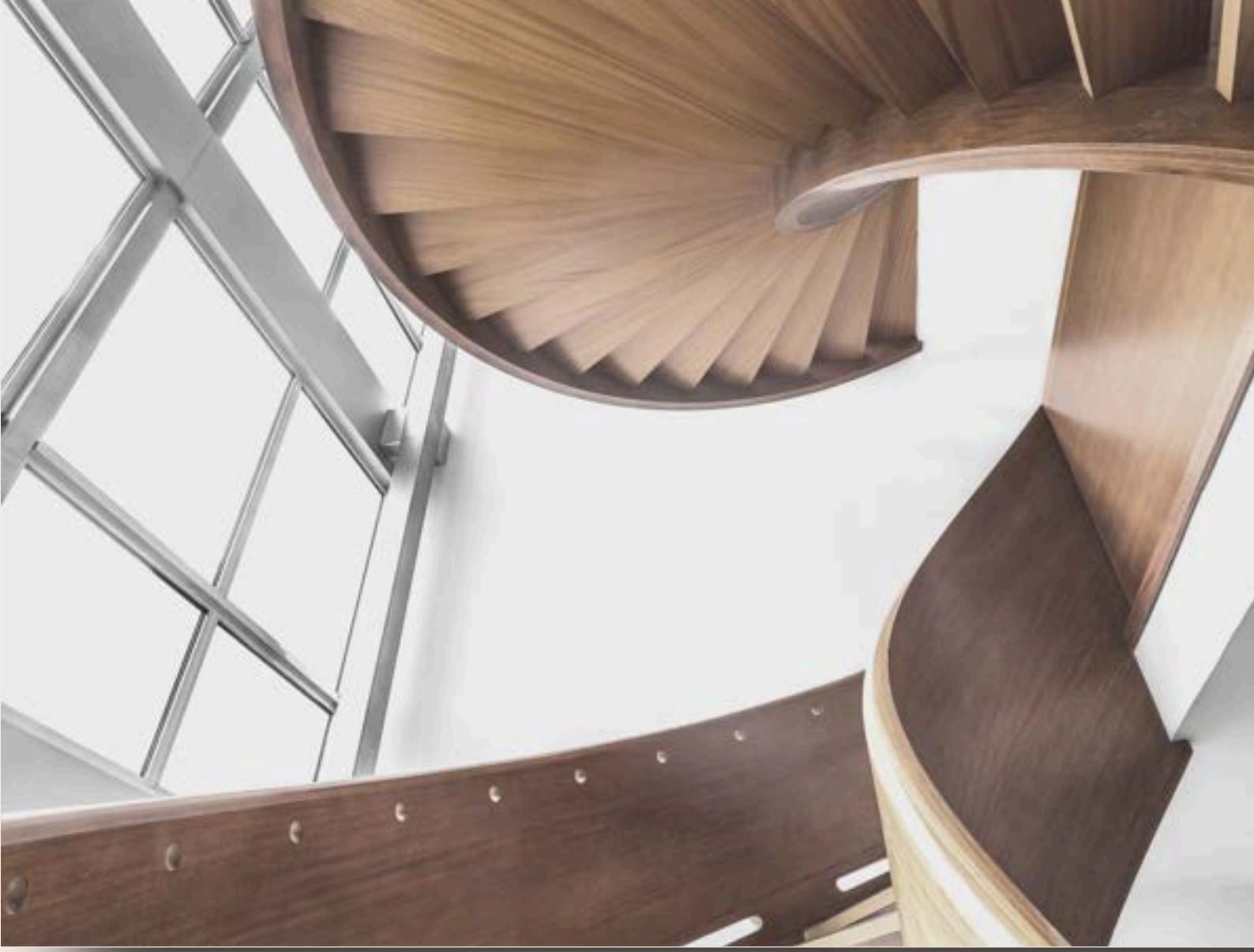

UBC BUILT
LOCAL 2041

Local 2041 Acoustic & Drywall Health & Welfare Trust Fund

Group Benefit Plan

Effective Date: February 1, 2025

Ellement

Keep This Booklet in a Safe Place

Your group benefits provide an important supplement to your income and valuable protection to 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	Policy Number	Appendix
Basic Life, Dependant Life and Long-Term Disability Insurance	Desjardins Financial Security Life Assurance Company	440280	Appendices A & B
Weekly Indemnity	Local 2041 Acoustic & Drywall Health & Welfare Trust Fund	61079	n/a
Accidental Death and Dismemberment (AD&D)	Chubb Life Insurance	AB10588001	Appendix C
Out of Province/Canada Medical Emergency Insurance	Zurich Insurance Company LTD	8621994	Appendix D
Extended Health Care and Dental Care	Local 2041 Acoustic & Drywall Health & Welfare Trust Fund	61079	n/a
Member assistance program (MAP)	BuildingTrades	n/a	n/a

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 613-704-3950 (toll free at 1-877-587-3950), or by fax at 844-736-5600, or email Local2041@ellement.ca.

Please visit the plan website at www.2041benefits.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 Local 2041 Acoustic & Drywall Health & Welfare Trust Fund, 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 Local 2041 Acoustic & Drywall Health & Welfare Trust Fund, or its trustees or designates, have the right to interpret the plan and decide any and 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 Local 2041 Acoustic & Drywall Health & Welfare Trust Fund, its trustees or 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 Local 2041 Acoustic & Drywall Health & Welfare Trust Fund 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 19, 1990, the Local 2041 Acoustic & Drywall Health & Welfare Trust Fund was established to provide a group health and benefit program for active and retired members of the United Brotherhood of Carpenters and Joiners of America (Local 2041), their eligible dependants and survivors.

Objectives

The purpose of this program is to reimburse eligible participants for all or part of 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 APPENDICES A & B – DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY

Members Qualifying Criteria	Volume Under age 65	Volume Age 65 to 69 (inclusive)
• actively at work on or after May 1, 2009	$100,000	$50,000
• not actively at work since April 30, 2009.	$50,000	$25,000
• not actively at work since December 31, 2001	$25,000	$12,500
• retired prior to January 1, 2002	$5,000	$2,500

Termination:	Age 70.

A retired member is considered to be a member in good standing of Local 2041 and in receipt of a retirement pension from the Local 2041 Acoustic & Drywall Pension Plan.

Life insurance coverage will continue into retirement to age 70, provided the required premiums are paid.

Dependant Life Insurance

REFER TO APPENDICES A & B – DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY

Benefit amount:	$15,000 spouse. $7,500 child aged 24 hours and older.
Termination:	Age 65.

Basic Member Accidental Death and Dismemberment (AD&D)

REFER TO APPENDIX C – CHUBB LIFE INSURANCE

Members Qualifying Criteria	Volume Under age 65	Volume Age 65 to 69 (inclusive)
• actively at work on or after May 1, 2009	$100,000	$50,000
• not actively at work since April 30, 2009	$50,000	$25,000
• not actively at work since December 31, 2001	$25,000	$12,500
• retired prior to January 1, 2002	$5,000	$2,500

Termination:	Age 70.

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

Weekly Indemnity

Benefit amount:	Equal to the Employment Insurance (EI) maximum per week. For each day of disability, 1/7th of the weekly income benefit is payable.
Non-evidence maximum:	Not applicable.
Maximum amount:	Equal to the EI maximum per week.
Maximum benefit period:	52 weeks, including the period of EI entitlement. If the disabled member is eligible for EI sickness benefits, WI benefits are not payable during the time for which EI payments are being made. A disabled member must show proof of application and response from EI by providing a copy of the decision letter, together with first and last EI cheque stubs, where applicable.
Elimination period:	0 day for accidental injury, 7 days for illness.
Recurrent disability:	14 days for same or related condition(s).
Tax status:	Taxable.
Termination:	Age 70, or retirement, whichever occurs first.

Note:

Contractors and their salaried employees, apprentices while in school, or retired members who have not returned to work for a participating employer are not eligible under this benefit.

Member Long-Term Disability

REFER TO APPENDICES A & B – DESJARDINS FINANCIAL SECURITYLIFE ASSURANCE COMPANY

Benefit amount:	$1,500 every month.
Elimination period:	52 weeks.
Maximum benefit period:	Age 65.
Tax status:	Taxable.
Termination:	Age 65 or retirement, whichever occurs first.

Note:

Contractors and their salaried employees, apprentices while in school, or retired members who have not returned to work for a participating employer are not eligible under this benefit.

Out-of-province/Canada Travel Medical Emergency Insurance

The information below summarizes your Emergency Medical Travel Insurance coverage. It contains important information with respect to certain eligibility and benefit limits that apply to your coverage, but it does not reference all of the terms, conditions, limitations, and exclusions. Please refer to the policy for complete details. All amounts indicated are in Canadian currency, unless otherwise stated.

Policyholder Name	**Local 2041 Acoustic & Drywall Health and Welfare Trust Fund**
Policyholder Number	8621994
Description of Classes	**Class I:** All Active members of the Policyholder under age 75. **Class II:** All Eligible Retired Members under age 85 **Class III:** All Active members of the Policyholder between age 75 and 85
Termination	**Class I:** Terminates at the earlier of the Members attainment of 75 years of age or retirement. **Class II:** Terminates at the attainment of age 85 **Class III:** Terminates at the earlier of the Members attainment of 85 years of age or retirement
Covered Trip Duration	**Classes I, 2 & 3:** Up to maximum 60 days per trip
Pre-existing Medical Condition Stability Period	90 days
Emergency Medical Treatment	$5,000,000 **Age at Date of Loss** — **Principal Sum** 70-74 — $2,000,000 75-84 — $ 500,000
Hospital Allowance	$50 per day to a maximum of $500
Paramedical Services	$500 per practitioner for up to 180 days
Ground Ambulance	Maximum $10,000
Emergency Dental Treatment	(1) $2,000 (2) $500
Medical Evacuation	Maximum $50,000

Bedside Companion	Round-trip economy airfare & up to $15,000 for meals and accommodation
Meals and Accommodation	$200 per day to a maximum of $2,000
Repatriation of Remains	(1) $15,000 (2) $5,000
Return of Dependent Child(ren)	One way economy airfare up to a maximum of $5,000
Childcare	$75 per day to a maximum of $500
Return of Travelling Companion / Business Colleague	One-way economy airfare up to a maximum of $5,000
Vehicle Return	$4,000
Dispatch of a Physician or Specialist Benefit	$50,000
Trip Cancellation and Trip Interruption	$2,000

Extended Health Care (EHC)

Deductible:	Nil.
Reimbursement level:	100% (unless otherwise specified).
Maximum benefit:	$100,000 lifetime maximum per insured person for all EHC services. An annual reinstatement of $1,000 will apply once the lifetime maximum has been reached.
Termination:	Not applicable.

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

Prescription drugs:

● Deductible:	Nil.
● Reimbursement level:	100% 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 healthcare practitioner or dentist and dispensed by a pharmacist, dentist or a physician.
● Generic substitutions:	Yes.
● Drug card:	Yes.

● **Maximums and exclusions:**

• Drug dispensing:	Limited to 34-day supply for prescription drugs or medicines and a 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:	Reasonable and customary charges.
• Smoking cessation aids:	Lifetime maximum of $1,500 per insured person (includes prescription medications and over-the-counter products).

• Sexual dysfunction drugs:	$1,000 per insured person per calendar year.
• Fertility drugs and treatment:	Excluded.
• Vitamins & nutritional supplements:	$2,000 per insured person per calendar year when required for life-sustaining reasons.
• 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).
● Coverage:	Cost of a semi-private room for each day of hospitalization.
● Palliative care:	Covered under hospital care coverage as indicated above.
● Detoxification facility:	Maximum of $15,000 and 28-days confinement period. (A doctor's or Members Assistance Program referral and pre-approval are required).

Vision care:

Deductible:	Nil.
Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum:	$600 per insured person once in any 18-month period. If an insured person has a change of prescription in the 18-month period, they will be entitled to claim for another pair of glasses (copies of the initial and current prescriptions required).

Eligible expenses:

- Prescription glasses including:
  - Regular lenses and frames
  - Safety lenses and frames
  - Sunglass lenses and frames
- Prescription contact lenses
- Laser eye surgery
- Special condition lenses (refer to section *3.4.10.1 Prescription Eyewear and Laser Eye Surgery* below for additional information)

Glasses or contact lenses following cataract surgery:	One pair per insured person following cataract surgery. If surgery is not done on both eyes at the same time, a 2nd pair will be eligible following the subsequent surgery.
Artificial crystalline lenses/intraocular lenses (IOL) for cataracts:	Reasonable and customary charges.
Eye examinations, including eye refraction:	Maximum of $125 per insured person every calendar year.
Emergency eye examinations:	Excluded
Fees for the diagnosis of an eye condition:	Excluded
Optical Coherence Tomography:	$200 per insured person every calendar year.
Visual field test:	$200 per insured person every calendar year.

Professional and paramedical services:

Deductible:	Nil.
Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum:	$2,000 per insured person for all practitioners combined every calendar year.
Eligible practitioners:	
Chiropractor:	Reasonable and customary.
Massage therapist or Orthotherapist:	Reasonable and customary.
Naturopath:	Reasonable and customary.
Osteopath:	Reasonable and customary.
Chiropodist:	Reasonable and customary.
Podiatrist	Reasonable and customary.
Physiotherapist:	Reasonable and customary.
Psychologist, Social Worker, Counsellor, Psychotherapist:	Reasonable and customary.
Speech therapist:	Reasonable and customary.

Imaging techniques ordered by a chiropractor, naturopath, or osteopath limited to maximum of $50 per insured person every calendar year for each of these specialists.

Medical supplies and services:

Deductible:	Nil.
Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum per service and/or supply:	
External breast prosthesis (following mastectomy):	One per insured person every calendar year.
Surgical brassieres:	Excluded.
Private duty nurse:	$5,000 per insured person every calendar year. Services of a registered nursing assistant or a licensed practical nurse if a registered nurse is not available.

