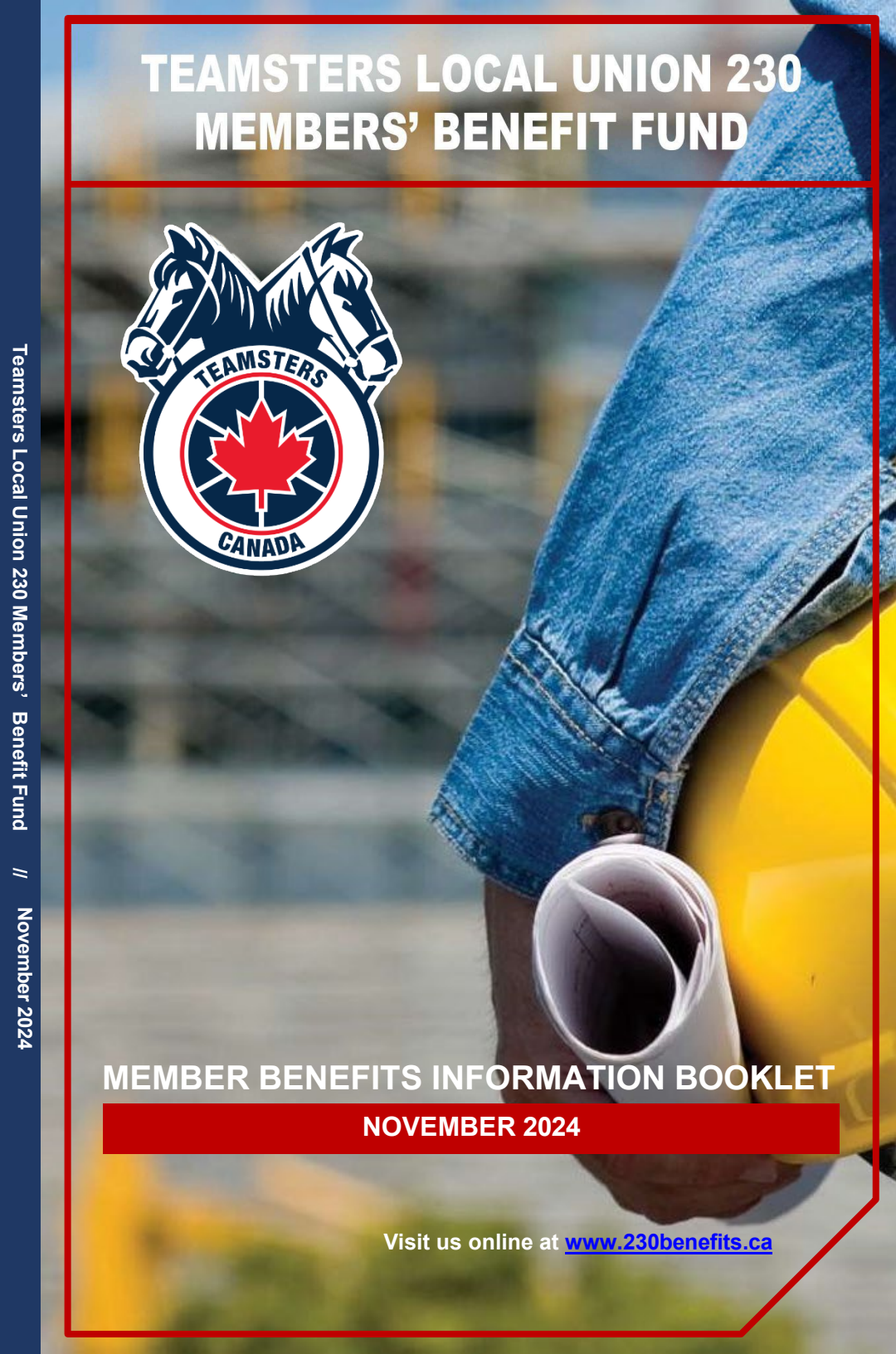
TEAMSTERS LOCAL UNION 230 MEMBERS' BENEFIT FUND



MEMBER BENEFITS INFORMATION BOOKLET

NOVEMBER 2024

Visit us online at www.230benefits.ca

CUSTOMER SERVICE

The Trust Fund's Administrative Agent, Ellement Consulting Group ("Ellement"), is available to assist you.

Trust Fund's Website

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

✓ Visit WWW.230benefits.ca

Claims Call Centre

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

✓ Phone 1-866-488-9135 or email teamsters230@ellement.ca

Plan Administrator

- Do you want to review the employer contributions received on your behalf?
- Do you need a (new) Registration Form?
- Do you need a replacement Prescription Drug Card?

- Phone 1-866-488-9135 or email teamsters230@ellement.ca

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

- To book an online or in person appointment please visit the benefit plan website at www.230benefits.ca and click on the "Book Your Appointment link" at the bottom of the page (https://calendly.com/vaughanreception-ellement)

Administrative Agent
Ellement Consulting Group ("Ellement")

6 Ronrose Drive, Suite 303
Vaughan, Ontario L4K 4R3

Phone Number: 365-363-7578
Toll-Free Number: 1-866-488-9135
Fax Number: 647-560-7923

CONTENTS

CONTENTS

A MESSAGE FROM THE BOARD

This booklet describes the eligibility requirements, coverage and claims procedures under the Teamsters Local Union 230 Members' Benefit Fund, which for descriptive ease is referred to in this booklet as the Trust Fund. The Board of Trustees is solely responsible for establishing the eligibility rules of the Trust Fund.

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

Effort has been made to ensure that the coverage descriptions in this booklet are consistent with the group insurance policies issued by the Insurance Companies and with related government Health coverages. However, this booklet is not, in itself, a legal contract, so it follows that the terms of the insurance policies, and of the governing legislation, take precedence in case of dispute. Any amendment to the governing insurance policies is effective without notice to you. As well, in an effort to treat all Members fairly and to guard the Trust Fund assets against abuse, the Board of Trustees is solely responsible for establishing the eligibility rules of the Trust Fund.

The Trustees hope that the benefit coverage, provided by the Trust Fund, is of real value to you and your eligible Dependents. Should you require additional information, please contact your plan's Administrative Agent, Ellement Consulting Group ("Ellement").

The Board of Trustees

HOW IT WORKS

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

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

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

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

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

ON THE IMPORTANCE OF BEING REGISTERED

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

If you have already completed a registration form and you have no desire to change your Beneficiary/Beneficiaries, it is not necessary for you to complete another form. Should you have any changes to your Dependents or designated Beneficiary/Beneficiaries (subject to Provincial Law), you must complete a new registration form to update the information. The change will take effect as of the date such request was executed, but without prejudice to the insurance company for any payment(s) made before such request is received at its Head Office.

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

Summary of Benefits

EXTENDED HEALTH For Eligible Members and their Dependents	
Percentage payable	100% except where noted
Deductible	NIL
Calendar year maximum	$250,000 for drugs
Lifetime maximum	$250,000 for healthcare
PRESCRIPTION DRUGS (Prescription Drug Card)	
Percentage payable	100% with a $6.50 dispensing fee maximum
Vaccines	Hepatitis A & B and Shingles are covered
Contraceptives	Oral and non-oral contraceptives and contraceptive appliances are covered
Glucose sensors	Covered
Anti-smoking aids	Zyban or Champix up to a $500 lifetime maximum, unless otherwise required by law
Fertility Drugs	$2,500 lifetime maximum
Medical Cannabis	$1,000 per calendar year per Member and eligible Dependent
PARAMEDICAL	
Reimbursement paid at 100% is based on the reasonable and customary fees per visit charged by each practitioner as determined by the insurance company every year.	
Regulated or licensed	
Chiropractor Chiropodist and Podiatrist	$70 per visit per practitioner up to $700 per calendar year per practitioner, including x-rays
Physiotherapist, Occupational Therapist, Acupuncturist, Registered Massage Therapist, and Speech Therapist, Dietician, Nutritionist	$70 per visit per practitioner up to $700 per calendar year per practitioner
Licensed Clinical Psychologist, Psychotherapist and Social Worker	$150 per visit per practitioner up to combined maximum of $2,000 per calendar year

