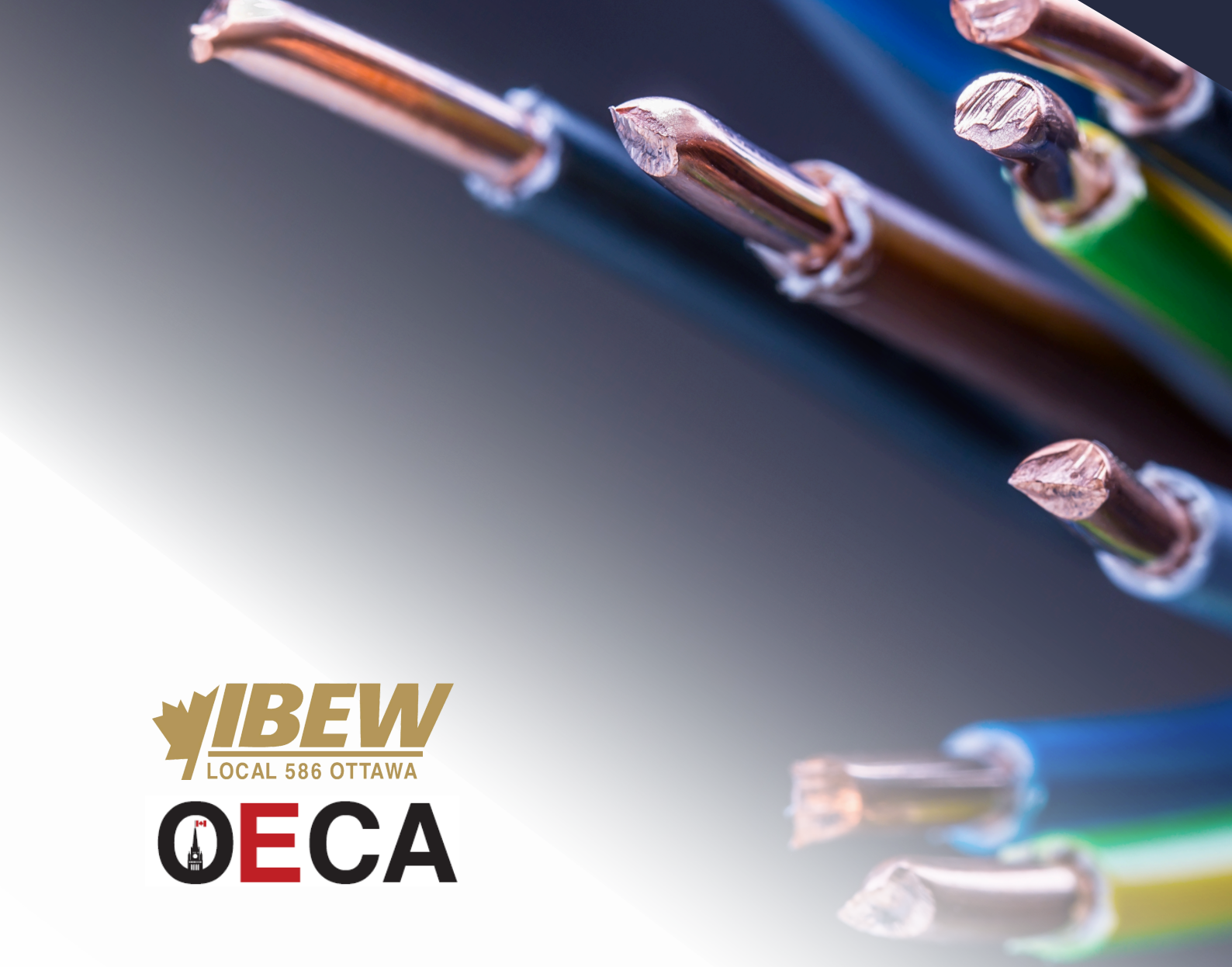

IBEW LOCAL 586 OTTAWA

OECA

The Electrical Industry of Ottawa

Group Benefit Plan
All Active and Retired Members

Effective Date: May 1, 2025

Ellement

Keep This Booklet in a Safe Place

Your group benefits provide an important supplement to your income and valuable protection for you and your family.

This booklet outlines the specific terms of your group benefit plan as well as the coverage levels of each benefit. Be sure to keep this booklet in a safe place for future reference.

The coverage for these benefits is underwritten as follows:

Benefit	Insurer/Administrator	Policy Number	Appendix
Basic Life, Dependant Life and Long-Term Disability Insurance	Canada Life Assurance	325077	Appendix A
Accidental Death and Dismemberment (AD&D)	Zurich Insurance Company Ltd	8622073	Appendix B
Extended Health Care and Dental Care	Electrical Industry of Ottawa Health and Benefit Trust Fund	61083	n/a
Member Assistance Program (MAP)	Building Trades	n/a	n/a
Telemedicine, Medical Second Opinion, and Therapy Assisted iCBT	CloudMD	n/a	Appendix C

If you have questions about your group benefits that are not covered in this booklet, please contact Ellement Consulting Group ("Ellement"), your plan administrator, at 613-699-8967 (toll free at 1-866-517-8967), or fax 844-736-5600 or email EIO@ellement.ca.

Please visit the plan website at www.eiobenefits.ca

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

Important

This document contains important information about your benefits coverage and should be kept in a safe place. It supersedes and replaces all previous communications material and is the plan document in respect to the benefits described herein.

As sponsor of the plan, the Electrical Industry of Ottawa, or its trustees or designates, establish rules or regulations for the administration or governance of the benefit plan and any transactions associated with it.

The Electrical Industry of Ottawa, or its trustees or designates, have the right to interpret 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 coverage described in this booklet.

The interpretations or decisions of The Electrical Industry of Ottawa, its trustees, or its designates, will be final and binding on all parties.

Protecting Your Personal Information

Ellement Consulting Group will collect, use, maintain, disclose and 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

Errors or Omissions

Every effort has been made to ensure that this booklet is accurate and complete. Should an error, omission, or dispute occur, the terms of the policies issued to the Electrical Industry of Ottawa will prevail. Clerical errors made by the trustees and the plan administrator will not invalidate benefits otherwise in force or continue benefits otherwise terminated.

Any fraud or willfully false statement in making a claim may invalidate your claim. You are not entitled to the claimed benefit. Sometimes, an overpayment situation may occur through no fault of yours. This means you received a greater benefit payment than you were entitled to receive. If you receive a benefit to which you are not entitled, you must immediately repay that amount to the plan sponsor, to Ellement, which administers your group benefit plan on behalf of the plan sponsor, or to the insurer. If you receive benefits to which you are not entitled and do not repay them, any one or more of the following may occur:

a) Any benefit payments to which you are entitled may be withheld to recover the amount you owe; and
b) Criminal or other legal action may be brought against you.

Mission Statement

Background

Effective October 1, 1962, the Electrical Industry of Ottawa (EIO) established a group health and benefit program for active and retired members of IBEW Local 586, their eligible dependants, and survivors.

Objectives

The purpose of this program is to reimburse eligible participants for all or part of the costs incurred for health care and dental care services and supplies not covered by the provincial health care plan. The plan is also designed to provide financial protection in the event of death or disability by providing group and life insurance coverage as well as accidental death and dismemberment and long-term disability insurance coverage.

The plan will:

- provide effective group health care, dental care, life insurance, and long-term disability coverage for all eligible plan members and beneficiaries;
- provide high quality, cost-effective, and efficient service to members and beneficiaries; and
- operate in a way that promotes the objectives of participants and plan members while supporting the principles of good governance and fiduciary responsibility.

The plan document describes the coverage and provisions in detail. The benefit program may be amended at any time thereafter. Claims will be administered in accordance with any amendments and their effective dates. Members can consult the plan document at any time through their union local.

Ellement, the plan administrator, has been contracted to adjudicate and pay claims in accordance with the plan document.

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Benefit Summary

The following is a summary of your benefit plan. For further details on each benefit, please refer to the appropriate section of this booklet.

Basic Member Life Insurance

REFER TO APPENDIX A – CANADA LIFE ASSURANCE

Members Qualifying Criteria *(All information refers to members under age 65 unless otherwise stated)*	**Volume**
• actively at work on or after November 1, 2018. • on temporary lay-off for less than 24 consecutive months.	$250,000
• not actively at work since October 31, 2018.	$125,000
• not actively at work since October 31, 2014.	$100,000
• not actively at work since September 30, 2005. • retired on or after July 1,1982 and prior to October 1, 2005.	$50,000
• retired prior to July 1, 1982.	$25,000
• Members (regardless of age) on temporary lay-off for more than 24 consecutive months but less than 36 months	$7,500

A retired member is considered to be a member in good standing of IBEW Local 586 and in receipt of a retirement pension from the Electrical Industry of Ottawa Pension Plan.

Reduction

- 50% reduction to the applicable above life insurance coverage amount will occur on January 1 coinciding with or immediately following your 65th birthday.
- 10% reductions to the remaining balance will occur each subsequent year on January 1.

Reductions will not exceed the following:

At Age:	Reduction from starting volume of:	$250,000	Original Starting Volume		
			$125,000	$100,000	$50,000
65	50%	$125,000	$62,500	$50,000	$25,000
66	10%	$100,000	$50,000	$40,000	$20,000
67	10%	$75,000	$37,500	$30,000	$15,000
68	10%	$50,000	$25,000	$20,000	$10,000
69 and older	10%	$25,000	$12,500	$10,000	$5,000

Life insurance coverage will continue into retirement, provided the required premiums are paid.

Dependant Life Insurance

REFER TO APPENDIX A – CANADA LIFE ASSURANCE

Benefit amount:	$10,000 spouse. $10,000 child 15 days of age and older.
Reduction:	50% reduction effective January 1 coinciding or immediately following member's 65th birthday.
Termination:	Date member life insurance coverage terminates.

Basic Member Accidental Death and Dismemberment (AD&D) Insurance

REFER TO APPENDIX B – ZURICH INSURANCE COMPANY LTD

Members Qualifying Criteria *(All information refers to members under age 65 unless otherwise stated)*	**Volume**
• actively at work on or after November 1, 2018. • on temporary lay-off for less than 24 consecutive months.	$250,000
• not actively at work since October 31, 2018.	$125,000
• not actively at work since October 31, 2014. • retired on or after August 1, 1998, but prior to November 1, 2014.	$100,000
• retired on or after July 1, 1982 but prior to August 1, 1998.	$50,000
• retired prior to July 1, 1982.	$25,000

Termination:	Age 70

Reduction

- 50% reduction to the applicable above life insurance coverage amount will occur on January 1 coinciding with or immediately following your 65th birthday.
- 10% reductions to the remaining balance will occur each subsequent year on January 1.

Reductions will not exceed the following:

At Age:	Reduction from starting volume of:		Original Starting Volume		
		$250,000	$125,000	$100,000	$50,000
65	50%	$125,000	$62,500	$50,000	$25,000
66	10%	$100,000	$50,000	$40,000	$20,000
67	10%	$75,000	$37,500	$30,000	$15,000
68	10%	$50,000	$25,000	$20,000	$10,000
69 and older	10%	$25,000	$12,500	$10,000	$5,000

AD&D coverage will continue into retirement to age 70, provided the required premiums are paid.

Member Long-Term Disability Insurance

REFER TO APPENDIX A – CANADA LIFE ASSURANCE

Benefit amount:	$2,500 every month.
Elimination period:	119 calendar days or date EI disability benefits end, if later.
Maximum benefit period:	To age 60; or at retirement, whichever occurs first.
Benefit payments:	Taxable.
Termination of coverage:	To age 60 less the elimination period; or at retirement, whichever occurs first.

The maximum amount may be reduced by benefits and payments provided from other sources as described in the *Long-Term Disability (LTD)* Benefit section of this booklet.

Extended Health Care (EHC)

Deductible:	Nil.
Reimbursement level:	90% (unless otherwise specified).
Maximum benefit:	$50,000 lifetime per insured person for drugs. See maximums listed under *Prescription Drugs* below.
Termination:	EHC coverage will continue into retirement provided the required premiums are paid.

Note: Some individual benefits are subject to monthly, yearly or lifetime maximums.

Prescription drugs:

• Deductible	$5.00 per prescription charge, which is waived if the dispensing fee charged by the pharmacy does not exceed the Ontario Drug Benefit program maximum.
• Reimbursement level:	90% of eligible expenses (unless otherwise specified).
• Eligible drugs:	Drugs, serums, vaccines and injectables, only available by prescription with a valid drug identification number (DIN), when prescribed by a licensed health care practitioner or dentist and dispensed by a pharmacist, dentist or a physician.
• Generic substitutions:	Yes.
• Drug card:	Yes.

- **Maximums and exclusions:**

- Drugs:	$50,000 lifetime per insured person. If the personal lifetime maximum has been reached, the annual limit of $1,000 per insured person will apply.
- Drug dispensing:	Limited to: • 34-day supply for prescription drugs or medicines, and • 100-day supply for maintenance drugs.
- Sclerosing injections for the treatment of varicosities:	Medically necessary treatment (medication only) in provinces where there is no provincial coverage.
- Viscosupplementation:	$1,500 per insured person every 6 months.
- Smoking cessation aids:	$500 lifetime per insured person (includes prescription medications and over-the-counter products) as well as therapies (includes hypnosis, laser, etc.).
- Sexual dysfunction drugs:	$1,000 per insured person every calendar year.
- Fertility drugs and treatment:	3 treatment cycles per lifetime (drugs only).
- Weight loss drugs	Certain medications are covered if specific criteria are met

Prior authorization may be required by the plan administrator for certain medications.

Hospital care:

• Deductible:	Nil
• Reimbursement level:	100% of eligible expenses (unless otherwise specified)
• Detoxification facility:	28 days maximum confinement period (pre-approval required).
• Nursing home:	90%, up to $31.25 daily maximum, private or semi-private room.

Vision care:

• Deductible:	Nil.
• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum:	$800 per insured person every 2 calendar years
Eligible expenses:	Prescription glasses including: ✓ regular lenses and frames, ✓ safety lenses and frames, ✓ sunglass lenses and frames. Prescription contact lenses. Laser eye surgery.
• Artificial crystalline lenses/intraocular lenses (IOL) for cataracts:	Reasonable and customary charges.

• Eye examinations, including eye refraction and Optical Coherence Tomography:	$125 per insured person for one regular eye exam every 2 calendar years.
• Emergency eye examination	$200 per insured person for one emergency eye examination every 2 calendar years.
• Fees for diagnosis of an eye condition	$200 per insured person for the diagnosis of an eye condition every 2 calendar years.
• Visual training:	Eligible if performed by a licensed optometrist.

Professional / paramedical services:

• Deductible:	Nil.
• Reimbursement level:	90% of eligible expenses (unless otherwise specified).
- Maximum	$1,900 per insured person for all practitioners combined every calendar year. **Note**: Psychological testing and assessments, and speech therapy are not subject to the combined yearly maximum of $1,900.
• Eligible practitioners:	
• Acupuncturist:	Reasonable and customary.
• Chiropodist:	Reasonable and customary.
• Chiropractor:	Reasonable and customary.
• Homeopath:	Reasonable and customary - includes supplies and supplements.
• Massage therapist or Orthotherapist:	Reasonable and customary.
• Naturopath:	Reasonable and customary.
• Occupational therapist:	Reasonable and customary.
• Osteopath:	Reasonable and customary.
• Physiotherapist:	Reasonable and customary.
• Podiatrist:	Reasonable and customary.
• Psychologist, Social Worker, Counsellor, Psychotherapist	Reasonable and customary.
• Speech therapist:	Reasonable and customary.

Medical supplies and services:

• Deductible:	Nil.
• Reimbursement level:	90% of eligible expenses (unless otherwise specified).
• Maximum per service and/or supply:	
- External breast prosthesis (following mastectomy):	Reasonable and customary charges.
- Surgical brassieres:	Purchase of 6 surgical brassieres per insured person every calendar year.

