ONTARIO TEAMSTER CONSTRUCTION BENEFIT TRUST FUND

MEMBER BENEFITS INFORMATION BOOKLET

JANUARY 2024

Visit us online at www.otcbenefits.com

CUSTOMER SERVICE

The Trust Fund's Administrative Agent, Benefit Plan Administrators Limited (BPA), is available to assist you.

TRUST FUND'S WEBSITE

- Do you want up-to-date information regarding your benefits?
- Do you need a claim form?

Visit www.otcbenefits.com

CLAIMS CALL CENTRE

- Do you have questions about any of the benefits described in this booklet?
- Do you need a standard claim form?
- Do you want to follow up on a claim?

Phone 1-800-867-5615 or Email claims@bpagroup.com

PLAN ADMINISTRATOR

- Do you want to review the employer contributions received on your behalf?
- Do you need a (new) Member Information Card?
- Do you need a replacement Benefit Card?

Phone 1-800-867-5615 or Email administration@bpagroup.com

All phone and email messages will be returned no later than the end of the next business day.

ADMINISTRATIVE AGENT
BENEFIT PLAN ADMINISTRATORS LIMITED (BPA)

P.O. Box 3071, Station "A"
Mississauga, Ontario L5A 3A4

Phone Number: 905-275-6466
Toll-Free Number: 1-800-867-5615
Fax Number: 905-275-6462

CONTENTS

CONTENTS

INTRODUCTION

A MESSAGE FROM THE BOARD

This booklet describes the eligibility requirements, conditions of coverage and claims procedures for the Ontario Teamster Construction Benefit Trust Fund, which for descriptive ease is referred to in this booklet as the Trust Fund. The Board of Trustees is solely responsible for establishing the eligibility rules of the Trust Fund.

Please read this booklet carefully and keep it for future reference.

Effort has been made to ensure that the coverage descriptions in this booklet are current and consistent with the group insurance policies issued by the Insurance Companies and with related government Health coverages. However, this booklet is not, in itself, a legal contract, so it follows that the terms and conditions of the insurance policies, and of the governing legislation, take precedence in case of dispute. Any amendment to the governing documents is effective without notice to you. **Possession of this booklet does not guarantee entitlement to the benefits described herein.**

Should you require additional information on the benefits, please contact your Plan's Administrative Agent, Benefit Plan Administrators Limited (BPA).

The Trustees hope that the benefit coverage, provided by the Trust Fund, is of real value to you and your eligible Dependents.

The Board of Trustees

THE BENEFIT TRUST FUND

HOW IT WORKS

The benefits provided by the Trust Fund are purchased from insurance companies with contributions made by your employer on your behalf. These contributions are made to the Trust Fund as a result of a Collective Bargaining Agreement. You will be eligible for benefits as described in this booklet. The Board of Trustees looks after the Trust Fund.

The Trustees are responsible for the design of the benefit package provided by the Trust Fund and for the allocation of the contributions made to the Trust Fund. To help carry out their duties, the Trustees have appointed various people such as accountants, consultants and lawyers to provide them with professional advice. The Trustees meet with these advisors from time to time to review matters that arise in the running of the Trust Fund. The Trustees make all decisions that are necessary at these meetings by taking a vote amongst themselves. The daily administrative functions of the Trust Fund are performed by the Plan's Administrative Agent who is Benefit Plan Administrators Limited.

It is hoped that the Trust Fund will be continued indefinitely, but as is customary in group insurance Plans, the right of change or discontinuance at any time must be reserved.

GENERAL INFORMATION

The benefits described in this booklet may be revised from time to time or discontinued. Detailed information about benefits or other provisions of the policies or copies of those provisions may be obtained from the Administrative Agent.

The intent of this booklet is to give you details of your Benefit Trust Fund and the insurance benefits provided by the Fund. This booklet is not a legal contract and does not confer any contractual rights. Should any discrepancy arise between the wording used in this booklet and in the master policy, the master policy wording will take precedence. The information contained in this booklet is important and we suggest it be kept in a safe place.

ON THE IMPORTANCE OF BEING REGISTERED

It is absolutely essential that you complete an information card, which you can obtain from your Administrative Agent. On this card, you name the beneficiary/beneficiaries to whom your Life Insurance should be paid, in the event of your death. Members should list all Dependents that are eligible for benefits.

If you have already completed an information card and you have no desire to change your beneficiary/beneficiaries, it is not necessary for you to complete another card. You may change your named beneficiary/beneficiaries, subject to Provincial Law, by written request, filed with the Administrative Agent. The change will take effect as of the date such request was executed, but without prejudice to the insurance company for any payment(s) made before such request is received at its Head Office.

Please be sure to fully complete and sign the card, and return it to the Administrative Agent. It is extremely important that a completed card be on file, since claims cannot be paid on behalf of you, or your eligible Dependents, unless a card is on file.

After your insurance becomes effective, it is necessary for you to notify the Administrative Agent of any change in your Dependent or marital status. This information is necessary so that your coverage can be adjusted accordingly.

SUMMARY OF BENEFITS

Definition: Percentage Payable, also known as co-insurance, is the maximum percentage of your costs that the Trust Fund will reimburse you and your Dependents' covered expenses after any deductible is satisfied.

Definition: A Dispensing Fee is the dollar amount charged by the pharmacist to (re)fill each prescription.

Definition: Deductible is the amount of covered expenses which you must pay each calendar year before benefits are payable by the Trust Fund.

Definition: Lifetime Benefit Maximum is the maximum amount the Trust Fund will reimburse each person for the specified benefit(s) in his/her lifetime.

Definition: Calendar Year Maximum is the maximum amount the Trust Fund will reimburse each person for the specified benefit(s) in a single calendar year.

Definition: Unit is a 15-minute interval or any portion of a 15-minute interval of dental service.

Definition: Waiting Period, also known as the qualifying period or elimination period, is the length of time, if any, that must pass before income benefits (Weekly Wage Replacement and LTD) are payable.

Definition: Benefit Period is the length of time after the waiting period when income benefits (Weekly Wage Replacement and LTD) are payable.

Definition: Principal Sum is the total amount payable by the Trust Fund if you are diagnosed with a covered critical illness or if you die. In the case of dismemberment, a percentage of this amount is paid.

EXTENDED HEALTH For Eligible Members and their Dependents	
Percentage payable	100% except where noted
Deductible	NIL
Lifetime maximum	$1,000,000 per insured person
PRESCRIPTION DRUGS (Prescription Drug Card)	
Percentage payable	100% with a $6.50 dispensing fee maximum
Vaccines	Hepatitis A and B and Shingles are covered
Medical cannabis	$1,000 per calendar year for each Member and eligible Dependent
HEALTH PRACTITIONERS	
Reimbursement paid at 100% is based on the reasonable and customary fees per visit charged by each practitioner as determined by the insurance company every year.	
Regulated or Licensed Chiropractor, Osteopath, Chiropodist/Podiatrist, Physiotherapist, Acupuncturist, Naturopath, Registered Massage Therapist, Clinical Psychologist/Social Worker, Speech Therapist	$40 per visit per practitioner up to $400 per calendar year per practitioner, including x-rays For massage therapy, a prescription by a physician is required
OTHER HEALTH BENEFITS	
Ambulance service (local and air)	Covered (air ambulance is limited to $200 per calendar year)
Semi-private hospital	Covered
Convalescent/Rehabilitation hospital (within home province)	$10 per day up to 100 days per period of disability (disability must commence prior to age 65)
Out-of-hospital nursing	$10,000 per calendar year (pre-approval is required)
Accidental dental	$500 per tooth up to $5,000 per accident (covered within 12 months of accident)
Durable medical equipment and supplies such as:	
Breast prosthesis	Once per lifetime*
Custom-made compression hose	2 pairs per calendar year*
Surgical brassieres	2 pairs per calendar year*
Wigs	$500 per lifetime*
Glucose meter	Once every 4 years

**Reasonable and customary fees*

EXTENDED HEALTH continued For Eligible Members and their Dependents	
HEARING AIDS	
$500 in any 60 consecutive months (includes replacements and repairs, excludes batteries)	
ORTHOPAEDIC SHOES or ORTHOTICS	
One pair of custom-made orthopedic shoes or orthotics	$500 in any 36 consecutive months
VISION CARE	
Percentage payable	100%
Adults – one pair of prescription lenses and frames or contact lenses	$350 every 24 months, including 1 eye examination to a maximum of $50 for claimants between the ages of 19 and 64
Dependent children under age 18 – one pair of prescription lenses and frames or contact lenses	$350 every 12 months
Prescription contact lenses for special conditions, in lieu of lenses and frames	$200 every 24 months

EXPEDITED ACCESS TO HEALTHCARE For Eligible Members and their Dependents
Expedited access to diagnostic scans and specialist consultations.

EMERGENCY TRAVEL MEDICAL For Eligible Members and their Dependents Terminates at Age 80	
Lifetime maximum under age 75	$5,000,000
Lifetime maximum ages 75 to 80	$1,000,000
Limited to trips of 90 consecutive days. Internal maximums may apply.	

MEMBER & FAMILY ASSISTANCE For Eligible Members and their Dependents
Confidential and professional counselling and referral services.

MENTAL WELLNESS For Eligible Members and their Dependents
Psychological treatment and care.

HOSPITAL CASH For Eligible Members and their Dependents Terminates at Age 70	
Benefit amount	$150 per day for a maximum of 120 days and up to $18,000
Patient must be in hospital for more than 3 consecutive days.	

Dental
For Eligible Members and their Dependents

Reimbursement is based on the general practitioner's provincial fee guide of your home province for the year recognized by the Trust Fund at the time the service is rendered.

Percentage payable	
Routine procedures	100%
Routine oral surgery	100%
Dentures – Initial placement and relines/rebases/repairs	100%
Dentures – Replacement	80%
Major procedures	80%
Extensive oral surgery	80%
Fixed prosthetics	80%
Orthodontic (for Dependent children under age 19)	50%
Deductible	NIL
Lifetime maximum	$2,500 for orthodontic
Calendar year maximum***	$2,500 per insured person for all procedures

***The dental maximum varies in the Member's first year of insurance:

Insurance effective between January 1 and March 31	$2,500
Insurance effective between April 1 and June 31	$1,500
Insurance effective between July 1 and September 30	$1,000
Insurance effective between October 1 and December 31	$500

ROUTINE PROCEDURES	
Complete oral examination	Once every 24 months
Recall or specific examination	Once every 6 months
Full mouth and panoramic x-rays	Once every 24 months
Polishing and fluoride application	Once every 6 months
Oral hygiene instruction	Once every 6 months

DENTAL continued
For Eligible Members and their Dependents

DENTURES

Relines/rebases/repairs	Once every 36 months
Replacements	When the existing appliance is at least 5 years old and unserviceable, or at least 12 months old if the existing appliance is a covered temporary appliance.

For initial dentures, teeth extraction or fracture must have occurred after the effective date of coverage by the Trust Fund.

WEEKLY WAGE REPLACEMENT
For Eligible Members ONLY

This is non-occupational (not work-related) coverage.

Waiting period	7 days for illness 0 days for accidents 0 days for hospitalization
Benefit amount	$668 per week
Benefit period	26 weeks, inclusive of 26-week Employment Insurance (E.I.) Sickness benefit period (benefit terminates at retirement)

This is a taxable benefit.

LONG TERM DISABILITY
For Eligible Members ONLY

This is non-occupational (not work-related) coverage.

Waiting period	26 weeks plus any E.I. period if you are eligible
Benefit amount	$1,500 per month
Benefit period	To the earlier of age 65 or retirement

This is a taxable benefit.

CRITICAL ILLNESS
For Eligible Members ONLY
Terminates at Age 70

Principal sum	$20,000

Covers only specific conditions.

LIFE For Eligible Members	
Eligible member	$100,000, reduces to $50,000 at age 80
Dependent spouse	$20,000
Dependent child	$10,000
ACCIDENTAL DEATH & DISMEMBERMENT For Eligible Members Terminates at Age 70	
Principal sum	$100,000
Dependent spouse	$50,000
Dependent child	$15,000
BEREAVEMENT PAY For Eligible Members ONLY	
Benefit amount	Up to 8 hours per day at the Member's regular rate of pay for straight time, to a maximum of 3 days

GROUP LEGAL
For Eligible Members and their Dependents

Legal services by Registered Paralegals or Lawyers.

GENERAL PROVISIONS

MEMBER ELIGIBILITY

To qualify for coverage you, and your eligible Dependents, must be insured under a provincial health plan. You must also maintain your membership in good standing with your Teamsters Local. The Plan's Administrative Agent keeps an account for you of the hourly contributions made by your employer on your behalf. This account is called a 'Dollar Bank Account'. The balance in this account determines your eligibility for benefits. Each month a deduction is taken from your dollar bank account to "pay" for your benefits. From time to time the Trustees will alter the amount of the monthly deductions when required to prudently manage the Benefit Trust Fund.

You become eligible for coverage under the Trust Fund when you have accumulated 2 monthly deductions in your dollar bank. Your coverage is effective on the first day of the second month following that accumulation. Your coverage continues for each month your dollar bank contains the required monthly deduction. The maximum dollar bank balance is 24 monthly deductions.

If you are absent from work because of disability due to illness or injury on the date your coverage, or any increase in your coverage, would otherwise become effective, such coverage will not become effective until the date you return to active full-time work for 1 full day.

CHANGE OF YOUR STATUS

As advised in the booklet section entitled On the Importance of Being Registered, it is your responsibility to notify the Administrative Agent of any change of your status (married, separated, divorced, new Dependents, etc.) to ensure that proper coverage is maintained.

DEPENDENT ELIGIBILITY

Your Dependents become eligible for coverage when you become eligible or, if acquired later, upon becoming your Dependent. To qualify for coverage your eligible Dependents must be insured under a provincial health plan. Newborn children are eligible for Dependent Life Insurance and Hospital Cash Benefits from 15 days of age and for all other coverage from birth, provided you advise the Administrative Agent within 31 days of the birth.

You must be a covered Member of the Plan and eligible for benefits in order for your Dependents to be covered.

Coverage or any increase in coverage, for your Dependent who is confined for medical treatment in any institution or at home on such date such coverage would otherwise become effective, will not become effective until given a final release by the physician from all such confinement. This shall not postpone the effective date for a child born while the Member's Dependents are insured under the Plan.

Definition: Dependent spouse means:

- A person lawfully married to you according to applicable provincial legislation – and residing with you,
- A person living with you in a common-law relationship for a minimum period of 12 consecutive months, who is publicly represented as your spouse, or
- The person to whom you were most recently married if you have been married to more than one person.

A former spouse is not eligible for coverage unless insurance protection for some of the benefits available under this Plan is mandated by court order. A former spouse is not eligible if your current spouse is covered under this Plan.

File a new Member Information Card every time your marital status changes.

Definition: Dependent child means:

- Your unmarried child (over 14 days of age for the Hospital Cash and Life Insurance Benefits only) and under 21 years of age provided he/she is not working more than 30 hours a week,

- Your unmarried child under 25 years of age provided he/she is not employed on a regular full-time basis and he/she is in full-time attendance at a university or similar institution (annual proof of student registration is required after the child reaches age 21), or
- Your natural child, legally adopted child, stepchild, or child of your spouse provided your spouse lives with you and has custody of the child and provided the other requirements are satisfied, and

A child as outlined above must be solely depending on the Member for support.

File a new Member Information Card every time your Dependent status changes.

Note: Coverage for dependent children is extended for drugs to age 26, if a full-time student and a resident of Quebec.

CONTINUATION OF COVERAGE FOR FUNCTIONALLY IMPAIRED CHILDREN

Extended Health Care, Dental Care and Dependent Life coverage will continue beyond the date an unmarried child attains the limiting age for coverage, provided proof is submitted to the insurance company within 31 days after such date that such child:

- Is incapable of self-sustaining employment by reason of functional impairment,
- Became so incapacitated prior to attainment of the limiting age, and
- Is wholly dependent upon you for support and maintenance.

Thereafter, such proof must be submitted to the Insurer, as required.

MAINTAINING COVERAGE

Your benefit coverage remains in force for every month your dollar bank account holds at least one monthly deduction.

DIRECT PAYMENTS (UNDER AGE 65)

In the event of lay-off or termination of employment, you may continue your insurance by making your own contributions directly to the Trust Fund. You may remit direct payments for up to 6 months at any one time. You must take advantage of the Direct Payment option when you first become eligible to do so.

All benefits may be continued by the Direct Pay method described above except for the Weekly Disability Income and Long Term Disability Benefits.

FUND ASSISTANCE (UNDER AGE 65)

In the event that you become disabled and are unable to work, your dollar bank will be frozen and your benefits will be maintained by the Trust Fund for up to 12 months, providing you are in receipt of Weekly Wage Replacement Benefits, LTD Benefits, *Workplace Safety and Insurance Board (WSIB) Benefits, *Motor Vehicle Insurance Disability Benefits, or Disability Pension Benefits.

*Proof of acceptance and monthly benefit payments for your WSIB Benefits or Motor Vehicle Insurance Disability claim must be submitted to the Administrative Agent. It is your responsibility to contact the Administrative Agent to confirm your continuing coverage.

Following a period of Fund Assistance, you may remain eligible for benefits if you have sufficient credits in your Dollar Bank to cover the monthly deduction. If your credits are insufficient, you have the option to make Direct Payments as per the above Direct Pay provision. Once you have exhausted the credits in your Dollar Bank you may be eligible for a further extension of the Extended Health Care, including Vision Care, and Dental Care Benefits, to a maximum of 4 additional years but only if you are approved for Waiver of Premium under the Life Insurance Benefit described later in this booklet.

