Health and Dental Expense benefits only.

5) Union Members and Associate Employees receiving Long Term Disability benefits provided under Policy No. 901743 may make self-payments to maintain their Supplementary Health (including Travel Medical Emergency and Member Family Assistance Program to age 65) and Dental Expense coverage only. (This is the only time Associate Employees may make self-payments).

   For Disabled Union Members (on or after July 1, 2004) and Associate Employees (on or after January 1, 2008), following 6 consecutive months of disability, the Plan will assume the applicable premium costs for Supplementary Health (including Travel Medical Emergency and Member Family Assistance Program to age 65) and Dental Expenses coverage to the earlier of 10 consecutive years, age 65, or recovery.

   This provision is subject to be reviewed from time to time and it may change at the discretion of the Board of Trustees due to the financial stability of the Plan.

6) Active Union members may make payments equal to the coverage costs to the earlier of the attainment of age 65, retirement, or 24 consecutive months with respect to Travel Medical Emergency.

7) Active Union members may make payments equal to the coverage costs to the earlier of the attainment of age 65, retirement, or 24 consecutive months with respect to Member Family Assistance Program.

8) Retired Union Members who have been insured in the Plan for 15 consecutive years prior to retirement and have depleted (run down) their accumulated Hour Bank account, are eligible to participate in the Retiree Health Benefit Program. A monthly self-payment is

required (amount may vary subject to annual review by the Trustees) and coverage will not be extended beyond attainment of age 75 for eligible Retired Members (also eligible spouse noting coverage ceases when Member attains age 75). Coverage will include the Supplementary Health Benefit, Visioncare, Emergency Travel Accident protection (subject to 90 day duration and 90 day treatment fee stability clause), Dental, and Employee Family Assistance Program. There is no benefit coverage for Life Insurance, AD&D, nor Disability.

Reinstatement for Union Members only

If your insurance has previously terminated because of insufficient hours in your Hour Bank Account, you will again become insured on the first day of the month following receipt of 140 hours in your Hour Bank Account within a 6-calendar month period. If your insurance has not been reinstated during this period, your insurance will be reinstated on the first of the month following receipt of 260 hours in your Hour Bank Account. If your insurance is not reinstated within a 6-calendar month period, any hours in your Hour Bank account will be forfeited.

Should you not be working or available for work on the day your insurance would ordinarily become reinstated, the insurance for you and your dependents will be delayed until you return to work or are available for work.

If upon termination of your Group Life Insurance you converted it in accordance with the section "Conversion Privilege", it would be necessary for you to submit evidence of insurability satisfactory to the Insurer before again becoming insured for Group Life Insurance.

Termination of Insurance for Union Members

The insurance for you and your eligible dependents will terminate:

1) The last day of the month in which you have less than 140 hours in your Hour Bank Account. (You may however, arrange to have your coverage continued on a contributory basis. See Self-Pay Provision above).

2) The date you cease to be a Member of the Union.

3) The earlier of the date that you attain age 70, retirement (following depletion of Hour Bank Account and 24 months self-pay period) for Life and Accidental Death & Dismemberment coverage.

4) The date you attain age 65 or earlier retirement (following depletion of Hour Bank and 24 month self-pay period) for Dependent Life Insurance coverage only.

5) The date you attain age 60 or earlier retirement for Long Term Disability only.

6) The date you retire and exhaust your Hour Bank Account for Supplementary Health and Dental coverage only.

7) The date you retire for Weekly Disability Income coverage only.

8) If you enter Military Service.

9) If the Group Policy Terminates.

10) The date you attain age 75 or early retirement for Travel Medical Emergency.

11) The date you retire for Member Family Assistance Program.

12) The date the Insured Retired Member attains age 75 for the Retiree Health Benefit Program.

A dependent's coverage will also terminate when he/she is no longer an eligible dependent.

Termination of Insurance for Associate Employees

1) The earlier of your retirement or the date your employment ceases, or attainment of age 75, for Supplementary Health Expense, Dental, Member Family Assistance Program, and Weekly Disability Income coverage's only.

2) The earlier of the date you attain age 70, retirement, or date your employment ceases for Member Life Insurance, Accidental Death and Dismemberment, and Travel Medical Emergency coverage only.

3) The earlier of the date you attain age 65, retirement, or date your employment ceases for Dependent Life Insurance.

4) The earlier of the date you attain age 60, retirement, or date your employment ceases for Long Term Disability only.

5) If you enter Military Service.

6) If the Group Terminates.

A dependent's coverage will also terminate when he/she is no longer an eligible dependent.

Eligible Dependents

1) Dependent means a Spouse or Child who is domiciled (permanent residence) in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

2) Unmarried children who are under age 21, or under age 25 if attending an accredited school, college, or university as a full time student. Dependent children must be dependent on you for support and not employed at a regular full-time job. With respect to Dependent Life Insurance, dependent children must be at least 24 hours of age.

3) Functionally impaired children who are totally dependent upon you for support. For the purpose of this plan, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired and who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.

4) A child of your spouse provided he/she is also your biological child or your spouse is living with you and has custody of the child.

5) Your spouse as the result of a valid civil or religious ceremony, or a person whose common-law relationship with you has existed for a minimum period of 12 consecutive months immediately prior to the date on which a claim arose.

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

If a dependent is confined for medical care or treatment in any institution or a home when coverage would normally start, the dependent will not be covered until given a final release by the doctor from all such confinement. No one will be eligible as a dependent while covered as a member or while in military service.

Member Life Insurance

In the event of your death while insured, the amount of your Life Insurance is payable to your beneficiary. You may change your beneficiary at any time through written notice to your Employer, subject to any policy or legal limitations.

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

Waiver of Premium for Disability

If you become totally disabled and, i) qualify for Long Term Disability benefits under this plan or ii) become totally disabled for at least 6 consecutive months before attaining age 65, your Life Insurance will be continued free of charge until you cease to be totally disabled or you reach age 70, whichever occurs first.