EXTENDED HEALTH continued For Eligible Members and their Dependents	
Durable medical equipment and supplies such as:	
Transcutaneous nerve simulators	$700 lifetime maximum
Breast prosthesis	One every 2 calendar years
Surgical stockings	2 pairs per calendar year
Surgical brassieres	2 per calendar year
Wigs	Once per lifetime
Oxygen	Covered
Glucometer	One per lifetime
X-Ray and Lab	Covered
Rental of wheelchairs, breathing machines and hospital beds	Rental to a maximum of 3 months, based on reasonable and customary fees
Continuous Positive Airway Pressure (CPAP) Sanitizer	Once every 5 years
Brace, Crutch, Splint	Covered
Convalescent Hospital	Not Covered
Artificial Eye/Limb	Covered
Stump socks	2 pairs per calendar year
Glucose Monitor (FreeStyle Libre Flash, Dexcom G6/G7)	Covered if insulin-dependent, Combined maximum of $4,000 per calendar year
MAJOR MEDICAL	
Ambulance service	Local ambulance & air ambulance in Canada, limited to the cost of one trip per disability
Out-of-hospital nursing	$5,000 per calendar year (pre-approval required)
Accidental dental	Covered within 12 months of the accident
HEARING AIDS	
	$2,000 every 24 months, purchase only, no batteries or repairs
ORTHOPAEDIC SHOES or ORTHOTICS	
Percentage payable	50%
Custom-made orthopaedic shoes or orthotics	1 pair per calendar year up to $500

VISION CARE	
Percentage payable	100%
Adults – any multiple of prescription lenses & frames or contact lenses or sunglasses	$400 every 24 months
Eye examination or Retinal scan	$100 for 1 exam/scan every 24 months
Dependent children under age 19 – any multiple of prescription lenses & frames or contact lenses	$400 every 12 months
Prescription disposable contact lenses	$100 every 6 months (up to 4 times) within 24 month period
Cataract Lenses	$500 per lifetime (includes Physician Measurements) for claimants between the ages of 19 and 64
Prescription safety glasses (for Members only)	$200 every 24 months
Laser Eye Surgery	50% of cost to maximum of $1,000 every 5 years
Optical Coherence Topography Picture/Exam	$100 every 24 months

EMERGENCY MEDICAL (TRAVEL) For Eligible Members and their Dependents Terminates at Age 85	
Lifetime maximum up to age 74	$5,000,000
Lifetime maximum ages 75 – 79	$1,000,000
Lifetime maximum ages 80 - 85	$ 500,000

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

SECOND OPINION
For Eligible Members and their Dependents
Terminates at Age 70

Second opinion e-consultation for serious illness.

HOSPITAL CASH
For Eligible Members and their Dependents
Terminates at Age 70

Benefit amount	$150 per day, maximum 120 days

Patient must be in hospital for minimum of 3 consecutive days.

DENTAL
For Eligible Members and their Dependents

Reimbursement is based on the ODA fee guide for the year recognized by the Trust Fund at the time the service is rendered.

Percentage payable	
Routine procedures	100%
Major procedures	100%
Orthodontic (for Dependent children)	50%
Deductible	NIL
Lifetime maximum	$2,000 for orthodontic
Calendar year maximum	$3,000 per individual for all procedures

LIMITS

Complete oral examination	Once every 24 months
Recall or specific examination	Once every 6 months
Full-mouth & panoramic x-rays	Once every 24 months
Intra-oral x-rays	15 films every 24 months
Bitewing x-rays	6 films every 6 months
Polishing and fluoride application	Once every 6 months
Oral hygiene instruction	Once every 6 months
Scaling	8 units per calendar year (combined with periodontal root planning)
Occlusal equilibration	covered
Study cast	Once every 12 months
Diagnostic tests & Lab exams (procedure codes: 04101-04401)	Once every 12 months

DENTAL continued For Eligible Members and their Dependents	
DENTURES	
Relines/rebases/repairs	Each once every 24 months
Denture Replacements	80% reimbursed when the existing appliance is at least 5 years old and unserviceable, or at least 12 months old if the existing appliance is a covered temporary appliance.
Other Prosthodontics	50% reimbursed

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

WEEKLY WAGE REPLACEMENT For Eligible Members ONLY	
This is non-occupational (not work-related) coverage.	
Waiting period	7 days for illness 0 days for accidents 0 days for hospitalization
Benefit amount	$695 per week (2025 EI maximum)
Benefit period	52 weeks, inclusive of weeks of EI Sick Benefits (benefit terminates at retirement)

This is a taxable benefit.

LONG TERM DISABILITY For Eligible Members ONLY	
This is non-occupational (not work-related) coverage.	
Waiting period	52 weeks plus any EI period if you are eligible
Benefit amount	$1,500 per month
Benefit period	To the earlier of 5 years, age 65, or retirement

This is a taxable benefit.

CRITICAL ILLNESS For Eligible Members ONLY Terminates at Age 70	
Principal sum	$30,000

Covers only specific conditions.

LIFE For Eligible Members	
Eligible member	$50,000
Dependent spouse	$5,000
Dependent child	$2,000
ACCIDENTAL DEATH & DISMEMBERMENT For Eligible Members ONLY Terminates at Age 70	
Principal sum	$50,000
JURY DUTY For Eligible Members	
Benefit amount	$100 per day, maximum 50 days
BEREAVEMENT PAY For Eligible Members	
Benefit amount	$150 per day, maximum 3 days

GENERAL PROVISIONS

MEMBER ELIGIBILITY

To qualify for coverage, you and your eligible Dependents must be insured under a provincial health plan. The Plan's Administrative Agent keeps an account for you of the hourly contributions made by your Employer on your behalf. This account is called an 'Dollar Bank Account'. The balance in this account determines your eligibility for benefits.

You become eligible for coverage under the Trust Fund when you have accumulated 3 monthly deductions in your dollar bank. Your coverage is effective on the first day of the second month following that accumulation. Your coverage continues for each month your dollar bank contains the required monthly deduction. The maximum dollar bank balance is 18 monthly deductions. If you earn an excess of 18 deductions, these funds will be transferred to the general reserve of the Trust Fund.

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

CHANGE OF YOUR STATUS

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

DEPENDENT ELIGIBILITY

Your Dependents becomes eligible for coverage when you become eligible or, if acquired later, upon becoming your Dependent. To qualify for coverage your eligible Dependents must be insured under a provincial health plan.

Newborn children are eligible for Hospital Cash and Life Insurance from the 15th day of age and for all other coverage from live birth, provided you advise the Administrative Agent within 31 days of the birth.

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

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

Dependent Spouse means:

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

A Member can only insure one spouse at a time and that spouse must be the same person for all spousal benefits provided under this Plan.

File a new Registration Form every time your marital status changes.

Dependent Child means:

- Your unmarried child (over 14 days of age for the Hospital Cash and Life Insurance Benefits only) and under 21 years of age provided he/she is not working more than 30 hours a week,
- Your unmarried child under 25 years of age provided he/she is not employed on a regular full-time basis and he/she is in full-time attendance at a university or similar institution (annual proof of student registration is required after the child reaches age 21), or

- Your natural child, legally adopted child, stepchild, or child of your spouse provided your spouse lives with you and has custody of the child and provided the other requirements are satisfied, and

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

File a new Registration Form every time your Dependent status changes.

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

CONTINUATION OF COVERAGE FOR FUNCTIONALLY IMPAIRED CHILDREN

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

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

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

MAINTAINING COVERAGE

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

DIRECT PAYMENTS (UNDER AGE 65)

In the event that your dollar bank does not contain a full monthly deduction, you may continue your insurance by making your own contributions directly to the Trust Fund with the approval of the Local. The Plan's Administrative Agent will advise when your dollar bank account is below the minimum requirement. You may remit Direct Payments for up to 12 months if your termination of employment is due to lay-off, or for up to 3 months if your termination of employment is voluntary.

When you have a partial monthly deduction in your dollar bank, it will remain there for up to 12 months and will be used to help satisfy your reinstatement requirements when you return to working on a full-time basis.

All benefits may be continued by the Direct Pay method described above, except for Weekly Wage Replacement, commonly known as Short-Term Disability (STD), and Long-Term Disability (LTD). The option to Direct Pay ceases upon your attainment of age 65.

Note: In the case of lay-off, Weekly Wage Replacement is payable provided you have been recalled to work.

CONTINUING BENEFITS WHEN DISABLED (UNDER AGE 65)

In the event that you become disabled after January 1, 2013, and are unable to work, your dollar bank will be frozen, and benefit coverage will be maintained by the Trust Fund for up to 12 months, providing you are in receipt of Weekly Wage Replacement benefits, LTD benefits, *Workplace Safety & Insurance Board (WSIB) benefits, or *Motor Vehicle Insurance Disability benefits.

Following a period of Fund Assistance if you remain totally and permanently disabled, you will continue to receive Fund Assistance to the earlier of age 65 or until you start to receive a Pension or Disability Pension.

Definition (for Fund Assistance only): Totally and Permanently Disabled means that you are receiving Canada Pension Plan (CPP) Disability Benefits and have been approved for a waiver of premium for Life benefits.

If you continue to be disabled but not approved for Waiver of Premium and not receiving CPP Disability Benefits, you may exhaust your dollar bank to provide benefit coverage. Should you still continue to be disabled, you are eligible to remit Direct Payments for a further 12 months, or to age 65 if earlier, provided you continue to be in receipt of one of the following benefits:

- Weekly Wage Replacement benefits,
- LTD benefits,
- *WSIB benefits, or
- *Motor Vehicle Insurance Disability benefits.