Artificial eye:	Purchase, including reimbursement for polishing or rebuilding of the artificial eye per insured person up to reasonable and customary charges.
Myoelectric limbs:	Excluded.
Stump socks:	Reasonable and customary charges.
Brace with orthopedic shoes:	Reasonable and customary charges.
Custom-made orthopedic shoes:	$50 per insured person every calendar year.
Custom-made orthotics or arch supports:	Purchase up to $500 per insured person every calendar year.
Support stockings:	4 pairs up to $50 per pair, per insured person every calendar year.
Conventional wheelchair:	Reasonable and customary charges.
Other therapeutic equipment:	Reasonable and customary charges.
Electric hospital bed:	Excluded.
Hearing aids:	Purchase, up to $2,000 per insured person every 5 consecutive years. A written prescription from a medical physician or an audiologist is required.
Diagnostic services:	Reasonable and customary charges.
Wigs for all medical conditions:	Excluded.
Diabetic supplies:	Reasonable and customary charges.
Glucometer or reflectance meter; FreeStyle Libre flash Monitor; or Continuous Glucose Monitor receiver:	Once every 5 calendar years, up to reasonable and customary charges. Glucometer and reflectance meter: eligible for all insured. Continuous Glucose Monitor receiver: eligible for children under the age of 13.
FreeStyle Libre sensors and Continuous Glucose Monitor transmitters and sensors:	$3,000 per insured person every calendar year for children under the age of 13.
TENS nerve stimulators:	Purchase or rental to a maximum of 6 months up to reasonable and customary charges.
Intra-uterine devices:	Reasonable and customary charges.
Out-of-province referral treatment:	Excluded.

Dental Care

Deductible:	Nil.
Fee guide:	Based on the current year's Dental Association fee guide for general practitioners, denturists, specialists, or independent dental hygienists where service is rendered.
Reimbursement amount:	
● Basic and Major services:	100% of eligible expenses.
● Maximum:	Combined maximum for basic and major services, to a maximum of $4,000 per insured person every calendar year. The maximum is reduced to $2,000 for the first calendar year that a family member is insured if the coverage starts on or after July 1st.
● Orthodontic services:	100% of eligible expenses for children from 6 years to age 18 at the time treatment commences. If treatment was approved and started prior to the child`s 18th birthday services will be covered. Also if coverage terminates, benefits for orthodontic treatment in progress continues for the 3-month period immediately following the termination.
● Maximum:	Lifetime maximum of $4,500 per insured person.

Treatment frequency:

● Complete oral examination:	Once every 6 consecutive months. Not in the same 6 month period as a recall exam.
● Recall oral examination:	Once every 6 consecutive months. Not in the same 6 month period as a complete exam.
● 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:	Reasonable and customary charges.
● 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:	One adjustment up to two units of time after the date of insertion.
• Pit and fissure sealants:	For children up to the age of 18.
• Occlusal equilibration:	Reasonable and customary charges.
• Space maintainers:	For missing primary teeth only.
• Oral hygiene instruction:	Once every 6 consecutive months.
• Anaesthetic:	Eligible in relation to dental surgery only.
• Denture adjustments including minor adjustments:	Eligible after 3-month post-insertion period.
• Denture rebase/reline:	Reasonable and customary charges.
• Preformed stainless steel and polycarbonate crowns:	Reasonable and customary charges.
• Crowns, inlays and onlays:	Once every 5 years. Porcelain crowns for molars are excluded
• Veneers:	Once every 5 years.
• Bridges and dentures:	Once every 5 years.
• Dental implants:	Once every 5 years.
• Laboratory fees:	Limited to the reasonable and customary fees specified for the dental treatment or service.
Termination:	Not applicable.

Member Assistance Program (MAP)

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

1. General Information

1.1 Plan Effective Date

The plan described in this booklet is up to date as of February 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

i) a member in good standing of the United Brotherhood of Carpenters and Joiners of America, Local 2041 who works for a contributing employer in Canada and works the required number of hours;

ii) a salaried employee of a contributing employer who is employed on a full-time basis or a contractor who has entered into a participation agreement with the union may be eligible for coverage under this contract, provided he/she has been approved by the Board of Trustees for the Local 2041 Acoustic & Drywall Health and Welfare Plan;

iii) a salaried employee of the United Brotherhood of Carpenters and Joiners of America, Local 2041 who is employed on a full-time basis;

iv) an apprentice while in school;

v) a retired member.

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

1.4 Waiting Period

200 Hour Bank hours must be accumulated before coverage begins. Following the accumulation, benefits are effective the first day of the third 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 otherwise;
- the date the plan administrator approves the evidence of insurability submitted for the dependant.

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.

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 Board of Trustees of the Local 2041 Acoustic & Drywall Health and Welfare Plan.

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 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, 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.

Dependant coverage is not available to children who work more than 30 hours per week and are not full-time students or who are not residents of Canada.

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 Board of Trustees of the Local 2041 Acoustic & Drywall Health & Welfare Trust Fund.

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

Employer: (can be any of the following):

- a 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;
- a 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;
- Local 2041 who is employing a salaried employee on a full-time basis.

Hours of work credit: hours that have actually been worked by the member and for which contributions have been made in respect of the member by his/her employer to the group policy holder pursuant to the collective agreement or participation agreement.

Hour bank account: the member's account to which their hours of work credit are credited by the group policy holder.

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

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

Member contribution: the amount, if any, a member is required to pay toward the insurance premium for insurance under this policy.

Policy holder: the Local 2041 Acoustic & Drywall Health & Welfare Trust Fund in its capacity as the policy holder of group contract numbers 440280, 61079, and 8621994, and AB10588001.

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 Local 2041 Acoustic & Drywall Pension Plan;
- completed the member election form confirming retirement status and choice of benefit package required at the time of retirement.

Revocable / Irrevocable beneficiary: *Revocable beneficiary* is the person that you name to receive the benefits of an insurance policy that can be changed. *Irrevocable beneficiary* is the person that you name to receive the benefits of an insurance policy that cannot be changed without the irrevocable beneficiary's written consent.

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 and must be a resident of either Canada or the United States.

Union: the United Brotherhood of Carpenters and Joiners of America (Local 2041)

1.7 Hour Bank Account

The plan administrator maintains an hour bank account for each member showing the hours worked for a contributing employer for which contributions have been made for the purchase of group insurance. For each hour you work, a contribution, as defined in your collective agreement or participation agreement, will be made to your account.

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

Each month, you will receive a statement confirming your coverage status and highlighting the hours you worked in the previous month.

It is important to understand the hours reporting cycle. The hours you work in a month are reported to the plan administrator the following month. They are then used to provide coverage in the third 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 May.

The following table illustrates this process:

Month Worked	Month Reported	Month Covered
February	March	May
March	April	June
April	May	July
May	June	August
June	July	September
July	August	October
August	September	November
September	October	December
October	November	January
November	December	February
December	January	March
January	February	April

Note: New and reinstated members are covered on the first day of the third month following the month in which 200 hours are accumulated. For example, if a member works 100 hours in April and 100 hours in May, they will be insured effective August 1st.

1.8 Hour Bank Account Balance Refund

On termination
On termination of coverage, in accordance with Canada Revenue Agency regulations, you will not be entitled to a refund of your account balance. It will be transferred to the trust general reserve. In the event of the suspension of your union membership and coverage, you will forfeit your account balance, which will be transferred to the general reserve after six months of suspension.

On death
On your death prior to retirement, your account balance can be used to extend coverage for your surviving spouse and eligible dependants for up to two years. Any remaining account balance after the two years will be transferred to the trust general reserve.

On retirement
On retirement, you may use your account balance to extend coverage beyond your retirement date. If you choose not to extend coverage into retirement, your remaining account balance will be transferred to the trust general reserve.

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 (e.g. 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 for a period of six months and your membership lapses, benefits under this plan will terminate as of the effective date of your suspension as reported by the Local 2041 union. If your suspension lasts more than six months, 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 third month following the month in which the number of bank hours in your account falls below the minimum required to continue insurance;
- 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; or
- the date contributions cease to be made for dependant coverage following your death (see *1.15.5 Health and dental benefits for dependants following death* below for more details).

1.14 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 200 hours of credit in any 12-month period is accumulated. Coverage will become effective on the first day of the third month following the date your Hour Bank account credit totals 200 hours, provided you are at work or eligible to resume work, and are a member in good standing of the union.

If your coverage was suspended with your union membership, the coverage will be reinstated to the date of suspension but not more than six months prior to the date of reinstatement of union membership. A member who reinstates his/her union membership after a suspension of six or more months will be considered a new member for eligibility purposes.

1.15 Continuation of Coverage

1.15.1 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 *1.13 Termination of Coverage* above.

If you are in receipt of disability benefits from the benefit plan, your health and dental coverage will be provided to you at no cost for the duration of your disability. If you continue to be disabled (proof of disability will be required), but you no longer meet the Total Disability definition necessary to maintain long term disability benefit payments from the benefit plan, you may elect to pay the monthly premium to maintain the health and dental coverage.

Note: Long-term disability coverage ceases at age 65, after which you will be considered to be a retired member. At that time, the terms and conditions outlined in *Following retirement* below will apply.

If you are unemployed and your hour bank has dropped below the minimum number of hours required to continue your insurance, you may continue to pay your premiums directly to the fund for a maximum of 12 months.

1.15.2 Following retirement

Once you retire, are over age 50 and are drawing a pension from the Local 2041 Acoustic & Drywall Pension Plan, you will continue to qualify for group life, dependant group life, accidental death and dismemberment, extended health care coverage (including out-of-country) and dental care, provided you continue to pay the required monthly premiums.

The life and accidental death and dismemberment insurance will reduce by 50% at age 65 and terminate at age 70. The dependant group life insurance will terminate at age 65. Out-of-country coverage will terminate at age 85.

A member election form confirming your retirement status and coverage selection will be required. If you are under age 70 and return to work for a participating employer following your retirement, you will also be eligible for weekly indemnity coverage.

1.15.3 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.

1.15.4 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.

1.15.5 Health and dental benefits for dependants following death

If you die prior to retirement, the health and dental benefits for your dependants may be continued for a period of two years following the date of your death. The premium should be paid by your hour bank account until depletion. Once your hour bank account is depleted, your surviving spouse may choose to pay the premiums for the remainder of the two-year period.

Your surviving spouse may choose to decline the benefits coverage, however no refund of your hour bank account balance is permitted.

If your surviving children cease to qualify as eligible dependants, their health and dental benefits will terminate.

If a dependant is disabled on the date insurance under this continuation clause terminates, insurance payments for that dependant will be continued until the earlier of the following:

- the date the disability ends; or
- 90 days from the date the insurance terminated.

1.16 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 $2,000, 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. 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.

An eligible excess is any amount in excess of what is required to provide 24 months of coverage under the Local 2041 Acoustic & Drywall Health & Welfare Plan, to a maximum of $2,000 per calendar year.

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 Local 2041 Acoustic & Drywall Health & Welfare Trust Fund 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/.

1.17 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 12 consecutive calendar months for all eligible benefits. You must remain in good standing of the union to participate. The maximum does not apply to eligible members on disability.

1.18 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.

1.19 Subsidy Program for Retired Members

Retired members who have depleted their hour bank accounts and pay out-of-pocket for their benefit coverage are entitled to a monthly premium subsidy of $250.

1.20 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.

1.21 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.

1.22 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. Any weekly indemnity or long-term disability benefits you collect are taxable income and will be reported on the tax form.

2. Weekly Indemnity Benefit

Contractors and their salaried employees, apprentices while in school or retired members who have not returned to work for a participating employer are not eligible for Weekly Indemnity (WI).

2.1 Payment of benefit

The WI benefit is designed to provide financial assistance if you become totally disabled and unable to work due to a non-occupational accident or sickness.

You will be considered totally disabled if, due to your condition, you are unable to perform substantially the whole of the duties of your regular occupation. Payments start after the elimination period, on the first day of disability due to an accident and on the eighth day of disability due to an illness. If you are hospitalized for at least 24 hours before the eighth day of illness, benefits will begin on the first day of hospitalization.

To be considered hospitalized, you must have either:

- been admitted in a hospital overnight as an in-patient;
- been admitted in a hospital as an outpatient and have undergone a surgical intervention; or
- undergone a procedure under general or epidural anaesthesia in a hospital.

You must be under the continuous care of a physician during the disability period. If you have not seen a physician (after your last day of work) on or before the date benefits would otherwise start, they will not start until after your first visit to the physician. The disability period is the period after your last day of work.

2.2 Integration with federal and provincial plans

Weekly indemnity benefits will not be payable after the first week when you are receiving Employment Insurance (EI) sickness benefit. You must show proof of application to and response from EI.

Your benefits will be directly reduced by any payments you are entitled to receive under the Workplace and Safety Insurance Board.

Note: WI benefits will be reduced by any amounts you receive under any automobile insurance plan, where permitted by law.

2.3 Recurrent disability

If your disability recurs after your return to work, it will be considered the same period of disability unless it is separated by:

- two complete consecutive weeks of active full-time work; or
- one full day of work, if the disability is due to completely different causes.

2.4 Subrogation

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

The plan administrator may require you to complete a reimbursement questionnaire and execute a reimbursement agreement. If within 30 days after a request, you do not complete and return the reimbursement agreement, the benefits that you would otherwise be entitled to receive under the WI benefit provision will not be paid until you do so.

2.5 Filing a claim

A claim should be filed within 90 days of the commencement of the disability.

2.5.1 Exclusions

Disability benefits are not payable under the following circumstances:

- self-inflicted injury, war (declared or not), service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- committing, or attempting to commit a criminal offence;
- during a period you are incarcerated for a criminal offence;
- disability due to cosmetic surgery or treatment;
- during a scheduled duration of a leave of absence;
- during a period of scheduled layoff, unless you become disabled
  a) before the notice of layoff is provided; or
  b) more than two months before the date the layoff is scheduled to begin, whether or not the layoff notice was given;
- you are not under the continuing care of a physician;
- for any period you do not participate and co-operate in a reasonable and customary treatment program that is prescribed and performed by a legally licensed physician and is of the nature and frequency for the condition involved. Depending on the severity of the condition, you may be required to be under the care of a specialist. If substance abuse contributes to total disability, the treatment program must include participation in a recognized substance withdrawal program;
- disability resulting from an accident that occurs while operating a motor vehicle when your blood contains more than 80 milligrams of alcohol in 100 millilitres of blood;
- you have been laid off and are not receiving an income from your employer. If you are unemployed, insured for benefits and become disabled during the lay-off period, benefits will not be paid until such time you are recalled to work, providing the elimination period has been satisfied; and
- any period of disability for which you are covered under WSIB or similar legislation.