- Private duty nurse:	Reasonable and customary charges for Registered Nurse (RN) services. $18.75 per day per family for Licensed Practical Nurse (LPN) services.
- Artificial eye:	Reasonable and customary charges.
- Stump socks:	Reasonable and customary charges.
- Custom-made orthopedic shoes:	2 pairs up to $500 per pair per insured person every calendar year.
- Custom-made orthotics or arch supports:	2 pairs up to $500 per pair per insured person every calendar year.
- Support stockings:	2 pairs up to $75 per pair per insured person every calendar year.
- Hearing aids:	$2,000 per insured person every 5 calendar years (includes hearing tests). A written prescription from a medical physician or an audiologist is required.
- Diagnostic services:	Reasonable and customary charges.
- Wigs as result of chemotherapy:	100% up to $1,000 lifetime maximum per insured person.
- Diabetic supplies:	Reasonable and customary charges (excluding alcohol swabs and rubbing alcohol).
- 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
- FreeStyle Libre sensors and Continuous Glucose Monitor transmitters and sensors:	$5,000 per insured person every calendar year for children under 18.
- TENS nerve stimulators:	Purchase or rental, one device every 5 calendar years, up to reasonable and customary charges.
- Intra-uterine devices:	Reasonable and customary charges.
- ObusForme® Backrest:	Once every 5 calendar years, up to reasonable and customary charges.
- Out-of-province referral treatment	Excluded.

Dental Care

Deductible:	Nil.
Fee guide:	Based on the 2024 Dental Association fee guide for general practitioners, denturists, specialists, or independent dental hygienists where service is rendered.
Reimbursement amount:	
• Basic and Major Services:	90%.
- Maximum:	Combined maximum for basic and major services, per insured person up to $2,000 each calendar year.
• Orthodontic Services:	80%.
- Maximum:	Lifetime of $6,000 per insured person.
Treatment frequency:	
• Complete oral examination:	Once every 24 consecutive months.
• Recall oral examination:	Once every 6 consecutive months.
• Specific oral examination:	Unlimited
• Emergency oral examination:	Unlimited
• Complete series of radiographs or a panoramic radiograph:	Once every 24 consecutive months.
• Polishing:	Once every 6 consecutive months.
• Bitewing radiographs:	Once every 6 consecutive months.
• Scaling:	8 units per calendar year.
• Root planing:	Reasonable and customary charges.
• Fluoride treatment:	Once every 6 consecutive months.
• Tooth coloured (composite) filling:	Eligible on all teeth.
• Special periodontal appliances, including occlusal guards and bruxism appliances:	Reasonable and customary charges.
• Adjustments to periodontal appliance to control bruxism:	Reasonable and customary charges.
• Pit and fissure sealants:	For children under age 18.
• Occlusal equilibration:	4 units per calendar year.
• Space maintainers:	For missing primary teeth only.
• Oral hygiene instruction:	Once every 6 consecutive months.

• Anaesthetic:	Reasonable and customary charges.
• Denture adjustments including minor adjustments:	Reasonable and customary charges.
• Denture rebase/reline:	Reasonable and customary charges.
• Preformed stainless steel and polycarbonate crowns:	Reasonable and customary charges.
• Inlays and onlays:	3 or more tooth surfaces, once every 5 years.
• Crowns and veneers:	Once every 5 years.
• Bridges and dentures:	Once every 5 years.
• Dental Implants:	Once every 5 years.
• TMJ related services:	Reasonable and customary charges.
• Laboratory fees:	Limited to the reasonable and customary fees specified for the dental treatment or service.
Termination:	Dental coverage will continue into retirement provided the required premiums are paid.

If coverage is terminated and reinstated within a 6 month period, the applicable maximum at termination is carried forward.

Bereavement Pay

Benefit amount:	Maximum of $400 per day[1] for up to 2 days of lost wages in relation to the death of a member's child, grandchild, parent, grandparent, parent-in-law, grandparent-in-law, sibling, sibling-in-law or spouse, as defined in 5. *Bereavement Pay*. [1]Note: Members earning less than the ICI Journeyperson base rate will receive a prorated benefit amount.

Member Assistance Program (MAP)

Deductible:	Nil.
Life events:	Personal issues including financial, legal, stress, marital, alcohol and drug abuse, etc.

Telemedicine

REFER TO APPENDIX C – OTHER SERVICES AVAILABLE VIA CLOUDMD

Services:	Virtual health care and medical support for non-urgent concerns, questions and needs.

Therapy-Assisted iCBT (TAiCBT)

REFER TO APPENDIX C – OTHER SERVICES AVAILABLE VIA CLOUDMD

Services:	Cognitive Behavioural Therapy delivered virtually by offering a combination of online content and direct one-to-one therapy.

Medical Second Opinion

REFER TO APPENDIX C – OTHER SERVICES AVAILABLE VIA CLOUDMD

Services:	Medical information reviewed by a medical expert to ensure the diagnosis is correct and treatment plan is optimal

General Information

1.1 The Plan Effective Date

The plan described in this booklet is up-to-date as of May 1, 2025.

1.2 This Plan Supplements Provincial Plans

This group benefit plan is designed to supplement protection, not duplicate or take the place of, the benefits available under provincial hospital and medical care plans. Therefore, this benefit 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.

1.3 Who is Eligible

A member in good standing of the union, who:

- is employed and directly compensated for services by an employer who, pursuant to collective agreement with the union, is obligated to make contributions to the Electrical Industry of Ottawa Health and Benefit Trust Fund on behalf of that member; or is employed on a full-time basis and is a salaried employee of:
  i) an electrical contractor; or
  ii) the union; or
  iii) the IBEW Construction Council of Ontario.
- a contractor who has entered into a participation agreement with the union.
- an owner/operator who has entered into a participation agreement with the union and who does not employ hourly workers, and remits the mandatory industry funds. Participation is optional.

Spousal and dependant coverage is available subject to the terms and conditions of this booklet.

Individuals residing outside Canada or the continental United States will not be eligible for coverage. Exceptions may be made by request of the member but must be approved in writing by the plan administrator and the insurer, where applicable.

1.4 Waiting Period

225 Hour Bank hours must be accumulated before coverage begins. Following the accumulation, benefits are effective the first day of the second month.

1.5 When Coverage Begins

Active member:

- when the eligibility and waiting period requirements have been satisfied.

Inactive member:

- upon return to active member status

Dependants:

- the date member coverage begins (if a dependant has been identified); or,
- the date a dependant becomes eligible for coverage; or
- the dependant coverage application date, provided the application is made within 31 days of initial eligibility for dependant coverage.

Complete a new Enrolment form to add or change a legally married or common-law spouse, or add or remove a child. Requests for changes to covered dependants are subject to review and approval by the IBEW Local 586 union.

1.6 Definitions

Active member or member actively at work: an employed and working member who performs all of the usual customary duties of the occupation.

Beneficiary: see *Revocable / Irrevocable beneficiary*

Collective agreement: the agreement in accordance with which contributions are made made to the Trust Fund by the employer on behalf of a member.

Dependant child: an unmarried person who resides with you, is dependent on you for support, and meets the following two requirements:

Requirement 1:

(i) your natural or adopted child; or
(ii) the natural or adopted child of a legal or common-law spouse

and

Requirement 2:

(i) younger than 21 years of age; or
(ii) 21 years of age or older, but younger than 25 years of age, and in full-time attendance at an accredited institute of learning, or
(iii) 21 years of age or older, and incapable of self-sustaining employment due to a mental or physical handicap. The child's coverage will be continued under the policy, provided the child's handicap has existed continuously from a time when he/she was otherwise insured as a dependant under this policy. Supporting documentation by a physician will be required.

To avoid delays or processing problems, contact the plan administrator when any change in dependant status occurs. Dependant change requests are subject to review and approval by the IBEW Local 586 union.

Disabled: defined under the life insurance and long-term disability (LTD) sections of this booklet.

Employer: (can be any of the following)

- the Policy holder;
- an electrical contractor who is employing a member on a full-time basis and who, pursuant to the collective agreement with the union, is obligated to make contributions to the Trust Fund on behalf of any such member;
- an electrical contractor who is employing a salaried employee on a full-time basis and who, pursuant to a participation agreement with the union, has agreed to make contributions to the Trust Fund on behalf of the employee;
- the IBEW Local Union 586 or the IBEW Construction Council of Ontario who is employing a salaried employee on a full-time basis; or
- an owner/operator who does not employ hourly workers and who, pursuant to a participation agreement with the union, has agreed to make contributions to the Trust Fund on his own behalf.

Full-time basis: salaried members that regularly work at least 20 hours per week.

Inactive / unemployed: a member who is temporarily absent from work due to disability, temporary layoff, authorized leave of absence, strike or any other work stoppage.

Insured person: member with coverage, spouse and dependant child.

Policy holder: the Electrical Industry of Ottawa Health and Benefit Trust Fund in its capacity as the policy holder of group contract numbers 325077, 8622073 and 61083.

Retiree: is a member in good standing who:

- has or is retired and has not returned to work for a participating employer;
- draws on the Electrical Industry of Ottawa Pension Plan;
- participated in the benefit plan for the preceding two years and whose benefits were in force at the time of retirement. (staff whose benefits are in force at the time of retirement are eligible.);
- completed the member election form confirming retirement status and choice of benefit package required at the time of retirement.

Spouse: can be:

- an individual to whom the member is legally married; or
- a common-law partner, including a same-sex partner, with whom the member has co-habited for a period of at least 12 months and who is publicly presented as the member's spouse/partner.

Members must state the name of the person to be considered a spouse for the purposes of the policy. Only one spouse will be covered under the policy at any time.

Union: the International Brotherhood of Electrical Workers, Local 586.

1.7 Hour Bank Account

For each hour of work, a contribution, as defined by the collective or participation agreement, will be made to your Hour Bank account.

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

Each month, you will receive a statement highlighting the hours worked in the previous month. It is important to understand how the cycle of reporting hours works. The hours worked in a month are reported to the plan administrator the following month. They are then used to provide coverage in the second month following the month worked.

For example, the hours worked in February are reported to the plan administrator in March. They are then used to determine eligibility for coverage for the month of April.

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
July	August	September
August	September	October
September	October	November
October	November	December
November	December	January
December	January	February
January	February	March

Note: New and reinstated members are in benefit on the first day of the second month following the month in which 225 hours are accumulated. For example, if a member works 100 hours in February and 125 hours in March, he/she will be insured effective May 1.

1.8 Hour Bank Balance Refund

If coverage lapses and you are out of benefit for 24 consecutive months, any balance remaining in your Hour Bank account will be forfeited.

On death

On your death, your surviving spouse and eligible dependants can use your account balance to extend coverage until the account is depleted. The pay direct program is not available to surviving spouses. However, the trust general reserve will pay the applicable premium to ensure that a minimum of six months of coverage is provided following the date of your death. No account balance refunds are permitted.

On retirement

On retirement, your account balance may be used to extend coverage beyond your retirement date; otherwise, the balance is forfeited.

1.9 Change in Coverage

If your coverage changes due to a change in age, class, earnings, etc., or as a result of a plan change, your coverage will not be adjusted until the first day of the month following the date of the change, unless the change occurs on the first day of the month. Additionally, you must be actively at work with the appropriate contribution being made.

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

1.10 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. new dependant, beneficiary or address) occurs.

1.11 Beneficiary Rules

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

You must make your beneficiary designation revocable or irrevocable. You may change a revocable designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable, unless you specify otherwise.

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.

If there is more than one beneficiary and the form does not specify their respective share of the insurance proceeds, 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.

1.12 Suspension of Union Membership and Coverage

If you do not pay union dues and your membership lapses, benefits under this plan will terminate as of the effective date of your suspension as reported by the IBEW Local 586 union. Any balance in your Hour Bank account will be forfeited and transferred to the trust general reserve.

1.13 Termination of Coverage

Member Coverage will terminate on the earliest of the following:

- the date union membership ceases for members 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 insurance;
- for AD&D and LTD insurance coverage, the first day of the second month following the date on which you have been laid-off for more than 24 months;
- for life and dependant life insurance coverage, the first day of the second month following the date on which lay-off is more than 36 months unless medical evidence is provided to support a life expectancy of less than two years;

- for the health and dental benefits, the first day of the second month following the date on which lay-off is more than 36 months and no Hour Bank balance exists;
- the first day of the second month following the date your Electrical Industry of Ottawa Pension Plan assets are transferred permanently from the plan, unless medical evidence is provided to support the fact that life expectancy is less than two years;
- the date you cease to be a member of any eligible class;
- the date your class is terminated;
- the date you become a full-time member of the armed forces of any country;
- the date you fail to make premium contributions;
- the premium due date coincident with or immediately following the date you attain the termination age shown in the *Benefit Summary*;
- the date the policy terminates; or
- the date you begin working for a non-union or non-participating employer.

Dependant coverage will terminate on the earliest of the following:

- the date your coverage terminates;
- the date the dependant ceases to be a qualified dependant;
- the date dependant coverage under the policy is terminated;
- the date contributions cease to be made for dependant coverage following your death (see *1.16.5 Health and Dental Benefits for dependants following death* below for more details).
- the date you have been unemployed for more than 36 consecutive months.

1.14 Termination of Coverage Following Termination of Pension Plan Membership

If you choose to terminate your membership in the Electrical Industry of Ottawa Pension Plan, for reasons other than a shortened life expectancy, by transferring your assets out of the plan while insured under this plan, coverage will terminate on the first day of the second month following the date of settlement of your pension account. Any banked hours remaining in your Hour Bank account will be forfeited.

If you proceed with a permanent transfer of pension assets under a reciprocal agreement but do not also reciprocate your health and benefit account balance, you will be allowed to continue to participate in this plan.

1.15 Reinstatement of Coverage

If benefits were terminated due to insufficient hours of credit in your Hour Bank account and you did not participate in the pay direct program, coverage may be reinstated when 225 hours of credit in any 12-month period is accumulated. Coverage will become effective on the first day of the second month following the date your Hour Bank account credit totals 225 hours, provided you are at work or eligible to resume work, and are a member in good standing of the union.

If coverage was suspended with your union membership, your benefits will be reinstated as of the reinstatement date of your union membership.

1.16 Continuation of Coverage

1.16.1 During absence from work

If you are absent from work due to:

- illness or injury; coverage may be continued until the earliest of the dates specified in the *Termination of Coverage* section;
- temporary lay-off;
  - (i) life and dependant life insurance coverage will be continued for a maximum period of 36 months, beginning on the first day of the second month following the month of lay-off, provided the required contributions are made. However, after the first 24 months of temporary lay-off, the life insurance benefit will be reduced to $7,500;
  - (ii) AD&D and LTD coverages will be continued for a maximum period of 24 months, beginning on the first day of the second month following the month of lay-off, provided the required contributions are made; and
  - (iii) health and dental coverage will be continued for a maximum period of 36 months, beginning on the first day of the second month following the month of lay-off, provided the required contributions are made. If the number of banked hours is sufficient to continue insurance beyond the 36 months, coverage may be continued until the first day of the second month following the depletion of your Hour Bank account.

If you are laid-off after becoming eligible for coverage, return to work for a minimum of 36 hours in a month and are subsequently laid-off, coverage may be continued for an additional 36 months of unemployment, beginning on the first day of the second month following the month of lay-off, provided the required contributions are made.

1.16.2 Following Retirement

Once retired and drawing a pension from the Electrical Industry of Ottawa Pension Plan, all benefits in effect at the time of retirement can be maintained until the earliest of the dates specified in the *Termination of Coverage* section, provided the required premiums are paid and provided you meet the eligibility requirements described below.

The required premiums will vary depending on your classification immediately prior to the effective date of your retirement from the Electrical Industry of Ottawa Pension Plan.

As the owner of a company recognized as a participating employer, as a contractor, or as one of its office workers, you are required to pay the full cost of the retiree benefit package.

Ten years of participation in the health and benefit plan is also required to qualify for coverage following retirement.

As an hourly worker or union employee you are also required to pay the full cost of the retiree benefit package. It is possible to participate as a retiree, provided the following eligibility criteria are met:

- you have a minimum of 225 hours of participating in the health and benefit plan in each of the 10 years immediately preceding the effective date of your retirement.
- If you failed to accumulate 225 hours in your account for any of the 10 years preceding the effective date of retirement, it is possible to still qualify for participation provided:

(i) you were disabled and in receipt of long-term disability, Workplace Safety and Insurance Board benefits or approved for waiver of life insurance premiums for the years in question; or

(ii) the IBEW Local 586 business manager confirms that, based on union records, you demonstrated you were available for and willing to work by:

a) being a member in good standing of the IBEW Local 586, as per the constitution; and

b) having signed the book at the union hall confirming that you were available for work as per the dispatch procedures; and

c) accepting a job when the opportunity arose within six months of your out-of-work date. If the job was less than 225 hours, you must have been available to take the next available call at the out-of-work date.