Totally Disabled, for the first 24 consecutive months of wavier of premium, shall mean the member is incapacitated to the extent that the member is not able to perform any and every duty of the member's occupation or employment. After such 24 months, Totally Disabled shall mean the member is incapacitated to the extent that the member is not able to perform any and every duty or any occupation or employment for which the member is reasonably qualified by education, training or experience.

Such incapacity must result from a medically determinable physical or mental impairment. You must submit proof of your continuing disability as may be required by the Insurer.

Note: In order to qualify for the Waiver of Premium benefit you must notify Manulife Financial of your disability within one (1) year of your last active day at work, and must furnish proof of your disability satisfactory to the Insurer within 18 months of that last active working day.

Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Life Insurance coverage to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Member

Life Insurance. If you die during this 31-day period, the amount of Member Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

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

Dependent Life Insurance

In the event of the death of your spouse and/or dependent children while insured, the amount of Dependent Life Insurance is payable to you.

Conversion Privilege

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your application for the individual policy, along with the first monthly premium, must be received by Manulife Financial, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for spousal coverage.

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

Waiver of Premium Benefit

If while insured for this coverage, you become disabled and quality for the Waiver of Premium Benefit under your Life Insurance coverage, the Insurer will also waive the payment of your Dependent Life Insurance premiums.

Your entitlement to Waiver of Premium Benefit ceases on the earlier of a) the date your Waiver of Premium for Life Insurance cease, or b) the date the policy or this coverage terminates.

Member Accidental Death and Dismemberment

Coverage

Your plan provides 24-hour Accidental Death & Dismemberment benefits for injuries as a result of covered accidents, on or off your job, on business, on vacation, at home, regardless of your health history.

Benefit Amount

You are automatically covered for the Principal Sum in the Highlight of Benefits section. The amount of benefit depends on the loss suffered by you and is limited to the percentage of the Principal Sum shown in the Table of Losses.

Coverage Ceases

Coverage terminates the date you or reach age 70 or retirement, whichever comes first.

Waiver of Premium for Disability

Waives premium payments under the policy if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage

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

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

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

Table of Losses

	Percentage Principal Sum Payable
Loss	
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Brain Death	100%
Loss of One Arm or One Leg	80%
Loss of One Hand or One Foot	75%
Loss of The Entire Sight of One Eye	75%
Loss of Thumb and Index Finger of the Same Hand	40%
Loss of Speech and Hearing	100%
Loss of Speech or Hearing	75%
Loss of Hearing in One Ear	66.7%
Loss of Four Fingers of One Hand	40%
Loss of All Toes of One Foot	25%

Paralysis	
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two times the Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times the Principal Sum

Additional Benefits

The Benefit Description is a summary only and does not include all of the provisions, sub-limits, conditions and exclusions. Please refer to the AD&D booklet on the Member Portal prepared by AIG for more information.

Policy Exclusions

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

(a) suicide or any attempt thereat;

(b) self-inflicted Injury or any attempt thereat;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) Injury or Loss sustained if you or your insured eligible dependents are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

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

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

(m) death by natural causes.

Weekly Disability Income

In the event you become totally disabled due to an injury or sickness, you will receive a disability benefit provided you are under the continual treatment of a qualified and licensed physician and medical information supports total disability.

Benefits for any one disability are payable from the 1st day of disability for injury resulting from an accident and the 1st continuous day of disability for sickness. Your benefit will be payable for not more than fifty-two (52) weeks during any one period of disability.

If following a period of disability, you return to active work for at least two weeks, a recurrence of this disability will be considered a new period of disability.

Offsets to Benefits

This benefit provides for an "Employment Insurance (E.I.) Integration" provision whereby:

- The first one (1) week of disability will be covered by the Plan. The Plan Administrator will advise you to apply for E.I. Disability benefits during the initial week.
- Weeks 2 to 26 will be covered by E.I. if available, or by the Plan if E.I. is not available.

Furthermore, the Amount payable to you under this benefit is calculated by deducting from your benefit income or benefits payable under any plan or program or any government including any plan or program established pursuant to a provincial automobile act but excluding Canada or Quebec Pension Plan benefits.

Exclusions

Benefits are not payable for:

- disability resulting from intentionally self-inflicted injuries unless medical evidence establishes that the injuries are related to a mental health illness;
- disability arising from voluntary participation in a war, riot, or insurrection;

- any portion of disability, or portion thereof, during any leave of absence (including maternity leave) as defined in the General Provisions section of this booklet, except where benefits are provided during the post-natal recovery period of maternity leave;
- for the portion of a period of disability during which you are imprisoned in a penal institution or confined in a hospital or similar institution as a result of criminal proceedings;
- for the portion of a period of disability during which the member is not under treatment by a physician;
- for the portion of a period of disability during which the member is eligible to receive benefits under any Workers' Compensation Law or any similar law; unless due proof is submitted to the Insurer that the member has been disqualified for such benefits.

Subrogation

If you are entitled to recover compensation for the loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will be subrogated to all your rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You shall execute such documents as required by the Insurer.

In the event you provide proof to the Insurer that you have not recovered full compensation for the loss of income, the Insurer shall determine the proportion of damages recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss for loss of income, and the Insurer's right of subrogation will apply.

The term compensation shall include any lump sum or periodic payments which you receive or are entitled to receive an account of past, present or future loss of income.

Submitting a Claim for Weekly Disability Income

If you are wholly and continuously disabled by bodily injury or sickness and prevented from performing your regular work, and have active coverage for this benefit, you should contact the Claims Adjudicator, Coughlin & Associates, at wdisabilityclaims@coughlin.ca or telephone 1-888-204-1234 for the corresponding forms to apply for this benefit.

Long Term Disability Income

Member Long Term Disability Benefits

If you become totally disabled for the required period of time known as the Qualifying Disability Period and you are under the continual treatment of a legally qualified physician deemed appropriate by the Insurer, you will receive a monthly income benefit.