*Proof of acceptance and monthly benefit payments for your WSIB benefits or Motor Vehicle Insurance Disability claim must be submitted to the Administrative Agent.

Note: The Direct Pay and Disability Assistance Provisions cease when you reach age 65, or upon your retirement if earlier. For disabilities incurred prior to January 1, 2013, please contact the Administrative Agent for information.

CONTINUING BENEFITS WHEN DISABLED (OVER AGE 65)

Effective January 1, 2017, if you turn age 65 while you are receiving Disability Income, Fund Assistance will continue for the duration of the STD, WSIB or Motor Vehicle Insurance Disability benefit, but in no event past 52 weeks.

If you continue to work over the age of 65 and become disabled after January 1, 2017, Fund Assistance will be available for the duration of your Disability Income to a maximum of 52 weeks, or until you elect a pension if earlier.

CONTINUATION OF COVERAGE IN THE EVENT OF YOUR DEATH

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

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

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

After 24 months, your Dependent spouse may remit Direct Payments for the benefits (based on the above), provided the following conditions were met at the time of your death:

- You were a Member paying Union Dues to the Teamsters Local Union 230;
- You participated in a Teamsters Benefit Plan for a minimum of 10 years;
- You participated in the Fund for the preceding 5 years;
- Your Dependent spouse notifies and confirms their wish to remit Direct Payments with the Administrative Agent within 31 days of becoming eligible.

Please contact the Administrative Agent for coverage and costs.

TERMINATION OF COVERAGE

Your insurance will cease as follows:

- The date the Group Master Policy is cancelled or terminated,
- The first day of any month you have less than the required deduction in your dollar bank,
- The last day of any month in which you have made the maximum number of contributions under the Direct Payments option, but not beyond your attainment of age 65,

- The last day of any month in which the Trust Fund has made 12 monthly contributions under the "Fund Assistance" provision, but not beyond your attainment of age 65,
- The first of the month following the month in which you attain the benefit age limit which may be set out in the "Summary of Benefits", or
- The date you cease to be in a class of persons who may be insured under this policy, i.e. you cease to pay Union Dues to the Teamsters Local Union 230.

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

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

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

REINSTATEMENT OF COVERAGE

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

If you have been out of benefit for 12 consecutive months, you will be treated as a new Member and the Member Eligibility provisions will apply.

EARLY RETIREE (AGES 60-65) & RETIREE COVERAGE (OVER AGE 65)

The Trust provides benefits for both Early Retirees between the ages of 60 and 65 and Retirees over the age of 65 on a reduced Self-Pay basis.

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

Please contact the Administrative Agent to obtain coverage information or to request benefit brochures, or visit www.230benefits.ca.

EXTENDED HEALTH

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

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

COVERED EXPENSES

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

The insurance will pay the covered expenses incurred by you or an eligible Dependent up to the limits described below and set out in the “Summary of Benefits”.

PRESCRIPTION DRUGS

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

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

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

A claims validation is done before a prescription is dispensed. Depending on the outcome of these validations, the pharmacist may refuse to dispense the prescribed drug.

MEDICAL CANNABIS

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

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

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

Members and their eligible Dependents are not required to use any particular licensed medical cannabis provider.

Claims related to all other medical cannabis providers must be submitted by mail to the Administrative Agent.

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

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

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

PRESCRIPTION DRUG LIMITATIONS

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

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment;
- Non-disposable insulin delivery devices or spring-loaded devices used to hold bloodletting devices;
- Delivery or extension devices for inhaled medications;
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions;
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories or contraceptive implants;
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada;
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered;
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital;
- Non-injectable allergy extracts;
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason;
- Drugs used to treat erectile dysfunction;
- Drugs or drug supplies not listed in the *Liste de medicaments* published by the *Régie de l'assurance- maladie du Québec* in effect on the date of purchase or which are received out-of-province, when prescribed for a Dependent child who is a student over age 25 and you are a resident of Quebec.

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

A one-time election may be made to be covered under this Plan. You must make this election and communicate it to your employer by the end of the 60-day period immediately following:

- the date you reach age 65; or
- the date you become a resident of Quebec, within the meaning of the Health Insurance Act, Quebec, if you are age 65 or over.

While your election to be covered under this Plan is in effect, you will be deemed not to be entitled to the basic plan provided by the *Régie de l'assurance-maladie du Québec*.

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

PARAMEDICAL

Health practitioner services are covered for a Regulated or Licensed Chiropractor, Chiropodist, Podiatrist, Physiotherapist, Occupational Therapist, Acupuncturist, Registered Massage Therapist, Speech Therapist, Dietician, Nutritionist, Psychotherapist, Social Worker or Licensed Clinical Psychologist, acting within the scope of their licences.

No amount will be paid for any health care practitioner services until any applicable Provincial Health Plan benefit is exhausted.

MAJOR MEDICAL

Ambulance
Reimbursable expenses are for ambulance services, including emergency air ambulance services, in excess of the amount payable under the insured person's Provincial Health Plan. The services must be required to transport the person from the place of injury (or where illness struck) to the nearest Hospital where treatment is available, or directly from that Hospital to the nearest Hospital for needed specialized treatment not available at the first Hospital, or from Hospital to a Convalescent/Rehabilitation Hospital.

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

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

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

Diagnostic Laboratory and X-Ray
Reimbursable expenses are for x-ray and diagnostic laboratory expenses not covered by a provincial government plan.

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

- Wheelchairs, canes, crutches, walkers, trusses and hospital beds,
- Rigid or semi-rigid braces for back, neck, arm or leg, non-dental prosthesis, such as artificial limbs and eyes, and a surgical corset, including replacement if required because of a change in physical condition,
- Breathing equipment, including continuous positive airway pressure (CPAP) machines and sanitizers,
- Respiratory equipment, including oxygen,
- Splints, casts, and catheters,
- Breast prosthesis,

- Purchase of surgical brassieres when required following a mastectomy,
- Surgical stockings, stump socks, excluding elastic stockings,
- Wigs,
- Glucose meter, and flash glucose monitoring machines when insulin-dependent,
- Non-oral contraception devices such as intrauterine devices (IUD's).

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

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

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

HEARING AID

The purchase of a hearing aid is reimbursable when provided by a certified clinical audiologist. Replacement, repairs and batteries are not reimbursable.

ORTHOPAEDIC SHOES OR ORTHOTICS

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

- a diagnosis, including list of symptoms and the primary complaint,
- a description of the physical findings from the clinical examination,
- a brief description of the gait abnormality associated with the diagnosis, and
- confirmation that the product has been custom-made, including a copy of the detailed lab invoice issued to the provider by the manufacturer of the custom-made shoe or orthotic.

In order to be eligible for reimbursement, orthopedic shoes and orthotics device must be:

- prescribed by either a licensed physician or chiropodist/podiatrist on an annual basis, and
- dispensed by one of the following provider types: licensed physician, chiropodist/podiatrist, orthotist or pedorthist.

VISION CARE

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

Vision care includes one eye examination and retinal scanning performed by a licensed ophthalmologist, optometrist or optician in any period of 24 consecutive months, for claimants between the ages of 19 and 64.

Prescribed safety glasses (for Members only), disposable contact lenses, scratch resistant and anti-reflective lens coating, and lens tinting, are covered under this benefit.

No amount is reimbursed for replacement of lost, stolen or broken glasses.

LIMITATIONS

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

- Expenses private insurers are not permitted to cover by law.

- Services or supplies for which a charge is made only because you have insurance coverage;
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan;
- Services or supplies that do not represent reasonable treatment;
- Services or supplies associated with:
    - treatment performed only for cosmetic purposes,
    - recreation or sports rather than with other daily living activities,
    - contraception other than contraceptive drugs and products containing a contraceptive drug, and contraceptive appliances such as intrauterine devices (IUD's), rings and patches.
- Services or supplies not listed as covered expenses;
- Extra medical supplies that are spares or alternates;
- Services or supplies received outside Canada;
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and the insurer would have paid benefits for the same services or supplies if they had been received in your home province;
- Expenses arising from war, insurrection, or voluntary participation in a riot;
- Services related to chronic care;
- Vision care services and supplies required by an employer as a condition of employment;
- Charges for examinations required for use by a third party;
- Charges for prescription safety glasses purchased for a Dependent;
- Charges for services and supplies which are provided without the recommendation and approval of a physician;
- Charges made by a physician for travel, broken appointments, communication costs, filling out forms or physician's supplies;
- Charges for eye examinations except where included as a reimbursable expense;
- Charges for medical treatment or surgical procedure by a physician;

- Charges for transport or travel, other than as specifically stated under reimbursable expenses;
- Charges which are from an occupational injury or disease covered by workplace safety and insurance law or similar legislation;
- Charges for dental work except as provided by under the “Accidental Dental” provision or where a third party is responsible for payment of such charges;
- Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society.

