U.A. LOCAL 71 HEALTH AND WELFARE TRUST FUND

GROUP BENEFITS PLAN BOOKLET

Effective Date: June 1, 2026

Prepared by:
Ellement

To: Members of U.A. Local 71

Dear Brothers/Sisters:

Your trustees are pleased to provide you with an updated description of the benefits currently in effect under your health and welfare plan. Through the services of Ellement Consulting Group LP., our appointed consultant and administrator, the trustees have made improvements to benefits while ensuring the best possible underwriting arrangements available to U.A. Local 71.

We encourage you to read the booklet carefully and familiarize yourself with the benefits. Any questions on the benefits, administration or claims should be directed to your plan administrator:

Ellement Consulting Group LP

Tel: 613-319-6266 or toll-free 1-844-431-6266
Email: UALocal71@ellement.ca

Street address:

1150 Cyrville Road, Suite 220
Ottawa, ON
K1J 7S9

Mailing address:

1345 Taylor Ave
Winnipeg, ON
R3M 3Y9

This booklet is also available for viewing on the U.A. Local 71 website at www.ualocal71.com and the health and welfare plan website at www.ua71benefits.ca. To book an online or in person appointment please visit the health and welfare plan website and click on the "Book Your Appointment" link at the bottom of the page or go directly to the booking site at https://outlook.office365.com/book/EllementOttawaBooking1@ellement.ca/

We are pleased to make these arrangements on your behalf and trust you will agree that your improved health and welfare plan is proof of our continued interest in the security and well being of you and your family.

Fraternally yours,

The Trustees,

Michael Crosbie
Richard Deneault
Angus Maisonneuve
Eric Turpin

Important

This document contains important information concerning your group benefits coverage and should be kept in a safe place. This booklet supersedes and replaces all previously communicated material and is the plan document in respect to the benefits described herein.

Manulife Financial underwrites the life, dependant life, and long-term disability insurance. Zurich Insurance Company Ltd underwrites the accidental death and dismemberment insurance. The weekly indemnity, extended health care and dental care benefits are underwritten on a self-insured basis by the U.A. Local 71 Health and Welfare Trust Fund.

As sponsor of the plan, the U.A. Local 71 Health and Welfare Trust Fund or its trustees or designates may establish rules or regulations for the administration or governance of the benefits plan and any transactions associated with it.

The U.A. Local 71 Health and Welfare Trust Fund, or its trustees or designates, have the right to interpret the self-funded coverage of the plan and decide all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the self-insured extended health care, dental or vision coverage described in this booklet.

Reasonable and customary means that the treatment provided is accepted by the appropriate Canadian medical profession as being proven scientifically and effective medically and of a form, intensity, frequency and duration essential to the diagnosis and management of the disease or injury.

In respect to these benefits, no payment will be made for expenses that are related to services, treatments or supplies payable by or covered by a government plan.

The interpretations or decisions of the U.A. Local 71 Health and Welfare Trust Fund, its trustees or designates with respect to the self-insured coverage, will be final and binding on all parties.

This information summarizes the benefits and provisions of your group benefits plan. It does not constitute the group contracts, nor does it create or confer any contractual or other rights. Every effort has been made to ensure that the information is accurate. However, if there is any question of interpretation, all rights with respect to a covered person will be governed by the group contracts issued or administered by the respective insurance companies or trust fund.

Change of Address

It is important to inform the plan administrator and the U.A. Local 71 union office of any address changes.

Errors or Omissions

Every effort has been made to ensure that this booklet is accurate and complete. Should errors, omissions or disputes occur, the terms of the policies issued to the U.A. Local 71 Health and Welfare Trust Fund will prevail.

Respecting your personal information

Ellement Consulting Group will collect, use, maintain and disclose communicate only the personal information considered necessary for the administration of the plan. Personal information will be protected pursuant to the relevant legislation. The plan may use and exchange information with the relevant persons and/or organizations such as, but not limited to: Institutions, Government Agencies, Investigating Agencies, the Union, Trustees, Companies affiliated with Ellement Consulting Group, Insurers, Re-Insurers, Auditors, and Regulators to manage the plan and entitlement to the benefits of the plan. Questions related to the privacy policy should be directed to our Privacy Officer by mail, or by email at privacy@ellement.ca

The Privacy Officer
Ellement Consulting Group LP
1345 Taylor Avenue
Winnipeg, MB R3M 3Y9

Table of Contents

Contract Policy Numbers

The insurers and administrators of these benefits are as follows:

Benefit	Insurer	Policy Number
Basic member life insurance, basic dependant life insurance, and long-term disability benefit	Manulife Financial	0031319
Basic accidental death and dismemberment (AD&D) insurance	Zurich Insurance Company Ltd	8622050
Weekly indemnity, extended health care, dental care and Hospital Cash	Self-insured	61084
Member assistance program (MAP)	Building Trades	

If you have questions about your group benefits that are not covered in this booklet, please contact Ellement Consulting Group LP, your plan administrator, at 613-319-6266, or toll-free 1-844-431-6266, or e-mail at UALocal71@ellement.ca.

If there are any discrepancies between the group contract and the member benefits booklet, your coverage will be determined by the terms and conditions of the group contract.

Benefit Summary

Life Insurance Benefit

Eligibility: Active and retired members under age 65 and members aged 65 and over who continue to work for a minimum of 40 hours per month for a contributing employer.

Amount:

- $200,000: Members who were active or who retired after May 31, 2021.
- $100,000: Members who did not work for a participating employer after May 31, 2021.
- $50,000: Members who did not work for a participating employer after May 31, 2012.
- $35,000: Members who did not work for a participating employer after December 31, 2000.

Termination: After 36 months of unemployment

Accidental Death and Dismemberment (AD&D)

Eligibility: Active and retired members under age 65 and members aged 65 to 69 (inclusive) who continue to work for a minimum of 40 hours per month for a contributing employer.

Amount:

- $200,000: Members who were active or who retired after May 31, 2021.
- $100,000: Members who did not work for a participating employer after May 31, 2021.
- $70,000: Members who did not work for a participating employer after May 31, 2012.

Termination: After 36 months of unemployment

Dependant Life Insurance

Eligibility: Active and retired members under age 65 and members aged 65 and over who continue to work for a minimum of 40 hours per month for a contributing employer.

Amount: Benefit Amount for Members who worked on or after the following dates:

June 1, 2021:	Spouse -	$30,000
	Child -	$30,000
June 1, 2001:	Spouse -	$10,000
	Child -	$10,000

Termination: After 36 months of unemployment

Weekly Indemnity Benefit

Gross weekly benefit	$668 and linked to changes in the level of Employment Insurance (EI) benefits
Elimination period:	Nil for accident or hospitalization; seven days for sickness
Maximum benefit period:	26 weeks from disability date
Termination:	After 24 months of unemployment, attainment of age 65, or retirement, if earlier
Note:	Benefits are not payable from the 2nd to the 26th week inclusive when the disabled member is eligible for Employment Insurance (EI) sickness benefits. No benefit is payable for the period in which a member receives a benefit payable from the E.I. Sickness Benefit.

Long-Term Disability

Gross monthly benefit:	$1,800 (may be reduced by other benefits)
Elimination period:	26 weeks
Maximum benefit period:	To age 65
Termination:	After 24 months of unemployment, attainment of age 65, or retirement, if earlier

Extended Health Care Benefit (Member and Dependants)

Deductible:	Maximum of $25 per calendar year for individual or family coverage (extended health care and dental care benefits combined)
Co-insurance:	100% for prescriptions and 90% of all other eligible expenses in excess of the deductible amount.
Lifetime maximum:	$80,000 per individual. A continuing maximum of up to $1,000 per individual each policy year will apply once the lifetime maximum has been reached.
Prescription drugs and medication maximums:	• Smoking cessation aids: $700 per insured person every calendar year • Fertility drugs and treatment: $1,000 per insured person every calendar year (drugs only) • Sexual dysfunction drugs: $1,500 per insured person every calendar year • Viscosupplementation: $1,500 per insured person every calendar year • Purchase or rental of any artificial limb or eye or spinal brace: $750 per appliance once in a lifetime per insured person • Purchase or rental of a brace for a limb, casts, splints, electronic heart pacemaker, truss, or crutch

- Purchase or rental of a walker, wheelchair, hospital bed or iron lung
- Purchase or repair of custom-made orthotics or arch supports: 2 pairs up to $500 per pair per insured person every calendar year
- Purchase or repair of custom-made orthopedic shoes, lifts, wedges, or Dennis Brown splints: 2 pairs to an overall maximum of $300 per pair per insured person every calendar year
- Support stockings: six pairs up to $60 per pair per insured person every calendar year
- Supplies required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, Parkinson's syndrome, Crohn's disease, and diabetes
- Purchase of external prostheses and bra(s) after mastectomy;
- Surgical brassieres: 6 surgical brassieres per insured person every calendar year.
- Purchase or rental of Cryo Cuff or continuous passive motion machines (CPM): combined maximum of $200 per insured person every three calendar years
- Purchase or rental of a transcutaneous nerve simulator (TNS): $200 per insured person every calendar year
- Purchase of wigs or hair piece: $300 lifetime maximum per insured person
- Circumcision: $100 lifetime maximum per insured person
- Plasma, blood or blood substitutes and their administration
- Hearing aids to a maximum $2,000 per five consecutive calendar years;
- Custom-molded ear plugs: one pair up to $300 per insured person every calendar year
- Purchase or rental of oxygen equipment
- IUDs to a limit of $500 every 60 months
- Diabetic supplies
- Glucometer or reflectance meter; or FreeStyle Libre flash monitor; or Continuous Glucose Monitor receiver: One device every 5 calendar years, up to reasonable and customary charges for individuals diagnosed with diabetes
- FreeStyle Libre sensors and Continuous Glucose Monitor transmitters and sensors: Reasonable and customary charges for individuals diagnosed with diabetes

