CARPENTERS' RESIDENTIAL HEALTH AND WELLNESS PLAN

RETIRED MEMBER HEALTH PLAN
PLAN MEMBER INFORMATION BOOKLET

UP TO DATE AS OF SEPTEMBER 1, 2023

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INTRODUCTION

Dear Retired 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 Retired Member Health Plan (RMHP). This booklet also provides information on how to 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 term "Plan" refers to the "Carpenters' Residential Health and Wellness Plan". The use of the term "Fund" refers to the "Carpenters' Residential Health and Wellness Fund".

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 Retired Member Health 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 Carpenters' Residential Health and Wellness Plan and the Carpenters' Residential Health and Wellness Fund are governed by a Board of Trustees, appointed by the Carpenters & Allied Workers Local 27, and/or the Carpenters' Local 1030. The Board of Trustees of the Fund reserve the right to amend the Plan in their absolute and total discretion, as deemed appropriate and as permitted by law. Any change to the Plan will be communicated to 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 Manulife Financial Insurance Policy Number 10042. The Member Assistance Program (MAP) is administered by Family Services Employee Assistance Programs (FSEAP).

All other benefits described in this booklet are self-funded, with benefits being provided through the assets of the Fund, and are governed by the provisions of the Plan's official Plan documents. The Plan's insurance policies and self-funded 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 future reference. You may contact the Plan administration office should you have any questions about the benefits of the Retired Member Health Plan, including any of the Plan's rules or procedures.

SUMMARY OF BENEFITS

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.

Subject to the limitations and exclusions of the Plan's official documents, and as described throughout this booklet, eligible Plan members and their eligible dependants qualify for the benefits of the Retired Member Health Plan, which are described on the following pages, starting with the benefit summary below:

MEMBER LIFE INSURANCE BENEFIT

Plan Member:	$25,000

DEPENDANT LIFE INSURANCE BENEFIT

Spouse:	$10,000
Each Dependant Child:	$2,000

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 any may require prior authorization; 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). The Plan has an automatic switching policy that will pay for a lower cost biosimilar drug when approved by Health Canada.
Drug Maximums:	methadone treatment $1,000 lifetime; erectile dysfunction $500 per year; fertility drugs $2,500 lifetime.
Dispensing Fee Maximum:	$9.00 per prescription
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, acupuncturist, speech therapist, physiotherapist, naturopath, osteopath, or podiatrist
Psychologist:	$500 annual maximum (includes psychotherapist/social worker)
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 covered 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:	benefits are reimbursed based on the current suggested dental 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 dependant:

Basic and Major Services:	$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 covered each 5 years

MEMBER ASSISTANCE PROGRAM (MAP) BENEFIT

Confidential counseling, information, advice and referral services are available to Plan members and their eligible dependants. Services are provided by Family Services Employee Assistance Plan (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 EXTENSION OF BENEFITS PERIOD

Upon the death of an eligible Plan member, the eligible surviving dependants (i.e., 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 12 consecutive months. Monthly pay direct payments may be required to continue coverage during this extension of benefits period.

LEGAL SERVICES BENEFIT

Legal services covered by 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 section of this booklet for details of the maximum annual benefits payable, which are dependant on the type of legal service used. The Plan also has overall calendar year maximums for all legal services combined, which are dependant 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 provisions that apply, and the benefits available to eligible Plan members.

Carpenters' Residential Health and Wellness Plan
Benefits at a Glance
Retired Member Health Plan Summary (as of September 1, 2023)