EMERGENCY MEDICAL (TRAVEL)

Each Canadian Province and Territory provides a Medicare Plan with comprehensive benefits for hospital confinement, the service of physicians and other health practitioners, ambulance services, etc. In many cases, the benefits provided by these plans will pay all, or almost all, of the expenses you incur in your home province.

When you are outside Canada and require these services, your Provincial Medicare Plan will usually make a payment towards your expenses, but that payment is usually limited to the amount that would have been paid for the same service in the Province in which you reside. Unfortunately, there is often a tremendous difference between the cost of these services outside Canada and the amount allowed by your Medicare Plan, which you would have to pay were it not for this valuable benefit.

This Plan provides extensive coverage for many services rendered outside Canada. It would be important to note that such expenses are covered provided that they were unexpected, and of an emergency nature. The Plan does not provide benefits for medical treatment if the purpose of your trip outside Canada is to obtain that medical treatment.

ELIGIBILITY

All Members and their Dependents, who are eligible under the Trust Fund and who are under age 85, are eligible for insurance under this Emergency Out of Province Medical Coverage.

PERIOD OF COVERAGE

You and your Dependents are covered while outside your province of residence, for such reasons as business or vacation. As noted earlier, expected expenses incurred by you or your Dependents are not covered in the event that the person incurring the expected expenses had left your province or territory of residence for the purpose of obtaining medical treatment. **Trips are limited to a maximum of 90 consecutive days.**

TERMINATION

Coverage will terminate in accordance with the terms and conditions as set out in the "Termination of Coverage" provision.

WHAT TO DO IN A MEDICAL EMERGENCY

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

Telephone the Coordination Center at the numbers listed below:

- U.S. & Canada **1-877-541-0127**
- Elsewhere (Collect Call) **1-416-649-2555**

An operator will ask you the following:

- ✓ Your name,
- ✓ Your location,
- ✓ The details of your emergency, and
- ✓ Your policy number which is 8623204

ADDITIONAL INFORMATION

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

MEMBER & FAMILY ASSISTANCE

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

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

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

PROFESSIONAL COUNSELLORS

Cloud MD have been retained to provide this professional counselling and referral service.

CONFIDENTIALITY AND PRIVACY

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

HOW THE PROGRAM WORKS

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

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

HOW TO USE THE PROGRAM

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

- Toll-free number **1-800-661-8193**

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

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

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

To access the online E- Counselling, visit the Cloud MD website at https://secure.kiihealth.ca/register?eac=TLU230&locale=en to register. Your Access Code is TLU230, Complete the “Online form to set up your account and access all the services.

ADDITIONAL INFORMATION

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

MENTAL WELLNESS

The benefit in this section applies to eligible Members and their eligible Dependents. The Cloud MD Therapist Assisted Mental Health Program ceases in accordance with the “Termination of Member Coverage” provision.

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

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

HOW THE PROGRAM WORKS

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

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

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

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

HOW TO USE THE PROGRAM

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

- Toll-free number **1-866-814-0018** (this number is not an emergency crisis line)

On this call, key contact details and eligibility information will be collected. Alternatively you may enrol yourself. To access the online CBT, visit the Cloud MD website at https://secure.kiihealth.ca/register?eac=TLU230&locale=en to register. Your Access Code is TLU230, Complete the “Online form to set up your account and access all the services.

ADDITIONAL INFORMATION

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

SECOND OPINION

The benefits in this section apply to eligible Members and their eligible Dependents. Second Opinion benefits cease when you reach age 70 or in accordance with the "Termination of Coverage" provision, whichever is earlier.

As the practice of medicine becomes more highly specialized, it can be difficult for any one physician to be aware of all of the latest information relating to the diagnosis and treatment of serious or complex diseases.

This benefit provides second opinion e-consultation services if you or an eligible Dependent is diagnosed with a serious illness. Your medical records will be collected by Cloud MD and then forwarded to one of the leading medical institutions in the United States where a team of physicians will review your case. These experts will provide you and your physician with a report, confirming or modifying the diagnosis and suggesting the best treatment options.

The second opinion includes:

- Review of relevant medical records and supporting diagnostic information, and the interpretation of a CT scan, MRI scan, x-ray, ultrasound, or other radiology or pathology studies by specialists,
- A written report which confirms a diagnosis and a suggested treatment plan,
- One follow-up second opinion, if necessary, and if additional diagnostic or consultation reports or questions related to the initial second opinion request are submitted within 30 days of receipt of the initial opinion report, and
- An audio or video conference, if needed, between your physician and the consulting physician from the Cloud MD network.

Members and their eligible Dependents are entitled to receive second opinions for the following acute, complicated and serious medical conditions:

COVERED SERIOUS ILLNESSES

- Aids
- Amyotrophic lateral sclerosis (ALS)
- Alzheimer's disease
- Any amputation
- Any life threatening illness
- Benign brain tumour
- Cancer
- Cardiovascular conditions
- Chronic pelvic pain
- Coma
- Deafness
- Embolism/Thrombophlebitis
- Emphysema
- Hip/knee replacement
- Kidney failure
- Loss of speech
- Major organ transplant
- Major or severe burns
- Major trauma
- Multiple Sclerosis
- Neuro-degenerative disease
- Paralysis
- Parkinson's Disease
- Rheumatoid Arthritis
- Stroke
- Sudden blindness due to illness

Each Member and eligible Dependent is entitled to 2 second opinions in each year, up to a maximum of 6 per lifetime.

EXCLUSIONS AND LIMITATIONS

Conditions resulting from the following are excluded from coverage:

- Attempted suicide, self-inflicted injuries or injuries caused by a third person with the Member's knowledge,
- Alcohol or drug abuse,
- Radioactive contamination,
- War or warlike operations (whether declared or not), riot, civil commotion, revolution, insurrections, conspiracy, or any events or causes which determine the proclamation or maintenance of martial law or state of siege,
- Natural disasters such as fire, flood, earthquake, tornado, hurricane, and other Acts of God, and
- Poisoning or poisonous gas inhalation.

HOW TO USE THE BENEFIT

To initiate a consultation, contact Cloud MD at the following toll-free number:

- Toll-free number **1-866-814-0018**

Telemedicine

The Telemedicine program provides you access to a doctor. You may use the online access or telephone number provided below.

The following is provided online or by phone

General Medical Advice
o Cold and flu symptoms, rash, headaches, eye pain, allergic reactions, joint pain, back pain, covid exposure, women's health, sexual health, child and infant care.

Prescriptions – New and Refills
o Avoid the back and forth with pharmacies and doctors and get your prescription easily and quickly.

Sick Notes, Lab Work Requests and Lab Results
o Get a sick note, requests for lab work such as blood tests and review your results with a clinician.

Referrals for Specialists
o Whether you don't have a family doctor or are looking for a trusted referral to a healthcare specialist we have a directory of over 20,000+ specialists in the country that we can connect you with.

HOW TO USE THE PROGRAM

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

- Toll-free number **1-866-814-0018** (this number is not an emergency crisis line)

On this call, key contact details and eligibility information will be collected. Alternatively you may enrol yourself. To access the online CBT, visit the Cloud MD website at https://secure.kiihealth.ca/register?eac=TLU230&locale=en to register. Your Access Code is TLU230, Complete the "Online form to set up your account and access all the services.

HOSPITAL CASH

The Hospital Cash Benefit provides a benefit in the event of extended hospitalization, for Eligible Members under age 70 and their eligible Dependents over the age of 14 days. The benefit can be used to pay for any expenses you wish and receipts are not required.

The Plan will pay an eligible Protected Person a daily benefit of $150 for the first 120 days while such person is confined to a hospital for 3 consecutive days or more and under the care of a licensed physician. Eligible Members or Dependents must be hospitalized for a minimum of 72 consecutive hours to receive the Hospital Cash benefit. Hospital stays less than 3 days do not qualify for this benefit.

Benefits are retroactive to the first day of hospital confinement. The total hospital days will be equal to the total number of days billed by the hospital as shown on the hospital discharge papers. The period of hospitalization must be necessary because of injury, illness or childbirth and begin while insurance under this Policy is in force.

Protected person (for Hospital Cash only): means a covered Member and his/her eligible spouse and dependent children more than 14 days of age.

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

Please contact the Administrative Agent for:

- ✓ a separate brochure for more information, and
- ✓ a Hospital Cash Benefit Form for a claim.

DENTAL

The Dental benefits described in this section apply to both eligible Members and their eligible Dependents.

REIMBURSEMENT

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

FREE CHOICE OF DENTIST

You may choose any licensed dentist or licensed denturist practicing within the scope of his/her profession.

WHAT THE INSURANCE COVERS

The insurance covers work included in a comprehensive list of “Covered Dental Expenses”, which appears below.

