CARPENTERS' RESIDENTIAL HEALTH AND WELLNESS PLAN

INTRODUCTORY BENEFIT PLAN
PLAN MEMBER INFORMATION BOOKLET

UP TO DATE AS OF JULY 1, 2021

WWW.CARPENTERSRESIDENTIAL.CA

TABLE OF CONTENTS

INTRODUCTION..... 1

SUMMARY OF BENEFITS..... 2

BENEFITS AT A GLANCE SUMMARY..... 6

ELIGIBILITY INFORMATION..... 8

GRADUATION PROCESS TO COMPREHENSIVE BENEFIT PLAN..... 12

WORKPLACE SAFETY INSURANCE (WSIB)..... 15

DESCRIPTION OF BENEFITS..... 17

LIFE INSURANCE BENEFIT..... 17

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT..... 18

SUPPLEMENTARY HEALTH CARE BENEFIT..... 30

DENTAL CARE BENEFIT..... 37

MEMBER ASSISTANCE PROGRAM BENEFIT..... 42

BEREAVEMENT / PARENTAL LEAVE PLAN..... 44

PRODUCTIVITY BONUS PLAN..... 46

VACATION PAY PLAN..... 48

LEGAL SERVICES PLAN..... 50

GENERAL PLAN RULES AND PROVISIONS..... 52

PLAN ADMINISTRATION OFFICE..... 57

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 Introductory 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 Introductory 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 Productivity Bonus Trust 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, Productivity Bonus 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 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 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 Introductory 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:	$50,000

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (AD&D)

Plan Member:	Principal Sum	$50,000
	Permanent & Total Disability Benefit	$50,000
	Occupational AD&D Benefit	$50,000

SUPPLEMENTARY HEALTH CARE BENEFIT

Deductible:	None
Reimbursement:	100% for Vision Care; 90% for Generic Prescription Drugs; 80% for Brand Name, Biologic and Biosimilar Prescription Drugs; 80% for all other eligible expenses
Overall Maximum:	Unlimited
Prescription Drugs:	Eligible Prescription Drugs must have a Drug Identification Number DIN) and a Compliance Certificate both issued by Health Canada
Biologic / Biosimilar Drugs:	These Drugs require the Plan's Prior Authorization. Reimbursement is based on the lowest cost, suitable Biologic or Biosimilar drug (where a Biosimilar drug is available)
Drug Maximums:	Methadone Treatment $1,000 Lifetime; Erectile Dysfunction $500 per year; Fertility Drugs $2,500 Lifetime.
Dispensing Fee Maximum:	$9.00
Medical Cannabis:	$500 annual maximum for specific medical conditions

Vision Care	
Lenses, Frames and Contact Lenses:	Maximum of $200 in any consecutive 24 month period (includes Prescription Sunglasses; excludes Safety Glasses)
Eye Examinations:	1 eye examination each 24 months
Paramedical Practitioners:	$150 Combined for all practitioners per calendar year including Chiropractor, Registered Massage Therapist, Speech Therapist, Physiotherapist, Naturopath, Osteopath, or Podiatrist.
Psychologist:	$500 annual maximum
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, 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 annual maximum

DENTAL CARE BENEFITS

Deductible:	None
Reimbursement:	100% for Basic Dental Services 50% for Major Dental Services
Dental Fee Guide Schedule:	Dental Benefits are reimbursed based on the current suggested fee guide for general practitioners 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 & Major Maximum: $1,000 per calendar year for Basic and Major Services combined

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 eligible 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 using the information provided under the Member Assistance Program heading in the Description of Benefits Section of this Booklet.

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, Dental Care and Member Assistance Program Benefits for a period of 30 consecutive months that commences 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.

PRODUCTIVITY BONUS / VACATION PAY PLAN

These Plans provides Plan Members with their entitlement to any Productivity Bonus or Vacation Pay they have earned under the terms of their applicable collective agreement each benefit year (Local Union 27 for Productivity Bonus and Local Union 1030 for Vacation Pay). The Plans makes one regular annual payout of either Productivity Bonus or Vacation Pay Benefits each year.

The details and processes of each of these Plans are described in the applicable Sections of this Booklet. Please review the Section that applies to you.