Benefit / Benefit Provision	Retired Member Health Plan (RMHP) Benefit Description
General Plan Provisions	
initial eligibility	must be at least age 55 - various other eligibility rules apply
RMHP coverage options	**Plan A - Full Plan** (all benefits); **Plan B - Life Only Plan** (life insurance & member assistance program benefits)
monthly pay direct cost	determined by plan administrator based on age and lifetime contributions to the Health and Wellness Plan at retirement
dependant definition - spouse	legally married / common law - only one spouse is eligible under the RMHP (the spouse registered on file at retirement)
dependant definition - children	under age 22, or under age 25 if in educational institution
termination of coverage	non payment of any required monthly pay direct amount
Member Life Insurance	$25,000
Dependant Life Insurance	spouse $10,000, child $2,000
Supplementary Health Care	
deductible / overall maximum	none / unlimited
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	90% reimbursement for generic drugs, 80% for brand name, biologic and biosimilar drugs
pharmacist's dispensing fee maximum	$9.00
prescription drug reimbursement / maximums	based on the lowest cost between a biologic or its biosimilar drug (where a biosimilar drug is available - prior authorization 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 / year - chiropractor, osteopath, podiatrist, physiotherapist, naturopath, speech therapist, massage therapist, acupuncturist
psychologist / psychotherapist / social worker	$500 combined each calendar year
orthotics / orthopaedic shoes	$500/24 months for orthotics and $500/24 months for orthopaedic shoes
hearing aids	$500 each 36 months
vision care	$200/24 months for prescription lenses, frames, contact lenses or sunglasses (excludes safety glasses)
eye examinations	1 eye exam each 24 months when not available under a provincial plan
medical transportation services	emergency ambulance
medical supplies and services	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)	12 month extension - same pay direct rate (where applicable)
Dental Care	
deductible	none
reimbursement level	basic services 100%, major services 50%
annual maximum	$1,000 combined for basic and major services
dental fee guide reimbursement basis	current Ontario Dental Association (ODA) fee guide
basic services included	diagnostic, preventative, restorative, surgery, fillings, anaesthesia
complete examination	1 exam each 24 months
recall examination	1 exam each 6 months
1 complete series of x-rays	covered
1 set of bitewing x-rays	covered
polishing / 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)	12 month extension - same pay direct rate (where applicable)
Member Assistance Program	confidential counselling & advisory services
survivorship benefit (for dependants)	12 month extension - same pay direct rate (where applicable)
Legal Services	overall $1,000 calendar year maximum; various eligible legal services subject to specific maximums

ELIGIBILITY INFORMATION

ABOUT THE RETIRED MEMBER HEALTH PLAN (RMHP)

The Carpenters' Residential Health and Wellness Plan provides this Retired Member Health Plan for active Plan members who are retiring from the Union.

WHO MAY BECOME ELIGIBLE FOR THE BENEFITS OF THE PLAN

The benefits of this Retired Member Health Plan are provided only to eligible members in good standing and/or officers of Local 27 and Local 1030 of the Carpenters' union, who have met the eligibility requirements as described throughout this booklet.

A member's status in the union is determined by the union and the Board of Trustees. The Plan administration office will accept the union's determination of a member's status.

All qualified Plan members and their eligible dependants must be Canadian residents and must be covered under their applicable provincial government health care plan.

WHEN DOES A PLAN MEMBER BECOME ELIGIBLE FOR BENEFITS?

A Plan member's eligibility for the coverage of the Retired Member Health Plan is determined based on age, and the total amount of employer contributions made to the Fund on the Plan member's behalf. To become eligible for the benefits of the Plan, a Plan member must meet all of the following criteria.

- be at least 55 years of age;
- be properly enrolled in the Carpenters' Residential Health and Wellness Plan at the time of retirement;
- have a minimum of 10 years of eligibility as a Plan member in the Carpenters' Residential Health and Wellness Plan, of which the 5 years immediately prior to the date of retirement must be continuous;
- have a minimum of $20,000 of total employer/contractor contributions reported to the Plan on behalf of the Plan member;
- be a member in good standing of the Carpenters & Allied Workers Local 27 Shingling and Siding Division, or the Carpenters' Local 1030 union for a continuous 5 year period immediately prior to retirement, and remain a member in good standing throughout retirement;

- not be in receipt of the Plan's Long Term Disability, Special Disability Benefit or WSIB benefits on the date of retirement;
- satisfy the applicable union and Board of Trustees that they have retired from the trade in both a union and non-union capacity;
- complete an application to become enrolled in the Retiree Member Health Plan within 30 days of the date of retirement.

WHAT RMHP COVERAGE OPTIONS ARE AVAILABLE?

The following RMHP coverage options are available to eligible retiring Plan members.