2.5.2 Appeals

You have the right to appeal any decision made by the plan administrator.

To conform to the deadline for filing proof of loss, your appeal must be submitted to the plan administrator in a timely manner. Since you must justify your position, you will be responsible for any fees that doctors, professionals or organizations may charge for providing this information.

To submit an appeal, you must outline in writing why you believe the plan administrator's decision is incorrect. Be sure to include any medical or other relevant information that has not already been provided. For more information, contact the plan administrator, Ellement.

3. Extended Health Care

3.1 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.

3.2 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, contact Ellement.

3.3 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.

3.4 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*:

3.4.1 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 and nicotine replacement products, to the limits outlined in the *Benefit 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. Smoking cessation therapies, such as hypnotherapy, are not covered
- Fertility drugs and treatment are not covered.
- 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.
- 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.
- 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 *Benefit Summary.*
- Viscosupplementation to the limits outlined in the *Benefit Summary.*
- The Ontario Drug Benefit (ODB) program deductible for seniors and the prescription copayment are reimbursed.

3.4.2 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.

3.4.3 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 *Benefit Summary*, with a reimbursement level of 100%.

For *Dental Care* not relating to an accidental blow to the mouth, see *4. Dental Care* below

3.4.4 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.

3.4.5 Medical Supplies

Charges for the following supplies are covered when provided upon the recommendation or approval of the attending physician, or, if it is legal to do so, by the attending nurse practitioner, osteopath or podiatrist. 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), excluding myoelectric limbs;
- blood transfusions, plasma, radium and radioactive isotope treatments when authorized by the patient's attending physician;
- braces (excluding lumbar supports), hernia belts, casts, 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;
- diabetic devices and supplies, such as:
    - diabetic needles, syringes, test strips, lancets (excluding alcohol swabs and rubbing alcohol), to the limits outlined in the *Benefit Summary*;
    - glucometer/reflectance meter; or 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;

- enuretic devices;
- hearing aids, to the limits outlined in the *Benefit Summary*. Diagnostic services, the services of an audiologist, hearing aid evaluation tests, ear examinations, and maintenance and replacement batteries for hearing aids are not covered;
- hospital bed (standard type, with or without mattresses) and including hospital bed rails, excluding electric hospital beds: *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;
- mobility aids, such as canes, crutches, walkers: *rental or purchase*. Reimbursement for rental fees will not exceed the purchase price.
- non-union bone stimulators;
- 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;*
- radium or cobalt or radioactive isotopes, laboratory tests and X-rays;
- respirator/ventilator (standard type), oxygen and its administration, and apnea monitors: *rental or purchase*. Reimbursement for rental fees will not exceed the purchase price;
- 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*;
- 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 quadriplegia;
- wheelchair (standard type) and wheelchair repairs: *rental or purchase*. Reimbursement for rental fees will not exceed the purchase price;
- Intra-uterine, to the limits outlined in the *Benefit Summary*;
- Out-of-province referral treatment is not covered;
- Wigs (for all medical conditions) are not covered.

3.4.6 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.

3.4.7 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.

3.4.8 Hospital Care

The plan will cover the costs for hospital and palliative care in the province where you live, up to the cost of accommodation listed in the *Benefit Summary.*

A hospital is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons, when approved by the plan administrator.

It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or beds set aside for any of these purposes in a hospital.

Palliative care establishment means any establishment in Canada designated as such by law that provides, under the supervision of a physician, care and treatment to patients, mainly during the terminal phase of their illness, and that provides nursing care 24 hours a day by a registered nurse and maintains daily records of each patient under the care of a physician. An active treatment hospital designated as such by law, extended care facility, rest home, convalescent or rehabilitation centre, home for the aged or the chronically ill, home for the mentally ill, sanatorium, convalescent hospital, or institution for the care and treatment of alcoholism or drug addiction is not considered a palliative care establishment.

3.4.9 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.

3.4.10 Vision Care

Vision care expenses are eligible when recommended 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.

3.4.10.1 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.

The plan will also cover contact lenses that are prescribed because the regular surface of the lens of the eye (the cornea) is impaired in some way and visual acuity cannot be improved to at least a 20/40 level in the better eye with ordinary eyeglasses.

3.4.10.2 Ocular Examinations

Eye examinations, including eye refraction to the limits outlined in the *Benefit Summary*.

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*.

4. 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 on 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 *3.4.3 Dental Expenses due to an Accidental Blow to the Mouth* above.

4.1 Pre-determination of Benefits

Where a course of treatment is expected to cost $300 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.

4.2 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 4.3 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 surgery only;
- 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.

4.3 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 *4.2 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;
- 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; or
    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.

Note: The five-year replacement clause for dentures does not apply to the first claim for a replacement appliance after the effective date of coverage.

4.4 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.

5. 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;
- services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for a correction to temporomandibular joint dysfunction (TMJ);
- 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;
- services not listed as covered expenses.

6. Member Assistance Program (MAP)

The Building Trades MAP is a confidential service to assist members and their dependants 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.2041benefits.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 *8. 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.

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 enroll, please request a Direct Deposit for Claims Reimbursement form by contacting us. (see *8. Contact Us* below for more details)

7.4 Claims Appeal 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:

613-704-3950

1-877-587-3950

844-736-5600

Local2041@ellement.ca

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

Office Address:
1150 Cyrville Road, Suite 220
Ottawa, ON K1J 7S9

To book an appointment, visit the benefits plan website at www.2041benefits.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, Dependent Life, and Long Term Disability Insurance

Active Members

Underwritten by DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY

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

360° | GROUP INSURANCE

Your Group Insurance Plan

THE BOARD OF TRUSTEES OF THE LOCAL 2041 ACOUSTIC & DRYWALL HEALTH &WELFARE TRUST FUND

Policy No. 440280 Active Union Employees
(Does not apply to Contractors or Apprentices)

Proud supporter of:

Heart &Stroke™

Desjardins Insurance
LIFE • HEALTH • RETIREMENT

Your Group Insurance

THE BOARD OF TRUSTEES
OF THE LOCAL 2041
ACOUSTIC & DRYWALL
HEALTH & WELFARE TRUST FUND

Policy No. 440280 number

Active Union Employees

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy. Only the Group Insurance Policy may be used to settle legal matters.

Use of masculine is intended to include both women and men.

Effective date of the revised plan: November 1, 2023

Table of Contents

BENEFIT SCHEDULE

GENERAL GUIDELINES

Participation:	Mandatory
Eligibility Requirements – Not applicable to Retirees	
Eligibility Period:	The first day of the third month following the date the Employee has accumulated 200 hours in his hour bank account. In addition to having the necessary hour bank credits, the Employee must be at work on the date he first becomes eligible or available for work. If not, coverage will begin on the first day of the month following the date he returns to work, or once again becomes available and able to work and have the necessary bank credits. "Hour bank account" means the Employee's account to which Employer contributions based on his hours of work are credited by the Policyholder.
Pay Direct Program:	Refer to the Continuation of Insurance provision

<u>Waiver of Premium</u>

Benefits for which premiums are waived in the event of Total Disability:	Basic Participant Life Insurance Benefit Dependent Life Insurance Benefit Participant Long Term Disability Benefit
Beginning of Waiver of Premium:	The first day of the month following 12 months of continuous Total Disability.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

Amount of Insurance:	* $100,000
Non-Evidence Maximum of Insurability:	$100,000
*** Reduction of Amount:**	On the 65th birthday of the Participant, the amount applicable to the Participant will be reduced by 50%.
Benefit Termination	
Age Limit:	Age 70 of the Participant

DEPENDENT LIFE INSURANCE BENEFIT

Amount of Insurance:	Spouse: $15,000 Each Child: $7,500
Commencement of Newborn Children Insurance:	24 hours after birth
Benefit Termination	
Age Limit:	Age 65 of the Participant

PARTICIPANT LONG TERM DISABILITY BENEFIT

Percentage and Maximum of Benefit:	$1,500
Non-Evidence Maximum of Insurability:	$1,500
Elimination Period:	52 weeks
Maximum Benefit Period	To age 65
Taxability of Benefits:	

Benefit Termination

Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

DEFINITIONS

Wherever used in the policy:

Accident means any event due to sudden and unforeseeable external causes that inflicts bodily injuries that are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.

Actively At Work means, on any day, the performance by the Employee of all the usual and customary duties of his job with the Employer for the scheduled number of hours for that day.

Age means the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

For a Participant domiciled in Quebec, Child means a person who:

is under 21 years of Age, and over whom the Participant or the Spouse of the Participant exercises parental authority or exercised parental authority until he reached the Age of majority; or

has no spouse, is 25 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and over whom the Participant or the Spouse of the Participant would exercise parental authority if he were a minor; or

has reached the Age of majority, has no spouse, and is suffering from a “functional impairment” that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a “person suffering from a functional impairment,” this person must be living with the Participant or the Spouse of the Participant who would exercise parental authority over him as if he were a minor.

It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

For a Participant domiciled in a province other than Quebec, Child means a person who:

is under 21 years of Age, and for whom the Participant or the Spouse of the Participant has legal guardianship or had legal guardianship until he reached the Age of majority; or

has no spouse, is 25 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and for whom the Participant or the Spouse of the Participant would have legal guardianship if he were a minor; or

has reached the Age of majority, has no spouse, and is suffering from a "functional impairment" that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the Participant or the Spouse of the Participant who would have legal guardianship of him as if he were a minor.

It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

Continuing Medical Care means the treatment a Participant receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific Illness or injury.

Dependent means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings means the regular rate of pay of an Employee paid by the Employer, including dividends, but excluding bonuses, overtime pay and any non regular form of remuneration.

Employee means a person who is domiciled in Canada and who is a member in good standing of The United Brotherhood of Carpenters and Joiners of America Local 2041 and employed by an Employer and works the required number of hours to be eligible for coverage.

However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

Employer means any company who is signatory to the Collective Agreement and agrees to make contributions to the Policyholder in respect of the insurance for an Employee covered by such Collective Agreement.

Family-Related Leave means any leave of absence from work taken by a Participant in accordance with such provincial or federal legislation, or an agreement between the Participant and the Employer.
will not be payable after the 1st week of receiving benefits if you are eligible for and receive EI sickness benefits. You must show proof of application to and response from EI. If you become disabled due to a non-occupational illness or sickness, application for EI benefits should be made immediately.

Hospital means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

Illness means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.

Immediate Family means a person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Participant.

Insured Person means the Participant or one of his insured Dependents, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a "health related portion". The "health related portion" of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean delivery). The person is considered to be on Maternity Leave during the entire period for which she is receiving maternity benefits under any provincial or federal legislation. If she is absent from work due to a Total Disability that commenced before or during pregnancy, she is considered to be on Maternity Leave in accordance with any provincial or federal legislation.

Parental Leave means any leave of absence from work taken by a Participant to take care of his newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Participant and the Employer.

Participant means an Employee who is insured under the policy.

Physician means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

Policyholder means the company or group indicated on the application and specified on the cover page of the policy.

Spouse means an eligible person who is domiciled in Canada and who at the time of the event giving rise to a claim:

is legally married to or living in a civil union with the Participant; or

has been living with the Participant in a conjugal relationship for at least 12 months and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship; or

is living in a conjugal relationship with the Participant who is the natural parent of the Spouse's Child and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship.

However, if two individuals fit the definition of Spouse, the Insurer will recognize only one Spouse for all benefits under the same plan in the following order:

the eligible Spouse whom the Participant last designated as such in writing to the Insurer, subject to approval of any evidence of insurability required under the policy; or

the Spouse to whom the Participant is legally married or with whom the Participant is living in a civil union.

At any one time, only one person may be insured as a Spouse of the Participant.

ELIGIBILITY

An Employee is eligible for insurance:

on the EFFECTIVE DATE, if he meets the Eligibility Requirements specified in the Benefit Schedule; or

after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the Benefit Schedule.

If benefits were terminated because the Employee did not have enough credit in his hour bank and did not participate in the Pay Direct Program, his coverage may be reinstated when the Employee accumulates 200 hours of credit in any 12-month period following the termination of benefits. Coverage will become effective after the completion of the Eligibility Period specified in the Benefit Schedule, provided the Employee is a member in good standing of the union.

DEPENDENT ELIGIBILITY

A Participant with a Dependent on the date he becomes eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Participant without Dependents who is insured under the policy will be eligible for Dependent insurance on the date he acquires a Dependent.

INSURANCE APPLICATION

An eligible Participant must complete an application or an application for exemption for himself and for his Dependents, if any, within 31 days of the date on which he becomes eligible.

EVIDENCE OF INSURABILITY

Evidence of insurability means any declaration relating to an individual’s physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF PARTICIPANT INSURANCE

The insurance of any Employee will become effective on the latest of the following dates, provided that Employee is Actively At Work on such date:

the Effective Date of the policy,

the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of his date of eligibility,

If an Employee is not Actively At Work on the date his insurance would have otherwise commenced, such insurance will commence on the first day he is subsequently Actively At Work.

If the Employee is not Actively At Work on the date his insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

If a Participant requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Participant is approved, if later.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Participant will become effective on the latest of the following dates:

the date the insurance of a Participant first becomes effective under the policy,

the date a Participant insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 31 days of the date of such eligibility,

the date the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Participant because his application for insurance is received more than 31 days after the date he became eligible,

the date the insurability of the Dependent is approved by the Insurer, if the application of the Participant for Dependent insurance is made more than 31 days after the Participant first became eligible for such insurance,

The insurance for any individual becoming an eligible Dependent of a Participant insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in the policy.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital.

CHANGE OF INSURANCE

Any increase or decrease in the amount of insurance or any change in Benefit will become effective on the later of the following dates, provided the Participant is Actively At Work on such date:

the date on which the Participant first becomes eligible for such change provided written request for change is received by the Insurer on or before that date,

the date on which the insurability of the Participant is approved by the Insurer,

if the increase in the amount of insurance requested exceeds the maximum amount that the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, or

if the request for change is received more than 31 days after the date of his eligibility for such change.

If a Participant is not Actively At Work on the date his insurance would have otherwise changed, such insurance will change on the first day he is subsequently Actively At Work. However, if the Policyholder and the Insurer agree, the change is effective as if the Participant was Actively at Work.