Diagnostic procedures:

- X-ray and diagnostic laboratory procedures and X-ray or radium therapy

Registered nurse:

- To a lifetime maximum of $10,000

Paramedical services:	• An aggregate calendar year maximum of $1,500 per person: • Acupuncturist • Audiologist • Chiropodist • Chiropractor • Massage therapist • Naturopath • Osteopath • Physiotherapist • Podiatrist • Psychologist, Social Worker, Counsellor, Psychotherapist • Speech therapist
Termination:	No age limit

Vision Care Benefit (Member and Dependants)

Termination:	Nil
Co-insurance:	100%
Eyeglasses:	Prescribed by an ophthalmologist or optometrist for the correction of defective vision including sunglasses and safety glasses; to a maximum of $200 each for frames plus the cost of lenses per individual, once in any 24 consecutive month period; or Replacement lenses for eyeglasses required within 24 consecutive months of the initial prescription due to a change in prescription; or
Contact lenses:	Prescribed by an ophthalmologist or optometrist; to a maximum of $150 per individual, once in any continuous period of 24 consecutive month period; or
Laser eye surgery	Laser eye surgery, including the cost of the guarantee, to a lifetime maximum of $2,000 per individual
Eye examinations, including eye refraction and Optical Coherence Tomography:	Eye examinations to a maximum of $125 every 24 consecutive months
Termination:	No age limit

Hospital Cash

Amount:	$150 per day to a max of 120 days after admitted to hospital for 72 hours
Termination:	Age 70

Dental Care Benefit (Member and Dependants)

Deductible	Maximum of $25 per calendar year for individual or family coverage (extended health care and dental care benefits combined)
Co-insurance:	Basic and major treatments: 95% of eligible dental expenses that are in excess of the deductible amount
Orthodontic services:	100% for a dependent child under age 19 to a lifetime maximum of $3,000
Calendar year maximum:	$2,000 per individual each year for basic and major treatments combined
Fee guide year:	The 2026 Dental Association fee schedule for general practitioners in the province where the dental procedure or service was rendered. The fee guide may be upgraded from time to time
Termination:	No age limit

Member Assistance Program (MAP)

Deductible	Nil
Services:	Individual, couple & family counselling, to help alleviate the symptoms and stresses from issues like: • Substance & Alcohol Misuse • Anxiety • Depression • Panic • Relationship Struggles • Abuse (physical, sexual, or emotional) • Trauma • Separation or Divorce • Anger Management

Note:

Please refer to the *General information* section for full details on the continuation and termination clauses applicable to this *Benefit Summary*.

General Information

Plan Effective Date

The plan described in this booklet is up to date as of February 1, 2024.

Your Plan Supplements Provincial Plans

Your group benefits plan is designed to provide valuable supplementary protection, but not to duplicate or take the place of the benefits available under the provincial hospital and medical care plans.

Therefore, the benefits plan excludes care and services that can be provided under a provincial plan. The group plan cannot provide any benefits where care or treatment by private insurance is prohibited.

Hour Bank Account

The fund administrator maintains an Hour Bank account for each member. It shows the hours you worked for a contributing employer for whom contributions have been made to purchase of group insurance

For each hour you work, a contribution, as defined in your collective agreement or participation agreement, will be made to your account.

Each month, an established number of hours will be deducted from your Hour Bank account to cover the cost of your benefits. The number of required hours can fluctuate depending on the cost of the benefits. Any hours over and above those required to maintain your monthly coverage will accumulate in your Hour Bank.

Each month, you will receive a statement highlighting the hours you worked in the previous month

The following table illustrates this process:

Month Worked	Month Reported	Month Covered
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August

Who May Be Insured

This plan is for members in good standing of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, Local 71, who work for contributing employers or who are U.A. local representatives.

The staff of the U.A. Local 71 union hall and the U.A. Canadian office who have entered into a participation agreement with the U.A. Local 71 may also participate.

Independent contractors and non-members are not eligible.

Subject to the prior approval of the board of trustees, the office staff of plumbing contractors who have a participation agreement with the U.A. Local 71 may be allowed to participate upon the submission of evidence of insurability and the disclosure of pre-existing conditions.

Member Eligibility

You and your eligible dependants will become insured on the first day of the second month coincident with or next following the accumulation of 280 hours in your Hour Bank account. The 280 hours must be accumulated in a 24-month period.

If you are absent from work on the date your insurance would normally become effective or increase, then that insurance will not take effect until you return to work. An absence due solely to a paid vacation or general holiday will not delay your coverage.

Continuation of Coverage

The continuation of coverage provisions below is contingent on you satisfying the eligibility requirements of the plan and are subject to the termination of insurance clauses.

During Absence from Work (Members of the Union Excluding U.A. Representatives)

You may elect to make direct payments to the plan for continued coverage according to the conditions of the collective agreement. You may make direct payments up to a maximum of 24 consecutive calendar months for all benefits. If you qualify for the subsidy program for disabled members, you may participate for a longer period on a self-pay basis. However, if you become totally disabled while unemployed, your weekly indemnity coverage will only be payable in the event you are recalled to work and your disability prevents you from returning to work.

After 24 months of unemployment, you will not be eligible for weekly indemnity or long-term disability benefits and your monthly payment will reduce accordingly. After 36 months of unemployment, life insurance, accidental death and dismemberment and dependant group life will cease, and your premiums will reduce again. At this point, your coverage will consist of extended health care, vision care, dental care, and the member assistance program.

During Absence from Work (Eligible Staff/Contractors/Salaried Workers)

Your coverage will continue until your Hour Bank account balance is depleted. Direct payments are not permitted while you are unemployed.

While on Workplace Safety and Insurance Board (WSIB) Benefits

If due to a job-related sickness or injury, you are accepted to receive WSIB benefits, health & welfare and pension contributions will be made on your behalf for up to 12 months. The contributions are based on the number of hours required to cover the monthly premium. They will be made once the plan administrator is provided with a copy of the incident report (Form 7) from your employer and copies of the monthly WSIB cheque stubs from you. Please contact the plan administrator for further details.

If you remain on WSIB for more than 12 months, your coverage under this plan may be continued without payment of premiums for a maximum of seven years or to the end of the WSIB work re-integration program or the attainment of age 65, whichever is earlier.

The seven-year period includes the first 12 months during which health & welfare and pension contributions are made on your behalf. It does not apply if you are approved for a lifetime WSIB pension.

While Disabled

If you become disabled as defined under the life insurance, the weekly indemnity or the LTD sections of this booklet, your coverage under this plan may be continued without payment of premiums, subject to the following conditions:

1. your Hour Bank account is completely depleted (for WI only); and 2. you have been accepted for waiver of premium by the insurer; or
3. you have been accepted for WI or LTD benefits by the insurer.

Following Retirement

When you retire and draw a pension from the U.A. Local 71 Pension Plan, your coverage will revert to one of the following options, providing the benefits are in force at the time you retire, and you participated in the health and welfare plan for the two years immediately preceding your effective date of retirement.

1. If you retire before attaining age 64, you may maintain group life, dependant group life, accidental death and dismemberment, extended health care and dental coverage until age 65. After that time, you may change your coverage to extended health care and dental coverage or extended health care coverage only.
2. If you retire at age 64, you may self-pay for all benefits (except weekly indemnity and long-term disability) for a maximum of 12 consecutive months. After that time, you may change your coverage to extended health care and dental coverage or extended health care coverage only.
3. If you retire at age 65 or later, you may select a benefits package that includes extended health care and dental coverage or extended health care coverage only.
4. If you retire at age 65 and continue to work a minimum of 40 hours per month, you may continue to have life, dependant group life, accidental death and dismemberment, extended health care and dental coverage. If you work less than 40 hours per month, you may choose between either of the options offered in Item 3 above.

The above options are also available to members in good standing who are insured at the time of their retirement and provide proof of retirement from another plan such as the Commission de construction du Québec (CCQ), the National Pipeline Plan or the U.A. International Plan administered in Washington. Staff of the U.A. Local 71 and U.A. Canadian office whose benefits are in force at the time of retirement are also eligible.

Completion of a member election form confirming your retirement status and choice of benefit package will be required at the time of your retirement.

A monthly payment is required from you to maintain your membership in the U.A. Local 71. A payment is also required for retiree coverage as described above. You may choose to have either or both of these monthly payments deducted automatically from your monthly pension payment by completing a payment deduction options form at retirement. As an alternative, you may subscribe to the Pre-Authorized Payment (PAP) program where the cost of your retiree coverage is taken directly from your bank account on the 1st day of every month. The PAP service cannot be used for the payment of membership dues.

Following Death

If you die while insured under this plan, your surviving spouse and dependent children are allowed to maintain extended health care and dental care benefits using the banked hours remaining in your account. If these banked hours are not sufficient to provide coverage for 24 months following your death, your surviving spouse may self-pay to the end of the 24-month period. If the banked hours are not sufficient to cover the first month's premium following the member's death, the plan will provide a one-month subsidy to the surviving spouse. If your surviving spouse is already insured as a plan member at the time of your death, your account balance will automatically be transferred to your surviving spouse's Hour Bank account.

