ABC Company

Your Benefits

Class A

Contract# XXXX
Effective Date: March 1, 2016

INTRODUCTION

The purpose of your Benefit Plan is to protect you from unexpected financial emergencies and to protect your ability to earn money in the future.

There are circumstances which, as you know, can interfere with your financial future, such as: ***Medical and Dental Expenses, Illness, and even Death***.

The purpose of this booklet is to provide a brief description of the Life Insurance, Disability, Medical and Dental portions of your Benefit Plan. Please remember that this booklet only provides a brief summary of your coverage and that the legal Contracts and Policies will govern and be binding in all cases.

We hope you will read this booklet carefully and that it will help you understand the benefits available to you. We also hope that it will assist you in understanding the value of your benefits as part of your total compensation.

If you have any questions, please contact **The Benefits Trust (the Plan Administrator)**, or your Benefits Administrator.

BENEFIT PLAN TRUSTEES

... Working together for your benefit

ABC Company is a member of The Benefits Trust.

The Board of Trustees of The Benefits Trust and ABC Company are solely responsible for the operation of your Plan. The Trustees meet regularly to be certain that the Plan works to benefit all employees on a fair and equitable basis. The Trustees and/or ABC Company may amend the Plan at any time as they consider prudent.

Consulting Broker

Mr. Henry Agent
Agency Benefits & Insurance
Brampton, Ontario

Phone: Fax:

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ELIGIBILITY

Joining the Plan

In order to be eligible for benefits, you must have completed 3 months of continuous full time employment, and work at least 30 hours per week. You must be a permanent resident of Canada and under 70 years of age in order to join the Plan. You may choose to cover your eligible dependants.

Eligible Dependants

1. Your spouse.
2. Your common law partner, an individual who has been living with and publicly represented as the Employee's domestic partner for more than one year.
3. Your unmarried children under age 21, or under 26 if full-time students. Children who are mentally and/or physically handicapped are covered without any restrictions if the physical or mental ailment commences before they turn 21 and the disorder has been continuous since that time.

Note: Children who are under age 21, but work more than 30 hours a week are not covered.

Enrollment Procedures

You will be asked to complete an Employee Benefits Application form before you first become eligible to join this Plan. It is important that you keep this information up to date.

If you wish to switch between single and family coverage, or if you wish to change your beneficiary, please advise your employer.

Termination of Benefits

Your benefits will terminate on the earliest of:

1. the date your employment terminates,
2. the date you are laid-off or granted leave of absence without pay, pensioned or retired,
3. the date you cease to be in a class of employees eligible for coverage,
4. the date on which you reach age 70,
5. the date you become a full-time member of the armed forces,
6. the date your employer fails to make a required contribution,
7. for dependant coverage - the date on which a covered person ceases to be a dependant,
8. the date the Contract is terminated.

Coordination Of Benefits

If you or your dependants are covered by any other plans for any of the benefits covered by this Plan, your benefit payments will be coordinated between the plans. Please submit details of any other coverage you have available or other payments made.

LIFE INSURANCE BENEFITS

Life Insurance

In the event of death resulting from any cause, the benefit will be paid to your beneficiary.

Coverage Amount:	Flat amount of $25,000.
Evidence of Insurability:	Not required.
Reduction Age:	When you reach age 65, your Life Insurance reduces by 50%.
Termination Age:	When you reach age 70 or earlier retirement, your Life Insurance benefit ends.

Individual Conversion Privilege

If you leave this plan before you are age 65, you may be entitled to convert all or part of your group life insurance benefit to an individual insurance policy. Please contact the Plan Administrator for further details.

Beneficiary

A beneficiary is the person who you select to receive your life insurance money in the event of your death. You may choose anyone to be your beneficiary (your spouse, a dependant, a friend, etc.). A Trustee must be appointed if your beneficiary is under age 18. You can change your beneficiary at any time using a Change of Record form.

Dependant Life Insurance

In the event of the death of a covered dependant, the benefit will be paid to you.