If the Participant is not Actively At Work on the date his insurance would have otherwise changed, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

WAIVER OF PREMIUM

For the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, premiums will be waived for a Participant who becomes Totally Disabled while insured under the policy but prior to attaining Age 65, if he submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:

the date on which the Participant is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request,

the date on which the Participant ceases to be Totally Disabled,

for the Life Insurance Benefit, the date on which the Participant converts his insurance under the CONVERSION PRIVILEGE provision,

the date on which the Participant attains Age 65 or retires, if earlier,

in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, the date on which each Benefit or the policy terminates except for the Basic Participant Life Insurance Benefit, the Dependent Life Insurance Benefit, the Participant Optional Life Insurance Benefit, the Spouse Optional Life Insurance Benefit, the Dependent Optional Life Insurance Benefit and the Participant Long Term Disability Benefit.

Under the policy, any provision for an increase in coverage is suspended during a Total Disability.

A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.

In the case of the Life Insurance Benefit, if a Totally Disabled Participant dies more than 31 days after his insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule that was in effect at the time his insurance terminated will be payable provided that

the Participant became Totally Disabled while insured under this Benefit,

the Total Disability of the Participant was uninterrupted from the onset of his Total Disability to the date of his death,

the Participant dies within 12 months from the onset of his Total Disability,

the Participant did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated, and

satisfactory proof of the Total Disability and death of the Participant is received by the Insurer within 90 days of his death.

To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Participant becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

TERMINATION OF INSURANCE

TERMINATION OF PARTICIPANT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Participant will terminate on the earliest of the following dates:

the date the Participant no longer qualifies as an Employee, as defined in the policy,

the date the Participant ceases to belong to a class of Participants eligible for insurance,

the date the Participant reaches the applicable Age Limit specified in the Benefit Schedule,

the end of the period for which required premiums were paid on behalf of the Participant,

the date the Participant retires,

the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Participant will terminate on the earliest of the following dates:

the date the insurance of the Participant terminates,

the date the Participant no longer has any Dependents,

the end of the period for which required premiums for Dependent insurance were paid on behalf of the Participant,

the date Dependent insurance under the policy is terminated.

The insurance of any Dependent of a Participant will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Participant ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

Every action or proceeding against the Insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the insurance act or other legislation of the province of residence of the Participant.

BENEFICIARY

This provision removes or restricts the right of the Participant to designate persons to whom or for whose amounts are to be payable for some benefits.

The Insurer will recognize the beneficiary(ies) designated by the Participant under the Employer's group insurance plan immediately prior to the Effective Date of the policy, unless the Insurer requires beneficiary(ies) to be designated again.

Subject to applicable laws, the Participant may designate or revoke, at any time, one or several beneficiaries. Only the benefits that include a benefit payment in the event of the Participant's death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits. The rights of a beneficiary who dies before the Participant revert to the latter. In the absence of a designated beneficiary, the amounts payable are paid according to applicable laws.

The amounts payable when a Dependent dies are paid to the Participant, if alive. If the Participant has died, the amounts are paid according to applicable laws.

The Insurer assumes no responsibility for the validity of any beneficiary designation or revocation.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Participant unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Participant must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Participant or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Participant, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Participant Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Participant's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

DEFINITIONS

As used in this Benefit

Total Disability or Totally Disabled means

during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months,

a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;

after the Elimination Period and the succeeding 24 months have elapsed,

a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

Whether or not any such gainful occupation is available in the area where the Participant resides does not affect his entitlement to disability benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Basic Participant Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Participant Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

LIVING BENEFIT

Subject to the approval of the Insurer, any Participant whose life expectancy is less than 24 months may apply for payment of a portion of the amount of Life Insurance applicable to him, subject to the following conditions:

A Totally Disabled Participant may be required to be examined by a Physician designated by the Insurer;

A Totally Disabled Participant must qualify for approval for the Waiver of Premium under the Basic Participant Life Insurance Benefit of the policy;

Any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the Insurer.

The Living Benefit is equal to 50% of the amount of Life Insurance applicable to the Participant in accordance with the Benefit Schedule. In addition, this amount may not be less than $5,000 or more than $100,000.

At the death of the Participant, the Value of the Living Benefit will be deducted from the amount that would otherwise have been payable under the Basic Participant Life Insurance Benefit.

The Policyholder is responsible for the premium payments for any Participant who has received an advance payment, unless a Waiver of Premium has been granted.

Value of the Living Benefit means the aggregate of the payments made under the Living Benefit, plus the reasonable costs of verifying the medical condition of the Totally Disabled Participant, plus the interest thereon from the date of payment until the date of death of the Totally Disabled Participant.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate will be that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

LIVING BENEFIT EXCLUSION

The Living Benefit will not be payable if there has been any material misrepresentation or non-disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to the Insurer by the recipient of the Living Benefit.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Life Insurance of a Participant aged 65 or younger terminates or is reduced (for any reason other than due to policy termination for Residents of Quebec only), the Participant will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of

the maximum amount applicable in the province of residence of the Participant; or

the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Participant is eligible under another group life insurance at the time of exercising his conversion right.

For Residents of Quebec only, if the Life Insurance of a Participant aged 65 or younger terminates because of the termination of the policy and provided that the Participant was insured under this Benefit for five consecutive years immediately prior to such policy termination, the Participant will be entitled to convert to an individual policy any amount of insurance, up to the higher of $10,000 or 25% of the Participant's amount of insurance, without evidence of insurability. However, such amount of insurance will be reduced by any group life insurance for which the Participant becomes eligible during the 31 days following the termination of the policy.

The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;

The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;

In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. The policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;

The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;

If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;

The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

The amount of Life Insurance for which a Participant who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Participant that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the Insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Participant will be paid to the beneficiary designated by the Participant within 30 days of receipt of satisfactory proof of claim to the Insurer.

DEPENDENT LIFE INSURANCE BENEFIT

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent died while insured under this Benefit, the Insurer will pay the amount of Dependent Life Insurance applicable to such individual in accordance with the Benefit Schedule and other applicable policy provisions.

COMMENCEMENT OF NEWBORN CHILDREN INSURANCE

Insurance for a newborn Child of a Participant with insured Dependents will commence in accordance with the terms specified in the Benefit Schedule and the policy provisions, including those that pertain to the COMMENCEMENT OF DEPENDENT INSURANCE.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

DEPENDENT CONVERSION PRIVILEGE

If the Dependent Life Insurance of a Dependent aged 65 or younger, insured for a minimum amount of $5,000, terminates, the Participant, or the insured Dependent in the event of the death of such Participant, may convert the Dependent Life Insurance to an individual policy, without evidence of insurability, subject to the following conditions:

The written application for conversion must be submitted to the Insurer and the first premium paid within 31 days of the date of termination of the insurance of the Dependent under this Benefit;

The individual policy may be any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times;

The individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Dependent's Age at nearest birthday and the class of risk to which the Dependent belongs;

If the amount of Dependent Life Insurance that may be converted is less than the minimum amount for which the Insurer will normally issue the selected plan, the individual policy must be for the full amount that the Dependent may convert;

The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Dependent under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Dependent dies within 31 days of the termination of his insurance under this Benefit, the amount of Dependent Life Insurance payable will be the amount that the Participant or the Dependent, in the event of the death of such Participant, was eligible to convert.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

PARTICIPANT LONG TERM DISABILITY BENEFIT

DEFINITIONS

As used in this Benefit

Elimination Period means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Long Term Disability Benefits commence under this Benefit.

If a Participant can and does continue his coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described in the policy, and such Participant becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Participant is scheduled to return to active work.

Net Monthly Earnings means the gross monthly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon, or any other contribution to a public income replacement plan.

Maximum Benefit Period means the maximum period during which monthly benefits are payable, as specified in the Benefit Schedule.

Total Disability or Totally Disabled means

during the Elimination Period and the succeeding 24 months,

> a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from working in any occupation;

after the Elimination Period and the succeeding 24 months have elapsed,

> a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.
>
> Whether or not any such gainful occupation is available in the area where the Participant is domiciled does not affect his entitlement to Long Term Disability Benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered Totally Disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any benefit amount of Long Term Disability in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Participant Long Term Disability Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

a Participant became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period; and

the Participant is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy;

the Insurer will pay monthly Long Term Disability Benefits for as long as the Participant is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

The "health related portion" of the Maternity Leave taken by a Participant is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Participant for this period, in accordance with the provisions of the contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Participant is still Totally Disabled and insured under this Benefit:

the end of Elimination Period;

the scheduled date of return to work.

The amount of Long Term Disability Benefit payable will be the amount specified in the Benefit Schedule based on the monthly Earnings in effect immediately prior to the initial date of Total Disability.

Long Term Disability Benefits are payable at the end of each monthly period of Total Disability, commencing on the date the Elimination Period is completed.

The Elimination Period commences on the later of the following dates:

the day after the last day the Participant was Actively At Work, if he consults a Physician within 14 days of the beginning of Total Disability; or

the first day the Participant consults a Physician if he does so more than 14 days after the Total Disability began.

Any payments for a period of less than one month will be at the daily rate of 1/30 of the monthly benefit.

Long Term Disability Benefits may be taxable in accordance with the Benefit Schedule.
Option cost of living

REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS

Direct Offset

Long Term Disability Benefits otherwise payable to the Participant under this Benefit will be reduced by

any benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation; and

any benefit the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan

excluding

benefits payable on behalf of his Dependents;
survivor’s benefits; and

any increase in benefits due solely to cost-of-living, after benefit payments commence; and

any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis;

any disability benefit payable by a private pension plan

Indirect Offset

In addition, the Insurer will further reduce Long Term Disability Benefits by any amount by which the total monthly income of the Participant from all sources exceeds

85% of his gross monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are included in his income under the Income Tax Act (Canada); or

85% of his Net Monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are not included in his income under the Income Tax Act (Canada).

85% of his gross monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are included in his income under the Income Tax Act (Canada); or

85% of his Net Monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are not included in his income under the Income Tax Act (Canada).

any benefits the Participant is eligible to receive under the Canada Pension Plan, but excluding benefits payable on behalf of his Dependents, survivor's benefits and any increase in benefits after benefit payments commence due solely to the cost-of-living;

any disability benefits payable under any Workers' Compensation Act or similar legislation or any other government plan, excluding the Employment Insurance Act;

any disability benefits payable under any other group or association insurance plan;

any disability benefit payable by a private pension plan, excluding any increase in benefits after benefit payments commence due solely to cost of living;

any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

In the event that a lump-sum payment is made under any of the above-mentioned sources in 1) and 2) in lieu of monthly payments, monthly benefits will be reduced by the equivalent monthly payment over a period of 60 months or by the number of months of disability for which the lump sum is paid, whichever is the lesser

The Insurer may also reduce the monthly Long Term Disability payments even if the Participant, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

Limitations

No benefits are payable for a period of Total Disability

during which the Participant is not under Continuing Medical Care, for the Illness or bodily injury causing the Total Disability;

during the voluntary leave portion of the Maternity Leave as described under the DEFINITIONS section, for a total disability occurring during this period;

during a Parental or Family-related Leave taken by a Participant, as provided for under provincial or federal legislation, for Total Disability occurring during this period;

during any work stoppage due to a strike or lock-out, for a Total Disability occurring during this period;

during any period of time during which the Participant is on approved leave of absence including maternity leave of absence. However, if the Participant becomes Totally Disabled due to pregnancy while on maternity leave of absence and his Long Term Disability coverage has been continued in accordance with the Continuation of Insurance provisions of the Termination of Insurance section, the leave will end on the first day the Participant is Totally Disabled. For the purposes of this coverage, the maternity leave of absence will resume when the Participant is no longer Totally Disabled;

during any period of time during which the Participant is laid-off. If the Participant becomes Totally Disabled while he is laid-off, he will be eligible for benefits on the date he is scheduled to return to work. Any such period may be counted towards the Elimination Period;

during the imprisonment of the Participant due to conviction of an offence;

if the Participant remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

No benefits are payable for any period of Total Disability beginning during the first 12 months of coverage of a Participant, if such Total Disability was directly or indirectly the result of an Illness or Accident that was treated by a Physician or for which prescribed drugs were taken during the 3 month period immediately prior to the effective date of such coverage.

However, if the policy has been in force for less than 12 months, and the Participant has been covered under a comparable benefit under the Employer's previous group insurance policy, for any period of time immediately prior to the Effective Date of the policy, that period of time will apply in determination of the 12 month coverage period.

Exclusions

No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following:

war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

committing, or attempting to commit a criminal offence;

cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident that occurred while the Participant was insured under this Benefit;

alcohol or drug abuse unless, for such abuse, the Participant is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;

driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

RECURRENT TOTAL DISABILITY

Successive periods of Total Disability due to the same cause or related causes are considered to be the same period of Total Disability unless they are separated by at least

2 consecutive weeks of active full-time employment during the Elimination Period; or

6 consecutive months of active full-time employment immediately following a period of Total Disability for which Long Term Disability Benefits were paid under this Benefit.

Successive periods of Total Disability due to entirely unrelated causes are considered to be the same period of Total Disability, unless they are separated by at least 1 day of active full-time employment.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

DISABILITY MANAGEMENT

The Insurer may at any time require a Totally Disabled Participant to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

co-ordination of access to health care services;

support program for returning to work;

negotiations for a gradual return to work,

rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Participant, while receiving Long Term Disability Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the Insurer:

the Participant will still be considered Totally Disabled while taking part in this program, subject to a maximum of 24 months;

if, while taking part in this program, a Participant becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Participant as if he had been Totally Disabled during the rehabilitation period;

the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Participant is taking part in an approved disability management program or rehabilitative employment;

if, while taking part in this program, the Participant earns any income, the Long Term Disability Benefits payable by the Insurer to the Participant will be reduced by the amount produced by the following formula:

$$(A - B) \times C$$

A = Income earned from any rehabilitative activity

B = Earnings of the Participant immediately prior to the commencement of Total Disability

C = Benefits otherwise payable under this Benefit

while the Participant is taking part in a disability management program, the Insurer will reduce his Long Term Disability Benefits so that his total income from all sources, if any, as listed in the INDIRECT OFFSET provision of the REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS section of this Benefit, does not exceed 100% of his Net Earnings immediately prior to the commencement of Total Disability if this Benefit is non-taxable, or 100% of his gross Earnings immediately prior to the commencement of Total Disability if this Benefit is taxable.