Subsidy Programs

Subsidy Program for Unemployed Members

As a member in good standing of the union, you may qualify for a monthly subsidy of no more than 24 consecutive months in duration in a 60 consecutive month period, if you meet the following criteria:

1. you are under the age of 65;
2. you are not collecting a pension from any source;
3. you are a member in good standing of the U.A. Local 71;
4. you are unemployed, or was not able to work more than 44 hours last month;
5. you have signed the book at the union hall confirming that you are available for work;
6. you have not refused a job from the U.A. Local 71 union hall dispatching;
7. your coverage is in force, but your Hour Bank account has been depleted and contains less than one month's premium;
8. you must obtain the business manager's signature, submit a new application to the plan administrator, Ellement., and pay the required $35 premium for every month you wish to be subsidized.

The subsidy programs may be terminated at any time without notice if the financial status of the plan no longer supports them. The $35 payment is also subject to change at the discretion of the Trustees.

Termination of Insurance

Your insurance coverage will terminate on the earliest of:

- the day you cease to be a member in good standing of the union;
- the first day of the second month following the month in which the number of bank hours in your account falls below the minimum required to continue your insurance;
- the first day of the month coincident with or immediately following the day you reach the applicable age limit, if any;
- for the WI and LTD benefits, the first day of the second month following the date on which you have been laid-off for more than 24 months;
- for life insurance, dependant life, and AD&D, the first day of the second month following the date on which you have been laid-off for more than 36 months;
- the first day of the second month following the date you have made 24 consecutive monthly self-payments;
- the day on which you become a full-time member of the armed forces;
- the day you fail to make your premium contribution; or
- the day the group policy terminates.

For your benefits on termination, refer to the Conversion privilege and the Benefits after termination sections in each benefit description.

Termination of Insurance Following Transfer to Another Plan or Local

If you enter into a temporary reciprocal agreement and request that the hours you work in Ontario, be transferred to your home plan with the Commission de Construction du Québec or another U.A. local in Canada, all remaining funds in your Hour Bank account will be reciprocated to the home plan and your coverage under this plan will terminate. A letter of understanding will be required by the plan administrator as soon as you enter in the temporary reciprocal agreement.

Reinstatement of Benefits

If some or all your coverage has terminated, you may again become eligible for that coverage on the date on which you have completed the waiting period as defined under Member eligibility, provided you remain within the eligible covered classes.

If coverage for extended health care, vision care and dental care is terminated and reinstated in the same calendar year, the applicable maximums established on January 1 are carried to the end of that calendar year

Hour Bank Account Balance on Termination or Death of Member

Individual, couple & family counselling, to help alleviate the symptoms and stresses from issues like:

If your coverage terminates because you are transferring to another local while a member in good standing, you will be entitled to a reciprocal transfer of your account balance.

If you die while insured under this plan, your surviving spouse and dependent children are allowed to maintain extended health care and dental care benefits using the banked hours remaining in your account. If these banked hours are not sufficient to provide coverage for 24 months following your death, your surviving spouse may self-pay to the end of the 24-month period. If the banked hours are not sufficient to cover the first month's premium following the member's death, the plan will provide a one-month subsidy to the surviving spouse. If your surviving spouse is already insured as a plan member at the time of your death, your account balance will automatically be transferred to your surviving spouse's Hour Bank account.

On retirement, you must use your account balance to extend coverage beyond your retirement date.

Hour Bank Account Balance Exceeding Two Years of Premiums

Health Care Spending Account (HCSA)

You may elect to transfer the eligible excess from your Hour Bank account, up to a maximum of either $500 or $1,000 per calendar year, to a member Health Care Spending Account (HCSA). A declaration and election form will be sent to you in advance of the new year with a confirmation of the balance available for transfer to your HCSA. An eligible excess is any amount more than what is required to provide you with 24 months of coverage under the U.A. Local 71 Health and Welfare Plan, to a maximum of $500 or $1,000 per calendar year.

If a claim is not fully reimbursed by the core plan or any other coordinated plans, the remaining balance can be submitted for payment using the available funds in your HCSA account.

The HCSA option is permitted under applicable law if you elect the transfer within the deadline provided. You will be able to claim against your HCSA for eligible medical expenses not covered under the provincial health care system, for a period not to exceed 24 months, as prescribed by the Canada Revenue Agency (CRA), after which your remaining balance, if any, in the HCSA must be forfeited. A list of eligible medical expenses for an HCSA can be found on the CRA's website at the following address: www.cra-arc.gc.ca/medical/.

Dependant Eligibility

If you already have dependants, you are eligible for dependant insurance on the date you are eligible for insurance under this plan. If you are without dependants, you will be eligible as of the date you acquire a dependant.

If a dependant (other than a newborn child) is confined to a hospital on the date his insurance would otherwise become effective, then his insurance will not become effective until the first day immediately following his/her discharge from the hospital.

Once your dependant insurance commences, new dependants are insured automatically.

Definition of Dependant

Qualified dependant means your spouse and dependent children as defined below.

Spouse means either:

1. an individual to whom you are legally married; or
2. your common-law partner who is an individual with whom you have been co-habiting for a period of at least 12 months and whom you publicly represent as your spouse.

For the purposes of the policy, you must state the name of the person to be considered your spouse. Only one spouse will be considered at any time as being covered under the policy. Divorced or legally separated spouses are not covered.

Dependent *child* means either:

- an unmarried person who is your natural or adopted child; or
- a child of a common-law spouse, who resides with you and is dependent on you for support and who is:

A younger than 21 years of age; or
B between the ages of 21 and 24 inclusively and in full-time attendance at an accredited institute of learning and dependent on you for support; or
C 21 years or older and incapable of self-sustaining employment due to a mental or physical disability. The child's coverage will be continued under the policy, provided the child's disability has existed continuously from a time when the child was otherwise insured as a dependant under this policy. Supporting documentation completed by a medical doctor will be required.

Termination of Dependant Insurance

Your dependant insurance will terminate on the earliest of:

- the day your insurance terminates;
- the day you no longer have any eligible dependants;
- the day you fail to make your premium contribution; or
- the day the dependant insurance terminates under the group policy.

The insurance of any one dependant will terminate the day that individual no longer meets the definition of dependant.

Beneficiary Rules

Beneficiary means the person you designate in writing to receive the benefits. Upon enrolment in the plan, a member must designate the beneficiary to whom the death benefits will be payable.

Benefits becoming payable under the policy on account of your death will be paid to your beneficiary. Any benefit amount for which there is no beneficiary at your death will be paid to your estate.

Subject to any statutory rights of any beneficiaries, you may change the beneficiary at any time by filing a new designation form with the plan administrator. The change will be effective on the date the form is signed, but it will not apply to any payment made by the insurer prior to the date the form is received by the plan administrator.

Where the Civil Code of Quebec applies, any designation of a spouse as beneficiary is irrevocable (cannot be changed without the written consent of the irrevocable beneficiary) unless you make the designation revocable (can be changed at any time without the consent of the revocable beneficiary). A spouse includes any person recognized by law in this context as equivalent to your spouse.

If there is more than one beneficiary and the form does not specify their shares, the beneficiaries will share equally in any payable benefit.

If a beneficiary dies before you, that beneficiary's interest will end. It will be shared equally by any remaining beneficiaries or, in the absence of a designated beneficiary or beneficiaries, your estate, unless the designation form states otherwise.

Co-Ordination of Benefits

If you or your dependants are also covered under another pre-paid health insurance program or contract, the payment of your benefits will be co-ordinated so that the total benefit you will receive will not exceed 100% of allowable expenses determined based on the reasonable and customary amount.

Subject to the consent of the covered person, the plan administrator may release to any person or corporation any data necessary to implement this provision.

Order of Benefit Determination

If a person is eligible to receive a benefit under this plan and the same or a similar benefit under any other plan, payment of benefits shall be decided in the following manner:

1. if another plan does not contain a co-ordination of benefits provision, the benefits of such plan shall be deemed payable prior to the application of benefits under the plan;
2. if another plan contains a co-ordination of benefits provision, the benefits of such plan shall be co-ordinated with the benefits under the plan as follows:
   A. the benefits payable under a plan which insures the individual other than as a dependant will be determined before the benefits of a plan which insures the
   B. individual as a dependant;
   C. the benefits payable under a plan that insures the individual as a dependant of a covered person with the earlier month and day of birth in the calendar year; or the benefits payable under a plan that insures the individual as a dependant of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday;
3. in cases of separation or divorce:
   A. the plan of the parent with custody of the child;
   B. the plan of the spouse-partner of the parent with custody of the child;

C. the plan of the parent not having custody of the child; or
D. the plan of the spouse-partner of the parent not having custody of the child;

4. if the person is covered under another plan, priority will go to:

A. the plan where the member is an active, full-time member;
B. the plan where the member is an active, part-time member; or
C. the plan where the member is a retiree.

If priority cannot be established in the above manner, the benefits shall be pro-rated among the plans in proportion of the amounts that would have been paid under each plan had there been coverage by just that plan.

Change in Coverage

If your coverage changes due to a change in age, class, earnings, dependant status, etc. or as a result of a plan change, it will not be adjusted until the first day, on or after the date of the change on which you are actively at work and the appropriate contribution is being made.