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

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

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

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

PRE-DETERMINATION OF BENEFITS

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

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

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

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

WHAT IS CONSIDERED AN ELIGIBLE CHARGE

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

A charge is considered incurred on the date the service is received, rather than on the date the charge is made. In the case of crowns, root canal therapy and dentures or bridgework, which may require multiple appointments, the date the expense is incurred will be the date the service is finally completed:

- For crowns, the date the service is finally completed will be the date the permanent crown is installed;
- For root canal therapy, the date the service is finally completed will be the date the canal is closed;
- For dentures or bridgework, the date the service is finally completed will be the date the prosthetic device is installed.

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

TERMINATION OF BENEFITS

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

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

- Where an impression for a denture, bridge or crown was taken or root canal therapy was started prior to the termination of insurance, dental expense in connection with these procedures and incurred within 30 days of termination will be considered as incurred prior to termination, and
- Where Orthodontic Treatment has commenced and a treatment plan has been submitted in advance to the insurer, dental expenses in connection with such treatment and incurred within 90 days of termination will be considered as incurred prior to termination, provided the dependent is under age 21.

In the event the final services are completed after the termination date, proof of the date the impression was taken for the insertion of an appliance and corresponding lab bill or proof of the date the root canal therapy commenced will be requested.

COVERED DENTAL EXPENSES

Charges for reasonable and customary services and supplies shall be considered covered expenses when incurred by you or your Dependents.

Eligible expenses include Basic and Preventive Treatment, Endodontics, Periodontics, Oral Surgery, Major Restorative and limited Prosthodontics. An expense is eligible to the extent that coverage is not prohibited by provincial health insurance plans or because of other limitations described below or in the “Summary of Benefits”.

BASIC PROCEDURES

The following basic procedures are reimbursable:

- Consultations;
- Oral examinations;
- Single diagnostic x-rays and complete series or equivalent;
- Study casts;
- Scaling and polishing (prophylaxis);
- Topical application of sodium or stannous fluoride;
- Oral hygiene instruction for dependent children under age 15 only;
- Pit and fissure sealants for dependent children under age 18 only;
- Passive space maintainers, those that do not move the teeth, for dependent children under age 19;
- Anaesthesia where reasonably and customarily required in connection with other covered procedures;
- Amalgam, acrylic, silicate or composite fillings;
- Occlusal equilibration;
- Prefabricated full coverage restorations for primary teeth;
- Retentive pins;
- Treatment of periodontal and other diseases of gums and tissues of the mouth, (special periodontal appliances);
- Emergency endodontic procedures and root canal therapy;
- Extractions;
- Oral surgery including excision of impacted teeth.

MAJOR PROCEDURES

The following major procedures are reimbursable:

- Metal inlays and crowns, used to restore natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filing; **Note:** when a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration.
- Denture adjustments;
- Repairing, relining and rebasing of dentures;
- Initial installation of partial or full removable dentures;
- Replacement of existing partial or full removable denture(s) providing:
    - the existing appliance is at least 5 years old and cannot be made serviceable, or
    - the existing appliance is replaced as a result of the initial placement of an opposing denture.

  Note: Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.
- Initial installation of fixed bridgework;
- Bridge repairs and recementation;
- Replacement of existing fixed bridgework providing:
    - the existing fixed prosthetic device is at least 5 years old and cannot be made serviceable, or
    - the replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this Plan.

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

ORTHODONTIC TREATMENT

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

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

LIMITATIONS

The following charges are not reimbursable:

- Duplicate x-rays, custom fluoride appliances, audio-visual and nutritional counselling;
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants;
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations;
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage;
- Hypnosis or acupuncture;
- Veneers, recontouring existing crowns, and staining porcelain;
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings;
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option:
    - If overdentures are provided, coverage will be limited to standard complete dentures,
    - If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework,

    - If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework, and
    - Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided.
- Expenses covered under another group plan's extension of benefits provision;
- Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare;
- Expenses private plans are not permitted to cover by law;
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage;
- Services or supplies that do not represent reasonable treatment;
- Services or supplies which are not furnished by a legally qualified dentist, denturist or dental hygienist acting within the scope of his license;
- Replacement of a lost or stolen prosthetic device;
- Charges for protective athletic appliances;
- Treatment performed for cosmetic purposes only;
- Congenital defects or developmental malformations in people 19 years of age or over;
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain;
- Expenses arising from war, insurrection, or voluntary participation in a riot;
- Charges for completion of claim forms, broken appointments, counselling, travel, communication costs or for advice by telephone;
- Dental examinations required by a third party;
- Expenses for services or treatment that are payable by Workplace Safety & Insurance Law (or similar legislation) or any government plan or which are received without charge.

WEEKLY WAGE REPLACEMENT

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

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

BENEFIT PERIOD

This Weekly Wage Replacement Benefit is subject to a waiting period before payments commence. The waiting period is 7 days if you become disabled due to a sickness, 0 days if you become disabled due to an accident, and 0 days if you are admitted as an in-patient for a minimum of 24 hours of hospitalization. The Plan pays benefits to the end of Employment Insurance Sickness Benefit's 1-week waiting period, minus the Short Term Disability waiting period. Benefits will then be suspended for the next 26 weeks, during which time you should be eligible to receive Employment Insurance Sickness Benefits. Should you not qualify for Employment Insurance Sickness Benefits and submit due proof of your disqualification to the Claims Department, benefits under this Plan will be reinstated. If you continue to be totally disabled after the 26-week EI period, you may apply to receive a further benefit from this Plan.

In-patient (for Weekly Wage Replacement only): 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.

The maximum payment period considered by this STD Benefit is 52 weeks, including any EI payment period, or until you are no longer disabled, whichever comes first. It is your responsibility to apply for EI and to supply due proof of your disqualification if applicable.

For Example:

	Sickness	Accident/Hospitalization
Waiting Period	7 days	0 days
Payment	Ø	1 week
EI	26 weeks	26 weeks
Payment	25 weeks	26 weeks

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

SUCCESSIVE DISABILITIES

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

LIMITATIONS

No benefits are paid for:

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

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

BENEFIT REDUCTIONS

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

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

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

VOCATIONAL REHABILITATION

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

MEDICAL COORDINATION

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

SUBROGATION

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

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

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

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

TERMINATION OF COVERAGE

Your eligibility for Weekly Wage Replacement terminates upon your retirement.

YOUR BENEFITS AND FEDERAL INCOME TAX

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

THREE-PART CLAIM FORM

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

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

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

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

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

LONG TERM DISABILITY

Long Term Disability (LTD) insurance is wage replacement insurance, which provides you a monthly income if you become totally disabled by a non-occupational accidental bodily injury or disease while insured under this Plan and under the age of 65. The LTD insurance covers you for disabilities that last beyond the period covered by Weekly Wage Replacement benefits. The amount of your LTD Benefit is specified in the "Summary of Benefits". This benefit does not apply to Dependents.

Total Disability (for Long Term Disability only): means you are incapacitated during the qualifying period and the next 24 months of a period of disability to the extent that, solely because of a non-occupational disease or non-occupational injury, you are unable to work at your own occupation.

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

After this 24-month period, and during the same period of disability, you will be considered totally disabled only if you are unable, solely because of a disease or an accidental bodily injury, to work at any reasonable occupation.

A reasonable occupation means any gainful activity for which you are, or may reasonably become, qualified by education, training or experience. Such disability must result from a medically determinable physical or mental impairment.

BENEFIT PERIOD

You will be eligible for your first income payment from the Plan after you have completed the qualifying period, which is the first 365 days of a period of total disability, or the duration of the Weekly Wage Replacement Benefit, whichever is greater, **plus any EI period if applicable**. However, you will not receive an income payment if you reach age 65 before you complete the qualifying period.

After completing the qualifying period, you will be eligible for income payments during the continuance of a period of total disability to the earlier of 5 years, retirement, or reaching age 65.

ELIGIBILITY

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

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

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

ALL SOURCE MAXIMUM

Under the LTD Benefit, your total income each month must not exceed 85% of your normal gross monthly earnings.

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

- Disability benefits to which you or another member of your family is entitled to on the basis of your disability under the Canada Pension Plan and Quebec Pension Plan except for cost of living increases that take effect after the benefit period has started. Benefits payable to another family member are not included;
- Retirement benefits to which you are entitled to on your own behalf under the Canada Pension Plan or Quebec Pension Plan;
- Loss of income benefits under a legislated automobile insurance plan, to the extent permitted by law;
- Disability benefits under a plan of insurance available through an association;
- Income received from any employer or from any occupation for compensation or profit.

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

REHABILITATION PROVISION

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

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

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

VOCATIONAL REHABILITATION

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

MEDICAL COORDINATION

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

SUBROGATION

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

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

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

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

CONTINUOUS PERIOD OF DISABILITY

If you become disabled from the same or related causes within 6 months after return to active work, it will be considered one continuous period of disability. If you have returned to active work for one full day and become disabled from different and unrelated causes, it will be considered a new period of disability.