A Participant who refuses to take part in a disability management program, does not participate in such program in good faith or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for monthly benefits payable under this Benefit.

TERMINATION OF BENEFITS

Long Term Disability Benefits will cease on the earliest of

the date the Participant ceases to be Totally Disabled;

the date the Participant engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;

the date set by the Insurer the participant was required to provide satisfactory proof of total disability or to undergo a medical examination requested by the Insurer, but neglected or refused to do so;

the date payments have been paid up to the Maximum Benefit Period for any one period of Total Disability;

the date the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and

the date the Participant attains the Age Limit specified in the Benefit Schedule.

the date the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and

the date the Participant attains the Age Limit specified in the Benefit Schedule.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant is Totally Disabled on the date his insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Participant were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

NOTICE AND PROOF OF CLAIM

Initial written notice of a claim must be submitted to the Insurer within 30 days of the expiry of the Elimination Period and initial written proof, within 60 days of the expiry of the Elimination Period.

In the event of the recurrence of Total Disability, written notice of a claim must be submitted to the Insurer within 30 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer at its request.

YOU SHOULD KNOW

GENERAL INQUIRIES

To obtain any other information, visit the “Contact us” section of Desjardins Financial Security’s website at www.desjardinslifeinsurance.com.

BENEFICIARY

This provision removes or restricts the right of the Participant to designate persons to whom or for whose amounts are to be payable for some benefits:

Only the benefits that include a benefit payment in the event of the Participant’s death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits.

ACCESS TO THE POLICY

Upon request to Desjardins Financial Security, the Participant may obtain a copy of his application, his insurability report and the policy.

MODIFICATION TO GOVERNMENT PLANS

If the Insurer’s obligations under the policy are increased due to a modification to government plans, the policy continues to apply as if government plans did not change, unless otherwise agreed in writing by the Policyholder and the Insurer.

HOW TO FILE A COMPLAINT

If a Participant is unhappy about something we've said or done, feels they've been wronged or wants us to take corrective action he can file a complaint with the Dispute Resolution Officer at Desjardins Financial Security. The role of the Officer is to evaluate the merit of the decisions and practices of the company when one of its customers believes he has not received the service to which he was entitled.

There are 3 ways to reach the Dispute Resolution Officer

In writing, at the following address:

Dispute Resolution Officer
Desjardins Financial Security
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

By e-mail at: disputeofficer@dfs.ca

By phone at: 1 877 838-8185

For further information on the procedure to follow in case of complaint, or to obtain the complaint form, visit the “Contact us” section of Desjardins Financial Security’s website at www.desjardinslifeinsurance.com.

Our Commitment to Our Plan Members

As one of our valued Plan Members, you are entitled to our attention and respect. We make it a point to be available to provide you with any assistance you may require. You can rely on our knowledgeable team that is committed to settling your claims objectively and diligently, thereby delivering the kind of service you have come to expect.

At Desjardins Insurance, the needs of the Plan Members are at the heart of the organization. Your financial security is vital to us and, as such,
we will provide financial support in the event of illness, an accident or death.

Please accept this brochure which summarizes our financial obligations toward you.

desjardinslifeinsurance.com

Desjardins
Insurance
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Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Appendix B: Basic Member Life, Dependent Life, and Long Term Disability Insurance

Apprentices while in school, Contractors, Retirees and Non-Active Union Employees

Underwritten by DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY

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

360° | GROUP INSURANCE

Your Group Insurance Plan

THE BOARD OF TRUSTEES OF THE LOCAL 2041 ACOUSTIC & DRYWALL HEALTH &WELFARE TRUST FUND

Policy No. 440280

Apprentices while in school, Contractors, Retirees and Non-Active Union Employees

Proud supporter of:

Heart &Stroke™

Desjardins Insurance

LIFE • HEALTH • RETIREMENT

Your Group Insurance

THE BOARD OF TRUSTEES
OF THE LOCAL 2041
ACOUSTIC & DRYWALL
HEALTH & WELFARE TRUST FUND

Policy No. 440280 number

Apprentices while in school, Contractors, Retirees and Non-Active Union Employees

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy. Only the Group Insurance Policy may be used to settle legal matters.

Use of masculine is intended to include both women and men.

Effective date of the revised plan: November 1, 2023

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BENEFIT SCHEDULE

GENERAL GUIDELINES

Participation:	Mandatory
Eligibility Requirements – Not applicable to Retirees	
Eligibility Period:	Apprentices while in school: Nil Contractors: The first day of the month following the approval by the Board of Trustees and once the required premiums have been paid. Non-Active Union Employees: Nil
Pay Direct Program:	Refer to the Continuation of Insurance provision

Waiver of Premium

Benefits for which premiums are waived in the event of Total Disability:	Basic Participant Life Insurance Benefit Dependent Life Insurance Benefit
Beginning of Waiver of Premium:	The first day of the month following 6 months of continuous Total Disability.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

Amount of Insurance:	* $100,000
Non-Evidence Maximum of Insurability:	$100,000
*** Reduction of Amount:**	On the 65th birthday of the Participant, the amount applicable to the Participant will be reduced by 50%.

Benefit Termination

Age Limit:	Age 70 of the Participant.

DEPENDENT LIFE INSURANCE BENEFIT

Amount of Insurance:	Spouse: $15,000 Each Child: $7,500
Commencement of Newborn Children Insurance:	24 hours after birth

Benefit Termination

Age Limit:	Age 65 of the Participant.

DEFINITIONS

Wherever used in the policy:

Accident means any event due to sudden and unforeseeable external causes that inflicts bodily injuries that are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.

Actively At Work means, on any day, the performance by the Employee of all the usual and customary duties of his job with the Employer for the scheduled number of hours for that day.

Age means the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

For a Participant domiciled in Quebec, Child means a person who:

is under 21 years of Age, and over whom the Participant or the Spouse of the Participant exercises parental authority or exercises parental authority until he reached the Age of majority; or

has no spouse, and is, or is deemed to be, a full-time student at at an accredited educational institution, and over whom the Participant or the Spouse of the Participant would exercise parental authority if he were a minor; or

has reached the Age of majority, has no spouse, and is suffering from a “functional impairment” that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a “person suffering from a functional impairment,” this person must be living with the Participant or the Spouse of the Participant who would exercise parental authority over him as if he were a minor.

It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

For a Participant domiciled in a province other than Quebec, Child means a person who:

is under 21 years of Age, and for whom the Participant or the Spouse of the Participant has legal guardianship or had legal guardianship until he reached the Age of majority; or

has no spouse, is 25 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and for whom the Participant or the Spouse of the Participant would have legal guardianship if he were a minor; or

has reached the Age of majority, has no spouse, and is suffering from a "functional impairment" that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the Participant or the Spouse of the Participant who would have legal guardianship of him as if he were a minor.

It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

Continuing Medical Care means the treatment a Participant receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific Illness or injury.

Dependent means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings means the regular rate of pay of an Employee paid by the Employer, including dividends, but excluding bonuses, overtime pay and any non regular form of remuneration.

Employee means a person who is domiciled in Canada and who is a member in good standing of The United Brotherhood of Carpenters and Joiners of America Local 2041 and

an apprentice while in school, or

a contractor who is not a member of The United Brotherhood of Carpenters and Joiners of America Local 2041 and is a salaried employee of a contributing employer who is employed on a full-time basis or a contractor who has entered into a participating agreement with the union, provided such individual has been approved by the Board of Trustees for the Local 2041 Acoustic & Drywall Health and Welfare Plan, or

a salaried employee of The United Brotherhood of Carpenters and Joiners of America Local 2041 who is employed on a full-time basis, or

retired, after having been immediately prior to such retirement, a person specified in 2) or 3) above.

However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

Employer means any company who is signatory to the Collective Agreement and agrees to make contributions to the Policyholder in respect of the insurance for an Employee covered by such Collective Agreement.

Family-Related Leave means any leave of absence from work taken by a Participant in accordance with such provincial or federal legislation, or an agreement between the Participant and the Employer.

Hospital means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

Illness means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.

Immediate Family means a person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Participant.

Insured Person means the Participant or one of his insured Dependents, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a "health related portion". The "health related portion" of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean delivery). The person is considered to be on Maternity Leave during the entire period for which she is receiving maternity benefits under any provincial or federal legislation. If she is absent from work due to a Total Disability that commenced before or during pregnancy, she is considered to be on Maternity Leave in accordance with any provincial or federal legislation.

Parental Leave means any leave of absence from work taken by a Participant to take care of his newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Participant and the Employer.

Participant means an Employee who is insured under the policy.

Physician means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

Policyholder means the company or group indicated on the application and specified on the cover page of the policy.

Spouse means an eligible person who is domiciled in Canada and who at the time of the event giving rise to a claim:

is legally married to or living in a civil union with the Participant; or

has been living with the Participant in a conjugal relationship for at least 12 months and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship; or

is living in a conjugal relationship with the Participant who is the natural parent of the Spouse's Child and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship.

However, if two individuals fit the definition of Spouse, the Insurer will recognize only one Spouse for all benefits under the same plan in the following order:

the eligible Spouse whom the Participant last designated as such in writing to the Insurer, subject to approval of any evidence of insurability required under the policy; or

the Spouse to whom the Participant is legally married or with whom the Participant is living in a civil union.

At any one time, only one person may be insured as a Spouse of the Participant.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

on the EFFECTIVE DATE, if he meets the Eligibility Requirements specified in the Benefit Schedule; or

after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the Benefit Schedule.

If benefits were terminated because the Employee did not have enough credit in his hour bank and did not participate in the Pay Direct Program, his coverage may be reinstated when the Employee accumulates 200 hours of credit in any 12-month period following the termination of benefits. Coverage will become effective after the completion of the Eligibility Period specified in the Benefit Schedule, provided the Employee is a member in good standing of the union.

DEPENDENT ELIGIBILITY

A Participant with a Dependent on the date he becomes eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Participant without Dependents who is insured under the policy will be eligible for Dependent insurance on the date he acquires a Dependent.

INSURANCE APPLICATION

An eligible Participant must complete an application or an application for exemption for himself and for his Dependents, if any, within 31 days of the date on which he becomes eligible.

EVIDENCE OF INSURABILITY

Evidence of insurability means any declaration relating to an individual’s physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF PARTICIPANT INSURANCE

The insurance of any Employee will become effective on the latest of the following dates, provided that Employee is Actively At Work on such date:

the Effective Date of the policy,

the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of his date of eligibility,

If an Employee is not Actively At Work on the date his insurance would have otherwise commenced, such insurance will commence on the first day he is subsequently Actively At Work.

If the Employee is not Actively At Work on the date his insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

If a Participant requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Participant is approved, if later.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Participant will become effective on the latest of the following dates:

the date the insurance of a Participant first becomes effective under the policy,

the date a Participant insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 31 days of the date of such eligibility,

the date the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Participant because his application for insurance is received more than 31 days after the date he became eligible,

the date the insurability of the Dependent is approved by the Insurer, if the application of the Participant for Dependent insurance is made more than 31 days after the Participant first became eligible for such insurance,

The insurance for any individual becoming an eligible Dependent of a Participant insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in the policy.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital.

CHANGE OF INSURANCE

Any increase or decrease in the amount of insurance or any change in Benefit will become effective on the later of the following dates, provided the Participant is Actively At Work on such date:

the date on which the Participant first becomes eligible for such change provided written request for change is received by the Insurer on or before that date,

the date on which the insurability of the Participant is approved by the Insurer,

if the increase in the amount of insurance requested exceeds the maximum amount that the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, or

if the request for change is received more than 31 days after the date of his eligibility for such change.

If a Participant is not Actively At Work on the date his insurance would have otherwise changed, such insurance will change on the first day he is subsequently Actively At Work. However, if the Policyholder and the Insurer agree, the change is effective as if the Participant was Actively at Work.

If the Participant is not Actively At Work on the date his insurance would have otherwise changed, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

WAIVER OF PREMIUM

For the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, premiums will be waived for a Participant who becomes Totally Disabled while insured under the policy but prior to attaining Age 65, if he submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:

the date on which the Participant is unable or unwilling to provide satisfactory proof Total Disability to the Insurer, if such proof is not provided within 3 months of the request,

the date on which the Participant ceases to be Totally Disabled,

for the Life Insurance Benefit, the date on which the Participant converts his insurance under the CONVERSION PRIVILEGE provision,

the date on which the Participant attains Age 65 or retires, if earlier,

in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, the date on which each Benefit or the policy terminates except for the Basic Participant Life Insurance Benefit and the Dependent Life Insurance Benefit

Under the policy, any provision for an increase in coverage is suspended during a Total Disability.

A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.

In the case of the Life Insurance Benefit, if a Totally Disabled Participant dies more than 31 days after his insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule that was in effect at the time his insurance terminated will be payable provided that

the Participant became Totally Disabled while insured under this Benefit,

the Total Disability of the Participant was uninterrupted from the onset of his Total Disability to the date of his death,

the Participant dies within 12 months from the onset of his Total Disability,

the Participant did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated, and

To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Participant becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

TERMINATION OF INSURANCE

TERMINATION OF PARTICIPANT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Participant will terminate on the earliest of the following dates:

the date the Participant no longer qualifies as an Employee, as defined in the policy,

the date the Participant ceases to belong to a class of Participants eligible for insurance,

the date the Participant reaches the applicable Age Limit specified in the Benefit Schedule,

the end of the period for which required premiums were paid on behalf of the Participant,

the date the Participant retires, unless eligible for retirement coverage as specified in the Benefit Schedule,

the date the Participant ceases to be Actively At Work,

the date of termination of the policy.

TERMINATION OF PARTICIPANT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Participant will terminate on the earliest of the following dates:

the date the insurance of the Participant terminates,

the date the Participant no longer has any Dependents,

the end of the period for which required premiums for Dependent insurance were paid on behalf of the Participant,

the date Dependent insurance under the policy is terminated.

The insurance of any Dependent of a Participant will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Participant ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

Every action or proceeding against the Insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the insurance act or other legislation of the province of residence of the Participant.