If a dependant is confined to a hospital on the day increased benefits are scheduled to become effective, they will not go into effect until he/she is released. In any case, payment of services and supplies received before the date of an increase in benefits will always be based on plan benefits in effect before the change.

Change in Information

To ensure that you receive all correspondence and that the proper information is stored in your file, contact the plan administrator as soon as a change (i.e. change in marital status, new dependant, beneficiary or address) occurs. The administrator will tell you which forms you will need to complete to confirm the change.

Taxation

All employer-paid group term life insurance and accidental death and dismemberment insurance premiums are taxable to the member. At the end of February of each year, you will receive the appropriate tax form to be included in your tax calculation for the prior fiscal year.

Member Life Insurance Benefit

The member life insurance benefit pays a lump sum amount to your named beneficiary in the event of your death. The amount of life insurance payable is shown in the Benefit Summary.

You may change your beneficiary at any time (subject to any limits set by law) by completing and returning the form available from the plan administrator.

If you survive your beneficiary and have not designated a new beneficiary, payment will be made to your estate. You should review your beneficiary designation to ensure it reflects your current intent.

Total Disability/Waiver of Premium

If you become totally disabled for at least six consecutive months before age 65, your life insurance will remain in force for as long as you remain disabled or to a maximum of age 65. No further premiums will be required.

To be considered totally disabled you must, as a result of sickness or injury, be unable to engage in any gainful occupation for which you are qualified or may reasonably become qualified by your training, education, or experience. Proof of your total disability will be required from time to time.

To be accepted for the waiver of premium, an application must be submitted to the insurer within 12 months of the date of your total disability. Please contact the plan administrator for the application.

Conversion Privilege

If your group benefits terminate or reduce, you may be eligible to convert your member life insurance coverage to an individual policy, without medical evidence. Your application for the individual policy, along with the first monthly premium, must be received by Manulife Financial within 31 days of the termination or reduction of your member life insurance. If you die during this 31-day period, the amount of member life insurance available for conversion will be paid to your beneficiary or estate, even if you did not apply for conversion.

For more information on the conversion privilege, please see your plan administrator. Provincial differences may exist.

Accidental Death and Dismemberment (AD&D) Insurance Benefit

Beneficiary Designation

It is understood that indemnity for loss of life of the insured person will be payable to the beneficiary or beneficiaries as per the designation made under the policyholder's group life insurance policy unless a further designation has been made that specifically identifies this policy. Failing such designation, to the estate of the insured person.

All other indemnities of this policy will be payable to the insured person.

Maximum Benefit

Coverage	Coverage Included / Not Included	Maximum Benefit Payable
		BENEFITS
Accidental Death and Dismemberment Insurance		Terminates at the at the earlier of the Members attainment of age 70 years or retirement. **Coverage available to all active and retired members under age 65. Members must work a minimum of 40 hours a month (or drawing down their bank) to maintain coverage over age 65 and up to 70.**
Principal Sum Principal Sum for the **Insured**	Included	Class I II& III: $200,000 $100,000 $70,000
b. **Accidental** Dismemberment Dismemberment of:	Included	
(1) Both Hands or Both Feet		100% of Principal Sum
(2) One Hand and One Foot		100% of Principal Sum
(3) One Hand or One Foot plus the loss of Sight of One Eye		100% of Principal Sum
(4) Sight of Both Eyes		100% of Principal Sum
(5) Speech and Hearing		100% of Principal Sum
(6) Speech or Hearing in both ears		50% of Principal Sum

Coverage	Coverage ncluded / Not Included	Maximum Benefit Payable
(7) One Hand; One Foot; or Sight of One Eye		50% of Principal Sum
(8) Thumb and Index Finger of the same Hand		33 1/3% of Principal Sum
(9) Hearing in One Ear		33 1/3% of Principal Sum
c. Loss of use Loss of use of: (1) Two **Limbs** (2) One **Limb**	Included	 200% of Principal Sum 75% of Principal Sum
d. Plegia Plegia of: (1) Quadriplegia (total paralysis of all four Limbs) (2) Triplegia (total paralysis of three Limbs) (3) Paraplegia (total paralysis of both lower Limbs) (4) Hemiplegia (total paralysis of upper and lower Limbs on one side of the body)	Included	 200% of Principal Sum subject to an all policies combined maximum Benefit Amount of $1,000,000. 200% of Principal Sum to an all policies combined maximum Benefit Amount of $1,000,000. 200% of Principal Sum to an all policies combined maximum Benefit Amount of $1,000,000. 200% of Principal Sum to an all policies combined maximum Benefit Amount of $1,000,000.
e Accidental Dismemberment and **Covered Loss** of use **Covered Loss** of: (1) Two **Limbs** (2) Both hands or all fingers and thumbs of both hands	Included	 200% of Principal Sum 200% of Principal Sum

(3) Sight of both eyes		100% of Principal Sum
(4) Paralysis of all **Limbs**		100% of Principal Sum

Aggregate Limit of Liability per **Covered Accident** $1,250,000.00

In-Hospital Indemnity Benefit		1. A monthly benefit of 3% of the Principal Sum to a maximum of $2,500; or 2. For periods of less than one (1) month, one thirtieth of the amount calculated in number 1 above, for each complete day of confinement.
ADDITIONAL BENEFITS		
After School Care Benefit	Included	$6,000
Carjacking Benefit	Included	10% of the applicable Principal Sum to a maximum of $10,000
Critical Burn Benefit	Included	Maximum benefit payable of $25,000
Specified Body Area		
(1) Face and Neck and Head		25%
(2) Both Hands or Both Feet		25%
(3) One Hand and One Foot		25%
(4) One Hand and the Sight of One Eye		25%
(5) One Foot and the Sight of One Eye		25%
(6) One Foot and the Sight of One Eye		20%
(7) Thumb and Index Finger of Same Hand		20%
(8) All other body parts		20%

Coverage	Coverage Included / Not Included	Maximum Benefit Payable
Day Care Benefit	Included	Day Care Benefit
Higher Education Benefit	Included	5% of the **Insured's** Principal Sum, to a maximum of $5,000. This amount will be paid annually for [four (4)] consecutive years if the **Dependent** Child continues his or her education. Before this benefit is paid each year, the **Dependent** Child must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis. The maximum amount payable under this benefit is $20,000.
Home Alteration and **Vehicle** Modification Benefit	Included	The lesser of 50% of Principal Sum or $50,000.
Parent Care	Included	$5,000.00 per **Dependent** Parent 5% of the **Insured's** Principal Sum to a maximum of $10,000.00 for all **Dependent** Parents.
Rehabilitation Benefit	Included	The lesser of: 1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the Rehabilitation Training; 2. $15,000
Seat Belt/Air Bag Benefit	Included	20% of the applicable Principal Sum up to a maximum of $25,000
Spouse/Domestic Partner Retraining Benefit	Included	The lesser of 20 % of the **Insured's** Principal Sum or $15,000.
Therapeutic Counseling Benefit	Included	$5,000.00 for any one **Covered Accident.**

Coverage	Coverage Included / Not Included	Maximum Benefit Payable
Funeral Benefit	Included	$5,000
Disability Fitness Benefit	Included	$5,000
Workplace Modification and Accommodation Benefit		$5,000 for each **Insured** Person

Dependant Life Insurance Benefit

The dependant life insurance benefit pays you a lump sum amount in the event of the death of any of your insured dependants. The amount of life insurance payable is shown in the Benefit Summary.

Conversion Privilege

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your application for the individual policy, along with the first monthly premium, must be received by Manulife Financial within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of spousal life insurance available for conversion will be paid to you, even if you did not apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the conversion privilege for spousal coverage.

For more information on the conversion privilege, please see your plan administrator. Provincial differences may exist.

Weekly Indemnity (WI) Benefit

This benefit is designed to provide financial assistance if you become unable to work because of a nonoccupational accident or sickness.

Total disability means you are unable, as a result of sickness or injury, to perform substantially the whole of the duties of your regular occupation and you do not engage in any other gainful occupation.

Non-occupational accident or sickness means an accident not related to employment or sickness not covered under any Workplace Safety and Insurance Board benefit or similar law.

Elimination period means the period of time shown in the *Benefit Summary* for weekly indemnity benefits that must elapse after the commencement of each period of total disability before any benefit is payable.

Weekly indemnity benefits pay you a regular weekly income while you are absent from work for brief periods of illness or disability. Benefits are available if you become totally disabled while insured under this benefit, provided you are under the regular and personal care of a physician. If you are on temporary lay-off at the time of your disability, the payment of benefits will not commence until you are called back to work, provided the elimination period has expired.

Payments start after the elimination period. They begin on the first day of disability due to an accident or hospitalization and on the eighth day of disability due to an illness. They continue if you remain totally disabled, up to the maximum benefit period shown in the Benefit Summary. Benefits are not payable from the 2nd week to the 26th week inclusive if you are eligible to receive sickness benefits from Employment Insurance.

Amount of Benefit

The amount of weekly indemnity payable is the amount shown in the Benefit Summary in effect when you become disabled. Weekly indemnity benefits are reduced by any amount payable to you because of your disability under any Workplace Safety and Insurance Board Act, (or similar legislation) and by any indemnity for loss of time payable to you under the Quebec Automobile Insurance Act. Any payment for a period of less than one week will be at the daily rate of one-seventh of the relevant weekly payment.

There is no offset for partial disability pensions or Workplace Safety Insurance Board allowances for prior or unrelated disabilities.