- Spouse $10,000.
- Each child $5,000.
- Children are insured from birth.
- Terminates at employee age 70 or earlier retirement.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Accidental Death & Dismemberment Insurance

In the event of your death within 365 days of an accident, as the direct result of the accident, your beneficiary will be entitled to the Accidental Death benefit shown below.

Coverage Amount:	Amount to match Basic Life Insurance.
Reduction Age:	When you reach age 65, your A.D. & D. reduces by 50%.
Termination Age:	When you reach age 70 or earlier retirement, your A.D. & D. benefits end.

If you suffer any of the losses listed in the Schedule of Losses (see next page) as a direct result of an accident which occurred while you were covered under this Benefit, the Insurer will pay the amount of insurance specified for the loss in the Schedule provided the loss occurred within 365 days after the date on which the accident occurred. The amount payable will be subject to any limitations and exclusions included in this Benefit.

Accidental Death & Dismemberment Exclusions

Exclusions for the coverages as outlined on the next page, where no amount is payable for a loss resulting directly or indirectly from the following, include:

- Suicide or intentionally self-inflicted injury;
- War or any act of war whether declared or undeclared;
- Participation in any riot or civil strife;
- Committing or attempting to commit a criminal act or provoking an assault;
- Piloting, operating or acting as a crew member in a civilian or military aircraft;
- Serving in full-time active duty in the Armed Forces of any country.

Schedule of Losses

The benefit is limited to the percentage shown in the following schedule:

Accidental Loss of	Sum Insured
Life	100%
Both hands or both feet	100%
One hand and one foot	100%
Sight of both eyes	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
Hearing in both ears and speech	100%
Use of both hands or both feet	100%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
One arm or one leg	75%
Use of one arm or one leg	75%
One hand or one foot	66 2/3%
Sight of one eye	66 2/3%
Speech	66 2/3%
Hearing in both ears	66 2/3%
Use of one hand or one foot	66 2/3%
Thumb and index finger on one hand	33 1/3%
Four fingers on one hand	33 1/3%
All toes on one foot	33 1/3%
Hearing in one ear	25%

DISABILITY BENEFITS

Long Term Disability Benefit

Coverage Amount:	66.67% of monthly earnings to overall monthly maximum of $5,000.
Evidence of Insurability:	Required for benefit amounts over $3,000.
Qualifying Disability Period:	119 days.
Disability Definition:	2 Year Own Occupation.
Taxability:	Non-Taxable.
Maximum Benefit Period:	Payable to age 65 if disability continues.
Termination Age:	Age 65 or earlier retirement.

Definitions of Disability

You are disabled when Insurer determines that:

- You are limited from performing the material and substantial duties of your **regular occupation** due to your sickness or injury;
- You have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury; and
- During the elimination period, you are unable to perform any of the material and substantial duties of your regular occupation.

After 24 months of payments, you are disabled when Insurer determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

Pre-Existing Condition Exclusion

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage.

For more details about your Long Term Disability benefits, refer to the supplemental booklet from Insurer.

HEALTH CARE BENEFITS

These benefits cover certain medical expenses which may be incurred by either you or a covered dependant. It is closely related to the protection you receive from your Provincial Medical Insurance.

Eligibility:	As per the Eligibility section on page 6 of this booklet.
Benefit Year:	January 1 to December 31.
Annual Deductible:	None.
Maximum Benefit:	$1,000,000 lifetime benefit per Covered Person for in-Canada Health Care claims.
Termination Age:	Age 70 or earlier retirement.