LEGAL SERVICES PLAN

The Benefits of the 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 this Booklet for the details of the maximum annual benefits payable depending on the type of legal service used. The Plan also has overall calendar year maximums for all legal services combined depending on your cumulative years as an eligible Plan Member.

BENEFITS AT A GLANCE

The following pages 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
Introductory Benefit Plan Summary (as of July 1, 2021)

Benefit / Benefit Provision	Health Benefit Plan Coverage / Rule
General Plan Provisions	
Monthly Dollar Bank Drawdown	$150
Dollar Bank Maximum	$1,800 (12 months of monthly Dollar Bank Drawdown)
Initial Eligibility	1st day of 2nd month, following the month the Member accumulates $450 in Dollar Bank
Reinstatement Eligibility	1st day of the month after accumulation of $300 in Member's Dollar Bank
Pay Direct Plan Options	Plan A (all benefits provided): $150 payment per month (plus applicable provincial tax)
Pay Direct Duration	3 month maximum (WSIB recipients 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 approved educational institution
Termination of Coverage	Retirement - (unless otherwise indicated under each benefit description)
Life Insurance	
Benefit Amount	$50,000
Termination of Coverage	Retirement - (other standard termination rules apply)
Accidental Death & Dismemberment (AD&D)	
Member Principal Amount	$50,000 benefit paid for Accidental Death; various percentages paid for Dismemberment
Occupational AD&D Benefit	$50,000 additional work related AD&D benefit (this provision terminates at age 75)
Permanent & Total Disability Benefit	$50,000 lump sum benefit when "Totally Disabled" (this provision terminates at age 65)
Schedule of Loss	percentage of Principal Amount paid for specific losses (also applies to Occupational AD&D)
Peripheral AD&D Benefits	various additional services and benefits available in relation to an approved claim
Termination of Coverage	Retirement - (other standard termination rules apply)
Bereavement Pay Benefit	
Maximum Benefit and Payment Period	$150 maximum benefit per day with a 3 day maximum
Eligible Family Members	Spouse, Child*, Parent*, Grand Parent, Brother*, Sister* (*or any in-laws).
Required Proof of Claim	must be actively working, provide employer note and death certificate
Parental Leave Benefit	
Maximum Benefit and Payment Period	$150 maximum benefit per day with a 3 day maximum
Eligible Family Members	new born child
Required Proof of Claim	must be actively working, provide employer note and birth certificate

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

Benefit / Benefit Provision	Health Benefit Plan Coverage / Rule
Supplementary Health Care	
Deductible	None
Reimbursement Level	100% for Vision Care; 80% for all other services and supplies (except where noted below)
Benefit / Prescription Drug Card	For direct payment of Prescription Drugs and other Health Care services and supplies
Prescription Drug Reimbursement Level - Tier 1	90% Reimbursement for Generic Prescription Drugs
Prescription Drug Reimbursement Level - Tier 2	80% Reimbursement for Brand Name, Biologic and Biosimilar Prescription Drugs
Dispensing Fee Maximum	$9.00
Overall Health Care Lifetime Maximum	Unlimited
Prescription Drug Reimbursement & Maximums	Based on the lowest eligible cost between a Biologic drug and its Biosimilar drug (where a Biosimilar drug is available). Prior Authorizations is required. Methadone Treatment: $1,000 Lifetime. Erectile Dysfunction: $500/Year. Fertility Drugs: $2,500 Lifetime.
Medical Cannabis	$500 annual maximum (only for specific medical conditions)
Private Duty Nursing	$10,000 each calendar year
Paramedical Practitioner Services	$150 combined for all Practitioners per calendar year - Chiropractor, Osteopath, Podiatrist, Physiotherapist, Naturopath, Speech Therapist and Massage Therapist.
Psychologist	$500 each calendar year
Orthotics / Orthopaedic Shoes	$500/24 months for Orthotics - Reasonable & Customary Charges for Orthopaedic Shoes
Hearing Aids	$500 each 36 months
Vision Care	$200/24 months for Lenses, Frames, or Contact Lenses (includes Prescription Sunglasses; excludes Safety Glasses)
Eye Examinations	1 Eye Exam each 24 months
Medical Transportation Services	Emergency Ambulance
Medical Supplies and Services	Convalescent Care, Durable Medical Equipment - Hospital Bed, Wheelchair, Braces, Crutches, Prosthetics, X-Rays, Lab Tests, Diabetic Supplies, Surgical Stockings, etc.
Accidental Dental Services	$5,000 per accident - dental work must be completed within 12 months
Survivorship Benefit (For Dependants)	balance of Member's Dollar Bank, plus a 30 month extension
Termination of Coverage	Retirement - (other standard termination provisions apply)
Dental Care	
Deductible	None
Coinsurance Basic Services	100% Reimbursement
Coinsurance Major Services	50% Reimbursement
Annual Maximum Basic Services	$1,000
Annual Maximum Major Services	combined with Basic Services maximum
Fee Guide Schedule	Current Dental Fee Guide
Basic Services Included	Diagnostic, Preventative, Restorative, Surgery, Fillings, Anaesthesia
Complete Examination	1 Exam each 24 months
Recall Exams	1 Exam each 6 months
1 Complete Series of X-rays	covered
1 Set of Bitewing X-rays	covered
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
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