Employment Insurance (EI) Benefits

Weekly indemnity benefits will not be payable after the 1st week of receiving benefits if you are eligible for and receive EI sickness benefits. You must show proof of application to and response from EI. If you become disabled due to a non-occupational illness or sickness, application for EI benefits should be made immediately.

Subrogation

If you are entitled to recover damages from loss of income from another person as a result of personal injuries sustained by you and for which you are entitled to receive benefits under the weekly indemnity benefit provision, the Health and Welfare Trust Fund will be subrogated to all your rights of recovery for loss of income to the extent of the sum of the benefits paid or payable to you under that provision.

In connection with the Health and Welfare Trust Fund's right of subrogation, the plan administrator may require that you complete a reimbursement questionnaire and execute a reimbursement agreement. If within 30 days of the request, you do not complete and return the reimbursement questionnaire and agreement to the plan administrator, the benefits which you would otherwise be entitled to receive under the weekly indemnity benefit provision will not be paid until you do so.

Exclusions

Disability benefits are not payable under the following circumstances:

- intentionally self-inflicted injuries while sane or insane;
- war (declared or not), service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- committing, or attempting to commit, a criminal offence;
- medical or surgical care that is cosmetic, but does not include cosmetic care provided as a result of an accident;
- during a pregnancy leave of absence where you qualify for EI sickness benefits;
- during a period in which you are entitled to disability payments under any policy of group long-term disability insurance;
- for any period where you do not participate and co-operate in a reasonable and customary treatment program that is prescribed and performed by a legally licensed doctor of medicine and is of the nature and frequency for the condition involved;
- for any period where injury or disability results from substance abuse including alcoholism or drug addiction, unless you are participating in a recognized substance withdrawal program; or
- for a disability resulting from an accident that occurs while you are the operator of a motor vehicle, and your blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (0.08%).

Recurrent Disability

If your disability recurs within 14 days of returning to work and it is due to the same or related causes, payments for the balance of the benefit period will resume immediately.

Extension of Benefit After Termination

If you are totally disabled on the date your weekly indemnity benefit terminates, you will continue to be covered for that disability as if the benefit were still in force, provided the disability remains continuous and you qualify for *long-term disability* benefits. Please refer to the Long-term disability section of this booklet.

Taxation

Under tax regulations, losses of income benefits are subject to federal and provincial income tax. The federal and provincial taxes shall be withheld from your cheque and remitted to the proper government. At year end, a T4A Supplementary form and Relevé 1, if applicable, will be issued and should be included with your tax return.

Long-Term Disability (LTD) Benefit

The long-term disability benefit provides income security should you become totally disabled and remain so over a long period of time.

While you are insured under the benefit, it will provide monthly income payments if you become totally disabled and remain so during the elimination period, providing you remain under the regular care and personal attendance of a physician. If you satisfy the elimination period while age 64, the maximum benefit period shall be 12 consecutive months.

Alcoholism or drug addiction is considered a sickness under the benefit provision as long as you are receiving continuous care and treatment satisfactory to Manulife Financial.

Payments start after the elimination period and continue as long as you remain totally disabled and provide proof of continued total disability, as required by the insurer, to the maximum benefit period shown in the *Benefit Summary.*

The following definitions apply:

Physician means a person who is duly licensed to prescribe and administer any drugs or to perform surgical procedures.

Gross pre-disability earnings mean your monthly earnings on the date of commencement of total disability.

Total disability or totally disabled means that, during the elimination period and the following 24 months, you are incapacitated to the extent that you are unable to perform any and every duty of your own occupation or employment.

Thereafter, you shall be considered totally disabled if you are incapacitated to the extent that you are unable to perform any and every duty of any occupation or employment for which you are reasonably qualified by education, training, or experience. Such incapacity must result from a medically determinable physical or mental impairment.

In no event shall total disability be deemed to exist for any period during which you are not under the regular care and treatment of a legally qualified physician.

Amount of Benefit

The amount of long-term disability benefit payable is the amount shown in the *Benefit Summary.* Any payments for a period of less than one month will be at the daily rate of 1/30 of the relevant monthly income.

Integration With Other Benefits

The long-term disability benefit determined from the Benefit Summary and payable to you will be reduced by any disability benefit which you are eligible to receive under any Workplace Safety and Insurance Act or similar law. In addition, it will be further reduced by the amount by which the sum of the long-term disability benefit plus all the amounts listed below, exceed 85% of your gross pre-disability earnings:

- any disability benefit which you are eligible to receive under the Canada or Quebec Pension Plan or a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan, excluding dependant benefits payable to you under those plans, and excluding cost of living increases made under those plans after the commencement of benefits under this benefit provision;
- any disability benefit or retirement benefit payable under any group insurance or retirement plan available through employment or a professional association;
- where permitted by law, any disability or loss-of-time benefits payable under any no-fault provision in any government plan of automobile insurance;
- any payments provided under any other government plan or law or by any other government agency, but excluding benefits payable by the Canada Employment Insurance Commission;
- any amounts paid by any employer as salary continuation or as severance allowance and vacation pay which commence on or after the date of the commencement of the total disability for which benefits are payable under this benefit provision, unless proof is submitted to Manulife Financial that your application for any such benefit has been denied;
- any income received while participating in a rehabilitation program;
- self-employment income.

If you participate in a rehabilitation program, your total monthly income while disabled cannot exceed 100% of your gross monthly earnings as of the date the disability commenced. If your income exceeds 100%, the long-term disability income benefit will be reduced by the amount of the excess

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of personal injuries sustained by you and for which you are entitled to receive benefits under the long-term disability benefit provision, Manulife Financial will be subrogated to all your rights of recovery for loss of income to the extent of the sum of the benefits paid or payable to you under that provision.

The company may require you to complete a reimbursement questionnaire and execute a reimbursement agreement. If within 30 days of the request you do not complete and return the reimbursement questionnaire and agreement to Manulife Financial, the benefits which you would otherwise be entitled to receive under the long-term disability benefit will not be paid until you do so.

Waiver of Premium

Effective with the first full policy month for which benefits become payable, Manulife Financial will waive any premium due under this benefit. Benefits will continue for each full policy month for which benefits are payable.

Rehabilitation

Manulife Financial may recommend an appropriate rehabilitation program for a member receiving LTD benefits. They will notify you in writing of their approval of the program and the extent of their support for it.
Any of the following may be eligible for consideration as a rehabilitation program:

- your regular occupation on a part-time basis;
- a formal vocational training program; or
- any other training program deemed suitable by Manulife Financial.

LTD benefits will continue to be payable to a member participating in a Manulife Financial-approved rehabilitation program for up to 24 consecutive months.

All reasonable and customary expenses incurred by you in connection with the program and for which you have received prior approval from Manulife Financial, will be reimbursed by that company. Expenses payable through government programs or a third party insurer will not be reimbursed by the insurer.

The gross benefit, less reductions, will be further reduced by 50% of any earnings received from employment under the rehabilitation program, subject to the all-source maximum outlined in the *Integration with other benefits* section.

Your involvement in a rehabilitation program will cease on the earliest of the following dates:

- the date you cease to be totally disabled;
- the date you complete the rehabilitation program; or
- the date Manulife Financial determines that you are not participating in the rehabilitation program to the extent previously agreed upon by you and the insurer.

If you are eligible for full benefits and elect a different and lesser paid occupation not related to the program of rehabilitation described above, the gross benefit less reductions shall be further reduced by 50% of the earnings from the lesser paid occupation elected, subject to the *Integration with other benefits* section.

Exclusions

Long-term disability benefits are not payable under the following circumstances:

- for disability resulting from intentional self-inflicted injury or disease or attempted self-destruction while sane or insane;
- from injury or disease that occurred while you are on active duty in the armed forces of any country, state, or international organization or which results from war, or act of war, whether declared or not;
- disability resulting from participation in the commission of a criminal offence;
- injury or disability resulting from substance abuse including alcoholism or drug addiction, unless you are participating in a recognized substance withdrawal program;
- during a period of imprisonment in a penal institution or confinement in a hospital or similar institution as a result of criminal proceedings;
- for any portion of a period of disability during which you receive treatment by a therapist, unless the treatment is recommended by a physician deemed appropriate by Manulife Financial;
- for disability resulting from an accident that occurs while you operate a motor vehicle, and your blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (0.08%);
- during any leave of absence, including maternity leave;
- if you refuse to participate in a rehabilitation program deemed appropriate by Manulife Financial, the attending physician or independent medical opinion; or
- during any portion of a period of disability during which you do not participate in the treatment program recommended by your physician.

Termination of Payments

Payments under this benefit will cease on the earliest of the following dates:

- the date on which you cease to be totally disabled;
- the date on which you engage in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;
- the date on which payments have been paid up to the maximum benefit period shown in the *Benefit Summary* for any one period of total disability;

- the premium due date coincident with or immediately following your 65th birthday;
- the date on which you die; or
- the date on which, as determined by Manulife Financial, you have failed to furnish satisfactory evidence of continued total disability or failed to submit to a medical examination as requested by that company.

Recurrent Disability

If your disability recurs within six months of returning to work and is due to the same or related causes, this subsequent period of total disability will be considered to be a continuation of the previous period of total disability. If you return to active work for one full day and become disabled for different and unrelated causes, you will begin a new period of disability.

Extension of Benefit After Termination

If you are totally disabled on the date your long-term disability insurance terminates, Manulife Financial will continue your coverage as if the benefits were still in force, provided the disability remains continuous.