Schedule of Benefits and Payment Levels

Prescription Drugs:	100% (pay-direct prescription drug card)
Hospitalization:	100% for private room.
Convalescent Home Care:	100% to maximum $20 per day for up to 120 days.
Nursing Care:	100%
Ambulance, Laboratory & Out-Patient:	100%
Paramedical Care:	100%
Appliances:	100%
Physician Services:	100%
Orthopaedics:	100%
Vision Care:	100%
Hearing Aids:	100%
Dental Accident:	100%
Travel Assistance:	100%
Out of Canada Emergency Care:	100%

Benefit Maximums

Nursing Care:	Maximum $10,000 per Covered Person per benefit year.	
Paramedical Care:	Maximum per Covered Person per benefit year for each discipline listed below:	
	Acupuncturist	$500
	Chiropodist / Podiatrist	$500
	Chiropractor	$500
	Registered Massage Therapist	$500
	Naturopath	$500
	Osteopath	$500
	Physiotherapist	$500
	Clinical Psychologist / Social Worker	$500
	Speech Therapist	$500
Orthopaedics:	Maximum $300 per Covered Person per benefit year for custom-made orthopaedic shoes and/or custom-made orthotic inserts.	
Vision Care:	Maximum $200 per Covered Person per 24 consecutive months for eye glasses or contact lenses.	
Hearing Aids:	Maximum $500 per Covered Person per 60 consecutive months.	
Dental Accident:	Maximum $3,000 lifetime per Covered Person.	
Out of Canada Emergency:	Maximum $5,000,000 lifetime per Covered Person.	

Benefit Descriptions

Prescription Drug Benefit

Covered Items

Payment will be made for the following items when prescribed by a physician, surgeon or dentist, unless otherwise excluded:

1. Prescribed drugs which bear a valid Drug Identification Number (DIN) and are listed as prescription-requiring in the federal or provincial drug schedule.

   If the drug is a brand name product which has a generic equivalent, the amount payable will be based on the lowest priced interchangeable product. However, if the physician has included the notation “Do not product select”, or “No Sub.”, or “No Substitution”, the amount payable will be based on the cost of the eligible product prescribed.
2. Prescribed drugs which bear a valid Drug Identification Number (DIN) and which by convention require a prescription.
3. Extemporaneous preparations or compounds provided one of the ingredients is eligible for coverage.
4. Insulin supplies, such as needles, syringes, lancets and diagnostic testing materials.
5. Anaesthetics, oxygen and administration thereof.
6. Blood and blood plasma and administration thereof to the extent that charges are not reduced by any blood donations.
7. Oral, transdermal, and injectable contraceptives.
8. Preventative immunization vaccines and toxoids.

Dispensing Limitations

The quantity of drugs which may be dispensed for any one prescription will be limited to that amount sufficient for up to a 100 day period.

Prescription Drug Benefit - Excluded Items

The following items are not covered, whether prescribed or not:

1. Drugs not requiring a written prescription or "over the counter" (OTC) drugs.
2. Alcohol, alcohol swabs, disinfectants, cotton or bandages.
3. Vitamins, other than injectable vitamins, minerals, dietary supplements, infant formulas or injectable Total Parental Nutrition (TPN) solutions.
4. Diaphragms, condoms, contraceptive jellies/sponges/foams/suppositories, contraceptive implants or appliances normally used for contraception.
5. Proprietary drugs bearing a General Product (G.P.) number.
6. Homeopathic preparations.
7. Prescriptions dispensed by a physician, dentist, clinic or by any non-accredited hospital pharmacy or for treatment as an outpatient in a hospital, including emergency status and investigational status drugs.
8. All allergy extracts, compounded by a lab, which do not bear a Drug Identification Number (DIN).
9. Items deemed cosmetic or hygienic (even if a prescription is legally required) such as topical minoxidil, sunscreens, or contact lens care products, whether or not a prescription is given for medical reasons.
10. Habit breaking drugs for, but not limited to, smoking (including all nicotine resin containing products), anti-obesity, drugs and alcohol.
11. Drugs considered lifestyle drugs such as, but not limited to, drugs for the treatment of infertility or erectile dysfunction.

Hospital Care

1. Payment will be made (unless otherwise excluded) for room and board in a Hospital in the Employee's province of residence up to the Hospital's semi-private room rate as indicated in the Schedule of Benefits and Payment Levels (including where permitted by law, any charges for services and supplies received while confined to Hospital).