Plan A – Full Plan

The Full Plan A option provides all of the benefits described in this booklet including Life Insurance, Dependant Life Insurance, Supplementary Health Care, Dental Care, Member Assistance Program Legal Services benefits.

Plan B – Member Life Only Plan

The Member Life Only Plan B option provides member Life Insurance, and the Member Assistance Program benefits.

Once a Retired Member Health Plan coverage option has been selected by the retiring Plan member, the Plan member may not change that option.

WHAT IS THE COST OF THE RETIRED MEMBER HEALTH PLAN?

The monthly costs of the two available Retired Member Health Plan (RMHP) coverage options are based on your age at retirement and the amount of lifetime contributions that have been made to the Fund on your behalf as outlined in the table below. Please contact the Plan administration office to receive a quotation for your monthly RMHP pay direct cost, applicable at the time of your retirement.

Retiring Age	Reported Lifetime Contributions at Retirement	Monthly RMHP Subsidy Provided	Monthly RMHP Pay Direct Cost
55 – 59	$20,000 or greater	0% of RMHP monthly cost	100% of RMHP monthly cost
60 or greater	$20,000 to $44,999	50% of RMHP monthly cost	50% of RMHP monthly cost
60 or greater	$45,000 or greater	80% of RMHP monthly cost	20% of RMHP monthly cost

The required monthly pay direct costs are continually monitored by the Board of Trustees and are subject to change as deemed necessary to maintain the Retired Member Health Plan.

To remain eligible under the Retired Member Health Plan, all monthly pay direct payments (including applicable provincial taxes) must be received by the Plan administration office when due. If the monthly pay direct payment is not received by the Plan administration office when due, coverage under the Retired Member Health Plan will terminate and cannot be reinstated.

BESIDES THE PLAN MEMBER, WHO ELSE CAN BE COVERED?

The eligible dependants 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, who was the Plan member's designated spouse enrolled under the Plan at the time of the Plan member's retirement; 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, and who was the Plan member's designated spouse enrolled under the Plan at the time of the Plan member's retirement.

Only the properly enrolled spouse of a Plan member at the time of their retirement will be considered an eligible spouse by the Plan. No new spouse will be considered eligible for RMHP benefits after a Plan member's enrolment in the RMHP. A spouse excludes a person divorced or separated from the Plan member.

Child / Children

a) each child (over 14 days of age with respect to Dependant Life Insurance) of a Plan member. A dependant child shall include children of the Plan member's marriage, legally adopted children, and step children. To be considered an eligible dependant, 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 dependant under this Plan since first becoming eligible, will continue to be considered an eligible dependant 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 be considered an eligible dependant 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 dependant shall remain covered beyond any limiting age for dependants, 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 retired Plan member's coverage, including coverage for any eligible dependants, will terminate under the Plan on the earliest of the following dates:

1. 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; or

2. the day a Plan member ceases to be a member in good standing of Carpenters' Local 27 or Local 1030, and is suspended or expelled; or

3. the day a Plan member commences active duty in the armed forces of any country, state or international organization; or

4. the date the applicable benefit, coverage or policy terminates.

Coverage for the eligible dependants of a Plan member will terminate at the same time that the retired 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 dependant's coverage will terminate if/when the dependant no longer qualifies as an eligible dependant as described above.

WHAT HAPPENS IF A RETIRED PLAN MEMBER RETURNS TO WORK?

To qualify for the Retired Member Health Plan (RMHP), a Plan member must satisfy their applicable Union and the Board of Trustees that they have retired from the trade in both a union and non-union capacity.

A retired Plan member who returns to work must notify their applicable union. The union will notify the Plan administration office who will present the circumstances to the Board of Trustees. The Trustees will then determine whether the Plan member's coverage under the RMHP may be continued, based on the type of work being performed.

A return to work may result in a termination of a Plan member's RMHP coverage. Once RMHP coverage is terminated it may not be reinstated. It is therefore recommended that any return to work being contemplated by a retired Plan member covered under the RMHP, particularly a return to work non-union within the jurisdiction of the union, be reviewed and approved beforehand by the union and the Board of Trustees.

If the retired Plan member's return to work is approved by the Board of Trustees, the employer contributions received by the Fund on the retired Plan member's behalf will be used to offset any monthly RMHP pay direct contribution that may be required to be made by the retired Plan member. Active Plan member coverage may not be reinstated once a Plan member becomes enrolled in the RMHP.