Note: The Direct Payment and Fund Assistance Provisions cease upon your attainment of age 65.

TERMINATION OF COVERAGE

Your insurance will cease as follows:

- The date the Group Master Policy is cancelled or terminated,
- The last day of the month in which your dollar bank does not contain a full monthly deduction,
- The date you retire,
- The last day of any month in which you have made the maximum number of contributions under the “Direct Payments” option, but not beyond your attainment of age 65,
- The last day of any month in which you have exhausted the benefit extensions provided under the “Fund Assistance” provision, but not beyond your attainment of age 65,
- The first of the month following the month in which you attain the benefit age limit which may be set out in the “Summary of Benefits”, or
- The date you cease to be in a class of persons who may be insured under this policy.

On termination of your coverage you may have the option to convert a portion of your Life Insurance coverage to an individual Life Insurance Policy. For more details please refer to the “Life” section.

In the event that you are disabled, or if you die, some benefits may be extended to you or your Dependents. Please refer to the specific benefit descriptions in this booklet.

Coverage for your Dependents will terminate on the date such Dependent ceases to meet the Dependent eligibility requirements.

REINSTATEMENT OF COVERAGE

Your coverage will be reinstated after a period of termination when you have accumulated 2 monthly deductions in your dollar bank. Your coverage is effective on the first day of the second month following that accumulation.

EXTENDED HEALTH

The benefits described in this section apply to both the eligible Member and their eligible Dependents.

The Extended Health Care benefit is designed to provide valuable supplementary protection but not to duplicate the Provincial Hospital and Medical Care Plans under which an individual is or could be protected. Therefore, the Extended Health Care Insurance excludes 1) services and supplies to the extent benefits can be obtained for them under a provincial Plan by fulfilling the requirements of that Plan, and 2) services and supplies where private insurance is prohibited. Additional exclusions are listed under “Limitations” at the end of this section. You should read the “Covered Expenses” with these exclusions in mind. Before incurring any major expenses, you may submit details to the Claims Department that will inform you what benefits, if any, are available under the Plan.

COVERED EXPENSES

This insurance applies to expenses you are required to pay for the treatment of pregnancies and non-occupational accidents and sicknesses. The charges will only be considered eligible expenses provided the charges are reasonable and customary. The supplies or services must be medically necessary and prescribed by a physician, or other qualified medical practitioner deemed appropriate by the insurance carrier. A medical expense shall be deemed incurred as of the date the service or supply is furnished to you, and you must be covered on that date for the expense to be considered. The insurance will pay the following covered expenses incurred by you or an eligible Dependent **up to the limits described below and set out in the "Summary of Benefits"**.

BENEFIT CARD

You and your spouse will be provided with a Benefit Card which may be used for all covered prescription drug and health care practitioner services. You may use any pharmacy and health care practitioner in Canada that will accept your card. This card may also be used for dental care.

PRESCRIPTION DRUGS

The following are some reimbursable prescription drug expenses:
Drugs including injectables, which are medically necessary, legally require a written prescription from a physician in order to be purchased, and are dispensed by a Licensed Pharmacist, or physician legally authorized to dispense such drugs, plus drugs that regardless of their legal status are not normally sold except by prescription. These drugs must be prescriptive, restrictive, controlled or narcotic in nature. Included are diabetic supplies, such as sensors for flash glucose monitoring machines, and oral contraceptives. Also included are substances used for injections, except when required for recreational or lifestyle reasons, such as non-work related travel.

In an effort to contain costs, it is requested that generic drug substitutes be used whenever possible. The maximum single purchase of drugs that will be considered is the amount that would reasonably be consumed within 34 days except for certain maintenance drugs that would reasonably be consumed or used within 100 days of the date of purchase.

When filling a prescription, present your Prescription Drug Card to the pharmacist who will use the information on the card to submit a claim electronically on behalf of you or your eligible Dependents. Immediately, your claim will be processed, and the pharmacy will receive notification of which expenses are reimbursable.

An Assure claims check is done before a prescription is dispensed. Depending on the outcome of these checks, the pharmacist may refuse to dispense the prescribed drug.

MEDICAL CANNABIS

Cannabis for medical purposes is covered for you and your Dependent when:

- Prescribed to treat one of the following 6 conditions: Anorexia, nausea/vomiting from chemotherapy, neuropathic pain (chronic), palliative care, spasticity, and spinal cord injury;
- A valid authorization has been issued by a Clinical Cannabis Physician;

- A valid prior authorization has been approved;
- A registration with Heath Canada under the Access to Cannabis for Medical Purposes Regulations has been completed;
- The product is purchased from a Licensed Producer in the province of Ontario;
- Provided that all other requirements under the Cannabis Act and Cannabis Regulations have been complied with.

Members and their eligible Dependents may use any Licensed Medical Cannabis Provider. Prior approval is required.

The limitations that apply to coverage for drugs and drug supplies apply with equal force to coverage for medical cannabis, except that cannabis for medical purposes does not require a drug identification number as defined by the Food and Drugs Act, Canada.

Active Members aged 65 and over will continue to be eligible for the same level of drug coverage as those active Members under age 65. These Members are required to claim through the Ontario Drug Benefit (ODB) first. The Trust Fund will cover the deductible and any drugs eligible under the Plan that is not included in the ODB formulary.

Note: The Trustees reserve the right to modify the drug formularies and definition at any time in the future, in order to deliver the benefit in a contemporary fashion.

PRESCRIPTION DRUG LIMITATIONS

The following drug expenses are not reimbursable except to the extent otherwise required by law:

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment;
- Non-disposable insulin delivery devices or spring-loaded devices used to hold blood letting devices;
- Delivery or extension devices for inhaled medications;
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions;

- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances, except for intrauterine devices (IUD's), rings and patches;
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada;
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered;
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital;
- Non-injectable allergy extracts;
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason;
- Smoking cessation drugs and products;
- Fertility drugs;
- Drugs used to treat erectile dysfunction;
- Drugs or drug supplies not listed in the *Liste de medicaments* published by the *Régie de l'assurance-maladie du Québec* in effect on the date of purchase or which are received out-of-province, when prescribed for a dependent child who is a student over age 25 and you are a resident of Quebec.

  Note: If you are age 65 or older and reside in Quebec, you cease to be covered under this Plan for basic prescription drug coverage and are covered under the basic Plan provided by the *Régie de l'assurance-maladie du Québec,* unless you elect to be covered under this Plan as set out below.

  A one-time election may be made to be covered under this Plan. You must make this election and communicate it to your employer by the end of the 60-day period immediately following:
  - The date you reach age 65, or
  - The date you become a resident of Quebec, within the meaning of the health insurance act, Quebec, if you are age 65 or over.

While your election to be covered under this Plan is in effect, you will be deemed not to be entitled to the basic Plan provided by the Régie de l'assurance-maladie du Québec. "Basic prescription drug coverage" means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec*.

Definition (for Extended Health only): Basic prescription drug coverage means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec*.

HEALTH PRACTITIONERS

Health practitioner services, including x-ray charges, are covered for a Regulated or Licensed Chiropractor, Osteopath, Chiropodist/Podiatrist, Physiotherapist, Acupuncturist, Naturopath, Registered Massage Therapist, Clinical Psychologist/Social Worker or Speech Therapist, acting within the scope of their licences. A physician must prescribe the services of a Registered Massage Therapist as to duration and type.

No amount will be paid for any health care practitioner services until any applicable provincial health plan benefit is exhausted.

OTHER HEALTH BENEFITS

Ambulance
Reimbursable expenses are for ambulance services within Canada, including emergency air ambulance services, in excess of the amount payable under the insured person's provincial health plan. The services must be required to transport the person from the place of injury (or where illness struck) to the nearest hospital where treatment is available, or directly from that hospital to the nearest hospital for needed specialized treatment not available at the first hospital, or from hospital to a convalescent/rehabilitation hospital.

Semi-Private Hospital
Room and board expenses in excess of the charges for ward accommodations in a licensed Canadian hospital are covered.

Convalescent/Rehabilitation Hospital (within Home Province)
Daily room and board in excess of ward rate is covered provided the individual is admitted to the convalescent hospital immediately following a minimum 3 consecutive day confinement in a hospital. The confinement must be for the continued care of the same condition for which the patient was hospitalized. All confinements in a convalescent hospital will be considered as one period of disability unless confinements are separated by at least 90 days. Disability must commence prior to age 65.

Out-of-Hospital Nursing
Reimbursable expenses are for the services of a Registered Nurse (R.N.), while the patient is not confined to a hospital. The nursing service must have been ordered by a physician as medically necessary and requiring the specialized training of a Registered Nurse. The nurse must not ordinarily reside in the Member's home or be a member of the family. Charges for services which do not require the specific skills of a Registered or Practical Nurse are not covered. Treatment must be acute, convalescent or palliative care.

Coverage is subject to obtaining pre-approval. For pre-approval, you should ask your physician to submit a letter to the Administrative Agent. A physician's letter should contain the following information:

- A description of your or your eligible Dependent's current medical condition and prognosis,
- A list of the required nursing services and their frequency,
- An indication of the level of skill required to perform the required services, meaning those of a Registered Nurse (RN), Registered Nursing Assistant (RNA) or Registered Practical Nurse (RPN),
- The number of hours of care required per day or week, and
- An estimate of the length of time care will be required.

Pre-approval of out-of-hospital nursing services is subject to all insurance contract provisions and eligibility for benefits on the date the service is performed for the expense to be reimbursable.

Dental Care for Accidental Injury
Reimbursable expenses are for necessary dental care by a Licensed Dentist for the prompt repair of sound natural teeth when required for a non-occupational accidental injury, external to the mouth, which occurs while insured. The dental work must be completed within 12 months of the accident to be a covered medical expense.

Diagnostic Laboratory and Imaging Procedures
Services performed in the insured person's province of residence are covered when that type of procedure is not listed as an insured procedure under their provincial government plan. For greater certainty, a procedure is not eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under their provincial government plan.

Durable Medical Equipment and Supplies
Reimbursable expenses are for the rental or, at the option of the insurance company, the purchase of durable medical equipment and supplies of the type and model adequate for the insured person's medical needs based on the nature and severity of the disability, such as but not limited to:

- Hospital beds,
- Wheelchairs, canes, crutches, walkers and trusses,
- Rigid or semi-rigid braces for back, neck, arm or leg and non-dental prosthesis, such as artificial limbs and eyes, a surgical corset, including replacement if required because of a change in physical condition,
- Respiratory equipment, including oxygen,
- Splints, casts, catheters, and hypodermic needles,
- Plasma, blood or blood substances,
- Breast prosthesis,
- Purchase of surgical brassieres when required following a mastectomy,
- Custom made Compression Hose, excluding elastic stockings,
- Wigs,
- Glucometer, and flash glucose monitoring machines when insulin-dependent,
- Non-oral contraception devices such as intrauterine devices (IUD's).

Not eligible are items of personal comfort, convenience, exercise, safety, self-help or environmental control items, or items which may also be used for non-medical reasons, such as, but not limited to heating pads or lamps, communication aids, air conditioners or cleaners, and whirlpool baths or saunas.

Before incurring any major expenses, you are encouraged to submit details to the Claims Office to determine to what extent benefits are payable. In any event, a letter will be required from a Licensed Physician describing the nature of the disability and the type, medical need and estimated duration of any required durable medical equipment.

Note: The Ontario Assistive Devices Program may provide partial reimbursement for certain expenses listed above, e.g. prosthetic devices, respiratory equipment, hearing aids, wheelchairs, hospital beds, etc. Further information regarding this program may be obtained by calling 1-800-268-6021.

HEARING AID

The purchase of a hearing aid, including replacement and repair, is reimbursable when provided by a Certified Clinical Audiologist. The financial limit does not apply in the event of an accidental injury to the ear. Batteries are not covered.

ORTHOPAEDIC SHOES OR ORTHOTICS

Reimbursable expenses are for orthopedic shoes (including repairs) and orthotics which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

- A diagnosis, including list of symptoms and the primary complaint,
- A description of the physical findings from the clinical examination,
- A brief description of the gait abnormality associated with the diagnosis, and

- Confirmation that the product has been custom-made, including a copy of the detailed lab invoice issued to the provider by the manufacturer of the custom-made shoe or orthotic.

In order to be eligible for reimbursement, orthopedic shoes and orthotics device must be prescribed by either a Licensed Physician or Chiropodist/Podiatrist on an annual basis, and dispensed by a Licensed Physician, Chiropodist/Podiatrist, Orthotist or Pedorthist.

VISION CARE

Reimbursable expenses are for one pair of lenses and frames or contact lenses, when prescribed by a legally qualified ophthalmologist or optometrist.

The vision care maximum includes one eye examination performed by a Licensed Ophthalmologist, Optometrist or Optician in any period of 24 consecutive months, for claimants between the ages of 19 and 64.

Prescribed contact lenses for special conditions such as severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia, in lieu of lenses and frames, are covered under this benefit when vision in the better eye cannot be corrected to the 20/40 level by glasses.

No amount is payable for replacement of lost or stolen glasses, broken glasses, duplicate glasses, safety glasses, sunglasses, anti-reflective coatings, or tints other than No. 1 and No. 2.

LIMITATIONS

The following charges are not reimbursable, except to the extent otherwise required by law:

- Expenses private insurers are not permitted to cover by law;
- Services or supplies for which a charge is made only because you have insurance coverage;
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan;

- Services or supplies that do not represent reasonable treatment;
- Services or supplies associated with:
    - Treatment performed only for cosmetic purposes,
    - Recreation or sports rather than with other daily living activities,
    - Contraception other than contraceptive drugs and products containing a contraceptive drug, and contraceptive appliances such as intrauterine devices (IUD's), rings and patches.
- Services or supplies not listed as covered expenses;
- Extra medical supplies that are spares or alternates;
- Services or supplies received outside Canada;
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and the insurer would have paid benefits for the same services or supplies if they had been received in your home province;
- Expenses arising from war, insurrection, or voluntary participation in a riot;
- Services related to chronic care;
- Vision care services and supplies required by an employer as a condition of employment;
- Charges for examinations required for use by a third party;
- Charges for services and supplies which are provided without the recommendation and approval of a physician;
- Charges made by a physician for travel, broken appointments, communication costs, filling out forms or physician's supplies;
- Charges for eye examinations except where included as a reimbursable expense;
- Charges for medical treatment or surgical procedure by a physician;
- Charges for transport or travel, other than as specifically stated under reimbursable expenses;
- Charges which are from an occupational injury or disease covered by workplace safety and insurance law or similar legislation;
- Charges for dental work except as provided by under the "Accidental Dental" provision or where a third party is responsible for payment of such charges;

- Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society.

CONTINUATION OF COVERAGE IF AN ELIGIBLE MEMBER DIES

Extended Health Care coverage for eligible Dependents shall continue without premium payment following your death up to a maximum of 24 months from the date of death to the earliest of the following dates:

- ✓ The date your Dependent ceased to be eligible,
- ✓ The date your widow remarries, or
- ✓ The date the insurance contract or coverage is cancelled or terminated.

Any extended benefits payable are subject to the provisions and limitations of the Plan.

EXPEDITED ACCESS TO HEALTHCARE

The QuikCare Platinum Expedited Access to Healthcare Program described in this section applies to eligible Members and their eligible Dependents.

Canadian medical specialists are limited to how many new patients they are able to diagnose each month, due to budgetary constraints with the Canadian Healthcare system. This creates average wait times of over 8 months to see a specialist and over 3 months for a diagnostic scan.

The QuikCare Platinum Expedited Access to Healthcare Program is designed to assist you so you can focus on taking care of your well-being. It assists in the alleviating the pain and worrying and returning you to a healthier life.

HOW THE PROGRAM WORKS

The program provides a unique healthcare benefit by allowing those who are placed on a medical wait list, immediate access to diagnostic scans (MRI/CT Scans) and specialist consultations with the cost fully covered. It will give you peace of mind knowing diagnostic scans will be booked and performed within 72 hours and you will see specialists within weeks not months.

All that is required for you or your eligible Dependents to rapidly access expedited health care treatment is a diagnostic requisition form or a specialist referral from your physician. QuikCare will liaise with you to attain the required documentation and utilize a network of specialists and diagnostic imaging services to coordinate and pay for the required services. Fees for diagnostic testing and specialist consultations are paid by QuikCare directly to health care providers. You **do not** have to pay for your health care treatment and then seek reimbursement.

COVERED SPECIALISTS	
• Cardiologist	• Neurosurgeon
• Gastroenterologist	• Ophthalmologist
• General surgeon	• Rheumatologist
• Neurologist	• Urologist

COVERED SERVICES	
• Cardiology	• Neurosurgery
• CT Scan	• Ophthalmology
• Ear, Nose and Throat	• Orthopedics
• Gastroenterology	• Rheumatology
• General surgery	• Ultrasound
• MRI	• Urology
• Neurology	

HOW TO USE THE PROGRAM

Once you receive a physician's diagnostic requisition or a physician's referral letter for a specialist, simply call the QuikCare Platinum Dedicated Helpline, which is available 24 hours a day, 7 days a week, at the following toll-free number:

- Toll-free number **1-844-900-8357**

You **must** call the helpline in advance of receiving a diagnostic procedure or specialist consultation and obtain approval from the Case Management Team in order to have your expedited health care arranged and paid for.

The Case Management Team will coordinate with you or your eligible Dependents to acquire the required documentation and assist you in every step.

