



**BENEFIT PLAN INFORMATION
FOR
BRITISH COLUMBIA'S
OWNER OPERATORS**

GENERAL INFORMATION

Coverage is through Sunlife of Canada (1-888-719-3583)
Policy # 25518. Membership I.D. = your Social Insurance #.

As an owner operator for Purolator Courier Ltd., you and your family are able to enjoy the many important features of our Benefit Program that assure you protection and security.

If at any time you are unsure of your entitlement to benefits, please contact your Human Resources Department at 604-273-4333 or 1-800-663-7969.

Eligibility

For You

As a unionized owner operator of Purolator Courier, with one year of service, you will become eligible for benefits outlined in your collective bargaining agreement.

Your Dependents

Your dependents are eligible for coverage under the following programs:

- Supplementary Hospital
- Health Care
- Dental Care

Dependent coverage will become effective when your coverage is effective.

An eligible dependent includes:

- Your spouse, legal or common-law, who is a resident in Canada. A common-law relationship is one where you have lived with your partner who you publicly represent as your husband or wife for a period of at least 12 consecutive months, or immediately if you and your spouse are the biological parents of an eligible dependent child. Under the Group Benefit Program, only one person will be recognized as your eligible spouse at one time.
- Unmarried children under the age of 21, or a child age 21 to 25 (inclusive) will be considered a dependent if in full time attendance at an accredited school, college or university.

The age limit does not apply for a mentally or physically handicapped child who is incapable of supporting his/herself and is depending on you for support and maintenance.

WHEN YOUR BENEFITS END

Your coverage will terminate at age 65, your earlier retirement date, or upon termination of your contract with Purolator Courier.

Your dependent's coverage terminates when your coverage terminates or when your dependent is no longer eligible. Under the Supplementary Health Care and Dental Care Plans, coverage for dependents will continue, following your death, for up to a maximum of 31 days from the date of death.

BENEFIT SUMMARY

As per the terms of the Collective Agreement, the following summary outlines more specifically, your coverage under Purolator's Benefit Program.

SUPPLEMENTARY HOSPITAL EXPENSES

You and your eligible dependents are covered for the difference in cost between semi-private room and board and standard ward accommodation, in a licensed Canadian Hospital.

EXTENDED HEALTH CARE

Benefit Percentage

Emergency Out of Province/ Canada Expenses

75% of first \$10,000 of eligible expenses per occurrence, then 100% in excess.

Vision Care	100%
Prescription Drug Card	75%
All Other Eligible Expenses	75%

Overall Maximum

Emergency Out of Province/Canada Expenses
\$500,000 lifetime

All Other Eligible Expenses

Unlimited subject to Specific Maximums below

Deductible No deductible applies

Specific Maximums

Charges for services of a certified, registered or licensed chiropractor, osteopath, podiatrist or naturopath, up to a maximum eligible benefit of \$250, once your provincial plan benefits have been exhausted, per specialty per covered individual for any calendar year.

Charges for the services of a certified, registered or licensed psychologist or speech therapist, up to a maximum eligible benefit of \$200, once your provincial plan benefits have been exhausted, per specialty per covered individual for any calendar year.

Charges for the services of a registered masseur (prescribed by a physician) for up to 20 treatments per calendar year.

Charges for the services of a Registered Nurse, licensed practical nurse, Certified Nursing Assistant, or a member of the Victorian Order of Nurses are limited to a maximum benefit of \$5,000 in any 3 consecutive calendar years, plus \$50 per day thereafter.

Charges for the initial external breast prosthesis, following mastectomy, subject to a maximum benefit of \$150 and up to 2 surgical brassieres per calendar year.

Charges for ObusForm supports and other "better back" supports, prescribed by a physician, are subject to a maximum of \$75 per person per calendar year. (check with Mutual for specific brand names that are covered.)

Charges for specially designed orthopedic shoes, as outlined in the Medical Expense insert. Only the charge associated with the customization is considered an eligible expense to a maximum benefit of \$75 per calendar year. The cost of the regular footwear is excluded.