Qualifying
Disability Period ⇒ As described in the Summary of Benefits

Monthly Benefit ⇒ $1,500

Maximum
Disability Period ⇒ to age 60

Benefits will not be payable beyond age 60, unless you satisfy the Qualifying Disability Period while age 59, in which case benefits will be payable for a maximum of 12 months.

Total Disability

You are considered totally disabled, during the first 24 consecutive months in which you receive benefits, if you are unable to perform any and every duty of your occupation. After this period you are considered totally disabled if you are unable to perform any and every duty of any occupation for which you are reasonably qualified by training, education or experience.

Recurrent Disability

If a disability recurs and it is due to the same or related causes, it will be considered as one continuous disability and will not be subject to the Qualifying Disability Period unless you have returned to active, full-time employment for a period of 6 consecutive months or longer.

If your new disability is due to causes unrelated to your prior disability you may be eligible for a new disability period, subject to the Qualifying Disability Period, if you have returned to active work for at least one full day.

Direct Offsets

The amount of disability benefit payable to you is the Benefit Amount shown on the previous page reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

- any Workers' Compensation law or similar law;
- any other plan or program of any government including any plan or program established pursuant to a provincial automobile insurance act. Your benefit will be reduced in respect of benefits payable by the Employment Insurance Commission.

All Source Maximum

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 75% of your gross monthly earnings (for Union Members) and net monthly earnings (for Associate Employees) as of the date your disability commenced. All sources include those sources stated above and any benefit you are entitled to receive from:

- Canada or Quebec Pension Plans, excluding dependent benefits
- any income payable to you under a pension or retirement plan of the employer, or any plan or arrangement resulting in the payment of any salary, wage or other payment by the employer to you during the total disability;
- any income or benefit payable under any plan or program provided to you by or through the employer. Such plan or program includes any permanent and total disability benefit of group life insurance for which you could have elected not to apply;
- income from the Program of Rehabilitation, with respect to a disabled member participating in a Program of Rehabilitation

Waiver of Premium

Once you have started receiving Long Term Disability payments, your premiums for Long Term Disability will be waived.

Exclusions and Limitations

Benefits are not payable for the following:

1) For any provision of a period of disability unless you are receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program recommended by said physician.

2) For any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer.

3) For any portion of a period of disability resulting from substance abuse, including alcoholism and drug addiction unless you are participating in a recognized substance withdrawal program.

4) Disabilities resulting from self-inflicted injuries or attempted suicide, unless medical evidence establishes that the inquiries are related to a mental health illness.

5) Disabilities as a result of participation in a war, riot, insurrection or criminal act.

6) For the portion of a period of disability during which you are imprisoned in a penal institution; or confined in a hospital, or similar institution, as a result of criminal proceedings.

7) Any period of disability, or portion thereof, during any leave of absence (including maternity leave) as defined in the General Provisions section of this booklet.

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will be subrogated to all your rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You shall execute such documents as required by the Insurer.

In the event that you provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually revered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for the loss of income, and the Insurer's rights of subrogation will apply.

The term compensation shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

Disability Case Management Program

Manulife Financial has developed a disability case management program. The purpose of this program is to assist you, if you become totally disabled and qualify for benefits, to return to productive employment. Our disability case management team includes medical consultants, claim adjudicators and a field coordinator. This team will work with you, your employer and your physician to assist you to recover and return to the workplace.

Rehabilitative Employment

If you are disabled, the Insurer may recommend that you undergo some suitable rehabilitative training program which would consider the nature and limitations of your disability. Further details on this aspect will be provided if you become disabled.

Supplementary Health Expense

Member and Dependent Coverage

In the event you incur in a calendar year any of the Eligible Expenses listed below, you will be a paid a percentage (coinsurance) of such expenses in excess of the deductible for that year. The percentage (coinsurance) and deductible are specified in the Summary of Benefits.

Deductible

The Deductible is that portion of the Eligible Expenses which you are required to apply in any year before you receive benefits. The deductible is specified in the Summary of Benefits.

Lifetime Maximum Benefit

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

Eligible Expenses

The following is a list of eligible expenses:

Expenses shown below are insured if they are:

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

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

c) reasonable taking all factors into account; and

d) used as prescribed or recommended by a Physician; and

e) supported by Manulife Financial's Due Diligence process.

These Expenses are covered to the extent that:

a) they are Reasonable and Customary, as determined by Manulife Financial; and

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

c) they can legally be insured; and

d) Due Diligence for the Drug, supply or service has been completed where required.

Reasonable and Customary is a term used to refer to the commonly charged or prevailing fees for healthcare services with a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for that particular service with that specific community.

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

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

This Policy will not automatically assume eligibility for all Drugs, services and supplies prescribed. New Drugs, existing Drugs with new indications, services and supplies are reviewed by Manulife Financial using the Due Diligence process. Once this process has been completed, the decision will be made by Manulife Financial to include, include with Prior Authorization criteria, exclude or apply maximum limits.

Manulife Financial maintains a list of Drugs, services and supplies that require Prior Authorization. Prior Authorization is applied to ensure that the therapy prescribed is Medically Necessary. Where there are Lower Cost Alternative treatments, a person may be required to have tried an alternative treatment.

At Manulife Financial's discretion, medical information, test results or other documentation may be required from the Physician to determine the eligibility of the Drug, service or supply.

Manulife Financial has the right to ensure insured persons access Manulife Financial's Exclusive Distribution channels where applicable when purchasing a Drug, service or supply. Manulife Financial may decline a

Drug, service or supply purchased from a provider outside the Exclusive Distribution channel.

Adherence

Non-compliance may result in the Drug, service or supply no longer being eligible for reimbursement.

Patient Assistance Programs

Manulife Financial may require an insured person to apply to and participate in any Patient Assistance Program to which the insured person is entitled. Manulife Financial reserves the right to reduce the amount of a Covered Expense by the amount of financial assistance the insured person is entitled to receive under a Patient Assistance Program.