It is always the retired Plan member's responsibility to ensure all required RMHP pay direct contributions are received by the Plan administration office by the required payment due date to avoid a permanent termination of the Plan member's RMHP coverage.

DESCRIPTION OF BENEFITS

MEMBER 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 Form for enrolment in the Plan 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 Form and filing it with the Plan administration office.

The insurer will generally pay any life insurance benefit proceeds to the designated beneficiary on the last Member Information Form filed with the Plan administration office.

It is therefore very important to keep all personal information filed with the Plan administration office current and up to date, as well as to review your designated beneficiary to be sure it reflects your current intent.

TAXABILITY OF LIFE INSURANCE PREMIUM PAID

All Member Life Insurance premiums paid by the Fund on a Plan member's behalf are considered under Canadian taxation laws to be a "taxable benefit" to the Plan member in the calendar year in which it was paid. A person making RMHP pay direct payments to the Fund will have those payments deemed to offset any taxable benefits paid to the Plan member to reduce the taxable benefit received.

In February of each year, a Plan member who was covered under the RMHP in the previous calendar year, and who does have an applicable taxable benefit, will receive an official tax form (T4A) from the Plan administration office indicating the total amount of taxable benefit provided to the Plan member by the Fund in the prior calendar year.

The amount of taxable benefit received shown on the official tax form must be reported as income in the Plan member's annual income tax return.

LIFE INSURANCE CLAIM FORM REQUIRED

No benefit payment will be made unless a completed claim form and all other required documents are submitted to the Plan administration office and/or the applicable 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. Claim forms can be obtained from the Plan's website at www.carpentersresidential.ca.

DEPENDANT LIFE INSURANCE BENEFIT

In the event of the death of a covered Plan member's eligible spouse and/or dependant child(ren) the amount(s) of Dependant Life Insurance shown in the **Summary of Benefits** section of this booklet is(are) payable to the Plan member.

TAXABILITY OF DEPENDANT LIFE INSURANCE PREMIUM PAID

All Dependant Life Insurance premiums paid by the Fund on a Plan member's behalf are considered under Canadian taxation laws to be a "taxable benefit" to the Plan member in the calendar year in which it was paid. A person making RMHP pay direct payments to the Fund will have those payments deemed to offset any taxable benefits paid to the Plan member to reduce the taxable benefit received.

In February of each year, a Plan member who was covered under the RMHP in the previous calendar year, and who does have an applicable taxable benefit, will receive an official tax form (T4A) from the Plan administration office indicating the total amount of taxable benefit provided to the Plan member by the Fund in the prior calendar year.

The amount of taxable benefit received shown on the official tax form must be reported as income in the Plan member's annual income tax return.

DEPENDANT LIFE INSURANCE CLAIM FORM REQUIRED

No benefit payment will be made unless a completed claim form and all other required documents are submitted to the Plan administration office and/or the applicable 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. Claim forms can be obtained from the Plan's website at www.carpentersresidential.ca.

SUPPLEMENTARY HEALTH CARE BENEFIT

Plan members and their eligible spouse will receive the Plan's benefit card that may be used to submit claims for many of the Plan's eligible supplementary health care expenses. Using the Plan's benefit card eliminates the need to complete a claim form and provides immediate payment for certain eligible expenses.

All Plan members and their eligible dependants 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 charge incurred and the reasonable and customary charge.

PRESCRIPTION DRUG EXPENSES

The Plan reimburses eligible expenses up to the reasonable and customary charges of medically necessary 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 life sustaining drugs that do not require a prescription.

Some brand name, 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". If a new suitable biosimilar drug is approved, the Plan's automatic biosimilar drug switching policy will reimburse the

lowest cost biosimilar drug. The covered person can decide to continue with the biologic drug or switch to the biosimilar drug that the Plan will base reimbursement on.

