CARPENTERS' RESIDENTIAL HEALTH AND WELLNESS PLAN

ENHANCED BENEFIT PLAN
PLAN MEMBER INFORMATION BOOKLET

UP TO DATE AS OF JULY 1, 2021

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INTRODUCTION

Dear Plan Member

This Plan Member Information Booklet has been prepared as an informal reference document to summarize the main features of the Benefits provided to eligible Plan Members of the Carpenters' Residential Health and Wellness Plan's Enhanced Benefit Plan. This Booklet also provides information on how to become, and remain an eligible Plan Member for the benefits of the Plan, as well as the rules and procedures for claim submission.

This Booklet is not a legal document, an insurance policy or a contract, and does not provide any contractual rights. Throughout this Booklet, the use of the terms "Plan", "the Plan", "your Plan", or "our Plan" refers to the "Carpenters' Residential Health and Wellness Plan". The terms "Plan Member", "you", "your", and "Covered Person" refers to a person who has satisfied the eligibility rules for the Benefits provided under the Carpenters' Residential Health and Wellness Enhanced Benefit Plan. The term "Insurer" refers to the applicable insurance company and/or benefits provider that insure the Plan's Benefits as described in this Booklet. The term "Fund" or "Funds" refers to the "Carpenters' Residential Health and Wellness Fund" and/or "Carpenters' and Allied Workers Local 27 – Shingling and Siding Division Legal Services Trust Fund" and/or "Carpenters' Local 1030 Vacation Pay Trust Fund".

The Carpenters' Residential Health and Wellness Plan, Bereavement/Parental Leave Plan, Vacation Pay Plan and Legal Services Plan, and the applicable Trust Funds, are governed by Boards of Trustees, appointed by the Carpenters & Allied Workers Local 27 and/or Carpenters Local 1030. The Boards of Trustees of these Funds reserve the right to amend these Plans in their absolute and total discretion, as deemed appropriate and as permitted by law. Any change to these Plans will be communicated to all Plan Members and such changes are deemed to amend and/or modify the Plan's Summary of Benefits and this Plan Member Information Booklet.

All Life Insurance and Long Term Disability (LTD) Benefits described in this Booklet and the rights thereto, are governed by the provisions of the Manulife Financial Insurance Policy Number 10042 (formerly 10077, 901202, 901857). All Accidental Death & Dismemberment (AD&D) benefits described in this Booklet and the rights thereto, are governed by the provisions of the CHUBB Life Insurance Company of Canada Insurance Policy Number AB10403501 (formerly ACE / INA Policy Number AB10403501). The Emergency Travel Assistance Benefit (ETA) is provided and administered by Green Shield Canada (GSC). The Member Assistance Program (MAP) is administered by Family Services Employee Assistance Programs (FSEAP).

All other benefits described in this Booklet are self-funded and provided through the assets of the Funds and governed by the provisions of the Plan's official Plan Texts. The insurance policies, contracts and Plan Text documents form part of the Plan's Official Documents, which are available from the Plan Administration Office.

The Board of Trustees has retained Employee Benefit Plan Services Limited as the Plan's Administrator to manage aspects of the Carpenters' Residential Health and Wellness Plan, including Plan administration and overseeing benefit payments for many of the Plan's Benefits. Please read this Plan Member Information Booklet carefully and keep it in a safe place for reference. You may contact the Plan Administration Office should you have any questions about the Benefits of the Plan, or any of the Plan's rules or procedures.

SUMMARY OF BENEFITS

Subject to the limitations and exclusions stated within the Plan's Official Documents, and as described throughout this Booklet, eligible Plan Members and their eligible Dependents qualify for the Benefits of the Enhanced Benefit Plan, which are described on the following pages, starting with the Benefit summary below.

You may find that the Plan does not cover every expense you may wish the Plan to pay for. The Plan is established to provide the broadest range of coverage that is suitable for the membership of the Plan. New drugs and treatments will come into the health care environment over time and the Trustees always reserve the right to cover, or not cover any of these, and to add limitations and/or exclusions to the coverage of the Plan.

LIFE INSURANCE BENEFIT

Plan Member: $150,000

DEPENDENT LIFE INSURANCE BENEFIT

Spouse: $50,000

Each Dependent Child: $10,000

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (AD&D)

Plan Member:	Principal Sum	$200,000
	Permanent & Total Disability Benefit	$200,000
	Occupational AD&D Benefit	$100,000
Spouse:	Principal Sum	$50,000
Each Dependent Child:	Principal Sum	$10,000

CRITICAL ILLNESS BENEFIT

Plan Member: $10,000 for 4 Specific Qualified Critical Illnesses

WEEKLY INDEMNITY (WI) BENEFIT

The maximum WI benefit payable is $500 per week. Benefit payments are integrated with Employment Insurance Sickness benefits. To qualify for WI benefit payments, a Plan Member must be "Wholly Disabled" (as defined in the Member Information Booklet and Plan Text).

WI benefit payments are payable from the 1st day of an accident, or after a 24 hour hospitalization period, or on the 8th day of illness, for a maximum period of 26 consecutive weeks for any one cause of disability.

LONG TERM DISABILITY (LTD) BENEFIT

The maximum LTD benefit payable is $1,000 per month. To qualify, a Plan Member must be under age 65 and be "Totally Disabled" (defined in the Plan Member Information Booklet and the contract of insurance) for a continuous period of 182 consecutive days. LTD benefit payments are payable until the earlier of the attainment of age 65, recovery, or death.

SUPPLEMENTARY HEALTH CARE BENEFIT

Deductible:	None	
Reimbursement:	100% for all eligible services and supplies	
Overall Maximum:	Unlimited	
Prescription Drugs:	Eligible Prescription Drugs must have a Drug Identification Number DIN) and a Compliance Certificate both issued by Health Canada	
Reimbursement:	Based on the lowest eligible cost between a Brand Name Drug and its Generic Drug equivalent (where a Generic equivalent is available)	
Biologic / Biosimilar Drugs:	Reimbursement is based on Prior Authorization of the lowest cost between a Biologic Drug or its Biosimilar Drug (where available)	
Drug Maximums:	Methadone Treatment $1,000 Lifetime; Erectile Dysfunction $500 per year; Fertility Drugs $2,500 Lifetime; Smoking Cessation $400 lifetime.	
Vision Care	***Lenses, Frames and Contact Lenses:***	Maximum of $400 in a consecutive 24 month period. Includes prescription safety and prescription sunglasses.
	Industrial Safety Glasses:	Maximum of $200 in a consecutive 24 month period (Plan Members only)
	Laser Eye Surgery:	$2,000 Lifetime
	Eye Examinations:	1 eye examination each 12 months
Paramedical Practitioners	$500 maximum per practitioner per calendar year for chiropractor, psychologist, registered massage therapist, speech therapist, physiotherapist, naturopath, osteopath, or podiatrist.	
Hearing Aids	$500 maximum benefit in any 36 consecutive month period for the purchase of hearing aids (batteries are not covered).	
Foot Orthotics	$500 maximum benefit in a 24 month period for orthotics which have been specially designed and molded for the insured person, and necessary to correct a diagnosed physical impairment.	
Other Medical Services & Supplies	Ambulance, convalescent care, accidental dental, durable medical equipment (hospital bed, wheelchair, braces, crutches), prostheses, x-rays, lab tests, surgical stockings.	
Private Duty Nursing	$10,000 each calendar year	

EMERGENCY TRAVEL ASSISTANCE (ETA) BENEFIT

The Plan provides travel coverage for a medical **Emergency** (in excess of your provincial/territorial health care plan) and travel assistance services for Plan Members and eligible Dependents who are **Canadian residents, under age 65 and properly enrolled under their provincial health care program**, and who are temporarily outside of their province of residence for vacation, business, or education.

It is important to read and understand the rules for this benefit before departure. The ETA benefit includes requirements, limitations, and exclusions that can affect your eligibility and/or the reimbursement of incurred medical expenses.

Please refer to the ETA section of this Plan Member Information Booklet for detailed information about the rules of this benefit. All ETA services (provided by Green Shield Canada (GSC)) are available 24 hours per day, 7 days per week.

GSC Travel Assistance should be contacted <u>before</u> travelling to any destination, to ensure you and/or your Dependents meet the conditions for ETA coverage, and that the destination is a country where the ETA coverage will be provided.

For assistance, please contact GSC Travel Assistance in Canada and the United States at 1-800-265-9977, or call collect at 1-519-741-8450 from any other location. The Plan's Benefit Card includes all of the necessary Plan and other information to contact GSC Travel Assistance to discuss a proposed trip, your or your Dependent's eligibility for coverage, to report a claim for a medical emergency, or to receive travel assistance or other information about your trip.

Emergency Medical Travel Coverage Maximums

$5,000,000 per Covered Person, per incident

Maximum Trip Duration of 60 consecutive days per trip

Emergency Travel Assistance Services

Coverage is provided for variety of specific travel assistance and advisory services.

Medical Referral Coverage Maximum

$50,000 per Covered Person, per calendar year (requires prior authorization).

<u>It is extremely important to contact GSC Travel Assistance prior to obtaining emergency medical treatment (if possible), or to have someone call on the Covered Person's behalf within 48 hours if it is medically impossible for the Covered Person to call.</u>

<u>Emergency</u> means a sudden, unexpected injury, illness or acute episode of disease that requires immediate medical attention and could not have been reasonably anticipated based upon the patient's prior medical condition.

There must not be a **Pre-Existing** medical condition. The Covered Person must be in **Stable** medical condition for the 90-day period prior to departure.

DENTAL CARE BENEFIT

Deductible:	None
Reimbursement:	100% for Basic Dental Services; 60% for Major Dental Services; 60% for Orthodontic Services.
Dental Fee Guide Schedule:	Dental benefits are reimbursed based on the current Dental Association's Suggested Fee Guide in effect on the date the expense is incurred, in the province or territory where the service is rendered.

Maximum Dental Benefit per Plan Member and per each Eligible Dependent

Basic and Major Dental Services:	$3,500 per calendar year for Basic & Major services combined
Orthodontic Services:	$2,500 lifetime. Only for dependent children under age 19. Pre-treatment plan required.
Basic Services:	Diagnostic, preventative, restorative, surgery, fillings, anesthesia, 1 complete series of x-rays, 1 set of bitewing x-rays, polishing, topical fluoride treatment, periodontal scaling.
Recall Examinations:	1 recall examination each 6 months
Complete Examinations:	1 complete oral examination each 24 months
Major Services:	Crowns, bridges, dentures replacement bridges / dentures covered each 5 years

MEMBER ASSISTANCE PROGRAM (MAP) BENEFIT

Confidential counseling, information, advice and referral services are available to Plan Members and their eligible Dependents. Services are provided by FSEAP 24 hours a day, every day of the year. Contact FESAP directly at 1-800-668-9920, or online at www.myfseap.com (Group Name: toloc27map / Password: myfseap1).

SURVIVOR BENEFIT

Upon the death of an eligible Plan Member, the eligible surviving Dependent(s) (e.g., Spouse and/or Children) will continue to be covered under the Plan for Supplementary Health Care, Emergency Travel Assistance, Dental and Member Assistance Program Benefits for a period of 30 consecutive months, commencing after the Plan Member's Dollar Bank Account has been exhausted. No payments will be required to continue coverage during this extension of benefits period.

BEREAVEMENT / PARENTAL LEAVE BENEFIT

If you suffer the loss of an eligible family member you may be eligible to receive Bereavement Pay. You must be actively working, obtain a letter from your employer indicating your last day of work and the days you did not work as a result, and provide an original death certificate or statement of death. Eligible family members include Spouse, Child*, Parent*, Grand Parent, Brother*, Sister* (*or any in-laws).

The benefit is a maximum of $150 per day, for a maximum of up to three business days and is payable from the 1st day of lost earnings due to bereavement, provided you were at work the day prior.

If actively working and you have a newborn child, you may be eligible to receive Parental Leave Benefits. You must be absent from work immediately following the birth of your child, provide a letter from your employer indicating you were working, your last day of work and the days you did not work, and an original birth certificate. The benefit is a maximum of $150 per day, for a maximum of up to three business days and is payable from the 1st day of lost earnings due to childbirth, provided you were actively at work.

VACATION PAY PLAN

The Plan provides Plan Members with their entitlement to any Vacation Pay they have earned under the terms of the applicable collective agreement, each benefit year. The Plan makes one regular annual payout of Vacation Pay benefits each November 1st.

Plan Members also have the option to receive their earned Vacation Pay benefits at one other time during the benefit year, as long as the requested optional payment is not within a 60 day period either before or after November 1st (i.e., optional payments will not be issued by the Plan between September 1st and February 1st of the following year.

LEGAL SERVICES PLAN

The benefits of the Legal Services Plan are intended to provide Plan Members with financial assistance for general legal services such as Wills, Power of Attorney documents, Real Estate transactions, Adoption proceedings, etc.

Please review the Schedule of Benefits within the Legal Services Plan Section of the Plan Member Information Booklet for details of the maximum annual benefits payable, which are dependent on the type of legal service used. The Plan also has overall calendar year maximums for all legal services combined, which are dependent on your cumulative years as an eligible Plan Member.

BENEFITS AT A GLANCE

The following pages of this Summary of Benefits provide a more detailed, quick reference summary of the Benefits available to eligible Plan Members and the provisions that apply.

Carpenters' Residential Health and Wellness Plan

Benefits at a Glance

Enhanced Benefit Plan Summary (as of July 1, 2021)

Benefit / Benefit Provision	Health Benefit Plan Coverage / Rule
General Plan Provisions	
Monthly Dollar Bank Drawdown	$380
Dollar Bank Maximum	$4,560 (12 Months of Benefits)
Initial Eligibility	1st Day of 2nd Month, Following the Month the Member Accumulates $1,140 in Dollar Bank
Reinstatement Eligibility	If Reinstatement is Within 12 Months, When Member Has $380 in Dollar Bank If Reinstatement is After 12 Months, Initial Eligibility Rule Applies
Pay Direct Plan Options *(plus applicable provincial tax)	Plan A - All Benefits Except WI & LTD - $300 Per Month* Plan B - Life Insurance Only - $30 Per Month*
Pay Direct Duration	12 Month Maximum (WSIB to Age 65)
Dependant Definition - Spouse	Legally Married, Common Law With 12 Month Cohabitation
Dependant Definition - Children	Under Age 22, or Under Age 25 if in Educational Institution
Termination of Coverage	Retirement (Unless Otherwise Noted Under Each Benefit Provision)
Life Insurance	
Benefit Amount	$150,000
Termination of Coverage	Retirement (Other Standard Termination Provisions Apply)
Dependant Life Insurance	
Spouse Benefit Amount	$50,000
Child Benefit Amount	$10,000
Termination of Coverage	Retirement (Other Standard Termination Provisions Apply)
Accidental Death & Dismemberment (AD&D)	
Member Principal Amount	$200,000
Spouse Principal Amount	$50,000
Child Principal Amount	$10,000
Permanent & Total Disability Benefit	$200,000 Lump Sum Benefit. "Any Occupation" Definition of Disability. Terminates at Age 65.
Schedule of Loss	Comprehensive
Peripheral AD&D Benefits	Comprehensive
Termination of Coverage	Retirement (Other Standard Termination Provisions Apply)
Occupational AD&D	$100,000 - Same Schedule of Loss as AD&D Benefit. Terminates at Age 75.
Critical Illness	$10,000 Lump Sum Benefit For 4 Qualified Critical Illnesses. Terminates at Age 65.
Weekly Indemnity	
Weekly Benefit Amount	$500
Qualifying Period	1st Day Hospital. 1st Day Accident. 8th Day Illness.
Definition of Disability	"Own Occupation"
Maximum Benefit Duration	26 Weeks
Direct Benefit Offsets	Employment Insurance
Termination of Coverage	Retirement (Other Standard Termination Provisions Apply)
Long Term Disability	
Monthly Benefit Amount	$1,000
Qualifying Period	26 Continuous Weeks of Total Disability.
Definition of Disability	"Own Occupation" During First 24 Months of Disability, "Any Occupation" After 24 Months
Maximum Benefit Duration	To Age 65
Direct Benefit Offsets	WSIB Benefits
Indirect Benefit Offsets	Various Sources of Income - All Source Limit 85% of Gross Pre-Disability Earnings
Pre-Existing Condition Limitation	Disabilities Treated 90 Days Prior May Not Be Claimed During First 6 Months
Termination of Coverage	Age 65 or Earlier Retirement - (Other Standard Termination Provisions Apply)
Bereavement Pay Benefit	
Maximum Benefit and Payment Period	$150 Maximum Benefit per Day, 3 Day Maximum
Eligible Family Members	Spouse, Child*, Parent*, Grand Parent, Brother*, Sister* (*or any in-laws).
Required Proof of Claim	Must be Actively at Work, Provide Employer Note and Death Certificate
Parental Leave Benefit	
Maximum Benefit and Payment Period	$150 Maximum Benefit per Day, 3 Day Maximum
Eligible Family Members	New Born Child
Required Proof of Claim	Must be Actively at Work, Provide Employer Note and Birth Certificate

Carpenters' Residential Health and Wellness Plan
Benefits at a Glance
Enhanced Benefit Plan Summary (as of July 1, 2021)

Benefit / Benefit Provision	Health Benefit Plan Coverage / Rule
Supplementary Health Care	Must Be Properly Enrolled Under Applicable Provincial Health Care Plan
Deductible	None
Coinsurance	100% For All Services & Supplies
Pay Direct Drug Card	Yes
Prescription Drug Reimbursement	Brand Name or Generic Drugs - 100% of the lowest cost alternative drug. Biologic or Biosimilar drugs (require Prior Authorization) - 100% of the lowest cost alternative (if available)
Dispensing Fee Maximum	N/A
Overall Health Care Lifetime Maximum	Unlimited
Prescription Drug Maximums	Methadone $1,000 Lifetime; Erectile Dysfunction $500/Year; Fertility Drugs-$2,500 Lifetime; Smoking Cessation $400 Lifetime. Includes Insulin and Diabetic Supplies, Allergy Serums, Vaccines and Toxoids, Injectable Drugs, Sclerotherapy (Maximum $20/Visit), IUDs and
Private Duty Nursing	$10,000 Each Calendar Year
Paramedical Practitioner Services	$500 Per Practitioner Each Calendar Year - Chiropractor, Osteopath, Podiatrist, Physiotherapist, Naturopath, Speech Therapist, Massage Therapist, Psychologist
Orthotics / Orthopaedic Shoes	$500/24 Months For Orthotics. $500/24 Months For Orthopaedic Shoes.
Hearing Aids	$500/36 Months
Vision Care (Prescription)	$400/24 Months for Lenses, Frames, Contact Lenses, Sunglasses or Industrial Safety Glasses
Laser Eye Surgery	$2,000 Lifetime Maximum for Laser Surgery
Industrial Safety Glasses (Prescription)	$200/24 Months (Plan Members Only)
Eye Examinations	1 Eye Exam Each 12 Months
Medical Transportation Services	Emergency Ambulance
Medical Services & Supplies	Convalescent Care, Durable Medical Equipment (Hospital Bed, Wheelchair, Braces, Crutches), Prosthetics, X-Rays, Lab Tests, Diabetic Supplies, Surgical Stockings, etc.
Accidental Dental Services	Subject to Reasonable & Customary Charges
Survivorship Benefit (For Dependants)	Balance of Member's Dollar Bank, plus a 30 Month Extension
Termination of Coverage	Retirement (Other Standard Termination Provisions Apply)
Emergency Travel Assistance	60 Day Maximum Trip Duration - Must Contact Green Shield Within 48 Hours
Emergency Travel Medical Maximum Benefit	$5,000,000 per Out of Province Medical Emergency Incident
Referral Medical Maximum Benefit	$50,000 Out of Province Referral Coverage per Calendar Year
Termination of Coverage	Age 65 or Earlier Retirement - (Other Standard Termination Provisions Apply)
Dental Care	
Deductible	None
Coinsurance Basic Services	100%
Coinsurance Major Services	60%
Coinsurance Orthodontic Services	60%
Annual Maximum Basic Services	$3,500
Annual Maximum Major Services	Combined With Basic Services Maximum
Lifetime Maximum Ortho Services	$2,500
Fee Guide Schedule	Current Ontario Dental Fee Guide (ODA)
Basic Services Included	Diagnostic, Preventative, Restorative, Surgery, Fillings, Anaesthesia
Complete Examination	1 Exam Each 24 Months
Recall Exams	1 Exam Each 6 Months
X-rays	1 Complete Series Each 12 Months
Bitewing X-rays	1 Set Each 12 Months
Polishing	Covered
Topical Fluoride Treatment	Covered
Periodontal Scaling	8 Units Each Calendar Year
Major Services Included	Crowns, Bridges, Dentures
Replacement Bridges / Dentures	Covered Each 5 Years
Orthodontic Services	Children Under Age 19. Treatment Plan Required.
Survivorship Benefit (For Dependants)	Balance of Member's Dollar Bank, plus a 30 Month Extension
Termination of Coverage	Retirement (Other Standard Termination Provisions Apply)
Member Assistance Program	Confidential Counselling & Advisory Services. Terminates at Retirement

ELIGIBILITY INFORMATION

WHO MAY BECOME ELIGIBLE FOR THE BENEFITS OF THE PLAN

The benefits of the Plan are provided only to eligible Members in Good Standing of Local 27 or Local 1030 of the Carpenters' Union, or to Officers of Local 27 or Local 1030, on whose behalf contributions have been made to the Fund, and who have met the eligibility requirements for the Plan's benefits as described throughout this Booklet.