Disease Management Programs

Participation in a Disease Management Program may be required. Participation will be at the discretion of Manulife Financial.

Preferred Accommodation in Canadian Hospitals

The difference between the charges made for ward and semi-private room and board in a licensed Canadian hospital. Outpatient services in a hospital, where permitted by law. Such charges shall not be subject to the Deductible or the Lifetime Maximum.

Prescription Drug Expenses (via TELUS– In Canada)

Refer to Summary of Benefits for plan maximums.

Payment will be made for:

1) Drugs, serums and vaccines prescribed in writing by a Physician, Dentist or other professional authorized by provincial legislation to prescribe drugs and dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines.

2) Contraceptives prescribed in writing by a Physician.

3) Insulin, including needles and syringes.

4) Ostomy supplies.

5) Expenses incurred for Viagra and any other erectile dysfunction drugs are limited to the amount specified in Summary of Benefits.

6) Fertility Drugs, laboratory tests and x-rays including ultrasound are covered, subject to a lifetime maximum as specified in Summary of Benefits.

Payment will not be made for:

1) Patent and proprietary medicines, cough medicines, baby foods and formula, minerals, proteins, vitamins and collagen treatments.

2) Any charge for the administration of serums, vaccines and injectable drugs.

3) Drugs, serums and vaccines dispensed by a Physician or Dentist (However, injectable allergy medication is covered).

4) Anti-obesity treatments including drugs, proteins and dietary or food supplements, whether or not prescribe for medical reasons.

5) Smoking cessation products.

6) Drugs, biologic and related preparations which are administered in hospital on an inpatient or outpatient basis.

7) Drugs determined to be ineligible as a result of due diligence.

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

The Plan is partnering with Pocket Pills, a digital pharmacy, to offer home delivery of prescription drugs. While the Plan will benefit from the lower dispensing fees they charge compared to most other pharmacies, it is the convenience of this provider and ease of their online platform that we wish to highlight. Furthermore, shipping and med-packs through Pocket Pills is provided at no additional charge. Access to this service can be obtained through https://app.pocketpills.com/coughlin or can be obtained on the Coughlin website at www.coughlin.ca.

Out of Province or Out of Country Referral Expenses

Expenses incurred outside Canada are subject to a lifetime maximum benefit of $1,000,000. Expenses incurred outside your Province but inside Canada, are unlimited.

If an insured is referred by a physician to a hospital outside the insured's province of residence (but inside Canada) or outside Canada for medical treatment, the following expenses in excess of any provincial government plan allowance are covered provided they are eligible for reimbursement in whole or in part by any provincial government plan:

1) Reasonable and customary charges for semi-private accommodation.

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

3) Reasonable and customary charges for hospital services and supplies furnished during hospitalization.

4) Reasonable and customary charges for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

Extended Health Expenses

1) Charges for a rehabilitation hospital when admitted immediately following a minimum of 3 consecutive days of hospital confinement. Charges for rehabilitation care services and supplies shall be subject to a daily maximum benefit of $20 for not more than 180 days of confinement for each period of disability. Confinement must be made for the continued care of the same condition for which the insured was hospitalized and must begin prior to the insured's 65th birthday.

2) Charges for the services of a certified, registered, or licensed speech therapist, clinical psychologist (and similar qualified specialists), osteopath, chiropractor, chiropodist, physiotherapist, naturopath, podiatrist, acupuncturist, or massage therapist when operating within their field of expertise, up to a maximum benefit as specified in Summary of Benefits, in excess of the provincial plan, per specialty for any benefit year for each individual; charges for x-rays are covered up to one x-ray examination per benefit year for each specialty practitioner and

are subject to Reasonable and Customary limits per visit/duration of visit.

3) Charges for the services of a Registered Nurse (R.N.), licensed practical nurse, Certified Nursing Assistant (C.N.A.) or a member of the Victorian Order of Nurses (V.O.N.) while the patient is not confined to a hospital, subject to an overall maximum benefit of $10,000 in any benefit year; provided such nurse does not ordinarily reside in the home of the member and is not a relative of the member or of the member's spouse. These charges will be considered eligible expenses only if recommended by a physician and if medically necessary.

4) Charges for rental (or, at the Insurer's option, purchase) of durable medical or surgical equipment required for therapeutic purposes and as approved by the Insurer.

5) Charges for rental (or, the Insurer's option, purchase) of braces and crutches, and purchase of prostheses.

6) Charges for professional ambulance service, other than airline, to and from the nearest hospital equipped to provide the required treatment.

   Emergency transportation by airline to and from the nearest hospital qualified to provide the necessary treatment. Such emergency transportation is subject to a maximum benefit equal to the economy airfare for the insured, and, if medically required, a medical attendant who is neither a resident in the member's home nor a relative of the member or the member's spouse.

7) Charges for necessary dental treatment required as the result of an accidental injury to natural teeth provided the accident occurred while insured under this coverage. The dental work must be completed within 6 months of the accident to be a covered medical expense. Only such charges directly related to such an accidental injury and approved by the Insurer are considered a covered medical expense.

8) Charges for purchase of hearing aids (excluding batteries), subject to a lifetime maximum benefit of $250 per person.

9) Charges for orthopedic shoes (including repairs) and orthotics which have been specially designed and molded for the insured

individual and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

a) a diagnostic, including list of symptoms and the primary complaint;
b) a description of the physical findings from the clinical examination;
c) a brief description of the gait abnormality associated with the diagnosis; and
d) confirmation that the product has been custom-made.

In order to be eligible for reimbursement, orthopaedic shoes and orthotics must be prescribed, on an annual basis, by providers with the following professional qualifications:

a) Medical General Practitioner or Specialist (MD); or
b) Podiatrist (DPM); or
c) Chiropodist (D CH or D Pod M); and

must be dispensed by one of the following provider types:

a) Medical General Practitioner or Specialist (MD); or
b) Orthotist Co(c) or CPO(c); or
c) Pedorthist C Ped (c) or C Ped (MC); or
d) Podiatrist (DPM); or
e) Chiropodist (D CH or D Pod M).