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.
- medical marijuana including any derivative product except as listed under Medicinal Cannabis below.
- food and food products, including infant formula & foods, salt & sugar substitutes.
- general products or any other product which can be sold at any retail outlet including, but not limited to, such items as contact lens care, non-medicated shampoo, toothpaste, skin protectors, emollients and soaps.
- any single purchase of drugs which would not reasonably be used within 100 days from the date of purchase.
- drugs that have not been issued a Compliance Certificate and/or a Drug Identification Number by Health Canada whether or not they have been approved under a provincial formulary.
- drugs prescribed or issued to manage an illness or disability arising out of a workplace accident, disability or injury or due to an automobile accident.
- Ontario residents and other covered individuals age 65 and over will not be covered for drugs that would be covered for an Ontario resident under the Ontario Drug Benefit (ODB) provincial formulary or similar formulary. However, if the ODB or similar formulary covers the cost of a generic drug only and the physician prescribes an alternate drug and verifies in writing "no substitution allowed", the Plan will pay the cost difference if, based on prior authorization, it meets the qualifications and

provided the ODB plan denies the physician's request to have the applicable drug covered by the ODB plan.

- Ontario Drug Benefit (ODB) program annual deductible and dispensing fee (in excess of ODB maximums) are eligible under the Plan. The Plan will not otherwise reimburse expenses for drugs that are covered by the ODB program.

Medicinal Cannabis

Medicinal 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 medicinal 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 medicinal 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 in the **Summary of Benefits** section of this booklet.

Lenses, Frames and Contact Lenses

The maximum benefit payment that will be paid for each covered person is $200 in any consecutive 24 month period. Eligible vision care expenses, subject to the Plan's vision care maximum, include:

- prescription lenses, including tints and anti-reflective coatings
- frames
- prescription contact lenses
- prescription sunglasses

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

The maximum benefit payment for each covered person is $150 per calendar year, combined for all practitioners. Included are charges for the services of a licensed speech therapist, osteopath, chiropractor, physiotherapist, naturopath, registered massage therapist, acupuncturist, or podiatrist/chiropodist. Charges for surgery performed by a podiatrist are subject to a maximum benefit of $200 per person, per calendar year.

The combined maximum benefit payable for psychologist, psychotherapist and/or master social worker charges for each covered person is $500 per calendar year, subject to specific per visit limitations depending on the type of services received.

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 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.

SUPPLEMENTARY HEALTH CARE LIMITATIONS AND EXCLUSIONS

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

1. charges that are considered an insured service of any provincial health care plan or government plan at the time the policy/benefit was issued and subsequently modified, suspended or discontinued;
2. charges for general health examinations, and examinations required for use of a third party;
3. charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
4. charges for medical treatment or surgical procedure by a physician;
5. charges for transport or travel, other than as specifically provided under eligible expenses;
6. charges for services or supplies that are furnished without the recommendation and approval of a physician acting within the scope of their license;
7. charges that are not medically necessary for the care and treatment of any existing or suspected injury, disease or pregnancy;
8. charges that result from an occupational injury or disease covered by any WSIB law or similar legislation, including from an automobile accident;
9. charges that would not normally have been incurred but for the presence of this insurance or for which the covered person is not legally obligated to pay;
10. charges that the Plan is not permitted, by any law or regulation, including rules established by the Trustees to cover;
11. charges for dental work where a third party is responsible for payment for such charges;
12. charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
13. charges for services or supplies resulting from any intentionally self-inflicted wound;
14. charges for drugs, sera, injectable drugs or supplies that are not approved by Health Canada with a Compliance Certificate or that do not have a Drug

Identification Number (DIN) or are experimental or limited in use whether or not so approved;

15. charges for drugs, sera, injectable drugs or supplies when administered in a hospital setting, whether administered on an inpatient or outpatient basis;
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. charges for medicinal marijuana, including any derivative product except as described under Medicinal Cannabis above.

SURVIVOR BENEFIT COVERAGE EXTENSION FOR DEPENDANTS

Upon the death of a Plan member, the eligible surviving dependants (spouse and children) may continue to be covered for the Supplementary Health Care benefit for a period of up to 12 months. Monthly pay direct payments may be required to continue coverage during this coverage extension period.

SUPPLEMENTARY HEALTH CARE CLAIM DOCUMENTS REQUIRED

No benefit payment will be made unless a completed claim form and all other required documents are submitted to the Plan administration office within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this booklet. Claim forms can be obtained from the Plan's website at www.carpentersresidential.ca.