If the eligibility criteria outlined above is not met, but you were a member in good standing of the IBEW Local 586 for 10 years immediately preceding retirement, your Hour Bank account balance may be used. Otherwise, you may pay out of pocket to extend benefits into retirement, provided the full cost of the retiree benefit package is paid.

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

1.16.3 While on Workplace Safety and Insurance Board (WSIB) benefits

If due to a job related sickness or injury, you are accepted to receive Workplace Safety and Insurance Board benefits, health and benefit and pension contributions will be made on your behalf for up to 12 months. The contributions required to maintain coverage 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, the claimant. Please contact the plan administrator for further details.

1.16.4 While totally and permanently disabled

If you become totally and permanently disabled as defined under the life insurance and LTD sections of this booklet, coverage under this plan may be continued, provided the required premiums are paid, subject to the following conditions:

- you have been accepted for waiver of premium by the insurer; or
- you have been accepted for LTD benefits by the insurer; or
- you have been in receipt of WSIB benefits for more than 12 months.

1.16.5 Health and Dental benefits for dependants following death

Upon your death, your surviving spouse and eligible dependants can use your account balance to extend coverage until the account is depleted. The pay direct program is not available to surviving spouses. However, the trust general reserve will pay the applicable premium to ensure that a minimum of six months of coverage is provided following the date of your death. No account balance refunds are permitted.

1.17 Reinstatement of Benefits/Applicable Maximums

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 1st are carried to the end of the calendar year.

1.18 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 $1,000, to a Health Care Spending Account (HCSA). A declaration and election form will be sent in advance of the new year with a confirmation of the balance available for transfer to the HCSA. Claims that have not been reimbursed at 100% by the core plan and are not coordinated with another benefit plan will automatically have the balance paid from the HCSA account's available balance. An eligible excess is any amount above what is required to provide 24 months of coverage under the Electrical Industry of Ottawa Benefit Plan, to a maximum of $1,000 per calendar year ($750 per year prior to 2024).

The HCSA option is permitted under applicable law if you elect the transfer within the deadline provided. You can 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 the remaining balance, if any, in your HCSA must be forfeited to the Electrical Industry of Ottawa Health & Benefit Trust General Reserve. 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/.

1.19 Pay Direct Program

If you are unemployed and do not have sufficient hours in your Hour Bank account to continue coverage, you may elect to continue benefits coverage by making direct payments to the plan for a maximum of 36 months of lay-off. You must remain in good standing of the union to participate. Certain benefits will terminate or reduce prior to the end of the 36-month period, in accordance with the other provisions in this booklet.

1.20 Pre-Authorized Payments

In lieu of sending in payments every month or providing a series of post-dated cheques for retiree benefit premiums, we encourage you to subscribe to the pre-authorized payments (PAP) service. PAP allows the plan administrator to debit the elected bank account on the 1st of each month. Simply complete an authorization form and provide a void cheque to the plan administrator.

1.21 Subsidy Program for Unemployed Members

As a member in good standing of the union, you may qualify for a monthly subsidy if unemployed and meeting the following criteria:

- you signed the book at the union hall confirming you were available for work as per the dispatch procedures; and
- your coverage is in force but your Hour Bank account is depleted and contains less than one month's premium; and
- you obtained the business manager's signature on the *Monthly Application – Subsidy Program* form and submitted it to the plan administrator with the payment as specified.

If within six months of your out-of-work date you fail to accept a job when the opportunity arises, you shall forfeit the entitlement to participate in the subsidy program and must pay the entire premium to maintain coverage. To qualify for the subsidy program if the job is less than 225 hours, you must be available to take the next available call at the out-of-work date.

1.22 Premium Rebate for Low Income Earners

The premium rebate offer is for retired/disabled members of the Electrical Industry of Ottawa, who meet all of the following criteria:

- must have a gross family income less than the national poverty level plus 20%;
- have completed the application and provided a copy of the previous year's notice of assessment (and spouse's, if applicable);
- must not have withdrawn any of the pension assets from the EIO Pension Trust Fund;
- qualify for retiree benefits under the EIO benefit plan;
- have first exhausted the balance remaining in the Hour Bank account; and
- must not have coverage available through their spouse's benefit plan.

The poverty level is defined by the Income Statistics Division of Statistics Canada for a city the size of Ottawa.

Total gross income is the combined income of the retired or disabled member and spouse (if applicable) from all sources including: any pension income; CPP/QPP and OAS payments; disability payments; and any other sources of income, excluding income payable to or on behalf of dependant children.

1.23 Co-ordination of Benefits

When payment for benefits provided under this plan is available to a person under any other pre-paid health service contract, insurance policy or plan, benefits shall be co-ordinated and the amount payable under this agreement shall be pro-rated and limited to the extent that the total amount available under all coverages does not exceed 100% of the eligible expenses.

The plan administrator may obtain from or release to any person or corporation, any information considered necessary to implement this provision and facilitate the payment of benefits under this plan, subject to consent of the covered member, if so required by law.

In co-ordination of benefits situations where Ellement is the secondary payer, the original Explanation of Benefits from the primary insurer and copies of the relevant receipts or dental claim forms must be submitted.

1.24 Order of Benefit Determination

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

- if another plan does not contain a co-ordination of benefits provision, the benefits of that plan will be paid first prior to the application of benefits under this plan;
- if another plan contains a co-ordination of benefits provision, its benefits will be co-ordinated with the benefits under this plan as follows:

Priority shall be attributed to the plan under which the person is eligible to receive the benefits in the following order:

(i) (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 individual as a dependant;
(ii) 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
(iii) 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;

- in cases of separation or divorce:
  (i) the plan of the parent with custody of the child;
  (ii) the plan of the spouse-partner of the parent with custody of the child;
  (iii) the plan of the parent not having custody of the child; or
  (iv) the plan of the spouse-partner of the parent not having custody of the child,
- if the person is covered under another plan, priority will go to:
  (i) the plan where the employee is an active, full-time employee;
  (ii) the plan where the employee is an active, part-time employee; or
  (iii) the plan where the employee is a retiree.

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

In co-ordination of benefits situations where Ellement is the secondary payer, the original Explanation of Benefits from the primary insurer and copies of the relevant receipts or dental claim forms must be submitted.

1.25 Taxation

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

1.26 Out-of-Country Coverage

The plan limits coverage to within Canada only. If you travel outside of Canada, it is recommended that independent out-of-country medical coverage be purchased.

2. Extended Health Care

2.1 Payment of Benefits

If you and/or your eligible dependants incur any eligible expenses for medically necessary services or supplies, the benefit plan will pay a benefit subject to limitations and exclusions. The benefit payable will be based on the amount shown in the *Benefit Summary* following the payment of the annual deductible, if applicable. All covered services and supplies must be considered reasonable and acceptable by the Canadian medical profession and proven to be effective and in a form, intensity, frequency and duration essential to the diagnosis and treatment of the illness or injury. Certain drugs may require prior authorization from the plan administrator.

2.2 Pay-Direct Drug Card

Prescription drugs can be reimbursed directly through the drug plan using the pay-direct drug card from TELUS Health and Ellement.

With the pay-direct drug card, prescription drug claims will be processed while you wait at the retail pharmacy of your choice anywhere in Canada. There are no forms to complete. Simply present the drug card to the pharmacist when purchasing prescription drugs. The claim payment will be processed immediately. The pay-direct drug card is designed to cover only prescription drug costs.

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.

When adjudicating second-payer co-ordination of benefit drug claims, TELUS Health will adjudicate up to the reasonable and customary amount.

Members will receive pay-direct drug cards in the mail. Please note that only the name of the covered member appears on the cards.

To request an additional card or if a card is lost or stolen, please contact Ellement.

2.3 Work-related Injuries/Expenses

Extended health care expenses for work-related injuries that are recoverable from the WSIB will be refunded to the plan as they are recovered from the WSIB.

2.4 Covered Expenses

The plan will pay for the following services and supplies, providing they are not covered by the provincial health care plan to the limits specified in the *Benefit Summary:*

2.4.1 Prescription Drugs and Medication

- Drugs, serums, vaccines and injectables, only available by prescription with a valid drug identification number (DIN), when prescribed by a licensed healthcare practitioner or dentist and dispensed by a pharmacist, dentist or a physician.
- Hospital-administered drugs are not covered.
- 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.
- Smoking cessation aids, including prescription medications, over-the-counter nicotine replacement products and smoking cessation therapies (including hypnosis, laser, etc.), to the limits outlined in the *Benefits Summary*. For over-the-counter nicotine replacement products, an official pharmacy receipt indicating the patient's name, date of service, item purchased, and amount paid is required.
- Fertility drugs, to the limits outlined in the *Benefit Summary*.
- 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
- Oral contraceptives.
- Sclerosing injections used in the treatment of varicosities, when this treatment is primarily for therapeutic and not cosmetic purposes, to the limits outlined in the *Benefits Summary*.
- Sexual dysfunction drugs, to the limits outlined in the *Benefit Summary*.
- Weight loss drugs, to the limits outlined in the *Benefit Summary*.
- Botox® is covered if prescribed for non-cosmetic reasons.
- Viscosupplementation, to the limits outlined in the *Benefit Summary*.
- The Ontario Drug Benefit (ODB) program deductible for seniors and the prescription co-payment are reimbursed.

2.4.2 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 and if:

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

2.4.3 Dental Expenses due to an Accidental Blow to the Mouth

Dental treatment for the repair or replacement of natural teeth as a direct result of an accidental blow to the mouth. Damage must be caused by a direct blow to the mouth, not from an object wittingly or unwittingly placed in the mouth. The accident must have occurred after the effective date of the plan and coverage must still be in effect when the services are rendered.

Treatment must be completed within 6 months of the date of the accident.

Reimbursement will be based on the amount for the least expensive procedure which will provide a professionally adequate result and will be based on the Dental Association fee guide outlined in the *Benefits Summary*, with a reimbursement level of 100%.

For Dental Care not relating to an accidental blow to the mouth, see 3. *Dental Care* below.

2.4.4 Ambulance Services

Charges for emergency transportation by a licensed ground ambulance or air ambulance, to the nearest hospital in which the required treatment can be provided.

2.4.5 Medical Supplies

Charges for the following supplies are covered when provided upon the recommendation of the attending physician, or, if it is legal to do so, by the attending nurse practitioner, osteopath or podiatrist. The referral must indicate the medical diagnosis. Any approved equipment will be reimbursed based on the date for which the item was paid in full.

It is strongly recommended that an estimate be submitted with all supporting medical documentation, prior to incurring costs for medical equipment with substantial cost implications:

- artificial eyes, to the limits outlined in the *Benefit Summary*;
- artificial limbs (standard type);
- blood or blood plasma
- braces (excluding lumbar supports), hernia belts, casts, bandages, surgical dressings, splints (excluding dental splints), cervical collar: *rental or purchase*. Reimbursement for rental fees will not exceed the purchase price. Braces must be constructed with rigid or semi-rigid material, required for normal activities of daily living, and not solely for sports-related activities;
- breast prosthesis (external) following a mastectomy and surgical brassieres, to the limits outlined in the *Benefit Summary*;
- colostomy or ileostomy and incontinent expenses, payable only after the provincial grant has been exhausted;
- continuous passive motion (CPM) machines: *rental*, when required post-operatively;
- cost of serum used during allergy testing;
- cryocuff: *rental or purchase*;
- diabetic devices and supplies, such as:
    - diabetic needles, syringes, test strips and lancets (excluding alcohol swabs and rubbing alcohol), to the limits outlined in the *Benefit Summary*;
    - glucometer/reflectance meter, FreeStyle Libre flash monitor or continuous glucose monitor receiver, to the limits outlined in the *Benefit Summary*;
    - FreeStyle Libre sensors and continuous glucose monitor transmitters and sensors, to the limits outlined in the *Benefit Summary*. Contact the plan administrator regarding prior authorization and required documentation;
- hearing aids, including repairs, maintenance, batteries or recharging devices, hearing aid moulds and hearing tests, to the limits outlined in the *Benefits Summary*. Proof of declined WSIB claims will be required for reimbursement under the plan;
- hospital bed (standard type, with or without mattresses) and including hospital bed rails and trapeze bar: *rental or purchase*. Reimbursement for rental fees will not exceed the purchase price. Traction apparatus when part of a hospital bed;
- insulin pump supplies, payable only after the provincial grant has been exhausted;
- intermittent positive pressure breathing machine, aerosol equipment mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma;
- intra-uterine devices, to the limits outlined in the *Benefit Summary*.
- iron lungs;

- mobility aids, such as canes, crutches, walkers: *rental or purchase*. Reimbursement for rental fees will not exceed the purchase price.
- nursing home/clinic for room and board and normal nursing care provided in a licensed nursing home or clinic, for convalescent or chronic care (excluding custodial care), to the limits outlined in the *Benefit Summary*;
- non-union bone stimulators;
- ObusForme® Backrest, to the limits outlined in the *Benefit Summary;*
- orthopedic shoes (custom-made) for the proper management of unusual, congenital or post-traumatic foot problems, to the limits outlined in the *Benefit Summary;*
- orthotics or arch supports (custom-made), if medically necessary, to the limits outlined in the *Benefit Summary*;
- out-of-province referral treatment is not covered;
- radium or cobalt or radioactive isotopes, laboratory tests and X-rays;
- respirator/ventilator (standard type), oxygen and its administration: *rental or purchase*. Reimbursement for rental fees will not exceed the purchase price;
- sleep apnea monitor for respiratory dysrhythmias;
- sleeves (including Jobst sleeves) for lymphoedema following mastectomy, burn garments (including Jobst burn garments), stump socks, shoulder harnesses, head halters;
- support stockings, to the limits outlined in the *Benefit Summary*;
- surgical supplies;
- transcutaneous electric nerve stimulator (TENS) machine: *rental or purchase*, to the limits outlined in the *Benefit Summary*. Reimbursement for rental fees will not exceed the purchase price;
- wheelchair (electric) and wheelchair repairs, when required due to medical condition;
- wheelchair (standard type) and wheelchair repairs: *rental or purchase*. Reimbursement for rental fees will not exceed the purchase price;
- Wigs for patients who have undergone chemotherapy treatment, to the limits outlined in the *Benefit Summary*. Wigs for all other medical conditions are not covered.

2.4.6 Nursing Expenses

Private duty nursing by a graduate registered nurse currently registered with the appropriate local authority who is not a resident at your home, a member of your family or a relative and does not ordinarily reside in your home for the period of time recommended by the attending physician.

If a graduate registered nurse is not available when needed, medically required nursing services of a registered nursing assistant or licensed practical nurse will be eligible, to the limits outlined in the *Benefit Summary*.

Note: These services must be pre-approved by the plan administrator before any nursing care services are incurred.

2.4.7 Paramedical Services

Professional services of 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) to the limits outlined in the *Benefit Summary*. Please note reasonable and customary per-visit fees will be considered. All receipts must clearly indicate the names of those attending the sessions.

Reimbursement is based on the dates the services were rendered. If you choose to enter into a block payment or annual payment plan for services, reimbursement will be made at the end of the contract period, upon submission of all receipts and a copy of the contract.

2.4.8 Detoxification Facility

If you enter a detoxification facility, the plan will pay expenses to the limits outlined in the *Benefit Summary* at the reasonable and customary charges applicable to provincially approved detoxification facilities, provided treatment is pre-approved by the plan administrator.

2.4.9 Vision Care

Vision care expenses are eligible when prescribed by a physician (including an ophthalmologist) or an optometrist.

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

2.4.9.1 Prescription eyewear and laser eye surgery

The plan covers the cost of prescription glasses, prescription safety glasses, prescription sunglasses, prescription contact lenses, or laser eye surgery to the limits outlined in the *Benefit Summary.*

The cost of the laser eye surgery can be amortized over a number of years.

2.4.9.2 Ocular Examinations

Eye examinations, including eye refraction and Optical Coherence Tomography, to the limits outlined in the *Benefit Summary*.

Emergency eye examinations are covered to the limits outlined in the *Benefit Summary*.

Fees for the diagnosis of an eye condition, when not covered by the province, to the limits outlined in the *Benefit Summary*.

2.4.9.3 Visual Training

Visual training, if performed by a licensed optometrist

3. Dental Care

If, while insured, you or your dependant incurs any of the eligible expenses for dental services, the plan will pay a benefit subject to the dental care limitations. The amount payable will be determined based on the percentage shown in the *Benefit Summary*.

Benefits are based the Dental Association Fee Guides indicated in the *Benefit Summary.*

Dental treatments are considered eligible, if performed by a dentist, denturist, specialist, or independent dental hygienist who practices within the scope of their license.