Such charges are limited to one pair in any benefit year. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed for these items.

10) Charges for laboratory tests and x-rays not covered by any provincial government plans.

11) Charges for mammary prostheses required as a result of surgery, subject to a maximum benefit of $500 per person in any benefit year.

12) Charges for elastic support stockings when prescribed by a physician, subject to a maximum benefit of 4 pairs per person in any benefit year. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed for these items.

13) Charges for treatment by the use of radiotherapy or coagulo therapy.

14) Charges for glucometers or continuous glucose monitor when recommended in writing by a diabetologist or a specialist in internal medicine for an insulin dependent diabetic whose control is difficult to maintain with conventional methods.

15) Charges for stop smoking aids and appliances up to $500 per individual per lifetime

Vision Care Expenses

Charges for Vision care as follows:

1) Reimbursement of up to the amount specified in Summary of Benefits for prescription eyeglasses or contact lenses or prescription safety glasses every 24 consecutive months (12 consecutive months for insured under age 18). Charges for non-corrective lenses, prescription sunglasses, and anti-reflective coatings are not considered eligible expenses.

2) Charges for laser eye surgery up to $1,500 every 10 years.

3) Reimbursement of up to the amount specified in Summary of Benefits for eye examinations performed by a licensed ophthalmologist or optometrist that are not covered by your provincial health plan. Coverage is limited to one eye examination every 24 consecutive months.

Exclusions

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

1) Charges which are considered an insured service of any provincial government plan.

2) Charges for general health examinations, examinations required for use of third party.

3) Charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment.

4) Charges for medical treatment or surgical procedure by a physician other than as provided under outside Canada or out of province expenses.

5) Charges for transport or travel, other than as specifically provided under eligible expenses.

6) Charges not specified in the foregoing list of eligible medical expense.

7) Charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his license.

8) Charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy.

9) Charges for which are from an occupational injury or disease covered by any Workers' Compensation law or similar legislation.

10) Charges which would normally have been incurred but for the presence of this insurance or for which the member or dependent is not legally obligated to pay.

11) Charges which the Insurer is not permitted, by any law or regulation, to cover.

12) Charges for dental work where a third party is responsible for payment of such charges.

13) Charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind.

14) For out-of-Province or out-of-Canada only, charges for services or supplies resulting from any self-inflicted injuries, unless medical evidence establishes that the injuries are related to mental health illness.

15) Charges for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare – Canada or are experimental or limited in use whether or not so approved.

16) Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society.

17) Charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies.

18) Charges for drugs, sera, injectable drugs or supplies when administered in a hospital setting, whether administered on an inpatient or outpatient basis, except as provided under the Outside Canada Expenses or Outside Canada Referral sections, where provided under the Supplementary Health Expense.

19) Charges incurred for anyone who is not insured under the Provincial Medicare Plan.

Extended Supplementary Health Expense Coverage

Supplementary Health Expense coverage for dependents shall continue without premium payment following the death of the member up to a maximum of 24 calendar months (including exhaustion of the employee's reserve account) from the date of death or to the date the policy or benefits terminates, whichever is earlier.

Travel Medical Emergency
(Underwritten by AIG/ Global Excel)

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

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

How to Claim

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

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

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

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

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

Give the operator your name and your Policy Number: CMG 9428933

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

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

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

Member and Family Assistance Program

Your Member & Family Assistance Program

From time to time we all face difficult or stressful events in our lives. Most of the time, we handle these personal challenges fairly well. Other times, our personal problems can become large enough that they begin to interfere with our effectiveness, happiness or safety, both at work, and at home.

Your Member and Family Assistance Program (MFAP) provides confidential, professional assistance for a broad range of personal and family problems. While the program can be used for crisis intervention, the ideal time to use the program is before problems escalate or become unmanageable.

The Member and Family Assistance Program is a pro-active option for helping you manage your personal health and happiness.

What Services Are Available To Me?

Your MFAP offers you and your eligible dependents short-term counselling in person, by phone (1-800-663-1142) or through the internet at www.homewoodhumansolutions.com.

What Does My Program Offer?

Your MFAP covers counselling, in addition to assessment and referral when required, for a full spectrum of personal difficulties including, but not limited to:

- work-related stress
- relationship and family problems
- separation/divorce/custody
- financial and legal difficulties
- alcohol and drug dependency
- gambling and other addictions
- eating disorders
- difficulties with children

- psychological disorders
- anger management
- sexual harassment and abuse
- bereavement
- aging parents
- child/elder care resources
- retirement planning

How Does My Program Work?

Call Homewood Human Solutions and we will assist you in setting up an appointment at a time and office location convenient to you.

Your counselor will work with you to address your specific concerns and help you develop efficient and practical solutions.

If longer term counselling, hospital treatment, or specialized services are required, your counselor will arrange an appropriate referral and follow-up with you.

Who Provides My Counselling?

All Homewood Human Solutions health professionals are registered psychologists or registered counselors chosen specifically for their extensive experience in dealing with a variety of psychological health issues.

They provide a non-judgmental and unbiased source of expertise and support, will listen carefully to your concerns and will help guide you toward positive outcomes.

Is The MFAP Confidential?

Yes, the MFAP is a confidential service. Homewood Human Solutions counselors are required by law to maintain the strictest confidentiality. No one who inquires about or receives services under this plan will be identified to anyone without your written approval.

Who Do I Contact?

To speak with someone confidentially, call Homewood Human Solutions at 1-800-663-1142.

Another way to reach us is through our website. Scroll down our home page to the Quick Links and click on "Help and Counselling" to book an appointment.

Childcare and Eldercare Services

The Child and Elder Care program provides information about personal and family care providers in Canada. This service can be used to generate customized online reports with in-depth service descriptions and provides instant access to quality checklists, financial aid information, advice, and more.