No claim form is required for claims processed with the Plan's benefit card and/or any online claim submission. Plan 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 online claims for 13 months.

DENTAL BENEFIT

Plan members and their eligible spouses will receive the Plan's benefit card that may 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 dental services
- 50% for major dental services

Dental Fee Guide

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

Medical Necessity and Reasonable and Customary Charges

Eligible dental care expenses are also based on medical necessity and reasonable and customary charges where applicable.

MAXIMUM DENTAL BENEFITS PAYABLE

Basic and Major Dental Services

The maximum dental benefit payable by this Plan for all dental care services combined is $1,000 per covered person, per calendar year.

ALTERNATE DENTAL BENEFITS

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

SUBMISSION OF A TREATMENT PLAN (PREDETERMINATION OF BENEFITS)

It is recommended that any proposed dental care expenses anticipated to exceed $500 be reviewed in advance, by the Plan administration office by submitting a Dental Treatment Plan.

As a service to Plan members, the Plan administration office will advise, in advance, of the amount the Plan will reimburse when a proposed course of dental treatment includes extensive dentistry.

To use this service, the covered person's dentist must complete a Dental Treatment Plan document 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 dependant children under age 13) per calendar year (combined with periodontal scaling and root planning);
- topical fluoride;
- passive space maintainers, those that do not move the teeth (for dependant 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 the Plan; or

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

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

Extensive Restorative Dentistry

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

Fixed Prosthetic Devices

The initial installation of fixed prosthetic devices is subject to the pre-existing condition limitations on teeth lost, extracted or fractured prior to becoming 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 the Plan; or

(b) the replacement is more than 12 months after the individual became insured under the 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 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.

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 the 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 DEPENDANTS

Upon the death of a Plan member, the eligible surviving dependants (spouse and children) may continue to be covered for the Dental Care benefit for a period of up to 12 months. Monthly pay direct payments may be required to continue coverage during this coverage extension period.

DENTAL CARE CLAIM DOCUMENTS REQUIRED

No benefit payment will be made unless a completed claim form and all other required documents are submitted to the Plan administration office within the specified time for submitting a claim. Please consult the **Claim Submission Deadline** provisions under the **General Plan Rules & Provisions** section of this booklet. Claim forms can be obtained from the Plan's website at www.carpentersresidential.ca.

No claim form is required for claims processed with the Plan's benefit card and/or any online claim submission. Plan 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 online claims for 13 months.

MEMBER ASSISTANCE PROGRAM (MAP) BENEFIT

The Plan's Member Assistance Program (MAP) is a confidential counselling, information, advice and referral service available to Plan members and eligible dependants. 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 dependants 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.ca**
- log-in using Group Name: **toloc27map**
- password: **myfseap1**

SUMMARY OF THE 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

MAP SURVIVOR BENEFIT COVERAGE EXTENSION FOR DEPENDANTS

Upon the death of a Plan member, the eligible surviving dependants (spouse and children) may continue to be covered for the Member Assistance Program benefit for a period of up to 12 months. Monthly pay direct payments may be required to continue coverage during this coverage extension period.

LEGAL SERVICES

The Plan's Legal Services benefit is intended to provide Plan members with financial assistance for a variety of commonly used, general legal services.

COVERED SERVICE SCHEDULE OF BENEFITS

The Plan's legal services benefits may not cover the full cost of legal services required by a Plan member. The schedule below indicates the maximum benefit payable for the specific 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 Plan, the 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 BENEFIT

In addition to the itemized maximum annual benefits payable noted in the covered services schedule of benefits above, the Plan also has a $1,000 overall maximum calendar year benefit for all itemized legal services combined.

A calendar year is the 12 month period commencing January 1st and ending December 31st.

Subject to the overall calendar year maximum benefit, a Plan member may claim one of each type of legal service described in the covered services schedule in each calendar year. The overall calendar year maximum benefit shall include any amounts paid in respect of legal services for a Plan member's dependants.