Appeal Procedure

If you appeal the denial/termination of a long-term disability claim, you must submit to the insurer a written notice of appeal. The notice must be submitted to Manulife Financial within 60 days of the date of the insurer's denial/termination notice. Medical or other supportive documentation must be submitted to the insurer within six months of the date of the denial/termination notice. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.

If the above provision is in conflict with the applicable law of your province of residence, the provision shall be deemed amended to conform to the minimum requirements of that law.

Taxation

Under tax regulations, losses of income benefits are subject to federal and provincial income tax. This tax shall be withheld from your cheque and remitted to the proper governments. At year end, a T4A Supplementary form and Relevé 1, if applicable, will be issued and should be included with your tax return.

- the premium due date coincident with or immediately following your 65th birthday;
- the date on which you die; or
- the date on which, as determined by Manulife Financial, you have failed to furnish satisfactory evidence of continued total disability or failed to submit to a medical examination as requested by that company.

Extended Health Care Benefit

The extended health care benefit helps pay the cost of eligible medical expenses incurred by you and your insured family members. You will be reimbursed for eligible expenses, not covered by your provincial medicare plan, subject to the deductible, co-insurance, and maximums, if any, shown in the *Benefit Summary*.

Payment will be made for those eligible expenses which are reasonable and necessary, and which are incurred on the prior recommendation of a legally qualified physician.

Deductible

The deductible amounts shown in the Benefit Summary is the total amount of eligible expenses you must absorb in any calendar year before reimbursement can be made.

Pay-Direct Drug Card

Members and their dependants can have their drug claims processed immediately at any pharmacy in Canada, using the pay-direct drug card, provided by Telus Health.

With the pay-direct drug card, your drug claims will be processed in seconds while you wait at the retail pharmacy of your choice. Simply present the card to your pharmacist when you purchase a prescription medication. There are no forms to complete.

The generic equivalent of a brand name drug will automatically be dispensed, and the plan will reimburse based on the generic price unless the physician has indicated that the patient has an adverse reaction to the generic drug.

If you have single coverage, you will receive one pay-direct drug card. If you have family coverage, you will receive two cards: one for you and one for your spouse. Note: Only the name of the covered member appears on the card.

An additional card will be issued in the name of each eligible dependant between the ages of 21 and 24 inclusively and in full-time attendance at college or university.

If you need an additional card, or if your card is lost or stolen, contact the plan administrator.

Eligible Expenses (In Canada)

Prescription Drugs and Medication

- Drugs, sera, vaccines and injectables available only by prescription when prescribed by a physician or dentist and dispensed by a pharmacist, physician, or dentist to a maximum of three months' supply at one time. Birth control drugs are subject to a maximum of a one-year supply. Certain eligible medications may require prior authorization of the administrator.

The generic equivalent of a brand name drug will automatically be dispensed, and the plan will reimburse based on the generic price unless the physician has indicated that the patient has an adverse reaction to the generic drug. A special form will need to be completed by the physician for the plan administrator;
- Compound mixture: when at least one ingredient is a prescription-requiring medication and is eligible under the plan.
- Charges for nicotine replacement products will be reimbursed as outlined in the *Benefit Summary*. A doctor's referral is required for the nicotine patch and gum.
- Fertility drugs are reimbursed as outlined in the *Benefit Summary*. The limit does not apply to drugs related to artificial insemination and in vitro-fertilization when listed on the Régie d'Assurance-Maladie du Québec (RAMQ) formulary.
- Erectile dysfunction drugs are reimbursed as outlined in the Benefit Summary.
- Xenical® is covered, if prescribed for non-cosmetic reasons.
- Allergy serum.
- Drugs and supplies available without a prescription and required as a result of a colostomy or ileostomy and/or the treatment of cystic fibrosis, diabetes and Parkinson's or heart disease are covered.
- Viscosupplementation products (such as Synvisc®, Neovisc®, or Replasyn®) are covered as outlined in the *Benefit Summary*.
- Hospital administered drugs are not covered.
- Only prescription drugs that are for non-cosmetic use will be considered.
- All medications listed under the RAMQ formulary.

Reimbursement for prescription drugs will not be permitted where the member and/or spouse qualifies for reimbursement under their provincial health plan. Members aged 65 and over must subscribe to a provincial plan, when available. Provincial deductible and co-payment charges are included as eligible expenses.

While the plan pays 90% of all drug costs, members who are residents of Quebec may apply to have the balance of the remaining 10% of charges to be covered by the RAMQ. Members residing in the province of Quebec must provide proof of payment of the maximum out-of-pocket expense under RAMQ before reimbursement can occur under this plan.

Medical Supplies

The plan will pay for the following medical supplies and expenses on the recommendation of a qualified, licensed physician:

- purchase or rental (not repair or replacement) of any artificial limb or eye or spinal brace where the loss of the limb or eye occurs while the individual is insured under this benefit. Coverage is limited as outlined in the *Benefit Summary*;
- purchase or rental (not repair or replacement) of a brace for a limb, casts, splints, electronic heart pacemaker, truss, or crutch (braces must be constructed in rigid or semi-rigid material required for normal activities of daily living not solely for sports related activities);
- purchase or rental of a walker, wheelchair, hospital bed or iron lung. The physician's referral must indicate the medical diagnosis;
- purchase or repair of custom-made orthotics or arch supports. Coverage is limited as outlined in the *Benefit Summary*. The physician's referral must indicate the medical diagnosis;

- purchase or repair of custom-made orthopedic shoes, lifts, wedges or Dennis Brown splints. Coverage is limited as outlined in the Benefit Summary. The physician's referral must indicate the medical diagnosis;
- support stockings, purchased from a medical supply store. Coverage is limited as outlined in the *Benefit Summary*. A prescription showing the brand name and compression ratio is required as well as the medical diagnosis;
- supplies required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, Parkinson's syndrome, Crohn's disease and diabetes;
- purchase of external prostheses and bra(s) after mastectomy; mastectomy bra(s) are eligible as outlined in the *Benefit Summary*;
- purchase or rental of Cryo Cuff or continuous passive motion machines (CPM). Coverage is limited as outlined in the *Benefit Summary*;
- purchase or rental of a transcutaneous nerve simulator (TNS). Coverage is limited as outlined in the Benefit Summary. The physician's referral must indicate the medical diagnosis and expected duration of treatment;
- purchase of wigs or hair piece in the event of loss of hair due to a medical condition. Coverage is limited as outlined in the Benefit Summary;
- circumcision. Coverage is limited as outlined in the *Benefit Summary*;
- plasma, blood, or blood substitutes and their administration;
- hearing aids when prescribed by the attending certified ear, nose and throat specialist. Coverage is limited as outlined in the *Benefit Summary*. It does not include payment for repairs and maintenance, batteries or recharging devices or other such accessories. If hearing loss is work-related, you should seek reimbursement from WSIB (Ontario) or the CSST (Quebec);
- custom-molded ear plugs. Coverage is limited as outlined in the *Benefit Summary*;
- purchase or rental of oxygen equipment; and
- IUDs as outlined in the *Benefit Summary*.
- Diabetic supplies
- Glucometer or reflectance meter; or FreeStyle Libre flash monitor; or Continuous Glucose Monitor receiver. Coverage is limited as outlined in the *Benefit Summary*:
- FreeStyle Libre sensors and Continuous Glucose Monitor transmitters and sensors. Coverage is limited as outlined in the *Benefit Summary*.

It is strongly recommended that an estimate be submitted, along with all supporting medical documentation, prior to incurring any costs. Any approved equipment will be reimbursed based on the date for which the item is paid in full.

Diagnostic Procedures

X-ray and diagnostic laboratory procedures and X-ray or radium therapy (not while confined to a hospital).

Registered Nurse

Charges for the services of a registered nurse (R.N.), licensed practical nurse, certified nursing assistant (C.N.A.) or a personal support worker (PSW) which are rendered in the patient's home, provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a legally qualified physician (M.D.) and only if it is medically necessary.

Paramedical Services

Professional services of the following licensed, certified, or registered practitioners (when operating within their recognized fields in the province in which they are registered and not treating members of their immediate family). Coverage is limited as outlined in the Benefit Summary. Reimbursement is based on the dates the services were rendered. If you choose to enter into a block payment plan for services, reimbursement will be made at the end of the contract period by submitting all receipts and a copy of the contract. All receipts must clearly indicate the names of those attending the sessions/services.

Note that fees for forms or reports for use by a third party are not eligible for reimbursement.

Practitioners

- Acupuncturist
- Audiologist
- Chiropodist
- Chiropractor
- Massage Therapist
- Naturopath
- Osteopath
- Physiotherapist
- Podiatrist
- Psychologist, Social Worker, Counsellor, Psychotherapist
- Speech therapist

* Psychology services are not subject to co-insurance factor.
** Payable on first dollar basis (provincial maximum does not have to be satisfied first).

Detox Facilities

Hospital expenses to cover the treatment of alcoholism or drug addiction in a residential treatment centre approved by the province, to a maximum period of 28 days per confinement for the treatment of alcoholism and to a maximum of 92 days for the treatment of drug addiction, to a maximum of $15,000 per confinement period. Doctor's recommendation is required.

Dental Treatment (Accidental Injury)

The repair or replacement of natural teeth as a direct result of an accidental injury sustained while the individual is insured under this benefit. Treatment must start within 90 days of the injury. Reimbursement will be made up to the suggested fees in the current provincial dental association fee guide for general practitioners (of the province where the dental treatment was provided) for the least expensive treatment that will provide a professionally adequate result. No reimbursement is made for treatment performed more than two years after the date of injury.