For information on dental care relating to accidental injury to natural teeth, see 2.4.3 *Dental Expenses due to an Accidental Blow to the Mouth.*

3.1 Pre-determination of Benefits

Where a course of treatment is expected to cost $500 or more or will involve the use of crowns, inlays, onlays, bridges, dentures, implants or orthodontic treatment, it is recommended that the insured person obtain a written estimate outlining the procedures and itemized charges, including X-rays, from the attending dentist. The estimate should be submitted to the plan administrator prior to commencement of the treatment. The plan administrator will review the estimate and advise the insured person on the amount of benefit payable.

3.2 Alternate Benefit Provision

Situations may arise where alternative methods of treatment may be available. It is solely for you and your dentist to decide which method will be employed. As the basis for determining liability under the benefit plan, the plan administrator reserves the right to use the least expensive method of treatment that would provide a professionally adequate result.

This provision cannot be applied on excluded provisions, services or devices. Only those treatments listed are eligible.

3.3 Basic Services

The following services will be eligible for payment. Refer to the *Benefit Summary* for relevant limitations:

- Recall oral examinations;
- Bite-wing X-rays;
- Polishing;
- Oral hygiene instruction;
- Fluoride treatment;
- Complete oral examinations;
- Complete series of radiographs or a panoramic radiograph;
- Simple alveolectomy (incision into tooth socket) at time of tooth extraction;
- Surgical extractions including extractions of impacted teeth;
- Surgical removal of tumours, cysts, neoplasms, plus the incision and drainage of an abscess;
- Amalgam, silicate, acrylic, and composite filings;
- Inlay or onlay of one or two tooth surfaces (for three or more tooth surfaces, see *3.4 Major Services* below);

- Pit and fissure sealants for children up to the age of 18;
- Therapeutic scaling;
- Root Planing
- Provision of space maintainers for missing primary teeth,
- Bruxism appliances and habit breaking appliances;
- Diagnostic X-ray and laboratory procedures required in relation to dental surgery;
- Anaesthetic required in relation to eligible dental treatment;
- Consultation required by the attending dentist;
- Re-lining, re-basing, adjustments or repairing of an existing denture;
- Endodontic treatment (i.e. those basic procedures necessary for pulp therapy and root canal therapy) and the bleaching of endodontically treated teeth.
- Periodontic treatment (i.e. those basic procedures necessary for the treatment of tissues supporting the teeth).
- Occlusal equilibration is limited as outlined in the *Benefit Summary*;
- Injection of antibiotic drugs when prescribed by a dentist.

3.4 Major Services

The following services will be eligible for payment. Refer to the *Benefit Summary* for relevant limitations:

- Inlays and onlays when three or more tooth surfaces are involved if the existing materials cannot be made serviceable and to the limits outlined in the *Benefit Summary* (for one or two tooth surfaces, see *3.3 Basic Services* above);
- Crowns, including gold and porcelain veneer restorations where other material is not suitable;
- The creation of an initial bridge or initial denture, once coverage is in force for at least 12 months;
- Dental implants and related services;
- Related dental services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for a correction to temporomandibular joint dysfunction (TMJ) are limited as outlined in the *Benefit Summary*;
- Repairs to an existing bridge, crown, inlay, onlay or veneer;
- The replacement of an existing bridge, crown, inlay, onlay, veneer or denture, only under the circumstances set out below:
  i) if the existing appliance is at least five years old and cannot be made serviceable; and
  ii) if the existing appliance is temporary and is replaced with a permanent appliance within 12 months of the date the temporary appliance was installed.

3.5 Orthodontic Services

Orthodontic services must be for a treatment that has as its primary objective the correction of malocclusion of the teeth.

Reimbursement for the initial orthodontic fee must not exceed 35% of the total 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.

4. General Exclusions

No payment will be made for expenses resulting from:

- self-inflicted injuries or illness while sane or insane;
- any injury or illness for which the covered person is entitled to indemnity or compensation under any Workplace Safety and Insurance Act;
- charges levied by a physician or 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;
- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot;
- 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 required for the use of a third party;
- travel for health reasons;
- dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union;
- 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, serums, injectables and supplies that are not approved by Health Canada (Food and Drugs) or are experimental or limited in use whether or not so approved;
- experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society;
- medical marijuana in any form;
- expenses required for recreation or sports;
- services or supplies received during a period of hospital confinement that began before your insurance became effective;
- transportation and delivery charges;
- hospital charges except detoxification facility charges and Nursing home charges as specified by the plan;
- Personal Protective Equipment (PPE);
- services not listed as covered expenses.
- Diaphragms
- Breast pumps

5. Bereavement Pay

Effective Date

Bereavement Pay benefits will be payable on or after May 1, 2025.

Definitions

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

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

Parent or Grandparent: a natural or legally adoptive parent or grandparent of the member.

Parent or Grandparent-in-Law: the parent or grandparent of the member's spouse.

Sibling: a natural or legally adopted brother or sister, stepbrother, stepsister, or other person sharing a common parent with the member.

Sibling-in-Law: a sibling of a spouse, including daughter-in-law or son-in-law.

Spouse: an individual to whom the member is legally married or a common-law partner, including a same-sex partner, with whom the member has co-habited for a period of at least 12 months and who is publicly presented as the member's spouse/partner.

Benefit Amount

Bereavement Pay benefits are payable to a maximum of $400 per day[1] for up to 2 days of lost wages in relation to the death of a member's child, grandchild, parent, grandparent, parent-in-law, grandparent-in-law, sibling, sibling-in-law, or spouse, as defined above.

[1]Note: Members earning less than the ICI Journeyperson base rate will receive a prorated benefit amount per day.

Eligibility

Bereavement Pay benefits shall only be paid to members who:

- were employed by a participating employer at the time of the Bereavement Pay leave period and were not reimbursed for the days claimed by their employer for lost wages;
- complete a Bereavement Pay Benefit Declaration Form available from IBEW Local 586 or Ellement Consulting Group LP
- provide a funeral director's statement or death certificate for the deceased; and
- obtain a letter from the Employer to indicate that the member was absent from work for the days in question and was not reimbursed by the employer for the time lost from work due to bereavement.

6. Member Assistance Program (MAP)

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.

7. How to Claim Extended Health Care, Dental Care, and HCSA Benefits

7.1 General Information

To be eligible for reimbursement, Ellement must receive proof of a claim within 12 months of the date of purchase or service. If your coverage terminates, you have 90 days following your termination date to submit claims for reimbursement.

Interest shall not be payable on any reimbursement under this plan.

All expenses incurred and paid by you shall be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement shall be made for expenses incurred and paid by you for any of the eligible services, substances and appliances set out in and in accordance with the provisions set forth in the policy, provided such expenses:

i) are incurred and paid for services, substances and appliances prescribed by, and given under the direction of a physician, subject to the conditions of this agreement; and
ii) are in the opinion of the plan administrator reasonable and customary in the area in which they are rendered or supplied.

Reimbursement shall not be made for any eligible expense unless the benefit premiums were paid when due for the months in which the service, substance or appliance was rendered or supplied.

7.1.1 Co-ordination of Benefits

In co-ordination of benefits situations where Ellement is the secondary payer, the original Explanation of Benefits from the primary insurer and copies of the relevant receipts or dental claim forms must be submitted.

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

7.2 Claims Submission Options

7.2.1 Ellement Group Benefits App or Claims Portal

You can submit all claim types through the Ellement Group Benefits app or Claims Portal. Before submitting your first claim, you will need to register on either the Ellement Group Benefits App or Claims portal by using your Group Number and Certificate Number found on your benefit card. You can download the app and set up your account directly from the App Store or Google Play by searching for 'Ellement Group Benefits' or by scanning the QR code.

7.2.2 Manual Claim Submissions (Email, Postal Mail or Drop-off)

If you prefer to submit claims manually for reimbursement, Ellement requires a completed and signed claim form.

For all expenses other than dental, we require the Extended Health Claim Form supplied by us.

For dental claims, we require the Standard Dental Claim Form supplied by your dental provider. If your dental provider does not supply this form, we can supply a Dental Care Claim Form for you to bring to your appointment to have your dentist complete.

Claim forms are available on the Benefits Plan website (www.eiobenefits.ca) or can be requested by contacting Ellement.

Claims can be submitted by email, postal mail, or by dropping them off in-person at our office (see *7. Contact Us* below for more details)

Drop-off Claims

Ellement offers a convenient drop-off service for your health and dental claims. Members can submit claim forms and original receipts in person:

Monday - Friday: regular business hours

Drop Claims to:

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

For added convenience, there is a secure drop box next to the front doors of the building for after-hours submissions. Claims dropped off will be processed within two to five (2-5) business days.

7.2.3 Direct Billing Submissions

7.2.3.1 Extended Health Care Providers

Your service provider can also submit claims on your behalf, helping reduce your out-of-pocket expenses. TELUS Health offers an eClaims service, allowing providers like chiropractors and optometrists to bill directly for their services. This means no reimbursement paperwork for you.

To see if your professional already uses eClaims, or to find a service provider who does in your area, visit https://plus.telushealth.co/page/eclaims/discover/.

If your provider experiences any issues, they can contact Ellement's dedicated provider line at 1-877-679-0088 or email providers@ellement.ca for support.

7.2.3.2 Dental Claims Submitted Directly by Your Dental Provider

Ellement will process dental claims using the Electronic Data Interchange (EDI) claims processing service. With EDI, dental claims can be sent directly from the 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 the dental claim will be transmitted to Ellement quickly, safely and confidentially right from the dentist's office.

To take advantage of Ellement's EDI service, inform the dentist that Ellement is the plan administrator and present them with the following information:

- 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 this group benefit plan.

The plan administrator can provide the required member identification number.

The plan administrator can provide the required member identification number.

7.3 Direct Deposit for Claims Reimbursements

Members can have their claim reimbursements deposited directly to their bank accounts.

You can receive reimbursement within two to five (2-5) days following the approval of your medical or dental claims. No need to wait for the arrival of a cheque and a trip to the bank before depositing the reimbursement.

To enrol, please request a Direct Deposit for Claims Reimbursement form by contacting Ellement at 613-699-8967 (toll free at 1-866-517-8967) or emailing EIO@ellement.ca .

7.4 Claims Appeals Process

In the event a claim is denied, and you disagree with the decision, you may submit an appeal in writing to Ellement Consulting Group LP, outlining the basis of your appeal and including any supporting medical information that justifies the expense as medically necessary.

The appeal will be reviewed, and the decision will be communicated to you in writing.

8. Contact Us

Ellement Consulting Group LP

For any questions or assistance regarding your benefits, you can reach out to Ellement Consulting Group LP using the following contact information:

613-699-8967

1-866-517-8967

844-736-5600

EIO@ellement.ca

Mailing Address:
1345 Taylor Avenue
Winnipeg, MB R3M 3Y9

Office Address:
1150 Cyrville Road, Suite No. 220
Ottawa, ON K1J 7S9

To book an appointment, visit the benefits plan website at www.eiobenefits.ca and click the "**Book Your Appointment**" link at the bottom of the page.

You can also visit: https://outlook.office365.com/book/ElementOttawaBooking1@ellement.ca/ or scan the QR code to schedule a time to meet with our team.

Appendix A – Basic Member Life, Dependant Life, and Long Term Disability Insurance

Underwritten by CANADA LIFE ASSURANCE

Policy No. 325077 – Basic Member Life, Dependant Life and Long Term Disability Insurance Policy

Contact Ellement Consulting Group, your benefits administrator for any and all questions related to the Basic Member Life Insurance, Dependent Life and Long Term Disability Insurance.

My group benefit plan

canada life™

ELECTRICAL INDUSTRY OF OTTAWA HEALTH & BENEFIT TRUST FUND

July 1, 2024

We are pleased to offer you our services. As we adhere to principles of inclusion, the words he, she, his and her refer to all genders.

Canada Life™ is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website at **www.canadalife.com** for:

- information and details on Canada Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

Customer Complaints

We are committed to addressing your concerns promptly, fairly and professionally. Here is how you may submit your complaint.

- toll free:
  - phone: 1-866-292-7825
  - fax: 1-855-317-9241
- email: **ombudsman@canadalife.com**
- in writing:

The Canada Life Assurance Company
Ombudsman's Office T262
255 Dufferin Avenue
London, ON N6A 4K1

For additional information on how you may submit a complaint, please visit **www.canadalife.com/complaints**.

Employer Role

The employer's role is limited to providing employees with information and not advice.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Plan is underwritten by

This booklet was prepared on: October 22, 2024

PROTECTING YOUR PERSONAL INFORMATION

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Canada Life's and its affiliates' internal data management and analytics
- preparing regulatory reports, such as tax slips

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Canada Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to **www.canadalife.com**.

GROUP BENEFIT PLAN

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YOU SHOULD KNOW

Effective Date - **November 1, 2020**

Covered Classes - **All eligible members, union staff, office staff of the Electrical Contractors Association (ECA), and office staff of the IBEW Construction Council of Ontario (CCO)**

IMPORTANT

The coverages described in this group benefit plan are insured under Group Policy No. 325077 issued to the Contractholder by Canada Life. They are available to you if you are included in the covered classes shown above. Only those coverages for which you become eligible will apply to you.

This booklet is a description of the group benefits at the date shown on the front cover.

Conformity with law

If any provision of this group benefit plan conflicts with any law which applies to individuals shown in the covered classes, the plan will be amended to conform to that law.

Access to documents

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

Cost

You will be advised of the amount of your **contribution** when you enroll for the coverage.

Waiting period

You will become eligible for coverage the first day of the second month following or coinciding with the date you complete 225 hours of work (for which contributions have been remitted to the Contractholder).

The coverages are described in full on later pages. Be sure to read these pages carefully. They show when benefits are or are not payable, and outline the conditions, limitations and exclusions that apply to the coverages.

DEFINITIONS

Unless specifically stated otherwise, the following definitions apply throughout this group benefit plan.

ACTIVE WORK or **ACTIVELY AT WORK** means you are working at your usual place of employment and performing all of the usual and customary duties of your occupation.

BENEFITS means any amounts which become payable under a coverage.

CALENDAR YEAR means January 1 through December 31.

CANADA LIFE means The Canada Life Assurance Company.

COLLECTIVE AGREEMENT OR PARTICIPATION AGREEMENT means the agreement in accordance with which contributions are made to the fund by the employer on behalf of a member.

CONTRACT means **Group Insurance Policy No. 325077.**

CONTRACTHOLDER means the Electrical Industry of Ottawa Health & Benefit Trust Fund in its capacity as the **Policyholder** of Group Insurance Policy No. 325077.

COVERED PERSON is an individual who is covered for member coverage under a coverage, or a qualified dependent with respect to whom a member is covered for dependents coverage under a coverage.

EMPLOYER means either of the following:

(1) the electrical contractor who is employing a member on a full-time basis and who, pursuant to the collective agreement with the union, is obligated to make contributions to the Fund on behalf of any such member;

(2) an electrical contractor who is employing a salaried employee on a full-time basis and who, pursuant to a participation agreement with the Union, has agreed to make contributions to the Fund on behalf of any such employee;

(3) the IBEW Local Union 586, the Electrical Contractors Association (ECA) and the IBEW Construction Council of Ontario (CCO) who is employing a salaried employee on a full-time basis.

FULL-TIME BASIS means, for salaried employees, that you regularly work at least 20 hours per week.

HE or SHE and HIS or HER refers to all genders.

MEMBER means either of the following:

(1) **a member of the Union,** who is employed and directly compensated for services by an employer who, pursuant to the collective agreement with the Union, is obligated to make contributions to the fund on behalf of any such member;

(2) **a salaried employee of an electrical contractor or the union, the ECA, or the CCO, or the electrical contractor himself,** who is employed on a full-time basis may be eligible for coverage under this contract.

PHYSICIAN means a duly licensed doctor of medicine (M.D.).

UNION means The International Brotherhood of Electrical Workers, Local 586.

YOU means the member.

WHO IS ELIGIBLE TO BECOME COVERED

FOR MEMBER COVERAGE

You are eligible for member coverage when:

(1) you are within the covered classes shown on the You Should Know page;

(2) you have completed the waiting period shown on the You Should Know page.

If your coverage ends for reasons other than disability and you resume active work thereafter, you will once again become eligible on the date you have again completed the waiting period shown on the You Should Know page.