A Member's status in the Union is determined by the Union and the Board of Trustees. The Plan Administrator will accept the Union's determination of a Member's status. A Member's eligibility under the Plan is based on the level of employer contributions being made to the Fund on a Plan Member's behalf, as determined by the Board of Trustees.

All qualified Plan Members and their eligible Dependents must be Canadian residents and must be covered under the applicable provincial government health care plan.

WHEN DOES A PLAN MEMBER FIRST BECOME ELIGIBLE FOR BENEFITS?

To become eligible for the benefits of the Plan, a Plan Member must first complete and submit a Member Information Card to the Plan Administration Office. Member Information Cards are available at the Union Office or from the Plan Administration Office. It is important to keep your Member Information Card up to date and advise the Plan Administration Office if there are any changes to the information already provided.

The Plan Administration Office will establish a Dollar Bank Account for each eligible Plan Member and deposit to that account, all of the employer contributions for the Plan received by the Plan Administration Office.

Coverage under the Plan for Plan Members and their eligible Dependents will commence on the first day of the second month, following the month in which a Plan Member's Dollar Bank Account balance is at least three times the required Monthly Dollar Bank Deduction. Based on the Plan's required Monthly Dollar Bank Deduction as of the date this Plan Member Information Booklet was prepared, the initially required Dollar Bank Account balance is $1,140.

All Dollar Bank Account deduction amounts are reviewed by the Board of Trustees on a regular basis and are subject to change at any time.

HOW DOES A PLAN MEMBER REMAIN ELIGIBLE FOR BENEFITS?

Each month an amount representing the monthly cost of the Plan's benefits will be deducted from the Plan Member's Dollar Bank Account. This amount is referred to as the Monthly Dollar Bank Deduction. As of the date this Plan Member Information Booklet was prepared, the required Monthly Dollar Bank Deduction is $380.

A Plan Member will remain covered for the benefits of the Plan (subject to the eligibility and termination provisions described throughout this Booklet), provided the Plan Member has the minimum Monthly Dollar Bank Deduction amount in their Dollar Bank Account for each month of coverage.

In any month that the Plan Administrator receives contributions on behalf of a Plan Member that are in excess of the required Monthly Dollar Bank Deduction, the excess will remain in the Plan Member's Dollar Bank Account, up to a Dollar Bank Account Maximum balance of $4,560.

The Dollar Bank Account Maximum balance (which is subject to change as described earlier) represents 12 months of Monthly Dollar Bank Deductions. A Plan Member who has the Maximum Dollar Bank Account balance will remain covered by the Plan for up to 12 months.

HOW CAN A PLAN MEMBER STAY IN BENEFITS IF THEY DO NOT HAVE THE REQUIRED DOLLAR BANK DEDUCTION IN THEIR DOLLAR BANK ACCOUNT?

The Plan Administration Office will send notification to a Plan Member if their Dollar Bank Account balance does not have a minimum Monthly Dollar Bank Deduction.

In that case, a qualified Plan Member may be eligible to make monthly Pay Direct payments for up to 12 consecutive months, to remain eligible for benefits. Only Plan Members who remain Members in Good Standing of Local 27 or Local 1030 of the Carpenters' Union may be covered under the Pay Direct extension of benefits.

The Plan Administration Office will advise qualified Plan Members of their option to make Pay Direct Plan payments to the Plan and the required payment schedule. To remain as an eligible Plan Member, all Pay Direct Plan payments must be received by the Plan when due and are subject to applicable provincial taxes, presently 8% in Ontario (Retail Sales Tax (RST)).

As of the date this Plan Member Information Booklet was prepared, a qualified Plan Member has the option to extend coverage by making monthly Pay Direct payments, based on one of the following Pay Direct options:

Plan A - a $300 monthly Pay Direct Plan (plus applicable taxes) that provides all benefits of the Plan, excluding the Weekly Indemnity and Long-Term Disability Benefits; or

Plan B - a $30 monthly Pay Direct Plan (plus applicable taxes) that provides only the Life Insurance benefit applicable to Plan Members (not for any eligible Dependents).

All Pay Direct Plan options and any required monthly Pay Direct Plan payment amounts are reviewed regularly by the Board of Trustees and are subject to change at any time.

HOW DOES A PLAN MEMBER BECOME REINSTATED FOR BENEFITS AFTER COVERAGE HAS STOPPED?

In the event that a Plan Member's coverage in the Plan has terminated due to an insufficient Dollar Bank Account balance, and the Plan Administration Office again receives contributions on the Plan Member's behalf due to a return to work for a contributing employer, the Plan Member may be reinstated for the coverage under the Plan.

If coverage has been terminated for a period of less than 12 consecutive months, a Plan Member will again be eligible for benefits on the first day of the month, following the month in which the Member's Dollar Bank Account has a minimum balance of the Monthly Dollar Bank Deduction as described above.

If a Plan Member's coverage has been terminated for a period of 12 consecutive months or greater, a Plan Member will again be eligible for benefits on the first day of the second month, following the month in which the Member's Dollar Bank Account balance is at least 3 times the required Monthly Dollar Bank Deduction described above.

The initially required Dollar Bank Account balance, the Monthly Dollar Bank Deduction and the ongoing eligibility rules described above are those that were in effect when this Booklet was printed. These rules are subject to review and change in the future. If any changes are made, Plan Members will be notified.

BESIDES THE PLAN MEMBER, WHO ELSE CAN BE COVERED FOR BENEFITS?

The eligible Dependents of a Plan Member shall include only the following persons who are residents of Canada and who are covered under their applicable provincial health care plan:

Spouse

a) the Spouse of a Plan Member includes a person legally married to the Plan Member as a result of a valid civil or religious ceremony and excludes a person divorced or separated from the Plan Member; or

b) the common-law Spouse of a Plan Member with whom the Plan Member has continuously cohabitated and publicly represented as their married Spouse for a period of no less than 12 consecutive months, immediately prior to the date of services for which a first claim is made.

Child / Children

a) each Child (over 14 days of age with respect to Dependent Life Insurance) of a Plan Member. A Dependent Child shall include children of the Plan Member's marriage, legally adopted children, and step children. To be considered an eligible Dependent, the Child must not be married, must not be employed on a regular full-time basis, and must be under 22 years of age; and

b) a Child under age 25 who has been continuously covered as a Dependent under this Plan since first becoming eligible, will continue to be considered an eligible Dependent if in full-time attendance at an accredited school, college or university. Verification of attendance must be provided to the Plan Administration Office.

A Child whose normal residence is in Canada will also be considered an eligible Dependent when attending an accredited school, college or university outside of Canada, subject to the limitations described under the Supplementary Health Care in the **Description of Benefits** section of this Booklet;

c) a functionally impaired Child who was covered as a Dependent shall remain covered beyond any limiting age for Dependents, provided the Child is incapable of self-sustaining employment and is wholly dependent upon the Plan Member for support and maintenance.

WHEN WILL ELIGIBLITY FOR THE BENEFITS OF THE PLAN TERMINATE?

A Plan Member's coverage, including coverage for any eligible Dependents, will terminate under the Health and Wellness Plan on the earliest of the following dates:

1. the first day of the month for which a Plan Member has less than the required Monthly Dollar Bank Deduction in their Dollar Bank Account;
2. the first day of the month for which the Plan Member did not make the necessary Pay Direct payment, or for which the Plan Member is no longer eligible to make Pay Direct payments;
3. the day a Plan Member ceases to be a Member in Good Standing of Local 27 or Local 1030 and is suspended or expelled, and for as long as the Plan Member remains suspended or expelled;
4. the day a Plan Member commences active duty in the armed forces of any country, state or international organization;
5. the date the coverage or policy terminates with respect to the benefit(s) covered under that policy;
6. the day on which a Plan Member retires and has exhausted the amount in his Dollar Bank Account;
7. for the Permanent and Total Disability benefit, Critical Illness, Long Term Disability and Emergency Travel Assistance Benefits, the earlier of the day on which a Plan Member attains age 65, or retires. If the Plan Member completely satisfies the Qualifying Disability Period for Long Term Disability while age 64 and is considered eligible for disability benefits, Long Term Disability benefit payments may be payable for a maximum of 12 months;
8. for the Occupational AD&D Benefit, the earlier of the day on which a Plan Member attains age 75, or retires;
9. the termination date as set out in accordance with any termination provision described within each benefit description throughout this Booklet.

Coverage for the eligible Dependents of a Plan Member will terminate at the same time that a Plan Member's coverage terminates as described above. In addition, a Dependent's coverage will terminate if/when the Dependent no longer qualifies as an eligible Dependent as described above.

Note that certain benefits may be extended by the Insurers to a disabled Plan Member (beyond a Plan Member's termination of benefits and/or beyond the Plan's termination of benefits). Please see the **Description of Benefits** section of this Booklet for further information.

WORKPLACE SAFETY INSURANCE

If a Plan Member becomes disabled while working for a contributing employer for which Workers' Compensation (WSIB) benefits are payable under the Workplace Safety and Insurance Act, Ontario, the Plan Member's Dollar Bank Account will be frozen, and they and their eligible Dependents will remain covered for the Plan's Benefits while the Plan Member is in receipt of WSIB benefits for a maximum period of 12 months.

Although the Plan Administration Office has arranged a process with contributing employers and the Union Office to receive notice of any work-related disabilities, the fact is that a Plan Member in receipt of WSIB benefits may be overlooked and may not receive their proper credit under the Plan.

Plan Members who suffer from a work-related disability must notify the Plan Administration Office directly, supply evidence that they are in receipt of WSIB benefits, provide the date of the disability and, if known, the expected date of recovery to ensure the applicable WSIB credit is received under the Plan.

ASSISTANCE WITH WORKPLACE SAFETY AND INSURANCE (WSIB) CLAIMS

Plan Members who become disabled due to a work-related disability may seek assistance from the Local Union 27 or 1030. The Union has a lawyer and other legal practitioners on staff to assist Plan Members when submitting a claim for WSIB benefits, including application for Employment Insurance (EI) and/or Canada Pension Plan (CPP) disability benefits.

What to do If you have an accident at work

1. Report the injury to your employer right away.
2. See a doctor or other health professional and make sure they complete a "**Health Professional's Report (Form 8)**".
3. Contact Local Union 27 or 1030 to report the accident. Nancy Amico at (905) 652-4140, extension 606 assists Plan Members in applying for WSIB benefits.
4. Complete a **"Worker's Report of Injury (Form 6)"**. Copies of the completed **Form 6** should be sent to WSIB and to your employer. Local Union 27 or 1030 can help you with this.
5. Contact the Plan Administration Office to report the accident and submit a claim for the Plan's Long-Term Disability benefit;
6. Apply for EI and/or CPP disability benefits.

WSIB Claim Appeals

A workplace injury may only become evident over time, without being caused by a single, specific event. These injuries can still be claimed as WSIB workplace injuries, however the claim process may be more difficult and often results in a claim appeal being filed. The Local Union can also assist Plan Members with a WSIB claim appeal.

Employer's Re-Employment Obligation & Your Return to Work

Employers in the construction sector have an obligation to offer suitable modified work to re-employ workers who have been injured. This applies even to workers who have fully recovered from their injury, as long as the employer still has work available to offer.

Both workers and employers have an obligation to try and identify suitable modified work together. Employers will often give workers a "Functional Abilities Form" to be completed by a doctor. This form provides information that helps to determine what type of modified work a worker may be able to perform. Employers want to offer modified work to injured workers because it will save them on WSIB claims costs.

According to WSIB rules, temporary modified work does not have to be construction-related and does not have to be work that falls under the collective agreement. It may include office work, if suitable and available. A dispute about the suitability of modified work could result in a WSIB Return to Work Specialist reviewing the duties, conditions and availability of the job to determine a worker's ability to perform that work.

Loss of Earnings Benefits & Tax Information

The WSIB will pay benefits during the first 12 weeks of an approved disability claim based on the net average earnings made by a worker during the 4 weeks before the injury. The WSIB normally recalculates these benefits at the 12th week and may review a worker's earnings for up to 2 years prior to the date of injury. This process is called a "Long Term Rate Calculation" and is intended to adjust the benefit amount to reflect a more accurate representation of a worker's actual earnings since earnings often fluctuate over time.

It is important to have all of your income tax returns completed and to be aware that WSIB disability benefit payments are based on net earnings (after tax and expense earnings).

Contacting the Office of Your Local Union 27 or 1030 for WSIB Assistance

For **general inquiries** about this assistance, or for help in submitting a claim for WSIB benefits, please contact **Nancy Amico at (905) 652-4140, extension 606**.

For questions and representation regarding **WSIB claim appeals**, and/or **return to work issues** or meetings, you may contact **Sally Chiappetta-Scapin at (905) 652-4140, extension 239, or Michael Farago at (905) 652-4140, 222**.

Sally and Michael represent workers at WSIB Return to Work meetings and with WSIB claim appeals at the Workplace Safety & Insurance Board and at the Appeals Tribunal.

DESCRIPTION OF BENEFITS

LIFE INSURANCE BENEFIT

In the event of a Plan Member's death while eligible for the benefits of the Plan, the amount of the Life Insurance Benefit shown in the **Summary of Benefits** section of this Booklet is payable to the Plan Member's Designated Beneficiary.

DESIGNATING A BENEFICIARY

A Plan Member may designate a Beneficiary when completing and filing a Member Information Card with the Plan Administration Office.

A Plan Member may change their Designated Beneficiary at any time (subject to any insurance policy or legal/provincial limitations) by completing a new Member Information Card and filing it with the Plan Administration Office.

The Insurer will generally pay any Life Insurance benefit to the Designated Beneficiary named on the last Member Information Card filed with the Plan Administration Office.

It is therefore very important to keep all personal information filed with the Plan Administration Office up to date, as well as to review your Designated Beneficiary to be sure it reflects your current intent.

LIFE INSURANCE BENEFIT CONVERSION PRIVILEGE

If the Life Insurance benefit of a Plan Member terminates or reduces, the terminated or reduced Life Insurance benefit amount may be eligible to be converted into an individual policy, without having to provide medical evidence of insurability to the Insurer.

An application for an individual policy along with the first monthly premium must be received by the Insurer within 31 days of the date of termination or reduction of the Life Insurance benefit. If a death occurs during this 31-day period, the amount of Life Insurance available for conversion will be paid accordingly to the Plan Member's Designated Beneficiary, even if there was no application for conversion. For more information on the Conversion Privilege, please contact the Plan Administration Office.

TAXABILITY OF LIFE INSURANCE PREMIUM PAID

Any Life Insurance premiums paid by the Fund on a Plan Member's behalf is considered under Canadian taxation laws to be a taxable benefit to the Plan Member in the calendar year in which it was paid.

In February of each year, a Plan Member who was covered for the Plan's Life Insurance benefit in the previous calendar year will receive an official tax form from the Plan that indicates the total amount of Life Insurance premium paid (together with any other taxable premiums paid) on the Plan Member's behalf by the Fund in the prior calendar year.

The amount shown on the official tax form must be reported as income in the Plan Member's annual income tax return.

TERMINATION OF LIFE INSURANCE BENEFIT

A Plan Member's Life Insurance benefit will terminate on the day the Plan Member retires and has exhausted the amount in their Dollar Bank Account. Coverage for a Plan Member will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

LIFE INSURANCE CLAIM FORM REQUIRED

No benefit payment will be made to a Plan Member's Designated Beneficiary unless a completed Claim Form and any other required documents are submitted to the Plan Administration Office and/or the Insurer within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

DEPENDENT LIFE INSURANCE BENEFIT

In the event of the death of a Plan Member's eligible Spouse and/or Dependent Child(ren) the amount(s) of Dependent Life Insurance shown in the **Summary of Benefits** section of this Booklet is(are) payable to the Plan Member.

DEPENDENT LIFE INSURANCE CONVERSION PRIVILEGE

If the Dependent Life Insurance benefit of a Plan Member's eligible Spouse terminates or reduces, the terminated or reduced Dependent Life Insurance benefit amount may be eligible to be converted to an individual policy, without medical evidence.

An application for an individual policy along with the first monthly premium must be received by the Insurer within 31 days of the date of termination or reduction of the Dependent Life Insurance benefit. If a death occurs during this 31-day period, the amount of the terminated or reduced Dependent Life Insurance benefit that was available for conversion will be paid accordingly, even if there was no application for conversion.

Provincial differences may exist. If you reside in the province of Quebec and if your Dependent Child's insurance terminates or reduces, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for Spousal coverage. For more information, please contact the Plan Administration Office.

TAXABILITY OF DEPENDENT LIFE INSURANCE PREMIUM PAID

Any Dependent Life Insurance premiums paid by the Fund on a Plan Member's behalf is considered under Canadian taxation laws to be a taxable benefit to the Plan Member in the calendar year in which it was paid.