Transportation

A licensed local ground or air ambulance to transport an individual because of either emergency or in-patient treatment:

- from the place where the individual suffers the accident or sickness to the nearest hospital where adequate treatment is available;
- from one hospital to another hospital; and
- from a hospital to the individual's residence.

Vision Care Benefit

Reimbursement of eligible eyewear is based on the date the items are paid for in full.

This benefit does not contain any deductible or co-insurance factor. The plan will pay for vision care charges incurred as outlined in the Benefit Summary.

You may claim either for eyeglasses or contact lenses, not both, in addition to prescription safety glasses, every 24 consecutive months.

Outside Canada

Expenses incurred outside Canada will not be reimbursable under this plan. However, if you are a member in good standing and are working for a U.A. contractor in the United States, your prescription drugs may be covered while out-of-country to a limit of $10,000 per lifetime and subject to approval by the board of trustees.

Out-of-Province but Within Canada

Expenses incurred out-of-province, but within Canada are covered as if benefits would have been payable had they been incurred in your home province providing:

- treatment is for an emergency or unexpected illness, if the insured person is temporarily out-of-province for business, vacation, or furthering education; or
- the required medical treatment is not readily available in the province of residence and the person is forced to seek such treatment elsewhere.

Benefit is limited to $10,000 per lifetime for retired members.

Expenses Not Covered

- Expenses incurred as a result of intentionally self-inflicted injuries (while sane or insane) or as a result of committing, or attempting to commit, a criminal offence.
- Dental treatment except those listed under the Dental care benefit or the Dental treatment (accidental injury) section.

- Cosmetic treatment unless due to an accidental bodily injury sustained while the individual was insured under this benefit.
- Any injury or illness for which the covered person is entitled to indemnity or compensation under any Workplace Safety and Insurance Board Act.
- Expenses for treatment required as a result of war (declared or not), service in the armed forces of any country or participation in a riot, insurrection, or civil commotion.
- Services, treatments, or supplies, eligible under this plan and payable under any government plan, whether or not the claimant is covered under such a plan; the plan administrator will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.
- Examinations or services required for the use of a third party.
- Travel for health reasons.
- Any charges for services, treatment or supplies for which there would be no charge except for the existence of coverage.
- The replacement of an existing appliance that has been lost, mislaid, or stolen.
- Drugs, sera, injectables and supplies that are not approved by Health Canada (Drugs and Health Products) or are experimental or limited in use whether or not so approved.
- Proprietary or patent medicines, dietary or health foods and nutritional products.
- Hospital room charges.
- Charges for the administration of drugs.
- Expenses that are required for recreation or sports.
- Experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society.
- Diaphragms and breast pumps.

Note: Faxed medical claims are not accepted.

Restoration of Lifetime Maximum

If the lifetime maximum has been paid for any individual, a continuing maximum of up to $1,000 per individual each calendar year will apply.

Extension of Benefit After Termination

This benefit normally ceases the date your coverage terminates. However, if on that date you are totally disabled or any of your insured dependants is confined to a hospital, this health benefit will continue for the duration of the disability or hospitalization up to the end of the next calendar year following the year you terminated employment. Benefits will cease on termination of the group policy.

To be considered totally disabled you must, as a result of sickness or injury, be unable to engage in any gainful occupation for which you are qualified or may reasonably become qualified by your training, education or experience.

Hospital Cash

The benefits in this section apply to eligible Members and their eligible Dependents over fourteen days of age. Hospital Cash benefits cease for the whole family when you reach age seventy or in accordance with the "Termination of Member Coverage" provision, whichever is earlier.

This benefit provides financial assistance in the event of extended hospitalization. There is no restriction on the use of the benefit: you may use it in any way that will meet your particular needs. Receipts are not required, but the discharge papers you will be provided at the end of your stay may be necessary to confirm the total number of days you were admitted to the hospital.

You and your eligible Dependents are covered for the daily benefit amount for a maximum of one hundred and twenty days, provided you or they have been confined to a hospital for three consecutive days or longer and are under the care of a physician.

Dental Care Benefit

The dental care benefit helps with the cost of certain eligible dental expenses incurred by you or your insured family members. To qualify as an eligible expense, the dental treatment must be recommended and performed by a dentist or an independent dental hygienist. Reimbursement will not exceed the suggested fees in the appropriate dental fee guide for the least expensive treatment that will provide a professionally

Fee Guide

Fee guide means the Dental Association Fee Guide for General Practitioners of the province where the dental procedure or service was rendered published for the calendar year identified in the *Benefit Summary*. If there is no applicable fee guide in that province or territory, the appropriate fee guide in Ontario will be used.

Alternate Benefit Clause

Situations may arise where alternate methods of treatment may be available. It is solely up to you and your dentist to decide which method will be employed. As the basis for determining its liability, the plan administrator reserves the right to use the least expensive method of treatment that would provide a professionally adequate result. The Alternate Benefit Clause cannot be applied to excluded provisions, services, or devices.

Only those treatments listed are eligible.

Pre-Existing Condition

Eligible expenses incurred by an individual during the first four months of his/her coverage, will not be reimbursed if those expenses result from dental treatment begun or arranged for in the four months before his/her coverage began.

Treatment Plan or Estimate

In order for you and your dentist to learn in advance how much the plan will pay and how much must be paid by you, it is recommended that a treatment plan be filed with the plan administrator whenever the total cost of the proposed dental work is expected to exceed $500. The plan identifies coverage and limitations for specific services, specific limits and dental fee guide allowance before dental treatment commences. It is not intended to limit your choice of dentist, tell you or your dentist what treatment should be performed, establish fees or to guarantee reimbursement after coverage ceases.

A treatment plan is a plan of dental treatment (including X-rays, if required) showing the patient's dental needs, a written description of the proposed treatment necessary in the professional judgment of the dentist, and the cost of the proposed treatment.

Deductible

The deductible amount shown in the Benefit Summary is the total amount of eligible expenses you must absorb in any calendar year before reimbursement can be made. If the deductible for the extended health care has already been paid, the deductible under the dental care does not need to be paid and vice-versa.

Eligible Expenses

Basic and Preventive Treatment

- The following services will be eligible for payment once every calendar year:
  - recall oral examinations (once every 9 months);
  - bite-wing X-rays (once every 9 months);
  - prophylaxis/polishing (maximum one unit of 15 minutes duration every 9 months); - topical application of an anti-carcinogenic substance.
- Complete oral examinations (once every 24 consecutive months).
- Dental X-rays, except that panoramic film and full mouth X-rays are each limited to one set in any period of 24 consecutive months.
- Dental consultations.
- Mouthguards and the initial provision and installation of space maintainers for missing primary teeth.

- Occlusal equilibration.
- Pit and fissure sealants, on permanent molars only, for dependent children up to age 18, once per tooth per lifetime.
- Amalgam, silicate, acrylic or composite restorations excluding prefabricated veneer application.
- Retentive pins, pre-formed stainless steel, and polycarbonate crowns.
- Injection of antibiotic drugs when prescribed by a dentist.

Note: Eligible expenses for services that are performed by a dental hygienist under the supervision of a dentist, or an independent dental hygienist will be covered.

Endodontics, Periodontics, Oral Surgery

- Endodontic services covering the treatment of disease of the pulp chamber and pulp canals (root canal therapy), including endodontic bleaching.
- Periodontic services covering the treatment of disease of the soft tissues (gums) and bone supporting the teeth.
- Uncomplicated removal of erupted teeth and the surgical removal of impacted teeth and residual roots.
- General anesthesia required in relation to dental surgery or extractions.
- Oral surgery not specifically provided under Basic and preventive treatment.
- Therapeutic scaling is limited to a maximum of 8 units of time (15 minutes per unit) every calendar year.

Major Restorative Treatment

- Full or partial dentures or fixed bridgework or other appliances:
  - if necessitated by the extraction of at least one natural tooth while the individual is insured under this benefit;
  - if the existing appliance is temporary and is replaced by a permanent denture or bridgework within 12 months of the date the temporary appliance was installed; or
  - if the existing appliance is at least five years old and cannot be made serviceable (does not apply to dentures).

- Metal inlays, onlays and crowns, once every five years.
- Repairs to an existing crown, bridge, inlay or onlay, once every five years.
- Veneer application for non-cosmetic reasons.
- Repair, re-basing and re-lining of dentures.
- Denture adjustments, except that minor adjustments are limited to once in any period of six consecutive months.
- Replacement dentures once every five years.
- Dental implants (payable under Alternate Benefit Clause).
- Note: Eligible expenses for services that are performed by a licensed denturist within the scope of his/her license will be covered.

Note: Eligible expenses for services that are performed by a licensed denturist within the scope of his/her license will be covered.

Orthodontic Treatment

Orthodontic treatment reimbursed for dependent children aged 19 or under. Coverage is limited as outlined in the *Benefit Summary*.

- Orthodontic examination.
- Diagnostic photographs and casts.
- Orthodontic observations, adjustments, or appliances.
- Payment for on-going treatment in progress.
- Related laboratory fees.

An orthodontic treatment plan must be submitted prior to initial claim. Reimbursement for the initial orthodontic fee must not exceed 35% of the total cost of the treatment plan. The balance of the orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, outlined in the orthodontic treatment plan. Reimbursement of the monthly fees will be based on the amount or date of payment, if different from the treatment plan.