LIMITATIONS

No benefits are paid for:

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

- Any 12-month period in which you do not live in Canada for at least 6 months;
- Any period of incarceration, confinement, or imprisonment by authority of law;
- Disability arising from war, insurrection, or voluntary participation in a riot;
- Disability related to any employment;
- Any period for which the person is entitled to loss of income benefits under a legislated automobile insurance plan, to the extent permitted by law;
- Disability arising from an accident which occurs while the person is operating a motor vehicle, vessel or aircraft and was impaired by drugs or alcohol, or his blood/alcohol is higher than 80 milligrams of alcohol per 100 millilitres of blood;
- Fees charged by a physician to complete claim forms or provide copies of medical reports.

CANADIAN RESIDENCY REQUIREMENT

No benefits are payable if the you reside outside Canada for any period exceeding 90 consecutive days or a total of 180 days in any 365-day period unless you:

- previously notified and received approval in writing from the insurer, or
- remained under the regular care of a licensed physician deemed appropriate by the insurer, and
- proof of the ongoing disability can be determined on evidence satisfactory to the insurer in English or French within 90 days of request.

EXTENDED INSURANCE

If your LTD insurance terminates during a period of total disability, the insurer continues to be liable as though the provision remained in force. If a recurrence of disability occurs within 6 continuous months after termination of this benefit, the insurer shall continue to pay your benefits but only for the remainder of the original maximum benefit period. Such disability must have been caused by an accident or sickness that occurred before termination.

The insurer shall not be liable for benefits after termination of either the contract or LTD income benefit, once a replacing insurer is bound contractually or as a matter of law.

TERMINATION OF COVERAGE

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

YOUR BENEFITS AND FEDERAL INCOME TAX

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

CRITICAL ILLNESS

This benefit applies only to you if you are an eligible Member under age 70. Critical Illness benefits cease in accordance with the "Termination of Coverage" provision, retirement or upon attainment of age 70, whichever is earlier.

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

You are covered for a flat amount of which is referred to as the principal sum. The principal sum reduces by 50% at age 65. A Recurrence benefit may be payable equal to the principal sum, subject to certain conditions as described under the Second Event Benefit.

BENEFIT PAYMENT CONDITIONS

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

- You survive for at least 30 days after diagnosis of a covered critical illness;
- The diagnosis is made within Canada;
- The diagnosis is made while you are eligible for coverage by the Trust Fund;
- Payment is not precluded by any general or specific exclusion or limitation set forth in the insurance contract;
- 100% of the principal sum has been paid, coverage terminates and no further benefits are payable, except as described under Second Event Benefit.

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

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

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

COVERED SERIOUS ILLNESSES*

- Addison's disease
- Amyotrophic Lateral Sclerosis
- Advanced Alzheimer's disease
- Benign brain tumour
- Coma
- Coronary artery bypass – surgical and non-surgical
- Heart attack
- Kidney (renal) failure
- Life-threatening cancer
- Loss of ability to perform nomal activities of daily living
- Blindness in both eyes
- Loss of speech
- Loss of hearing in both ears
- Loss of Hands and Feet
- Multiple sclerosis
- Muscular Dystrophy
- Non-life-threatening cancer (partial payment)
- Occupational Hepatitis and HIV infection
- Paralysis - Quadriplegia, paraplegia and hemiplegia
- Parkinson's disease
- Severe burn(s)
- Stroke

DIAGNOSTIC REQUIREMENTS

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

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

- Malignant melanoma to a depth of 1.00 mm or less, as determined using Breslow method,
- Any melanoma not invading the dermis classified as T1N0M0 under TNM Classification,
- Chronic Lymphocytic Leukemia (CLL), less than or equal to Stage I, as defined by RAI classification.
- Any papillary tumour of the bladder classified as Ta under TNM Classification,
- Any papillary tumour of the thyroid that is classified as T1N0M0 or less under TNM Classification and is one centimeter or less in diameter;
- Any tumour of the prostate classified as T1N0M0 under TNM Classification, and is one centimeter or less in diameter,

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

RECURRENCE BENEFIT

If you are diagnosed with cancer for which the principal sum has been paid and you have thereafter been considered actively at work for at least 90 days and are then diagnosed with a Heart Attack, End Stage Renal Failure, Stroke, Paralysis, Major Organ Transplant or Heart Transplant, then a Recurrence benefit equal to the principal sum will be payable. The Recurrence benefit subject to you surviving 30 days after the diagnosis of the second event.

If you are diagnosed with heart attack, stroke or coronary artery bypass for which the principal sum has been paid and you have

thereafter been actively at work for at least 90 days and are then diagnosed with Type 1 or Type 2 cancer, Advanced Alzheimer's disease, Addison's disease, muscular dystrophy, occupational HIV, coma, blindness in both eyes, loss of speech, loss of hearing, multiple sclerosis, Parkinson's disease, paralysis, loss of hands and feet, end stage renal failure, or severe burn(s), then a Recurrence Benefit equal to the principal sum will be payable. The Recurrence Benefit is subject to you surviving 30 days after the diagnosis of the second event.

The Recurrence benefit is payable only once. Payment of the Recurrence benefit will represent full and final discharge of all claims under Critical Illness benefits.

The insurer reserves the right to have any diagnosis of a critical illness or condition reviewed by a second physician of its choosing. If case of dispute regarding the appropriateness or correctness of the diagnosis, the insurer has the right to request an independent medical examination to examine you or the evidence used in the previous physicians' diagnosis. The decision of the third physician will be final.

Diagnosis (for Critical Illness benefits only): means a definitive and unequivocal diagnosis made by a physician based upon the use of clinical and/or laboratory investigations as supported by your medical records, and meeting any diagnostic requirements described in the insurance contract.

EXCLUSIONS

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

- the insured person not satisfying the survival period,
- suicide or attempted suicide while sane or insane, or from intentionally self-inflicted injury,
- any act of war, whether declared or undeclared,
- involvement in any type of active military service,
- engaging in an illegal occupation,

- being intoxicated while operating a motor vehicle:

  a. an insured person shall be conclusively presumed to be intoxicated if the level of alcohol in their 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 shall be considered proof of the insured person's intoxication. Being under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage,

- a diagnosis for which proof is submitted by a physician that is related to the insured person,

- refusing certain types of recommended medical treatment as follows:

  a. a Physician has recommended treatment with angioplasty or Coronary Artery Bypass Surgery for coronary artery disease, the Insured Person refuses this treatment, and they suffer a heart attack; or

  b. a Physician has recommended treatment for a brain aneurysm or carotid artery stenosis, the Insured Person refuses treatment, and they suffer a stroke; or

  c. a Physician has recommended a diagnostic biopsy or diagnostic/therapeutic excision of a mass or lesion suspected of being cancer the Insured Person refuses, and the Insured Person develops Type 1 Cancer, Skin Cancer, or Type 2 Cancer.

CLAIMS

Written notice of the covered loss within ninety (90) days of such covered loss, or as soon thereafter as reasonably possible. A claim form may be obtained from the Administrative Agent.

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

LIFE

MEMBER LIFE

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

BENEFICIARY

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

WAIVER OF PREMIUM BENEFIT

If, while covered under this Life Insurance, you become totally disabled and have not retired or attained the age of 65 and remain so disabled for 6 consecutive months, the insurer will waive payment of the Life Insurance premiums up to age 65, provided you remain so disabled and proof of disability are furnished as required. You must apply and be approved for Waiver of Premium.

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

The Trust Fund will maintain your premium payments for this 6-month qualifying period, provided you continue to be in receipt of WSIB or STD benefits. In order to qualify for a Waiver of Premium, you **must** notify the insurer within 12 months of the last active day at work and **must** furnish due proof of disability, satisfactory to the insurer, within 18 months of that last active working day.

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

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

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

If you die within 1 year of becoming totally disabled and unable to work due to such disability, but before due proof of the disability was furnished to the insurer, the insurer will pay your beneficiary the amount of Life Insurance to which you were entitled on the date you became so disabled. The insurer must receive proof of the death and total disability during this period not later than 1 year after your death.

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

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

However, if this contract or Waiver of Premium provision terminates, the insurer remains liable to provide Waiver of Premium benefits for a continuous disability caused by an accident or sickness that occurred prior to termination provided a claim is submitted within 12 months of the Member's last active day at work and due proof of disability, satisfactory to the insurer, is furnished within 18 months of the last active working day. At the end of any 6-month period during which the Member was not disabled, the insurer ceases to be liable for any further Waiver of Premium for disability caused by an accident or sickness that occurred prior to termination.