In February of each year, a Plan Member who was covered for the Plan's Dependent Life Insurance benefit in the previous calendar year will receive an official tax form from the Plan that indicates the total amount of Dependent Life Insurance premium paid (together with any other taxable premiums) on the Plan Member's behalf by the Fund in the prior calendar year.

The amount shown on the official tax form must be reported as income in the Plan Member's annual income tax return.

TERMINATION OF THE DEPENDENT LIFE INSURANCE BENEFIT

A Plan Member's Dependent Life Insurance Benefit will terminate on the earlier of the day the Plan Member retires and has exhausted the amount in their Dollar Bank Account. Coverage for a Plan Member and for any Dependents will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

DEPENDENT LIFE INSURANCE CLAIM FORM REQUIRED

No benefit payment will be made to a Plan Member unless a completed Claim Form and any other required documents are submitted to the Plan Administration Office and/or the Insurer within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT AD&D

ACCIDENTAL DEATH BENEFIT (PLAN MEMBERS & DEPENDENTS)

Accidental death is defined as death resulting from accidental bodily injury. The Accidental Death & Dismemberment benefit is payable in addition to the Plan's Life Insurance Benefit.

Within 365 days of a Plan Member's accidental death, and upon receipt of due proof of loss satisfactory to the Insurer, the Designated Beneficiary will receive the Plan Member Principal Sum described in the **Summary of Benefits** section of this Booklet (see the Life Insurance Benefit description above for more information about designating a Beneficiary).

A Plan Member's eligible Dependents are also covered under the Accidental Death Benefit.

The Principal Sums for a Spouse and each Dependent Child are indicated in the **Summary of Benefits** section of this Booklet and are payable to the Plan Member.

OCCUPATIONAL ACCIDENTAL DEATH BENEFIT (PLAN MEMBERS ONLY)

Within 365 days of an occupational accidental death, and upon receipt of due proof of loss satisfactory to the Insurer, the Plan Member's Designated Beneficiary will receive the Occupational Accidental Death benefit indicated in the **Summary of Benefits** section of this Booklet. An occupational accidental death is the result of an accident which happens while a Plan Member, who is under age75, is:

i) on the premises of the job site, during the course of a Plan Member's job; or

ii) making a specific, authorized business trip (Business Travel but not including daily travel to a job site).

PERMANENT TOTAL DISABILITY BENEFIT (PLAN MEMBERS ONLY)

After one year (12 months) of **"Continuous Total Disability"**, if the Plan Member who is under age 65 then becomes **"Permanently and Totally Disabled"**, the Insurer will pay the Permanent Total Disability Benefit indicated in the **Summary of Benefits** section of this Booklet to the Plan Member. The Insurer will deduct any payments made under the Accidental Dismemberment Benefit Loss Schedule (see further below), on account of such same injuries.

A **"Continuous Total Disability"** which results from such injuries and commences within 30 days after the date of an accident, means a Plan Member's complete inability during the first year to perform the substantial and material duties of the Plan Member's own occupation or employment.

"Permanently and Totally Disabled" means the Plan Member's complete inability, after one year of Continuous Total Disability as defined above, to engage in any occupation or employment for which the Plan Member is fitted by reason of education, training or experience for the remainder of the Plan Member's life.

ACCIDENTAL DISMEMBERMENT BENEFIT (PLAN MEMBERS & DEPENDENTS) & OCCUPATIONAL ACCIDENTAL DISMEMBERMENT BENEFIT (PLAN MEMBERS)

The Insurer will pay 100% of the applicable Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that a Plan Member or an eligible Dependent should suffer any of the accidental losses listed below. In addition to the Accidental Dismemberment Benefit, the Insurer will also pay 100% of the applicable Occupational Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that the Plan Member, who is under age75, should suffer any of the accidental losses listed below due to an Occupational Accidental.

- Loss of Entire Sight of Both Eyes
- Loss of One Hand and One Foot
- Loss of Use of One Hand and One Foot
- Loss of One Hand and Entire Sight of One Eye

- Loss of One Foot and Entire Sight of One Eye
- Loss of Speech and Hearing in Both Ears
- Brain Death

The Insurer will pay 200% of the applicable Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that a Plan Member or an eligible Dependent should suffer any of the accidental losses listed below.

In addition to the Accidental Dismemberment Benefit, the Insurer will also pay 200% of the applicable Occupational Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that the Plan Member, who is under age75, should suffer any of the accidental losses listed below due to an Occupational Accidental.

- Loss of Both Arms, Both Hands, Both Legs or Both Feet
- Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet
- Quadriplegia
- Paraplegia
- Hemiplegia

The Insurer will pay 75% of the applicable Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that a Plan Member or an eligible Dependent should suffer any of the accidental losses listed below. In addition to the Accidental Dismemberment Benefit, the Insurer will also pay 75% of the applicable Occupational Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that the Plan Member, who is under age75, should suffer any of the accidental losses listed below due to an Occupational Accidental.

- Loss of One Arm or One Leg
- Loss of Use of One Arm or One Leg
- Loss of One Hand or One Foot
- Loss of Use of One Hand or One Foot
- Loss of Entire Sight of One Eye
- Loss of Speech or Hearing in Both Ears

The Insurer will pay 33 1/3% of the applicable Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that a Plan Member or an eligible Dependent should suffer any of the accidental losses listed below. In addition to the Accidental Dismemberment Benefit, the Insurer will also pay 33 1/3% of the applicable Occupational Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that the

Plan Member, who is under age75, should suffer any of the accidental losses listed below due to an Occupational Accidental.

- Loss of Thumb and Index Finger of the Same Hand
- Loss of Use of Thumb and Index Finger of the Same Hand
- Loss of Four Fingers of the Same Hand
- Loss of Hearing in One Ear

Quadriplegia, Paraplegia, Hemiplegia and "Loss of Use" Losses are subject to an all policies combined maximum benefit amount of $1,000,000.

The Insurer will pay 25% of the applicable Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that a Plan Member or an eligible Dependent should suffer any of the accidental losses listed below. In addition to the Accidental Dismemberment Benefit, the Insurer will also pay 25% of the applicable Occupational Accidental Dismemberment Principal Sum described in the **Summary of Benefits** section of this Booklet to the Plan Member in the event that the Plan Member, who is under age75, should suffer any of the accidental losses listed below due to an Occupational Accidental.

- Loss of All Toes of the Same Foot

ACCIDENTAL DISMEMBERMENT DEFINITIONS

"Loss" as used above in reference to the hand and / or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint.

"Loss" as used with reference to arm or leg means complete severance through or above the elbow or knee joint.

"Loss" as used with reference to thumb and index finger means complete severance at or above the metacarpophalangeal joint.

"Loss" as used with reference to toe means complete severance at or above the metatarsophalangeal joint.

"Loss" as used with reference to eye means the irrecoverable loss of the entire sight thereof.

If a Covered Person suffers complete severance of a hand, foot, arm or leg, a benefit will be paid, even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used above in reference to speech means complete and irrecoverable loss of speech which does not allow communication in any degree.

"Loss" as used with reference to hearing "Loss" means complete and irrecoverable loss of hearing, which cannot be corrected by any hearing aid or device.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for one hundred and eighty consecutive days and such loss of function is hereafter determined on evidence satisfactory to the Insurer to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

"Loss of Use" means total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and is determined to be permanent by the Insurer.

If such injuries shall result in any one of the specific losses listed above within one year from the date of accident, the Insurer will pay the specified applicable benefit based upon the applicable Principal Sum(s) however, not more than one (the largest) of such benefits shall be paid with respect to all injuries resulting from one accident for an Accidental Dismemberment or an Occupational Accidental Dismemberment.

ADDITIONAL AD&D BENEFITS (PLAN MEMBERS & DEPENDENTS)

EXPOSURE AND DISAPPEARANCE BENEFIT

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the benefits afforded a Covered Person. If the body of a Covered Person has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which they were riding at the time of the accident, it shall be presumed, subject to all other conditions of the benefit, that they suffered loss of life resulting from bodily injuries sustained in the accident.

REPATRIATION BENEFIT

When an injury covered results in loss of life of a Covered Person outside one hundred and fifty (150) kilometres from their city of permanent residence or outside Canada and within 365 days from the date of the accident, the Insurer will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

REHABILITATION BENEFIT

When injuries shall result in a payment being made by the Insurer under any benefit excluding the loss of life benefit, in addition the Insurer will pay the reasonable and necessary expenses actually incurred up to the maximum amount of $15,000, for special training of the Covered Person, provided:

a) such training is required because of such injuries and in order for the Covered Person to be qualified to engage in an occupation in which he/she would not have been engaged except for such injuries;
b) expenses are incurred within two (2) years from the date of the accident;
c) no payment will be made for ordinary living, traveling or clothing expenses.

FAMILY TRANSPORTATION BENEFIT

When injuries result in a Covered Person being confined as an in-patient in a hospital outside one hundred and fifty (150) kilometers from the Covered Person's city of permanent residence or outside Canada and requires personal attendance of a member of the immediate family as recommended by the attending physician, in writing, the Insurer will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to the confined Covered Person, but not to exceed the maximum amount of $15,000.

"Immediate Family Member" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

SPOUSAL OCCUPATIONAL TRAINING BENEFIT

When injuries to a Plan Member shall result in a payment being made by the Insurer under the Accidental Death Benefit, in addition, the Insurer will pay the expense actually incurred, within 365 days from the date of the accident, by the Spouse of the Plan Member for a formal occupational training program for the purpose of specifically qualifying such Spouse to gain active employment in an occupation for which the Spouse would otherwise not have sufficient qualifications. The maximum payable shall not exceed the amount of $15,000.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

This benefit is payable in the event a Covered Person sustains an injury which results in one of the Accidental Dismemberment losses payable excluding the Accidental Death Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory.

The Insurer will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1) the one-time cost of alterations to the Covered Person's principal residence to make it wheelchair accessible and habitable; and
2) the one-time cost of modifications necessary to a motor vehicle utilized by the Covered Person to make the vehicle accessible or operable for the Covered Person.

   Benefit payments herein will not be paid unless:

   a) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
   b) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 combined will not exceed 10% of the applicable Principal Sum indicated in the **Summary of Benefits**, to a maximum of $50,000.

DAY CARE BENEFIT

If a Plan Member or the eligible Spouse of a Plan Member suffers loss of life in a covered accident while the insurance policy is in force, the Insurer will pay, in addition to all other benefits payable under the Accidental Death and Dismemberment Benefit, a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to:

a) the lesser of 5% of the Covered Person's applicable Principal Sum amount; or

b) a maximum of $5,000 per year:

for any Dependent Child who is 12 years of age and under. The Dependent Child must be enrolled in a legally licensed day care centre on the date of the accident or must be enrolled in a legally licensed day care centre within 365 days following the date of the accident.

The Day Care Benefit will be paid each year for four (4) consecutive years, but only upon receipt of satisfactory proof that the Child is enrolled in a legally licensed day care centre.

SPECIAL EDUCATION BENEFIT

If a Plan Member or the eligible Spouse of a Plan Member suffers loss of life in a covered accident while the insurance policy is in force, the Insurer will pay, in addition to all other benefits payable under the Accidental Death and Dismemberment Benefit, a **"Special Education Benefit"**, of 5% of the Covered Person's applicable Principal Sum up to a maximum of $5,000 per year, on behalf of any Dependent Child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The **"Special Education Benefit"** is payable annually for a maximum of four (4) consecutive annual payments but only if the Dependent Child continues his education as a full-time student in an institution of higher learning.

BEREAVEMENT BENEFIT

When injuries covered by the Accidental Death and Dismemberment Benefit result in loss of life of a Covered Person within 365 days from the date of the accident, the Insurer will pay the reasonable and necessary expenses actually incurred by the surviving Plan Member, or eligible Dependents of the Plan Member (Spouse and Children) for up to six (6) sessions of grief counselling, by a Professional Counsellor, subject to a maximum amount of $1,000.

"Professional Counsellor" means the treatment or counselling by a therapist or counsellor who is licensed, registered or certified to provide such treatment.

IN-HOSPITAL CONFINEMENT MONTHLY INCOME BENEFIT

In the event a Covered Person sustains an injury which results in a payment being made under the Accidental Dismemberment Benefit, excluding the Accidental Death Benefit, and the Covered Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself, the Insurer will pay for each full month, one percent (1%) of the applicable Principal Sum, subject to a maximum benefit of

$2,500, or one-thirtieth (1/30) of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements:

1. operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
2. provides 24 hour a day nursing service by registered or graduate nurses;
3. has a staff of one or more licensed physicians available at all times;
4. provides organized facilities for diagnosis and surgical facilities; and
5. is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

COSMETIC DISFIGUREMENT BENEFIT

If a Covered Person suffers a third degree burn due to an accident, the Insurer will pay a percentage of the applicable Principal Sum depending on the area of the body which was burned according to the following table, subject to a maximum benefit payable of $25,000:

Body Part	(A) Area Classification	(B) Maximum allowable % for Area Burned	(C) Maximum % of Principal Sum Payable
Face, Neck, Head	11	9.0%	99.0%
Hand & Forearm	5	4.5%	22.5%
Either Upper Arm	3	4.5	13.5%
Torso (Front or Back)	2	18.0%	36.0%
Either Thigh	1	9.0%	9.0%
Either Lower Leg (below knee)	3	9.0%	27.0%

The **"Maximum Percent of Principal Sum Payable"** (item (C) in the table above) is determined by multiplying the Area Classification ((A) in the table above) by the Maximum Allowable percent for Area Burned ((B) in the table above).

In the event of a 50% surface burn, the Maximum Allowable percent for Area Burned (B) is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Covered Person suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

SEAT BELT BENEFIT

This benefit is only payable in the event a Covered Person sustains an injury which results in one of the losses payable under the Accidental Death or Dismemberment Benefit. The Covered Person's amount of Principal Sum will be increased by 10%, to the maximum amount of $25,000, if, at the time of the accident, the Covered Person was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Seat Belt" means those belts that form a restraint system. "Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile.

IDENTIFICATION BENEFIT

In the event accidental loss of life is sustained by the Covered Person not less than one hundred and fifty (150) kilometers from the Covered Person's normal place of residence and identification of the body by a member of the immediate family has been requested by the police or a similar governmental authority, the Insurer will reimburse the reasonable expenses actually incurred by such family member for:

a) transportation by the most direct route to the city or town where the body is located; and

b) hotel accommodation in such city or town, subject to a maximum duration of three (3) days.

The reimbursement of such expenses incurred is subject to the Accidental Death Benefit being subsequently payable in accordance with the terms of this Benefit following the identification of the body as the Covered Person.

The maximum amount payable will not exceed $15,000 for all such expenses. Payment will not be made for board or other ordinary living, traveling or clothing expenses, and transportation must occur in a vehicle or device operated under a license, for the conveyance of passengers for hire.

CONVERSION PRIVILEGE

On the date of termination of the Accidental Death & Dismemberment Benefit or during the 31-day period following termination, a Covered Person may convert his or her insurance to an individual Accidental Death and Dismemberment only insurance policy (excluding the Critical Illness Rider) of the Insurer.

The individual policy will be effective either as of the date that the application is received by the Insurer or on the date that coverage under the Plan terminates, whichever occurs later.

The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time.

Application for an individual policy may be made by contacting the Plan Administration Office. The amount of insurance benefit converted shall not exceed that amount issued during Plan

Membership up to a maximum of $200,000. The individual policy will cover Accidental Death and Dismemberment only.

ACCIDENTAL DEATH & DISSMEMBERMENT LIMITATIONS & EXCLUSIONS

This benefit does not cover loss caused by or resulting from any one or more of the following:

a) Intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;

b) Declared or undeclared war or any act thereof;

c) Travel or flying in an aircraft owned or leased by the policyholder, a Covered Person or a member of a Covered Person's household, or aircraft being used for any test or experimental purpose, firefighting, powerline inspection, pipeline inspection, aerial photography or exploration;

d) Losses occurring while the Covered Person is serving on full-time active duty in the Armed Forces of any country or international authority;

e) Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the description of this benefit.

With respect to air travel, the insurance afforded shall apply to loss caused by or resulting from travel or flight in any aircraft or any other device for aerial navigation, including boarding or alighting there from, except:

a) while being used for any test or experimental purpose; or

b) while the Covered Person is operating, learning to operate or serving as a member of the crew thereof; or

c) while being operated by or for or under the direction of any military authority, other than transport type aircraft operated by the Canadian Armed Forces Air Transport Command or the similar air transport service of any other country; or

d) any such aircraft or device which is owned or leased by or on behalf of the Union or employer or any subsidiary or affiliate thereof, or by a Covered Person or any member of his/her household; or

e) while being used for firefighting, pipeline inspection, power line inspection, aerial photography or exploration.

The **"Additional Accidental Death and Dismemberment Benefits"** described earlier (other than the Accidental Death, Accidental Dismemberment, Occupational Accidental Death and Occupational Accidental Dismemberment benefits) will be limited to only one (1) insurance policy in the event the benefits are contained in two (2) or more policies issued by the Insurer covering the same Covered Person.

TAXABILITY OF ACCIDENTAL DEATH & DISMEMBERMENT PREMIUM PAID

Any Accidental Death and Dismemberment premiums paid by the Fund on a Plan Member's behalf is considered under Canadian taxation laws to be a taxable benefit to the Plan Member in the calendar year in which it was received.

During February of each year, a Plan Member who was covered for the Plan's Accidental Death and Dismemberment Benefit in the previous calendar year will receive an official tax form from the Plan that indicates the total amount of Accidental Death and Dismemberment premium paid (together with any other taxable premiums paid) on the Plan Member's behalf by the Fund in the prior calendar year.

Any Accidental Death and Dismemberment premium paid on behalf of a Plan Member (shown on the official tax form) must be reported by the Plan Member as income in the Plan Member's annual income tax return, in the calculation of their taxable income.

TERMINATION OF THE ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

A Plan Member's Permanent & Total Disability Benefit will terminate on the earlier of the day the Plan Member retires or attains age 65. A Plan Member's Accidental Death & Dismemberment Benefit will terminate on the day the Plan Member retires and has exhausted the amount in their Dollar Bank Account. Coverage for a Plan Member and for any Dependents will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

ACCIDENTAL DEATH & DISMEMBERMENT CLAIM FORM REQUIRED

No benefit payment will be made to a Plan Member unless a completed Claim Form and any other required documents are submitted to the Plan Administration Office and/or the Insurer within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

CRITICAL ILLNESS BENEFIT

If, while a Plan Member is insured for the Critical Illness Benefit, but only after insurance coverage has been in effect on a Plan Member for a period of 90 days (applicable to Cancer only), a Plan Member who is under age 65 is then diagnosed with **Cancer, Heart Attack, Kidney Failure or Stroke**, and a Plan Member survives for a period of 30 days thereafter, the Insurer will pay the Critical Illness Benefit shown in the **Summary of Benefits** section of this Booklet.

The Insurer shall only be obligated to pay the Critical Illness Benefit once, notwithstanding that a Plan Member may be diagnosed with more than one of the covered illnesses.

30 DAY SURVIVAL

If, while insurance coverage is in effect, a Plan Member suffers from Cancer, Heart Attack, Kidney Failure or Stroke and a Plan Member survives for a period of 30 days thereafter, the Insurer will pay the benefit amount as outlined above.