Convalescent Home Care

1. Payment will be made (unless otherwise excluded) for room and board charges made by a convalescent home, to the extent that these are not covered by other plans and do not include any part of a charge exceeding the limit stated in the Schedule of Benefits and Payment Levels, for a maximum of 120 days during any one continuous period of confinement in the convalescent home provided such confinement:

    1) occurs within 48 hours following a hospital stay of at least 3 consecutive days,
    2) is for the same cause or causes as the preceding hospital stay,
    3) has been recommended and approved, in writing, by a legally licensed physician, and
    4) is primarily for rehabilitation or convalescent care and not primarily for custodial care.

    A convalescent home means an extended care facility, such as a sanitarium or skilled nursing home or a special wing or ward of a hospital which is licensed by the appropriate licensing authority and which provides supervision by registered nurses 24 hours per day.

Nursing Care

1. Services, rendered in the person's home, of a Private Duty Nurse, who is not related to the person and not normally resident in his home, certified in writing by a Physician as medically necessary and pre-approved by the Administrator. A Private Duty Nurse is a registered nurse, or a registered nursing assistant in Newfoundland, New Brunswick, Ontario, Quebec, Manitoba or Alberta, a licensed nursing assistant in Prince Edward Island, a certified nursing assistant in Nova Scotia or Saskatchewan, and a licensed practical nurse in British Columbia; licensed, registered or certified through their respective organizations. Payment is subject to the Reimbursement Level and Maximum shown in the Schedule of Benefits and Payment Levels.

Paramedical Care

1. Without the requirement of a physician’s recommendation, services of practitioners licensed as an Acupuncturist, Chiropodist/Podiatrist, Chiropractor, Registered Massage Therapist, Naturopath, Osteopath, Physiotherapist, Clinical Psychologist, or Speech Therapist, not normally resident in the patient’s home, including a maximum of one x-ray examination per Benefit Year ordered by the practitioner. Payment is subject to the Reimbursement Level and Maximum shown in the Schedule of Benefits and Payment Levels.

Hearing Aids

1. Purchase and repairs of hearing aids prescribed in writing by an otolaryngologist, but not batteries or routine maintenance of hearing aids. Payment is subject to the Reimbursement Level and Maximum shown in the Schedule of Benefits and Payment Levels.

Vision Care

1. Cost of frames, lenses and fitting of prescription glasses or contact lenses which are prescribed by a licensed optometrist or ophthalmologist and dispensed by a licensed optician, optometrist or ophthalmologist. Payment is subject to the Reimbursement Level and Maximum shown in the Schedule of Benefits and Payment Levels.

2. Routine eye examination (including eye refractions) performed by an optometrist or ophthalmologist (unless covered under provincial legislation and regulation). Payment is subject to the Reimbursement Level and Maximum shown in the Schedule of Benefits and Payment Levels.

Ambulance, Laboratory and Out-Patient Charges

1. Essential use of a licensed ambulance for local transportation of the person to the nearest hospital qualified to render the necessary medical services, in excess of the charges paid by the Provincial Health Plan.

2. Essential use of a licensed air ambulance for transportation of the person to the nearest hospital qualified to render necessary emergency medical services, in excess of the charges paid by the Provincial Health Plan.

3. X-ray examinations and other diagnostic laboratory tests done in a commercial laboratory for diagnosis of an illness (but excluding any tests performed in a Physician's office or a pharmacy).