QuikCare will then arrange the required expedited health care and will advise you or your eligible Dependents of the appointment time and location.

Following the scan or specialist appointment, the Case Management Team will contact you and ensure the results are sent to your physician and to arrange any further treatment.

ADDITIONAL INFORMATION

For more information, obtain a separate brochure from the Trust Fund's website or the Administrative Agent.

EMERGENCY TRAVEL MEDICAL

Coverage for this benefit is available on an emergency basis only. It provides benefits for covered losses resulting from injury or sickness occurring during the first 90 consecutive days of a trip outside of the province of residence, subject to the following provisions and exclusions. An eligible spouse and each eligible dependent child is insured for the same coverage as the Member. In no event will coverage extend beyond age 80.

When injuries or sickness result in Emergency Hospital Confinement or require Emergency Medical or Therapeutic Services as listed herein, benefits will be paid up to the maximum shown in the “Summary of Benefits”, for the actual expenses incurred outside the province of residence, that exceed the amount which is payable with respect to such expenses under any government hospitalization or medical care plan in Canada, or if an insured person is not covered under any such plan, to the extent they exceed any amount which would be payable with respect to such expenses under the government hospitalization or medical care plan if he or she were covered under any such plan.

EMERGENCY HOSPITAL CONFINEMENT

If you are confined as a resident inpatient in a hospital, reimbursement will include those reasonable and customary charges made by the hospital for services rendered and supplies provided, including semi-private accommodation, to the extent that they are medically necessary.

In the event that an insured person is confined to hospital at the end of his/her trip outside the province of residence and thus prevented from returning to the province of residence, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first covered expense was incurred.

EXTENDED COVERAGE AFTER TERMINATION

In the event of the delayed arrival of a common carrier or hospitalization of the insured person, this benefit will automatically be extended at no charge: 1) 24 hours in the event of a delayed common carrier, 2) the period of hospitalization plus 72 hours after the insured person is released from hospital.

EMERGENCY MEDICAL AND THERAPEUTIC SERVICES

Benefits are payable for reasonable and customary charges to the extent they are medically necessary, for the following:

- The services of a legally qualified physician or surgeon (other than an immediate family member of the insured person);
- Laboratory tests and x-ray examination ordered by a legally qualified physician for the purpose of diagnosis;
- The services of a Registered Graduate Nurse (other than an immediate family member of the insured person), up to a maximum of 50 nursing shifts at a fee, but not to exceed $100 per shift;
- Rental of crutches or hospital type bed, or the cost of splints, canes, slings, trusses, braces or other approved prosthetic appliances;
- The services of a legally qualified anaesthetist;
- Drugs or medicines that require a legally qualified physician's written prescription;
- Services of a chiropodist, chiropractor, osteopath, physiotherapist, or podiatrist (other than an immediate family member of the insured person) up to a maximum of $300 for each class of practitioner;
- Expenses for accidental injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires treatment by a legally qualified dentist or dental surgeon within 30 days from the date of the accident, not to exceed in the aggregate the amount of $2,000 as the result of any one accident;
- Out-patient services provided by a hospital.

REPATRIATION BENEFIT

If an insured person suffers injury or sickness resulting in loss of life and:

- Such loss of life occurs outside his/her province of residence, and
- Such loss of life occurs within 365 days of the date of the accident causing the injury or sickness causing loss of life,

the Insurer will pay the actual expenses incurred for preparing the deceased insured person for burial or cremation and shipment of the body to the city of residence of the deceased insured person.

The maximum amount payable for Repatriation is $15,000 per insured person.

IDENTIFICATION BENEFIT

If an insured person suffers injury or sickness resulting in loss of life and the insured person's body requires identification, the Insurer will pay the reasonable and necessary expenses actually incurred by one member of the immediate family for:

- Commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of three consecutive nights), and
- Transportation by the most direct route to the location.

This benefit is payable only if the body is located outside the said immediate family member's normal province of residence and the identification of the body is requested by the police or similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometre travelled.

The benefit is payable only once in connection with injuries, sickness and losses suffered by any one insured person, regardless of the number of policies providing coverage for this benefit for such insured person, that may be issued by the Insurer.

The maximum amount payable for Identification Benefit is $10,000, per insured person.

TRIP INTERRUPTION BENEFIT

If your scheduled departure is delayed for at least 12 hours due to sickness or hospitalization as provided by the Plan, or due to sickness or hospitalization of your covered travelling companion, the Company will reimburse you up to a maximum of $500 for the extra cost of your one-way economy/charter air fare via the most cost-effective itinerary to your next scheduled travel destination or original departure point of the same trip.

The Company will also reimburse the additional and unplanned hotel and meal expenses, telephone calls and taxi fares up to a combined maximum of $300 per day to a maximum of 5 days.

In order to claim any of the above outlined expenses, original itemized invoices must be provided at time of claim.

The combined maximum amount payable for this benefit is $2,000 per insured person per incident.

AUTOMOBILE RETURN BENEFIT

If injury or sickness results in an insured person becoming totally disabled and unable to continue his/her trip, the Insurer will pay the actual expense incurred for a commercial agency to return the insured person's private or rental vehicle used for the trip, to the insured person's place of residence or nearest rental agency, up to a maximum of $5,000.

Definition (for Emergency Travel Medical only): Totally disabled means complete inability of the insured person, on medical evidence, to continue his/her duties or activities and to continue the trip or vacation.

Definition (for Emergency Travel Medical only): Vehicle means a passenger automobile or truck with a factory rated load capacity of 2,500 pounds or less, or a motorcycle or a self-propelled mobile home designed and used for recreational purposes. Such vehicle must be insured for public liability and property damage for at least the minimum amount required by law in the insured person's province of residence.

OUT OF POCKET EXPENSE

The Insurer will pay up to $150 per day for reasonable and necessary commercial living expenses incurred by any insured person or their insured travel companion if an insured person becomes totally disabled and cannot continue their trip, up to a maximum benefit of $1,500.

FAMILY TRANSPORTATION

If an insured person suffers injury or sickness resulting in the insured person being confined to a hospital located outside his/her permanent province of residence, the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of one member of the immediate family to such hospital if:

- Confinement to the hospital occurs within 365 days of the accident causing the injury or sickness, and
- Reimbursement of expenses are limited to the cost of one economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such immediate family member, and incidental travel expenses up to a maximum of $250.

The maximum amount payable for Family Transportation for all injuries resulting from any one accident or sickness is $15,000 per insured person.

RETURN TRANSPORTATION FOR TRAVELLING COMPANION

If the insured person is repatriated to his/her home province or territory of residence in accordance with the Repatriation Benefit, or is returned to his/her home province or territory residence in accordance with the Ground or Air Transportation Benefit, the Insurer will pay a benefit to such insured person (or the estate of such insured person) for the extra cost of a one-way economy air fare on a commercial flight or charter via the most cost effective itinerary to transport the insured person's travel companion to Canada.

The maximum amount payable for this benefit for any one trip is $2,000 per insured person for the transport of one travel companion.

RETURN AND ESCORT OF DEPENDENT CHILDREN UNDER AGE

If the insured person is repatriated to his/her home province or territory of residence in accordance with the Repatriation Benefit, or is returned to his/her home province or territory residence in accordance with the Ground or Air Transportation Benefit, the Insurer will pay a benefit to such insured person (or the estate of such insured person) for the cost of a one-way economy air fare on a commercial flight or charter via the most cost effective itinerary to transport the insured person's dependent children travelling with the insured person on a trip to such dependent children's home, plus reasonable overnight hotel accommodation and meal expenses and for the services of an attendant to escort dependent children under age 16, if required.

The maximum amount payable for this benefit for any one trip is $5,000 per repatriated or returned insured person.

EMERGENCY TRANSPORTATION

Ground Transportation

The Insurer will pay the reasonable and necessary charges for the use of a licensed ground ambulance to a maximum of $5,000 for any one injury or sickness.

Air Transportation
If an injury or sickness commencing during the course of a trip results in the medically necessary emergency air transportation of the insured person, the Insurer will pay benefits for covered expenses up to a maximum of $50,000. Air transportation must first be approved by the Insurer and it must be ordered by a legally Licensed Physician who certifies that the severity of the insured person's injury or sickness warrants the air transportation of the insured person and that such is medically necessary.

If, due to the geographical area at the onset of the medical emergency, an air ambulance is deemed necessary, the Insurer will pay the cost of a licensed air ambulance to transport the insured person to the nearest hospital or medical facility where appropriate medical treatment can be obtained.

Air transportation means:

- The insured person's medical condition warrants immediate transportation from the place where the insured person is injured or sick to the nearest hospital where appropriate medical treatment can be obtained;
- After being treated at a local hospital, the insured person's medical condition warrants transportation to the place where he or she resides (provided such residence is located in Canada) to obtain further medical treatment or to recover; or
- Both of the above.

Covered expenses are only those reasonable and customary expenses, up to the maximum, for transportation, medical services and medical supplies which are medically necessary and incurred in connection with the air transportation of the insured person. All transportation arrangements made for transporting the insured person must be the most direct and economical route. Expenses for special transportation must be recommended by the attending physician, or required by the standard regulations of the conveyance transporting the insured person. Expenses for medical supplies and services must be recommended by the attending physician.

Definition (for Emergency Travel Medical only): Air transportation means any land, water or air conveyance required to transport the insured person during air transportation. Special transportation includes, but is not limited to, air ambulance, land ambulances, commercial airlines and private motor vehicles.

EXCLUSIONS

There is no coverage under this policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks:

- Injuries received while the insured person is participating in any manoeuvres or training exercises of the armed forces, national guard or organized reserve corps of any country or international authority;
- Pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of an unexpected pregnancy complication of which occur before the end of the seventh month;
- Sickness or injury where the trip is undertaken for the purpose of securing medical treatment or advice for such sickness or injury;
- Dental surgery or cosmetic surgery unless such surgery is a result of a covered injury;
- Emotional or mental disorders unless the insured person is confined in a hospital;
- Sickness or injury due to participation in professional sports;
- Treatment or services that contravene any Government Health Insurance Plan in Canada;
- Expenses incurred on an elective (non-emergency) basis;
- Suicide or any attempt at suicide while sane or insane;
- Intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury, while sane or insane;
- An act of declared or undeclared war, civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority;
- Any services or supplies provided by an insured person or an immediate family member of the insured person;

- A sickness or injury that, at the time of departure, might reasonably be expected to require an insured person to undergo treatment, surgery or hospitalization;
- Any service, treatment, surgery or stay in hospital not required for the immediate relief of acute pain or suffering or which is not medically necessary;
- Any treatment or surgery which reasonably could be delayed until the insured person returns to his/her province of residence;
- Anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to the insured person prior to departure;
- That portion, if any, of any expenses for treatment, advice or hospitalization which are not reasonable and customary.

WHAT TO DO IN A MEDICAL EMERGENCY

Call AIG Insurance Company of Canada immediately in the event of a serious medical emergency. Their operators are backed by a team of emergency care professionals – physicians and nurses who work closely with the doctor looking after you and, if necessary, your family or company doctor, to help ensure that you receive the medical care you need.

- U.S. and Canada **1-877-204-2017**
- Elsewhere (Collect Call) **0-715-295-9967**

You will be asked to provide the following information to the operator:

- ✓ Your name,
- ✓ Your location,
- ✓ The details of your emergency, and
- ✓ Your policy number which is SRG 9022531-C.

ADDITIONAL INFORMATION

For more information, obtain a separate brochure from the Trust Fund's website or the Administrative Agent.

MEMBER & FAMILY ASSISTANCE

The Member and Family Assistance Program is a professional counselling and referral service to help eligible Members and their eligible Dependents deal with a broad range of personal and work-related problems, such as:

- Alcohol misuse
- Career and vocational concerns
- Child related concerns
- Drug abuse
- Emotional difficulties
- Family problems
- Financial worries
- Legal problems
- Marital issues

The counsellors can assist you or an eligible Dependent with any concern that may be troubling you or them.

PROFESSIONAL COUNSELLORS

Homewood Health Incorporated (HHI) have been retained to provide this professional counselling and referral service.

CONFIDENTIALITY AND PRIVACY

The program is completely private and confidential. When you or an insured Dependent wants to use the service, you make contact directly to HHI. Names or individual information will never be released to the Board of Trustees, any union officials or any other person.

HOW THE PROGRAM WORKS

The program provides short term counselling related to each concern at no cost to you or your eligible Dependent. Should longer-term or specialized counselling be required, HHI counsellors will make a referral to the appropriate professionals and agencies in the community.

If referrals are required, attempts will be made to utilize the services of government agencies so the cost will be covered under the Provincial Health Plan or your Extended Health Care benefits. However, if fees are incurred for referral services, they become your responsibility.

HOW TO USE THE PROGRAM

The HHI Ontario counselling and referral service is available 24 hours a day. Call the Intake Coordinator at the following toll-free number:

- Toll-free number **1-866-462-8047**

You will be asked for your name and address, and HHI will then look for a counsellor who is in your area and who would be a good fit to help address your specific concerns.

When HHI has confirmed that the counsellor is available, they will call you with his/her name and number and you can then call to schedule a time that works best for you.

You and your eligible Dependents may meet with a counsellor in person, speak over the phone, or access online E- Counselling.

To access the online E- Counselling, visit the Homewood Health website at www.homeweb.ca and click on “Sign Up”. Then follow the instructions to “Create a Homeweb Account”.

ADDITIONAL INFORMATION

For more information, obtain a separate brochure from the Trust Fund’s website or the Administrative Agent.

MENTAL WELLNESS

The QuikCare Confidential Mental Health Program described in this section applies to eligible Members and their eligible Dependents.

One of the biggest issues today facing members and their eligible Dependents is mental health. Currently, 1 in 4 Canadians leave work due to anxiety, stress or depression. Mental illness is one of the top drivers for short and long-term disability claims.

The QuikCare Confidential Mental Health Program has been designed to improve functioning well-being. Members and their eligible Dependents struggling with mental health can benefit from assistance that enables them to deal with life's challenges. This is achieved by utilizing a specialized psychological method with a strong focus on getting better and living a healthier life.

HOW THE PROGRAM WORKS

The program provides Cognitive Behavioral Therapy (CBT) with a psychologist for a range of psychological conditions including anxiety, addiction, depression, stress and substance abuse. By ensuring rapid access to CBT, Members and their eligible Dependents get effective psychological treatment that will improve and sustain their overall mental health.

CBT is delivered virtually in the form of digital therapy sessions in the comfort and privacy of the Members' own home for up to 12 weeks. Members feel supported, get the care they need digitally, and become mentally stronger. The confidential evidence-based treatment alleviates the social stigma associated with mental health care. Should more intensive therapy or psychiatric intervention be needed, escalation can be facilitated.

What is CBT and how does it help?
CBT is a short-term therapy with long term benefits that is structured and focused on providing individuals with skills to help manage their emotions, thoughts and behaviours. CBT can help individuals to change how they think (“cognitive”) and what they do (“behaviour)”. CBT focuses on the “here and now” problems instead of focusing on the “root causes” of distress or symptoms, which may have originated in the distant past. CBT uses a skills-oriented approach to problem solving that will help Members find ways to improve their state of mind and help them to develop techniques so they can avoid problems in the future.

Results show that CBT based treatment consistently increased the Member's well-being. CBT is effective alone or in combination with medication for the treatment of mood, anxiety and several other psychological disorders. CBT enhances the Member’s resilience which equips them to adapt and cope with negative situations and adversity such as workplace and financial worries, relationship issues or health problems.

HOW TO USE THE PROGRAM

Once you receive a physician’s referral for psychological intervention, simply call the confidential QuikCare Helpline at the following toll-free number:

- Toll-free number **1-844-900-8357** (this number is not an emergency crisis line)

On this call, key contact details and eligibility information will be collected.

Within 1 business day, QuikCare will contact you to discuss needs, outcome goals and next steps, and to obtain required documentation (referral letter and medical release).

QuikCare Mental Wellness Cognitive Behavioral Therapy is then arranged, and details are shared with you.

Within 3 business days of treatment approval, QuikCare will follow-up to ensure you were able to initiate Cognitive Behavioral Therapy, or to provide assistance if required.

QuikCare will conduct ongoing monitoring for any potential ‘red flags’ for escalation and care path adjustments, as well as outcome measuring at the end of the 12 weeks treatment to compare initial goals and treatment outcomes.

ADDITIONAL INFORMATION

For more information, obtain a separate brochure from the Trust Fund’s website or the Administrative Agent.

HOSPITAL CASH

The benefits described in this section apply to eligible Members under age 70 and their eligible Dependents.

The Member will be paid a daily benefit of $150 for the first 120 hospital days, to a maximum of $18,000, while he/she or any eligible Dependent is admitted as an in-patient in a hospital for a minimum of one consecutive day and under the care of a Licensed Physician.

A hospital day will be recognized in accordance with the hospital's billing practices. Such period of hospitalization must:

- Be necessary because of injury, illness, or childbirth, and
- Begin while insurance under the policy is in force with respect to such member.

If any injury or illness requires more than one period of hospitalization, then the maximum benefit period of 120 days in a hospital will be reinstated provided that at least 61 days has elapsed between such periods of hospitalization.

For injury or illness that begins while this coverage is in force, a benefit of 50% of the daily benefit will be paid for the number of days the insured person recovers at home, not to exceed the number of days that the insured person was hospitalized for the covered injury or illness to a maximum of 20 days, subject to a maximum of $1,250.

Note: Newborn children must be over 14 days of age to be eligible for Hospital Cash benefits.