ELIGIBILITY INFORMATION

ABOUT THE INTRODUCTORY BENEFIT PLAN

The Carpenters' Residential Health and Wellness Plan provides the Introductory Benefit Plan for Plan Members who may not be able to meet and/or maintain eligibility for the Benefits of the Carpenters' Comprehensive Benefit Plan, due to the level of contributions received and/or the greater monthly Dollar Bank requirement of the Comprehensive Plan.

The Introductory Benefit Plan allows these Plan Members to become eligible for Benefits as soon as possible, and allows them to remain covered for Benefits longer.

Plan Members who are enrolled in the Introductory Benefit Plan will be given periodic opportunity to graduate to the Comprehensive Benefit Plan throughout each benefit year. This process and the requirements to do so are described later in this Booklet.

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 applicable Fund(s), 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.

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 applicable Monthly Dollar Bank Deduction is $150.

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 $1,800.

The Dollar Bank Account Maximum balance (which is subject to change as described earlier) represents 12 months of Monthly Dollar Bank Deductions. Therefore, 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 directly to the Plan Administration Office, for up to a maximum period of three consecutive months, to remain eligible for the Benefits of the Plan.

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)).

A Plan Member has the option to extend coverage by making monthly Pay Direct payments, based on the following Pay Direct Plan:

Plan A – a Pay Direct Plan for Active Plan Members that provides all Benefits of the Introductory Plan, requiring a $150 monthly Pay Direct payment (plus applicable provincial taxes)

This Pay Direct Plan and the required monthly Pay Direct payment amount are those in effect as of the date this Plan Member Information Booklet was prepared. Pay Direct Plan options and any required monthly Pay Direct 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 2 times the required Monthly Dollar Bank Deduction. Based on the Plan's monthly Dollar Bank Deduction as of the date this Plan Member Information Booklet was prepared, the required Dollar Bank Account balance for the reinstatement of benefits is $300.

The required Monthly Dollar Bank Deduction, the Dollar Bank Account balances, and the ongoing eligibility rules described above are those that were in effect when this Plan Member Information Booklet was prepared. 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 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, the earlier of the day on which a Plan Member attains age 65, or retires.

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, however certain Benefits may be extended as described in the Description of Benefits Section of this Booklet. 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.

GRADUATION PROCESS

GRADUATION TO THE COMPREHENSIVE BENEFIT PLAN

The Carpenters' Residential Health and Wellness Introductory Benefit Plan was created to ensure that all Plan Members become eligible for Benefits as soon as possible and remain eligible for Benefits.

The Plan offers eligible Plan Members a greater level of benefit coverage and is available to Introductory Plan Members under certain conditions.

There are quarterly evaluation periods each calendar year where the Plan Administration Office reviews the status and ability of all Introductory Plan Members to determine whether the Plan Member would have had sufficient employer/contractor contributions to maintain eligibility in the Comprehensive Benefit Plan.