4. Out-patient hospital charges.

5. Treatment of an illness by the use of radio-therapy or coagulotherapy.

Appliances

The Administrator will rent or purchase at its option the following:

splints excluding dental splints,
apnea monitors for respiratory disrhythmias,
canes and walkers,
crutches,
casts,
burn garments,
sleeves for lymphoedema following mastectomy,
support hose and/or surgical stockings (benefit year maximum of four pairs per covered person),
braces with rigid support,
orthopaedic shoes and/or orthotic inserts which have been custom made, customized or custom molded for the covered person and which were recommended, in writing, by a legally licensed physician, podiatrist or chiropodist ($300 per covered person per benefit year),
artificial eyes (repairs and replacements up to a benefit year maximum of $1,000 per covered person),
artificial limbs and prostheses other than myoelectric and electric prostheses (repairs and replacements covered up to a benefit year maximum of $2,000 per covered person),
wigs required as a result of chemotherapy or bodily injury (lifetime maximum of $500 per covered person),
back supports,
stump socks,
shoulder harnesses,
head halter,
traction apparatus,
cervical collar,
colostomy and ileostomy apparatus and supplies,
catheters,
external breast prosthesis (two per covered person per benefit year),
surgical bras (two per covered person in any benefit year),
diabetic monitoring and administration equipment (lifetime maximum of $1,000 per covered person),

non-electric wheelchairs (lifetime maximum of $2,000 per covered person) or electric wheelchairs where medically necessary (lifetime maximum of $4,000 per covered person),
hospital beds,
bed rail,
trapeze bar,
transcutaneous nerve stimulator (lifetime maximum of $2,000 per covered person),
intermittent positive pressure breathing machine,
aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma,
oxygen tent and oxygen supplies,
sphygmomanometers (lifetime maximum of $200 per covered person).

Dental Accident

Charges by a legally licensed dentist for treatment necessitated by a traumatic injury to sound natural teeth or the surrounding tissues provided:

1. The damage is not due to an object or food placed wittingly or unwittingly in the mouth.
2. The injury occurs while the covered person is covered under this Benefit.
3. The charges are incurred within twelve months of the injury. However, if the charges are to be incurred more than 60 days after such an injury, a treatment plan must be submitted to the Administrator within 60 days of the injury.
4. In no event will payment exceed the charges for the least expensive professionally adequate procedure in the Provincial Dental Association Fee Guide for a General Practitioner which is current in the Employee's province of residence on the date the treatment is received.

The total amount payable under this covered expense during the lifetime of the covered person (whether or not the covered person is continually covered) including any amount payable for charges incurred following discontinuance of the covered person’s coverage under this Benefit shall not exceed the limit stated in the Schedule of Benefits and Payment Levels.

Physician's Services

1. Charges made by a legally licensed physician or surgeon in your province of residence, in excess of the current tariff of the relevant Medical Association, where not prohibited by any government legislation or regulations.

2. Charges made by a legally licensed physician or surgeon in respect of services performed outside of your province of residence but excluding any benefit payable under the provincial government plan and where not prohibited by any government legislation or regulations.

Out of Canada Emergency Care

1. The expenses of the following out of province emergency medical services, in excess of that paid by the Covered Person's Provincial Health Plan, incurred while travelling outside the Employee's province of residence on business or on vacation, provided that such emergency occurs during the first sixty (60) days after the commencement of his absence from the province:
   a) room and board in a Hospital up to the Hospital's ward rate,
   b) other Hospital supplies or services while confined to Hospital,
   c) services of a Physician,
   d) out-patient services in a Hospital.

   No payment will be made for services not covered by his Provincial Health Plan.

Supplementary Out of Canada Emergency Assistance Coverage

1. In the event of a medical emergency, contact the travel assist service provider immediately or as soon as possible, at the telephone numbers shown on your travel assist card. For further details concerning travel assist services and claim procedures, please refer to the supplementary Out of Province/Canada Travel Medical Emergency Insurance Booklet.