Please contact the Administrative Agent for:

- ✓ a separate brochure to obtain more information, and
- ✓ a Hospital Cash Benefit Form to submit a claim.

DENTAL

WHAT THE INSURANCE COVERS

The Dental Benefits described in this section apply to both the Member and their eligible Dependents. The insurance covers work included in a comprehensive list of “Covered Dental Expenses”, which appears below.

This Plan is designed to help pay your dental expenses but not on the basis of treatment that is more expensive than necessary for good dental care. Many dental conditions can properly be treated in more than one way. Thus, if a condition is being treated for which 2 or more services included in the list are suitable under reasonable and customary dental practices, the benefit under the Plan will be based on the least expensive of the services.

Treatment is considered reasonable if it is recognized by the Canadian Dental Association, it is proven to be effective, it is of a form, frequency and duration essential to the management of the person’s dental health, and expenses do not exceed the dental fee guide.

If a dental service is performed that isn't in the list, but the list contains one or more other services that under customary dental practices are suitable for the condition being treated, then for the purpose of the Plan, the least expensive of the suitable services listed will be considered to have been performed. Additional exclusions are listed under “Limitations” at the end of this section.

The final choice of treatment is always between the patient and the dentist. You are financially responsible to your dentist for the cost of dental work performed. Treatment must be performed by a dentist or under a dentist’s supervision, by a denturist, or by a dental hygienist entitled by law to practice independently.

REIMBURSEMENT

Dental reimbursement is based on the general practitioner's provincial fee guide of your home province for the year recognized by the Trust Fund at the time the service is rendered. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are performed by a dental hygienist practicing independently. Percentage payable, calendar year maximums and lifetime benefit maximums are specified in the "Summary of Benefits" and will be applied to determine the final amount payable.

FREE CHOICE OF DENTIST

You may choose any Licensed Dentist or Licensed Denturist practicing within the scope of his/her profession.

PRE-DETERMINATION OF BENEFITS

Pre-determination of benefits permits the review of the proposed treatment in advance and allows for a solution of any questions before, rather than after, the work has been done. Additionally, both you and the dentist will know in advance what the Plan will allow assuming you, or the Dependent, remain covered.

If the cost of services is expected to exceed $500, you should ask your dentist to submit a Treatment Plan to the Administrative Agent. A Treatment Plan contains the following information at a minimum:

- ✓ The dentist's recommended services,
- ✓ The dentist's charge for each service, and
- ✓ Supporting x-rays or a letter of expertise.

A copy of the Treatment Plan will be returned to both you and the dentist showing the estimated amount that you will be reimbursed. Predetermination of benefits is only valid for 90 days and subject to all insurance contract provisions and eligibility for benefits on the date the service is performed for the expense to be reimbursable.

WHAT IS CONSIDERED AN ELIGIBLE CHARGE

An eligible charge is one the dentist makes to you for a covered dental service furnished to you or a covered Dependent, provided the service is included in the list of “Covered Dental Expenses” and not listed under “Exclusions”.

A charge is considered incurred on the date the service is received, rather than on the date the charge is made. In the case of root canal therapy, or dentures, which may require multiple appointments, the date the expense is incurred will be the date the service is finally completed. For dentures, this date will be the date the prosthetic device is installed. For root canal therapy, this will be the date the canal is closed.

All expenses are assessed on a reasonable and customary basis. Lab fees may be cut back accordingly.

TERMINATION OF BENEFITS

No benefits for Covered Dental Expenses will be paid for expenses incurred after the policy terminates, or after the individual’s coverage terminates.

The following exceptions apply only if the treatments specified are covered under this policy and there is no replacement dental insurance coverage after such termination:

- Where an impression for a denture was started prior to the termination of insurance, dental expenses in connection with these procedures and incurred within 30 days of termination will be considered as incurred prior to termination;
- Where Orthodontic Treatment has commenced and a treatment Plan has been submitted in advance to the insurer, dental expenses in connection with such treatment and incurred within 90 days of termination will be considered as incurred prior to termination.

BENEFIT CARD

You and your spouse will be provided with a Benefit Card which may be used for all covered dental care services. You may use any dental care office in Canada that will accept your card. This card may also be used for prescription drugs and health care practitioners.

COVERED DENTAL EXPENSES

Charges for reasonable and customary services and supplies specified below shall be considered covered expenses when incurred by you or a covered Dependent. Eligible expenses include Basic and Preventive Treatment, Endodontics, Periodontics, Oral Surgery, Major Restorative and Prosthodontics. An expense is eligible to the extent that coverage is not prohibited by provincial health insurance plans or because of other limitations described below or in the “Summary of Benefits” of this booklet.

Services Where Percentage Payable is 100%:

- Oral examinations including scaling, polishing and cleaning of teeth;
- Topical application of sodium or stannous fluoride;
- Single diagnostic x-rays and complete series or equivalent;
- Oral hygiene instruction;
- Consultations;
- Extractions;
- Routine oral surgery including excision of impacted teeth;
- Amalgam, acrylic, silicate or composite fillings;
- Retentive pins;
- Anaesthesia where reasonably and customarily required in connection with other covered procedures;
- Treatment of periodontal and other diseases of gums and tissues of the mouth, (special periodontal appliances);
- Emergency endodontic procedures and root canal therapy limited to one course of treatment per tooth per lifetime;
- Prefabricated full coverage restorations for primary teeth;
- Passive space maintainers, those that do not move the teeth for dependent children under the age of 18;
- Pit and fissure sealants for dependent children under the age of 18 only, for molar and bicuspid teeth;
- Caries, trauma and pain control;

- Study casts;
- Repairing, relining and rebasing of dentures;
- Initial installation of partial or full removable dentures to replace teeth lost, extracted or fractured after the effective date of this insurance.

Services Where Percentage Payable is 80%:

- Replacement of existing partial or full removable denture(s) providing:
    - The replacement is more than 12 months after the individual became insured under this coverage, and the existing appliance is at least 5 years old and cannot be made serviceable, or,
    - The existing appliance is replaced as a result of extraction, loss of one or more sound natural teeth after the individual became insured under this plan, or the initial placement of an opposing denture.

  Note: Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures are not covered.
- Repair or recementing of crowns, inlays or fixed prosthetics;
- Extensive oral surgery;
- Injection of antibiotic drugs;
- Metal inlays, onlays and crowns, used to restore natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filing;
  Note: when a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration.
- Initial installation of fixed bridgework;
- Bridge repairs and recementation;
- Replacement of existing fixed bridgework providing:
    - The replacement is more than 12 months after the individual became insured under this coverage, and the existing fixed prosthetic device is at least 5 years old and cannot be made serviceable, or,
    - 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.

A temporary appliance or bridge is considered to be permanent if not replaced within 12 months from the date the temporary appliance or bridge was inserted.

Major Procedures and Fixed Prosthetic Devices are not eligible for teeth fractured, lost or extracted prior to the effective date of coverage under this Trust Fund.

ORTHODONTIC TREATMENT

Orthodontic treatment includes the diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as “straightening of the teeth”. These include active space maintainers, or orthodontic appliances for the purpose of repositioning or moving the teeth.

A Pre-Treatment Plan is always required for this benefit. Treatment will generally extend over a 2 or 3-year time span. The Claims Office will respond to the Pre-Treatment Plan with an explanation of how the monthly reimbursement process will work for the duration of the orthodontic treatment. Claim payment is on a reimbursement basis, subject to the submission of paid receipts.

LIMITATIONS

The following charges are not reimbursable:

- Duplicate x-rays, custom fluoride appliances and nutritional counselling;
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants;
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post-surgical treatment and periodontal re-evaluations;
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage;

- Hypnosis or acupuncture;
- Veneers, recontouring existing crowns, and staining porcelain;
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, alternative benefits will be based on coverage for fillings;
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option:
    - If overdentures are provided, coverage will be limited to standard complete dentures,
    - If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework,
    - If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework, and
    - Alternative benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided.
- Expenses covered under another group Plan's extension of benefits provision;
- Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare;
- Expenses private plans are not permitted to cover by law;
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage;
- Services or supplies that do not represent reasonable treatment;

- Services or supplies which are not furnished by a legally qualified dentist, denturist or dental hygienist acting within the scope of his license;
- Replacement of a lost or stolen prosthetic device;
- Charges for protective athletic appliances;
- Treatment performed for cosmetic purposes only;
- Congenital defects or developmental malformations in people 19 years of age or over;
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain;
- Expenses arising from war, insurrection, or voluntary participation in a riot;
- Charges for completion of claim forms, broken appointments, counselling, travel, communication costs or for advice by telephone;
- Dental examinations required by a third party;
- Expenses for services or treatment that are payable by Workplace Safety and Insurance Law (or similar legislation) or any government plan or which are received without charge.

CONTINUATION OF COVERAGE IF AN ELIGIBLE MEMBER DIES

Dental Care coverage for eligible Dependents shall continue without premium payment following your death up to a maximum of 24 months from the date of death to the earliest of the following dates:

- ✓ The date your Dependent ceased to be eligible,
- ✓ The date your Widow remarries, or
- ✓ The date the insurance contract or coverage is cancelled or terminated.

Any extended benefits payable are subject to the provisions and limitations of the Plan.

WEEKLY WAGE REPLACEMENT

The Plan pays you Weekly Wage Replacement Benefits, commonly known as Short Term Disability (STD), for disability absences during which you are prevented from performing your usual job duties solely as a result of a non-occupational accidental bodily injury or disease, including pregnancy related conditions. Your disability absence must commence while you are covered under the Plan. If you are laid off at the time you become disabled, the benefit period will not start until you are recalled to work. You do not have to be confined at home, but your disability must be severe enough to prevent you from performing your regular work. The amount of your STD Benefit is specified in the "Summary of Benefits" of this booklet. This benefit does not apply to Dependents.

Definition (for Weekly Wage Replacement only): Disabled means that because of a non-occupational illness or non-occupational accidental bodily injury, you are incapacitated to the extent that you are unable to perform any and every duty of your occupation.

BENEFIT PERIOD

This Weekly Wage Replacement Benefit is integrated with Employment Insurance Sickness Benefits (E.I.). Your benefits under this Plan will be reduced by the number of full or partial weeks for which you are entitled to E.I. Benefits, whether you apply for them or not. If you do not qualify for E.I. Sickness Benefits, payments will be made under this Plan, however you must submit proof of your disqualification for E.I. The maximum benefit period provided by this STD coverage is 26 weeks, inclusive of E.I. Benefits. The Weekly Wage Replacement Benefit is subject to a waiting period before payments commence. The waiting period is 7 days if you become disabled due to a sickness, 0 days if you become disabled due to an accident, and 0 days if you are admitted as an in-patient for a minimum of 24 hours of hospitalization. The Plan pays benefits to the end of E.I. Sickness Benefit's 1-week waiting period, minus the Short Term Disability waiting period. No benefits are payable for the next 26 weeks, unless you prove your disqualification for E.I. Sickness Benefits.

Definition (for Weekly Wage Replacement only): 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.

If your disability continues beyond the initial 1-week period and the 26-week E.I. period, you may again claim benefits from this Plan for a combined maximum period of 26 weeks, or until you are no longer disabled, whichever comes first.

Note: You must be under the active and ongoing care of a physician for the full benefit period, including any E.I. payment period. Payments do not begin prior to the date you see a physician.

SUCCESSIVE DISABILITIES

Successive disabilities separated by less than 2 weeks of active, full-time work will be considered one disability, unless the subsequent disability is due to an entirely different and unrelated cause. Disabilities arising from different and unrelated causes will be considered as a new disability provided they commence after you return to full-time work, for at least one full day. Disabilities arising from the same or a related cause will be considered as a new disability provided you returned to regular, full-time work for a period of at least 2 weeks.

LIMITATIONS

No benefits are paid for:

- Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition. Depending on the severity of the condition, you may be required to be under the care of a specialist. If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program;
- The scheduled duration of a lay-off or leave of absence. This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy;

- Disability which commences on or after the date a strike begins, subject to any provincial Employment Standards Act or Labour Standards Regulations, however, you may fulfill your waiting period during a strike;
- Disability related to any employment;
- Any period of employment, except in an approved rehabilitation plan or program;
- Any period during which benefits are payable under E.I.;
- Any period after you fail to participate or cooperate in an approved rehabilitation plan or program;
- Any period after you fail to participate or cooperate in a recommended medical coordination program;
- The normal recovery period for treatment performed for cosmetic purposes only. This limitation does not apply where such treatment was undertaken as a result of a disease or injury;
- Any period of confinement in a prison or similar institution;
- Disability arising from war, insurrection or voluntary participation in a riot;
- Disability arising from a motor vehicle accident occurred in Ontario or Quebec;
- Fees charged by a physician to complete claim forms and provide copies of medical reports.

BENEFIT REDUCTIONS

Your Weekly Wage Replacement Benefits will be reduced by any income or benefit payable under:

- The Canada or Quebec Disability Pension Plan that you are entitled to on your own behalf except for increases that take effect after the benefit period has started,
- The Workers Compensation Act or similar law,
- Any other plan or program provided to you by your employer, or
- Any plan or program of any government, including that established pursuant to the *Automobile Insurance Act*, when the government benefit is being paid for the current disability.

Earnings received from an approved rehabilitation plan or program are not used to reduce your Weekly Wage Replacement Benefit unless those earnings, together with your income from this Plan and any other plan listed above, exceed your weekly earnings before you became disabled, in which case your benefit is reduced by the excess amount.

VOCATIONAL REHABILITATION

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

MEDICAL COORDINATION

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

SUBROGATION

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will be subrogated to all the rights of your recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You shall execute such documents as required by the Insurer.

In the event that you can provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, you should understand that the sum reached in settlement would be deemed to be full compensation for loss of income, and the Insurer’s right of subrogation will apply.

Definition (for Weekly Wage Replacement and Long Term Disability only): Compensation includes any lump sum or periodic payments that you receive or are entitled to receive on account of past, present or future loss of income.

TERMINATION OF COVERAGE

Your eligibility for Weekly Wage Replacement terminates upon your retirement.

YOUR BENEFITS AND FEDERAL INCOME TAX

This benefit is taxable and Income Tax will be withheld from your cheques. You will be mailed a T4A for all paid amounts by the end of February of the following year.

THREE-PART CLAIM FORM

To claim Weekly Wage Replacement Benefits, a claim form is sent out to you that contains three parts:

- Employee's Statement (to be completed by the Member),
- Employer's Statement (to be completed by the employer), and
- Attending Physician's Statement (to be completed by the treating physician).

The date you last worked must be shown on this form. Do not ask your doctor to complete the "Attending Physician's Statement" portion of the form until after you stop working and your disability commences. Make sure that the "Attending Physician's Statement" includes the following information:

- ✓ The diagnosis,
- ✓ The date(s) of treatment for this condition,
- ✓ The type(s) of treatment rendered, and
- ✓ An estimated return to work date.

To avoid delay in the assessment of your claim, you should provide all required information. Throughout your disability, you should keep your own records: make copies of your completed claim forms, keep track of your medical appointments and make copies of doctors' notes.

LONG TERM DISABILITY

Long Term Disability (LTD) insurance is wage replacement insurance, which provides you a monthly income if you become so totally disabled by an accidental bodily injury or disease while insured under this Plan and under the age of 65 that you can no longer work for your living. LTD insurance covers you for those total disabilities that last beyond the period covered by the Weekly Wage Replacement benefits. The amount of your LTD Benefit is specified in the "Summary of Benefits". This benefit does not apply to Dependents.

Definition of Total Disability (for Long Term Disability only): You will be considered "totally disabled" during the first next 24 months in which you receive LTD Benefits if you are unable, solely because of disease or accidental bodily injury, to work at your own occupation.

Your own occupation means the type of work in which you were engaged and is not limited to the actual job you were performing prior to the start of a period of total disability.

After this 24-month period, and during the same period of disability, you are totally disabled only if you are incapacitated to the extent that solely because of a disease or accidental bodily injury, you are unable to work at any occupation or employment for which you are, or may reasonably become, qualified by education, training or experience. Such disability must result from a medically determinable physical or mental impairment.

BENEFIT PERIOD

You will be eligible for your first income payment from the Plan after you have completed the qualifying period, which is the first 26 weeks of a period of total disability, or the duration of the Weekly Wage Replacement benefit, whichever is greater. However, you will not receive an income payment if you reach age 65 before you complete the qualifying period.

After completing the qualifying period, you will be eligible for income payments during the continuance of a period of total disability up to age 65.

ELIGIBILITY

You will receive the monthly benefit amount specified in the "Summary of Benefits" if you satisfy the following requirements:

- You are totally disabled from a non-occupational injury or disease,
- Your disability absence begins when you are eligible for coverage by the Trust Fund,
- You are under the active and ongoing care of a physician,
- Your physician is providing accepted standard professional treatment appropriate for the medical condition being treated. This could include seeing a Certified Specialist or Therapist recommended by your physician,
- You provide sufficient medical evidence as requested by the insurer that establishes and maintains your inability to perform the functions of any occupation for which you may be suited by reason of education, training or experience. The amount and type of evidence required will depend on your medical condition, and
- You report for an independent medical examination by a physician of the insurer's choice if requested.

The availability of work is not considered by the insurer in assessing your claim.

ALL SOURCE MAXIMUM

Under the LTD benefit, your total income each month must not exceed 75% of your normal gross monthly earnings.