If you resume active work following your retirement from the Electrical Industry of Ottawa Pension Plan, your will be eligible for the long term disability coverage provided you return to active status prior to your 60th birthday.

FOR DEPENDENT COVERAGE

You are eligible for dependent coverage while you are eligible for member coverage and you have a qualified dependent.

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

SPOUSE

"Spouse" means either:

(1) an individual to whom you are legally married; or

(2) your common-law spouse who is an individual with whom you have been cohabiting for a period of at least 12 months and whom you publicly represent as your spouse. There is no minimum period of cohabitation if a child is born of this common-law union.

You must state the name of the person to be considered your spouse for the purposes of the contract. Only one spouse will be considered at any time as being covered under the contract.

DEPENDENT CHILD

"Dependent child" means either:

(1) an unmarried person who is your natural or adopted child; or

(2) a child of a common-law spouse, who resides with you and is dependent on you for support;

and who is:

(1) younger than 21 years of age; or

(2) 21 years but younger than 25 years of age, in full-time attendance at an accredited institute of learning, and dependent on you for support.

(3) 21 years or older and incapable of self-sustaining employment due to a mental or physical handicap. Such child's coverage will be continued under the contract, provided the child's handicap has existed continuously from a time when the child was otherwise insured as a dependent under this policy.

Any individual residing outside of Canada or the continental United States of America will not be eligible to be covered, unless an exception is requested by the Administrator and approved in writing by Canada Life.

No person may be covered as a dependent while covered as a member.

EFFECTIVE DATE OF COVERAGE

MEMBER COVERAGE

Your coverage will commence on your date of eligibility.

If you are not actively at work on the date your coverage is to be effective, it will become effective when you return to active work.

DEPENDENTS COVERAGE

The effective date of a dependent's coverage will be the latest of the following dates:

(1) The date the member coverage is effective. However, if you applied later than 31 days after the effective date of your own coverage, evidence of insurability must also be submitted for each of your dependents and their coverage will be effective on the date Canada Life approves the evidence.

(2) The date a person becomes eligible for dependents coverage if you had previously selected dependents coverage.

(3) The date you apply for dependents coverage, provided application is made within 31 days of the date you are first eligible for dependents coverage, otherwise on the date Canada Life approves the evidence of insurability submitted for the dependents.

Evidence of a dependent's insurability may be required to be submitted at your expense.

CHANGE IN COVERAGE

If your coverage would change due to a change in classification or as a result of a plan change, your coverage 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.

TERMINATION OF COVERAGE

MEMBER COVERAGE

Your coverage will terminate on the earliest of the following dates:

(1) 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 coverage;

(2) **for members of the Union,** the date on which your Union membership ceases;

(3) the first of the second month following the date on which you have been laid-off for more than 24 months except for your life coverage, for which you remain covered until the first of the second month following 36 months of lay-off;

(4) the date you cease to be a member of any eligible class;

(5) the date your class is terminated;

(6) the date you become a full-time member of the armed forces of any country;

(7) the date the Contractholder ceases to make contributions for you;

(8) the premium due date coinciding with or immediately following the date you attain the termination age shown in the Summary of Coverages; and

(9) the date the contract terminates.

CONTINUATION OF COVERAGE DURING ABSENCE FROM WORK

If you are absent from work due to

(1) **illness or injury,**

(a) for life coverage, with payment of premium,

(i) and you are younger than age 65 and do not qualify for waiver of premium, until the date which is the earliest of:

1. the date the employer stops paying premiums or otherwise determines that coverage has terminated, and

2. your attainment of age 65.

(ii) and you are age 65 or over, until the date which is the earliest of:

1. the date the employer stops paying premiums or otherwise determines that insurance has terminated, and

2. the end of the sixth month following the date you ceased to be actively at work due to disease or injury,

(b) for all other coverage, until the earliest of the dates specified in the above Member Coverage section.

(2) **temporary layoff -**

(a) **your life coverage** will be continued for a maximum period of 36 months, beginning on the first day of the second month following the month in which you were laid off, provided the required contributions are being made. However, after the first 24 months of temporary layoff, the benefit will be reduced to $7,500;

if you retire while you are temporarily laid off, you will continue to be subject to the provisions of the "Reduction" clause shown in the Summary of Coverages and of paragraph (2)(a) above. However, if you retire after the first 24 months of continuation of coverage during a temporary layoff, your amount of $7,500 will be reduced to $5,000 on the January 1 coinciding with or following your attainment of age 65;

(b) **all other coverages** will be continued for a maximum period of 24 months, beginning on the first day of the second month following the month in which you were laid off, provided the required contributions are being made.

If you are laid off after having become eligible for coverage, return to work for a minimum of 36 hours in a month and are subsequently laid off, your coverage may be continued for an additional 24 months of unemployment, beginning on the first day of the second month following the month in which you were laid off, provided the required contributions are being made.

(3) **retirement,** all coverages, with the exception of the long term disability coverage may be continued until the earliest of the dates specified in the above member coverage section, provided the required contributions are being made.

Reinstatement of benefits

If your coverage has terminated, you may again become eligible for coverage on the date on which you have completed the waiting period shown on the You Should Know page, provided you remain within the eligible covered classes.

DEPENDENTS COVERAGE

A dependent's coverage will terminate on the earliest of the following dates:

(1) the date your own coverage terminates;

(2) the date the dependent ceases to be a qualified dependent;

(3) the date dependents coverage under the present contract is terminated; or

(4) the date contributions cease to be made for dependents coverage.

WHEN YOU HAVE A CLAIM

LIFE COVERAGE

Member life coverage

Your beneficiary must send proof of death to the Administrator, who will provide the proper claim forms for completion.

Dependents life coverage

You must provide the Administrator with proof of death. The Administrator will provide the proper claim forms for completion.

LONG TERM DISABILITY COVERAGE

To submit claims online, go to **www.canadalife.com**.

To submit paper claims, obtain an *Employee Claim Submission Guide* (form M5454 or M4307B) and follow the guide's instructions. You can get this form from your employer, or online at **www.canadalife.com**.

Forms should be completed without delay to ensure prompt payment of your benefits.

GENERAL INFORMATION

ASSIGNMENT RULES

Death benefits are not assignable, meaning that ownership of death benefits cannot be transferred to any person or organization.

BENEFICIARY RULES

"Beneficiary" means the person designated by you to receive the benefits.

Benefits becoming payable under the contract on account of your death will be paid to your named beneficiary. Any benefit amount for which you have not named a beneficiary or there is no surviving beneficiary at your death will be paid to your estate.

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

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

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

CLAIM RULES

Proof of loss

The time limits for submitting proof of loss under a coverage are described in the applicable coverage description page.

Failure to furnish any such proof within the time required will not invalidate or reduce any such claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Quebec time limit for the payment of benefits

Where Quebec law applies, Canada Life will pay benefits in accordance with the terms set out in this policy within the following time period:

Death benefits – 30 days following receipt of the required proof of loss.

Disability income benefits – for which there is no waiting period, 30 days following the receipt of the required proof of loss. For disability income benefits for which there is a waiting period, 30 days from the expiry of the waiting period provided the required proof of loss has been received.

Physical examination

Canada Life, at its own expense, will have the right and opportunity to have any covered person, whose injury or illness is the basis of a claim, examined by a physician designated by Canada Life when and as often as it may reasonably require during the period of a claim under the contract.

Appeals

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

Legal action

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), The *Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

OVERPAYMENT OF BENEFITS

Nothing in this group benefit plan will prevent Canada Life from recovering from the person or organization to whom such payment has been made any overpayment of benefits, irrespective of the cause of such overpayment.

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

TO WHOM PAYABLE

Benefits under a coverage will be payable to you unless otherwise specified.

SUMMARY OF COVERAGES

COVERAGES FOR YOU

LIFE COVERAGE

Amount:

Union staff, office staff of the Electrical Contractors Association (ECA), office staff of the IBEW Construction Council of Ontario (CCO) and members who are actively at work on or after November 1, 2018: $250,000

Members not actively at work since October 31, 2018: $125,000

Members not actively at work since October 31, 2014: $100,000

Members not actively at work since September 30, 2005; or retired on or after July 1, 1982 and prior to October 1, 2005: $50,000

Members who retired prior to July 1, 1982: $25,000

Members (regardless of age) on temporary lay-off for more than 24 consecutive months but less than 36 months: $7,500

Reduction:

Union staff, office staff of the Electrical Contractors Association (ECA), and office staff of the IBEW Construction Council of Ontario (CCO) and members who are actively at work: On the January 1 coinciding with or immediately following your 65th birthday, your amount will be 50% of the amount shown above. On each subsequent January 1, your amount will be reduced by an amount equal to 10% of the amount applicable prior to your 65th birthday.

Members who are retired: On the January 1 coinciding with or immediately following your 65th birthday, your amount will be 50% of the amount shown above. On each subsequent January 1, your amount will be reduced by an amount equal to 10% of the amount applicable prior to your 65th birthday. In no event will your amount of life coverage reduce to less than:

Members who retired after November 1, 2018: $25,000

Members who retired after November 1, 2014 and prior to November 1, 2018: $12,500

Members who retired after October 1, 2005 and prior to November 1, 2014: $10,000

Members who retired prior to October 1, 2005: $5,000

Termination: This coverage continues throughout your retirement.

LONG TERM DISABILITY COVERAGE

For Electrical members who are actively at work

Monthly benefit: $2,500

Taxability of benefit: Since you do not pay the entire premium for this coverage, the long term disability benefit payments are taxable.

Elimination period: Benefits will be payable for each period of total disability after 119 days of continuous total disability or, if later, on the date that any disability benefits payable under the Employment Insurance Act of Canada end.

Maximum benefit period: Benefits are payable up to your 60th birthday or, if earlier, to the date on which you elect to receive early retirement benefits under any employee benefit plan.

Termination of eligibility: At your attainment of age 59 years and 246 days or your retirement, if earlier.

For union staff, office staff of the Electrical Contractors Association (ECA), and office staff of the IBEW Construction Council of Ontario (CCO) who are actively at work

Monthly benefit: An amount equal to 66.67% of your monthly earnings as of the commencement of total disability (rounded to the next higher multiple of $1.00 if not already a multiple thereof), up to a maximum of $7,500.

Taxability of benefit: Since you pay the entire premium for this coverage, the long term disability benefit payments are nontaxable.

Elimination period: Benefits will be payable for each period of total disability after 119 days of continuous total disability or, if later, on the date that any disability benefits payable under the Employment Insurance Act of Canada end.

Maximum benefit period: Benefits are payable up to your 65th birthday or, if earlier, to the date on which you elect to receive early retirement benefits under any employee benefit plan.

Termination of eligibility: At your attainment of age 64 years and 246 days or your retirement, if earlier.

COVERAGE FOR YOUR QUALIFIED DEPENDENTS

LIFE COVERAGE

Amount: Your spouse and each dependent child who is 15 days of age and older will be eligible for:

Union staff, office staff of the Electrical Contractors Association (ECA), office staff of the IBEW Construction Council of Ontario (CCO) and members who are actively at work:	**Spouse -**	$10,000
	Child -	$10,000
All other members:	**Spouse -**	$5,000
	Child -	$2,500

Reduction: On the January 1 coinciding with or immediately following your 65th birthday, the amount of dependents life coverage will be 50% of the amount shown above.

Termination: On the date your member life coverage terminates.

MEMBER LIFE COVERAGE

FOR YOU

PART I. DEATH BENEFITS

DEFINITION

Where used in this coverage, "total disability" or "totally disabled" means that because of accidental bodily injury or Illness you are:

(1) during the elimination period for the long term disability coverage (shown in the Summary of Coverages) and the next 24 months of total disability, unable to perform any and every duty pertaining to your job, and

(2) thereafter, not able to engage in any and every gainful occupation for which you are reasonably fitted by education, training or experience, and for which you would receive 60% or more of your pre-disability monthly earnings, and

(3) at any time not working at any job for wage or profit (other than rehabilitative employment).

A. DEATH BENEFIT

If you die while covered under this coverage, the amount of your life coverage (shown in the Summary of Coverages) that is in effect on the date of your death will be paid when Canada Life receives due written proof of death.

B. EXTENDED DEATH BENEFIT DURING TOTAL DISABILITY

If you become totally disabled while covered under this coverage and are younger than age 65, Canada Life will, upon receipt of satisfactory proof of total disability, continue the coverage **without** payment of premiums **once you have completed the elimination period of the long term disability coverage** (shown in the Summary of Coverages), while you are totally disabled, subject to the remainder of this section B.

Satisfactory proof of total disability must be given to Canada Life during the first year of total disability, and thereafter when and as required by Canada Life once each year.

The amount of coverage continued is the amount for which you were covered at the date of commencement of total disability. However, if the coverage would normally reduce when you attain a certain age or for any other reason, the amount of coverage continued under this section B. will reduce accordingly.

Upon your death the amount of coverage will be paid provided satisfactory proof is submitted that such total disability continued to the date of death.

If you die before age 65 and within a year after the date of commencement of total disability and before any proof has been given, then notice that total disability continued to the date of death must be given to Canada Life within one year after death. Satisfactory proof must be given to Canada Life within 3 months of the date the notice is received by Canada Life.

If an individual policy of life insurance has been issued in accordance with section D. Conversion Privilege, payment will be made only if the individual policy is surrendered without claim.

This extension protection will immediately terminate if you:

(1) cease to be totally disabled; or

(2) fail to submit to a medical exam by physicians named by Canada Life when and as often as Canada Life requires.

If the extension protection ends after you have given proof of total disability and for another reason than retirement, you have the same rights and benefits under section D. Conversion Privilege as if you ceased to be covered under this coverage.

C. EXTENSION OF BENEFIT

A death benefit is payable if you die within 31 days after ceasing to be covered under this coverage. The amount of the benefit is equal to the amount of life coverage you were entitled to convert under Section D. Conversion Privilege.

D. CONVERSION PRIVILEGE

If you cease to be covered under this coverage prior to attaining age 65, your coverage may be converted to an individual life insurance policy without evidence of insurability. The policy will be issued in accordance with the applicable laws or guidelines in effect in your province of residence. The amount converted must be at least equal to the minimum amount for which Canada Life will issue an individual policy for the plan of insurance chosen.

The premium for the individual policy will be based on Canada Life's rate as of the effective date of the individual policy, according to the plan of insurance chosen, the amount of insurance converted and your attained age.

You must apply for the individual policy and pay the first premium within 31 days after ceasing to be covered under this coverage. The individual policy will be effective 31 days after this coverage is terminated.

If you convert all or part of your life coverage under the terms of this section D., you will not be eligible for further coverage under this coverage, unless the individual policy is cancelled.

E. TO WHOM PAYABLE

Any benefits becoming payable in the event of your death will be paid to your beneficiary determined under the beneficiary rules shown on the General Information page.

F. PROOF OF CLAIM

Written proof of claim must be given to Canada Life not later than 5 years after the date of death.

PART II. LIVING BENEFITS

DEFINITIONS

Where used in this coverage, the following phrases have the meanings set forth below:

(1) "Living benefits" means the amount of life coverage that you may elect to place under this option. The living benefits is a one-time lump sum payment which is equal to 50% of your total amount of life coverage (shown in the Summary of Coverages) in effect on the date Canada Life receives proof that you are terminally ill, to a maximum of $50,000. However, the living benefits may be reduced if, within 6 months after the date Canada Life receives such proof, a reduction on account of age would have applied to your amount of life coverage. In that case, the amount of living benefits will be 50% of your amount of life coverage after applying the reduction, subject to the living benefits maximum.

(2) "Terminally ill" means your life expectancy is 12 months or less.

A. OPTION

If you become terminally ill while covered under this coverage or while your coverage is being continued under the Extended Death Benefit During Total Disability section of this coverage, you may elect to have the living benefits option. Such election is subject to the provisions set forth below.

B. PAYMENT OF LIVING BENEFITS

If you elect this option, Canada Life will pay the living benefits in one sum when it receives proof that you are terminally ill.

C. TO WHOM PAYABLE

The benefit under this option is payable to you.

D. AMOUNT PAYABLE ON YOUR DEATH

Canada Life will pay to your beneficiary as determined under the beneficiary rules shown on the General Information page, in one sum, the amount of the life coverage proceeds, LESS the total of (1) the amount of the living benefits option you received, and (2) an amount representing interest calculated from the date of the living benefits payment to the date of your death, using an effective annual interest rate as notified by Canada Life when applying for living benefits.