BENEFICIARY

This provision removes or restricts the right of the Participant to designate persons to whom or for whose amounts are to be payable for some benefits.

The Insurer will recognize the beneficiary(ies) designated by the Participant under the Employer's group insurance plan immediately prior to the Effective Date of the policy, unless the Insurer requires beneficiary(ies) to be designated again.

Subject to applicable laws, the Participant may designate or revoke, at any time, one or several beneficiaries. Only the benefits that include a benefit payment in the event of the Participant's death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits. The rights of a beneficiary who dies before the Participant revert to the latter. In the absence of a designated beneficiary, the amounts payable are paid according to applicable laws.

The amounts payable when a Dependent dies are paid to the Participant, if alive. If the Participant has died, the amounts are paid according to applicable laws.

The Insurer assumes no responsibility for the validity of any beneficiary designation or revocation.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Participant unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Participant must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Participant or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Participant, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Participant Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Participant's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

DEFINITIONS

As used in this Benefit

Total Disability or Totally Disabled means a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

Whether or not any such gainful occupation is available in the area where the Participant resides does not affect this entitlement to disability benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Basic Participant Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Participant Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

LIVING BENEFIT

Subject to the approval of the Insurer, any Participant whose life expectancy is less than 24 months may apply for payment of a portion of the amount of Life Insurance applicable to him, subject to the following conditions:

A Totally Disabled Participant may be required to be examined by a Physician designated by the Insurer;

A Totally Disabled Participant must qualify for approval for the Waiver of Premium under under the Basic Participant Life Insurance Benefit of the policy;

Any individual having an interest in the insurance money must sign a consent to such such payment on a form provided by the Insurer.

The Living Benefit is equal to 50% of the amount of Life Insurance applicable to the Participant in accordance with the Benefit Schedule. In addition, this amount may not be less than $5,000 or more than $100,000.

At the death of the Participant, the Value of the Living Benefit will be deducted from the amount that would otherwise have been payable under the Basic Participant Life Insurance Benefit.

The Policyholder is responsible for the premium payments for any Participant who has received an advance payment, unless a Waiver of Premium has been granted.

Value of the Living Benefit means the aggregate of the payments made under the Living Benefit, plus the reasonable costs of verifying the medical condition of the Totally Disabled Participant, plus the interest thereon from the date of payment until the date of death of the Totally Disabled Participant.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate will be that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

LIVING BENEFIT EXCLUSION

The Living Benefit will not be payable if there has been any material misrepresentation or non-disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to the Insurer by the recipient of the Living Benefit.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Life Insurance of a Participant aged 65 or younger terminates or is reduced (for any reason other than due to policy termination for Residents of Quebec only), the Participant will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of

the maximum amount applicable in the province of residence of the Participant; or

the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Participant is eligible under another group life insurance at the time of exercising his conversion right.

For Residents of Quebec only, if the Life Insurance of a Participant aged 65 or younger terminates because of the termination of the policy and provided that the Participant was insured under this Benefit for five consecutive years immediately prior to such policy termination, the Participant will be entitled to convert to an individual policy any amount of insurance, up to the higher of $10,000 or 25% of the Participant's amount of insurance, without evidence of insurability. However, such amount of insurance will be reduced by any group life insurance for which the Participant becomes eligible during the 31 days following the termination of the policy.

The individual policy selected in accordance with the above will be subject to the following conditions:

The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;

The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;

In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. The policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;

The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;

If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;

The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

The amount of Life Insurance for which a Participant who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Participant that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the Insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Participant will be paid to the beneficiary designated by the Participant within 30 days of receipt of satisfactory proof of claim to the Insurer.

DEPENDENT LIFE INSURANCE BENEFIT

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent died while insured under this Benefit, the Insurer will pay the amount of Dependent Life Insurance applicable to such individual in accordance with the Benefit Schedule and other applicable policy provisions.

COMMENCEMENT OF NEWBORN CHILDREN INSURANCE

Insurance for a newborn Child of a Participant with insured Dependents will commence in accordance with the terms specified in the Benefit Schedule and the policy provisions, including those that pertain to the COMMENCEMENT OF DEPENDENT INSURANCE.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

DEPENDENT CONVERSION PRIVILEGE

If the Dependent Life Insurance of a Dependent aged 65 or younger, insured for a minimum amount of $5,000, terminates, the Participant, or the insured Dependent in the event of the death of such Participant, may convert the Dependent Life Insurance to an individual policy, without evidence of insurability, subject to the following conditions:

The written application for conversion must be submitted to the Insurer and the first premium paid within 31 days of the date of termination of the insurance of the Dependent under this Benefit;

The individual policy may be any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times;

The individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Dependent's Age at nearest birthday and the class of risk to which the Dependent belongs;

If the amount of Dependent Life Insurance that may be converted is less than the minimum amount for which the Insurer will normally issue the selected plan, the individual policy must be for the full amount that the Dependent may convert;

The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Dependent under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Dependent dies within 31 days of the termination of his insurance under this Benefit, the amount of Dependent Life Insurance payable will be the amount that the Participant or the Dependent, in the event of the death of such Participant, was eligible to convert.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

YOU SHOULD KNOW

GENERAL INQUIRIES

To obtain any other information, visit the “Contact us” section of Desjardins Financial Security’s website at www.desjardinslifeinsurance.com.

BENEFICIARY

This provision removes or restricts the right of the Participant to designate persons to whom or for whose amounts are to be payable for some benefits:

Only the benefits that include a benefit payment in the event of the Participant’s death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits.

ACCESS TO THE POLICY

Upon request to Desjardins Financial Security, the Participant may obtain a copy of his application, his insurability report and the policy.

MODIFICATION TO GOVERNMENT PLANS

If the Insurer’s obligations under the policy are increased due to a modification to government plans, the policy continues to apply as if government plans did not change, unless otherwise agreed in writing by the Policyholder and the Insurer.

HOW TO FILE A COMPLAINT

If a Participant is unhappy about something we've said or done, feels they've been wronged or wants us to take corrective action he can file a complaint with the Dispute Resolution Officer at Desjardins Financial Security. The role of the Officer is to evaluate the merit of the decisions and practices of the company when one of its customers believes he has not received the service to which he was entitled.

There are 3 ways to reach the Dispute Resolution Officer

In writing, at the following address:

Dispute Resolution Officer
Desjardins Financial Security
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

By e-mail at: disputeofficer@dfs.ca

By phone at: 1 877 838-8185

For further information on the procedure to follow in case of complaint, or to obtain the complaint form, visit the “Contact us” section of Desjardins Financial Security’s website at www.desjardinslifeinsurance.com.

Our Commitment to Our Plan Members

As one of our valued Plan Members, you are entitled to our attention and respect. We make it a point to be available to provide you with any assistance you may require. You can rely on our knowledgeable team that is committed to settling your claims objectively and diligently, thereby delivering the kind of service you have come to expect.

At Desjardins Insurance, the needs of the Plan Members are at the heart of the organization. Your financial security is vital to us and, as such,
we will provide financial support in the event of illness, an accident or death.

Please accept this brochure which summarizes our financial obligations toward you.

desjardinslifeinsurance.com

Desjardins
Insurance
LIFE• HEALTH • RETIREMENT

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Appendix C: Accidental Death and Dismemberment Insurance

Underwritten by CHUBB LIFE INSURANCE COMPANY

Contact **Ellement Consulting Group**, your benefit administrator for any and all questions related to Accidental Death and Dismemberment Insurance.

CHUBB

Basic Accidental Death & Dismemberment Insurance

For the eligible members of:
Local 2041 Acoustic and Drywall Health and Welfare Trust Fund

Policy Number:
AB10588001

Underwritten by:
Chubb Life Insurance Company of Canada

Effective Date:
10/01/2023

This brochure has been prepared in connection with a group plan underwritten by Chubb Life Insurance Company of Canada (“Chubb Life”). For ease of reference it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult your Employer.

COVERAGE

The plan offers you full 24-hourprotection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

ELIGIBILITY

All eligible members of the policyholder under age 70.

BENEFIT AMOUNT

Flat amount of $100,000

Benefit reduces by 50% at age 65 and terminates at age 70 or earlier retirement.

In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

Benefits payable under the following section will be limited to only one policy in the event the benefits are contained in two or more policies issued to the Policyholder by Chubb Life (not applicable to the Schedule of Losses, Exposure and Disappearance, Conversion)

SCHEDULE OF LOSSES

Accidental Death & Dismemberment

If such injuries shall result in anyone of the following specific losses within one year from the date of the accident, Chubb Life will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

	Percentage of Benefit Amount
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	75%
Loss of Use of one Hand or One Foot	75%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	75%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs),and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

All benefits that are payable at 200% of the Principal Sum are subject to an all policies combined maximum benefit amount of $1,000,000.

Repatriation Benefit

When injuries result in loss of life of an Insured Person outside 50 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an Insured Employee provided:

a. such training is required because of such injuries and in order for an Insured Employee to become qualified to engage in an occupation in which he or she
b. would not have been engaged except for such injuries;
c. expenses are to be incurred within two years from the date of the accident; no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

When injuries result in an Insured Person confinement as an in-patient in a hospital outside 50 kilometers from an Insured Person's city of permanent residence or outside Canada and requires personal attendance of a "Family Member" as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to an Insured Person, while confined, but not to exceed $15,000.

"Immediate Family Member" means the spouse, legal or common-law, parent, and grandparent, child over age 18, brother or sister of the Insured Person

Spousal Occupational Training Benefit

When injuries result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Spousal Occupational Training Benefit

When injuries result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation trainingprogram for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory,

Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to an Insured Person's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by an Insured Person to make the vehicle accessible or operable for an Insured Person.

The maximum payable under both items 1 and 2 shall be 10% of an Insured Person's Principal Sum amount to a maximum of $50,000.

Day Care Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of an Insured Person's Principal Sum amount or a maximum of $5,000 per year, on behalf of any dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for four consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

"Dependent Child or Dependent Children" means the Insured Person's eligible unmarried natural, legitimate, illegitimate, adopted, step child, or common law child who is principally dependent on the Insured Person or the Insured Person's spouse for financial support

Continuance of Coverage

In the case of a Primary Insured who is (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, or (3) on leave of absence, coverage shall be extended for a period of 12 months following the beginning of any such event subject to payment of premiums.

In the case of a Primary Insured who is on maternity or parental leave coverage shall be extended for a period of up to 18 months following the beginning of any such event subject to payment of premiums.

If an Insured assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Seat Belt Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, an Insured Person Principal Sum amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, an Insured Person was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile.
"Seat Belt" means those belts that form a restraint system.

Special Education Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured Person's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

Conversion Privilege

On the date of termination of employment or during the 31-dayperiod following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DEATH and DISMEMBERMENT only insurance policy of Chubb Life. The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time.

Waiver of Premium

If an Insured Employee, under age 65, becomes totally disabled for twelve consecutive months and an Insured Employee provides evidence of total disability satisfactory to Chubb Life Insurance, Chubb Life Insurance will then waive the payment of each premium which falls due with respect to an Insured Employee and any Insured Dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Employee until age 65 or earlier termination of the policy. If an Insured Employee ceases to be disabled and an Insured Employee returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to an Insured Employee may be continued upon resumption of premium payments by an Insured Employee or the Policyholder. If after 120 days, an Insured Employee receives approval of any long term disability claim provided under a policy of group insurance through the Policyholder, Chubb Life will then waive the payment of each Accidental Death and Dismemberment insurance premium subject to the terms stated above.

Recurrent Disabilities

When an Insured Employee becomes totally disabled again from the same or related causes within six months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and Chubb Life will waive the six month qualification period.

If the same disability recurs more than six months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one day.

Termination of Waiver of Premium

Waiver of Premiums will cease on the earliest of:

a) the date the Insured Person ceases to meet this policy's definition of Totally Disabled;
b) the date the Insured Person does not supply the Company with appropriate medical evidence as deemed necessary by the Company;
c) the date the Insured Person is no longer receiving regular, ongoing care and treatment of a Physician appropriate for the disabling condition, as determined by the Company;
d) the date the Insured Person does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by the Company;
e) the date the Insured Person turns 65;
f) the date the policy terminates; or (applicable to Accidental Death and Dismemberment Insurance and Critical Illness Insurance only)
g) the date the Insured Person dies.

Coverage During Waiver of Premium

While premiums are being waived, Basic Accidental Death and Dismemberment Insurance under the policy on an Insured Employee will continue to be in force.

The amount of such insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

"Totally Disabled or Total Disability" with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Person's regular occupation for six consecutive months.

In-Hospital Confinement Monthly Income

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and an Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, Chubb Life will pay for each full month, 1% of an Insured Person's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses;(3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Identification Benefit

In the event accidental loss of life is sustained by an Insured Person not less than 150 kilometers from an Insured Person's normal place of residence and identification of the body by a "Family Member" has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

a) transportation by the most direct route to the city or town where the body is located; and
b) hotel accommodation in such city or town, subject to a maximum duration of three days.

The reimbursement of such expenses incurred is subject to the accidental Loss of Life Benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

Bereavement Benefit

When injuries covered by the policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured Person for up to six sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $5,000.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

Cosmetic Disfigurement

If an Insured Person suffers a third degree burn due to an accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table, subject to a maximum benefit payable of $25,000:

Body Part	% of Principal Sum Payable
Face, Neck, Head	100%
Hand& Forearm	25%
Either Upper Arm	15%
Torso (Front or Back)	35%
Either Thigh	10%
Either Lower Leg (below knee)	25%

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Funeral Benefit

When injuries covered by this policy result in loss of life of an Insured Person within 365 days from the date of the accident, the Company will pay the actual expense incurred for preparing the deceased for burial or cremation, but shall not exceed the maximum amount of $5,000.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded an Insured Person.

If the body of an Insured Person has not been found within one year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured Person was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured Person suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

EXCLUSIONS

The plan does not cover any loss, which is the result of:

a. Intentionally self-inflicted injury, suicide or any attempt thereat;
b. Declared or undeclared war, or any act of war, terrorism, riot or insurrection, or service in the armed forces of any country, government or international organization;
c. Travel or flying in an aircraft owned or leased by the Policyholder, an Insured or a member of an Insured's household, or aircraft being used for any test or experimental purpose, firefighting, powerline inspection, pipeline inspection, aerial photography or exploration;

d. Losses occurring while the Insured is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by the Company pro-rata for any such period of full-time active duty.
e. This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims. All other terms and conditions of the policy remain unchanged.