Graduation to the Comprehensive Plan for New Introductory Plan Members

For new Introductory Plan Members, the Plan Administration Office will consider the following requirements during the very first graduation period, before graduating the Introductory Plan Member to the Comprehensive Benefit Plan. The new Introductory Plan Member must have:

- been continuously covered under the Introductory Benefit Plan for the three months prior to the graduation period, by having sufficient Employer/Contractor contributions remitted to the Plan on the Plan Member's behalf to meet the Introductory Benefit Plan's $150 Monthly Dollar Bank Deduction (Pay Direct payments are not considered eligible during the continuous three month period);
- earned sufficient employer/contractor contributions each month to meet the Comprehensive Benefit Plan Monthly Dollar Bank Deduction for the quarter period immediately prior to the graduation period;
- been a Member in Good Standing of Local Union 27 or Local Union 1030 continuously during the three month period immediately prior to the graduation period;

If the new Introductory Plan Member is not able to meet these requirements and graduate to the Comprehensive Benefit Plan, the Plan Member will remain eligible in the Introductory Benefit Plan and be reevaluated for eligibility in the Comprehensive Benefit Plan during the next graduation period.

Graduation to the Comprehensive Plan for Ongoing Introductory Plan Members

For Introductory Plan Members who were not able to graduate to the Comprehensive Benefit Plan during their first graduation period, the Plan Administration Office will consider the following requirements during the second and subsequent graduation periods, before graduating the Introductory Plan Member to the Comprehensive Benefit Plan. In this case, the Introductory Plan Member must have:

- been continuously covered under the Introductory Benefit Plan for the three months prior to the graduation period, by having sufficient employer/contractor contributions remitted to the Plan on the Plan Member's behalf to meet the Introductory Benefit Plan's $150 Monthly Dollar Bank Deduction (Pay Direct payments are not considered eligible during the continuous six month period);
- earned sufficient employer/contractor contributions each month to meet the Comprehensive Benefit Plan's Monthly Dollar Bank Deduction for the quarter period immediately prior to the graduation period;
- been a Member in Good Standing of Local Union 27 or Local Union 1030 continuously during the 12 month period immediately prior to the graduation period;

When Are the Graduation Periods Each Year

The Plan Administration Office evaluates the ability of Introductory Plan Members to maintain eligibility in the Comprehensive Benefit Plan every quarter. There are no exceptions to these evaluation/graduation periods.

When Do Benefits Start in the Comprehensive Plan for Graduating Members

Graduation into the Comprehensive Benefit Plan will take effect on the first day of the second month following the month of the Plan Administrator's evaluation.

What if Employer/Contractor Contribution Are Made to the Introductory Benefit Plan Late

The Plan Administration Office will not wait for employer/contractor contributions to be remitted to the Introductory Benefit Plan to complete the evaluation process. Late contributions will not be reevaluated after they have been received. In this case the Introductory Plan Member's eligibility in the Comprehensive Benefit Plan will be reevaluated in the next scheduled graduation period.

What if a Graduated Member Cannot Maintain Eligibility in the Comprehensive Plan

Graduation to the Comprehensive Benefit Plan is not voluntary. Introductory Plan Members who qualify for the Comprehensive Benefit Plan are not permitted to remain in the Introductory Benefit Plan and will be automatically graduated to the Comprehensive Benefit Plan.

Once an Introductory Plan Member graduates to the Comprehensive Benefit Plan, the Plan Member may not move back to the Introductory Benefit Plan, regardless of the Member's ability to maintain ongoing eligibility in the Comprehensive Benefit Plan.

If a Comprehensive Plan Member does not have sufficient employer/contractor contributions to maintain eligibility in the Comprehensive Benefit Plan, then it is recommended that the Plan Member make the necessary Pay Direct payments for one of the Comprehensive Benefit Plan Pay Direct Plan options.

Does Graduation Affect Coverage and Benefit Maximums

The expenses Plan Members submit to the Plan as claims will be considered under the Benefits of the Plan the Member was covered under at the time the expense was incurred.

For Benefits with frequency limitations or maximums, any usage under the Introductory Benefit Plan will be considered and count towards the limits and maximums that apply under the Comprehensive Benefit Plan.

WORKLPLACE 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 such 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 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 your 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 (where applicable);
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 assist Plan Members with any 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.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT AD&D

ACCIDENTAL DEATH BENEFIT

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).

OCCUPATIONAL ACCIDENTAL DEATH BENEFIT

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 age 75, 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

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 & OCCUPATIONAL ACCIDENTAL DISMEMBERMENT BENEFIT

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 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 age 75, 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 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 age 75, 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 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 age 75, 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 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 age 75, 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

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 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 age 75, 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.