E. CONDITIONS

Your right to be paid under this option is subject to these terms:

(1) You must choose this option in writing in a form satisfactory to Canada Life.

(2) You must furnish satisfactory proof to Canada Life that your life expectancy is 12 months or less, including certification by a physician.

(3) Living benefits will be made available to you on a voluntary basis only.

Therefore:

(a) If you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this option.

(b) If you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this option.

(c) The deduction of the living benefits and its accrued interest take priority over any other demand or claim for the insurance proceeds payable on your death.

F. EFFECT ON COVERAGE

When you elect this option, the total amount of life coverage payable on your death, including any amount under the Extended Death Benefit During Total Disability section of this coverage, will be reduced by the living benefits. Also, any amount you could otherwise have converted to an individual policy will be reduced by the living benefits.

LONG TERM DISABILITY COVERAGE
(FOR MEMBERS WHO ARE ACTIVELY AT WORK)

FOR YOU

DEFINITIONS

Where used in this coverage, the following words and phrases have the meanings set forth below:

(1) "Maternity leave of absence" means:

(a) any period of maternity leave taken by you in accordance with a federal or provincial law or pursuant to mutual agreement between you and the employer; or

(b) any period of maternity leave which the employer requires you to take in accordance with a federal or provincial law.

The period of maternity leave will commence on the earlier of the elected date of the leave and the date of delivery, and will end on the day you are scheduled to return to work.

(2) "Physician" means a duly licensed doctor of medicine (M.D.) as directed or authorized by Canada Life.

(3) "Pre-disability earnings" means your earnings as of the commencement of total disability.

(4) "Rehabilitative employment" means any work for wage or profit approved by Canada Life and performed by you while you are unable to work on a full-time basis.

(5) "Total disability" or "totally disabled" means that because of accidental bodily injury or illness you are:

(a) during the elimination period (shown in the Summary of Coverages) and the next 24 months of total disability, unable to perform any and every duty pertaining to your occupation, and

(b) thereafter, not able to engage in any and every gainful occupation for which you are reasonably fitted by education, training or experience, and for which you would receive 60% or more of your pre-disability monthly earnings, and

(c) at any time not working at any job for wage or profit (other than rehabilitative employment).

A. BENEFITS FOR DISABILITY

A monthly benefit (shown in the Summary of Coverages) will be paid if you become totally disabled while covered for this coverage, are under the regular care of a physician, and are younger than age 60. The monthly benefit is subject to section B. Benefit Amount and Integration With Other Benefits.

Payments will start when the elimination period (shown in the Summary of Coverages) has been completed and will continue while you are totally disabled up to the maximum benefit period (shown in the Summary of Coverages).

Payment will be made monthly, computed from the end of the elimination period, provided you submit satisfactory evidence of continuing total disability as requested by Canada Life.

Benefits for part of a month will be paid at the rate of one-thirtieth of the monthly benefit rate multiplied by the number of days you are totally disabled during that month.

Premiums will be waived when the elimination period has been completed and for as long as you are totally disabled.

B. BENEFIT AMOUNT AND INTEGRATION WITH OTHER BENEFITS

(1) The amount of monthly benefit will be directly reduced by the total of the following amounts (adjusted to a monthly basis if not so payable), if any, payable for the same period of total disability:

   (a) retirement benefits to which you are entitled under the Quebec Pension Plan because you are receiving Quebec Pension Plan disability benefits; these benefits are considered payable and can be estimated when the person is entitled to them, whether or not they have been awarded or received;

   (b) income replacement benefits commencing on or after the date you became totally disabled and which are payable either periodically or in a lump sum under any Workers' Compensation Act or similar law;

   (c) 50% of the pay received from rehabilitative employment. if your income from all sources exceeds 100% of your monthly earnings as of the commencement of total disability, your monthly benefit will be reduced by the excess; and

   (d) any amount payable under the Electrical Industry of Ottawa Pension Trust Fund.

(2) Your monthly benefit may be further reduced so that the amount payable together with payments (adjusted to a monthly basis if not so payable) from the following sources will not exceed 85% of your gross monthly earnings (as of the commencement of total disability):

   (a) any disability pension benefits to which you or any other person is entitled on the basis of your disability under the Canada/Quebec Pension Plan; this does not include benefits to which another person who is 18 or more years of age is entitled;

(b) benefits payable under a plan or program of any government or of any subdivision or agency thereof, including but not limited to income replacement benefits payable under any government plan for automobile insurance and income replacement benefits commencing on or after the date you became totally disabled which are payable under any Worker's Compensation Act or similar law;

(c) any association group or any other group insurance contract for which the Contractholder or the employer makes regular payroll deductions;

(d) salary continuance from the employer;

(e) retirement benefits payable either periodically or in a lump sum from any source, commencing on or after you became totally disabled; and

(f) disability benefits payable under a group life insurance policy.

Any cost-of-living increase in the amount described in (1)(b) and (2)(a) and (b) above, that becomes effective after a monthly benefit becomes payable, will not further reduce your monthly benefit.

Canada Life also reserves the right to estimate the amount of any benefits payable under (1)(b) and (2)(a) and (b) of the preceding page, until such time as evidence of either the exact amount of such benefits, or that you are not eligible for such benefits, is furnished.

C. RECURRENT DISABILITIES

If you return to work with the employer after a period of total disability for which benefits have been paid, successive periods of total disability due to the same or related causes which are separated by less than 6 consecutive months during which you are actively at work with the employer will be considered as one continuous period of total disability. Payments will commence one month from the date the total disability recurs.

D. REHABILITATIVE EMPLOYMENT

You may make an advance written request to Canada Life to commence rehabilitative employment and continue to be eligible for some benefits under this coverage. Canada Life will notify you in writing if you are to be placed on rehabilitation status and for how long. The duration will not exceed 3 months but may be further extended by making a written request. In no event will you be on rehabilitation status for more than 24 months for all total disability due to the same or related causes.

E. REHABILITATION PROGRAM

Canada Life may determine, after consulting your physician, that:

(1) you are to be in a program of rehabilitation; and

(2) you should be able to support yourself after being in such program.

Canada Life will inform you in writing of the terms under which payment for the cost of the program will be made. This will include the type of expenses which will be covered and when they may be incurred.

Benefits will not be provided by Canada Life to the extent coverage for the expenses is required, or is available at no cost to you under a law or governmental program which provides rehabilitation. Nor will benefits be provided to the extent that coverage for the expenses is provided by an insured or uninsured plan (other than the contract) under which the Contractholder or the employer has paid any of the cost or made payroll deductions.

Long term disability benefits will not be payable if you refuse to participate in a rehabilitation program approved by your physician and Canada Life.

F. LIMITATIONS AND EXCLUSIONS

Benefits are subject to the following limitations:

(1) **Alcohol and drug abuse**

Benefits will be payable for a total disability resulting from alcohol, drug or other substance use disorder only when you are actively involved in a rehabilitation program which is supervised by a physician and approved in writing by Canada Life.

(2) **Out of Canada**

Benefits will be discontinued during any period that you are out of Canada unless:

(a) you are receiving regular and continuous treatment from a physician; and

(b) evidence satisfactory to Canada Life of regular and continuous treatment is given to Canada Life within 30 days of your departure and thereafter as often as Canada Life reasonably requires.

During this period Canada Life reserves the right to have a physician of its choice examine you.

Benefits will not be payable for any period of total disability under the following circumstances:

(1) Any period of time that you are not under the regular care of a physician. Any such period will not count towards the elimination period.

(2) Any period of time during which you are on approved leave of absence including maternity leave of absence. However, if you become totally disabled due to pregnancy while on maternity leave of absence and your long term disability coverage has been continued in accordance with the Continuation of Coverage During Absence From Work provisions of the Termination of Coverage page, the leave will end on the first day you are totally disabled. For the purposes of this coverage, the maternity leave of absence will resume when you are no longer totally disabled. If you become totally disabled while on approved leave of absence other than maternity leave of absence and your long term disability coverage has been continued in accordance with the provisions noted above, the elimination period will begin immediately, but monthly benefits will not be payable until the date on which you are scheduled to return to work.

(3) Any period of time during which you are laid-off. If you become totally disabled while you are laid-off, you will be eligible for benefits on the date you are scheduled to return to work. Any such period may be counted towards the elimination period.

(4) If the disability commences while you were not actively at work due to suspension of business operations or strike.

(5) If the disability results from commission of, or attempt to commit, any criminal offence but not when injuries are sustained as a result of driving a vehicle when your blood contained more than 80 milligrams of alcohol in 100 millilitres of blood (.08).

(6) If the disability is caused, or contributed to by, war or any act of war, civil commotion, insurrection or hostilities of any kind.

(7) If you are confined in a penal institution or other house of correction.

G. EXTENSION OF BENEFITS

If your coverage terminates for any reason and you are totally disabled on the date of termination, benefits will continue during the period of total disability as if the coverage had not terminated.

H. THIRD PARTY CLAIM

If you receive benefits under this coverage and seek compensation from a third party for causing you to become totally disabled, the claim for compensation will include reimbursement for loss of earnings. If you are awarded compensation, you will have to refund to Canada Life any benefits received under this coverage for such disability, up to the amount awarded under the third party claim.

I. PROOF OF CLAIM

Written notice of claim must be given to Canada Life not later than 90 days after commencement of total disability. Written proof of claim must be given to Canada Life not later than 90 days after the elimination period.

LONG TERM DISABILITY COVERAGE

(UNION STAFF, OFFICE STAFF OF THE ELECTRICAL CONTRACTORS ASSOCIATION (ECA), AND OFFICE STAFF OF THE IBEW CONSTRUCTION COUNCIL OF ONTARIO (CCO) WHO ARE ACTIVELY AT WORK)

FOR YOU

DEFINITIONS

Where used in this coverage, the following words and phrases have the meanings set forth below:

(1) "Maternity leave of absence" means:

(a) any period of maternity leave taken by you in accordance with a federal or provincial law or pursuant to mutual agreement between you and the employer; or

(b) any period of maternity leave which the employer requires you to take in accordance with a federal or provincial law.

The period of maternity leave will commence on the earlier of the elected date of the leave and the date of delivery, and will end on the day you are scheduled to return to work.

(2) "Physician" means a duly licensed doctor of medicine (M.D.) as directed or authorized by Canada Life.

(3) "Pre-disability earnings" means your earnings as of the commencement of total disability.

(4) "Rehabilitative employment" means any work for wage or profit approved by Canada Life and performed by you while you are unable to work on a full-time basis.

(5) "Total disability" or "totally disabled" means that because of accidental bodily injury or illness you are:

(a) during the elimination period (shown in the Summary of Coverages) and the next 24 months of total disability, unable to perform any and every duty pertaining to your job, and

(b) thereafter, not able to engage in any and every gainful occupation for which you are reasonably fitted by education, training or experience, and for which you would receive 60% or more of your pre-disability monthly earnings, and

(c) at any time not working at any job for wage or profit (other than rehabilitative employment).

A. BENEFITS FOR DISABILITY

A monthly benefit (shown in the Summary of Coverages) will be paid if you become totally disabled while covered for this coverage, are under the regular care of a physician, and are younger than age 65. The monthly benefit is subject to section B. Benefit Amount and Integration With Other Benefits.

Payments will start when the elimination period (shown in the Summary of Coverages) has been completed and will continue while you are totally disabled up to the maximum benefit period (shown in the Summary of Coverages).

Payment will be made monthly, computed from the end of the elimination period, provided you submit satisfactory evidence of continuing total disability as requested by Canada Life.

Benefits for part of a month will be paid at the rate of one-thirtieth of the monthly benefit rate multiplied by the number of days you are totally disabled during that month.

Premiums will be waived when the elimination period has been completed and for as long as you are totally disabled.

B. BENEFIT AMOUNT AND INTEGRATION WITH OTHER BENEFITS

(1) The amount of monthly benefit will be directly reduced by the total of the following amounts (adjusted to a monthly basis if not so payable), if any, payable for the same period of total disability:

(a) any disability pension benefits to which you or any other person is entitled on the basis of your disability under the Canada/Quebec Pension Plan; this does not include benefits to which another person who is 18 or more years of age is entitled;

(b) retirement benefits to which you are entitled under the Quebec Pension Plan because you are receiving Quebec Pension Plan disability benefits; these benefits are considered payable and can be estimated when the person is entitled to them, whether or not they have been awarded or received;

(c) income replacement benefits commencing on or after the date you became totally disabled and which are payable either periodically or in a lump sum under any Workers' Compensation Act or similar law;

(d) 50% of the pay received from rehabilitative employment. if your income from all sources exceeds 100% of your monthly earnings as of the commencement of total disability, your monthly benefit will be reduced by the excess; and

(e) any amount payable under the Electrical Industry of Ottawa Pension Trust Fund.

(2) Your monthly benefit may be further reduced so that the amount payable together with payments (adjusted to a monthly basis if not so payable) from the following sources will not exceed 85% of your net monthly earnings (as of the commencement of total disability):

(a) any disability pension benefits to which you or any other person is entitled on the basis of your disability under the Canada/Quebec Pension Plan; this does not include benefits to which another person who is 18 or more years of age is entitled;

(b) benefits payable under a plan or program of any government or of any subdivision or agency thereof, including but not limited to income replacement benefits payable under any government plan for automobile insurance and income replacement benefits commencing on or after the date you became totally disabled which are payable under any Worker's Compensation Act or similar law;

(c) any association group or any other group insurance contract for which the Contractholder or the employer makes regular payroll deductions;

(d) salary continuance from the employer;

(e) retirement benefits payable either periodically or in a lump sum from any source, commencing on or after you became totally disabled; and

(f) disability benefits payable under a group life insurance policy.

Any increase in the amount described in (1)(a) and (2)(a) and (b) above, that becomes effective after a monthly benefit becomes payable, will not further reduce your monthly benefit.

Canada Life reserves the right to estimate the amount of any benefits payable under (1)(a) and (2)(a) and (b) of the preceding page, until such time as evidence of either the exact amount of such benefits, or that you are not eligible for such benefits, is furnished.

C. RECURRENT DISABILITIES

If you return to work with the employer after a period of total disability for which benefits have been paid, successive periods of total disability due to the same or related causes which are separated by less than 6 consecutive months during which you are actively at work with the employer will be considered as one continuous period of total disability. Payments will commence one month from the date the total disability recurs.

D. REHABILITATIVE EMPLOYMENT

You may make an advance written request to Canada Life to commence rehabilitative employment and continue to be eligible for some benefits under this coverage. Canada Life will notify you in writing if you are to be placed on rehabilitation status and for how long. The duration will not exceed 3 months but may be further extended by making a written request. In no event will you be on rehabilitation status for more than 24 months for all total disability due to the same or related causes.

E. REHABILITATION PROGRAM

Canada Life may determine, after consulting your physician, that:

(1) you are to be in a program of rehabilitation; and

(2) you should be able to support yourself after being in such program.

Canada Life will inform you in writing of the terms under which payment for the cost of the program will be made. This will include the type of expenses which will be covered and when they may be incurred.

Benefits will not be provided by Canada Life to the extent coverage for the expenses is required, or is available at no cost to you under a law or governmental program which provides rehabilitation. Nor will benefits be provided to the extent that coverage for the expenses is provided by an insured or uninsured plan (other than the contract) under which the Contractholder or the employer has paid any of the cost or made payroll deductions.

Long term disability benefits will not be payable if you refuse to participate in a rehabilitation program approved by your physician and Canada Life.

F. LIMITATIONS AND EXCLUSIONS

Benefits are subject to the following limitations:

(1) **Alcohol and drug abuse**

Benefits will be payable for a total disability resulting from alcohol, drug or other substance use disorder only when you are actively involved in a rehabilitation program which is supervised by a physician and approved in writing by Canada Life.

(2) **Out of Canada**

Benefits will be discontinued during any period that you are out of Canada unless:

(a) you are receiving regular and continuous treatment from a physician; and

(b) evidence satisfactory to Canada Life of regular and continuous treatment is given to Canada Life within 30 days of your departure and thereafter as often as Canada Life reasonably requires.

During this period Canada Life reserves the right to have a physician of its choice examine you.

Benefits will not be payable for any period of total disability under the following circumstances:

(1) Any period of time that you are not under the regular care of a physician. Any such period will not count towards the elimination period.