PRE-EXISTING MEDICAL CONDITION PROVISION

Means a sickness suffered from or injury sustained by a Plan Member for which he sought or received medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a physician during the 24 months immediately prior to the Plan Member's initial effective date for eligibility of the Plan's Benefits (or for any increased amount of insurance, if applicable) which directly or indirectly causes the condition to occur within the first 24 months from the Plan Member's initial effective date of Plan Membership (or for any increased amount of insurance, if applicable).

CRITICAL ILLNESS DEFINITIONS

"Cancer": means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and Invasive Melanoma but does not include:

- Carcinoma in situ
- Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of Human Immunodeficiency Virus (HIV)
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth
- Prostate cancer diagnosed as TI N0 M0 or equivalent staging
- a recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage

A Physician certified as an Oncologist must confirm diagnosis in writing.

"Heart Attack": means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

a) heart attack symptoms; or

b) new electrocardiogram (ECG) changes consistent with a heart attack; or

c) development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of Heart Attack must be made by a Specialist.

Heart Attack Exclusions: No Benefit will be payable under this condition for:

a) elevated biochemical cardiac markers with a:

  i) Troponin Level of less than 1

  ii) CK-Mb Level of less than 4, or

b) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

"Kidney Failure": means end stage renal disease due to chronic irreversible failure of both kidneys ability to function, requiring the Plan Member to undergo regular hemodialysis, peritoneal dialysis, or renal transplantation. A Physician who is certified in Nephrology must confirm diagnosis in writing.

"Stroke": means that the Plan Member has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from and intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the Stroke, confirmed in writing by a Physician who is certified as a neurologist.

90 DAY CANCER EXCLUSION

The Cancer exclusion period is 90 days from the later of:

a) the effective date of a Plan Member's coverage, or;

b) the date of the last reinstatement of the insurance policy.

Within this exclusion period, there shall be no coverage for cancer if a diagnosis of any type of cancer, whether included or excluded under the insurance policy, is made or if any symptoms or medical problems manifest themselves which, or the persistence or recurrence of which, subsequently results in an investigation leading to the diagnosis of cancer.

In the event of any such diagnosis the Critical Illness Benefit will remain in force but cancer will no longer be considered an insured condition, except for a subsequent diagnosis of an unrelated cancer.

CRITICAL ILLNESS BENEFIT LIMITATIONS AND EXCLUSIONS

The Insurer will not pay a Critical Illness Benefit under any of the following circumstances:

1. for injury or sickness, other than one of the covered illnesses, even though such injury or sickness may have been complicated by one of the covered illnesses;
2. a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex;
3. the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;
4. intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane;
5. declared or undeclared war or any act thereof;
6. the commission or attempted commission by a Plan Member of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed;

7. misuse of medication or the abuse of drugs or intoxicants;
8. any Pre-Existing Medical Condition, except where coverage has been in effect for a period of 24 consecutive months following a Plan Member's initial effective date of eligibility for the Benefits of the Plan.

TAXABILITY OF CRITICAL ILLNESS PREMIUM PAID

Any Critical Illness premiums paid by the Fund on a Plan Member's behalf is considered under Canadian taxation laws to be a taxable benefit to the Plan Member in the calendar year in which it was received.

During February of each year, a Plan Member who was covered for the Plan's Critical Illness Benefit in the previous calendar year will receive an official tax form from the Plan that indicates the total amount of Critical Illness premium paid (together with any other taxable premiums paid) on the Plan Member's behalf by the Fund in the prior calendar year.

Any Critical Illness premium paid on behalf of a Plan Member (shown on the official tax form) must be reported by the Plan Member as income in the Plan Member's annual income tax return, in the calculation of their taxable income.

TERMINATION OF THE CRITICAL ILLNESS BENEFIT

A Plan Member's Critical Illness Benefit will terminate on the earlier of the day the Plan Member retires or attains age 65. Coverage for a Plan Member will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

CRITICAL ILLNESS CLAIM FORM REQUIRED

No benefit payment will be made to a Plan Member unless a completed Claim Form and any other required documents are submitted to the Plan Administration Office and/or the Insurer within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

WEEKLY INDEMNITY BENEFIT (WI)

A Plan Member who becomes Wholly Disabled due to a sickness and/or an injury that is not work-related may be eligible to receive Weekly Indemnity (WI) benefit payments.

A Plan Member is considered to be **"Wholly Disabled"** if unable to perform any and every duty of the Plan Member's own occupation or employment. To qualify for WI weekly benefit payments, a Plan Member must provide proof of a disabling condition that is satisfactory to the Plan and must be under the continual care and treatment of a legally qualified and licensed Physician or Specialist.

WI WEEKLY BENEFIT PAYMENT START DATE

WI weekly benefit payments are payable for any one continuous period of disability during which a Plan Member remains Wholly Disabled commencing upon the:

1) 1st day of a disability resulting from an accident; or
2) 1st day of a disability requiring out-patient surgery that is not cosmetic in nature; or
3) 8th continuous day of a disability resulting from an Illness.

MAXIMUM WI WEEKLY BENEFIT PAYMENT PERIOD

26 weeks is the maximum period for which a Wholly Disabled Plan Member may receive WI weekly benefit payments, for any one consecutive period of disability, however not beyond the day the Plan Member retires.

The 26-week maximum WI weekly benefit payment period includes the 15-week period that Employment Insurance Accident and Sickness (EI) benefits are payable, if applicable. 26 weeks is the total duration of WI weekly benefit payments provided by the Plan and EI combined.

MAXIMUM WI WEEKLY BENEFIT PAYMENT PAYABLE

The maximum WI weekly benefit payment is $500 per week. This payment will be pro-rated based on the number of days disabled during the week, if less than one week.

For the purposes of determining the WI weekly benefit payable to a Plan Member, the date a Plan Member is considered to have become Wholly Disabled will not be earlier than the date the Plan Member first consults a Physician or Specialist for the disability.

Only one WI weekly benefit payment will be payable to a Plan Member, regardless of whether the Plan Member is Wholly Disabled by more than one disability.

WI WEEKLY BENEFIT PAYMENT REDUCTIONS

WI weekly benefit payments payable to a Plan Member will be reduced by any income or benefits payable to a Plan Member under any other working arrangement, plan or program of any employer, or government agency, including any plan or program established pursuant to a provincial automobile insurance act where applicable.

The Plan reserves the right to request and obtain information regarding any income that a Plan Member may be receiving, or is eligible to receive during a period of disability, for which a Plan Member has submitted a WI claim to the Plan.

A Plan Member who submits a WI claim to the Plan or who is already in receipt of WI weekly benefit payments is required to advise the Plan Administration Office of all sources of income that are provided to the Plan Member. No WI weekly benefit payments will be paid to a Plan Member who fails to provide any requested information about their other sources of income.

TAXABILITY OF WI WEEKLY BENEFIT PAYMENTS

Any WI weekly benefit payment issued to a Plan Member is considered to be taxable income to the Plan Member in the calendar year in which it was received.

In February of each year, a Plan Member who received one or more WI weekly benefit payments in the previous calendar year will receive an official tax form from the Plan that indicates the total amount of WI weekly benefit payments paid to the Plan Member in the prior calendar year.

Any amount shown on the official tax form must be reported as income in the Plan Member's annual income tax return.

WI INTEGRATION WITH EMPLOYMENT INSURANCE (EI) DISABILITY BENEFITS

The Plan's WI Benefit is coordinated with the EI Accident and Sickness benefit.

If a Plan Member is unable to work due to a non-work-related disability, the Plan Member should immediately file a disability claim for the Plan's WI Benefit, as well as for EI Accident and Sickness benefits.

The Plan will pay WI weekly benefit payments during the initial EI waiting period, which is presently one calendar week. After the EI waiting period, EI may pay an Accident and Sickness disability benefit for a maximum of 15 weeks.

During this 15-week EI Accident and Sickness disability period, the Plan will not pay any WI benefit payments unless proof is provided that a Plan Member is not eligible for EI Accident and Sickness benefits.

In order to receive WI weekly benefit payments from the Plan during the 15 week EI disability benefit period, the Plan Member must provide a statement from the Department of Employment and Social Development Canada, indicating the number of weeks that EI Accident and Sickness benefits were paid, or which confirms that EI Accident and Sickness disability benefits have been denied.

A Plan Member who remains Wholly Disabled after the 15-week EI maximum benefit period is then eligible to have WI weekly benefit payments resume from the Plan, provided the Plan Member submits any required medical statements that support the Plan Member's claim of being continuously Wholly Disabled to the Plan Administration Office.

It is important to distinguish that a Plan Member must apply for EI Accident and Sickness benefits, and not EI Unemployment benefits. If a Plan Member has an EI Unemployment claim already approved and is in receipt of EI Unemployment benefits on the date when the Plan Member becomes Wholly Disabled, then in addition to notifying the Plan Administration Office, the Plan Member should immediately notify the Department of Employment and Social Development Canada of their disability and have their claim changed from EI Unemployment benefits to EI Accident and Sickness benefits.

RECURRING WI DISABILITIES

If a Plan Member who is already receiving WI weekly benefit payments returns to work and then subsequently resumes their claim of being disabled, the Plan will consider this to be one continuous period of being Wholly Disabled, provided the return to work (or availability for work) is a period of two (2) weeks or less.

In these circumstances, the Plan's Maximum WI Benefit Period of 26 weeks (described earlier) will continue to be based on the initial (earlier) date of disability. The only exception to this rule is if the Plan Member's subsequent absence from work is due to a new, unrelated disability, which began after the Plan Member had returned to work (or was available for work) for at least one full day.

SUBROGATION OF WI WEEKLY BENEFIT PAYMENTS

As part of the claim submission process, the Plan requires that a Plan Member who submits a disability claim for the Plan's WI Benefit must complete and submit a Reimbursement Agreement.

If, as a result of the incident that caused or contributed to a Plan Member's disability, the Plan Member is entitled to recover Compensation for loss of income from a third party, the Plan will be subrogated to all of the Plan Member's rights of recovery for the loss of income. The amount to be recovered by the Plan will not exceed the sum of the WI weekly benefit payments paid or that are payable by the Plan.

In the event a Plan Member provides proof to the Plan that the Plan Member has not recovered full Compensation for loss of income, the Plan shall determine the proportion of damages actually recovered by the Plan Member and share pro rata in that amount.

Should a Plan Member choose to settle the matter with the third party prior to judicial determination, it is understood that the sum reached in settlement will be deemed by the Plan to be full Compensation for loss of income, and that the Plan's right of subrogation will apply.

The term **"Compensation"** shall include any lump sum or periodic payments which a Plan Member receives or is entitled to receive on account of past, present or future loss of income.

WEEKLY INDEMNITY BENEFIT LIMITATIONS AND EXCLUSIONS

WI weekly benefit payments are not payable under the following circumstances:

1. for any portion of a period of disability during which the Plan Member is not receiving ongoing supervision/treatment by a licensed Physician or Specialist deemed appropriate by the Plan for the impairment causing the disability;

2. for any portion of a period of disability during which the Plan Member is receiving treatment only by a Therapist unless such treatment is recommended by a licensed Physician or Specialist and deemed appropriate by the Plan for the impairment causing the disability;
3. for disabilities resulting from substance abuse, including alcoholism and drug addiction, unless the Plan Member is participating in a recognized substance withdrawal program;
4. for any portion of a period of disability during which the Plan Member does not participate in a treatment program recommended by a licensed Physician or Specialist deemed appropriate by the Plan for the impairment causing the disability;
5. for any portion of a period of disability the Plan Member does any kind of work for wage or profit;
6. for disabilities for which benefits are payable under a Workers' Compensation law or similar law unless due proof is submitted that the Plan Member has been disqualified for such benefits;
7. subject to applicable legislation, the Plan does not cover disabilities arising from a motor vehicle accident;
8. surgical procedures or treatments performed in a hospital that are primarily for cosmetic or beautification purposes excluding disabilities resulting from complications due to such surgical procedures or treatments;
9. for disabilities resulting from intentionally self-inflicted injuries or disease or attempted self-destruction, whether the Plan Member is sane or insane;
10. for disabilities resulting from the Plan Member's attempt or participation in the commission of a criminal offense;
11. for disabilities resulting from an accident that occurs while the Plan Member was operating a motor vehicle and their blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%) or more than the legislated legal blood alcohol limit in the jurisdiction where the accident occurred;
12. for any portion of a period of disability during which the Plan Member is imprisoned in a penal institution or confined in a hospital, or similar institution, as a result of criminal proceedings;
13. for disabilities resulting from injury or disease that occurs while the Plan Member is on active duty in the Armed Forces of any country, state or international organization;
14. for disabilities that are a result of the Plan Member's participation in a war, riot, or insurrection;
15. for disabilities for which a claim has not been submitted within twelve (12) months of the date of disability;
16. on the date the Plan Member refuses or fails to complete and return or comply with the terms of the Reimbursement Agreement in accordance with the **SUBROGATION OF WI WEEKLY BENEFIT PAYMENTS** provision;

17. for any portion of a period of disability during any Leave of Absence (including Maternity Leave) except where benefits are provided during the post-natal recovery period of maternity leave.

"Leave of Absence" shall mean a period of time away from work mutually agreed to by the employer and Plan Member. In the case of a maternity leave of absence, the leave shall begin on the earlier of:

i) the elected start date of the maternity leave; or

ii) the date of delivery; or Member's performance is affected by the pregnancy.

Such leave shall terminate on the latter of the date defined by provincial or federal statute, or the date agreed to between the employer and Plan Member.

TERMINATION OF THE WI BENEFIT AND WI WEEKLY BENEFIT PAYMENTS

WI coverage and any weekly benefit payments being made to a disabled Plan Member will terminate on the day the Plan Member retires. Coverage is not provided during any Pay Direct period. Coverage for a Plan Member will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

WEEKLY INDEMNITY CLAIM FORM REQUIRED

No benefit payment will be made to a Plan Member unless a completed Claim Form and any other required documents are submitted to the Plan Administration Office within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

LONG TERM DISABILITY BENEFIT (LTD)

A qualified Plan Member who is under age 65 and who becomes Totally Disabled due to a sickness and/or an injury for the required period of time referred to as the Qualifying Disability Period may be eligible to receive LTD monthly benefit payments.

A Plan Member is considered to be **"Totally Disabled"** during the first 24 months in which they receive LTD monthly benefit payments, if the Plan Member is unable to perform any and every duty of their own occupation or employment. After this period the Plan Member is considered to be Totally Disabled if unable to perform any and every duty of any occupation for which the Plan Member is reasonably qualified by training, education or experience.

To qualify for LTD monthly benefit payments, a Plan Member must provide proof of a disabling condition which is satisfactory to the Insurer and must be under the continual care and treatment of a legally qualified and licensed Physician or Specialist.

LTD MONTHLY BENEFIT PAYMENT START DATE

LTD monthly benefit payments may be payable to a Plan Member for any one continuous period of disability during which a Plan Member remains Totally Disabled after the Qualifying Disability Period which is 26 continuous weeks or after the exhaustion of any WI weekly benefit payments which are payable to the Plan Member (whichever is longer), completed prior to the attainment of age 65.

If the initial period of disability is not continuous during the 26-week Qualifying Disability Period, the number of days a Plan Member is disabled will be accumulated toward satisfying the 26-week Qualifying Disability Period provided:

1) there is no interruption in the continuous Qualifying Disability Period of longer than 2 weeks (14 days); and
2) the disabilities (before and after the interruption in Qualifying Disability Period) arise from the same or a related disease or injury causing the disability.

MAXIMUM LTD MONTHLY BENEFIT PAYMENT PERIOD

A Totally Disabled Plan Member may receive LTD monthly benefit payments, for any one consecutive period of disability, however not beyond the attainment of age 65, recovery from the disability, or death.

A Plan Member who is receiving LTD monthly benefit payments must provide continual proof of disability to the Insurer as required and must remain under the continual care and treatment of a legally qualified and licensed Physician or Specialist.

LTD monthly benefit payments will not be payable beyond a Plan Member's attainment of age 65, unless a Plan Member satisfies the Qualifying Disability Period while age 64 and is considered eligible for LTD monthly benefit payments. In this case, LTD monthly benefit payments will be payable for a maximum duration of 12 months, provided the Plan Member remains Totally Disabled during this period.

MAXIMUM LTD MONTHLY BENEFIT PAYMENT PAYABLE

The maximum LTD monthly benefit payment payable is $1,000 per month. This LTD monthly benefit payment will be pro-rated based on the number of days disabled during the month, if less than one month.

For the purposes of determining the LTD monthly benefit payable to a Plan Member, the date a Plan Member is considered to have become Totally Disabled will not be considered to be earlier than the date the Plan Member first consults a Physician or Specialist for the disability.

Only one LTD monthly benefit payment will be payable to a Plan Member per month, regardless of whether the Plan Member is Totally Disabled by more than one disability.

LTD MONTHLY BENEFIT PAYMENT REDUCTIONS

The amount of the LTD monthly benefit payable to a qualified disabled Plan Member may be reduced due to income a Plan Member may receive from other sources.

The Insurer reserves the right to request and obtain information regarding any income that a Plan Member may be receiving, or is eligible to receive during a period of disability, for which a Plan Member has submitted a Long-Term Disability claim to the Plan.

A Plan Member who submits a Long-Term Disability claim or who is already in receipt of monthly benefit payments from the Plan is required to advise the Insurer of all sources of income that are provided to the Plan Member. No LTD monthly benefit payments will be paid to a Plan Member who fails to provide any requested information about their other sources of income.

DIRECT REDUCTIONS TO THE LTD MONTHLY BENEFIT PAYMENT

The LTD monthly benefit payment payable is calculated by first directly deducting all monthly income the Plan Member receives from any WSIB law (or similar law), on account of a Plan Member's disability, from the Plan's LTD monthly benefit payment payable.

INDIRECT REDUCTIONS TO THE LTD MONTHLY BENEFIT PAYMENT - All Source Income Limit

After the application of any Direct Reductions as described above, the net LTD monthly benefit payment payable to a Plan Member may be further reduced by any other income or benefits payable to a Plan Member under any other working arrangement, other plan or program of any employer, or government agency, including any plan or program established pursuant to a provincial automobile Insurance Act (where applicable).

If a disabled Plan Member's total monthly income received from all sources (including this Plan's LTD monthly benefit payment) exceeds 85% of the Plan Member's pre-disability gross monthly Earnings, the net LTD monthly benefit payment will be further reduced by the amount of such excess.

A Plan Member's total monthly income received from all sources includes all of the following:

a) LTD monthly benefit payments payable under this Plan; and

b) WSIB disability income benefits described above under "Direct Benefit Reduction"; and

c) wages or retirement benefits payable from your employer including your employer's pension or retirement plan or from self-employment; and

d) any type of benefit payments received from the Canada or Quebec Pension Plan (primary or family benefits); and

e) any income or benefit payable under any other plan or program of any government or the crown or any subdivision or agency of the government or the crown, including any plan or program established pursuant to a provincial automobile Insurance Act where applicable; and

f) income or benefits payable under any other plan or program provided to the Plan Member by or through the employer. Such plan or program includes any permanent and total disability benefit of group insurance for which the Plan Member could have elected not to apply.

"Earnings" means a Plan Member's normal earnings as specified in the T4 slip or other tax information issued to or earned by the Plan Member in the year prior to the date of the Plan Member's disability.