Therefore, your gross benefit amount may be reduced by the amount of the excess, if you are receiving other disability payments or compensations such as:

- Disability benefits to which you are entitled to on the basis of your disability under the Canada Pension Plan and Quebec Pension Plan except for cost of living increases that take effect after the benefit period has started. Benefits payable to another family member are not included,
- Retirement benefits to which you are entitled to on your own behalf under the Canada Pension Plan or Quebec Pension Plan,

- Loss of income benefits under a legislated automobile insurance plan, to the extent permitted by law,
- Disability benefits under a plan of insurance available through an association, or
- Income received from any employer or from any occupation for compensation or profit.

Note: Your normal gross monthly earnings are determined according to the hourly rate for your normal workweek from the Collective Agreement that was in effect when your disability commenced, and exclude overtime pay, bonuses or any other extra compensation. Any retroactive change in the rate of earnings will be deemed to be effective on the date of the determination of the change in the rate of earnings.

REHABILITATION PROVISION

If you recover sufficiently to work again at any occupation, you may be able to do so without jeopardizing your total disability status. The insurer may contact you to recommend a program of rehabilitation that would be appropriate for you.

Earnings received from an approved rehabilitation plan are not used to further reduce your LTD benefit unless 50% of those earnings, together with your income from this Plan and the other income listed above, exceed your indexed monthly earnings before you became disabled, in which case your benefit is reduced by the excess amount.

Cost-of-living increases to this income that take effect after the benefit period starts, except for income from an approved rehabilitation plan, are not included.

VOCATIONAL REHABILITATION

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to your own occupation or other gainful employment and is recommended or approved by the insurer. In considering whether to recommend or approve a rehabilitation plan, the insurer will assess such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to work.

MEDICAL COORDINATION

Medical coordination is a program, recommended or approved by the insurer, that is designed to facilitate medical stability and provide you with cost effective, quality care. In considering whether to recommend or approve a medical coordination program, the insurer will assess such factors as the expected duration of disability, and the level of activity required to facilitate medical stability.

SUBROGATION

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will be subrogated to all the rights of your recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You shall execute such documents as required by the Insurer.

In the event that you can provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, you should understand that the sum reached in settlement would be deemed to be full compensation for loss of income, and the Insurer's right of subrogation will apply.

Definition (for Weekly Wage Replacement and Long Term Disability only): Compensation includes any lump sum or periodic payments that you receive or are entitled to receive on account of past, present or future loss of income.

CONTINUOUS PERIOD OF DISABILITY

If you become disabled from the same or related causes within 6 months after return to active work, it will be considered one continuous period of disability.

If you have returned to active work for one full day and become disabled from different and unrelated causes, it will be considered a new period of disability.

LIMITATIONS

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect;
- Any period after you fail to participate or cooperate in a prescribed plan of medical treatment appropriate for your condition:
    - Depending on the severity of the condition, you may be required to be under the care of a specialist, and
    - If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.
- Any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by the insurer;
- Any period after you fail to participate or cooperate in an approved rehabilitation plan;
- Any period after you fail to participate or cooperate in a recommended medical coordination program;
- The scheduled duration of a leave of absence. This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy;
- Disability which commences on or after the date a strike begins, subject to any provincial Employment Standards Act or Labour Standards Regulations, however, you may fulfill your waiting period during a strike;
- Any period in which you are outside of Canada. This exclusion does not apply during the first 30 days of an absence, or if the Insurer pre-authorized the absence prior to your departure;
- Any period of incarceration, confinement, or imprisonment by authority of law;
- Disability arising from war, insurrection, or voluntary participation in a riot;
- Disability related to any employment;

- Any period for which the person is entitled to loss of income benefits under a legislated automobile insurance plan, to the extent permitted by law;
- Disability arising from an accident which occurs while the person is operating a motor vehicle, vessel or aircraft and was impaired by drugs or alcohol, or his blood/alcohol is higher than 80 milligrams of alcohol per 100 millilitres of blood;
- Fees charged by a physician to complete claim forms or provide copies of medical reports.

CANADIAN RESIDENCY REQUIREMENT

No LTD benefits are payable for any period in which you are outside of Canada. This exclusion does not apply during the first 30 days of an absence, or if the Insurer pre-authorized the absence prior to your departure.

EXTENDED INSURANCE

If your LTD insurance terminates during a period of total disability, the Insurer continues to be liable as though the provision remained in force. If a recurrence of disability occurs within 6 continuous months after termination of this benefit, the Insurer shall continue to pay your benefits but only for the remainder of the original maximum benefit period. Such disability must have been caused by an accident or sickness that occurred before termination. The Insurer shall not be liable for benefits after termination of either the contract or Long Term Disability Income benefit once a replacing Insurer is bound contractually or as a matter of law.

TERMINATION OF COVERAGE

Your eligibility for Long Term Disability terminates the earlier of your retirement or attainment of age 65.

YOUR BENEFITS AND FEDERAL INCOME TAX

This benefit is taxable however no tax will be withheld from your monthly payments. You will be mailed a T4A for all paid amounts by the end of February of the following year.

CRITICAL ILLNESS

This benefit applies only to you if you are an eligible Member under age 70. Critical Illness benefits cease upon retirement or attainment of age 70, whichever is earlier.

The Critical Illness Benefit provides financial assistance in the event you are diagnosed with one of the covered illnesses. The benefit is designed to alleviate some of the financial stress resulting from a critical illness at a time when the focus should be on recovery. There is no restriction on the use of the benefit; you can use it in any way that will meet your particular needs.

You are covered for a flat amount of which is referred to as the principal sum. A Multiple Event Benefit may be payable equal to the Benefit Amount, subject to certain conditions as described under the Multiple Event Benefit.

BENEFIT PAYMENT CONDITIONS

Payment of benefits upon the first diagnosis of a covered critical illness is subject to the following conditions:

- The diagnosis is made within Canada,
- The diagnosis is made while you are eligible for coverage by the Trust Fund,
- Payment is not precluded by any general or specific exclusion or limitation set forth in the insurance contract, and
- Once 100% of the principal sum has been paid, coverage terminates and no further benefits are payable, except as described under Second Event benefit.

COVERED CRITICAL ILLNESSES

All covered critical illnesses must be diagnosed after the insured person's effective date of coverage. To be considered a covered illness, it must be positively diagnosed by a Licensed or Certified Specialist in that field of medicine, and must be supported by medical evidence collected by a physician.

Life-threatening and non-life-threatening cancer must be positively diagnosed by a physician and supported by a pathological report. Clinical diagnoses alone do not meet this standard.

Diagnoses must be for one of the following covered critical illnesses or conditions:

COVERED CRITICAL ILLNESSES*

- Aortic surgery
- Aplastic anemia
- Bacterial Meningitis
- Benign brain tumour
- Blindness
- Coma
- Coronary artery bypass surgery
- Coronary angioplasty (partial payment of 10% of the principal sum
- Deafness
- Dementia, including Alzheimer's Disease
- Heart attack
- Heart valve replacement or repair
- Kidney (renal) failure
- Life-threatening cancer
- Loss of independent existence
- Loss of limbs
- Loss of speech
- Major organ failure on waiting list
- Major organ transplant
- Motor neuron disease
- Multiple sclerosis
- Muscular dystrophy
- Non-life-threatening cancer (partial payment – see below)
- Occupational HIV infection
- Parkinson's disease and specified atypical Parkinson disorders
- Quadriplegia, paraplegia, hemiplegia
- Severe burn
- Stroke

*****For each covered illness or condition, the insurance contract specifies what the illness or condition is, what signs and symptoms need to be present to be diagnosed with the illness or condition, who needs to make the diagnosis, and the tests and/or diagnostic procedures that must be performed to arrive at the diagnosis. Contact the Administrative Agent for these details.

Partial Payment for Non-Life-Threatening Cancer
The benefit will provide 25% of the principal sum for the following non-life-threatening conditions:

- Stage I malignant melanoma of the skin;
- Basal or Squamous Cell Carcinoma;

- Stage I Colon cancer (T1 or T2);
- Carcinoma in situ;
- T1a or T1b Prostate cancer;
- Papillary thyroid cancer or follicular thyroid cancer;
- Chronic lymphocytic leukemia classified as Rai stage 0, and
- Any tumour in the presence of any Human Immunodeficiency (HIV).

Upon payment of the partial payment for non-life-threatening cancer, your insurance remains in effect with the principal sum reduced by the amount of the partial payment. Only one claim per condition is permitted for partial payment for non-life-threatening cancer.

MULTIPLE EVENT BENEFIT

If you are diagnosed with a critical illness for which the principal sum has been paid and are then diagnosed with a subsequent critical illness, an additional payment equal to the principal sum is payable. The subsequent critical illness must be a different critical illness group than the initial group for which the principal sum has been paid.

You are eligible for payment of the principal sum one time per following critical illness group:

- **Group 1:** Aortic surgery, coronary artery bypass surgery, heart attack, heart valve replacement or repair, stroke.
- **Group 2:** Aplastic anemia, kidney failure, major organ failure on waiting list, major organ transplant.
- **Group 3:** Bacterial meningitis, benign brain tumor, coma, dementia including Alzheimer's disease, loss of independent existence, loss of speech, motor neuron disease, multiple sclerosis, muscular dystrophy, Parkinson's disease and specified atypical Parkinson disorders, quadriplegia, paraplegia, hemiplegia.
- **Group 4:** Blindness.
- **Group 5:** Deafness.
- **Group 6:** Life-threatening cancer.
- **Group 7:** Loss of limbs.
- **Group 8:** Occupational HIV infection.
- **Group 9:** Severe burn.

CANCER RECURRENCE BENEFIT

If you have already been diagnosed with cancer and, while insured, a new Diagnosis of Life-Threatening Cancer is made, you will receive a benefit equivalent to the Benefit Amount applicable to the person Diagnosed with Life-Threatening Cancer, if the following conditions have been met:

- More than 60 months have passed since the previous cancer diagnosis; and
- No treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventive medications and follow up visits to the doctor).

The Diagnosed cancer must meet the definition of Life-Threatening Cancer, as presented under the Critical Illness Definitions and Diagnostic Requirements section of the policy in order to be eligible for a payment under this provision.

DIAGNOSTIC REQUIREMENTS

The insurer reserves the right to have any Critical Illness diagnosis reviewed by a physician of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the diagnosis, the insurer shall have the right to request an examination of either you or the evidence used in the arriving at your diagnosis by an independent acknowledged expert selected by the insurer in the applicable field of medicine. The opinion of such expert as to such diagnosis shall be binding on both you and the insurer.
Definition (for Critical Illness Benefits only): Diagnosis means a definitive and unequivocal diagnosis made by a physician based upon the use of clinical and/or laboratory investigations as supported by your medical records, and meeting any diagnostic requirements described in the insurance contract.

EXCLUSIONS

Benefits are not payable if a critical illness or condition is caused in whole or in part by the following events:

- Any illness not specifically listed as a covered critical illness,
- Commission of or attempt to commit a felony,

- Declared or undeclared war, or any act of declared or undeclared war,
- Voluntary participation in any riot or civil insurrection, or
- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.

CLAIMS

Written notice of claim must be filled within 30 days after the diagnosis, or as soon thereafter as is reasonably possible.

Upon receipt of due written proof of loss, which must be furnished within 90 days after the date of the diagnosis, benefit payments will be made to (or on behalf of, if applicable) the insured Member suffering the loss. If an insured Member dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, to any relative by blood or connection by marriage of the payee, who in the Insurer's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

LIFE

MEMBER LIFE

The Life Insurance benefit is payable in the event of your death from any cause at any time or place while you are insured. Payment will be made to the beneficiary designated by you. If there is no designated beneficiary living at the time of your death, the Insurer will pay the benefit to your Estate. The amount of Life Insurance is specified in the "Summary of Benefits" of this booklet.

BENEFICIARY

For Member Death Benefits, you may name a beneficiary or beneficiaries and, from time to time, change such named beneficiary/beneficiaries, subject to Provincial Law, by written request filed with the Administrative Agent. The change will take effect as of the date such request was executed, but without prejudice to the insurance company for any payments made before such request is received at its head office.

WAIVER OF PREMIUM

If, while covered under this, you become totally disabled and have not retired or had your 65th birthday and remain so disabled for 6 consecutive months, the Insurer will waive payment of the life insurance premiums up to age 65 provided you remain so disabled, and provided proofs of disability are furnished as required.

Definition (for waiver of premium for Life Benefits only): Totally disabled means you are incapacitated by an injury or disease to the extent that you are not able to perform any work for compensation or profit and are not able to engage in any business or occupation.

In order to qualify for the Waiver of Premium benefit, you must notify the Insurer within 12 months of the last active day at work and must furnish due proof of disability, satisfactory to the Insurer, within 6 months of that last active working day.

From time to time during the first 2 years that premiums are waived, the Insurer shall have the right to require proof of continuance of your disability. After 2 years, proof shall only be required no more than once a year. You may be required to be examined by a medical examiner designated by the Insurer, at the Insurer's expense. No benefits will be provided under this benefit if you fail to submit proof of disability when required.

The Insurer will waive premiums starting with the date the required proof is approved. Premiums shall not be waived beyond the earlier of attainment of age 65 or the date you cease to be totally disabled. The benefit will cease if you fail to submit proof of continuance of disability when required or if you fail to be examined by a qualified physician when required.

If you die while your life insurance is being continued under this Waiver of Premium Benefit, the amount of insurance payable will be the amount of insurance for which premiums are being waived at the time of death.

If you die within one year of becoming totally disabled and unable to work due to such disability, but before due proof of the disability was furnished to the Insurer, the Insurer will pay your beneficiary the amount of life insurance to which you were entitled on the date you became so disabled. The Insurer must receive proof of the death and total disability during this period not later than one year after your death.

If you do not return to work within 31 days after this benefit ceases, you may convert the amount of insurance that was subject to this provision as though the insurance had ceased on that date due to termination of employment. If a benefit is payable under the "Conversion Privilege" of this policy, the amount of insurance payable under this provision shall be reduced by the amount of that benefit. If an individual policy has been issued in accordance with the Conversion Privilege, no payment shall be made under this provision unless the individual policy is surrendered to the Insurer, without payment of the claim. If the policy is surrendered, the Insurer will refund any premium paid on the individual policy.

The Insurer shall not be liable for Waiver of Premium benefits after termination of the contract or Waiver of Premium provision once a replacing Insurer is bound contractually or as a matter of law.

However, if this contract or Waiver of Premium provision terminates, the Insurer remains liable to provide Waiver of Premium benefits for a continuous disability caused by an accident or sickness that occurred prior to termination provided a claim is submitted within 12 months of the Member's last active day at work and due proof of disability, satisfactory to the Insurer, is furnished within 18 months of the last active working day. At the end of any 90-day period during which the Member was not disabled, the Insurer ceases to be liable for any further Waiver of Premium benefit for disability caused by an accident or sickness that occurred prior to termination.

CONVERSION PRIVILEGE

If your entire amount of life insurance is discontinued because of a change in your eligibility status, you are entitled to purchase an individual life insurance policy issued by the Insurer, subject to the following conditions:

- The amount of the individual policy shall not exceed the amount of insurance for which the Member was covered when coverage was discontinued;
- The individual policy shall be, at the Member's option, in the form of a non-convertible term insurance to age 65, a permanent plan that the Insurer offers to the public at the time of conversion, or a one-year non-renewable term insurance which may be converted while it is in force to any plan described above, but shall be without disability waiver or other supplementary benefits;
- The premium for the individual policy shall be determined by the Insurer according to:
    - The Insurer's current rates for your attained age (nearest birthday) on the effective date of the individual policy,
    - The class of risk to which you then belong, and
    - The form and amount of the individual policy.
- The first premium and written application for the individual policy shall be delivered to the Insurer within 31 days after the date on which your insurance is terminated;
- Insurance under the individual policy shall be effective at the end of the 31-day period described above;
- Evidence of insurability shall not be required for such individual policy.

If your life insurance is discontinued because of termination of this policy, or if you cease to be eligible for life insurance for a reason other than a change in your eligibility status in this Trust Fund, you shall be entitled to purchase an individual policy of life insurance under the same conditions as outlined above, provided you have been a covered Member of this Trust Fund for a least 5 years. All of the above conditions apply except that the total amount of individual life insurance you can purchase shall be limited to 3 times the Year's Maximum Pensionable Earnings as established under the Canada Pension Plan, less any amount for which you become eligible under another group policy within 31 days of the date of discontinuance of this insurance.

If you die within the 31-day period during which you could have converted, the Insurer shall pay the maximum amount of insurance you could have converted. If an individual policy has already been issued through conversion, no payment shall be made through this provision unless the individual policy is surrendered without payment of claim. Upon surrender the Insurer shall refund premiums paid on the individual policy. A beneficiary designated in any conversion application shall be the beneficiary under this provision.

DEPENDENT LIFE

In the event of the death of your spouse and/or dependent children while insured, the amount of Dependent Life Insurance as specified in the "Summary of Benefits" is payable to you. If you are no longer living, the benefit will be payable to your estate.

PREMIUM WAIVER FOR DEPENDENTS

If you become totally disabled in accordance with the terms and conditions as described under "Member Life", and Waiver of Premium is approved for your Life Insurance, then the premium requirement for the Dependent Life benefit will also be waived until the earliest of:

- The date your Waiver of Premium for Life Insurance ceases, or
- The date the policy or coverage terminates.

Further details on the Waiver Benefit can be found under the "Member Life" section of this booklet.