Financial Counselling

Counselling can be provided for the following:

- debt crisis management
- preventative money and debt management
- cost of living analysis
- financial options related to separation and divorce
- illness and disability
- workforce transition and job loss
- early or planned retirement

Legal Counselling

The legal service provides two options:

- a telephone consultation through Lawline, an exclusive service provided by Homewood Human Solutions, or

- in our domestic service locations you can select a lawyer under contract with Homewood Human Solutions to provide legal consultation.

For Immediate Response North America Wide:

English 1-800-663-1142
French 1-866-398-9505
Hearing Impaired.....1-888-384-1152

International Access:

(Call Collect) 604-689-1717

Homewood Human Solutions is an industry leader and benchmark provider in-human solutions for organizations and their employees.

Homewood Human Solutions sets the standard for services such as EFAP, health strategy and planning, disability management, employee selection and development, and workplace conflict resolution.

Healthcare Spending Account

Purpose

The Trustees have implemented a Healthcare Spending Account (H.S.A.) with allocations made, from time to time, to Insured Members in good standing with Alberta Sheet Metal Workers. If you were entitled to an H.S.A. allocation this H.S.A. will assist Union Members and their families up to their entitlement in offsetting Healthcare and Dentalcare expenses incurred above and beyond the coverage presently provided by the Alberta Sheet Metal Workers Health & Welfare Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums). Future allocations if any will be subject to the discretion of the Trustees considering the financial stability of the Plan etc.

Claims Submission

For claims submitted via paper claim, any remaining Health, Vision, or Dental benefit expenses not covered by the basic Plan will automatically be applied to the extent of your H.S.A., if any, unless you indicate otherwise on the applicable claim form.

For online submissions via the Claims Member Portal or Coughlin Mobile App, you must select (i.e. toggle) to apply to your H.S.A.

For claims submitted electronically (eClaim) from a Provider's office (i.e. no claim form submitted) on behalf of you or your eligible dependents, the H.S.A. will not be applied automatically unless you contact Coughlin prior to claims submission at the Provider's office to request any remaining balance to be applied to your H.S.A. balance.

If you are submitting claims that require redirection to your spouse's plan for coordination of benefits, we will not automatically apply to your H.S.A. Subsequently, any remaining balance following coordination of benefits with your spouse's plan will need to be submitted to Coughlin along with a summary statement from your spouse's Insurer, to be applied to your H.S.A.

Obtaining H.S.A. Balance

You can obtain your remaining H.S.A. balance by the following 3 options:

1) By contacting the Plan Administrator
2) Online through the claims Member Portal at www.coughlin.onlineclaimsaccess.net
3) Coughlin Mobile App obtained from the Google Play or the Apple App store

Please note that Members cannot utilize their account for cash withdrawals or pay a provider directly (i.e. the account balance must be used to reimburse Vision, Health or Dental related expenses). Furthermore, Members must remain in good standing with the Local Union to be eligible for the balance in their H.S.A.. Upon termination as a Union Member, any remaining balance in your account will be forfeited back to the Plan and not reallocated.

Eligibility

For Union Members who are no longer in benefit (i.e. Retirees, Non-Working Members, Disabled), you may still make claims against your Healthcare Spending Account balance following your last day of coverage under the Group Insurance Plan provided you maintain your good standing as a Member of the Alberta Sheet Metal Workers.

As per Canada Income Tax Technical interpretation (9431185) regulations, the Healthcare Spending Account is subject to forfeiture every 24 months.

Termination

In the event of termination of Membership from the Alberta Sheet Metal Workers, the remaining Healthcare Spending account balance will be immediately forfeited to the Trust Fund.

Death

In the event of a Union Member's death, coverage will be extended to the surviving dependents as follows:

1. Spouse – until the balance of the Healthcare Spending Account is depleted.

2. Dependent Children – until they no longer qualify as dependents under the Group Insurance Plan or the balance of the Healthcare Spending Account is depleted.

Reinstatement

Reinstatement of a Union Member's Healthcare Spending Account is not applicable as it is a requirement that a Member maintain a positive status with the Alberta Sheet Metal Workers at all times.

Marital Separation / Divorce

As per the provisions for the insured benefits, the Healthcare Spending Account will not be extended to the spouse following separation or divorce. Alternatively, eligible dependent children will continue to be eligible for participation at the discretion of the Union Member.

Dental Expense Benefit

Member and Dependent Coverage

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

In the event you incur in a calendar year any of the eligible expenses listed below, you will be paid 80% of minor service, and 50% of major services and orthodontics.

Maximum Benefit

The total benefits payable are subject to the maximums specified in the Summary of Benefits

Extension of Benefits

No benefits for Eligible Expenses will be paid for claims incurred after the termination of the Master Policy or after your insurance under this coverage ceases.

Dental Claim Forms

Paper claims will not be processed unless a Dental Claim Form completed by your dental office, satisfactory to the Administrator, is submitted to their office.

Alternatively, electronic claims can also be submitted by participating dentists via Electronic Data Input (EDI).

Alternate Benefits and Submission of Treatment Plan

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, the Administrator reserves the right to determine eligible expenses on the basis of an alternate benefit.

As a service to you, the Administrator will advise you in advance of the amount of its liability when a proposed course of treatment includes major restorative dentistry or orthodontics. To use this service, simply have your dentist complete a treatment plan on forms available from your

Union or the Administrator, including pretreatment x-rays if the proposed treatment involves crowns or bridgework.

Eligible Expenses

Minor Procedures

Diagnostics

Procedures required to assist the dentist in evaluation existing conditions and determining the any further dental care which may be required subject to the following limitations:

1) Oral examinations limited to once each year, complete oral exam and diagnosis is covered only once every 2 years.

2) Bitewing x-rays once each Benefit year.

3) X-rays: single diagnostic x-rays; complete series or equivalent once every 2 years.

4) Study casts: once per year.

5) Consultations.

Preventative Therapy

Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

1) Polishing and topical fluoride once in any Benefit year.

2) Scaling, limited to a Reasonable and Customary amount of units.