With respect to a disabled Plan Member participating in a Rehabilitation Employment Program (described later), if the Plan Member's total monthly income from all sources exceeds 100% of the Plan Member's pre-disability monthly Earnings, the Plan Member's LTD monthly benefit payment will be reduced by the amount of such excess.

TAXABILITY OF LTD MONTHLY BENEFIT PAYMENTS

Any LTD monthly benefit payment issued to a Plan Member is considered under Canadian taxation laws to be taxable income to the Plan Member in the calendar year in which it was received.

During February of each year, a Plan Member who received one or more LTD monthly benefit payments in the previous calendar year will receive an official tax form from the Insurer that indicates the total amount of LTD monthly benefit payments paid to the Plan Member in the prior calendar year.

Any LTD monthly benefit payment(s) paid to a Plan Member (shown on the official tax form) must be reported by the Plan Member as income in the Plan Member's annual income tax return, in the calculation of their taxable income.

RECURRING LTD DISABILITIES

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

If a new disability is due to causes unrelated to a prior disability, a Plan Member may be eligible for a new disability period, subject to a new Qualifying Disability Period, if there has been a return to active work for at least one full day.

REHABILITATION EMPLOYMENT PROGRAM

If a Plan Member is receiving LTD monthly benefit payments, the Insurer may recommend and require that the Plan Member participate in a suitable Rehabilitation Employment and/or Training Program, which would take into account the nature of the disability and the Plan Member's functional abilities. Additional details will be provided to applicable Plan Members in the event they qualify for a Rehabilitation Employment Program.

If a Plan Member refuses to participate in a Rehabilitation Employment and/or Training Program recommended by the Insurer, the Plan Member's LTD monthly benefit payments will be terminated.

Note that any earnings paid to a Plan Member in a Rehabilitation Employment Program may reduce the Plan Member's LTD monthly benefit payment. Please see the **LTD MONTHLY BENEFIT PAYMENT REDUCTIONS** section above for further information.

SUBROGATION OF LTD MONTHLY BENEFIT PAYMENTS

As part of the claim submission process, the Insurer requires that a Plan Member who submits a disability claim for the Plan's Long-Term Disability Benefit must complete and submit a Reimbursement Agreement.

If, as a result of the incident which caused or contributed to a Plan Member's disability, the Plan Member is entitled to recover Compensation for loss of income from a third party, the Insurer will be subrogated to all of the Plan Member's rights of recovery for the loss of income.

The amount to be recovered by the Insurer will not exceed the sum of the LTD monthly benefit payments paid or that are payable by the Insurer.

In the event a Plan Member provides proof to the Insurer that the Plan Member has not recovered full Compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered by the Plan Member and share pro rata in that amount.

Should a Plan Member choose to settle the matter with the third party prior to judicial determination, it is understood that the sum reached in settlement will be deemed by the Insurer to be full Compensation for loss of income, and that the Insurer's right of subrogation will apply.

The term **"Compensation"** shall include any lump sum or periodic payments which a Plan Member receives or is entitled to receive on account of past, present or future loss of income.

PRE-EXISTING DISABILITY EXCLUSION

No LTD monthly benefit payments are payable for any period of Total Disability which begins within the first 6 months of a Plan Member's initial eligibility effective date for the Long Term Disability Benefit, if the period of Total Disability is caused or contributed to by a sickness or injury for which the Plan Member had received medical treatment services or had taken a prescribed drug at any time during the 90 day period immediately prior to the Plan Member's initial eligibility effective date for the Long Term Disability Benefit.

LONG TERM DISABILITY BENEFIT LIMITATIONS AND EXCLUSIONS

LTD monthly benefit payments are not payable to a Plan Member under the following circumstances:

1. for any portion of a period of disability during which the Plan Member is not receiving ongoing supervision/treatment by a licensed physician or specialist deemed appropriate by the Insurer for the impairment causing the disability;

2. for any portion of a period of disability during which the Plan Member is receiving treatment only by a Therapist unless such treatment is recommended by a licensed physician or specialist and deemed appropriate by the Insurer for the impairment causing the disability;

3. for disabilities resulting from substance abuse, including alcoholism and drug addiction, unless the Plan Member is participating in a recognized substance withdrawal program deemed appropriate by the Insurer for the impairment causing the disability;

4. for any portion of a period of disability during which the Plan Member does not participate in a rehabilitation and/or treatment program recommended by a licensed physician or specialist deemed appropriate by the Insurer for the impairment causing the disability;

5. for disabilities resulting from intentionally self-inflicted injuries or disease or attempted self-destruction, unless medical evidence establishes that the injuries are related to a mental health illness;

6. for disabilities resulting from the Plan Member's attempt or participation in the commission of a criminal offense;

7. for disabilities resulting from an accident which occurs while the Plan Member was operating a motor vehicle and their blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%) or more than the legislated legal blood alcohol limit in the jurisdiction where the accident occurred;

8. for any portion of a period of disability during which the Plan Member is imprisoned in a penal institution or confined in a hospital, or similar institution, as a result of criminal proceedings;

9. for disabilities resulting from injury or disease which occurs while the Plan Member is on active duty in the Armed Forces of any country, state or international organization;

10. for disabilities which are a result of the Plan Member's participation in a war, riot, or insurrection;

11. for disabilities for which a claim has not been submitted within twelve (12) months of the date of disability;

12. on the date the Plan Member refuses or fails to complete and return or comply with the terms of the Reimbursement Agreement in accordance with the SUBROGATION OF LTD MONTHLY BENEFIT PAYMENTS provision;

13. subject to applicable legislation, the Plan does not cover disabilities arising from a motor vehicle accident;

14. for any portion of a period of disability during any Leave of Absence (including Maternity Leave).

"Leave of Absence" shall mean a period of time away from work mutually agreed to by the employer and Plan Member. In the case of a maternity leave of absence, the leave shall begin on the earlier of:

i) the elected start date of the maternity leave; or

ii) the date of delivery; or

iii) the date the employer may require the leave of absence to commence if the Plan Member's performance is affected by the pregnancy.

Such leave shall terminate on the latter of the date defined by provincial or federal statute, or the date agreed to between the employer and Plan Member.

TERMINATION OF THE LTD BENEFIT AND LTD MONTHLY BENEFIT PAYMENTS

A Plan Member's Long-Term Disability Benefit coverage will terminate on the earlier of the day the Plan Member retires or attains age 65. Coverage is not provided during any Pay Direct Plan period. Coverage for a Plan Member will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

LTD monthly benefit payments will not be payable beyond a Plan Member's attainment of age 65, unless a Plan Member satisfies the Qualifying Disability Period while age 64 and is considered eligible for LTD monthly benefit payments. In this case, LTD monthly benefit payments will be payable for a maximum duration of 12 months, provided the Plan Member remains Totally Disabled during this period.

LONG TERM DISABILITY CLAIM FORM REQUIRED

No benefit payment will be made to a Plan Member unless a completed Claim Form and any other required documents are submitted to the Plan Administration Office and/or the Insurer within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

SUPPLEMENTARY HEALTH CARE BENEFIT

Plan Members and their eligible Spouses will receive the Plan's Benefit Card that may be used to pay claims for many of the Plan's eligible Supplementary Health Care expenses. Using the Benefit Card eliminates the need to complete a claim form and provides immediate payment for eligible expenses.

All Plan Members and their eligible Dependents must be properly enrolled in their provincial health care plan. The Supplementary Health Care Benefit will not provide reimbursement for any incurred charges that are eligible under a provincial health care plan, whether the person is properly enrolled or not.

REIMBURSEMENT OF ELIGIBLE EXPENSES

The Plan will reimburse 100% of the eligible health care charges incurred by Plan Members and their eligible Dependents, subject to the rules for reimbursement as described below.

ELIGIBLE EXPENSES MUST BE MEDICALLY NECESSARY

Charges for any eligible expenses covered by the Plan must be considered by the Plan to be Medically Necessary. A prescription or recommendation from a Physician is usually required.

BENEFITS ARE PAID BASED ON REASONABLE & CUSTOMARY CHARGES

The Plan provides reimbursement of eligible health care expenses based on the Reasonable and Customary cost of the Medically Necessary health care services or supplies.

If the medical expense incurred is greater than what is considered by the Plan to be Reasonable and Customary for that service or supply, the Plan Member will be responsible for the difference in cost between the actual charges incurred and the Reasonable and Customary charges the Supplementary Health Care benefit will reimburse.

PRESCRIPTION DRUG EXPENSES

The Plan reimburses eligible expenses up to the Reasonable and Customary charges of Medically Necessary Prescription Drugs which by law must be prescribed by a physician for the treatment of a diagnosed illness or injury and which must be dispensed by a legally authorized licensed pharmacist or Physician. Eligible drugs must be approved for use by Health Canada and have both a Health Canada compliance certificate and a Drug Identification Number (DIN).

The Plan may also cover certain drugs which do not require a prescription, which are considered to be life sustaining.

Reimbursement for Biologic and Biosimilar drugs requires Prior Authorization from the Plan and is made based on the lowest eligible cost between a Biologic Drug and its Biosimilar Drug, where a Biosimilar Drug is available.

The Plan's Benefit Card may be used at participating pharmacies to purchase most prescription drugs. The Plan will reimburse 100% of the cost of the lowest cost alternative between a Brand/Biologic Name drug and a Generic/Biosimilar drug (if available).

Specific Drug Maximums

- Erectile Dysfunction: $500 per calendar year
- Smoking Cessation: $400 lifetime maximum
- Methadone Treatment: $1,000 lifetime maximum
- Fertility Drugs: $2,500 lifetime maximum

Other Eligible Drug Expenses

- Insulin and diabetic supplies
- Allergy serums, vaccines and toxoids
- Injectable drugs and injectable vitamins
- Sclerotherapy treatments (up to a maximum of $20 per visit)
- IUDs and diaphragms

Ineligible Drug Expenses

- Charges over the maximum or specific drug expenses not covered by the Plan
- Non injectable vitamins, vitamin supplements, dietary supplements, or diet foods
- Weight loss drugs
- Food and food products, including infant formula & foods, salt & sugar substitutes
- General products or any other product which can be sold at any retail outlet including, but not limited to, such items as contact lens care, non-medicated shampoo, toothpaste, skin protectors, emollients and soaps
- Any single purchase of drugs which would not reasonably be used within 100 days from the date of purchase
- Drugs that have not been issued a compliance certificate and/or a drug identification number by Health Canada whether or not they have been approved under a provincial formulary
- Drugs purchased or issued to manage an illness or disability arising out of a workplace accident, disability or injury or due to an automobile accident.

Medicinal Cannabis

Medical Cannabis is an eligible expense subject to a $500 maximum annual benefit, when its use is authorized by a legally authorized physician (MD) for covered persons at least 25 years of age, for the treatment of medical conditions approved by the Plan for coverage.

All claims for medical cannabis are subject to the Plan's prior authorization drug process.

Reimbursement for medical cannabis (including applicable tax and shipping charges) will be considered as a treatment of last resort when all other standard medications and treatment options, including commercially available cannabinoids that have been issued a DIN by Health Canada, have failed or been deemed inappropriate, and the medical cannabis is:

- A form that is considered legal for medical purposes as defined by the Access to Cannabis for Medical Purposes Regulations; and
- Dispensed by a producer licensed by Health Canada

Reimbursement will not be made for any equipment or supplies required to grow or harvest any plants, or produce any form of medical cannabis or cannabinoid, regardless if such form is

approved for use by Health Canada, or any devices required to administer the product such as, but not limited to pipes or vaporizers.

Expenses will be considered eligible for the medical conditions approved for by the Plan, which are based on Canadian Family Physician Guidelines for prescribing medical cannabinoids. The eligible medical conditions are:

- Refractory pain in palliative cancer care
- Nausea and vomiting due to cancer chemotherapy
- Spasticity in multiple sclerosis or spinal cord injury

VISION CARE

The incurred charges for the eligible Vision Care expenses listed below will be reimbursed up to the maximum benefit shown.

Lenses, Frames and Contact Lenses

The maximum benefit payment that will be paid for each Covered Person is $400 in any consecutive 24-month period.

Eligible Vision Care expenses (subject to the Plan's Vision Care maximum) include:

- Prescription lenses, including tints and anti-reflective coatings
- Frames
- Prescription contact lenses
- Prescription sunglasses
- Prescription industrial safety glasses

Eye Examinations

The Plan will reimburse the charges for one eye examination per covered person, each 12 months when not covered by the covered person's provincial health care plan.

Corrective Laser Eye Surgery

The maximum benefit payment that will be paid for each covered person is $2,000 in a Covered Person's lifetime.

Industrial Safety Glasses (Plan Member Only)

The Plan will reimburse the charges for a Plan Member's prescription industrial safety glasses up to a $200 maximum in any consecutive 24-month period. This Benefit is provided in addition to the Vision Care Benefit.

OTHER SUPPLEMENTARY HEALTH CARE SERVICES & SUPPLIES

Paramedical Practitioners

Included are charges for the services of a licensed speech therapist, osteopath, chiropractor, physiotherapist, naturopath, registered massage therapist, psychologist or podiatrist/chiropodist. The maximum benefit payment for each covered person is $500 per practitioner per calendar year.

Charges for surgery performed by a podiatrist are subject to a maximum benefit of $200 per person, per calendar year.

Chiropractic X-Rays

Charges for x-rays required by a chiropractor up to a maximum benefit payment of $45 per covered person, per calendar year.

Optometrist

Charges for the services of an optometrist for visual motor therapy, subject to a maximum benefit payment of $10 per half hour.

Custom Orthotics

Charges for custom made foot orthotics which have been specially designed and molded for the covered person and which are required to correct a diagnosed physical impairment, subject to a maximum benefit payment of $500 in any consecutive 24-month period.

Orthopedic Shoes

Charges for orthopedic shoes which have been specially designed and molded for the covered person and which are required to correct a diagnosed physical impairment, subject to a maximum benefit payment of $500 in any consecutive 24-month period.

Hearing Aids

Charges for the purchase of hearing aids (excluding batteries), subject to a maximum benefit payment of $500 in any consecutive 36-month period.

Lab Tests & X-Rays

Reasonable and Customary charges for laboratory tests and x-rays when not covered by the covered person's provincial health care plan.

Rehabilitation Hospital

The Plan covers Reasonable and Customary charges for a licensed rehabilitation hospital facility when the covered person is admitted immediately following a minimum of three consecutive days of hospital confinement. Coverage is subject to a daily maximum charge of $30 for semi-private room accommodation and for not more than 120 days of confinement per disability. Confinement must be for the continued care of the same condition for which the Covered Person was hospitalized and must begin prior to the Covered Person's 65th birthday.

Private Duty Nursing

Charges for the services of a Registered Nurse (R.N.) that are rendered while the Covered Person is not confined to a hospital, subject to an overall maximum benefit payment of $10,000 per calendar year, provided such nurse is not a resident in the Covered Person's home or a relative of the Covered Person's family. These charges will be considered eligible expenses only if recommended by a physician and only if Medically Necessary.

Durable Medical Equipment

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

Other Medical Equipment

Charges for rental or purchase at the Plan's option of braces and crutches and the purchase of prostheses.

Surgical Stockings

Charges for stump socks are limited to 6 pairs per calendar year for each covered person.

Other Stockings

Charges for elastic stockings are limited to 2 pairs per calendar year for each covered person.

Ambulance Services

Reasonable and Customary charges for professional ambulance services, other than airline, to and from the nearest hospital qualified to provide the necessary treatment.

Medical Transportation

Charges for emergency medical transportation by airline within the Covered Person's province of residence, to and from the nearest hospital qualified to provide the necessary medical treatment. Such transportation is subject to a maximum benefit payment equal to the economy airfare for the Covered Person, and if medically required, a medical attendant who is neither a resident in the Covered Person's home nor a relative of the Covered Person's family.

Accidental Dental

Charges for the necessary dental treatment required as the result of an accidental injury to natural teeth provided the accident occurred while the Covered Person is eligible for the benefits provided under this Plan. Only the charges directly related to such an accidental injury (as determined by the Plan) are considered to be a covered medical expense. The maximum benefit payable is $5,000 per dental accident. The dental work must be completed within 12 months of the accident to be considered an eligible medical expense.

SUPPLEMENTARY HEALTH CARE LIMITATIONS AND EXCLUSIONS

The Supplementary Health Care eligible expenses listed above are considered eligible subject to the following coverage limitations and/or exclusions. Reference should also be made to the exclusions under the Plan's drug coverage. The Plan will not pay for:

1. charges that are considered an insured service of any provincial health care plan or government plan at the time the policy/benefit was issued and subsequently modified, suspended or discontinued;

2. charges for general health examinations, and examinations required for use of a 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;
5. charges for transport or travel, other than as specifically provided under eligible expenses;
6. charges for services or supplies that are furnished without the recommendation and approval of a physician acting within the scope of their license;
7. charges that are not Medically Necessary for the care and treatment of any existing or suspected injury, disease or pregnancy;
8. charges that result from an occupational injury or disease covered by any WSIB law or similar legislation including from an automobile accident;
9. charges that would not normally have been incurred but for the presence of this insurance or for which the Covered Person is not legally obligated to pay;
10. charges that the Plan is not permitted, by any law or regulation including rules established by the Trustees, to cover;
11. charges for dental work where a third party is responsible for payment for such charges;
12. 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;
13. charges for services or supplies resulting from any intentionally self-inflicted wound;
14. charges for drugs, sera, injectable drugs or supplies that are not approved by Health Canada with a compliance certificate or that do not have a Drug Identification Number (DIN) or are experimental or limited in use whether or not so approved;
15. 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 / Emergency Travel Assistance Benefit;
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 not specified in the foregoing lists of eligible Supplementary Health Care expenses;
19. charges for services or supplies resulting from injury or disease which occurs while the Plan Member is on active duty in the Armed Forces of any country, state or international organization;

20. charges for services or supplies resulting from an accident which occurs while the Plan Member was operating a motor vehicle and their blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%) or more than the legislated legal blood alcohol limit in the jurisdiction where the accident occurred;

21. charges for services or supplies resulting from the Plan Member's attempt or participation in the commission of a criminal offense;

22. eligible expenses arising as the result of a Motor Vehicle will be considered eligible only after first being submitted to your automobile insurer (subject to applicable legislation).

SURVIVOR BENEFIT COVERAGE EXTENSION FOR DEPENDENTS

Upon the death of an eligible Plan Member, the eligible surviving Dependents (spouse and children) will continue to be covered for the Supplementary Health Care benefit for a period of up to 30 months. This period commences after the Plan Member's Dollar Bank Account has been depleted. No premiums or contributions will be required to continue coverage during this Survivor Benefit Extension period.

TERMINATION OF THE SUPPLEMENTARY HEALTH CARE BENEFIT

A Plan Member's Supplementary Health Care Benefit coverage will terminate on the day the Plan Member retires and has exhausted the amount in their Dollar Bank Account. Coverage for a Plan Member and their Dependents will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

SUPPLEMENTARY HEALTH CARE CLAIM DOCUMENTS REQUIRED

No benefit payment will be made to a Plan Member unless a completed Claim Form and all other required documents are submitted to the Plan Administration Office (and/or the company contracted by the Insurer to provide the Emergency Travel Assistance Benefit services, where applicable) within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

No claim form is required for the Benefit Card and/or online claim submission. Members may be asked to submit their receipts to the Plan Administration Office for claims filed electronically. These random audits ensure the Plan is protected. You must therefore retain your receipts for 13 months.