Health Care Exclusions and Limitations

“Covered Expenses" shall not include any charge:

1. For any services or benefits which are "insured services or benefits" under any government legislation or regulation and to the extent that insurance for such service is prohibited by law.
2. For or in connection with the treatment of pre-existing dental disease or orthodontic malocclusion in order to facilitate treatment for a traumatic injury to sound natural teeth or the surrounding tissues.
3. For or in connection with a surgical procedure or treatment performed for primarily cosmetic reasons, or for hospital confinement for such procedure or treatment.
4. For or in connection with any services or supplies which are for the sole purpose of facilitating the covered person's participation in sports or recreational activities and not for other daily living activities.
5. Which occurs as a result of an insurrection, war or any act of war (declared or undeclared).
6. Which occurs as a result of participation in a riot or civil commotion.
7. Which results from the commission of or attempted commission of a criminal offense or the provoking of an assault.
8. Which results from an intentionally self-inflicted injury while sane or insane.
9. For services for which the covered person is not required to make payment or where payment is received as a result of legal action or settlement.
10. For any drugs, medicines, medical testing, surgical procedures and appliances considered by the Insurer to be experimental and not recognized by the Canadian Medical Association as an established standard treatment for the condition.
11. For or in connection with any services received or performed outside of Canada which (i) are due to a pregnancy (includes childbirth, miscarriage or any complications incident to a pregnancy) and which are received or performed after the 32nd week of gestation, or (ii) are due to the deliberate inducement of a miscarriage.

12. For any emergency services provided outside of Canada if the absence from Canada was for a purpose other than business or vacation travel.
13. For which the covered person incurs while attending an accredited educational institute, college or university outside of Canada.
14. For or in connection with any services or supplies received outside of Canada during an emergency if such services or supplies could have been delayed until the covered person returned home without endangering the covered person's health.
15. For any non-emergency services received or performed outside of Canada.
16. For which the covered person may apply and receive indemnity or compensation under any Worker's Compensation Act.

DENTAL BENEFITS

The cost of necessary dental care can be a substantial expense for most people. This part of our Benefits Plan has been designed to cover much of the regular dental care which you or a covered dependant may require.

Eligibility:	As per the Eligibility section on page 6 of this booklet.
Benefit Year:	January 1 to December 31.
Deductible:	None.
Predetermination:	Required for all work of more than $500 except for emergencies.
Fee Guide:	Current Dental Association Fee Guide for General Practitioners in your province of residence.
Termination Age:	Age 70 or earlier retirement.

Schedule of Benefits and Payment Levels

100% for Part A Services:	Preventative, Diagnostic, Emergency, Palliative, Restorative or Minor Surgical Services, including Denture repair, reline and rebase
100% for Part B Services:	Endodontic or Periodontic Services

Note: Tooth coloured composite restorations on permanent anterior teeth are eligible for reimbursement.

Benefit Maximums

Part A and Part B Services: Maximum $1,500 per Covered Person per benefit year.

Recall Visits

Must be separated by at least 5 months.

Benefit Descriptions

Part A Services (Basic Services)

Preventive, Diagnostic, Emergency, and Palliative Services

1. Oral Examinations:
   a) Complete oral examination – not more than once in 2 consecutive benefit years,
   b) Recall examinations – limited to the period stated in the Schedule of Benefits and Payment Levels and no more than 1 per day,
   c) Emergency or specific examinations – combined limit of 2 per benefit year, and no more than 1 per day.
2. Radiographs and radiographic interpretations:
   a) Complete series of radiographs and/or panoramic x-rays – not more than once in 3 consecutive benefit years,
   b) Bitewing radiographs – not more than 4 films in any benefit year,
   c) Radiographs to diagnose a symptom or examine progress of a particular course of treatment.
3. Required consultations with another dentist – not more than 2 units per benefit year.
4. Scaling – limited to 14 units per benefit year combined with root planing.
5. Prophylaxis and topical application of fluoride limited to the period stated in the Schedule of Benefits – limited to 2 per benefit year.
6. Emergency or palliative services.
7. Diagnostic tests and laboratory examinations.
8. Space maintainers for missing primary teeth - limited to children 18 years of age and under.
9. Pit and fissure sealants – limited to children age 15 and under.
10. Oral hygiene instruction – not more than once per lifetime.