CONVERSION OPTION FOR DEPENDENTS

An individual life insurance policy issued by the Insurer may be purchased on the life of a spouse who is under 65 years of age if the insurance ceases due to your insurance terminating, a change in your spouse's status as a Dependent, or because of your death. The conditions under which this policy may be purchased are the same as those described in the "Member Life" section, however the policy will be on the life of the spouse and the premium rates will be based on the age and class of risk of the spouse. You will be the owner of the individual policy, unless you are deceased and then your spouse will be the owner. You or your spouse should contact the Administrative Agent for details.

If the policy is terminated and your spouse has been continuously insured with this Trust Fund for at least 5 years, a conversion privilege is available but the amount of the individual policy you can purchase shall be limited to 3 times the Year's Maximum Pensionable Earnings as established under the Canada Pension Plan, less any amount for which the spouse become eligible under another group policy within 31 days of the date of discontinuance of this insurance.

Written application together with the initial premium due must be submitted to the insurance company within 31 days of the date your spouse's coverage terminates.

If your spouse dies within the 31-day period during which the spouse's life insurance could have been converted, the insurer will pay the maximum amount of the insurance that could have been converted. If an individual policy has already been issued through conversion, no payment shall be made through this provision unless the individual policy is surrendered without payment of claim. Upon surrender the Insurer shall refund premiums paid on the individual policy.

CONTINUATION OF COVERAGE IF AN ELIGIBLE MEMBER DIES

Dependent Life coverage for Dependents shall continue as long as there is sufficient money in your dollar bank from which to make the required deductions.

Any extended benefits payable are subject to the provisions and limitations of the Trust Fund.

ACCIDENTAL DEATH & DISMEMBERMENT

The benefits described in this section apply to eligible Members under age 70 and their eligible Dependents.

PRINCIPAL SUM

All eligible Members are covered for a Principal Sum of $100,000.

The eligible spouse is covered for a Principal Sum of $50,000.

Each eligible dependent child is covered for a Principal Sum of $15,000.

ACCIDENTAL DEATH AND SPECIFIC LOSS SCHEDULES

When an insured eligible Member or spouse receives injuries resulting in any of the following losses within 365 days of the accident, benefits will be payable for:

LOSS SCHEDULE	
Loss of	**Maximum % of Principal Sum Payable**
Brain death	200%
Quadriplegia, paraplegia, hemiplegia	200%
Life	100%
Both hands, or both feet, or one hand and one foot	100%
Entire sight of both eyes	100%
One hand or one foot, and entire sight of one eye	100%

LOSS SCHEDULE CONTINUED	
Loss of	**Maximum % of Principal Sum Payable**
Speech and hearing in both ears	100%
Use of both arms or both hands or both legs or both feet	100%
One arm, or one leg, or use of one arm, or one leg	80%
One hand, or one foot, or use of one hand, or one foot	75%
Entire sight of one eye	75%
Speech or hearing in both ears	75%
Hearing in one ear	66 ⅔%
Thumb and index finger of the same hand	33 ⅓%
Four fingers of the same hand	33 ⅓%
Thumb of either hand	25%
All toes of the same foot	25%
One to three fingers of either hand	16 ⅔%

When an eligible child receives Injuries resulting in any of the following Losses within 365 days of the accident, benefits will be payable for:

LOSS SCHEDULE	
Loss of	**Maximum % of Principal Sum Payable**
Brain death	1,000%
Both hands, or both feet, or one hand and one foot	1,000%
Entire sight of both eyes	1,000%
One hand or one foot, and entire sight of one eye	1,000%
Speech and hearing in both ears	1,000%
Use of both arms or both hands or both legs or both feet	1,000%
Quadriplegia, paraplegia, hemiplegia	1,000%
Life	100%
One arm, or one leg, or use of one arm, or one leg	80%
One hand, or one foot, or use of one hand, or one foot	75%
Entire sight of one eye	75%
Speech or hearing in both ears	75%
Thumb and index finger of the same hand	33 ⅓%
Four fingers of the same hand	33 ⅓%
Hearing in one ear	66 ⅔%

LOSS SCHEDULE CONTINUED	
Loss of	**Maximum % of Principal Sum Payable**
Thumb of either hand	25%
All toes of the same foot	25%
One to three fingers of either hand	16 ⅔%

If more than one Loss is sustained as the result of any one accident, only one benefit shall be payable, the largest.

The amount specified for losses of (a) both hands, both feet or both eyes, (b) one hand and one foot, (c) one hand and one eye, (d) one foot and one eye, (e) use of both arms, both hands, both legs or both feet, (f) speech and hearing, (g) thumb and index finger or at least 4 fingers of one hand and (h) all toes of one foot is payable only when such double loss occurs as a result of the same accident.

The maximum payable for all losses sustained by an insured person as a result of the same accident shall not exceed the Principal Sum, except as noted for Brain Death, Paraplegia, Hemiplegia, and Quadriplegia, or for children as noted.

DISAPPEARANCE

If the body of an insured person has not been found within one year of the forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then, for the purposes of this benefit, such insured person shall, in the absence of any evidence to the contrary, be deemed to have suffered loss of life.

PERMANENT AND TOTAL DISABILITY BENEFIT

When a Member or spouse receives injuries resulting in Permanent and Total Disability within 365 days of an accident, the Principal Sum will be paid less any amount paid or payable under the Accidental Death and Specific Loss Schedule for the same accident.

REHABILITATION BENEFIT

When injuries result in a payment being made under the Specific Loss Schedule, the Insurer will pay the reasonable and necessary expenses actually incurred up to a limit of $15,000, for the occupational training of the insured person provided:

- Such training is required because of such injuries and in order for the insured person to be qualified to engage in an occupation in which he or she would not have been engaged except for having suffered such injuries, and
- The training expenses are incurred within 2 years from the date of the accident.

No payment will be made for ordinary living, travelling or clothing expenses.

HOME ALTERATION AND VEHICLE MODIFICATION

When injuries result in a payment being made under the Specific Loss Schedule, and these injuries result in and necessitate the use of a wheelchair for the insured person to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred for:

- The one-time cost of alterations to the injured insured person's residence to make it wheel-chair accessible and habitable, and
- The lesser of:
    - The one-time cost of modifications necessary to a motor vehicle, owned by the injured insured person, and
    - The one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the insurer.

This benefit will not be paid unless:

- Home alterations are made on behalf of the insured person and carried out by an experienced individual in such alterations and recommended by a registered organization, providing support and assistance to wheel-chair users, and

- Vehicle modifications are made on behalf of the insured person and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities in the insured person's province of residence.

The maximum payable under Home Alteration and Vehicle Modification resulting from any one accident is $15,000 per insured person.

PARENTAL CARE BENEFIT

If an insured person suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Specific Loss Schedule, the Insurer will pay a Parental Care Benefit for an eligible dependent parent.

A dependent parent is eligible if, at the time of the accident:

- He/she is resident in a licensed nursing care facility,
- He/she is enrolled in a home health care program,
- He/she is living in the insured person's residence, or
- He/she is receiving support and care provided by the insured person as evidenced by cancelled cheques, income tax returns showing the parent as a dependent, or other similar forms of proof.

The maximum amount payable for the Parental Care Benefit for all injuries resulting from any one accident is the lesser of 10% of the insured person's Principal Sum or $5,000.

FAMILY TRANSPORTATION

When injuries covered under the Specific Loss Schedule result in an insured person being confined to a hospital, more than 100 Kilometres from his/her permanent place of residence, the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of one member of the immediate family to such hospital if:

- Confinement to hospital occurs within 365 days of the accident causing the injury, and

- Reimbursement of expenses are limited to the cost of one economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such immediate family member.

The maximum amount payable for Family Transportation for all injuries resulting from any one accident is $15,000 per insured person.

REPATRIATION BENEFIT

If an insured person suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Specific Loss Schedule, and:

- Such loss of life occurs more than 50 kilometres from his/her permanent city of residence, and
- Such loss of life occurs within 365 days of the date of the accident causing the injury, the insurer will pay the actual expenses incurred for preparing the deceased insured person for burial or cremation and shipment of the body to the city of residence of the deceased insured person.

The maximum amount payable for Repatriation is $15,000 per insured person.

IDENTIFICATION BENEFIT

If an insured person suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Specific Loss Schedule, and the insured person's body requires identification, the Insurer will pay the reasonable and necessary expenses actually incurred by one member of the immediate family for:

- Commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of 3 consecutive nights), and
- Transportation by the most direct route to the location.

This benefit is payable only if the body is located not less than 150 kilometres from the said immediate family member's normal place of residence and the identification of the body is requested by the police or similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometre travelled.

The benefit is payable only once in connection with Injuries and Losses suffered by any one insured person, regardless of the number of policies providing coverage for this benefit for such insured person, that may be issued by the Insurer.

The maximum amount payable for Identification Benefit is $10,000, per insured person.

SEAT BELT RIDER

If an insured person suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Specific Loss Schedule, the Insurer shall pay an additional amount equal to 10% of the insured person's Principal Sum if injury causing the loss of life results while he or she is a passenger or driver of a Private Passenger Type Automobile and his/her seat belt is properly fastened. The actual use of the seat belt must be verified and be evidenced in the official report of accident or certified by the investigating officer.

BEREAVEMENT BENEFIT

If a Member suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Specific Loss Schedule, the Insurer will pay the reasonable and necessary expenses actually incurred for grief counselling provided that:

- The counselling is for the spouse and/or dependent children,
- Such expenses are incurred within 365 days of the date of the accident causing loss of life, and
- Such grief counselling is provided by a therapist or counsellor who is licensed, registered or certified to provide such treatment and who is not a member of the member's immediate family.

The Insurer will pay the person who has incurred the actual expense. The maximum amount payable for the Bereavement Benefit is $1,000.

DAY CARE BENEFIT

If an insured person suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Specific Loss Schedule, the Insurer will pay to the legal guardian of any surviving dependent child of the insured person, an amount equal to the lesser of:

- The actual annual cost charged by a commercial and licensed day care centre,
- 5% of the insured's principal sum, or
- $5,000 per year.

The benefit is payable annually for a maximum of 4 consecutive payments per dependent child:

- And only for such dependent child who at the date of the insured person's loss of life is under age 13,
- Provided such dependent child is enrolled in a commercial and licensed day care centre no later than 90 days following the insured person's loss of life, and
- Provided that the dependent child continues his/her enrolment in a commercial and licensed day care centre.

SPECIAL EDUCATION BENEFIT

If a Member suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Specific Loss Schedule, the Insurer will reimburse the annual tuition, not including room and board, charged by an institution of higher learning per school year for each dependent child of that Member up to the lesser of the following amounts:

- $5,000 per school year, or
- 5% of the Member's Principal Sum.

The Special Education Benefit is payable annually up to a maximum of 4 consecutive payments per dependent child:

- Only for such dependent child who is, at the time of the Member's loss of life, enrolled as a full-time student in an institution of higher learning beyond the 12th grade level, and
- Only while such dependent child continues his/her continuous enrolment in an institution of higher learning.

The Insurer will reimburse the person who has incurred the actual tuition expenses.

If, at the time of Loss, the Member has no covered Dependent(s) eligible for the Special Education Benefit, an additional amount of $2,500 will be paid to the designated beneficiary.

SPOUSAL OCCUPATIONAL TRAINING BENEFIT

If a Member suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Specific Loss Schedule, the Insurer will pay to the Member's spouse the actual cost incurred for a professional or trades training program in which such spouse enrols for the purpose of obtaining an independent source of support and maintenance, provided such cost is incurred not later than 36 months after the Member's loss of life.

The maximum payable for Spousal Occupational Training is $15,000.

SERIOUS ILLNESS BENEFIT (NON-CANCER)

If, while coverage is in effect and coverage has been in effect on the Member for a period of not less than 90 days, the Member is then diagnosed with any one of the Covered Illnesses listed below and the Member satisfies the following conditions:

- Has been hospitalised as an in-patient continuously for at least 48 hours as a consequence of the Covered Serious Illness,
- Survives for a period of at least 30 days after the diagnosis has been made, and

- The Member is under age 65 at the time of diagnosis,

then the Insurer will pay a benefit of $10,000. The Insurer shall only be obligated to pay this benefit once per Member even though the Member may be diagnosed with more than one of the Covered Serious Illnesses.

COVERED SERIOUS ILLNESSES

- Major burns
- Major organ failure requiring transplant
- Major organ transplant
- Motor neuron disease
- Multiple sclerosis
- Necrotizing fasciitis
- Parkinson's disease

BURNS, LACERATIONS AND SURGICAL PROCEDURES INDEMNITY BENEFIT

If an insured person suffers injury resulting in the destruction of his/her skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with Loss of fluid (3rd) degree burn or worse), by means of exposure to fire, heat, caustics, electricity or radiation, the Company will pay up to $25,000 per insured person, based on a percentage of the insured person's Principal Sum, provided that the insured person survives for a period of at least 30 days after the date of the accident causing the burn.

The Insurer will pay depending on the area of the body which is burned and determined in accordance with the following table:

Body Part	(A) Body Classification	(B) Maximum % for that Body Part
Face, neck, head	11	99%
Torso (front or back)	2	36%
Either lower leg (below knee)	3	27%
Hand and forearm	5	22.5%
Either upper arm	3	13.5%
Either thigh	1	9%

The amount of the benefit is determined by multiplying the Body Classification (A) by the actual percentage of the insured person's Body Part that is burned and then multiplying the resulting percentage (not to exceed the Maximum Percentage for that Body Part (B) by the Principal Sum for such insured person.

The maximum amount payable for this Burn Benefit for all Injuries resulting from any one accident is $25,000 per insured person.

For Lacerations Requiring Suturing	
Over 5 inches in length	$300
Between 2 to 5 inches in length	$100
Less than 2 inches in length	$50

For Surgical Procedures Requiring General Anaesthesia	
External and internal injuries requiring a general anaesthesia	$500
Arthroscopy	$100

FRACTURE BENEFIT

If an insured person sustains injury resulting in a fracture or dislocation listed in the following Fracture Table, the Insurer shall pay the amount specified in the Fracture Table, provided that such fracture or dislocation occurs within 30 days after the date of accident causing it and such injury requires surgical treatment from a physician.

The maximum amount payable for this Fracture Benefit is $5,000 per insured person for all Injuries resulting from any one accident. Only one indemnity, the largest, shall be payable as the result of any one accident.

Fracture Table	
Cranium * (depressed fracture)	$5,000
Spine (two or more vertebrae)	$5,000
Pelvis	$3,000
Spine (one vertebra)	$2,000
Cranium * (other compound)	$2,000
Thigh (femur)	$1,650

Fracture Table Continued	
Upper jaw (maxilla)	$1,650
Knee cap (patella)	$1,350
Leg (tibia or fibula)	$1,250
Shoulder blade (scapula)	$1,250
Ankle (Pott's fracture)	$1,250
Wrist (Colle's fracture)	$1,250
Forearm (compound or comminuted)	$1,150
Spine (compression fracture)	$1,000
Arm, between elbow and shoulder	$ 850
Sacrum or coccyx	$ 850
Sternum	$ 850
Forearm (not compound)	$ 600
Collar bone (clavicle)	$ 600
Nose	$ 600
Two or more ribs	$ 500
Facial bones	$ 400
Lower jaw (mandible)	$ 400
One hand (one or more metacarpal)	$ 400
One foot (one or more metatarsal)	$ 400
One rib	$ 250
Any bone not specified above	$ 250

* **Cranium (as used in this policy)** means the vault of the skull consisting of the following bones: frontal, parietals, occipital, temporals, sphenoid and ethmoid.

Dislocation Table	
Complete dislocation of the:	
Hip	$2,100
Knee (with open primary repair)	$1,650
Shoulder (with open reduction)	$1,250
Wrist	$ 850
Ankle	$ 850
Elbow	$ 600
Bone of foot, other than toes	$ 400

The Insurer shall only be obligated to pay once for each dislocation benefit. Recurrent dislocations are not provided for under this policy.

WAIVER OF PREMIUM

In the event a Member becomes Permanently and Totally Disabled and his/her waiver of premium claim is accepted and approved under the Trust Fund's current Group Life Policy, then the Accidental Death and Dismemberment premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Insurer until one of the following occurs, whichever is earlier:

- The date the Member attains age 65,
- The date of the death or recovery of the Member,
- The date the Member is no longer eligible for total disability waiver of premium under the Trust Fund's group life policy, or
- The date the policy is terminated.

EXCLUSIONS

No coverage shall be provided under the Accidental Death and Dismemberment Benefit and no payment shall be made for any Loss or claim resulting from, or contributed to, in whole or in part by, or as a natural and probable consequence of any of the following excluded risks, even if the proximate or precipitating cause of the Loss or claim is an accidental injury:

- Suicide or any attempt thereat by the insured person while sane;
- Self inflicted injury or any attempt thereat by the insured person while sane or insane;
- Declared or undeclared war or any act thereof;
- Sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
- Mental incapacity whether the loss or claim results directly or indirectly from any mental incapacity;
- Sustained while the insured person is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
- Stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the insured person is:

    - Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers,
    - Performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft, or
    - Riding as a passenger in an owned aircraft or leased aircraft operated by the policyholder.
- Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
- Injury or loss sustained while the insured person is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (unearned premium for any period for which the insured person is on full-time active duty shall, upon application to the company by the policyholder, be refunded);
- The commission or attempted commission by an insured person or injury incurred while an insured person is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed;
- An act, attempted act or omission taken or made by the insured person, or an act, attempted act or omission taken or made with the insured person's consent, for the purposes of interrupting the blood flow to the insured person's brain or to cause asphyxiation to the insured person whether with intent to cause harm or not;
- Natural causes.