CONVERSION PRIVILEGE

If your entire amount of Life Insurance is discontinued because of a change in your eligibility status or your termination in this Plan, and you are under 65 years of age, you are entitled to purchase an individual Life Insurance policy issued by the insurer, subject to the following conditions:

- The amount of the individual policy shall not exceed the amount of insurance for which you were covered when coverage was discontinued, subject to a maximum of $200,000;
- The individual policy shall be, at your option, in the form of a convertible 1-year term insurance policy, a term to age 65 insurance policy or an ordinary Life Insurance policy. This individual policy shall be without dividends and without disability waiver or other supplementary benefits;
- The premium for the individual policy shall be determined by the insurer according to:
    - the insurer's current rates for your attained age (nearest birthday) on the effective date of the individual policy,
    - the class of risk to which you then belong, and
    - the form and amount of the individual policy.
- The first premium and written application for the individual policy shall be delivered to the insurer within 31 days after the date on which your insurance is terminated;
- Insurance under the individual policy shall be effective at the end of the 31- day period described above;
- Evidence of insurability shall not be required for such individual policy.

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

Note: This conversion privilege does not apply to Life Insurance that is terminating or reducing because you retire or attain a certain age specified in the Group Policy.

DEPENDENT LIFE

In the event of the death of your eligible spouse and/or dependent children while insured, the amount of dependent Life Insurance as specified in the "Summary of Benefits" is payable to you. If you die, the benefit will be payable to your estate.

PREMIUM WAIVER FOR DEPENDENTS

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

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

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

CONVERSION OPTION FOR DEPENDENTS

An individual Life Insurance policy issued by the insurer may be purchased on the life of an eligible spouse who is under 65 years of age if the insurance ceases due to your insurance terminating, a change in your spouse's status as a dependent, or because of your death. The conditions under which this policy may be purchased are the same as those described under the "Member Life" section, however the policy will be on the life of the spouse. The premium rates will be based on the age and class of risk of the spouse. You will be the owner of the individual policy, unless you are deceased and then your spouse will be the owner. You or your spouse should contact the Administrative Agent for details. Written application together with the initial premium due must be submitted to the insurance company within 31 days of the date your spouse's coverage terminates.

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

ACCIDENTAL DEATH & DISMEMBERMENT

The benefits described in this section apply to eligible Members only. Accidental Death & Dismemberment (AD&D) benefits cease when you reach age 70 or in accordance with the "Termination of Coverage" provision, whichever is earlier.

Unlike other benefits that only cover what government benefits do not, AD&D benefits pay a lump sum **on top of** other coverage you may have. For example, for non-occupational accidents, you would get a lump sum AD&D payment as well as your provincial government plan covering your hospital and medical bills. For occupational accidents, you would get a lump sum AD&D payment as well as EI coverage for treating your injury.

The benefit is payable for the loss of life, limbs, fingers, toes, eyesight and hearing as well as the use of certain body parts which are the result of accidental bodily injuries that occur within 1 year from the date of the accident.

This coverage applies 24 hours a day, 365 days a year, on or off the job, anywhere in the world, including while traveling (as a passenger only) in commercial or chartered aircraft.

The insurer shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pending and payment period, if any, of such claim.

YOUR BENEFICIARY

If you die, the Principle Sum specified in the "Summary of Benefits" is payable to your named Beneficiary. If you have not named a Beneficiary or if the Beneficiary on file has died, benefits are payable to your estate. The Beneficiary you name for AD&D will also apply to Life Insurance.

You may change your named Beneficiary, subject to governing law, by filing a new Registration Form with the Administrative Agent. Your form will be forwarded to the insurer and the change will take effect as of the date such request was executed, but without prejudice to the insurer for any payment(s) made before such request is received at its head office.

You should review your Beneficiary designation to be sure that it reflects your current intent.

LOSS SCHEDULE

The table titled “Loss Schedule” lists specific losses and the amount that will be payable if an injury results in a loss within 1 year from the date of an accident. The amount that will be payable appears as a percentage of the principal sum which is specified in the “Summary of Benefits”. For example, you may receive 200% or 2 times the Principle Sum for total paralysis. If more than one loss listed on the “Loss Schedule” results from a single accident within 1 year from the date of the accident, the insurer will pay for one (the largest) of the benefits.

LOSS SCHEDULE	
Loss of	**Maximum % of Principal Sum Payable**
Life	100%
Both hands or both feet	100%
Entire sight of both eyes	100%
One hand and one foot	100%
One hand and entire sight of one eye	100%
One foot and entire sight of one eye	100%
Speech and hearing in both ears	100%
Brain death	100%
One arm or one leg	75%
One hand or one foot	75%
Entire sight of one eye	75%
Speech or hearing in both ears	75%
Thumb and index finger of the same hand	34%
Four fingers of the same hand	34%
Hearing in one ear	34%

LOSS SCHEDULE CONTINUED Loss of Use of	Maximum % of Principal Sum Payable
Both hands or both feet	100%
One hand and one foot	100%
One hand or one foot plus loss of sight in one eye	100%
Thumb and index finger of the same hand	34%
Total Paralysis of	
Both upper and lower limbs (quadriplegia)	200%
Both lower limbs (paraplegia)	200%
Upper and lower limbs of one side of the body (hemiplegia)	200%

ADDITIONAL BENEFITS

If you sustain a loss that results in a payment being made under the "Loss Schedule", you may be eligible for additional benefits according to the table titled "Additional AD&D Benefits". Contact the Administrative Agent for more information about these benefits.

ADDITIONAL AD&D BENEFITS		
Benefit	**Maximum Amount**	**When Applicable**
Home alteration & vehicle modification	$50,000	Injury
Rehabilitation	$15,000	Injury
Family transportation	$15,000	Injury
In-hospital confinement monthly income	$2,500 per month	Injury
Seat belt	10% increase to max $10,000	Injury or loss of life
Air Bag	5% increase to max $5,000	Injury or loss of life
Repatriation (return home)	$15,000	Loss of life
Spousal occupational training	$15,000	Loss of life
Day care	$5,000	Loss of life
Parental care	$5,000	Loss of life
Special education	$5,000	Loss of life
Funeral	$5,000	Loss of life
Identification	$5,000	Loss of life
Cosmetic disfigurement	$25,000	Second-degree or higher burn
Serious illness	$10,000	Illness

Exposure and Disappearance
Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded you. If your body has not been found within 1 year of the disappearance, stranding, sinking or wrecking of the conveyance in which you were riding at the time of the accident it shall be presumed, subject to all other conditions of this policy that you suffered a loss of life resulting from bodily injuries sustained in a covered accident.

Loss (for AD&D benefits only): with respect to hand or foot, is actual severance through or above the wrist or ankle joint; with respect to arm or leg is actual severance through or above the elbow or knee joint; with respect to eye is the total and irrecoverable loss of sight; with respect to speech is the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing is the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger is actual severance through or above the first phalange; with respect to fingers is the actual severance through or above the first phalange of all 4 fingers of the same hand; with regard to toes is the actual severance of both phalanges of all toes of the same foot. If you suffer complete severance of a hand, foot, arm or leg as described above, the insurer will pay the applicable benefit amount, even if the severed limb is surgically attached, whether successful or not.

Loss of Use (for AD&D benefits only): means the total and irrecoverable loss of function of an arm, hand, leg, foot, or thumb and index finger, provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to the insurer to be permanent.

Brain Death (for AD&D benefits only): 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.

Loss (for AD&D benefits only): used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs) and hemiplegia (paralysis of upper and lower limbs of one side of the body) means the complete and irrecoverable paralysis of such limbs.

PREMIUM WAIVER

Payment of premiums for AD&D benefits may be waived if the insurer has approved your application for a waiver of premium for Life benefits.

EXCLUSIONS

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

- Flying in an aircraft owned or leased by your employer, yourself or a member of your household, or aircraft being used for any test or experimental purpose,
- Firefighting, power line inspection, pipeline inspection, aerial photography or exploration,
- Flying as pilot or crew member in any aircraft or device for aerial navigation,
- Full-time, active duty in the armed forces,
- Declaration of war or any act thereof, and
- Intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane.

JURY DUTY

You are eligible for Jury Duty benefits, if you:

- are an insured Member under the Teamsters Local Union 230 Members' Benefit Fund,
- are employed by a contributing Employer to the Trust Fund at the time of Jury Duty, and
- have suffered a loss of earnings due to an interruption of employment normally performed as a result of Jury Duty Leave.

A Jury Duty Benefit is payable in the amount of $100 per day, up to a maximum of 50 days, for attending court proceedings. Proof of loss wages from work due to Jury Duty Leave is required. **Partial Days are not covered.**

Jury Duty Benefits shall only be paid once you:

- complete and sign a Declaration Form available from the Local,
- submit a copy of the courthouse summons letter, and
- submit a copy of the letter from the courthouse confirming dates attended.