SELECTION OF LAWYER

Plan members choose their own lawyer. The Plan does not provide legal advice or recommend lawyers. The 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 Legal Services claim for reimbursement, 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 and must be submitted within 90 days from the date the expenses were incurred. Claims submitted after 90 days from the date the expense was incurred will not be considered eligible for reimbursement.

Payments from the Plan are made only to the member. The Plan will not issue payments to anyone else, including dependants, lawyers or legal firms.

TAXABILITY OF BENEFITS

All Legal Services benefit payments paid by the Fund to a Plan member are considered under Canadian taxation laws to be a "taxable benefit" to the Plan member in the calendar year in which they were paid. A person making RMHP pay direct payments to the Fund will have those payments deemed to offset any taxable benefits paid to the Plan member to reduce the taxable benefit received.

In February of each year, a Plan member who was covered under the RMHP in the previous calendar year, and who does have an applicable taxable benefit, will receive an official tax form (T4A) from the Plan administration office indicating the total amount of taxable benefit provided to the Plan member by the Fund in the prior calendar year. The amount of taxable benefit received shown on the official tax form must be reported as income in the Plan member's annual income tax return.

GENERAL PLAN RULES & PROVISIONS

PRIVACY POLICY STATEMENT

The Carpenters' Residential Health and Wellness Plan, its Plan administration office and providers working with the Plan or Plan administration office will collect, maintain, use and disclose only the information that is necessary for the administration of the Plan.

Personal information will be protected pursuant to the applicable legislation. The Plan may collect, maintain, use and disclose personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plan and entitlement to the benefits of the Plan, and may include information such as financial, health or benefits related information. Questions related to the Plan's Privacy Statement should be directed to the Plan's Privacy Officer.

Ryan Laird
Privacy Officer
Employee Benefit Plan Services Limited 45 McIntosh Drive
Markham, Ontario L3R 8C7
Tel: 905-946-9700
Toll Free: 1-800-263-3564
Fax: 905-946-2535
Email: rlaird@mcateer.ca

DESIGNATED BENEFICIARY

A Plan member has the right to name (or change) a designated beneficiary on their Member Information Form 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 policy(ies), 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 covered person.

All other indemnities of the policy(ies) 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 insurer(s) 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 dependant incurs an eligible expense covered under one of the benefits of the Plan, the claim must be submitted to the Plan. 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 prior to the applicable 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 Plan
45 McIntosh Drive
Markham ON
L3R 8C7

Eligible expenses for supplementary health care and dental should be claimed for by 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 retired Plan members when receiving their benefit card.

Plan 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.

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 for Life and Dependant Life 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. Claim forms can also be obtained on the Plan's website at www.carpentersresidential.ca.

MISREPRESENTATION & FRAUDULENT CLAIMS

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 incurred loss. It is also a serious offence if there has been misrepresentation concerning the eligibility of any dependants.

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 a fraudulent claim has been 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 – PROOF OF LOSS

All claims submitted to the Plan administration office and/or to the insurer(s) or service provider(s) for reimbursement must be submitted prior to the claim submission deadline applicable for each benefit.

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 / Dependant Life Insurance	**within 12 months from the date of death**
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**
Legal Services	**90 days from the date of the expense**

Failure to provide notice or furnish proof of claim within the claim filing deadlines stated above and as described throughout 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 insurer(s) 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 an applicable insurance policy is terminated, a claim must be submitted within 90 days following the date of termination.

LEGAL ACTION

A Plan member may not commence legal action against the insurer(s) of the Plan, service provider(s), 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, service provider(s), 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), service provider(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 dependants) do not exceed 100% of the eligible claim expense amount.

For this purpose, the insurer(s) 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" statement 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" statement from the spouse's plan so this Plan will know how much has already been paid by the spouse's plan.

3. If a dependant 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" statement 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.

APPEALS OF PLAN DECISIONS

In the event that the Plan or the Plan's insurer(s) and/or service provider(s) 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 file a claim appeal according to the Plan's Appeal Policy in care of the Plan administration office, which may be contacted for more information.

PLAN ADMINISTRATION OFFICE

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

The Trustees rely on the experience of the Plan administrator with respect to the eligibility for benefits of the Plan 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 Plan or the administrative rules about how the Plan works. 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