Restorative, Surgical, Endodontic and Periodontic Services

1. Fillings - amalgam, composite, acrylic, or equivalent.
2. Removal of teeth.
3. Removal of impacted teeth and related anaesthesia.
4. Preformed stainless steel full-coverage restorations and repairs to preformed stainless steel full-coverage restorations, other than in conjunction with the replacement of permanent crowns (limited to children under 18 years of age).
5. Surgery and related anaesthesia, excluding that for the purpose of:
   a) implants and transplants, or
   b) repositioning of the jaw or temporal mandibular joint.

Additional Services

1. Denture repair – limited to twice in any benefit year.
2. Denture rebasing or relining – limited to once every 3 benefit years.

Part B Services (Endodontic and Periodontic Services)

1. Endodontics - root canal therapy, root canal fillings, and treatment of disease of the pulp tissue – claims for service on same tooth within 3 months of previous claim will be reduced by amount of previous benefit.
2. Periodontics - treatment of disease of the gum and other supporting tissues of the teeth - limited to 14 units of time of root planing service per benefit year, combined with scaling.

Dental Care Exclusions and Limitations

1. For services or treatment due to insurrection or war, declared or undeclared, whether or not the covered person is actually participating in such insurrection or war.

2. For services or treatment due to participation in any riot or civil commotion.

3. For services or treatment due to the commission of or attempted commission of a criminal offense or provoking an assault.

4. For services or an examination performed by a legally licensed dentist solely for the use of a third party.

5. For intentionally self-inflicted injury while sane or insane.

6. For recent duplication of services by the same or a different dentist.

7. For a broken appointment.

8. For a full mouth reconstruction, for a vertical dimension correction, or for a correction of a temporomandibular joint dysfunction.

9. For endodontics and coping with respect to over-dentures.

10. For services or treatment considered by the Administrator to be experimental and not recognized by the Canadian Dental Association as an established, standard treatment for the condition.

11. For services or treatment which the covered person received while attending an accredited educational institute, college or university outside of Canada.

12. For services or treatment performed for primarily cosmetic reasons.

13. For services or treatment for which a covered person is not required to pay, including any expenses reimbursed, assumed or allowed under any other non-contractual plan, scheme, or arrangement.

14. For services for which the covered person receives payment as a result of legal action or settlement.

15. For services or treatment furnished or started before the date on which the covered person on whose account the charge was made became covered under this Dental Expense Benefit.

16. For the placing of crowns to restore occlusal height or as a preventive measure.

17. For the permanent splinting of teeth.

18. For any services or treatment prohibited by law.

19. For which the covered person may apply for and receive indemnity or compensation under any Workers' Compensation Act.

20. Any portion of the charge over the usual, customary and reasonable charge of the least expensive alternate service or material consistent with adequate dental services when such alternate service or material is customarily provided.

HOW DO I MAKE A CLAIM?

Life Insurance

In the event of a death of an employee or dependent, please contact The Benefits Trust to obtain claim forms. Proof of claim should be filed with The Benefits Trust within 90 days of the date of loss.

Accidental Death & Dismemberment

In the event of a death of an employee as the result of an accident, or an injury or loss as the result of an accident, please contact The Benefits Trust to obtain claim forms. Proof of claim should be filed with The Benefits Trust within 90 days of the date of loss.

Long Term Disability Claims

Claim forms can be obtained from The Benefits Trust. The claim must be completed by and signed by your physician, then submitted to your employer and to The Benefits Trust.

If your doctor states that you will be disabled beyond the 120 day waiting period for Long Term Disability, submit your claim form at least 5 weeks prior to the end of the waiting period. It is important to submit your claim form early so that benefits can commence promptly.

At the latest, proof of claim should be filed with The Benefits Trust within 90 days after the end of the waiting period.

From time to time, you may be asked to provide additional medical information from your physician so that your claim can be continued where appropriate.