EMERGENCY TRAVEL ASSISTANCE (ETA) BENEFIT

The Plan's Emergency Travel Assistance (ETA) benefit is provided by Green Shield Canada (GSC). The Medical Emergency Travel coverage and Travel Assistance services described below are available 24 hours per day, 7 days per week from GSC Travel Assistance, which utilizes the international medical service organization Allianz Global Assistance.

It is very important to read and understand the rules for this benefit before your departure.

Emergency Medical Travel coverage is provided for eligible expenses arising as a result of a **medical emergency** while Plan Members and/or their eligible Dependents are travelling temporarily outside of the regular province/territory of residence for vacation, business, or education. This benefit also provides Travel Assistance and advisory services both before departure, and while travelling.

Qualified Plan Members and Dependents who are **Canadian residents and properly enrolled in their respective provincial/territorial government health insurance plan** (or equivalent) at the time the emergency medical expenses are incurred, are eligible for the ETA benefit.

EMERGENCY TRAVEL ASSISTANCE CARD

Plan Members and their eligible Spouse will receive a Benefit Card which includes all of the necessary Plan and ETA contact information to access the Plan's ETA benefit at any time, 24/7. For eligible Dependents who are travelling without a Plan Member or a Spouse, the Plan Administration Office can provide an additional ETA Benefit Card.

EMERGENCY TRAVEL ASSISTANCE BENEFIT & TRIP MAXIMUMS

Emergency Medical Travel Coverage

Coverage is provided with a **$5,000,000 maximum per Covered Person, per incident** for expenses incurred as a result of a sudden and an unforeseen medical emergency while travelling outside of your province/territory of residence.

There is no limitation on the number of trips that may be taken, however coverage is provided for a **maximum period of 60 consecutive days per trip.**

Emergency Travel Assistance Services Coverage

Coverage is provided for variety of specific travel assistance and advisory services to help with any travel plans, or travel related emergencies while traveling outside of your province/territory of residence.

Medical Referral Coverage

Coverage is provided for medical services referred outside of the province/territory of residence, when they are not readily available within the province/territory of residence. Coverage is subject to a **$50,000 maximum per Covered Person, per calendar year**.

CONTACTING GSC TRAVEL ASSISTANCE

You can contact the GSC Travel Assistance team at the telephone numbers provided on the back of the Plan's Benefit Card, which are also noted below:

In Canada and the United States: 1-800-936-6226

Elsewhere Call Collect: 1-519-742-3556

When calling for travel assistance, or in relation to a medical emergency, please quote the Plan's **GSC Travel Assistance group plan number 4932**. The GSC Travel Assistance team will also require the Covered Person's unique **Plan Member GSC Identification Number**. All of this information appears on the Plan's Benefit Card. In addition, the Covered Person's provincial/territorial health insurance plan number may be required and should be available at the time of calling GSC Travel Assistance.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GSC Travel Assistance and you may submit them for reimbursement upon your return to Canada.

Note that when a Covered Person is advised of their necessity to receive treatment for an accidental injury or a medical emergency, **the Covered Person must contact GSC Travel Assistance prior to obtaining emergency treatment, or have someone call GSC Travel Assistance on the Covered Person's behalf within 48 hours of commencement of treatment** if it is medically impossible for the Covered Person to call GSC prior to obtaining emergency medical treatment.

PRE-DEPARTURE TRAVEL ASSISTANCE SERVICES

The ETA benefit might not cover expenses related to a medical emergency while travelling, or provide travel assistance services if the Covered Person is travelling to a destination/country which is under duress.

GSC Travel Assistance should be contacted before travelling to any destination, to ensure that the destination is a country where the ETA coverage will be provided. GSC Travel Assistance may also be contacted prior to departure to obtain up-to-date information on passport, visa, vaccination and inoculation requirements for the intended destination country.

Although not a substitute for contacting GSC Travel Assistance, the **Global Affairs Canada** (GAC) web site provides extensive travel information about various destinations and where travel for Canadians is currently not recommended by the Canadian Federal Government. It is further recommended that this information be reviewed prior to departure.

http://travel.gc.ca/travelling/advisories

EMERGENCY MEDICAL COVERAGE PROCESS

After contacting GSC Travel Assistance concerning a medical emergency, a multilingual Travel Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate medical treatment.

Upon admission to a hospital, or when consulting a legally qualified physician or surgeon for major emergency treatment, GSC Travel Assistance will guarantee the provider (hospital, clinic or physician) that the Covered Person has both provincial/territorial health insurance plan coverage (if those benefits are provided under the government health plan) and/or GSC ETA travel benefits. The provider may bill GSC Travel Assistance directly for these approved services for amounts in excess of $200.

The GSC Travel Assistance medical team will follow the medical progress to ensure that the Covered Person is receiving the best available medical treatment. These physicians also keep in constant communication with the family physician and family members, depending on the severity of your condition.

PAYMENT AND COORDINATION OF CLAIMS

In most cases GSC Travel Assistance will coordinate the payment of claims with the medical provider. GSC Travel Assistance will assess the amount payable under the Covered Person's provincial/territorial health care plan (if applicable) and provide reimbursement for the balance of any eligible expenses.

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed $200 (Canadian), payment of such expenses will be arranged by GSC Travel Assistance and claims will be coordinated on behalf of the Covered Person.

Payment and co-ordination of eligible expenses will take into account the amount payable under the Covered Person's provincial/territorial health care plan (if that provincial/territorial plan provides such coverage) and this Plan, and provide reimbursement for the balance of any eligible expenses.

If such payments are subsequently determined to be in excess of the amount of benefits to which the Covered Person is entitled, Green Shield Canada shall have the right to recover the excess amount by assignment of provincial/territorial health care plan benefits (if applicable) and/or refund from the Covered Person.

If the Covered Person's provincial/territorial health insurance plan includes out-of-Canada benefits, hospital and medical services are eligible under the ETA benefit only if the provincial/territorial health insurance plan provides payment toward the cost of the incurred services. This limitation does not apply if you reside in a province/territory that does not offer out-of-Canada coverage.

For eligible expenses incurred that are under $200, the Covered Person must make payment to the medical provider directly and then submit the receipts to the Plan for reimbursement.

To make a claim, submit the patient's name, provincial/territorial health insurance plan number, address and GSC Identification Number with a detailed statement showing the services rendered and the fees charged for each service.

If you have incurred out of pocket expenses, **make sure you tell GSC Travel Assistance about all the travel coverage you have when submitting a claim.** Claims must be submitted together with supporting original receipts to GSC Travel Assistance who will then co-ordinate with the provincial/territorial health insurance plan reimbursement of those approved, eligible expenses from all sources (e.g., provincial plans that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.)

Claim forms, including Pre-Authorization forms (for Referral coverage), and valuable claims submission information, is available at **greenshield.ca**. All manually submitted claims must be received by GSC **no later than 12 months** from the date the eligible expense was incurred.

Please note that in addition to a completed claim form, **claims reimbursement requires the original itemized paid receipt (cash receipts or credit card receipts alone are not acceptable)**. GSC reserves the right to request supplementary claims information. Failure to respond to such requests may result in the denial of the claim.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud. Submission of a fraudulent claim is a criminal offence and will be reported to the applicable law enforcement and/or regulatory agencies.

GSC reserves the right to recover all amounts resulting from overpaid or unsupported claims for benefits by deducting such amounts from future claims and/or by any other legal means.

Eligible ETA medical expenses will be considered based on the **Reasonable and Customary** charges in the area where they were received, less the amount payable by the applicable provincial/territorial government health insurance plan, if your province/territory provides such coverage.

If you are covered for Supplementary Health Care and Dental benefits under more than one plan, your ETA benefits under this Plan will be coordinated with the other plan(s) so that you may be reimbursed up to 100% of the eligible expense incurred.

Claims must be submitted to the primary payer first. Any unpaid balances should then be submitted to the secondary plan(s). Please refer to the Coordination of Benefits Section of this Plan Member Information Booklet for further information.

When GSC is identified as a secondary carrier, submit the original Explanation of Benefits statement from the primary carrier and a copy of the claim form in order to receive any balances owing.

EMERGENCY TRAVEL MEDICAL & REFERRAL COVERAGE DETAILS

Important: **This ETA travel benefit includes requirements, limitations, and exclusions that can affect your eligibility and/or the reimbursement of incurred expenses. You must be accurate and complete in your dealings with GSC Travel Assistance at all times. Please take the time to read through this benefit before you travel to ensure you are aware of the terms and conditions, making note of the following:**

- With the exception of the "**Referral Services**", this Travel benefit is an **emergency** medical benefit only and provides coverage while you are temporarily outside of your regular province/territory of residence for vacation, education, or business reasons. It does not cover any non-emergency, elective, cosmetic, or experimental treatment, surgery, procedure, or any other service a Covered Person chooses to have performed outside of his or her home province/territory – whether pre-planned or not.

- GSC reserves the right to review your medical information at the time of claim. Any invasive or investigative procedures must be pre-approved by GSC Travel Assistance. **If the Covered Person is the patient and it is medically impossible for the Covered Person to call prior to obtaining emergency treatment, <u>it is extremely important to have someone call GSC Travel Assistance on the Covered Person's behalf within 48 hours</u>.** If GSC Travel Assistance is not notified within the first 48 hours, reimbursement of incurred expenses may be limited to **the lesser of** the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident **or** the plan maximum. This means the Covered Person will be responsible for all expenses thereafter.

Emergency means a sudden and unforeseen Medical Condition that requires Treatment. An emergency no longer exists when the evidence reviewed by GSC Travel Assistance indicates that no further Treatment is required at destination or you are able to return to your province/territory of residence for further Treatment. If GSC Travel Assistance determines that you transfer to another facility or return to your home province/territory of residence, and you choose not to, the benefits will not be paid for further medical treatment and coverage will be limited for unrelated events.

Emergency excludes Treatment of a **Pre-existing Condition** that was not completely **Stable** for the **90-day period** immediately preceding the Covered Person's departure.

Pre-existing Condition means any Medical Condition that exists prior to the date of the Covered Person's departure.

Medical Condition means any disease, illness or injury (including symptoms of undiagnosed conditions).

A Medical Condition is considered **Stable** when all of the following statements are true during the **90-day period** immediately preceding the date of the Covered Person's departure.

a) There has not been any **new Treatment** prescribed or recommended, or change(s) to existing Treatment (including stoppage in Treatment), and

b) The Medical Condition has **not become worse**, and

c) There has not been any **new, more frequent, or more severe symptoms**, and

d) There has been **no hospitalization** or referral to a specialist, and

e) There have **not been any tests, investigation or Treatment** recommended, but not yet complete, nor any outstanding test results, and

f) There is **no planned or pending treatment**, and

g) There has not been **any change to an existing prescribed drug** (including an increase, decrease, or stoppage to prescribed dosage), or any recommendation or starting of a new prescription drug. The following are not considered changes to existing prescribed drug Treatment.

   i. Routine dosage adjustments of Coumadin, Warfarin, or insulin, as long as these medications have not been newly prescribed or stopped;

   ii. A change from a brand name to a generic equivalent product as long as the dosage is the same – including a transition from a biologic to a biosimilar product;

   iii. A decrease in the dosage of a medication due to the improvement of a condition

All of the above conditions must be met during the 90-day period prior to the Covered Person's departure in order for a Medical Condition to be considered Stable.

Treat, Treated, Treatment means a procedure prescribed, performed, or recommended by a Physician for a Medical Condition. This includes but is not limited to prescribed medication, investigative testing, and surgery.

- To qualify for benefits, the **claimants must be covered by their respective provincial/territorial government health plan** or equivalent at the time the expenses are incurred; otherwise, there is no coverage under this benefit.
- Eligible travel benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial/territorial health insurance plan, if your province/territory provides such coverage.

- All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, based on the country of the payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.
- Eligible benefits are limited to the maximum days per trip shown in the Summary of Benefits and the EMERGENCY TRAVEL ASSISTANCE BENEFIT MAXIMUMS section above, commencing with the date of departure from your province/territory of residence. If you are hospitalized on the 60th day of your specific trip duration, your benefits will be extended until the date of discharge.

EMERGENCY TRAVEL ASSISTANCE ELIGIBLE MEDICAL EXPENSES

Eligible emergency medical travel expenses include the following:

Hospital services and accommodation up to a standard ward rate in a public general hospital;

Medical/surgical services rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;

Emergency Transportation

- **Land ambulance** to the nearest qualified medical facility
- **Air ambulance -** the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial/territorial health insurance plan or to the nearest qualified medical facility

Referral services – (a) hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or (b) medical surgical services rendered by a legally qualified physician or surgeon;

- **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial/territorial health insurance plan and GSC **must be obtained**. Your provincial/territorial health insurance plan may cover this referral benefit entirely. You must provide GSC with a letter from your attending physician stating the reason for the referral, and a letter from your provincial/territorial health insurance plan outlining their liability. **Failure to comply in obtaining pre-authorization will result in non-payment.**

Services of a registered private nurse up to a maximum of $5,000 per calendar year, at the reasonable and customary rate charged by a qualified Registered Nurse (R.N.) registered in the jurisdiction in which treatment is provided. You must contact GSC Travel Assistance for pre-approval;

Diagnostic laboratory tests and X-rays when prescribed by the attending physician. Except in emergency situations, GSC Travel Assistance must pre-approve these services (i.e., cardiac catheterization or angiogram, angioplasty and bypass surgery);

Reimbursement of prescriptions for drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded). Submit to GSC Travel Assistance the original paid receipt from the pharmacist, physician or hospital outside your province/territory of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

Medical appliances including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province/territory of residence;

Treatment by a dentist only when required due to a direct accidental blow to the mouth up to a maximum of $2,000. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GSC Travel Assistance along with dental X-rays;

Coming Home - when your emergency illness or injury is such that:

- GSC Travel Assistance specifies in writing that you should immediately return to your province/territory of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major air terminal nearest the departure point in your province/territory of residence

  This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, cancellation penalties or airfares for accompanying family members or friends are not included;
- GSC Travel Assistance or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant

Cost of returning your personal use motor vehicle to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $1,000 per trip. GSC Travel Assistance requires original receipts for costs incurred (i.e., gasoline, accommodation and airfares);

Meals and accommodation up to $1,500 (maximum of $150 per day for up to 10 days) will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you when you remain with a travelling companion or a person included in the "family" coverage, when the trip is delayed or interrupted due to an illness, accidental injury to or death of a travelling companion. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from commercial organization;

Transportation to the bedside including round trip economy airfare by the most direct route from your province/territory of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of 5 days for meals and accommodation at a commercial establishment will be paid for that family member to:

- be with you or your covered dependent when confined in hospital. This benefit requires that the Covered Person must eventually be an inpatient for at least 7 days outside your province/territory of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit
- identify a deceased prior to release of the body

Return airfare if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you by the most direct route to the major airport nearest your departure point in your province/territory of residence. An official report of the loss or accident is required;

Return of deceased up to a maximum of $5,000 toward the cost of embalming or cremation in preparation for homeward transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province/territory of residence. The benefit excludes the cost of a burial coffin or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc.;

EMERGENCY TRAVEL ASSISTANCE ELIGIBLE TRAVEL SERVICES

The following services are also available 24 hours per day, 7 days per week through GSC's Travel Assistance international medical service organization.

These Travel Assistance services include:

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination
- Multilingual assistance
- Assistance in locating the nearest, most appropriate medical care

- International preferred provider networks
- Medical consultation and monitoring to review appropriateness and quality of medical care
- Assistance in establishing contact with family, personal physician and employer as appropriate
- Monitoring of progress during treatment and recovery and confirming when the patient is medically fit for transportation when a transfer or repatriation is necessary
- Emergency message transmittal services
- Translation services and referrals to local interpreters as necessary, pertaining to the medical emergency
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers
- Special assistance regarding the co-ordination of direct claims payment
- Co-ordination of embassy and consular services
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary
- Management, arrangement and co-ordination of repatriation of remains
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
  - the return of unaccompanied travel companions
  - travel to the bedside of a stranded person
  - rearrangement of ticketing due to accident or illness and other travel related emergencies
  - the return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance
- Co-ordination of securing bail bonds and other legal instruments
- Guidance in replacing lost or stolen travel documents including passports
- Courtesy assistance in securing incidental aid and other travel related services

EMERGENCY TRAVEL ASSISTANCE COVERAGE LIMITATIONS

1. Coverage becomes effective at the time you or your Dependent crosses the provincial/territorial border departing from their province/territory of residence and terminates upon crossing the border returning to their province/territory of residence on the return home. If traveling by air, coverage becomes effective at the time the aircraft takes off in the province/territory of residence and terminates when the aircraft lands in the province/territory of residence on the return home.

2. **GSC Travel Assistance must be notified before obtaining Emergency Treatment in order for GSC Travel Assistance to:**

   - confirm coverage; and
   - provide pre-approval of treatment.

   If it is medically impossible for the Covered Person to call prior to obtaining Emergency Treatment, GSC Travel Assistance requires either the Covered Person or someone on behalf of the Covered Person to call GSC Travel assistance within 48 hours of commencement of treatment.

   If GSC Travel Assistance is not notified before the Emergency Treatment was received, benefits will be limited to **the lesser of** the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident **or** the plan maximum. This mean you will be responsible for all expenses thereafter.

3. After your medical emergency treatment has started, GSC Travel Assistance must assess and pre-approve additional medical treatment. If you undergo tests as part of a medical investigation, treatment or surgery, obtain treatment or undergo surgery that is not pre-approved, your claim will not be paid. This includes invasive testing, surgery, cardiac catheterization, other cardiac procedures, transplants, MRI.

4. **Repatriation is mandatory** when GSC Travel Assistance determines that the Covered Person should transfer to another facility or return to the home province/territory of residence for treatment, or at the end of the emergency. If you choose not to return:

   - no benefits will be paid for any further medical treatment;
   - no benefits will be paid for any recurrence or complications related directly or indirectly to the Medical Condition that caused the emergency; and
   - for the remainder of the trip, coverage will be limited to Medical Conditions completely unrelated to the Medical Condition that caused the emergency.

5. Air ambulance services will only be eligible if:

   - they are pre-approved by GSC Travel Assistance
   - there is a medical need for you or your Dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey

- you or your Dependent are admitted directly to a hospital in your province of residence, and
- medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GSC Travel Assistance
- proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC Travel Assistance

6. If planning to travel in areas of political or civil unrest, or in areas where the Canadian government has issued a formal travel warning regarding non-essential travel, **contact GSC Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services.**

7. **GSC reserves the right, without notice, to suspend, curtail or limit its services** in any area if any of the following occurs:
   - political or civil unrest, including rebellion, riot, military uprising;
   - labour disturbance or strike;
   - act of God; or
   - refusal of authorities in a foreign country to permit GSC Travel Assistance to provide service.