3) Passive space maintainers for missing primary teeth.

4) Appliances to control harmful habits (provided the recipient is a dependent child when treatment is received).

5) Pit and fissure sealants (provided the recipient is a dependent child when treatment is received).

Basic Restorative Dentistry

The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, or synthetic restorations (fillings), including white fillings on molars and prefabricated full-coverage restorations for primary teeth. In addition, sedative dressings are covered.

Extractions

Uncomplicated procedures.

Endodontics

Endodontic procedures and root canal therapy.

Periodontics

1) Adjunctive Services as follows: Root planning, Acute infections, Occlusal Adjustment, Provisional splinting.

2) Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery.

3) Special Periodontal Appliances.

Oral Surgery

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

Anaesthesia

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

Repairs, Relining and Rebasing of Dentures

Repairs or relining and rebasing of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

<u>Major Procedures</u>

Removable Prosthetic Devices

The initial installation of partial or full dentures.

Replacement of existing dentures is not covered except if the existing denture is at least 5 years old and no longer serviceable. However, charges for replacement will be considered during this 5 year period if such replacement is needed:

- because the denture has caused temporomandibular joint disturbances and cannot be economically modified to correct the condition; or

- to replace a transitional denture which was inserted shortly following the extraction of teeth and cannot be economically modified to the final shape required.

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

Extensive Restorative Dentistry

Those procedures, including gold inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration. Repairs to crowns are also covered, other than performed stainless steel crowns (otherwise called prefabricated full-coverage restorations), which are covered under Minor Procedures.

Fixed Prosthetic Devices

The initial installation of fixed prosthetic devices.

The replacement of existing fixed prosthetic devices is not covered except if the existing fixed prosthetic device is at least 5 years old and no longer serviceable. However, charges for replacement will be considered during this 5 year period if such replacement is needed because the existing fixed prosthetic device has caused temporomandibular joint disturbances and cannot be economically modified to correct the condition.

Implants and/or Related Services

Should implants and/or related services be obtained, reimbursement will be considered but only up to the maximum that would have been paid for the least costly professionally adequate treatment to restore the entire arch, such as prosthetic devices (crowns, dentures and/or bridgework) as defined under the Alternate Benefit provision, subject to the co-insurance applicable to the treatment determined to be eligible.

Orthodontics

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of teeth". These include active space retainers, or orthodontic appliances, for the purpose of repositioning or moving of the teeth.

Exclusions and Limitations

No benefit is payable for the following:

1) Services or supplies that are primarily for cosmetic dentistry.

2) Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license.

3) Any charge for an injury resulting from war, riot, insurrection or participating in a criminal act.

4) Any miscellaneous charges such as counseling or instruction, travel, broken appointments, communication costs or filling in of forms.

5) Any services covered in whole or in part by any government plan, services for which no charge is made, or services which the insurer is not permitted by law to cover.

6) Any charge for services which would not normally have been incurred, but for the presence of this insurance, as for which you are not required to pay.

7) Any hospital charges for board and room and related services and supplies.

8) Any dental examinations required by a third party.

9) Services or supplies are not medically necessary to the care and treatment of any existing or suspected injury, or disease.

10) Diagnostic procedures in connection with any benefit categories excluded as eligible expenses.

Extended Dental Expense Coverage

Dental Expense coverage for dependents shall continue without premium payment following the death of the member up to a maximum of 24 calendar months (including exhaustion of the employee's reserve account) from the date of death or to the date the policy or benefit terminates, whichever is earlier.
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General Provisions

Definitions

Adherence shall mean use of Drug, service or supply in accordance with the terms for which it was prescribed.

Advisory Body shall mean Manulife Financial approved external experts that may provide Manulife Financial with recommendations, applying a Pharmacoeconomic or cost effectiveness evaluation.

Disease Management Programs shall mean an approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

Drug means a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Due Diligence means a process employed by Manulife Financial to assess new Drugs, existing Drugs with new indications, services or supplies to determine eligibility under the Policy. This process may use Pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an Advisory Body.

Earnings

Shall mean that amount of money, based on the number of hours in the regular work week, as per the Collective Agreement multiplied by the hourly wage rate for each particular member in the wage rate classification to which he belongs.

Exclusive Distribution means Manulife Financial approved vendors.

Experimental or Investigational means not approved as an effective, appropriate and essential treatment of an illness or injury.

Hospital

Shall mean an institution operated pursuant to law for the care and treatment of sick and injured persons. The hospital must be continuously

starred and supervised by licensed physicians and registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term hospital, as used in this booklet, shall not include a rest home, nursing home, rehabilitation hospital, health spa, a place for custodial care, a home for the aged or an institution used primarily for the confinement or treatment of alcoholism or drug addiction, tuberculosis or mental illness.

Leave of Absence

Shall mean period of time away from work mutually agreed to by the employer and member. In the case of maternity leave of absence, the leave shall begin on the earliest of:

- the elected start date of the maternity leave; or
- the date of delivery; or
- the date the employer may require the leave of absence to commence if the member's performance is affected by the pregnancy.

Shall leave terminate on the later of the date defined by Provincial or Federal Statute, or the date agreed to between the employer and member.

Life-Sustaining Drugs means non-prescription Drugs which are necessary to sustain life.

Lower Cost Alternative means if two or more Drugs, supplies or services result in therapeutically similar results, the Lower Cost Alternative will be considered.

Medically Necessary means accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of a phase of an illness or injury. Manulife Financial has the right after Due Diligence has been completed to determine whether the Drug, service or supply is eligible under the Policy.

Member

Shall mean a person who conforms to the definition of employee as defined in the collective agreement of the Alberta Sheet Metal Health and Welfare Plan, meets the eligibility requirements as set out in this booklet, and is resident in Canada.

Patient Assistance Program means a program that provides assistance to insured persons with respect to select prescribed Drugs, supplies or services. Manufacturers and distributors may provide Patient Assistance Programs that include financial support, along with education and training.