All of the information requested must be submitted to the Administrative Agent at:

Teamsters Local Union 230 Members' Benefit Fund
c/o Ellement Consulting Group
10154 108 Street NW,
Edmonton, Alberta T5J 1L3

BEREAVEMENT PAY

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

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

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

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

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

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

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

Bereavement Pay benefits are payable to Members in the amount of $150 per day for up to 3 days of lost work in relation to a Member's attendance at a funeral or memorial service upon death of a child, grandchild, parent, grandparent, parent-in-law, grandparent in law, sibling, sibling-in-law, or spouse, as defined above.

Bereavement Pay benefits shall only be paid to Members who:

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

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

GROUP LEGAL

A description of the Group Legal benefits is available at the following Trust Fund website: www.230benefits.ca.

HOW TO CLAIM

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

GENERAL CLAIMS INFORMATION

Extended Health Care Claims

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

If you prefer to submit your claims manually for reimbursement, claim forms are available on the website (www.230benefits.ca) or can be requested by contacting Ellement. Paper claims can also be submitted via email or mailed to Ellement's office for processing.

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

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

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.

Dental Claims

Ellement will process dental claims using the TELUS AdjudiCare electronic claims processing service. With AdjudiCare, dental claims can be sent directly from the dental office to our claims department for adjudication.

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 this service, inform the dentist that Ellement is the plan administrator and present them with the following security codes:
the TELUS AdjudiCare Dental Network **carrier** identification number (also known as the BIN number) is **000034** and your Certificate number, as it appears on your benefit card; and the policy number of **62482** for this group benefit plan.

The plan administrator can provide the required Certificate number.

When a dental care claim is submitted electronically, it will be processed within two business days.

Drop Off Your Claims

Ellement offers a convenient drop-off service for your health and dental claims. Employees can submit claim forms and original receipts in person Monday to Friday during regular business hours to Ellement’s office located at 16 Ronrose Drive, Suite 303, Vaughan, Ontario L4K 4R3.

Direct Deposit for Claims Reimbursement

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

With Ellement’s Direct Deposit for Claims Reimbursement Form, you can receive reimbursement within two to five days following the approval of your medical or dental claims. No need to wait for the arrival of a cheque and a trip to the bank before depositing the reimbursement.

To enrol, please contact Ellement to request a Direct Deposit for Claims Reimbursement Form.

HOW COORDINATION OF BENEFITS (COB) WORKS

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

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

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

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

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

- the plan of the parent with custody of the child;
- the plan of the spouse of the parent with custody of the child;
- the plan of the parent without custody of the child;
- the plan of the spouse of the parent without custody of the child.

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

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

The first plan to receive the claim should also receive the original

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

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

CLAIMS FOR SPECIFIC BENEFITS

The claims process for some benefits is different than standard vision care, major medical or dental claims. The processes for Prescription Drug, Group Emergency Medical (Travel), Member & Family Assistance, Second Opinion, Weekly Wage Replacement, LTD, Life and Accidental Death & Dismemberment claims are explained below.

Prescription Drug Claims
To claim prescription drug benefits, present your Prescription Drug Card to your pharmacist who will electronically submit a claim on you or your eligible Dependents' behalf. Immediately, your claim will be processed and the pharmacy will receive notification of which expenses are reimbursable.

If you have any other difficulties using your Prescription Drug Card, contact the Administrative Agent.

Group Emergency Medical Insurance Claims (Travel)
If you require emergency travel medical care or hospitalization, you or someone acting on your behalf should contact Zurich Travel Assist immediately:

- U.S. and Canada **1-877-541-0127**
- Elsewhere (collect call) **1-416-649-2555**

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

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

To make a claim for out-of-pocket expenses, contact Zurich Canada Travel Assist operator. Give the operator your name and your policy number: 8623205. The operator will send you a claim form. When you complete the form, provide the:

- ✓ Name of your Trust Fund,

- ✓ Policy number,
- ✓ Patient's first and last name,
- ✓ Patient's provincial health card number, and
- ✓ Your identification number.

You may also need to attach the following information:

- ✓ Proof of payment by the insured person and by any other benefit plan; medical records including completed diagnosis by the attending physician or documentation from the hospital, which must support that the treatment was medically necessary; proof of accident if insured person submitting claim for dental expenses resulting from accident; proof of travel including departure date and return date; original itemized receipts for all bills and invoices; if requested, historical medical records.

Send your completed form and attachments either by:

Mail:

Claims Department
Zurich Canada Travel Assistance
c/o Zurich Travel Assist
100 King St West, Suite 5300
Toronto, ON M5X 1C9

Email: **travelclaims@wtp.ca**

Zurich Canada will then coordinate with the provincial plan reimbursement of those approved, reimbursable expenses.

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

- Call toll-free **1-866-814-0018**

Cloud MD Second Opinion
The second opinion may be requested by calling the number below and identifying yourself as a member of the Teamsters Local Union 230 Members' Benefit Fund.

- Call toll-free **1-866-814-0018**

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

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

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

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

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

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

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

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

TIME LIMITS FOR FILING CLAIMS

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

- ✓ **Extended Health**: 12 months after the date the expense was incurred;
- ✓ **Dental**: 12 months after the date a service is received;
- ✓ **Hospital Cash**: 90 days after the date of hospitalization;
- ✓ **Emergency Medical Insurance (Travel):** 90 days after emergency treatment and/or services were provided;
- ✓ **Weekly Wage Replacement**: within 6 months after the termination of the first month following the waiting period;
- ✓ **Long Term Disability**: within 6 months after the termination of the first month following the waiting period;
- ✓ **Critical Illness**: 12 months after the date of diagnosis;
- ✓ **Life**: 12 months after death;
- ✓ **Waiver of Premium for Life Benefits**: 18 months of your last day at work because of total disability;
- ✓ **Accidental Death & Dismemberment**: 12 months after death or accident.

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

WHEN TO EXPECT PAYMENT

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

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

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

HELP GUARD AGAINST INSURANCE FRAUD

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

You can help guard against insurance fraud by:

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

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

GOVERNMENT BENEFITS

The Trust Fund cannot reimburse you for charges that are considered an insured service or item of any provincial government plan. This means that you should apply for these programs before or instead of seeking reimbursement from the Trust Fund. The following 7 programs are available to residents of Ontario:

Ontario Health Insurance Plan (OHIP)

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

The Ontario Drug Benefit (ODB)

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

The Trillium Drug Program (TDP)

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

The Ontario Assistive Devices Program (ADP)

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

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

Employment Insurance (EI)

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

Workplace Safety and Insurance Board (WSIB)

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

Canada Pension Plan (CPP) Disability Benefits

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

DEFINITION OF GENERAL TERMS

Active Member is a person who is working for a contributing employer or is available for work as determined by his/her name appearing on the Union Out-of-Work List and satisfies the eligibility requirements of the Teamsters Local Union 230 Members' Benefit Fund.

Administrative Agent performs the daily administrative functions of the Trust Fund. When you contact the Administrative Agent's claims office, you are speaking to a staff member of Ellement Consulting Group ("Ellement").

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

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

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

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

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

Eligible Dependent is a person who has satisfied the Dependent eligibility requirements of the Teamsters Local Union 230 Members' Benefit Fund.

Eligible Member is a person who has satisfied the Member eligibility requirements of the Teamsters Local Union 230 Members' Benefit Fund.

Eligible Widow is a person who:

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

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

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

Licensed Nurse is a registered nurse (RN), a registered nursing assistant (RNA), or a registered practical nurse (RPN).

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

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

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

Reasonable and Customary Expense means

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

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

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

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

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

Trust Fund refers to the Teamsters Local Union 230 Members' Benefit Fund

You refers to an Active Member who has satisfied the eligibility requirements of the Teamsters Local Union 230 Members' Benefit Fund.

YOUR PRIVACY

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

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

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

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

PRIVACY OFFICER
1345 Taylor Avenue
Winnipeg, Manitoba R3M 3Y9

Email: privacy@ellement.ca

Telephone: 204.954.7300
Toll Free: 1.888.840.1045
Fax: 204.954.7310

NOTICES

NOTICE A: THIS BOOKLET IS NOT A CONTRACT

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

NOTICE B: RIGHT CHANGE OR TERMINATE

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

NOTICE C: COVERAGE CANNOT BE ASSUMED

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

NOTICE D: INSURANCE FRAUD

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

NOTICE E: THE INTERNET IS NOT SECURE

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

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

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

NOTICE F: LEGAL ACTIONS

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

NOTICE G: APPEALS

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

NOTICE H: BENEFIT LIMITATION FOR OVERPAYMENT

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

NOTICE I: CHANGE OF INSURER

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

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

INSURERS

Canada Life (Policy #163849)

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

Cloud MD

- Second Opinion
- Member & Family Assistance Program

Zurich Canada

- Accidental Death & Dismemberment (Policy # 8623204)
- Critical Illness (Policy # 8623209)
- Emergency Medical Insurance (Policy # 8623205)