   This includes travel if when you booked your trip (including delay of travel), or before your departure date, **the Canadian government issued a formal travel warning advising Canadians to avoid either all travel or all non-essential travel** regarding the country, region, city, or other key components of your travel arrangements (e.g., cruise ship) due to a likely or actual epidemic or pandemic. In this limitation, non-essential travel means anything other than a significant medical or family emergency, such as the death of a family member).

EMERGENCY TRAVEL ASSISTANCE COVERAGE EXCLUSIONS

In addition to the Supplementary Health Care Exclusions provided earlier in this Plan Member Information Booklet, Travel claims will not be paid for the following:

1. Any expenses incurred for the treatment related directly or indirectly to a **Pre-existing Medical Condition** that, at the time of your departure from your province/territory of residence and the **90-day period immediately preceding your** departure from your province/territory of residence:
   a) was not completely **Stable** in the professional opinion of GSC Travel Assistance Team;
   b) where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling; or
   c) a physician advised the covered person not to travel.

GSC Travel Assistance reserves the right to review the Covered Person's medical information at the time of claim. **A physician's opinion that the Covered Person was fit to travel does not override** or eliminate the requirement for the Covered Person to satisfy all the conditions of **Stable**.

2. Any expenses submitted if the Covered Person or anyone acting on behalf of a Covered Person attempts to deceive GSC Travel Assistance, or makes a fraudulent, false, or exaggerated statement or claim.

3. Any expenses incurred for any services received that:
   a) were not required to treat an **Emergency**;
   b) were not recommended by a legally qualified physician or surgeon;
   c) are not covered under your provincial/territorial health insurance plan; or
   d) are normally covered under the out-of-Canada benefits of your provincial/territorial health insurance plan's out-of-Canada coverage (where applicable), when the provincial/territorial plan has declined payment;

4. Any expenses incurred for services received after GSC Travel Assistance determined:
   a) the Covered Person was to return to the province/territory of residence for treatment, but the Covered Person chose not to return to the province/territory of residence;
   b) the services could be reasonably delayed until the Covered Person returned to the province/territory of residence;
   c) the emergency had ended; or
   d) the services are for a recurrence or complication directly or indirectly related to the emergency that GSC Travel Assistance determined 3.a), b), or c) above.

5. Any expenses incurred for services to treat a medical condition or complications of a medical condition directly or indirectly related to an epidemic or pandemic if, when the trip was booked, or before the departure date **an official travel advisory was issued by the Canadian government advising Canadians to avoid either all travel or all non-essential travel** regarding any country, region, city, or other key components of your travel arrangements (e.g., cruise ship).

   To view the Canadian travel advisories, visit the Government of Canada Travel site.

6. Any expenses incurred for services to treat:
   a) any medical condition, including symptoms of withdrawal, arising from or in any way related to the chronic use of alcohol, drugs, or other intoxicants whether prior or during the trip;

b) any medical condition arising during the trip resulting from, or in any way related to, the abuse of alcohol that results in a blood alcohol level of more than 80 milligrams in 100 millilitres of blood, drugs or other intoxicants; or

c) any medical condition resulting from not following Treatment as prescribed, including prescribed or over-the-counter medication.

7. Any expenses related to **pregnancy**, delivery, or complications of either, arising during the **8-week period before and after the expected date** of delivery.

8. Any expenses incurred for a child born during the trip.

9. Any expenses incurred during any trip made for the purpose of obtaining a diagnosis, Treatment, surgery, palliative care, or any alternative therapy, as well as any directly or indirectly related complication.

GSC does not assume responsibility for, nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other healthcare provider or facility recommended by GSC Travel Assistance.

DUPLICATE SUPPLEMENTARY HEALTH CARE COVERAGE

The eligible expenses covered under the Supplementary Health Care benefit, which are incurred outside the Covered Person's province of residence (in the event of a medical emergency while travelling) shall be covered under the Emergency Travel Assistance Benefit and not under the Supplementary Health Care Benefit.

SURVIVOR BENEFIT COVERAGE EXTENSION FOR DEPENDENTS

Upon the death of an eligible Plan Member, the eligible surviving Dependents (Spouse and Children) will continue to be covered for the Emergency Travel Assistance Benefit for a period of up to 30 months. This period commences after the Plan Member's Dollar Bank Account has been depleted. No premiums or contributions will be required to continue coverage during this Survivor Benefit Extension period.

TERMINATION OF THE EMERGENCY TRAVEL ASSISTANCE BENEFIT

A Plan Member's Supplementary Health Care Benefit and Emergency Travel Assistance Benefit coverage will terminate on the earlier of the day the Plan Member retires or attains age 65. Coverage for a Plan Member and their Dependents will also terminate as described earlier in the Eligibility Information section of this Booklet.

EMERGENCY TRAVEL ASSISTANCE CLAIM FORM REQUIRED

No benefit payment will be made to a Plan Member unless a completed Claim Form and any other required documents (described above) are submitted to the Plan Administration Office and/or Green Shield Canada (and/or the company contracted by Green Shield Canada) within the specified time for submitting a claim. Please consult the Claim Submission Deadline provisions under the General Plan Rules & Provisions section of this Booklet.

DENTAL CARE BENEFIT

Plan Members and their eligible Spouses will receive a Benefit Card that should be used to submit claims for many of the Plan's eligible Dental expenses. Using the Benefit Card eliminates the need to complete a claim form and to wait for expenses to be reimbursed.

REIMBURSEMENT FOR DENTAL EXPENSES

The Plan provides reimbursement of eligible Dental Care expenses as noted below. If the expense incurred is greater than what is considered to be eligible for reimbursement, the Plan Member will be responsible for the difference in cost between the actual charges incurred and the charges the Dental Care benefit will reimburse.

Reimbursement Level

- 100% for Basic Services
- 60% for Major Services
- 60% for Orthodontic Services

Dental Fee Guide

Benefit payments will be made in accordance with the current dental association fee guide, in effect for General Practitioners in the province or territory where the dental service is rendered on the date the dental expense is incurred.

Medical Necessity and Reasonable and Customary Charges

Eligible dental care expenses are also based on Medical Necessity and Reasonable and Customary charges where applicable.

MAXIMUM DENTAL BENEFITS PAYABLE

Basic and Major Dental Services

The Maximum annual Dental benefit payable by this Plan for all dental care services combined (excluding orthodontic services) is $3,500 per Covered Person, per calendar year.

Orthodontic Services

The Maximum Lifetime Orthodontic Benefit payable for each Dependent Child under the age of 19 is $2,500.

ALTERNATE DENTAL BENEFITS

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

SUBMISSION OF A DENTAL TREATMENT PLAN (PREDETERMINATION)

It is recommended that any proposed dental care expenses anticipated to exceed $500 be reviewed in advance, by the Plan Administration Office by submitting a Dental Treatment Plan. Submission of a Dental Treatment Plan is required before any Orthodontic procedures begin or benefits payments being made.

As a service, the Plan Administration Office will advise, in advance, of the amount the Plan will reimburse when a proposed course of dental treatment includes Major Restorative or Orthodontic dentistry.

To use this service, the covered person's dentist must complete a Dental Treatment Plan that includes pre-treatment x-rays if the proposed treatment involves crowns or bridgework.

ELIGIBLE DENTAL EXPENSES

Charges for the following dental services and supplies are considered dental care expenses that are eligible for reimbursement.

BASIC DENTAL SERVICES

Diagnostic Services

Procedures required in the evaluation and/or care of existing conditions and to determine any further dental care which may be required.

- Recall oral examinations including fluoride treatment once in a 6-month period
- A complete oral examination and diagnosis once in a 24-month period
- X-rays
- Study casts

Preventive Services

Procedures intended to eliminate or reduce the need for future dental treatment.

- Scaling and polishing (prophylaxis) subject to a maximum of 8 units (2 units for dependent children under age 13) per calendar year (combined with periodontal scaling and root planning);
- Topical fluoride;
- Passive space maintainers, those that do not move the teeth (for dependent children only).

Basic Restorative Dentistry

Procedures to restore natural teeth to their normal function with the use of silver amalgam, silicate, or synthetic restorations (fillings). In addition, sedative dressings are covered.

Extractions

Uncomplicated removal of teeth.

Endodontics

Emergency endodontic procedures and conservative root canal therapy.

Periodontics

- Adjunctive services as follows: scaling, root planning (subject to the combined maximum number of units indicated above under preventative services), acute infections, occlusal adjustment, provisional splinting;
- Surgical services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;
- 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 dental care procedures.

Repairs, Relining and Rebasing of Dentures

Repair or relining and rebasing of dentures (once every 3 years), including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

MAJOR DENTAL SERVICES

Removable Prosthetic Devices

The initial installation of partial or full dentures, subject to the pre-existing condition, limitations on teeth lost, extracted or fractured prior to becoming insured. Replacement of existing dentures is not covered except if:

a) the replacement is required due to extraction or loss or fracture of one or more sound natural teeth after the individual became covered under this Plan; or

b) the replacement takes place more than 12 months after the covered person became covered under the Plan, and the existing dentures are at least 5 years old and no longer serviceable.

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, which are used to restore the natural teeth to their normal functions where the teeth, as a result of extensive caries or fracture, cannot be restored with a filling. When teeth can be restored with silver amalgam, silicate or synthetic restorations, the benefit payable will be determined based on the usual costs of such a restoration. Such procedures are subject to the pre-existing condition limitations on teeth lost, extracted, or fractured prior to becoming covered.

Fixed Prosthetic Devices

The initial installation of fixed prosthetic devices is subject to the pre-existing condition limitations on teeth lost, extracted or fractured prior to becoming covered. Re-cementing services and the replacement of the facing or veneer of the fixed prosthetic device are eligible expenses. The replacement of existing fixed prosthetic devices is not eligible except if:

(a) the replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became covered under this Plan; or

(b) the replacement is more than 12 months after the individual became covered under this Plan, and the existing fixed prosthetic device is at least 5 years old and no longer serviceable.

ORTHODONTIC DENTAL SERVICES

Only a Dependent Child who is under age 19 is covered for Orthodontic Services. Coverage includes the diagnosis and correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of the teeth". This includes active space retainers, or orthodontic appliances, used to reposition or move teeth.

Orthodontic benefits are only payable if the treatment is required for an overbite of at least four millimetres, a cross bite or a protrusive or retrusive relationship of at least one cusp. An Orthodontic Pre-Treatment Plan must be submitted to the Plan Administration Office and returned to the Dentist showing the estimated benefits payable by the Plan prior to the treatment commencing.

An "Orthodontic Pre-Treatment Plan" is a report on a form satisfactory to the Plan that describes the recommended type and duration of treatment, provides the estimated charge, and is accompanied by cephalometric x-rays, study models and other supporting evidence of the proposed treatment.

Benefit payments will be made once the Orthodontic Pre-Treatment Plan has been approved by the Plan Administration Office and the treatment has begun.

In any event the following Orthodontic expenses are not eligible:

1. charges for a procedure for which an active appliance was installed before the Covered Person was covered under the Plan; and
2. any expense incurred while the person's coverage was not in effect. If benefit payments were being paid at the termination of coverage for any Orthodontic procedure which commenced while covered by the Plan, they will be continued for expenses incurred during the 90 days following the date coverage terminated. Oral examinations, dental prophylaxis or diagnostic x-rays are not considered to be the start of a procedure or a series of treatments.

DENTAL EXCLUSIONS AND LIMITATIONS

Dental benefit payments will not be made for any procedure for any injury or dental disease for which the covered person was advised to receive treatment or for which treatment first began before the person became covered for that dental procedure.

No Dental benefit payments will be made for any dental procedure in respect of teeth extracted, lost, or fractured before the person became covered for that procedure except for appliance replacement as specifically stated under Eligible Dental Expenses.

Payments will not be made for the initial installation or addition of prosthetic devices unless such installation or addition is required primarily due to teeth that were lost, extracted or fractured after becoming covered under the Plan.

In addition to the limitations and exclusions above, no Dental benefit payment is payable by the Plan 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, hygienist or denturist acting within the scope of their license;
3. any charge for an injury resulting from war, riot, insurrection or participation in a criminal act;
4. any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or completion of forms;
5. any charge resulting from any intentionally self-inflicted injury;
6. any services covered, in whole or in part, by any provincial health care plan, services for which no charge is made, or services the Plan is not permitted by law to cover;
7. any charge for services which would not normally have been incurred, but for the presence of this insurance, or for which no charges are incurred;
8. any hospital charges for room and board and related services and supplies;
9. any dental examinations required by a third party;
10. diagnostic procedures in connection with any benefit categories excluded as eligible expenses;

11. services or supplies for implantology;
12. services or supplies which are not medically necessary for the care and treatment of any existing or suspected injury, or disease;
13. eligible expenses arising as the result of a Motor Vehicle will be considered eligible only after first being submitted to your automobile insurer (subject to applicable legislation).

EXTENSION OF COVERAGE FOR CERTAIN DENTAL PROCEDURES

Payments will be paid for charges incurred after the termination of the Plan or this benefit or after the covered person's coverage under this Dental Care Benefit ceases, with the exception of completing the installation of dentures or dental expenses in connection with a denture, bridge or crown where an impression was taken or root canal therapy was started, within 30 days of the termination of coverage, provided the impression was taken prior to termination and the expense is covered by the Plan.

DENTAL CARE SURVIVOR BENEFIT COVERAGE EXTENSION FOR DEPENDENTS

Upon the death of an eligible Plan Member, the eligible surviving Dependents (Spouse and Children) will continue to be covered for the Dental Care benefit for a period of up to 30 months. This period commences after the Plan Member's Dollar Bank Account has been depleted. No premiums or contributions will be required to continue coverage during this Survivor Benefit Extension period.

TERMINATION OF THE DENTAL CARE BENEFIT

A Plan Member's Dental Care Benefit coverage will terminate on the day the Plan Member retires and has exhausted the amount in their Dollar Bank Account. Coverage for a Plan Member and their Dependents will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

DENTAL CARE CLAIM FORM DOCUMENTS REQUIRED

No benefit payment will be made to a Plan Member unless a completed Claim Form and any other required documents are submitted to the Plan Administration Office and/or the Plan within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this Booklet.

No claim form is required for the Benefit Card and/or online claim submission. Members may be asked to submit their receipts to the Plan Administration Office for claims filed electronically. These random audits ensure the Plan is protected. You must therefore retain your receipts for 13 months.

MEMBER ASSISTANCE PROGRAM (MAP) BENEFIT

The Member Assistance Program (MAP) is a confidential counselling, information, advice and referral service available to Plan Members and eligible Dependents.

The counselling services are provided by Family Services Employee Assistance Programs (**FSEAP**). A Covered Person can contact FSEAP 24 hours a day, every day of the year directly by calling **1-800-668-9920**. For TTY service call 1-888-234-0414.

From time to time, many people become overwhelmed with personal concerns and the everyday stresses of life. Whenever a crisis or emergency situation occurs and/or whenever immediate help is required, FSEAP professional counsellors are a phone call away.

However, not all of the stresses of everyday life involve an emergency. Plan Members and their Dependents may choose to speak with a FSEAP counsellor about a variety of everyday personal issues such as anxiety, depression, relationship issues, addiction (including alcohol and gambling), or to receive support or information regarding care giving needs, childcare, job related issues, quitting smoking, weight loss, nutrition and dietary concerns, or even legal or financial assistance.

Callers will be connected immediately with a qualified FSEAP counsellor who can provide assistance, or arrange for a face-to-face counselling appointment. FSEAP provides confidential counselling across Canada and the United States.

FSEAP staff includes experienced social workers and psychologists. If longer-term or specialized counselling is required, the FSEAP counsellor will assist you with a referral to another resource within your community. This referral may involve a fee. More information is available to you online at:

- **www.myfseap.com**
- Log-in using Group Name: **toloc27map**
- Password: **myfseap1**

SUMMARY OF THE MEMBER ASSISTANCE PROGRAM SERVICES PROVIDED

The Member Assistance Program provides direct access to experienced professional FSEAP counsellors who can assist in finding the answers and services that are right. Listed below are just some of the areas of confidential assistance available through FSEAP:

- Personal or Job Stress
- Relationship Issues
- Depression or Anxiety
- Addictions (including alcohol, substance abuse and gambling)
- Separation and Divorce
- Parenting Challenges
- Eldercare and Childcare
- Balancing Work Life and Family Life
- Financial and Legal Assistance
- Nutritional, Dietary and Weight Loss Consultation
- Smoking Cessation
- Grief Counselling

TERMINATION OF THE MEMBER ASSISTANCE PROGRAM BENEFIT

A Plan Member's Member Assistance Program coverage will terminate on the day the Plan Member retires and has exhausted the amount in their Dollar Bank Account. Coverage for a Plan Member and their Dependents will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

BEREAVEMENT / PARENTAL LEAVE BENEFIT

The Bereavement / Parental Leave Benefit is intended to provide Plan Members with some financial assistance during absences from work due to certain life events.

The Bereavement Parental Leave Benefit is self-funded. The eligibility rules and termination rules are the same as those under the Health and Wellness Plan. To be eligible for benefits, a Plan Member must also be a Member in Good Standing of Local Union 27 or 1030.

BEREAVEMENT BENEFIT

In the unfortunate event of a Family Member's death, a Plan Member will be eligible to receive the Plan's Bereavement Benefit provided the Plan Member was at work the day prior to the loss. Only Plan Members are eligible for this benefit. Dependents of Plan Members are not eligible for this benefit.

WHO QUALIFIES AS A "FAMILY MEMBER"

For the purposes of the Bereavement Benefit, the Plan defines an eligible Family Member as a Plan Member's:

- Spouse
- Child, including Children in-law
- Parent, including Parents in-law
- Grand Parent
- Brother, including Brothers in-law
- Sister, including Sisters in-law

PARENTAL LEAVE BENEFIT

If a Plan Member has a newborn Child, the Plan Member will be eligible to receive the Plan's Parental Leave provided the Plan Member was at work the day prior to the birth of the Child and that the Plan Member is absent from work immediately following the birth of the Child. Only Plan Members are eligible for this benefit. Dependents of Plan Members are not eligible for this benefit.

BENEFIT AMOUNT

The Bereavement and Parental Leave benefit pays a maximum of $150 per day, for a maximum of up to 3 business days. No benefit is payable for Saturday or Sunday. Benefits are payable from the 1st day of lost earnings, provided the Plan Member was at work the day prior to the loss or birth. No Bereavement benefits are payable for lost time following the funeral unless the Plan Member is required to travel for the purposes of attending the funeral.

TAXABILITY OF BENEFIT PAYMENTS

Bereavement and Parental Leave benefit payment(s) are taxable income to the Plan Member in the calendar year in which it was paid.

In February of each year, a Plan Member who received benefit payments in the previous calendar year will receive an official tax form that indicates the total amount of benefit payments paid to the Plan Member in the prior calendar year.

Any benefit payment(s) paid to a Plan Member shown on the official tax form must be reported in the Plan Member's annual income tax return.

HOW ARE CLAIMS FILED TO THE PLAN

To submit a claim for the Plan's Bereavement or Parental Leave benefit, the Plan Members must complete the applicable claim form and provide sufficient proof of loss including:

- a letter from the employer or Local Union indicating that the Plan Member was working, the last day of work, and the days that the Plan Member did not work causing the leave
- a Death Certificate or a Funeral Director's Statement (for Bereavement benefits)
- an original Birth Certificate for your newborn Child (for Parental Leave benefits)

Claim forms are available from the Plan Administration Office or online from the Plan Member website.

