



The Electrical Industry of Ottawa

Group Benefit Plan

All Active and Retired Members

Effective Date: January 1, 2026

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 <i>(All information refers to members under age 65 unless otherwise stated)</i>	Volume
<ul style="list-style-type: none"> actively at work on or after November 1, 2018. on temporary lay-off for less than 24 consecutive months. 	\$250,000
<ul style="list-style-type: none"> not actively at work since October 31, 2018. 	\$125,000
<ul style="list-style-type: none"> not actively at work since October 31, 2014. 	\$100,000
<ul style="list-style-type: none"> not actively at work since September 30, 2005. retired on or after July 1, 1982 and prior to October 1, 2005. 	\$50,000
<ul style="list-style-type: none"> retired prior to July 1, 1982. 	\$25,000
<ul style="list-style-type: none"> 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	Volume
<i>(All information refers to members under age 65 unless otherwise stated)</i>	
<ul style="list-style-type: none"> actively at work on or after November 1, 2018. on temporary lay-off for less than 24 consecutive months. 	\$250,000
<ul style="list-style-type: none"> not actively at work since October 31, 2018. 	\$125,000
<ul style="list-style-type: none"> not actively at work since October 31, 2014. retired on or after August 1, 1998, but prior to November 1, 2014. 	\$100,000
<ul style="list-style-type: none"> retired on or after July 1, 1982 but prior to August 1, 1998. 	\$50,000
<ul style="list-style-type: none"> 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:	\$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

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 <i>Prescription Drugs</i> 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: <ul style="list-style-type: none"> • 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
- 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:	Refer to the "Medical supplies and services" section
- FreeStyle Libre sensors and Continuous Glucose Monitor transmitters and sensors:	\$5,000 per insured person every calendar year

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:	<p>Prescription glasses including:</p> <ul style="list-style-type: none"> ☑ regular lenses and frames, ☑ safety lenses and frames, ☑ sunglass lenses and frames. <p>Prescription contact lenses. Laser eye surgery.</p>
• 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:

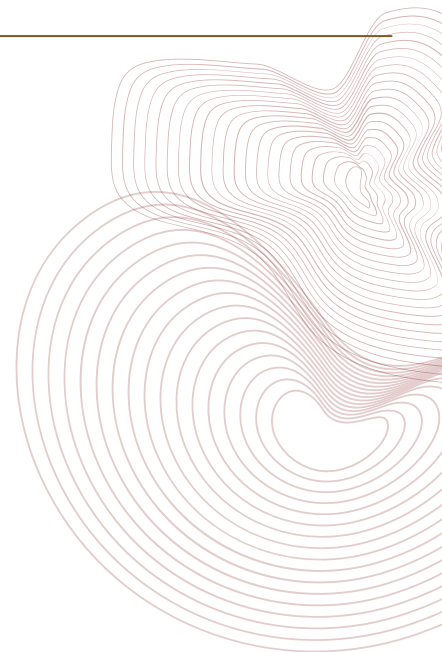
• Deductible:	Nil.
• Reimbursement level:	90% of eligible expenses (unless otherwise specified).
- Maximum	\$1,900 per insured person for all practitioners combined every calendar year.
	Note: Psychological testing and assessments, and speech therapy are not subject to the combined yearly maximum of \$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:	Refer to the "Prescription drugs" section.
- 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:	Refer to the "Prescription drugs" section.

- 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 day¹ 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*.

¹Note: 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. 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).

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

The HCSA option is permitted under applicable law if you elect the transfer within the deadline provided. You 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.
- Diabetic devices and supplies, such as:
 - 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* (refer to "Medical supplies and services" section);
 - FreeStyle Libre sensors and continuous glucose monitor transmitters and sensors, to the limits outlined in the *Benefit Summary*.

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 (refer to the "Prescription drugs" section)*;
 - 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 (refer to the "Prescription drugs" section)*;
- 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

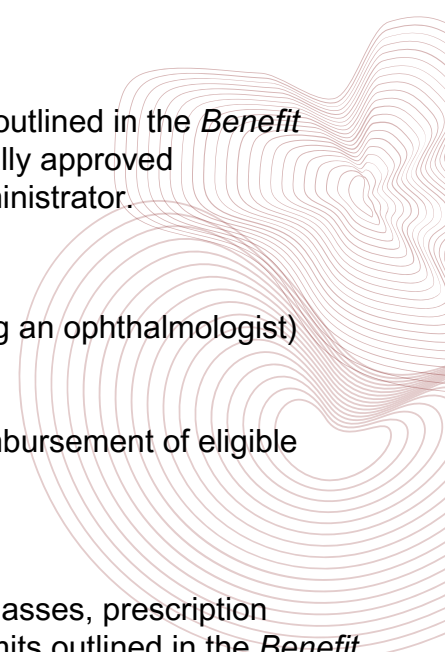
Eye examinations, including eye refraction and Optical Coherence Tomography, to the limits outlined in the *Benefit Summary*.

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 fillings;
- 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 day¹ 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.

¹Note: 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:

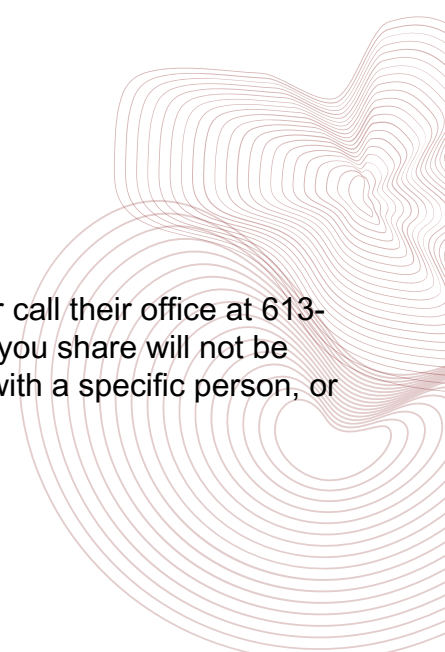
- were employed by a participating employer at the time of the Bereavement Pay leave period and were not reimbursed for the days claimed by their employer for lost wages;
- complete a Bereavement Pay Benefit Declaration Form available from IBEW Local 586 or Ellement Consulting Group LP
- provide a funeral 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

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.

Drop Claims to:

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

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.

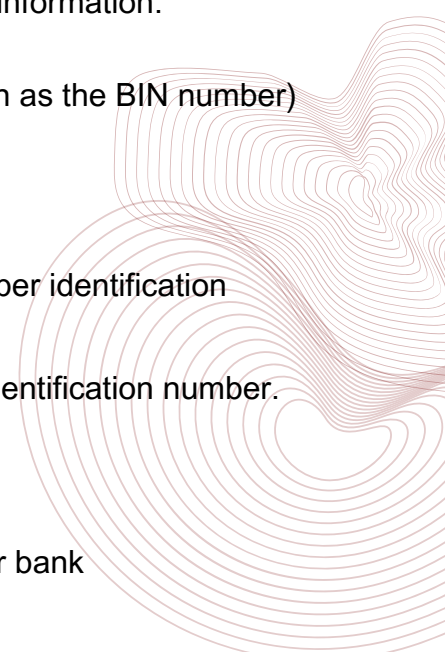
You can receive reimbursement within two to five (2-5) days following the approval of your medical or dental claims. No need to wait for the arrival of a cheque and a trip to the bank before depositing the reimbursement.

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



844-736-5600



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



1-866-517-8967



EIO@ellement.ca



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/EllementOttawaBooking1@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.

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.



Appendix C – Other Services available via Cloud MD

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