Hearing aid charges are subject to a maximum benefit of \$300 per person in any 60 consecutive months.

Prescription Drugs

90% for Generics.

75% of the reasonable and customary expenses for drugs legally requiring a prescription. Generic substitutions should be requested by you or your family member and will be automatically made where provincially regulated.

Vision Care

100% of eligible charges, subject to a maximum benefit of \$125 per covered individual in any 24 consecutive months.

*\$125
\$200*

DENTAL CARE

Your Dental Care Plan will reimburse eligible expenses based on the Dental Association Fee Guide in effect in your province of residence on the date the expense was incurred.

Benefit percentage

85% 85% for Routine procedures;
50% for Major procedures (Dentures only)

Maximum Benefit

\$1,500 per covered individual, per calendar year

Deductible

No deductible applies

SURVIVOR BENEFITS

Basic Life Insurance

Your Basic Life Insurance is equal to ~~\$20,000~~ *\$40,000*

Accidental Death & Dismemberment Insurance

Your Accidental Death & Dismemberment coverage is equal to ~~\$40,000~~ *\$80,000*.
This benefit is payable in the event of accidental death or dismemberment, 24 hours a day, on or off the job.

MAJOR MEDICAL BENEFITS

Medical Expense Benefits are designed to meet the hospital and health expenses that you and your family may have.

These benefits are made up of the following parts:

- Provincial Hospital/Medical Coverage
- Supplementary Hospital
- Extended Health Care

The provincial government plans are designed to cover basic hospital and medical expenses. Purolator's benefit program provides additional coverage to supplement expenses that are not covered by government plans.

Under Purolator's benefit program, if there is a Health Care lifetime maximum benefit, it will be outlined in your Benefit Summary (above).

Provincial Hospital/Medical Coverage

The benefits from your MSP plan cover most medical and hospital expenses for you and your family.

Benefits include standard ward hospital accommodation, necessary nursing care, drugs and surgical supplies while in hospital and most of the other usual expenses of a hospital stay.

Most physician fees are also covered.

Supplementary Hospital Expenses

Your Purolator Supplementary Hospital Plan is designed to supplement the hospital benefit available under the Provincial Hospital plan. This plan pays the difference between the cost of standard ward accommodation and semi-private accommodation charged by a licensed Canadian hospital.

Extended Health Care Expenses

Your Purolator Extended Health Care Plan is designed to complement the Provincial MSP plan. This plan pays a percentage of all eligible health care expenses that are not covered by the provincial plans, and are allowable for coverage under provincial law.

Eligible expenses are listed below, the maximum benefit, if a maximum applies, will be outlined in your Benefit Summary.

- Charges for an eligible convalescent care facility, when admitted following at least 3 consecutive days of hospital confinement, and within 48 hours following discharge. Charges for convalescent care services and supplies are subject to the daily maximum charge for semi-private accommodation, for no more than 180 days for each period of disability;
- Charges for the services of various certified, registered or licensed health practitioners - if benefits are payable under your Provincial Plan, no benefits are payable under this plan until the Provincial Plan has paid out its maximum benefit - as follows:
 - ◊ Services of a chiropractor, osteopath, podiatrist or naturopath, or masseur - if medically necessary and prescribed by a physician - subject to a maximum benefit as outlined in your Benefit Summary (charges for x-rays are covered for one x-ray per calendar year per specialty);
 - ◊ Services of a licensed psychologist (excluding charges for the services of Social or Welfare Workers and Marriage or Family Counselors), or speech therapist, up to a per specialty maximum as outlined in your Benefit Summary; and
- Services of a physiotherapist when not covered by a provincial government plan. If benefits are payable under a provincial government plan, no benefits are payable under this plan until the provincial government plan has paid out its annual maximum benefit;
- 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.) who is not a member of your family or lives in your home, when these services are required in the home. These services are subject to a maximum benefit as outlined in your Benefit Summary; must be medically necessary; and must be a service not available by a lesser-qualified individual. Please contact Human Resources to confirm the eligibility of your expense;