BEREAVEMENT PAY

Definitions for the purpose of the Bereavement Pay benefits, as set out below:

"Child or Grandchild" means a natural or legally adopted child or grandchild of the Member, or a stepchild or other child who is dependent upon the member for support and lives with the Member in a regular parent-child relationship.

"Parent or Grandparent" means a natural or legally adoptive parent or grandparent of the Member.

"Parent or Grandparent in Law" shall mean the parent or grandparent of a Member's spouse.

"Sibling" shall mean a natural or legally adopted brother or sister, stepbrother, stepsister, or other person sharing a common parent with a Member.

"Sibling-in-Law" shall mean a sibling of a spouse, including daughter-in-law and son-in-law.

"Spouse" means a husband or wife by virtue of a religious or civil marriage ceremony, except that, a person living with a Member in a common-law relationship will be deemed to be the Member's spouse, if such person is publicly represented as the Member's spouse.

Bereavement Pay benefits to a maximum of 8 hours per day at the Member's regular rate of pay for straight time shall be paid to any Member for up to 3 days of lost work in relation to the Member's attendance at a funeral or memorial service upon death of a child, grandchild, parent, grandparent, parent in law, grandparent in law, sibling, sibling in law, or spouse, as defined above.

Bereavement Pay Benefits shall only be paid to Members who:

- Were employed by a contributing employer to the Trust Fund at the time of the funeral or memorial service and were not reimbursed for the days claimed by their employer for lost wages,

- Complete a Declaration Form available from your Local Union Office or the Administrative Agent's Office, and
- Obtain a letter from the employer to indicate that the Member was absent from work for the days in questions and was not reimbursed by the employer for the time lost from work due to bereavement.

GROUP LEGAL

Definitions for the purpose of the Group Legal Benefit Plan, as set out below:

“A” Real Estate
A Plan Member and/or their dependent spouse shall be provided with legal assistance in connection with the sale or purchase of a family dwelling, which shall be used by the Plan Member's family as a dwelling place; the purchase of a lot on which to build a family dwelling (provided a building permit is issued within one year) and the purchase of a vacation property. Assistance in the arrangement of new or renewal of mortgage is also covered under the Plan insofar as they relate to the principal family residence. A Plan Member and their dependent spouse shall not be entitled to assistance in connection with commercial or income producing property. Maximums include one sale, one purchase and one new or renewal of mortgage in any 12-month period. Vacation property shall be limited to a lifetime maximum of one purchase. Benefits relating to the sale, purchase, mortgage (new or renewal) or discharge on vacation or recreational property are limited to a lifetime maximum of one per Plan Member.

“B” Divorce and Domestic Proceedings
The Plan Member and the spouse of the Plan Member (i.e., the spouse of the Plan Member in respect of whom the contributions are being made for coverage under their Plan) shall be entitled to representation in connection with any matrimonial or divorce proceedings. Representation of the Plan Member and spouse shall include preparation of a separation agreement, filing a petition of divorce or separation and all other acts necessary for terminating the relationship, establishing the custody of the children and effecting an equitable distribution of property. If proceedings are non-contested, the spouse of the Plan Member will be encouraged to seek the advice and consultation of separate counsel. In the event of a contested divorce where the services exceed the limit of the Plan, the Law Firm may assess a separate fee upon prior mutual agreement of the parties and the Plan will only be responsible for the maximum allowable amounts as herein set out. Cheques for legal services for a Plan Member's Dependent in divorce or separation matters will be mailed directly to the Dependent or the Dependent's lawyer.

“C” Preventive Law
Each Plan Member and their eligible Dependents shall be entitled to receive legal advice by telephone or direct office consultation on any problem that the Plan Member believes to be of a legal nature.

“D” Non-Complex Legal Documents
Legal documents which are not deemed to be excessively complex will be prepared for the Plan Member and their eligible Dependents.

“E” Wills and Estates
Plan Members and/or their spouse shall be entitled to have prepared what is commonly regarded as a Simple Will (i.e. a Will which does not include the creation of any trust or other estate). A Plan Member and/or their spouse shall, for the duration of membership in the Plan, be entitled to the periodic review and amendment of all testamentary instruments, including the preparation of revised Wills and Codicils, not to exceed one revision in any 12 consecutive months.

“F” Landlord and Tenant Matters
A Plan Member, as lessee, shall be represented in connection with any claims or controversies arising out of a tenant lessor - lessee relationship in respect of their apartment or dwelling. Proceedings in which the Plan Member and/or their eligible Dependents are the landlord will not be a covered benefit under this Plan.

“G” Consumer and Personal Property Law
A Plan Member and their eligible Dependents shall be entitled to legal representation in connection with any claim against a manufacturer, distributor or retailer for defects in any merchandise, article or service or in a recovery on any warranty given in connection with the sale of merchandise, article or service, where such claim is in excess of $100. The Plan shall not be obliged to litigate on any claim unless the dollar value shall exceed $300.

“H” Civil Litigation (Defendant)
A Plan Member and their eligible Dependents shall be represented in connection with any civil action or civil administrative proceeding in which the Plan Member, spouse or other eligible Dependent is named as a defendant or respondent, provided that such representation shall not exceed 20 hours in a calendar year.

The Plan shall be under no duty to provide legal representation to a Plan Member or their eligible Dependents where representation is provided for under statutory programs. Plan Members shall be required to pay any disbursements in connection with such defensive litigation including the costs of discovery, witness fees, etc.

"H" Civil Litigation (Plaintiff, Plan Member Only)
A Plan Member shall be represented in connection with the filing of a civil or administrative action for and on behalf of the Plan Member in connection with any material injury to person or property for the deprivation or injury of any constitutionally or statutorily guaranteed right, any right conferred at common law or for the adjustment of any grievance both recognizable and actionable in either law or equity. No representation shall be available under this item for any action that is either non-meritorious, calculated to be vexatious only, or a non-material or non-consequential nature or would be contrary to Public Policy. In the event any damages are recovered, or some form of monetary claim effected, the first $4,000 excluding damages for property replacement and/or medical expenses of any such recovery shall be free of any assessment by the Plan for legal costs expended on the Plan Members behalf. The Plan shall be entitled to recover any legal costs expended on behalf of the Plan Member from costs awarded by the court and from any monetary settlement in excess of $4,000.

"I" Government Programs and Assistance
A Plan Member shall be entitled to legal representation on behalf of themselves or their eligible Dependents in any matter requiring legal assistance arising out of disputes or appeals with Social Assistance or Employment Insurance. A Plan Member shall be entitled to legal representation in matters of immigration on behalf of himself or his Dependents, or on behalf of any other relative who the Member has directly sponsored immigration into Canada.

"J" Insurance Related Matters
Plan Members and their eligible Dependents shall be represented in connection with any claim against his Insurer (except for benefits provided by the Teamster Construction Benefit Trust Fund or benefits provided by a contributing employer to this Group Legal Benefit Plan) by reason of failure to provide or pay the benefits as contracted for or to render advice in the interpretation of any Policy Provision.

"K" Automobile Related Matters
Plan Members and their eligible Dependents shall be represented in connection with some automobile related events. Parking violations are excluded from coverage under this item.

ELIGIBILITY

Plan Members who are employed by contributing employers and on whose behalf contributions to the Group Legal Benefit Plan have been received, and who are currently eligible for benefit coverage under the Ontario Teamster Construction Benefit Trust Fund, shall be entitled to benefit coverage in the Group Legal Benefit Plan. Members and their eligible Dependents shall continue to be eligible for legal benefits as long as they remain eligible for benefits in the Ontario Teamster Construction Benefit Trust Fund. The Group Legal Benefit coverage is not provided for Plan Members whose Life and Health Benefits are extended by Fund Assistance, or who elect to continue benefit coverage by paying direct.

COVERAGE SUMMARY

The Plan covers expenses of legal services rendered by Registered Paralegals or Lawyers of any Law Firm up to the limits specified in the schedule of fees, and a calendar year maximum of 30 hours of legal service per insured Participant. The schedule of fees sets out the maximum amount payable by the Plan for the services described. All additional charges are the responsibility of the Plan Member.

SCHEDULE OF FEES	
"A" Real Estate Code and Name	**Maximum Amount**
A1-Purchase Family Dwelling	$650
A2-Sale of Family Dwelling	$550
A3-Purchase Lot for Family Dwelling	$450
A4-Purchase Vacation Property	$450
A5-Transfer of Title	$250
A6-Mortgage, New or Renewal	$450
A7-Mortgage Incidental to Purchase	$150
A8-Discharge of Mortgage	$100

"B" Divorce and Domestic Proceedings Code and Name	Maximum Amount
B1-Divorce, Member	$550
B2-Divorce, Spouse	$550
B3-Property and Custody Support, Member	$500
B4-Property and Custody Support, Spouse	$500
B5-Separation Agreement, Member	$500
B6-Separation Agreement, Spouse	$500
B7-Modification of Separation Agreement	$300
B8-Adoption (Private)	$300
B9-Guardianship	$300
B10-Change of Name	$250
B11-Birth Certificate Assistance/Passport	$200
B12-Post or Pre-Nuptial Agreement	$400
"C" Preventive Law Code and Name	**Maximum Amount**
C1-Preventive Law	2 hrs max $100/hr (includes telephone consultations)
"D" Non-Complex Legal Documents Code and Name	**Maximum Amount**
D1-Power of Attorney	$125
D2-Deeds	$100
D3-Simple Contract	$200
D4-Tenant Leases (Residential)	$150
D5-Notarized Affidavits or Documents	$25
D6-Other Legal Documents	$100
"E" Wills and Estates Code and Name	**Maximum Amount**
E1-Simple Will, Member	$125
E2-Simple Will, Spouse	$125
E3-Revised Will or Codicil, Member	$125
E4-Revised Will or Codicil, Spouse	$125
"F" Landlord and Tenant Matters Code and Name	**Maximum Amount**
F1-Leases/Tenancy	$300

"G" Consumer and Personal Property Law Code and Name	Maximum Amount
G1-Contracts/Warranty	$300
G2-Consumer Protection Act	$300
G3-Bankruptcy (Personal)	$400
G4-Garnishment of Wages	$300
G5-Tax Advice	$250
G6-Liens (Personal)	$250
"H" Civil Litigation Code and Name	**Maximum Amount**
H1-Defendant Representation	20 hrs max. $100/hr
H2-Plaintiff Representation (Plan Members only)	20 hrs max. $100/hr
"I" Government Programs and Assistance Code and Name	**Maximum Amount**
I1-Social Assistance	$150
I2-Employment	$150
I3-Immigration	$500
"J" Insurance Related Matters Code and Name	**Maximum Amount**
J1-Accident and Death	$250
J2-Life and Annuity	$250
J3-Fire and Homeowners	$250
J4-Casualty	$250
J5-Automobile Liability	$250
J6-Marine	$250
J7-Other	$250
"K" Automobile Related Matters Code and Name	**Maximum Amount**
K1-Civil Actions (Re: Auto Accident)	$500
K2-Damage and Personal Injury	$500
K3-Uninsured Motorist (for Passenger and insured Motorist only)	$400

EXCLUSIONS

The following services are excluded from coverage under the Group Legal Plan:

- Disbursements, retainer fees, court costs, filing fees, land transfer taxes, registration fees, including mortgage registration fees, G.S.T.;
- Title searches and survey fees;
- Fines and penalties, whether civil or criminal;
- Any judgment for damages, including judicially awarded costs;
- Any proceedings or dispute involving an employer or their Officers, Agents, Representatives or Employees;
- Any proceedings or dispute involving the Union, its Officers, Agents, Representatives or Employees;
- Any proceedings, including Appeals, arising under the Ontario Labour Relations Act or any other statute that relates to labour relations or terms and conditions of employment, including but not limited to W.S.I.B., Employment Insurance, the Occupational Health and Safety Act or the Ontario Human Rights Code in matters involving the employer;
- Any dispute involving this Plan, the Benefit Plan or any other Plan or Trust Fund provided by a contributing employer or a Teamsters Local;
- Matters involving election to any public office;
- Non-personal legal services (i.e.: any business-related matters);
- Any controversy between a Member and his/her spouse or any Dependents, apart from divorce, separation or annulment.
- No service shall be provided that will violate Public or Statutory Law;
- Any case in which defense or other legal representation is provided through insurance or other indemnification;
- Action instituted prior to becoming a Plan Member or civil actions requested to file arising out of pre-existing conditions. Exceptions may be waived by the Board of Trustees;
- Class actions or interventions or *amicus curiae* filings in any suit or controversy among other parties not involving the immediate and direct interest of a Plan Member;

- Any case in which defence or other legal representation is provided through any government agency, which will represent a Plan Member without charge;
- Any representation required by reason of any acts committed, or acts which a Plan Member omitted to perform, giving rise to tort, negligence, or criminal claims;
- Court appearance in connection with small claims involving an amount less than $300;
- Stale dated claims which were incurred over 24 months prior to their submission;
- Legal services in excess of 30 hours in any calendar year.

TERMINATION OF COVERAGE

Your Group Legal Benefit will terminate on the same date that the Plan Member ceases to be eligible for benefits in the Benefit Trust Fund. Legal services which commence following this date will be ineligible for coverage.

CLAIMS

Plan Members may obtain a claim form from the Administrative Agent. This form must be completed and submitted to the Administrator with an itemized statement of account from the Law Firm providing the legal services.

HOW TO CLAIM

The benefits for which you may be eligible are insured by a variety of insurers. This may influence how you make claims.

GENERAL CLAIMS INFORMATION

Obtain a Claim Form
When needed, you may obtain claim forms from the Administrative Agent, your union office or the Trust Fund's website.

The Trust Fund does not reimburse physician's fees. Any charges by physician's or suppliers to complete claims forms or provide additional supportive information are not reimbursable.

For dental claims, generic claim forms that are available at your dentist's office are also acceptable. Assignment of benefits is accepted, if the dentist allows it. This means that the dentist will submit a claim on your behalf.

Benefit Plan Administrators Limited (BPA)
Phone Number: 905-275-6466
Toll-Free Number: 1-800-867-5615
Fax Number: 905-275-6462

Submit your Claim
If any of the following information is missing on the claim form, your claim will be delayed:

- ✓ Name of your Trust Fund,
- ✓ Your first and last name,
- ✓ Your birth date,
- ✓ Your Identification Number,
- ✓ Your full mailing address,
- ✓ The patient's name and birth date,
- ✓ The dentist's signature on an original claim form and
- ✓ Your signature.

Where relevant, the following information should be attached to the claim form:

- ✓ Original receipts or paid invoices for the item or service being claimed. The receipt should show the patient's full name and full details of the charges. Cash register receipts or labels from containers are not acceptable,
- ✓ For vision care, this means charges for lenses, frames and miscellaneous items,
- ✓ For medical services and supplies, proof of payment is required. Accepted are copies of cheques, or debit/credit card receipts, or in the case of a cash payment, a signed statement from the provider of the service,
- ✓ The physician's referral where required, and/or
- ✓ The Explanation of Benefits (EOB) that you received from the other plan if you are coordinating benefits (coordination of benefits is explained below).

Mail the form and all attachments directly to the Administrative Agent:

Ontario Teamster Construction Benefit Trust Fund
c/o Benefit Plan Administrators Limited
P.O. Box 3071, Station "A"
Mississauga, Ontario L5A 3A4

HOW COORDINATION OF BENEFITS (COB) WORKS

Coordination of Benefits (COB) is a procedure for reimbursing families who are insured under multiple benefit plans by determining which plan pays first (and thus where to submit the claim first) and which plan(s) pays next.

Benefits for you or a Dependent will be directly reduced by any amount payable under a government plan. If you or a Dependent are entitled to benefits for the same expenses under another group plan or as both a member and Dependent under this Plan or as a Dependent of both parents under this Plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.

Definition: Benefit Plan or Plan means any contract of group insurance or other arrangement for members of a group (whether on an insured basis or not), prepaid health care coverage or student accident insurance.

You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the Plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered).

If you are separated or divorced, the Plan which will pay benefits for your children will be determined in the following order:

- The Plan of the parent with custody of the child;
- The Plan of the spouse of the parent with custody of the child;
- The Plan of the parent without custody of the child;
- The Plan of the spouse of the parent without custody of the child.

You may submit a claim to the Plan of the other spouse for any amount which is not paid by the first plan.

On the claim form, you must put a check in the “Yes” box if you are claiming benefits for an eligible Dependent who is covered by another plan. If your Dependent is covered by another plan, you will seek reimbursement from both plans according to the Canadian Life and Health Insurance Association’s (CLHIA) guidelines.

The first plan to receive the claim should also receive the original receipts. The next plan to receive the claim should also receive copies of receipts and the Explanation of Benefits (EOB) received from the previous plan(s).

Definition: Explanation of Benefits (EOB) is information that you receive from all insurance companies every time one of your claims is assessed. The purpose of the EOB is to explain to you what was paid and what wasn’t, to make sure that you verify that you actually received those services and to provide you with documentation that you can use for Coordination of Benefits (COB).

CLAIMS FOR SPECIFIC BENEFITS

Explained below are the processes for claims for Extended Health Care, Dental Care, Expedited Access to Healthcare, Emergency Travel Medical, Member and Family Assistance, Mental Wellness, Weekly Wage Replacement, Long Term Disability, Critical Illness, Life and Accidental Death and Dismemberment.

Extended Health Care* and Dental Care Claims
Every time you have a prescription filled or a dental service performed, present your Benefit Card to the pharmacist or dentist who will electronically submit a claim on your or your eligible Dependents' behalf. Immediately, your claim will be processed and you will be notified of which expenses are reimbursable.