Claims for Bereavement or Parental Leave benefits must be submitted within 12 months from the date of applicable event. Late claims will not be paid.

TERMINATION OF THE BEREAVEMENT / PARENTAL LEAVE BENEFIT

A Plan Member's Bereavement / Parental Leave benefit will terminate on the day the Plan Member retires and has exhausted the amount in their Dollar Bank Account. Coverage for a Plan Member and their Dependents will also terminate as described earlier in the **Eligibility Information** section of this Booklet.

VACATION PAY PLAN

OVERVIEW OF THE PLAN

The Carpenters' Local 1030 Vacation Pay Plan provides Plan Members with their benefit entitlement to any Vacation Pay they have earned under the terms of the applicable Local 1030 collective bargaining agreement, each benefit year. The Plan makes one regular annual payout of Vacation Pay each November 1st.

Plan Members also have the option to receive their earned Vacation Pay benefits at one other time, as long as the requested optional payment is not within a 60-day period either before or after November 1st.

The current Local 1030 collective bargaining agreement requires that each contributing contractor/employer make a contribution to the Carpenters' Local 1030 Vacation Pay Trust Fund. The Vacation Pay contribution is expressed as a percentage of the gross payments receive on behalf of Plan Members from contributing contractors/employers.

The percentage currently in effect can be determined by reviewing the applicable current Collective Bargaining Agreement.

FREQUENTLY ASKED QUESTIONS

The following information provides answers to common questions regarding the operation of the Local 1030 Vacation Pay Plan. If you have any difficulty understanding the rules of the Vacation Pay Plan or your entitlement under the Plan, the Plan Administration Office is pleased to help answer any questions.

How does the Vacation Pay Plan work?

The Plan Administration Office establishes and maintains a Vacation Pay "account" recording all of the Vacation Pay contributions received on behalf of each Plan Member from any Employer/Contractor signatory to an applicable Collective Bargaining Agreement.

These Vacation Pay accounts are maintained on an annual basis from September 1st of each year to August 31st of the following year, recording the Vacation Pay contributions received in respect of the September work month of one year, to the end of the August work month of the next year.

How are the contributions to the Vacation Pay Trust Fund invested?

The Board of Trustees invests the contributions to the Vacation Pay Trust Fund in short-term securities. This type of investment provides the best combination of interest income and minimum investment risk, ensuring that the funds are available on short notice if required. The interest income earned is used primarily to pay the operating costs of the Vacation Pay Plan and the Vacation Pay Trust Fund.

Do Plan Members receive 100% of their Vacation Pay contributions?

Plan Members always receive 100% of the Vacation Pay contributions they are entitled to, provided the applicable Employer/Contractor has remitted all of a Plan Member's earned Vacation Pay contributions to the Vacation Pay Trust Fund, less any applicable administration fee as described below.

How do plan Members receive their Vacation Pay entitlement?

The Plan has an automatic pay out in November of each year. On or about November 1st of each year, the Plan Administration Office delivers a cheque to Local Union 1030 for each eligible Plan Member, which includes all Vacation Pay earned by the Plan Member and contributed on a Plan Member's behalf for the 12-month period ending August 31st. Direct Deposit of these benefits is also available by contacting the Plan Administration Office.

A statement of the Plan Member's Vacation Pay account for the prior 12-month period is provided with the Vacation Pay cheque which indicates the Vacation Pay contributions received on behalf of the Plan Member and the Employer/Contractor who remitted them.

Can a Vacation Pay entitlement be paid out before the annual November Pay Out?

Plan Members have the option to receive one additional Vacation Pay payment each year. To request this optional payment, the Plan Member must complete the Vacation Pay Application, available from the Plan Administration Office.

The Plan does not issue optional payments within a 60-day period either before or after November 1st (i.e., optional payments will not be issued by the Plan between September 1st and February 1st of the following year. Payments are not made during this period because the Plan is in the process of its annual automatic payment. An administration fee as established by the Trustees is charged by the Plan for any optional payment pay out.

Can a lost or stale dated Vacation Pay cheque be reissued?

If a Plan Member has lost their Vacation Pay cheque, or if it becomes stale dated, the Plan Administration Office can reissue the payment upon request.

Are there any fees associated with receiving a Vacation Pay entitlement?

An administration fee, as established by the Trustees, is applicable to all Vacation Pay payments.

Is Vacation Pay subject to Income Tax?

Any Vacation Pay payment(s) issued to a Plan Member is considered under Canadian taxation laws to be taxable income to the Plan Member in the calendar year in which it was paid.

In February of each year, a Plan Member who was paid Vacation Pay payment(s) in the previous calendar year will receive an official tax form from the Plan that indicates the total amount paid to the Plan Member in the prior calendar year.

LEGAL SERVICES PLAN

The Legal Services Plan is intended to provide Plan Members with some financial assistance for a variety of commonly used, general legal services.

COVERED SERVICES SCHEDULE

The benefits of the Legal Services Plan are not intended to cover the full cost of legal services that may be provided by a Lawyer. The Schedule below indicates the maximum benefit payable for the legal services covered by the Plan.

The nature, extent and amount of legal services provided are a matter to be resolved between the Plan Member and the Plan Member's Lawyer. The Legal Services Plan, the Legal Services Trust Fund and the Board of Trustees accept no responsibility for the determination of reasonable legal fees, the outcome of the legal service or the payment by the Plan Member of any legal fees incurred which are above the Covered Services Schedule.

Type of Legal Service	*Maximum Annual Benefit*
Will – Plan Member or Spouse Separately	$100.00
Will – Plan Member and Spouse Together	$150.00
Codicil to Will – Plan Member or Spouse Separately	$50.00
Codicil to Will – Plan Member and Spouse Together	$60.00
Probate of Will – Plan Member or Spouse*	$250.00
Purchase, Sale or Mortgage of Plan Member's Principal Residence	$500.00
Renewal / Discharge of Mortgage on Plan Member's Principal Residence	$50.00
Prepare / Review Lease on Plan Member's Principal Residence	$60.00
Preparation of Power of Attorney for Plan Member or Spouse	$60.00
Adoption of Child by Plan Member	$250.00
Violation under the Highway Traffic Act	$300.00

**or administration of such Estate where there is no Will*

OVERALL CALENDAR YEAR MAXIMUM ANNUAL BENEFIT

In addition to the itemized Maximum Annual Benefit payable noted in the Covered Services Schedule above, the Plan also has an Overall Maximum Annual Benefit for all itemized legal services combined in a calendar year as follows.

First Calendar Year of Plan Membership	$400.00
Second / Subsequent Calendar Year of Plan Membership	$1,000.00

A Calendar Year is the 12-month period commencing January 1st and ending December 31st.

Subject to the Overall Calendar Year Maximum Annual Benefit, a Plan Member may only claim for each type of legal service described in the Covered Services Schedule once in each Calendar Year. The Overall Calendar Year Maximum Annual Benefit shall include any amounts paid in respect of legal services for a Plan Member's Dependents.

SELECTION OF LAWYER

Plan Members choose their own Lawyer. The Legal Services Plan does not provide legal advice or recommend lawyers. The Legal Services Plan requires that the selected Lawyer be properly licensed to practice law in the province of Ontario. For referral to a Lawyer, the Plan Member can contact the Law Society of Upper Canada at (416) 947-3300.

All legal matters are strictly between the Plan Member and the Plan Member's selected Lawyer, as are the legal fees to be charged by the Lawyer. The Trustees will not give any opinion at all with respect to the type, or the quality of the legal services provided by a Lawyer to any Plan Member.

HOW TO FILE CLAIMS

To submit a claim for reimbursement under the Legal Services Plan, please contact the Plan Administration Office. They will provide the proper claim form that must be completed by the Plan Member. The Plan Member must provide the selected lawyer's full invoice for the services provided that are being claimed for, including:

- the particulars of the legal services rendered
- the date the legal services were rendered
- the time allotted for each legal service rendered
- total charge for each legal service rendered

Claims for legal expenses incurred will only be considered eligible when the legal service has been completed by the Lawyer.

Claims for legal services must be submitted within 180 days from the date the expenses were incurred. Late claims will not be paid.

Payments from the Legal Services Plan are made only to the Member. The Plan will not issue payments to anyone else, including Lawyers or legal firms.

TAXABILITY OF BENEFITS

Any Legal Services Plan payments issued to a Plan Member is considered under Canadian taxation laws to be taxable income to the Plan Member in the calendar year in which it was paid.

In February of each year, a Plan Member who received any Legal Services Plan payment(s) in the previous calendar year will receive an official tax form from the Plan that indicates the total amount paid to the Plan Member in the prior calendar year.

GENERAL PLAN RULES & PROVISIONS

PRIVACY POLICY STATEMENT

The Carpenters' Residential Health and Wellness Plan (and its Insurers and providers where applicable), the Bereavement/Parental Leave Plan, the Vacation Pay Plan and the Legal Services Plan (the "Plans") will collect, maintain and communicate only the personal information considered necessary for the administration of these Plans. Personal information will be protected pursuant to the applicable legislation.

The Plans may use and exchange personal information with relevant persons or organizations (i.e., unions, health professionals, financial institutions, investigative agencies, insurers, re-insurers, regulators, legal counsel, etc.) in order to manage the Plans and any entitlement to the benefits of the Plans.

Questions related to the Privacy Policy of the Plans should be directed to the Plan Administration Office.

DESIGNATED BENEFICIARY

A Plan Member has the right to name (or change) a Designated Beneficiary on their Member Information Card as described in the Life Insurance Benefit description section of this Booklet. It is understood that the beneficiary designation made under the Plan's insurance policies shall be recognized as the Designated Beneficiary under the policies, unless a further designation has been made that specifically identifies the policy(ies). Failing such designation, all benefits will be paid to the estate of the Insured Person.

All other indemnities of the policy will be payable to the Plan Member. A Plan Member can change their Designated Beneficiary at any time, where permitted by law. The Plan and the Insurers assume no responsibility for the validity of such designation or change of beneficiary. Plan Members should periodically review their existing beneficiary designation to ensure it reflects the current intention.

HOW TO SUBMIT A CLAIM TO THE PLAN

When a Plan Member or an eligible Dependent incurs an eligible expense that is covered under one of the Benefits of the Plan, the claim must be submitted to the Plan for reimbursement. Most types of claims can be submitted to the Plan in a variety of ways but all claims must be submitted properly, with any required accompanying documents and before the Claim Submission Deadline.

Claims may be submitted:

- **Using the Plan's Benefit Card at the pharmacy, health care provider or dental office**
- **Online by registering with Green Shield Canada at benefits@carpentersresidential.ca**
- **By Email to the Plan Administration Office at benefits@carpentersresidential.ca**
- **By Fax to the Plan Administration Office at 1-905-946-2535**
- **In person or via email to the Plan Administration Office at**

Carpenters' Residential Benefit Plans
45 McIntosh Drive
Markham ON
L3R 8C7

Eligible expenses for Supplementary Health Care and Dental may be claimed for using the Plan's Benefit Card. These claims may also be submitted online to Green Shield Canada by following the instructions in the Welcome Package provided to new Plan Members when receiving their Benefit Card. Members may be asked to submit their receipts to the Plan Administration Office for claims filed electronically. These random audits ensure the Plan is protected. You must therefore retain your receipts for 13 months.

Claims for Emergency Travel Assistance expenses may be submitted either directly to the Plan Administrator (if under $200) or by calling the for Emergency Travel Assistance telephone number on the back of the Benefit Card.

In addition, or for any other types of claims, Plan Members may contact the Plan Administration Office who will then provide the necessary claim form(s) and assistance for completion and submission of the claim to the Plan or to the Insurer as required. In order to quickly process claims, all claim forms must be completed fully and clearly and indicate the following information:

- the claimant's full name, residential mailing address and date of birth;
- the Plan Member's full name, residential mailing address and date of birth;
- the Plan Member's Plan Identification Number;
- the Manulife Financial Insurance Policy Number 10042 (formerly Policy Number 10077and 901202) for Life, Dependent Life and Long-Term Disability claims;
- the Green Shield Canada Travel Assist Group Number 4932, Plan Member Identification Number and the claimant's provincial health care plan card number (for Emergency Travel Assistance claims);
- the CHUBB Life Insurance Company of Canada Policy Number AB10403501 (for AD&D and Critical Illness claims).

All claims (with claim forms, original receipts and all other required supporting documentation) should be submitted either online or to the Plan Administration Office as soon as possible.

It is a serious offence to submit a claim to the Plan for expenses that are rightfully the responsibility of another party, or for an expense for which there was no loss. For example, claims for expenses due to an illness or disability that is work-related are to be submitted to the Workers' Safety Insurance Board. It is also a serious offence if there has been misrepresentation concerning the eligibility of Dependents.

The Trustees will take action to recover any funds paid to a Plan Member or to a provider of services or supplies if misleading information has been given or fraudulent claim submitted. The Trustees may terminate all of the Benefits of a Plan Member who has intentionally submitted inappropriate or fraudulent claims or provided inaccurate or misleading information to the Plan.

CLAIM SUBMISSION DEADLINES

All claims submitted to the Plan Administration Office and/or to the Insurer(s) for reimbursement must be submitted prior to the claim submission deadline.

Claims that are not received by the Plan and/or the Plan's Insurers within the stipulated timeframes will not be considered eligible for adjudication. It is therefore recommended that all claims be submitted accordingly as soon as possible after the expense or loss is incurred.

BENEFIT	***DEADLINE FOR SUBMITTING A CLAIM***
Life Insurance	**Within 12 months from the Date of Death**
Dependent Life Insurance	**Within 12 months from the Date of Death**
Accidental Death & Dismemberment	**Within 30 Days from the Date of the Accident**
Critical Illness	**Within 30 Days from the Date of the Diagnosis**
Weekly Indemnity	**Within 6 Months from the Date of Disability**
Long Term Disability	**Within 6 months after termination of the first month following the qualifying disability period**
Supplementary Health Care	**Within 12 months from the Date of the Expense**
Emergency Travel Assistance	**Within 48 Hours from the Date of the Expense**
Dental Care	**Within 12 months from the Date of the Expense**
Member Assistance Program	**Not Applicable**
Bereavement/Parental Leave	**Within 12 months from the Date of the Event**
Legal Services Plan	**Within 180 days from the Date of the Expense**
Vacation Pay Plan	**Not Applicable**

Failure to provide notice or furnish proof of claim within the claim filing deadlines stated above and as described in this Booklet will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the required claim filing deadline. Under no circumstances will the Insurers or the Plan accept notice of claim beyond one (1) year.

In the event of termination of a Plan Member's eligibility for the benefits of the Plan, or if a benefit is terminated under the Plan, or if an (the) insurance policy(ies) is(are) terminated, a claim must be submitted within 90 days following the date of termination, with the exception of the AD&D and Critical Illness Benefits, which remain as 30 days and the Emergency Travel Assistance which remains 48 hours.

LEGAL ACTION

A Plan Member may not commence legal action against the Insurer(s) of the Plan, or the Plan less than 60 days after proof of loss has been filed as outlined under the **CLAIM SUBMISSION DEADLINES** section of this Booklet. Every action or proceeding against the Insurer(s) of the Plan, or the Plan for the recovery of money payable under this Plan is absolutely barred unless commenced within the time period set out in the Insurance Act or applicable legislation.

The Insurer(s) and the Plan shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pendency and payment period, if any, of such claim.

In Ontario, every action or proceeding against GSC for recovery of benefit payment under the Plan is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002.* In British Columbia, Alberta and Manitoba, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the *Insurance Act.*

COORDINATION OF BENEFITS (COB)

The payment of Supplementary Health Care, Emergency Travel Assistance and Dental Care Benefits shall be coordinated so that the total benefits payable from all plans available (to a Plan Member and/or their eligible Dependents) do not exceed 100% of the eligible claim expense amount.

For this purpose, the Insurers and the Plan have a right to receive and release information on Benefit coverage and benefit payments and if necessary, collect any overpayments. The claim filing procedures, agreed to by Canadian Health Insurers and benefit plans that will be used to coordinate benefit payments under this Plan are as follows:

1. if the claim expense was incurred by a Plan Member, then submit the claim to this Plan first. If there is still an unpaid balance, then submit the claim to the Plan Member's Spouse's plan together with this Plan's Explanation of Benefits so that the Spouse's plan will know how much has already been paid by this Plan.

2. if the claim expense was incurred by a Plan Member's Spouse, then submit the claim to the Spouse's plan first (if the Spouse has a plan). If there is still an unpaid balance, then submit the claim to this Plan together with the Explanation of Benefits from the Spouse's plan so this Plan will know how much has already been paid by the Spouse's plan.

3. if a Dependent Child incurs a claim expense, submit the claim first to the plan that covers the parent who has the earlier birthday in the calendar year. If there is still an unpaid balance, then submit the unpaid claim expense to the second plan (of the other parent), together with the Explanation of Benefits from the first plan so the second plan will know how much has already been paid by the first plan. If a Plan Member's Spouse does not have a benefit plan and the claim expense can only be submitted to one plan, then submit the claim to this Plan.

4. if a Plan Member and their Spouse are both covered by this Plan as Plan Members, a note should be attached to the claim form advising the Plan Administration Office of the Plan Members' names and both Plan Certificate Numbers (Plan Member Identification). The Plan Administration Office will settle the claim accordingly.

The claim submission process described above is the Coordination of Benefits (COB) procedures agreed to amongst most Canadian group insurance plans. Please contact the Plan Administration Office if further explanation is required about how the Coordination of Benefits procedures work.

CLAIM APPEALS

In the event that the Plan or the Plan's Insurers determine the claim expenses submitted are not eligible for reimbursement under the Plan, or that they are not Medically Necessary, or that they are not Reasonable or Customary, the claim (or a portion thereof) may be denied.

Plan Members are able to discuss the decision made in relation to the processing of any claim submitted to the Plan. To discuss the payment, or non-payment, of any claim submitted to the Plan, please contact the Plan Administration Office.

If a Plan Member believes they have a special circumstance in relation to a submitted claim and would like to have the decision of any submitted claim reviewed or reconsidered (whether the claim was paid or denied) please write to the Board of Trustees in care of the Plan Administration Office.

PLAN ADMINISTRATION OFFICE

The Board of Trustees has retained a Plan Administrator, **Employee Benefit Plan Services Limited**, to handle the day to day matters of the Carpenters' Residential Health and Wellness Plan including Plan administration and claims payment for many of the Plans' Benefits.

The Trustees rely on the experience of the Plan Administrator with respect to the eligibility for benefits of the Plans and whether claim expenses submitted are eligible for reimbursement.

Plan Members may contact the Plan Administration Office if there are any questions about the benefits of the Plans or the administrative rules about how the Plans work. The Plan Administration Office is there to help Plan Members. The Plan Administrator is:

EMPLOYEE BENEFIT PLAN SERVICES LIMITED

45 McIntosh Drive
Markham, Ontario
L3R 8C7

Toll Free: 1-800-263-3564

Tel: (905) 946-9700

Fax: (905) 946-2535

E-mail: benefits@carpentersresidential.ca

www.carpentersresidential.ca