Health Care and Dental Care Claims

A Certificate Card is provided for your use, with the contract and certificate number needed for completing the claim form. Claims for Health Care and Dental Care must be received at The Benefits Trust within 30 days of the benefit year end.

Health Care Claims

Prescription Drug Claims at the Pharmacy

A Pay-Direct Certificate Card for purchasing prescription drugs is provided for your use. The pharmacist may submit claims electronically through ***Claimsecure,*** and this logo is printed on the back of the card as a reminder. You will be responsible for any deductible or expense if in excess of the maximums shown in the summary of benefits.

Medical Claims with a Claim Form

Complete and sign a standard Medical and Drug Expenses claim form, available from the Employee Resource Centre at www.thebenefitstrust.com. It is important for the claim form to be completed in full, including the employee name, address, contract number, certificate number, and details of each expense.

For every claim, an itemized receipt must be submitted showing the patient name, the service performed or goods purchased, the date, and the amount paid. A cash register "tape" or credit card receipt is not sufficient for medical claims.

Where required, include a copy of the physician's letter of diagnosis and recommendation.

When submitting a paper claim for prescription drugs, the claim must include an official pharmacy receipt. These receipts will be produced automatically by the pharmacist after each drug purchase and will include the name of the patient, the name of the drug, the date of purchase, and the drug identification number (DIN).

Claims may be submitted by mail, fax, or email. To submit by email, scan the completed claim form and each of the receipts, invoices, or statements for their expenses. Scanned claim forms and scanned receipts should be submitted to: claims@thebenefitstrust.com.

Making a Claim continued

Claims can also be submitted using **The Benefits Trust Claim App**, available for Android or Apple. Please register in full including the employee name, address, email address, contract number, and certificate number.

The Benefits Trust conducts periodic random audits of email, fax, and app claims submissions. Keep your original receipts, as you may be asked to submit them for review.

Claims for active employees should be received by The Benefits Trust within 90 days of the end of the calendar year in which the expense was incurred.

Dental Claims

Your Certificate Card provides you with the contract and certificate number needed for completing the claim form. Your dentist may submit dental claims through electronic claims submission to ***The Benefits Trust*** using the contract, certificate and NDC Health number shown on the front of the Card. You or your dentist may also submit a dental claim form by mail or fax. If you submit a paper claim for dental expenses, your dentist should provide the dental procedure codes and fees, and the claim form should be sent to The Benefits Trust. You may assign payment directly to the dentist.

For Claims Questions, contact:

THE BENEFITS TRUST
3800 Steeles Avenue West, Suite 102W, Vaughan, Ontario L4L 4G9

Phone: (905) 264-8990
or (416) 498-7723
Fax: (905) 264-1123

Toll Free: 1-800-487-2993
Email: info@thebenefitstrust.com
www.thebenefitstrust.com

IMPORTANT NOTICE

This booklet describes in summary form, the benefits contained in your group benefits contract and policies. In the event of any discrepancy between any information contained in this booklet and the group benefits contract and policies, the terms of the group benefits contract and policies will apply.

Benefits described in this booklet are applicable only to persons enrolled according to the records maintained for the group benefits contract and policies.

The Life Insurance, Accidental Death & Dismemberment Insurance, Long Term Disability benefits, Excess Medical Stop Loss Insurance, Out of Province/Canada Emergency Care and Travel Assist benefits are insured by XYZ Life Insurance Company. All other benefits are self-funded by ABC Company through a participation agreement with The Benefits Trust.

Claim forms are available from the ABC Company Human Resources Department and are available for download at www.thebenefitstrust.com under the Clients and Members section. Send your claims to The Benefits Trust.

FOR CLAIMS ASSISTANCE, CALL THE PLAN ADMINISTRATOR:

The Benefits Trust
3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9

Phone: (905) 264-8990 or (416) 498-7723
Toll Free: 1-800-487-2993
Fax: (905) 264-1123
Email: info@thebenefitstrust.com

or contact your employer

Name of Employer: ABC Company

Date Issued: 2016

the benefits trust

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