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

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

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 Plan Member. If the body of a Plan Member 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 Plan Member 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 Plan Member, provided:

a) such training is required because of such injuries and in order for the Plan Member 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 Plan Member being confined as an in-patient in a hospital outside one hundred and fifty (150) kilometers from the Plan Member'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 Plan Member, 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 Plan Member 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 Plan Member'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 Plan Member to make the vehicle accessible or operable for the Plan Member.

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 Plan Member'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 Plan Member, within 365 days from the date of the accident, the Insurer will pay the reasonable and necessary expenses actually incurred by the surviving 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 Plan Member sustains an injury which results in a payment being made under the Accidental Dismemberment Benefit, excluding the Accidental Death Benefit, and the Plan Member 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 Plan Member 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 Plan Member 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 Plan Member sustains an injury which results in one of the losses payable under the Accidental Death or Dismemberment Benefit. The Plan Member'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 Plan Member 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 Plan Member not less than one hundred and fifty (150) kilometers from the Plan Member'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 Plan Member.

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 Plan Member may convert his or her insurance to an individual Accidental Death and Dismemberment only insurance policy 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 & DISMEMBERMENT BENEFIT 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 Plan Member or a member of a Plan Member'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 Plan Member 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 Plan Member 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 Plan Member 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 Plan Member.

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.

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. The Benefit Card may be used at participating pharmacies to purchase most prescription drugs. 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 eligible expenses as follows:

- 100% for Vision Care
- 90% for Generic Prescription Drugs
- 80% for Brand Name, Biologic and Biosimilar Prescription Drugs
- 80% for all other eligible Health Care expenses

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

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 that do not require a prescription, which are considered to be life sustaining.

Biologic and Biosimilar drugs require Prior Authorization from the Plan. Reimbursement for Biologic and Biosimilar drugs is based on the lowest eligible cost between a Biologic drug or its Biosimilar drug (where a Biosimilar drug is available), regardless of whether the prescribing physician indicates "no substitutions".

Dispensing Fee Maximum

The maximum pharmacist's dispensing fee the Plan will reimburse is $9.00 per prescription.

Specific Drug Maximums

- Erectile Dysfunction $500 per calendar year
- Fertility Drugs $2,500 lifetime maximum
- Methadone Treatment $1,000 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 the 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 products 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 (DIN) by Health Canada whether or not they have been approved under a provincial formulary
- Drugs prescribed 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 that will be paid for each Covered Person is $200 in any consecutive 24 month period. Safety Glasses are not eligible for reimbursement.

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

Eye Examinations

The Plan will reimburse the charges for one eye examination per Covered Person, each 24 months when not covered by the Covered Person's provincial health care plan.

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, or podiatrist/chiropodist. The maximum benefit payment for each covered person is $150 per calendar year combined for all practitioners.

The maximum benefit for psychologist charge for each covered person is $500 per calendar year, subject to specific per visit limitations depending on the type of services received.

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 that have been specially designed and molded for the covered person and that 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 that have been specially designed and molded for the covered person and that 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 (RN) 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 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 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 Accident 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.

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
- 50% for Major 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

- $1,000 per calendar year for Basic and Major Dental Care services combined

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.

DENTAL TREATMENT PLAN (PREDETERMINATION)

It is recommended that any proposed dental expenses expected to exceed $500 be reviewed in advance, by the Plan Administration Office by submitting a Dental Treatment Plan. 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 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 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 (includes Periodontal Scaling and Root Planning combined);
- 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 insured under this Plan; or

b) the replacement takes place more than 12 months after the covered person became eligible for Benefits under this 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 insured.

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 insured. 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 insured under this Plan; or

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

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 Accident will be considered eligible only after first being submitted to your automobile insurer (subject to applicable legislation).

EXTENSION OF COVERAGE FOR CERTAIN DENTAL PROCEDURES

No 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 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 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 MAP 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

MEMBER ASSISTANCE PROGRAM 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 Member Assistance Program 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 during this Survivor Benefit Extension period.

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 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 Benefit, 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 three 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 payments 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 payments 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 the 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.

PRODUCTIVITY BONUS PLAN

OVERVIEW OF THE PLAN

The Carpenters' Local 27 Productivity Bonus Plan provides Plan Members with their benefit entitlement to any Productivity Bonus earned under the terms of the applicable Local 27 collective bargaining agreement, each benefit year. The Plan makes one regular annual payout of the Productivity Bonus Plan benefits each December 1st.