(2) Any period of time during which you are on approved leave of absence including maternity leave of absence. However, if you become totally disabled due to pregnancy while on maternity leave of absence and your long term disability coverage has been continued in accordance with the Continuation of Coverage During Absence From Work provisions of the Termination of Coverage page, the leave will end on the first day you are totally disabled. For the purposes of this coverage, the maternity leave of absence will resume when you are no longer totally disabled. If you become totally disabled while on approved leave of absence other than maternity leave of absence and your long term disability coverage has been continued in accordance with the provisions noted above, the elimination period will begin immediately, but monthly benefits will not be payable until the date on which you are scheduled to return to work.

(3) Any period of time during which you are laid-off. If you become totally disabled while you are laid-off, you will be eligible for benefits on the date you are scheduled to return to work. Any such period may be counted towards the elimination period.

(4) If the disability commences while you were not actively at work due to suspension of business operations or strike.

(5) If the disability results from commission of, or attempt to commit, any criminal offence but not when injuries are sustained as a result of driving a vehicle when your blood contained more than 80 milligrams of alcohol in 100 millilitres of blood (.08).

(6) If the disability is caused, or contributed to by, war or any act of war, civil commotion, insurrection or hostilities of any kind.

(7) If you are confined in a penal institution or other house of correction.

G. EXTENSION OF BENEFITS

If your coverage terminates for any reason and you are totally disabled on the date of termination, benefits will continue during the period of total disability as if the coverage had not terminated.

H. THIRD PARTY CLAIM

If you receive benefits under this coverage and seek compensation from a third party for causing you to become totally disabled, the claim for compensation will include reimbursement for loss of earnings. If you are awarded compensation, you will have to refund to Canada Life any benefits received under this coverage for such disability, up to the amount awarded under the third party claim.

I. PROOF OF CLAIM

Written notice of claim must be given to Canada Life not later than 90 days after commencement of total disability. Written proof of claim must be given to Canada Life not later than 90 days after the elimination period.

DEPENDENTS LIFE COVERAGE

FOR YOUR QUALIFIED DEPENDENTS

A. DEATH BENEFIT

If a dependent dies while covered under this coverage, the amount of life coverage (shown in the Summary of Coverages) that is in effect for that dependent on the date of death will be paid when Canada Life receives due written proof of death.

B. EXTENSION OF BENEFIT

A death benefit is payable if your spouse dies within 31 days after ceasing to be covered under this coverage. The amount of the benefit is equal to the amount your spouse was entitled to convert.

C. CONVERSION PRIVILEGE

If you cease to be covered under this coverage because of termination of employment, the coverage on the life of your spouse may be converted to an individual life insurance policy provided your spouse is younger than age 65. Evidence of insurability is not required. The amount converted cannot exceed your spouse's amount of coverage when his or her coverage ends. This amount must be at least equal to the minimum amount for which Canada Life will issue an individual policy for the plan chosen.

The premium for the individual policy will be based on Canada Life's rate as of the effective date of the individual policy, according to the plan of insurance chosen, the amount of insurance converted and the spouse's attained age.

Your spouse must apply for the individual policy and pay the first premium within 31 days after ceasing to be covered under this coverage. The individual policy will be effective 31 days after this coverage is terminated.

D. TO WHOM PAYABLE

Any benefit becoming payable will be paid to you. If you predecease the dependent, the death benefit will be paid to the estate of the dependent or, at Canada Life's option, to a surviving relative of the dependent.

E. WAIVER OF PREMIUMS

If your premiums are being waived under the long term disability coverage, your dependents life coverage will be continued **without payment of premiums**, until the earliest of the following:

(1) the date your waiver of premiums under the long term disability coverage ceases;

(2) the date your dependents life coverage terminates;

(3) the date the contract terminates.

F. PROOF OF CLAIM

Written proof of claim must be given to Canada Life not later than 5 years after the date of death.

Appendix B – Accidental Death & Dismemberment Insurance

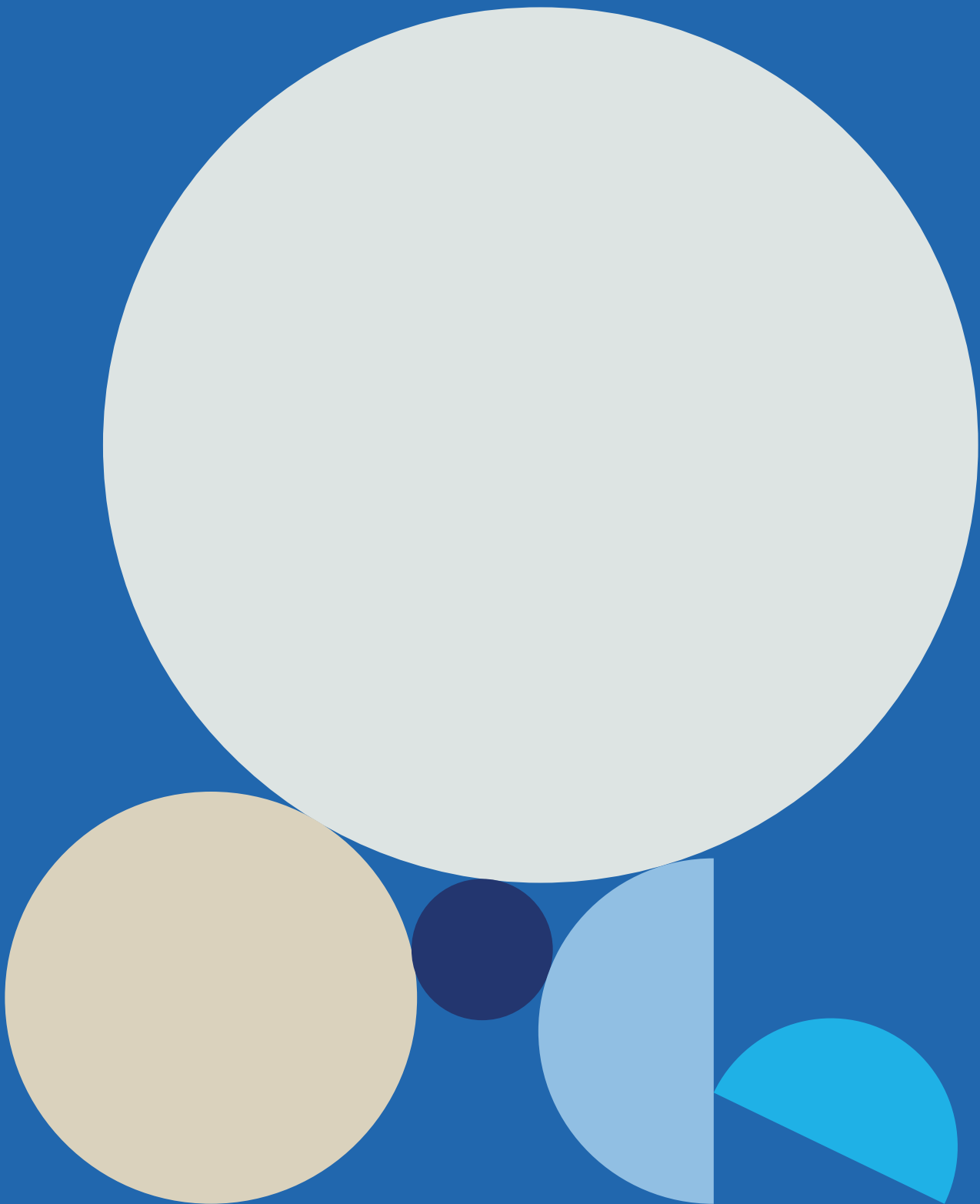
Underwritten by Zurich Insurance Company Ltd

Policy No. 8622073

Contact Ellement Consulting Group, your benefits administrator for any and all questions related to the Accidental Death & Dismemberment Insurance.

Accidental Death & Dismemberment Coverage Summary of Benefits

Electrical Industry of Ottawa Trustees and IBEW Local 586



Coverage

This coverage offers 24-hour **accident** protection for an **insured person** anywhere in the world. It includes protection for both fatal and non-fatal **accidents**, covering dismemberment, paralysis, loss of limb use, blindness, and loss of hearing.

Additionally, this insurance provides valuable living benefits to help safeguard your family's financial security in the event of **injury** or death due to an **accident**. These benefits include:

- Rehabilitation Benefit
- Therapeutic Counseling Benefit
- Home Alteration and Vehicle Modification Benefit

Policyholder Name	Electrical Industry of Ottawa Trustees and IBEW Local 586
Policy Number	8622073
Aggregate	$1,250,000
Class Description	**Class I:** All Active Electricians, salaried employees, and office staff, in good standing of the Policyholder who are actively at work on or after November 1, 2018. **Class II:** All Electricians, salaried employees, and office staff, in good standing of the Policyholder who have not been actively at work on or after October 31, 2018. **Class III:** All Electricians, salaried employees, and office staff, in good standing of the Policyholder who have not been actively at work on or after October 31, 2014. **Class IV:** All Active Electricians, salaried employees, and office staff, in good standing of the Policyholder who have not been actively at work on or after July 31, 1998. **Class V:** All Active Communication Workers, Ground Workers, and Utility Workers in good standing of the Policyholder who are actively at work on or after June 1, 2015. **Class VI:** All Communication Workers, Ground Workers, and Utility Workers in good standing of the Policyholder who have not worked since May 31st, 2015.
Principal Sum	Class I: $250,000 Class II: $125,000 Class III: $100,000 Class IV: $50,000 Class V: $125,000 Class VI: $100,000
Termination	Terminates at the at the earlier of the Members attainment of age 70 years or retirement. **At age 65, the Principal Sum shall be reduced based on the insured person's previous Principal Sum per the following schedule:** **Age at Date of Loss** — **Percent of Principal Sum** **65-70** — **50%**
Exposure and Disappearance	100% of the Principal Sum
In-Hospital Indemnity Benefit	A monthly benefit of 4% of the Principal Sum to a maximum of $2,500;
Funeral Benefit	$5,000
Day Care Benefit	5% of the insured's Principal Sum to a maximum of $5,000, for four (4) consecutive years up to a maximum amount payable of $20,000.
After School Care Benefit	6% of the insured's Principal Sum to a maximum of $6,000, for four (4) consecutive years
Parent Care Benefit	5% of the insured's Principal Sum to a maximum of $10,000 for all dependent parents.
Higher Education Benefit	5% of the insured's Principal Sum. This amount shall be paid annually for four (4) consecutive years if the dependent child continues their education. The maximum amount payable under this benefit is $20,000.

Spouse Retraining Benefit	20% of the principal sum or $15,000
Rehabilitation Benefit	a. the actual expenses that are incurred within two (2) years from the date of the accident for the rehabilitation training; b. $15,000;
Therapeutic Counselling Benefit	$5,000 for any one covered accident
Disability Fitness Benefit	$5,000
Home Alteration and Vehicle Modification Benefit	The lessor of 50% of the Principal Sum or $50,000.
Workplace Modification Benefit	$5,000
Carjacking Benefit	10% of the applicable Principal Sum to a maximum of $10,000
Seat Belt and Air Bag Benefit	25% of the applicable Principal Sum up to a maximum of $25,000. An additional benefit equals to 5% of the insured person's Principal Sum to a maximum of $5,000.
Bedside Companion Benefit	Up to a maximum of $15,000 for round-trip economy transportation fare, meals and accommodation.
Repatriation of Remains Benefit	A maximum of $15,000 shall be provided for reasonable and necessary expenses provided the covered loss occurred more than one hundred and fifty (150) kilometers away from the insured person's normal place or residence.
Identification Benefit	Up to a maximum of $15,000 for return economy class transportation, hotel and meal expenses provided the body of the deceased insured person is at least one hundred and fifty (150) kilometers from their normal place of residence.
Brain Damage Benefit	1% of the insured person's Principal Sum per month for the first eleven 11 months. At the end of the eleven 11 months of payment, if the insured person remains in a brain damage state, we shall pay a lump sum benefit equal to the Principal Sum payable under the Accidental Death Benefit less the amount of the 11 months of benefit already received.
Critical Burn Benefit	Maximum of $25,000

Table of Losses	
Dismemberment of: • **Both hands or both feet** • **One hand and one foot** • **One hand or one foot plus the loss of sight in one eye** • **Sight of both eyes** • **Speech and hearing**	100 % of Principal Sum
• **Speech or hearing** • **One hand; one foot; or sight in one eye**	50% of Principal Sum
• **Thumb and index finger of the same hand** • **Hearing in one ear**	33.33% of Principal Sum
Loss of use of: • **Two limbs*** • **One limb**	200% of Principal Sum 75% of Principal Sum
***Limb(s) includes hands and feet.**	
Covered Loss of: • **Two limbs** • **Both hands or all fingers and thumbs of both hands**	200 % of Principal Sum
• **Sight of both eyes** • **Paralysis of both limbs**	100 % of Principal Sum
Plegia Benefit	

Plegia of: • Quadriplegia (total paralysis of all four limbs)	200% of the Principal Sum
• Triplegia (total paralysis of three limbs) • Paraplegia (total paralysis of two limbs) • Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	200% of the Principal Sum
• Uniplegia (total paralysis of one limb)	75% of the Principal Sum

Summary of Benefits

Core Benefits

Accidental Death

If there is a loss of life as the result of a covered **injury**, **we** will pay the applicable Principal Sum.

Accidental Dismemberment

We will pay the applicable benefit amount if you suffer an **injury** listed in the **covered losses** in your Schedule.

Loss of Use

A benefit will be paid to the **insured** if they suffer an **injury** which results in total paralysis of one or more limbs which is considered to be permanent, complete, and irreversible.

Plegia

Benefits will be provided in the event you have sustained an **injury** which has resulted in the permanent, complete and irreversible loss of voluntary movement that affects the motor function of one or more limbs for at least 12 consecutive months.

Exposure and Disappearance

Benefits are payable if you suffer a **covered loss** due to unavoidable exposure to the weather resulting from a covered **accident**. In addition, if the conveyance in which you are riding disappears, is wrecked, or sinks, and you are not found within 365 days of the event on a trip which is otherwise covered, **we** will presume that you lost your life as a result of **injury** and benefits will be payable.

In-Hospital Indemnity Benefit

When you suffer an **injury** resulting in **covered loss** which requires you to be hospitalized for more than 7 consecutive days, this benefit provides additional financial help to pay for unforeseen expenses.

Funeral Benefit

An additional funeral amount will be paid in the event of the **accidental** death of an **insured.**

Day Care Benefit

A benefit which helps to pay for day care costs after the death of an **insured,** for each dependent child under the age of 13 who are enrolled in an Accredited Child Care Facility.

After School Care Benefit

This benefit helps to pay for after school care for each dependent child under the age of 11, after the death of an **insured person.**

Parent Care Benefit

If you were to pass away, as a result of an **accident**, an additional benefit would be provided for the care of your dependent parent if you are their primary caregiver.

Higher Education Benefit

Benefit to help pay for post-secondary costs for children enrolled full time in an accredited college, university or trade school when an **accident** results in the death of an **insured.**

Spouse Retraining Benefit

An additional benefit will be provided to your surviving spouse for the cost of any professional or trade training program should they need to make a career adjustment as the result of your **accidental** death.

Rehabilitation Benefit

When you suffer an **injury** under the **Accidental** Dismemberment, **Covered Loss** of Use, and Plegia Benefit, this additional benefit provides you with special training in the event you need to change occupations.

Therapeutic Counseling Benefit

If you suffer an **injury** resulting in a **covered loss** under the **Accidental** Death and Dismemberment, **Covered Loss** and Plegia Benefit and require therapeutic counselling, the charges will be reimbursed to the person who incurs the expense.

Disability Fitness Benefit

If you suffer an **injury** which results in a **covered loss** payable under the **Accidental** Dismemberment, **Covered Loss** of Use and Plegia Benefit, **we** will pay the reasonable and necessary expenses for the purchase of specially designed fitness training or athletic equipment.

Home Alternation and Vehicle Modification Benefit

When you are injured in an **accident**, this benefit provides additional financial assistance to make any modifications to your home or vehicle if required.

Workplace Modification Benefit

If you sustain an **injury** resulting in a loss which necessitates the use of special adaptive equipment or workplace modifications in order to reasonably accommodate your return to active full-time work with the **Policyholder. We** shall pay the **policyholder,** upon your return to active full-time work with the employer, the reasonable and necessary expenses actually incurred by your employer for such adaptive equipment or workplace modifications up to the maximum shown in the Schedule.

Carjacking Benefit

An additional benefit will be provided if the **insured** suffers an **injury** or death, as a result of a carjacking while either operating a vehicle, getting in or out, or as a passenger.