Expenses Not Covered

- Expenses incurred as a result of intentionally self-inflicted injuries (while sane or insane) or as a result of committing or attempting to commit a criminal offence.
- Dental treatment received outside Canada.
- Any injury or illness for which the covered person is entitled to indemnity or compensation under any Workplace Safety and Insurance Board Act.
- Expenses for treatment required as a result of war (declared or not), service in the armed forces of any country, or participation in a riot, insurrection, or civil commotion.
- Charges levied by a dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.
- Cosmetic surgery or treatment (when so classified by the plan administrator) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.
- Expenses for permanent splinting of teeth.
- Services, treatments, or supplies, eligible under this plan and payable under any government plan, whether or not the claimant is covered under such a plan; the plan administrator will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.
- Dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union.
- The replacement of an existing appliance that has been lost, mislaid, or stolen.
- Examinations required for the use of a third party.
- Porcelain appliances on molar teeth.

Benefit After Termination

No benefits are payable for dental care expenses incurred after the date your coverage under this benefit terminates. This would apply even if you had submitted a detailed treatment plan and the plan administrator had advised you of the amount of eligible reimbursement.

Member Assistance Program (MAP)

Purpose of the Program

The Building Trades MAP is a confidential service to assist members and their Dependents who are experiencing personal problems. Their counsellors are available to help alleviate the symptoms and stress from issues like:

- Substance & Alcohol Misuse
- Anxiety
- Depression
- Panic
- Relationship Struggles
- Abuse (physical, sexual, or emotional)
- Trauma
- Navigating Separation or Divorce
- Anger Management

Please visit their website for more information at https://tradesmap.org/ or call their office at 613- 742-7962 or 1-800-258-0580. Confidentiality means that any information you share will not be given to anyone, unless you give written permission to share something with a specific person, or unless demanded by law.

How to Claim Benefits

When you have a claim, ask the plan administrator for the appropriate claim form. Complete it promptly and return it to the plan administrator. Make sure your claims are submitted within the time period required. You can be assured of faster payment of claims, where required information is complete and accurate.

Sometimes, physicians or dentists send in the claim forms directly. This frequently delays claim settlement as they may not realize that the member and/or employer sections must also be completed.

Life and Dependant Life

Written proof of the occurrence, cause and circumstances of the loss will be required by the earliest of the following:

- 15 months following the date the loss was incurred;
- 90 days following the date of termination of an individual's insurance; or
- 90 days following the date of termination of a coverage or the policy.

Accidental Death and Dismemberment

In the event of a claim, immediately contact Ellement who will provide the necessary information.

Notice and proof of claim must be given to Zurich Insurance Company Ltd within 90 days from the date of the accident, the beginning of the disability or after the survival period.

Long-Term Disability

Initial written notice of a claim must be submitted to the plan administrator within 30 days of the expiry of the elimination period and initial written proof, within six months after termination of the first month following the qualifying disability period. Proof of a continuing total disability will be required from time to time.

Access to Plan Documents with Respect to Benefits Covered by Manulife Financial

You or any of your covered dependants have the right to request a copy of any or all of the following items:

- the sections of the group policy and/or plan document that apply to you and your dependants;
- your application for group benefits; and
- any evidence of insurability you submitted as part of your application for benefits.

Manulife Financial reserves the right to charge you for such documentation after your first request.

Time Limit for Legal Action with Respect to Benefits Covered by Manulife Financial

You may not commence legal action against Manulife Financial (with respect to benefits underwritten by Manulife Financial) less than 30 days after proof has been filed as outlined under How to claim benefits. Every action or proceeding against Manulife Financial for the recovery of money payable under the plan is absolutely barred unless commenced within the time period set out in the Insurance Act or applicable legislation.

Weekly Indemnity

Written notice of a claim must be submitted to the plan administrator within 90 days and written proof within 120 days of the date your total disability commenced. Proof of continuing total disability will be required from time to time.

Extended Health Care and Vision Care

Keep a record of all out-of-pocket expenses incurred by you and your covered dependants. It is important that all original receipts for eligible expenses clearly indicate the name of the person for whom the expense was incurred.

If expenses are incurred, obtain a claim form from plan administrator or from their website, www.ua71benefits.ca/. Complete the form in its entirety and return it, along with any original receipts, to the plan administrator. TELUS Health eClaims simplifies the process for your healthcare providers, beyond just your pharmacist and dentist, to conveniently direct bill for services. This means you won't have to handle reimbursement paperwork. To check if your healthcare provider utilizes eClaims, please visit https://plus.telushealth.co/page/eclaims/discover/.

To be eligible for payment, health claims must be submitted by the end of the calendar year following the year in which the expense was incurred.

Note:
Original receipts in support of claims will not be returned. They will be retained by Ellement.

Dental Care

Standard Dental Claim forms are available from all dentists and are acceptable provided the member, employer information and/or policy number is clearly indicated.

If dental expenses are incurred, obtain a claim form from the plan administrator or your dentist, have the dentist complete his/her portion of the form, complete your portion of the form, and return it to Ellement for validation. Written proof of claim must be given by the end of the calendar year following the year in which the expense was incurred.

Electronic Dental Claims Processing

Ellement will process your dental claim using the electronic data interchange (EDI) claims processing service. With EDI, your dental claim can be sent directly from your dental office to our claims department for adjudication.

Our EDI service uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association. With Telus, you can be assured that the information contained in your dental claim will be transmitted to Ellement quickly, safely, and confidentially right from your dentist's office.

To take advantage of the EDI service, please inform your dentist that Ellement is your plan administrator and present them with the following security codes:

- the Telus carrier identification number (also known as the BIN number) is 000034 on the Telus network;
- your unique member identification number; and
- the policy number of your group benefit plan.

The plan administrator can provide you with your member identification number. When your dental care claim is submitted electronically, it will be processed within two to four business days.

Pre-Authorized Deposit

You can have your health and dental claim reimbursements deposited directly to your bank account.

With the Pre-Authorized Deposit (PAD) reimbursement program, you can receive your reimbursements within two to five days following the approval of your health and dental claims. You will not have to wait for the arrival of a cheque and a trip to the bank before depositing your reimbursement.

To enrol in this service, please contact the plan administrator.

Health Care Claims – Online Claims Submission

You can submit extended health claims online or through the Ellement benefit app. Before submitting your first claim, you will need to register on the Ellement Claims portal by using your Group Number and Certificate Number identified on your benefit card. You can download the app and set up your account directly from the App Store or Google Play.

If you prefer to submit your claims manually for reimbursement, claim forms are available on the site or can be obtained by contacting Ellement.

Note: Original claims receipts will be retained by Ellement. It is recommended that you photocopy receipts prior to submitting claims.

In coordination of benefits situations where Ellement is the secondary payer, the original explanation of benefits form of the primary insurer and copies of the relevant receipts or health claim forms must be submitted.

Co-Ordination of Benefits

If you or any of your dependants are insured under another plan with similar benefits, the benefits payable under this plan will be adjusted so that the total amount reimbursed from all plans does not exceed the actual expense incurred.

This provision permits you to claim any unpaid portion of a claim under your spouse's plan. To determine which spouse should submit a claim for a dependent child, check the birth dates of the two adults. The spouse whose month and day of birth falls first in the year must submit the child's claim under his/her plan. The remainder can be submitted to the other spouse's plan.

Administration of the Health and Welfare Plan

Subject to the limitation of the health and welfare plan, the trustees may establish rules or regulations for its administration and the transaction of its business. The trustees have the right to interpret the plan and to decide any and all matters, including the right to remedy possible ambiguities, inequities, inconsistencies, or omissions. All interpretations, determinations, and decisions of the trustees with respect to any matter within their competence shall be final and binding on all parties. In carrying out the provisions of the plan, the trustees may:

- establish committees with powers as they shall determine;
- authorize one or more committee members or an agent to execute or deliver any instrument or make any payment on their behalf;
- retain actuaries, legal counsel, and other professional advisors; and
- employ agents and provide for clerical, accounting, and actuarial services, as they may require.

Insurance

The trustees shall have the right to enter into an agreement with any properly licensed body to underwrite any or all portion(s) of the benefits.

Payment of Plan Expenses

All reasonable and customary expenses incurred in the operation of the health and welfare plan shall be paid out of the trust fund.

Transactions of the U.A. Local 71 Health and Welfare Trust Fund

The plan administrator shall maintain accounts showing the fiscal transactions of the plan and shall keep this data as necessary for periodic review.

Register

The plan administrator shall keep a register of the names of all members insured under the plan, the amount of benefit coverage in force with respect to each of these members, together with the date coverage became effective and the effective date of any coverage increase or decrease.

Clerical Errors

Clerical errors made by the trustees and the plan administrator will not invalidate benefits otherwise in force or continue benefits otherwise terminated. Upon discovery of an error or delay, an appropriate adjustment of premiums will be made.

Claims Appeals Process

In the event a claim is denied, and the member is not in agreement, an appeal may be submitted in writing by the member to Ellement., identifying the basis of the appeal and including supporting medical information justifying the expense as medically necessary.

These appeals will be reviewed in conjunction with our medical/dental consultants and the decision will be communicated in writing to the member.

Your Plan is Administered by:

Ellement Consulting Group LP
1150 Cyrville Road, Suite 220
Ottawa, ON K1J 7S9

Tel: 613-319-6266
Toll free: 1-844-431-6266

Email: UALocal71@ellement.ca