You may use any pharmacy or dental care office in Canada that will accept your card. If you need to obtain a claim form or have any other difficulties using your Benefit Card, contact the Administrative Agent.

You may also submit your claims online with the BPA eClaims mobile app and website. To get started, all you need to do is register. You can do so by downloading the app to your phone or by accessing BPA eClaims from our website.

To download the mobile app to your phone or tablet, go to the App Store (iPhone) or Google Play (Android) and search "BPA eClaims". To access BPA eClaims from your computer, visit our website at https://iupat.on.ca/iupat-members/member-benefits.

To register your account, you will need your Benefit Card. You will be asked to provide your Group Number, which consists of the first six digits of your Benefit Card number, as well as your Certificate Number, which consists of the second set of ten digits of your Benefit Card number. If you have any technical questions about the app or website, contact the Administrative Agent.

***Vision care claims may only be submitted using a claim form from the Administrative Agent.

Expedited Access to Healthcare Claims
No claim forms are required for services providing expedited access to specialist consultations, diagnostic scans, general and orthopedic surgeries and addiction and substance abuse treatment.

- Call toll-free 1-844-900-8357

Emergency Travel Medical Claims
If you require emergency travel medical care or hospitalization, you or someone acting on your behalf should contact AIG Insurance Company of Canada immediately:

- U.S. and Canada **1-877-204-2017**
- Elsewhere (collect call) **0-715-295-9967**

If you contact them immediately, your claim may be pre-approved so you can avoid having to pay up front and claim for reimbursement later.

If you are not able to contact them before being billed for the charges or if your medical needs are minor in nature (i.e., costing less than $500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip.

To make a claim for out-of-pocket expenses, contact an AIG Insurance Company of Canada Coordination Centre operator. Give the operator your name and your policy number: SRG 9022531-C. The operator will send you a claim form. When you complete the form, provide the:

- ✓ Name of your Trust Fund,
- ✓ Policy number,
- ✓ Patient's first and last name,
- ✓ Patient's provincial health card number, and
- ✓ Your identification number.

You may also need to attach the following information:

- ✓ Medical records, statements or detailed receipts received at the time of treatment and/or discharge.

Member & Family Assistance Claims
No claim forms are required. This short-term counselling and referral service is available without service fees.

- Call toll-free **1-866-462-8047**

Mental Wellness Claims
No claim forms are required for this in-person or online confidential program designed to improve functioning well-being.

- Call toll-free 1-844-900-8357

Weekly Wage Replacement Claims
To claim Weekly Wage Replacement benefits, a claim form is sent out to you that contains three parts:

- Employee's Statement (to be completed by the member),
- Employer's Statement (to be completed by the employer), and
- Attending Physician's Statement (to be completed by the treating physician).

The date you last worked must be shown on this form. Do not ask your doctor to complete the "Attending Physician's Statement" portion of the form until after you stop working and your disability commences. Make sure that the "Attending Physician's Statement" includes the following information:

- ✓ The diagnosis,
- ✓ The date(s) of treatment for this condition,
- ✓ The type(s) of treatment rendered, and
- ✓ An estimated return to work date.

To avoid delay in the assessment of your claim, you should provide all required information. Return the completed form to the Administrative Agent. If or when your claim is accepted or approved, your cheques will be mailed directly to you.

You should maintain contact with the Administrative Agent throughout your disability, including the period where you receive benefits from E.I. Keeping these lines of communication open will allow for a smoother transition back into payment after a period of receiving E.I. Benefits.

Long Term Disability Claims
The LTD benefit has a waiting period equal to the period when you will likely be receiving Wage Replacement benefits. The Administrative Agent will send you an LTD claim form by approximately 14 weeks into your disability period. If you do not receive this form and anticipate that you will not be able to return to work when your Weekly Wage Replacement benefit ends, please contact the Administrative Agent and request an LTD claim form.

Critical Illness Claims
Claim forms can be obtained from the Administrative Agent.

Life and Accidental Death & Dismemberment Claims
You should acquaint your beneficiary with the fact that one of the first duties they should perform in the event of your death or dismemberment is to contact the Administrative Agent immediately.

TIME LIMITS FOR FILING CLAIMS

You should notify the Administrative Agent as soon as is reasonably possible of your injury/claim. Documented proof of your loss is due no later than:

- **Extended Health**: 12 months after the date the expense was incurred;
- **Dental**: 12 months after the date a service is received;
- **Hospital Cash**: 90 days after the date of hospitalization;
- **Emergency Travel Medical**: 90 days after emergency treatment and/or services were provided;
- **Weekly Wage Replacement**: within 6 months after the termination of the first month following the waiting period;
- **Long Term Disability**: within 6 months after the termination of the first month following the waiting period;
- **Critical Illness**: 12 months after the date of diagnosis;
- **Life**: 12 months after death;
- **Waiver of Premium for Life Benefits**: 6 months of your last day at work because of total disability;
- **Accidental Death and Dismemberment**: 12 months after death or accident.

Documented proof of loss is due within 90 days if your coverage or the policy is terminated. Failure to furnish proof of loss within the time required will not invalidate nor reduce any claim if it is not reasonably possible to furnish the proof within such time, provided proof is given as soon as is reasonably possible. In no event will the insurer accept notice of claim beyond one year.

WHEN TO EXPECT PAYMENT

The Administrative Agent's service standard is 5 business days. Several factors could affect the time it takes for your claim to be assessed:

- Your claims could be delayed if your employer does not report your work hours on a timely basis. Rather than decline your claim, the claims office will wait until your hours are reported;
- Your claims could be delayed during heavy demand in December and January. At times of extremely heavy demand, Weekly Wage Replacement claims are given priority because you will have no other income except for these cheques.

For all other claims, you should contact the Administrative Agent if you have not received payment within 3 weeks.

HELP GUARD AGAINST INSURANCE FRAUD

Insurance fraud costs the Trust Fund and ultimately reduces the amount of funds available for benefits. It should be a significant concern for all Members. Insurance fraud occurs whenever a person knowingly provides misinformation or withholds information to ensure a claim is paid.

You can help guard against insurance fraud by:

- Verifying the information contained in each Explanation of Benefits (EOB) to ensure you actually received those services and by;
- Reporting suspected abuse by professional suppliers to their governing body.

A Member who participates in insurance fraud jeopardizes his or her right to make future claims for benefits under the Trust Fund.

GOVERNMENT BENEFITS

The Trust Fund cannot reimburse you for charges that are considered an insured service or item of any provincial government plan. The following seven programs are available to Ontario residents:

Ontario Health Insurance Plan (OHIP)

- OHIP pays most medical and surgical services required by residents of Ontario and their eligible Dependents. It also pays for hospital standard ward room and board charges. Regulations for OHIP are made under the *Ontario Health Insurance Act* and will change from time to time.
- Claim OHIP benefits by presenting a valid provincial health card at the time of service.
- If you have any questions relating to the commencement date or termination procedures of your OHIP coverage, you should communicate directly with OHIP.

The Ontario Drug Benefit (ODB)

- ODB pays first if you are an Ontario resident age 65 or over. Then, the Trust Fund will cover the deductible and any eligible drugs that are not included on the ODB Formulary.
- Gain access to your ODB benefits by speaking to your pharmacist who will enter your information into the system when you fill a prescription.

The Trillium Drug Program (TDP)

- Apply for the TDP if your drug expenses are not fully covered by the Trust Fund or if your coverage under the Trust Fund is terminated.
- Your eligibility for TDP benefits will be based on the amount of your household income after taxes.
- Begin the application process for TDP benefits by filling out an application found on the Ontario Ministry of Health and Long-Term Care website.

The Ontario Assistive Devices Program (ADP)

- Apply for the ADP if you have a long-term physical disability that necessitates medical equipment, medical supplies and/or drugs.

- File a claim with the ADP first. Then, seek further reimbursement through the Trust Fund to the extent allowed by the Trust Fund.
- Begin the application process for ADP benefits by speaking to the health care professional who has provided your diagnosis or the government-authorized supplier.

Employment Insurance (EI)

- Apply for temporary financial assistance through EI if you are unable to work for variety of reasons including a non-occupational injury or illness.
- Begin the application process for EI benefits by filling out an application found on the Service Canada website or by visiting a Service Canada Centre.

Workplace Safety and Insurance Board (WSIB)

- Apply for WSIB Benefits if you become unable to work because of an occupational (directly related to your work) accident or sickness.
- Begin the application process for WSIB Benefits by filling out the forms found on the WSIB/CSPAAT website.

Canada Pension Plan (CPP) Disability Benefits

- ✓ Apply for CPP Disability Benefits if you anticipate your disability will extend beyond CPP's 6-month waiting period and you made contributions to the CPP while you were working.
- ✓ Begin the application process for CPP Disability Benefits by filling out the forms found on the Service Canada website.

DEFINITIONS OF GENERAL TERMS

Active Member is a person who is working for a contributing employer or is available for work as determined by his or her name appearing on the Union Out-of-Work List and satisfies the eligibility requirements of the Ontario Teamster Construction Members' Benefit Fund.

Administrative Agent performs the daily administrative functions of the Trust Fund. When you contact the Administrative Agent's claims office, you are speaking to a staff member of Benefit Plan Administrators Limited (BPA).

Benefit Plan or Plan means any contract of group insurance or other arrangement for members of a group (whether on an insured basis or not), prepaid health care coverage or student accident insurance.

Coordination of Benefits (COB) is a procedure for reimbursing families who are insured under multiple benefit plans. This procedure ensures that the reimbursed amount does not exceed the expenses you originally incurred by determining which plan pays first (and thus where to submit the claim first) and which plan(s) pays next. Further details about how COB works appears in the "How to Claim" section of this booklet.

Disabled Member is a person who is receiving one of the following benefits:

- Weekly Wage Replacement benefits,
- Long-Term Disability benefits,
- Workplace Safety and Insurance Board (WSIB) benefits,
- Motor Vehicle Insurance Disability Benefits or
- Canada Pension Plan (CPP) Disability Benefits.

Eligibility Requirements mean the rules, regulations and procedures established from time to time by the Board of Trustees for determining the eligibility of members for health and welfare benefits provided by the Trust Fund.

Eligible Dependent is a person who has satisfied the Dependent eligibility requirements of the Ontario Teamster Construction Members' Benefit Fund.

Eligible Member is a person who has satisfied the Dependent eligibility requirements of the Ontario Teamster Construction Members' Benefit Fund.

Eligible Widow is a person who:

- Conforms to the definition of dependent spouse in the "Eligibility" section of this booklet when an eligible Member dies,
- Satisfies the requirements described under "Continuing Coverage If an Eligible Member Dies" in the "Eligibility" section of this booklet, and
- Is named as a dependent spouse on the most recent Member Information Card on file.

Hospital is an institution licensed for the care and treatment of sick and injured persons. The hospital must be continuously staffed and supervised by physicians and Licensed Nurses. Such institution must have facilities both for diagnosis and for major surgery. The term hospital does not include a health spa or hotel, long-term care home, retirement residence, establishment providing custodial care, rehabilitation hospital or an institution used primarily for the treatment of addictions or mental disorders.

Leave of Absence means a period of time away from work mutually agreed to by you and your employer. In the case of maternity leave of absence, the leave shall begin and finish on dates agreed to by you and your employer or as required by provincial or federal law.

Licensed Nurse is a Registered Nurse (RN), a Registered Nursing Assistant (RNA), or a Registered Practical Nurse (RPN).

Non-Occupational means an injury that does not arise in the course of any employment for wage or profit or a disease where a person is not entitled to receive benefits under any workplace safety and insurance law or similar legislation.

Physician is a healthcare provider who is licensed in the jurisdiction where he or she practices to prescribe and administer any drugs, to perform minor surgical procedures and to order diagnostic tests.

Provincial Government Plan means the body of provincially-enacted laws as amended from time to time, governing provincial health insurance plans, provincial hospital insurance plans, provincial Medicare Plans, provincial medical care and services acts and other provincial government-sponsored hospitalization, Medicare, drug or dental insurance plan which provides health insurance to residents of Canada.

Reasonable and Customary Expense means

- The prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred as determined by the insurer,
- The amount shown in the applicable professional fee guide, or
- The maximum price established by law.

Rehabilitation Hospital means a licensed, extended hospital facility or institution, or chronic care facility or institution that is regularly engaged in the care of sick and injured persons. Such institution must provide 24-hour nursing service and regular medical supervision. The term rehabilitation hospital does not include a health spa or hotel, long-term care home, retirement residence, establishment providing custodial care or an institution used primarily for the treatment of addictions or mental disorders.

Reimbursable Expense means any necessary, reasonable and customary expense incurred while eligible for benefits under the Trust Fund, part or all of which are recognized under any of the benefits, but not any expenses contained in a list of exclusions.

Retired Member or (Early) Retiree is a person who receives a pension benefit from a Teamsters Pension Plan.

Retirement is the date a person starts to collect a pension benefit under any pension plan.

Trust Fund refers to the Ontario Teamster Construction Members' Benefit Fund.

You refers to an Active Member who has satisfied the eligibility requirements of the Ontario Teamster Construction Members' Benefit Fund.

YOUR PRIVACY

The Board of Trustees and Administrative Agent operate according to a strict Privacy Policy that complies with the *Personal Information Protection and Electronic Documents Act* ("PIPEDA"). The PIPEDA is designed to protect the personal information the Trust Fund collects on its participants.

The Board of Trustees and the Administrative Agent are required to collect personal information about you, your beneficiary(ies) and your Dependent(s) for the purposes of administering your benefits under the Trust Fund, including the determination of eligibility, enrolling you for coverage, the payments of benefits, and for routine activities such as audit, record-keeping and reporting. The personal information you share with the Board of Trustees and the Administrative Agent stays confidential and is used only to determine your benefit entitlements under the Trust Fund.

The Administrative Agent will, however, provide personal information to other parties such as insurers to determine benefit entitlements when payments are made to you and your Dependent(s) or as required by law. Your employment history may be shared with your local union for the purpose of monitoring the contributions required to be made under the terms of the Collective Agreement. Insurers and your local union are also required by law to respect the confidentiality of any such information.

If you have any concerns about the handling of your personal information or would like to obtain a copy of the Trust Fund's Privacy Policy, contact the Privacy Officer.

PRIVACY OFFICER
P.O. Box 3071, Station A
Mississauga, Ontario L5A 3A4

Email: privacy_officer@bpagroup.com
Telephone: 905-275-6466
Toll Free: 1 -800-867-5615
Fax: 905-275-6462

NOTICES

NOTICE A: THIS BOOKLET IS NOT A CONTRACT

Effort has been made to ensure that the material in this booklet is current, complete and accurate; however, this booklet is not in itself a legal contract, so it follows that the terms and conditions of the insurance contracts, governing legislation and the Trust Fund documents take precedence in case of dispute.

NOTICE B: RIGHT CHANGE OR TERMINATE

As is customary in group insurance plans, the right of change or discontinuance at any time without notice to you must be reserved. Changes could include reduction or elimination of benefits, modification of the eligibility requirements, or modification of the benefits in order to prudently manage the Trust Fund and to deliver benefits in a contemporary fashion. The right to change or terminate is applicable to all participants, including retirees. Since benefits are funded by ongoing current contributions, coverage cannot be guaranteed.

NOTICE C: COVERAGE CANNOT BE ASSUMED

You cannot assume you are eligible for coverage by the Trust Fund, even if you obtain this booklet, obtain a Member Information Card or obtain a claim form. You and your Dependents do not have coverage until the eligibility requirements have been satisfied.

NOTICE D: INSURANCE FRAUD

If you participate in insurance fraud, you jeopardize your right to make future claims for benefits under the Trust Fund. Insurance fraud occurs when a person knowingly provides misinformation or withholds information to ensure a claim is paid.

NOTICE E: THE INTERNET IS NOT SECURE

The Administrative Agent takes all reasonable measures to protect its systems from unauthorized access and evolving malware. Even so, like other forms of communication, email communications may be vulnerable to interception by unauthorized parties.

Unless directed otherwise by you, sending an email message to the Administrative Agent implies that you consent to communicating with the Administrative Agent by email. If you do consent, consider that no additional security measures will be taken.

When you communicate with the Administrative Agent by email, also consider leaving out sensitive information such as your Social Insurance Number (SIN) and details of your medical condition(s).

NOTICE F: LEGAL ACTIONS

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in whatever legislation is in place at the time and place of the claim.

NOTICE G: APPEALS

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

NOTICE H: BENEFIT LIMITATION FOR OVERPAYMENT

If benefits are paid that were not payable under the Plan, you are responsible for repayment within 30 days after the insurer sends you a notice of the overpayment, or within a longer period if agreed to in writing by the insurer. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit the insurer’s right to use other legal means to recover the overpayment.

NOTICE I: CHANGE OF INSURER

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

NOTICE J: ACCESS TO DOCUMENTS

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to the Insurer as evidence of insurability, subject to certain limitations.

INSURERS

Canada Life Assurance Company (Policy #163193)

- Extended Health
- Vision Care
- Dental
- Weekly Wage Replacement
- Long Term Disability
- Life

AIG Insurance Company of Canada

- Emergency Travel Medical (Policy #SRG 9022531-C)
- Hospital Cash (Policy #SRG 9148912)
- Critical Illness (Policy #CI 9600302A)
- Accidental Death & Dismemberment (Policy #SRG 9148903)

Homewood Health Incorporated (HHI) (Ontario)

- Member & Family Assistance Program

TeksMed Services Incorporated

- QuikCare Expedited Access to Healthcare Program
- QuikCare Confidential Mental Health Program