- Charges for rental of certain medical supplies, appliances and prosthetic devices prescribed by a doctor, including:
 - ◊ A wheelchair, hospital bed, walker or oxygen equipment and similar durable medical equipment required for temporary therapeutic purposes.
- If appropriate and approved by the Insurance Company this equipment may be purchased.
- Charges for braces, trusses, crutches and artificial limbs or eyes. The initial external breast prosthesis following mastectomy, subject to a maximum benefit as outlined in your Benefit Summary;
- Charges for professional ambulance service, other than airline, to the nearest hospital where adequate treatment is available;
- Emergency transportation by air ambulance to the nearest hospital qualified to provide necessary treatment;
- Charges for necessary dental treatment as the result of an accidental injury to natural teeth or jaw, provided the accident occurred while you were covered. The dental work must be completed while you are an owner operator and within 6 months of the accident in order to be eligible;
- Charges for lab tests and x-rays not covered by the provincial plan;
- Charges for ObusForm supports and other "better back" supports, prescribed by a doctor, subject to a maximum benefit as outlined in your Benefit Summary;
- Charges for specially designed orthopedic shoes, orthopedic shoes which form part of a brace, or modification to orthopedic shoes, subject to a maximum as outlined in your Benefit Summary. Also covered are charges for orthotics which have been specially designed and molded and are required to correct a diagnosed physical impairment; and
- Charges for the purchase of, or repair or maintenance to, hearing aids (excluding batteries) subject to a maximum as outlined in your Benefit Summary.

Vision Care Expenses

A percentage of the charges for the purchase of (or repair if accidentally damaged) lenses and frames for eyeglasses or contact lenses are covered, provided they are prescribed by an ophthalmologist or optometrist. The maximum benefit payable is outlined in your Benefit Summary. This maximum also incorporates the charges associated with one optometrist's examination per calendar year.

Benefits are **not** payable for sunglasses or safety glasses.

Prescription Drug Expenses

A percentage of the reasonable and customary expenses for medications legally required by prescription from a physician, that are dispensed by a licensed pharmacist. Where available the generic equivalent will be used.

The maximum benefit amount payable is outlined in your Benefit Summary.

Lifetime maximum amounts, if applicable will be outlined in your Benefit Summary.

Out of Province Expenses

If, while travelling outside your province of residence (whether inside or outside Canada), you or your eligible dependents require hospitalization or medical treatment as the result of an emergency, the following reasonable and customary expenses in excess of the government plan allowances are covered (provided they are eligible for reimbursement in whole or in part by a provincial medical plan) up to the lifetime maximum outlined in your Benefit Summary;

- ◊ reasonable charges for ward accommodation and hospital services and supplies;
- ◊ reasonable charges for the services of a physician;
- ◊ reasonable charges for x-ray examinations and lab tests related to medical treatment without hospitalization;
- ◊ economy airfare for the claimant's return to the province of residence.

If you or an eligible dependent is referred by a physician to a hospital outside the province of residence for medically necessary treatment which is unavailable in the province of residence, or for which there is not medically sufficient alternative treatment available in your province of residence, and which is eligible for reimbursement in whole or in part by a provincial medical plan, the above noted reasonable and customary charges are covered, with the exception that the physician's charges are limited to the

physician charges in the employee's province of residence and hospital charges to \$75 per day for 60 days per calendar year.

General Exclusions

The following are not eligible expenses:

- Charges which are considered an insured service of any provincial government plan;
- Charges for general health examinations, and examinations required for use of a third party;
- Charges for a surgical procedure or treatment primarily for cosmetic reasons, or charges for hospital confinement for such surgical procedure or treatment, unless required for treatment of accidental injuries and commenced within 365 days of the accident;
- Charges for transport or travel, other than as specifically provided under eligible expenses;
- Charges not specified in the list of eligible medical expenses;
- Charges which are furnished without the recommendation and approval of a physician acting within the scope of his/her license;
- Charges which are not medically necessary;
- Charges which are from an occupational injury covered by any Workers' Compensation law or similar legislation;
- Charges which would have not normally been incurred had this plan not been in existence, or for which you or your dependent are not legally obligated to pay;
- Charges for bodily injury whether wholly or partly, directly or indirectly as the result of committing, attempting or provoking an assault or criminal offence or by war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
- Charges for bodily injury resulting from injury or disease which occurred while you were on active duty in the armed forces of any country, state or international organization or for bodily injury resulting from war or act of war whether declared or undeclared;
- Charges for services or supplies resulting from any intentionally self-inflicted wound;
- Charges for drugs, sera, injectibles or supplies which are not approved by Health and Welfare Canada or are experimental or limited in use whether or not so approved;
- Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association;
- Charges made by a physician for travel, broken appointments, communication costs, filling in of forms, any service provided by phone or physician supplies;
- Charges for any hospital service or supply furnished on the day of confinement in any hospital or institution which is a place of drug addiction or alcoholism, a tuberculosis hospital or sanitarium, a hospital or institution for the mentally ill, or a nursing home, home for the aged, infirmary or other institution if for custodial care;
- Charges which the Plan is not permitted, by any law or regulation, to cover;
- Charges for dental work for which a third party is responsible for payment;

- Charges for any service or supply provided by any person who is a member of your immediate family or who ordinarily resides in your home; and
- Charges excluded as eligible expenses under the master agreement.

The above briefly describes your medical benefits as of September 1, 1998. Actual benefits will be paid according to the master agreement in force when eligible expenses are incurred.

DENTAL BENEFITS

The Purolator Dental Care Plan is designed to help you pay for dental expenses incurred by you and your eligible dependents.

Dental expenses incurred inside Canada will be paid according to the Dental Association Schedule of Fees in effect as outlined in your Benefit Summary.

Dental Pre-Treatment Plan - \$250.00

In order for you and your dentist to learn in advance how much the Insurance Company will pay, it is recommended that a treatment plan be submitted whenever the proposed dental work is expected to exceed \$250.00. The Insurance Company will advise the amount payable. This confirmation will remain valid for a period of 90 days.

Your Dental Plan reimburses you for a percentage of eligible Dental expenses, to a maximum benefit for each insured person, in any calendar year. The maximum and percentage are outlined in your Benefit Summary.

The following are the eligible Routine procedures:

Diagnostics - which are the procedures required to assist your dentist in evaluating both existing and future dental care, including:

- Oral examinations: oral recall exam limited to once every six months;
- Dental X-rays, bitewing x-rays once every 6 months and complete series or equivalent once every 2 years;
- Study casts, once per year;
- Consultations;
- Emergency services not already outlined.

Preventive Therapy - which are the procedures intended to eliminate or reduce the need for future treatment, including:

- Polishing one unit of time every six months, scaling*, topical fluoride once every 6 months.

*Preventive Therapy scaling and periodontal scaling are limited to a combined maximum of 6 units of time every year.

- Oral hygiene instruction.

Basic Restorative Dentistry - which are the procedures used to restore the natural teeth to their normal functions, including:

- The use of silver amalgam, silicate or synthetic fillings, sedative dressings and stainless steel crowns for primary teeth only.

Extractions - the removal of teeth.

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

Emergency Endodontic procedures - including root canal therapy.

Periodontics - which are the procedures related to the treatment of gum disease, including:

- Scaling, root planing;
- The treatment of acute infections;
- Occlusal adjustment and provisional splinting (occlusal equilibration is limited to 8 time units per year);
- Special periodontal appliance;
- Surgical services including gingival curettage, gingivectomy, gingivoplasty or osseous surgery.

Oral surgery - routine oral surgical procedures including:

- Surgical removal of impacted teeth, residual roots and associated post operative care;
- Repair of uncomplicated soft tissue and treatment of dislocation of mandible;
- Control of secondary hemorrhage;
- Miscellaneous surgical services.

Rebasing and relining of dentures (once every 24 consecutive months).

The following are the eligible Major procedures:

- Repair of dentures, including the addition of new teeth;
- Initial installation of partial or full dentures;
- Replacement of existing dentures is only covered if:
 - ◊ required because at least one additional natural tooth was lost, fractured or necessarily extracted after the date you or your eligible dependent became covered under this plan;
 - ◊ The replacement is more than 12 months after you or your eligible dependent became covered under this plan, and the existing denture is at least 3 years old and no longer serviceable.