HOW TO CLAIM

In the event of a claim, claim forms can be obtained from the Plan Administrator.

Notice of claim must be given to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

In no event, will Chubb Life accept notice of claim beyond one year.

GENERAL PROVISIONS

Beneficiary

An employee or any spouse has the right to name a beneficiary when he applies for insurance. It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

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

An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act, Limitations Act, 2002 or other applicable legislation in the Insured's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.
The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations. In no event, will Chubb Life accept notice of claim beyond one year.

08/18

CHUBB

Chubb Life is part of the Chubb group of insurance companies, with operations in 54 countries, Chubb provides commercial and personal propertyand casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients.

Chubb Limited,the parent companyof Chubb Life,is listed on the New York Stock Exchange (NYSE:CB) and is a component of the S&P 500 index.

Appendix D: Out of Province/Canada Medical Emergency Insurance

Underwritten by Zurich Insurance Company Ltd

SECTION I – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

ELIGIBILITY AND CLASSIFICATION OF **INSUREDS:**

The following individuals are eligible to become **Insureds** upon the submission of completed enrollment material, if required:

Class I: All **Active** members of the Policyholder under the age of 75.

Class II: All eligible **Retired Members** under the age 85.

Class III: All **Active** members of the Policyholder between age 75 and 85.

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, and he or she is covered under more than one class, **We** will pay only one benefit, the largest benefit.

SECTION II – SCHEDULE

COVERAGE (S):	COVERAGES(S):
EMERGENCY MEDICAL INSURANCE BENEFITS	All
TRIP CANCELLATION & INTERRUPTION	All

EMERGENCY MEDICAL TRAVEL COVERAGE SUMMARY

The information below summarizes your Emergency Medical Travel Insurance coverage. It contains important information with respect to certain eligibility and benefit limits that apply to your coverage, but it does not reference all of the terms, conditions, limitations, and exclusions. Please refer to the policy for complete details. All amounts indicated are in Canadian currency, unless otherwise stated.

Policyholder Name	**Local 2041 Acoustic & Drywall Health and Welfare Trust Fund**
Policy Number	8621994
Description of Classes	**Class I:** All Active members of the Policyholder under age 75. **Class II:** All Eligible Retired Members under age 85 **Class III:** All Active members of the Policyholder between age 75 and 85
Termination	**Class I**: Terminates at the earlier of the Members attainment of 75 years of age or retirement. **Class II:** Terminates at the attainment of age 85 **Class III:** Terminates at the earlier of the Members attainment of 85 years of age or retirement
Covered Trip Duration	**Class I, 2&3:** Up to maximum 60 days per trip
Pre-existing Medical Condition Stability Period	90 days
Emergency Medical Treatment	$5,000,000 **Age at Date of Loss** **Principal Sum** 70-74 $2,000,000 75-84 $ 500,000
Hospital Allowance	$50 per day to a maximum of $500
Paramedical Services	$500 per practitioner for up to 180 days
Ground Ambulance	Maximum $10,000
Emergency Dental Treatment	(1) $2,000 (2) $500
Medical Evacuation	Maximum $50,000
Bedside Companion	Round-trip economy airfare & up to $15,000 for meals and accommodation
Meals and Accommodation	$200 per day to a maximum of $2,000
Repatriation of Remains	(1) $15,000 (2) $5,000
Return of Dependent Child(ren)	One way economy airfare up to a maximum of $5,000
Childcare	$75 per day to a maximum of $500
Return of Travelling Companion / Business Colleague	One-way economy airfare up to a maximum of $5,000
Vehicle Return	$4,000
Dispatch of a Physician or Specialist Benefit	$50,000
Trip Cancellation and Trip Interruption	$2,000

EMERGENCY MEDICAL TRAVEL COVERAGE SUMMARY

SECTION 1 – INTRODUCTION

Emergency Medical Insurance covers the Reasonable and Customary Charges incurred as a result of Treatment required by an Insured during a Covered Trip due to a Medical Emergency that begins after a Covered Person leaves their province or territory of residence that are in excess of or not covered under their Government Health Insurance Plan or by any other insurance or benefit Plan under which they are covered.
The most We will pay for all benefits combined under this subsection Emergency Medical Insurance Benefit, for each Covered Person for each Covered Trip, is limited to:

(1) the amount shown in the Schedule if the Within Canada Plan is purchased and shown as "Included" therein;
(2) the amount shown in the Schedule if the Outside of Canada Plan is purchased and shown as "Included" therein; or
(3) the amount shown in the Schedule if both the Outside of Canada Plan and Within Canada Plan is purchased and shown as "Included" therein.

Subject to the Aggregate Limit of Liability and only if Coverage for the applicable benefit is shown as "Included" in the Schedule, benefits are payable.

SECTION 2 – ELIGIBILITY

ELIGIBILITY AND CLASSIFICATION OF INSUREDS:

The following individuals are eligible to become Insureds upon completion and submission of completed enrollment material, if required:

Class I: All Active members of the Policyholder under age 75.
Class II: All Eligible Retired Members under age 85.
Class III: All Active members of the Policyholder between age 75 and 85.

If a Covered Person suffers an Injury resulting in a Covered Loss, and they are covered under more than one class, We will pay only one benefit, the largest benefit.

ELIGIBILITY OF AN INSURED'S DEPENDENTS:

Individuals who enroll may elect to cover their eligible Dependents. An eligible Dependent includes the Insured's legally married Spouse/Domestic Partner and the Insured's Dependent Child(ren), and their legally married Spouse's Dependent Child(ren), and their Domestic Partner's Dependent Child(ren). A legally married Spouse/Domestic Partner will not be eligible as a Dependent if they are also an Insured under this Policy. If the Insured and their legally married Spouse/Domestic Partner, legally separated Spouse/Domestic Partner], former Spouse/Domestic Partner are both Insureds under this Policy, only one may select a Plan covering their mutual Dependents.

SECTION 3 – COVERAGE

1. EMERGENCY MEDICAL INSURANCE BENEFIT

Expenses for Emergency Medical Treatment – Within Canada Plan

For any Covered Loss occurring within Canada, the maximum amount for all Coverages combined under this benefit is limited to the amount shown in the Schedule for each Covered Person, for each Covered Trip. This Policy covers Reasonable and Customary Charges for:

(1) Medical care and procedures received from a Physician in or out of the Hospital;
(2) The cost of a semi-private Hospital room (or an intensive or coronary care unit if medically necessary);
(3) The services of a licensed private duty nurse in a Hospital;
(4) The rental or purchase (whichever is less) of a Hospital bed, wheelchair, brace, crutch or other medical appliance;
(5) Tests that are needed to diagnose or find out more about a condition; and
(6) Drugs that are prescribed and are available only by prescription from a Physician or a licensed dentist.

There is no Coverage for loss occurring outside of Canada under this section.

Expenses for Emergency Medical Treatment – Outside of Canada Plan

For any Covered Loss occurring outside of Canada:

(1) The maximum amount for all Coverages combined under this benefit is limited to the amount shown in the Schedule for each Covered Person, for each Covered Trip; and
(2) All medical procedures or tests, including but not limited to MRI, MRCP, CAT Scan, CT Angiogram, Nuclear Stress Test, Angiogram or Cardiac Catheterization or any surgery, must be authorized in advance by Zurich Travel Assist.

This Policy covers Reasonable and Customary Charges for:

(a) medical care and procedures received from a Physician in or out of the Hospital;
(b) the cost of a semi-private Hospital room (or an intensive or coronary care unit if medically necessary);
(c) the services of a licensed private duty nurse in a Hospital;
(d) the rental or purchase (whichever is less) of a Hospital bed, wheelchair, brace, crutch or other medical appliance;
(e) tests that are needed to diagnose or find out more about the Covered Person's condition; and
(f) drugs that are prescribed for the Covered Person and are available only by prescription from a Physician or a licensed dentist.

There is no Coverage for loss occurring within Canada under this section.

Hospital Allowance

This Policy covers expenses up to the daily and maximum limit shown in the Schedule, for a Covered Person's incidental Hospital expenses (telephone calls, television rental) while a Covered Person is Hospitalized for at least 48 consecutive hours.

Expenses for Paramedical Services

This Policy covers expenses for Treatment due to a Medical Emergency by a licensed physiotherapist, chiropractor, chiropodist or podiatrist up to the maximum limit per practitioner shown in the Schedule, for up to 180 days after the Medical Emergency.

Expenses for Ground Ambulance

This Policy covers Reasonable and Customary Charges for local licensed ambulance service to transport a Covered Person to the nearest Hospital or appropriate medical service provider in a Medical Emergency. This includes local taxi or ride sharing service (such as Uber) fare in lieu of local ground ambulance service where an ambulance is medically required but not available.

Expenses for Emergency Dental Treatment – Within & Outside of Canada

For any Covered Loss occurring within Canada:

(1) If a Covered Person suffers an Accidental blow to the mouth, this Policy covers up to the maximum limit shown in the Schedule during their Covered Trip for the Reasonable and Customary Charges to repair or replace their natural or permanently attached artificial teeth; and
(2) If a Covered Person needs emergency dental Treatment, this Policy covers up to the maximum limit shown in the Schedule for the relief of dental pain received from a licensed dentist.

There is no Coverage for loss occurring outside of Canada under this section.

Medical Evacuation Expenses to Return to Province or Territory of Residence

If a Covered Person's treating Physician recommends in writing that they return to their province or territory of residence because of their Medical Condition or if Zurich Travel Assist's medical advisors recommend that they return to their province or territory of residence following a Medical Emergency, this Policy covers one or more of the following:

(1) The extra cost of economy class airfare via the most cost-effective itinerary;
(2) A stretcher airfare on a commercial flight via the most cost-effective itinerary, if a stretcher is medically necessary;
(3) The cost of return economy class airfare via the most cost-effective itinerary for a qualified medical attendant to accompany the Covered Person, and the attendant's reasonable fees and expenses, if this is medically necessary or required by the airline; and
(4) The cost of air ambulance transportation if this is medically necessary.

This benefit must be pre-authorized and arranged by Zurich Travel Assist.

Expenses to Bring Someone to a Covered Person's Bedside

If a Covered Person is travelling alone and is Hospitalized for three days or more during their Covered Trip because of a Medical Emergency, and a bedside companion is required, this Policy covers:

(1) The cost of the return economy class airfare via the most cost-effective itinerary for someone to be with a Covered Person;
(2) Up to the maximum limit shown in the Schedule for a Covered Person's bedside companion's accommodation and meals; and
(3) Emergency Medical Insurance for their bedside companion under the same terms and limitations of this Policy until a Covered Person is medically fit to return to their province or territory of residence.

This benefit must be pre-authorized and arranged by Zurich Travel Assist.

Expenses for Meals and Accommodation

EMERGENCY MEDICAL TRAVEL COVERAGE SUMMARY

If a Medical Emergency prevents a Covered Person or their Travel Companion / Business Colleague from returning to their province or territory of residence as originally planned, or if their covered emergency medical Treatment or that of their Travel Companion / Business Colleague requires their transfer to a location that is different from the original destination, this Policy will reimburse a Covered Person up to the per day and maximum limit shown in the Schedule for their total cost of meals, hotel and taxi or ride sharing service (such as Uber) fares.

This benefit must be pre-authorized and arranged by Zurich Travel Assist.

Expenses Related to Repatriation of Remains

If, during a Covered Trip, a Covered Person dies from a Medical Emergency covered under this Policy:

(1) This Policy covers up to the maximum limit shown in the Schedule to:
   (a) have their body prepared where they die and the cost of the standard transportation container normally used by the Common Carrier, plus the return of their body to their province or territory of residence;
   (b) have their body prepared and the cost of a standard burial container, plus up to $5,000 for their burial where death occurs; or
   (c) cremate their body where they die, plus the return of their ashes to their province or territory of residence; and

(2) If someone is legally required to identify the Covered Person's body and must travel to the place of death, this Policy will pay the return economy class airfare via the most cost-effective itinerary for that person and up to the maximum limit shown in the Schedule for that person's hotel and meal expenses. We will also provide that person with Emergency Medical Insurance under the same terms and limitations of this Policy for up to 72 hours.

Expenses to Return Travel Companion / Business Colleague

This Policy covers the extra cost of one-way economy class airfare via the most cost-effective itinerary, to return their Travel Companion / Business Colleague (who is travelling with the Covered Person at the time of their Medical Emergency and who is Insured under a travel insurance Plan issued by Us) to their province or territory of residence, if the Covered Person returns to their province or territory of residence under Medical Evacuation Expenses to return them to their province or territory of residence above or are repatriated under Expenses Related to Repatriation of Remains above.

This benefit must be pre-authorized and arranged by Zurich Travel Assist.

Expenses to Return Vehicle

If, because of a Medical Emergency, the Covered Person is unable to drive the Vehicle they Used during their Covered Trip to its point of origin, this Policy covers up to the maximum limit shown in the Schedule charged by a commercial agency to return their Vehicle to their province or territory of residence. If the Covered Person rented a Vehicle during their Covered Trip, this Policy covers its return to the commercial rental agency.

This benefit must be pre-authorized and arranged by Zurich Travel Assist.

Dispatch of a Physician or Specialist Benefit

If a Covered Person is Injured or ill on a Covered Trip and, based on the information available, We or Our Assistance Provider cannot adequately assess whether or not medical care can be provided in accordance with Western Medical Standards and/or medical evacuation, medical repatriation, transportation and/or services are necessary, We or Our Assistance Provider will arrange for, and cover the cost of, a Physician's or specialist's travel to the Covered Person's location. We or Our Assistance Provider must pre-authorize such costs for this Dispatch of a Physician or Specialist Benefit to be payable.

2. TRIP CANCELLATION AND INTERRUPTION INSURANCE BENEFIT

The most We will pay for all benefits combined under this subsection Trip Cancellation and Interruption Insurance Benefit, for each Covered Person, for each Covered Trip, is limited to the amount shown in the Schedule.