Seat Belt and Air Bag Benefit

When you suffer an **injury** in an automobile **accident** when properly wearing your seatbelt, which results in your death, an additional benefit will be paid. If the seat belt benefit is payable, **we** may pay an additional amount to the Principal Sum if you were driving or riding as a passenger with a manufacturer equipped airbag which inflated properly.

Bedside Companion Benefit

If you are hospitalized at least 150 km away from your place of residence for 3 or more days due to an **injury** resulting in a **covered loss**, **we** will cover the costs associated with having a companion at your bedside if required.

Repatriation of Remains Benefit

Repatriation of Remains: If the **insured** were to pass away due to an **injury** while travelling at least 150 km away from their primary residence, **we** will pay the benefit for expenses to either: prepare the body and transport it back to the normal place of residence or cremate the body and return the ashes back to the **insured's** province of residence.

Identification Benefit

In the event that someone is legally required to identify the body of the **insured**, and they must travel to the location where the **insured** has passed away, **we** will provide payment for transportation, commercial accommodation and a subsistence allowance as indicated in the Schedule.

Additional Benefits

Brain Damage Benefit

This benefit will be payable if you suffer an **injury** resulting in brain damage, within 365 days of an **accident** which results in hospitalization for at least thirty-one (31) consecutive days.

Critical Burn Benefit

If you suffer an **injury** due to a critical burn as determined by a physician, on the surface of your body resulting from an **accident**, an additional benefit will be payable as described in your Schedule.

Ancillary Benefits

Waiver of Premium Benefit

If you become totally disabled due to an **injury** while covered under this policy, **we** will waive the premiums due provided the disability has continued for longer than 6 consecutive months.

Continuation of Coverage Benefit

Coverage will be extended for 12 months provided premiums are paid if the insured is: on a temporary lay-off, temporarily absent from work due to short term disability, on leave of absence, or

on maternity leave.

Exclusions

Benefits shall not be provided under the policy for any **injury** or **covered loss** if it is caused by, contributed to, or results from:

1. Suicide or attempted suicide while sane or insane or from an intentional self-inflicted **injury** or attempt thereat.
2. Any act of war, whether declared or undeclared.
3. Involvement in any type of **active** military service.
4. Illness or disease regardless of how contracted, medical or surgical **treatment** of an illness or disease, or complications following the surgical **treatment** of an illness or disease.
5. Participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot.
6. Parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity.
7. Alcohol, Drugs, or Other Toxic Substances

   Sickness, death or **injury** sustained as a result of:
   a. abuse of alcohol, drugs, medication, or other toxic substances;
   b. non-compliance with prescribed medical **treatment** or therapy;
   c. operating any vehicle or means of transportation while under the influence of alcohol when the **insured's** blood alcohol level is more than eighty (80) mg of alcohol per hundred (100) ml of blood. An autopsy report from a licensed medical examiner, law enforcement officer report, or similar items shall be considered proof of intoxication.
8. Piloting or operating any aircraft, or you are a cabin attendant or member of the crew of any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.
9. Release, whether **accidental** or not, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release.
10. A cardiovascular event or stroke caused by exertion prior to or at the same time as an **accident**.
11. Alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a licensed medical provider operating within their scope of authority.

12. Medical **treatment** within Canada at a private hospital.
13. Benefits are not payable for costs incurred due to, contributed to by, or resulting from an epidemic or pandemic.
14. Involvement in any kind of daily occupational work or activity related to underground mining operations.

Important Definitions

Accident or **accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the Policy term.

Active and **actively at work** describes an employee who is able and available for active performance of all of their regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered actively at work provided the employee is able and available for active performance of all their regular duties and was working the day immediately prior to the date of their absence.

Covered loss means a loss which meets the requisites of one or more benefits or additional benefits, results from an **injury**, and for which benefits are payable under this Policy.

Injury means sudden bodily harm directly caused by external and **accidental** means and that is independent of all other causes, including sickness or disease.

Insured means an individual who is eligible for coverage under this Policy as provided above, and who completes the enrollment material, if required.

Insured person means any person who has insurance under the terms of this policy as shown in the Declarations Page under the section for Eligibility and Classification of Insured Persons. It may include the **insured's** spouse or child(ren) if a plan covering the spouse or child(ren) is selected.

Policyholder means the group, company, or legal entity named on the front page of this Policy and with whom **we** enter into the policy.

Total disability (totally disabled) means that the **insured** is unable to perform at least 30% of the substantial and material duties required by their regular occupation.

Treatment means hospitalization, medical, therapeutic, diagnostic or surgical services or procedures prescribed, performed or recommended by a physician or other licensed medical practitioner including, but not limited to, prescribed medication, investigative testing and surgery related to any medical condition, **injury**, or sickness.
We, **us**, and **our** refers to Zurich Insurance Company Ltd.

How to Submit a Claim

You or someone on your behalf, must provide **us** with written notice of the **covered loss** within ninety (90) days of such **covered loss**. The notice must include the name of the **insured person** who sustained the **injury**, the name of the primary **insured**, and the **policy** number. To request a claim form, the **insured person** or someone on their behalf must contact **us** by email or through the claims portal listed below. The notice must name the **insured person** and the policy number. Notice can be sent digitally or mailed to the addresses provided below.

To access the Digital First Notice of Loss Portal:
https://ca-uat-fnol-users-ui.claims.global/zurichcanada
Email: ZurichGroup@crawco.ca
Address: Zurich Group Claims C/O **Crawford & Company**
100 Milverton Drive, Suite 300
Mississauga, Ontario L5R 4H1

Note: Notice to **our** agents is considered notice to **us**.

Claim Forms

We shall send the claimant proof of **covered loss** forms within fifteen (15) days after **we** receive notice. If the claimant does not receive the proof of **covered loss** form in fifteen (15) days after submitting notice, they can send **us** a detailed written report of the claim and the extent of the **covered loss**. **We** shall accept this report as a proof of **covered loss** if sent within the time fixed below for filing a proof of **covered loss**.

Proof of Covered Loss

Written proof of **covered loss**, acceptable to **us**, must be sent within ninety (90) days of the **covered loss**. Failure to furnish proof of **covered loss** acceptable to **us** within such time shall neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **covered loss**, and the proof was provided as soon as reasonably possible.

Provider Note

This document provides a brief description of the important features of the insurance program. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy. All claims under the policy will be adjudicated according to the events and circumstances of that particular claim pursuant to the terms and conditions of the Policy and in compliance with applicable law, including law governing economic sanctions. This Policy will not cover any loss, injury, damage or legal liability arising directly or indirectly from planned or actual travel in, to, or through Iran, Syria, Sudan, North Korea or the Crimea region. Possession of this document does not guarantee payment.

Data Sharing Consent

In order to provide a seamless insurance service globally, Zurich may transfer any data Zurich has received from and any data it holds on the policyholder to other units of Zurich Insurance Group Ltd, such as branches, subsidiaries, or affiliates within Zurich Insurance Group Ltd, cooperative partners of Zurich Insurance Group Ltd, coinsurance and reinsurance companies located in the country of the policyholder or abroad.

The recipient(s) will be required to maintain the confidentiality of the data to the same degree as required of the Zurich party that transferred it.

Zurich as well as such recipients may use, process and store the data, in particular for the purpose of risk evaluation, policy execution, premium setting, premium collection, claims assessment, claims processing, claims payment, statistical evaluation or to otherwise ensure Zurich' global insurance service delivery.

If a broker or agent is acting on behalf of the policyholder, Zurich is authorized to use, process and store data of the policyholder received from such broker or agent, and to forward to such broker or agent data of the policyholder relating to the execution of the Policy and the collection of premiums and payment of claims.

Zurich may procure data from government offices and third parties relating to the policyholder to assess a claim in the event of loss or damage.

Disclaimer

This letter constitutes Zurich Insurance Company Ltd's ("Zurich") summary of coverages and terms, which may differ from the coverages and terms requested or on the policy. Please note the terms and conditions of this letter form part of the policy which will be issued. Zurich reserves the right to modify the terms of this letter, including premium amounts, if any of the factors used as a basis for this quotation are incorrect or change, including new risks being added, existing risks changing or multi-line pricing efficiencies no longer applying. This letter will not be superseded by the Policy to be issued.

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Privacy Consent Notice

By submitting the requested information, which may include, but is not limited to, an individual's name, address, date of birth, and medical information, you covenant and warrant that you have obtained the appropriate consent from such individual to disclose their personal information to Zurich Insurance Company Ltd and its subsidiaries and affiliates located in your country of residency or abroad (collectively, "Zurich"), for the collection, storage, use, disclosure, and processing of such personal information as may be necessary for the purposes of securing and administering the requested insurance coverage(s), including but not limited to, risk evaluation, policy execution, premium setting, premium collection, claims adjusting, administration, investigation and settlement, fraud prevention, detection and suppression, or statistical evaluation. You also covenant and warrant that you have obtained consent from the individual for Zurich's disclosure of their personal information to third parties, as required for and in relation to the above-stated purposes, including reinsurers, third party administrators, brokers, agents, claims adjusters, regulators or other governmental or public bodies, taxing authorities, industry associations, other insurers, and other third parties involved in providing insurance services ("Third Parties").

Zurich is committed to protecting the privacy and confidentiality of information provided. Personal information may be processed by and is securely stored within the offices of Zurich and authorized Third Parties, both in domestic and foreign jurisdictions outside Canada and is subject to applicable laws.

Zurich may retain personal information as needed for any of the above-stated purposes or as necessary to comply with Zurich's legal and regulatory obligations, resolve disputes, and enforce Zurich's agreements. Individuals may request to review the personal information Zurich maintains about them and make corrections by writing to: Privacy Officer, Zurich Insurance Company Ltd (Canadian Branch), 100 King Street West, Suite 5500, P.O. Box 290, Toronto, ON M5X 1C9 or by emailing privacy.zurich.canada@zurich.com.

Individuals may refuse to consent or withdraw their consent to the collection, storage, use, disclosure or processing of their personal information; however, their refusal to provide consent may result in Zurich being unable to offer and administer insurance coverage or prevent Zurich from being able to pay any claim benefits payable under the policy.

Please contact the Zurich Privacy Officer for further information regarding the collection, use, disclosure, processing and storage of personal information or for any complaints via email at privacy.zurich.canada@zurich.com. Our Privacy Policy is available at https://www.zurichcanada.com/en-ca/about-zurich/privacy-statement.

For the purpose of the *Insurance Companies Act* (Canada), this document was issued in the course of the Insurer's insurance business in Canada.

Signature

Head of Underwriting, Canada Authorized Representative

Appendix C – Other Services available via Cloud MD

Contact Ellement Consulting Group, your benefits administrator for any and all questions related to these services.

CLOUD MD VIRTUAL CARE & KII HEALTH & WELLNESS PROGRAM
Have a health question or concern? These two virtual care platforms are designed to address your health care needs via secure text and video chat – anytime, wherever you are.

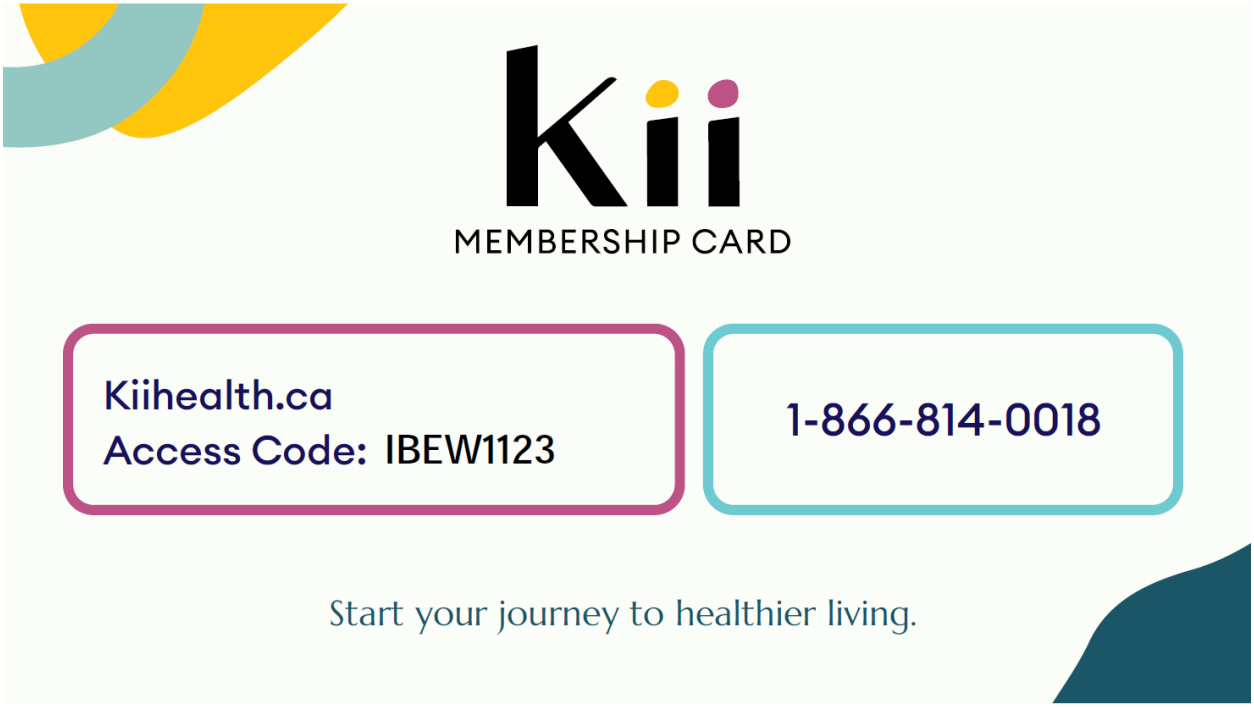
This online platform provides you and your family with 24/7, personalized medical support wherever you are in Canada. Connect instantly with a healthcare provider for your primary health questions and concerns.

- Unlimited virtual consultations via secure text and video chat, 24/7
- Convenient primary and mental-health care support
- Fill and refill prescriptions, specialist referrals, and lab requisitions
- Coverage for you and your eligible dependants
- Virtual follow-ups with no appointments required
- Health records on the platform, with updates sent to your family doctor with your consent.

Avoid visits to walk-in clinics or emergency rooms for non-emergency issues such as:

- Infections, rashes and skin irritations
- Anxiety and depression
- Stomach and digestive issues
- Cough, cold and flu
- Weight loss counselling and smoking cessation
- And much more

This service is not for emergencies.



MEDICAL SECOND OPINION – HEALTHCARE ASSISTANCE AND NAVIGATION

Obtain a medical second opinion and disease assistance through the Kii program. *Kii's Medical Second Opinion* program connects you to the expertise of top specialists without the time and expense of travel.
Either through phone or through the secure web platform, members and eligible dependents can submit their detailed health information, medical records and diagnostic test results. The most appropriate expert is assigned to the consultation and will render a detailed second opinion. They will also help you navigate care to specialists and other resources related to help you with your medical condition.

Medical Second Opinion helps to:

- Make the most informed decision about your healthcare or that of an eligible dependent
- Ensure your diagnosis is correct
- Ensure your treatment plan is optimal for you
- Learn about new, innovative treatment options
- Guide you through the process.

For more information, please contact Kii at 1-866-814-0018, you can also register online at Kiihealth.ca/register (Access Code IBEW1123).

ONLINE COGNITIVE BEHAVIOURAL THERAPY AND MENTAL HEALTH RESOURCES

Personal challenges might be impacting or affecting your mindset or ability to be your best self. Electrical Industry of Ottawa Health and Benefit Plan Trustees have invested in Kii, a health & wellness program to provide you and your dependents with the support you need, when you need it. Kii offers a wide variety of options to help you feel your best, like:

Cognitive Behavioral Therapy (CBT)

o Your therapist guides you through an online CBT program of readings and exercises to help you improve your resilience and face life's challenges.

Mental Health Coaching

o Work with a mental health coach to set your goals, create an action plan, and have regular check-ins to keep you on track. Your coach is here for you.

Kii is completely confidential, and no one will know if you have joined or if you have accessed help.

Connect to Kii from anywhere, anytime. Whenever or wherever you need to.

It's really easy to get started too. It takes less than a minute to activate your account.

Activate your free account by:

1. Visit www.kiihealth.ca on any web browser (computer, tablet or smartphone)

2. Click “ Sign Up Here”

2. Enter: <Access Code IBEW1123>

3. Complete your profile and create a password

4. Click the link in the email confirmation and you’re done!