Pre-Existing Condition

Payments will not be made for any dental procedure required due to any injury or dental disease for which you or an eligible dependent was advised to receive treatment or for which treatment first began before the effective date for that procedure.

No benefit will be payable for the initial installation (or addition) of removable prosthetic devices unless this installation (or addition) is required primarily due to teeth that were lost, extracted or fractured after the effective date for removable prosthetic devices.

The effective date means the earlier date from which you or an eligible dependent has been continuously eligible for the dental procedure under the terms of this Plan or any previous Purolator dental plan.

Termination

No benefits will be paid for expenses incurred after the earlier of:

- termination of the Plan; or
- termination of your coverage for benefits.

Expenses not covered:

- Dental care which is primarily cosmetic;
- Services or supplies which are not furnished by a legally qualified dentist acting within the scope of his license;
- Services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result of committing, attempting or provoking an assault or criminal offence or by a war or act of war (whether declared or undeclared), insurrection, riot or hostilities of any kind;
- Miscellaneous charges such as for completion of claim forms, broken appointments, counseling and travelling;

- Services or supplies resulting from any intentionally self-inflicted wound;
- Any services which are covered by any government plan or program; or for which no charge is made; or which the Plan is not permitted by law to cover;
- Any dental examinations required by a third party;
- Services or supplies which are not medically necessary;
- Any charges which would not have been made if this plan did not exist, or for which you or your dependent is not legally obligated to pay;
- Services or supplies in connection with any procedures which are not eligible expenses;
- Any occupational injury or disease covered by Workers' Compensation;
- Any charges for protective athletic appliances;
- Services or supplies for or in connection with extensive restorative dentistry, fixed prosthetic devices and orthodontics;
- Services excluded as eligible expenses under the master agreement.

Where there is an alternative course of treatment with the same professional results, the Insurance Company reserves the right to determine eligible expenses based on this course of treatment.

The above briefly describes your dental benefits as of September 1, 1998. Actual benefits will be paid according to the master agreement in force when eligible expenses are incurred.

HOW TO CLAIM

If you have claims under your benefit program, your Human Resources Department will help you. All forms related to benefits will be available from your Human Resources Department.

Completed forms should be sent back to the Human Resources Department for Extended Health Care and Dental Care Expenses within 12 months of incurring the expense.

Supplementary Hospital Expenses

The Hospital should look after completing and submitting a claim form.

Extended Health Care Expenses

Save your medical receipts. Complete a claim form, attach your receipts and submit everything to your Human Resources Department.

For the services of a Registered Nurse in the home, please contact Human Resources to confirm eligibility before the expense is incurred.

Make sure each receipt includes:

- ◊ the patient's name;
- ◊ the date of the service;
- ◊ the type of medical service;
- ◊ all itemized charges;
- ◊ Drug identification number and/or name for drug claims.

Out-of-province claims must be submitted to your Provincial Medicare Plan before you submit your claim to Human Resources.

Dental Care Expenses

A completed dental claim form is required. After your dentist has completed this form and you have filled in the appropriate information, return the form to Human Resources. Some dentist offices may have computerized claims which can be directly forwarded to Mutual Life.

It is advised that you get a pre-determination of the dental work to be done if the dental work is going to be more than \$250. A pre-determination allows the Insurance Company to advise you of the eligibility of the expenses before they are incurred.

The Insurance Company may propose an alternative course of treatment yielding the same professional results.

A dental expense is considered an incurred expense as of the date the procedure or service is rendered. In the case of a procedure, which requires multiple appointments, the date the expense is incurred will be the date the service is finally completed. For dentures, this date will be the date the final impression was made. For root canal therapy, the date the canal is closed.

Survivor Benefits

The Human Resources Department will help your beneficiaries with a claim for Survivor benefits. If you are injured due to an accident and are eligible to claim benefits under the Accidental Death and Dismemberment Plan, Human Resources will help you with your claim.