Plan Members also have the option to receive their earned Productivity Bonus Plan benefits at one other time during the benefit year, as long as the requested optional payment is not within a 30 day period either before or after December 1st.

The current applicable Local 27 collective bargaining agreement requires that each contributing contractor/employer make a contribution to the Carpenters' and Allied Workers Local 27 – Shingling and Siding Division Productivity Bonus Trust Fund. The Productivity Bonus 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 27 Productivity Bonus Plan. If you have any difficulty understanding the rules of the Productivity Bonus Plan or your entitlement under the Plan, the Plan Administration Office is pleased to help answer any questions.

How do the Plans work?

The Plan Administration Office establishes and maintains a Productivity Bonus "account" recording all of the Productivity Bonus contributions received on behalf of each Plan Member from any contractor/employer signatory to an applicable collective bargaining agreement.

Productivity Bonus accounts are maintained on an annual basis from November 1st of each year to October 31st of the following year. They record the Productivity Bonus contributions received in respect of the November work month of one year, to the end of the October work month of the next year.

How are the contributions to the Fund invested? What happens to any Interest Income?

The Board of Trustees invests the contributions to the Productivity Bonus 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 to pay the operating costs of the Productivity Bonus Plan and the Productivity Bonus Trust Fund.

Do Plan Members receive 100% of their Productivity Bonus contributions?

Plan Members always receive 100% of their Productivity Bonus contributions paid by the applicable contractor/employer, less any applicable administration fee as described below.

How Do Plan Members receive their Productivity Bonus entitlement?

The Plan has an automatic pay out in December of each year. On or about December 1st of each year, the Plan Administration Office delivers a cheque to Local Union 27 for each eligible Plan Member, which includes all Productivity Bonus paid by the applicable contractor/employer for the Plan Member for the 12 month period ending October 31st. Direct Deposit of these benefits is also available by contacting the Plan Administration Office.

A statement of the Plan Member's Productivity Bonus account for the prior 12 month period is provided with the Productivity Bonus cheque and indicates the monthly contributions received for the Plan Member, and the contractor/employer that remitted them. An administration fee of $5.00 is charged by the Plan for every Productivity Bonus cheque issued.

Can the Productivity Bonus be paid out before December?

Plan Members have the option to receive one additional Productivity Bonus pay out each year. To request this optional pay out, the Plan Member must complete the Productivity Bonus Application, which is available from the Plan Administration Office.

The Plan does not issue optional pay outs within the 30 day period before or after December 1st (i.e., optional pay outs will not be issued by the Plan between November 1st and January 1st of the following year. Pay outs are not made during this period because the Plan is in the process of its annual automatic pay out. 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 Productivity Bonus cheque be reissued?

If a Plan Member has lost their Productivity Bonus Cheque, or if it becomes stale dated, the Plan Administration Office can reissue the payment upon request. An administration fee is charged by the Plan as established by the Trustees for any replacement Cheque.

Is the Productivity Bonus subject to Income Tax?

Any Productivity Bonus 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 any Productivity Bonus in the previous calendar year will receive an official tax form from the Plan that indicates the total amount of Productivity Bonus paid to the Plan Member in the prior calendar year.

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 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 contractor/employer signatory to an applicable collective bargaining agreement.

These Vacation Pay accounts are maintained on an annual basis from November 1st of each year to October 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 issues a cheque 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 the 60 day period 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 any Vacation Pay payment.

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 SERVICE 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.

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, 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 90 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 Productivity Bonus 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 covered under one of the Benefits of the Plan, the claim must be submitted to the Plant. Most types of claims can be submitted to the Plan in a variety of ways but all claims must be submitted properly, with all required 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 mail 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 should 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 files electronically. These random audits ensure the Plan is protected. You must therefore retain your receipts for 13 months.

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 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 claims).

All claims (with claim forms, original receipts and all other 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**
Accidental Death & Dismemberment	**Within 30 Days from the Date of the Accident**
Supplementary Health Care	**Within 12 months 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**
Productivity Bonus Plan	**Not Applicable**
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 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.

COORDINATION OF BENEFITS (COB)

The payment of Supplementary Health Care 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 to the Plan 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