Pharmacoeconomics means the scientific discipline that compares the value of one pharmaceutical Drug or drug therapy to another. Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by Manulife Financial.

Physician shall mean only a person who is duly licensed to prescribe and administer any drugs or to perform surgical procedures.

Prior Authorization means a claims management feature applied to a specific list of Drugs, supplies or services to determine eligibility based on predefined clinical criteria and a Pharmacoeconomic or cost effectiveness evaluation.

Provincial government plan shall mean the body of provincially enacted laws, as amended from time to time, governing provincial Health Insurance Plans, provincial Hospital Insurance Plans, provincial Medicare Plans, provincial medical care and services Acts and other provincial government sponsored hospitalization, medicare, drug or dental insurance plan which provides health insurance to residents of Canada.

Reasonable and Customary Charges

Shall mean a charge made by the provider of health care, services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.

Rehabilitation Hospital

Shall mean a licensed, Extended hospital care facility or institution regularly engaged in the care of sick persons during the rehabilitation state of an illness or injury. Such institution must provide 24 hour nursing service and regular medical supervision. The term rehabilitation hospital as used in this booklet shall not include a home for the aged, health spa or hotel, an establishment providing custodial care or an institution for the

care and treatment of alcoholism or drug addition, tuberculosis or mental illness.

Change in Amounts of Insurance

A change in the amount of your insurance shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are actively at work.

Change in Government Sponsored Programs

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

Co-Ordination of Benefits

If you or your dependents are insured for similar benefits under another Plan (i.e. Group Health Program, or other arrangements covering individuals in a group), Manulife Financial will take this into account when determining the amount of expenses payable under this Plan.

This process is known as Co-ordination of Benefits.

Payment of Supplementary Health, Vision Care and Dental benefits shall be coordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, the Insurer has a right to receive and release information on benefits and if necessary, collect any overpayments made by it.

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e. responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e. responsible for making the payment to cover the remaining eligible expense).

1) If your Spouse's Plan does not allow for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.

2) If your Spouse's Plan does allow for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

- **For Claims incurred by you or your dependent Spouse**

  The Plan insuring you or your Spouse as an Employee/Member pays benefits before the Plan insuring you or your Spouse as a Dependent.

  In situations where you or your Spouse have coverage as an Employee/Member under more than one Plan, the order of benefit payment will be determined as follows:

  - The Plan where the person is covered as an active full-time Employee; then

  - The Plan where the person is covered as an active part-time Employee; then

  - The Plan where the person is covered as a Retiree.

- **For Claims incurred by your Dependent Child**

  The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

3) If you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child pays; then

- The Plan of the spouse of the parent with custody of the child pays (i.e. if the parent with custody of the child is remarried or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child); then

- The Plan of the parent not having custody of the child pays; then

- The Plan of the spouse of the parent not having custody of the child (i.e. the parent without custody of the child (i.e. if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).

- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.

- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

Submitting a Claim for Co-Ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

1) As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.

2) Submit all necessary claim forms and original receipts to the Primary Carrier.

3) Keep a photocopy of each receipt until your claim has been settled.

Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms to the Secondary Carrier for further consideration of payment, if applicable.

How to Make a Claim

Time Limitations

Life Insurance
Claims must be submitted within twelve (12) months of the date of loss.

AD&D
Notice of claim must be submitted within thirty (30) days of the accident, and proof of claim submitted within ninety (90) days of the accident. However, these time limitations may be extended up to twelve (12) months from the date of accident, if deemed not reasonably possible to provide notice or proof within the applicable period.

Major Medical, Visioncare and Dentalcare
Claims for these benefits must be submitted within eighteen (18) months of the date incurred.

Weekly Disability Income
A claim for disability income benefits must be submitted within six (6) months of the end of the qualifying disability period.

Long Term Disability Income
A claim for the waiver of premium benefit and Long Term Disability benefits must be submitted within twelve (12) months of the date disabled.

Member Portal – Electronic Claims

Coughlin & Associates Ltd. offers plan members the option to submit claims for prescription drugs, health and dental online. To access this service, please register at Coughlin's plan member portal at https://coughlin.onlineclaimsaccess.net/ or download the mobile app from the App Store or Google Play. Once you are on the portal or have accessed the app:

- Follow the on-screen instructions and provide your group and certificate numbers, both of which can be found on your all-in-one benefits card.

Once registered, click *Submit a Claim* to get started with online claiming.

Point of Sale Claims Submission

For Drug, Dental, and select Health claims you may use your all-in-one Benefits Card for direct bill payment (POS). Your claims can be submitted through a Point-Of-Service (POS) claims system provided by an approved list of healthcare providers. The following information (found on your all-in-one Benefits Card) must be provided to the provider:

Dental:

1) Bin # 000034 on Telus Adjudicare network
2) Group Number # 58839
3) Individual certificate number (printed on your card)

Health :

1) Bin #34 on Telus Adjudicare network
2) Group Number # 58839
3) Individual certificate number (printed on your card)

Dentalcare and Health claims must be made within eighteen (18) months from the date of service.

Pre-Authorized Deposit (PAD)

Pre-authorized Deposit is the fastest way for plan members to receive claim reimbursements. Claim reimbursement deposits can be made into your bank account within two to five business days following the approval of your claim and eliminate both the wait for cheques to arrive by mail and the trip to the bank.

To enroll in the PAD program:

- Login to Coughlin's plan member portal
- Click on your profile icon and select *Direct Deposit*

To be eligible for PAD, deposits must be made to an accredited Canadian financial institution. Please note that lines of credit are not accepted.

Pre-Authorization

For treatment where the estimated cost is $500 or more, predetermination of costs should be obtained from the Plan Administrator.

Have your dentist/denturist complete the appropriate form or section. Mail the form to the Plan Administrator.

For a proposed treatment plan which includes crown or bridgework, please ask your dentist to send the applicable x-rays with the form.

A letter will be sent to the dentist/denturist with a copy to you, showing how much the Plan will pay.