Subject to the Aggregate Limit of Liability and only if Coverage for the applicable benefit is shown as "Included" in the Schedule, benefits are payable if any of the following happen:

Trip Cancellation (Before Departure)

If the Covered Person is unable to travel due to an applicable covered cause listed below in Trip Cancellation and Interruption which occurs before their Departure Date, this Policy covers the prepaid unused portion of their Covered Trip that is non-refundable and non-transferable to another travel date up to the maximum limit shown in the Schedule. In addition, if the Covered Person's Travel Companion / Business Colleague must cancel their trip due to a Trip Cancellation and Interruption covered cause applicable to them, and the Covered Person decides to go on their Covered Trip as planned, this Policy covers the cost of the next occupancy charge up to the maximum limit shown in the Schedule.

Trip Interruption (After Departure)

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If the Covered Person's Covered Trip is interrupted due to an applicable covered cause listed below in Trip Cancellation and Interruption which occurs on or after the Departure Date of this Policy, up to the maximum limit shown in the Schedule:

(1) The amount of unused travel arrangements paid for prior to their Departure Date up to the maximum covered amount that is non-refundable and non-transferable to another travel date, less the prepaid unused return transportation;
(2) The Covered Person's additional and unplanned hotel and meal expenses and their essential phone calls and taxi or ride sharing service (such as Uber) fares, to a maximum of $300 per day for up to two days when no earlier transportation arrangements are available; and/or
(3) The Covered Person's one-way economy class airfare via the most cost-effective itinerary to their next destination, or to return them to their province or territory of residence. We will pay the change fee charged by the airline for their missed connection if this option is available or up to $1,000 for the cost of their one-way economy airfare to the next destination.

SECTION 4 – EMERGENCY MEDICAL EXCLUSIONS

This Policy does not pay for any Treatment, service, expense or benefit arising from, caused by, contributing to, relating to, or resulting from, whether directly or indirectly, any one or more of the following:

(a) Pre-existing Condition that is not Stable at least ninety (90) days before the Covered Person's Effective Date; and/or
  (1) The Covered Person's heart condition if, within the ninety (90) days before their Effective Date, any heart condition has not been Stable or they have taken any form of nitroglycerine for the relief of angina pain; and/or
  (2) The Covered Person's lung condition if, within the ninety (90) days before their Effective Date, any lung condition has not been Stable or they required Treatment of Prednisone for a lung condition.
(b) Expenses that exceed the Reasonable and Customary Charges where the Medical Emergency happens.
(c) Expenses that exceed 80% of the cost We would normally have paid under this Policy if the Covered Person does not, or someone on their behalf does not, contact Zurich Travel Assist at the time of the Medical Emergency.

(d) Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans sonograms, ultrasounds or biopsies, cardiac catheterization, angioplasty and/or cardiovascular surgery including any associated diagnostic test or charge unless approved in advance by Zurich Travel Assist prior to being performed. All surgery must be authorized by Zurich Travel Assist prior to being performed except in extreme circumstances where a request for prior approval would delay surgery needed in a life-threatening medical crisis.
(e) Any non-emergency, investigative or elective Treatment such as cosmetic surgery, chronic care, rehabilitation, or any directly or indirectly related complications.
(f) The continued Treatment of a Medical Condition when the Covered Person has already received Treatment for that Medical Condition during their Covered Trip and Zurich Travel Assist's medical advisors or Our medical advisors determine that their Medical Emergency has ended.
(g) A Medical Condition that meets any of the following criteria:
  (1) When the Covered Person knew, or for which it was reasonable to expect before they left their province or territory of residence, or before the Effective Date of Coverage, that they would need or be required to seek Treatment for that Medical Condition.
  (2) A Medical Condition for which future investigation or Treatment was planned before the Covered Person left their province or territory of residence.
  (3) A Medical Condition that produced symptoms that would have caused an ordinarily prudent person to seek Treatment in the three months before the Covered Person left their province or territory of residence.
  (4) A Medical Condition that had caused the Covered Person's Physician to advise them not to travel.
  (5) A Medical Condition that is the result of their not following Treatment as prescribed to the Covered Person, including prescribed medication, Treatments and therapy.
(h) A Medical Emergency resulting from: mountain climbing requiring the Use of specialized equipment, including carabineers, crampons, pick axes, anchors, bolts and lead-rope or top-rope anchoring equipment to ascend or descend a mountain; rock-climbing; parachuting, skydiving, hang-gliding or Using any other air-supported sporting device; participating in a motorized speed contest; or the Covered Person's professional participation in a sport, snorkeling or scuba-diving when that sport, snorkeling or scuba-diving is the Covered Person's principal paid occupation.
(i) If the Covered Person specifically purchased this Policy to obtain such Treatment or services, whether or not it was authorized by a Physician.
(j) Committing, or the Covered Person direct or indirect attempt to commit, a criminal act.
(k) Intoxication, the misuse, abuse, overdose of, or chemical dependence on medication, drugs, alcohol or other intoxicant.
(l) (1) the Covered Person's routine prenatal care; (2) the Covered Person's pregnancy or childbirth or complications thereof when they happen in the nine weeks before or after the expected date of delivery; (3) the Covered Person's child born during their Covered Trip, or Coverage for such child.
(m) For Insured children under two years of age, any Medical Condition related to a birth defect.
(n) Any benefit that must be authorized or arranged in advance by Zurich Travel Assist when it has given no authorization or made no arrangement for that benefit.

(o) Any Medical Emergency that occurs or recurs after Our medical advisors recommend that the Covered Person returns to their province or territory of residence following Treatment, and they choose not to.
(p) Death or Injury sustained while piloting an aircraft, learning to pilot an aircraft, or acting as a member of an aircraft crew.
(q) For Policy extensions or top ups: any Medical Condition that first appeared, was diagnosed or treated after the scheduled Departure Date and prior to the Effective Date of the insurance extension or top up.
(r) Any loss or any Medical Condition the Covered Person suffers or contracts in a specific country, region or city when a Government of Canada Travel Advisory, issued before their Effective Date, advises Canadians to avoid all or all nonessential travel to that specific country, region or city. In this Exclusion, "Medical Condition" is limited, related or due to the reason for the Travel Advisory.
If the Travel Advisory is issued after the Covered Person's Departure Date, their Coverage under this Emergency Medical Insurance Benefit in that specific country, region or city will be limited to a period of ten days from the date the Travel Advisory was issued, or to a period that is reasonably necessary for them to safely evacuate the country, region or city.
(s) Any Act of Terrorism directly or indirectly caused by, resulting from, arising out of, or that is in connection with biological, chemical, nuclear or radioactive means.

SECTION 5 – TRIP CANCELLATION AND INTERRUPTION INSURANCE EXCLUSIONS AND LIMITATIONS

In addition to the GENERAL TRAVEL BENEFITS EXCLUSIONS, this Policy does not pay for any expense or benefit arising from, caused by, contributing to, relating to, or resulting from, whether directly or indirectly, any one or more of the following:

(a) Any Pre-existing Condition that was not Stable in the three months prior to the Covered Person's Effective Date.
(b) Any heart condition the Covered Person or their Travel Companion / Business Colleague has if, during the three months prior to their Effective Date, they or their Travel Companion / Business Colleague have taken any form of nitroglycerine for the relief of angina pain.
(c) Any lung condition the Covered Person or their Travel Companion / Business Colleague has if, during the three months prior to their Effective Date, they or their Travel Companion / Business Colleague required Treatment with oxygen or Prednisone for a lung condition.
(d) An event when, on the Effective Date the Covered Person or their Travel Companion / Business Colleague knew, or it was reasonable to expect, may eventually prevent them from going on or completing their Covered Trip as booked.
(e) The Medical Condition or death of a person who is ill when the purpose of their Covered Trip is to visit that person.
(f) The Covered Person committing or attempting to commit a criminal act.
(g) Not following a prescribed therapy or Treatment.
(h) Any loss, Injury or death related to intoxication, the misuse, abuse, overdose of, or chemical dependence on medication, drugs, alcohol or other intoxicant, other than as prescribed by a Physician.
(i) (1) Routine prenatal care; (2) pregnancy or childbirth or complications thereof when they happen in the nine weeks before or after the expected date of delivery; (3) a child who is born after the Covered Person leaves their province or territory of residence.
(j) A Medical Condition:
  (1) the Covered Person knew or for which it was reasonable to expect before the Effective Date that they would need or be required to seek Treatment for that Medical Condition;
  (2) for which future investigation or Treatment was planned before their Effective Date;
  (3) that produced symptoms that would have caused an ordinarily prudent person to seek Treatment in the three months before their Effective Date; or
  (4) that caused a Physician to advise them, before the Effective Date, not to go on their Covered Trip.
(k) Any non-emergency, investigative or elective Treatment such as cosmetic surgery, chronic care, rehabilitation, or any directly or indirectly related complications.
(l) A travel visa that is not issued because of its late application.
(m) Failure of any travel supplier with which the Covered Person contracts for services. No protection is provided for failure of any travel agent, agency or broker.
(n) Any loss or any Medical Condition the Covered Person suffers or contract in a specific country, region or city when a Government of Canada Travel Advisory, issued before their Effective Date, advises Canadians to avoid all or non-essential travel to that specific country, region or city. In this Exclusion, "loss" and "Medical Condition" is limited, related or due to the reason for the travel advisory.
If the Travel Advisory is issued after their Departure Date, Coverage under this Trip Cancellation and Interruption Insurance Benefit in that specific country, region or city will be limited to a period of ten days from the date the Travel Advisory was issued, or to a period that is reasonably necessary for them to safely evacuate the country, region or city.
(o) Any Act of Terrorism directly or indirectly caused by, resulting from, arising out of or that is in connection with biological, chemical, nuclear or radioactive means.

SECTION 6 – GENERAL TRAVEL BENEFITS EXCLUSIONS

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In addition to the Exclusions for specific benefits outlined in SECTION IV – TRAVEL BENEFITS, this Policy does not pay for any Treatment, service, expense or benefit arising from, caused by, contributing to, relating to, or resulting from, whether directly or indirectly, any one or more of the following:

A. suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of auto-eroticism or auto-erotic asphyxiation, unless medical evidence establishes that the Injuries are related to a mental health illness.
B. an Act of War.
C. involvement in any type of Active military service.
D. participation in the commission or attempted commission of a crime, any felony, an assault, insurrection, or riot.
E. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity.
F. being intoxicated while operating a motor Vehicle.
    a. They will be conclusively presumed to be intoxicated if the level of alcohol or drugs or both in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the Accident occurred, to be intoxicated, if operating a motor Vehicle.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of their intoxication.
G. being under the influence of any prescription drug, controlled substance or cannabis, or hallucinogen, unless such prescription drug, controlled substance or cannabis, or hallucinogen was prescribed by a Physician and taken in accordance with the prescribed dosage.
H. travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.
I. release, whether or not Accidental, or by any person unlawfully or intentionally, of nuclear energy or radiation, including Sickness or disease resulting from such release.
J. alcoholism, drug addiction or the Use of any drug or controlled substance or cannabis except as prescribed by a licensed medical provider operating within his or her scope of authority.
K. participation in any team sport or any other athletic activity as a professional.
L. any condition for which a Covered Person is entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.
M. riding in or driving any type of motor Vehicle as part of a speed contest or scheduled race, including testing such Vehicle on a track, speedway or proving ground.
N. any payment or any service or benefit to any Policyholder, Covered Person, beneficiary, or third party who may have any rights under this Policy to the extent that such cover, payment, service, benefit, or any business or activity of the Policyholder, the Covered Person, beneficiary, or third party would violate any applicable trade or economic sanctions law or regulation.

SECTION 7 – HOW TO FILE A CLAIM

A. Notice. The Insured or the beneficiary, or someone on their behalf, must give Us written notice of the Covered Loss within ninety (90) days of such Covered Loss. The notice must name [the Covered Person who sustained the Injury,] the Insured, and the Policy Number. To request a claim form, the Insured or the beneficiary, or someone on their behalf may contact Us at [1-877-541-0127.] The notice must be sent to the Claims Department, [Zurich Canada Travel Insurance c/o Zurich Travel Assist; 901 King Street west; Toronto, ON M5V 3H5. 1 (877) 541-0127 (toll-free call from the USA or Canada) or (416) 649-2555 collect to Canada from anywhere else in the world], or any of Our agents. Notice to Our agents is considered notice to Us.

B. Claim Forms. We will 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, he or she can send Us a detailed written report of the claim and the extent of the Covered Loss. We will accept this report as a proof of Covered Loss if sent within the time fixed below for filing a proof of Covered Loss.
C. 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 will 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.

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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.

The Zurich logo and Zurich are trademarks of Zurich Insurance Company Ltd. This is intended as a general description of certain types of insurance and services available to qualified customers through Zurich Insurance Company Ltd in Canada. Nothing herein should be construed as a solicitation, offer, advice, recommendation, or any other service with regard to any type of insurance product underwritten by Zurich Insurance Company Ltd. Your policy is the contract that specifically and fully describes your coverage. The description of the policy provisions contained herein gives a broad overview of coverage and does not revise or amend the policy. Coverages and rates are subject to individual insured meeting our underwriting qualifications.

Privacy Consent Notice

By submitting the requested information, which may include, but is not limited to, name, address, date of birth, driver's licence number, medical information, financial information, driving record, automobile insurance policy history, and automobile insurance claims history, you are providing consent 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 your 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 are also providing consent to Zurich for the disclosure of your 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"). If your policy is being arranged by a broker or an agent, you authorize Zurich to collect, store, use, disclose, and process personal information received from such broker or agent in relation to the above-stated purposes. Additionally, by providing information about a third party, including but not limited to, a family member, director, officer, employee, or any party that has an interest in or derives a benefit from the policy, you hereby covenant and warrant that you have obtained the appropriate consent from such third party to disclose their personal information to Zurich and for Zurich to use and disclose such information for any of the above-stated purposes.

Zurich is committed to protecting the privacy and confidentiality of information provided. Your 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 your 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. You may request to

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review the personal information Zurich maintains about you 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.

You may refuse to consent or withdraw your consent to the collection, storage, use, disclosure or processing of your personal information; however, your 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 your policy.

Please contact the Zurich Privacy Officer if you require further information regarding the collection, use, disclosure, processing and storage of your personal information or if you have any complaints via email at privacy.zurich.canada@zurich.com. You can also review our Privacy Policy 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 Company's insurance business in Canada.

Signature

Head of Underwriting, Canada Authorized Representative