TEAMSTERS AND TORONTO READY-MIX PRODUCERS' BENEFIT PLAN TRUST FUND

Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund // April 2018

MEMBER BENEFITS INFORMATION BOOKLET
April 2018

Visit us online at
www.gtareadymixbenefits.com

CUSTOMER SERVICE

The Trust Fund's Administrative Agent, Benefit Plan Administrators Limited (BPA), 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.gtareadymixbenefits.com

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 1-800-867-5615 or email claims@bpagroup.com

Plan Administrator

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

✓ Phone 1-800-867-5615 or email administration@bpagroup.com

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

Administrative Agent
Benefit Plan Administrators Limited (BPA)

P.O. Box 3071, Station "A"
Mississauga, Ontario L5A 3A4

Phone Number: 905-275-6466
Toll-Free Number: 1-800-867-5615
Fax Number: 905-275-6462

INSURERS

Great West Life Assurance Company (Policy #156286)

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

AIG Insurance Company of Canada

- Emergency Travel Medical (Policy #SRG 9104748)
- Hospital Cash (Policy #SRG 9136858)
- Critical Illness (Policy #CI 9136855)

Homewood Health Incorporated (HHI) (Ontario)

- Member & Family Assistance Program

WorldCare International Incorporated

- Second Opinion

Chubb Life Insurance Company of Canada (Policy #ABT 10241018)

- Accidental Death & Dismemberment

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INTRODUCTION

This booklet describes the eligibility requirements, conditions of coverage and claims procedures for The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund, which is referred to in this booklet as the Trust Fund.

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 the Collective Agreement. We, the Board of Trustees, look after the Trust Fund.

We are responsible for the design of the benefit package provided by the Trust Fund, for the allocation of the contributions made to the Trust Fund, for establishing the eligibility requirements in an effort to treat all Members and their families fairly and to guard the Trust Fund against abuse.

To help us carry out our duties, we have appointed various people such as accountants, consultants and lawyers to provide us with professional advice. We meet with these advisors from time to time to review matters that arise in the running of the Trust Fund. We make all decisions that are necessary at these meetings by taking a vote among ourselves.

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, Benefit Plan Administrators Limited (BPA). It performs the daily administrative functions of the Trust Fund.

We hope that these benefits are of value to you and your eligible Dependents.

The Board of Trustees

ELIGIBILITY

MEMBER ELIGIBILITY

This Trust Fund is for members of Teamsters Local Union 230.

Eligibility Requirements
You are eligible for Active coverage if:

- You live in Canada,
- You are insured by a provincial health plan,
- You are a member in good standing of Teamsters Local Union 230,
- You accumulate three monthly deductions in your Dollar Bank. Your coverage is effective on the first day of the month following that accumulation, and
- You return to active, full-time work for one full day 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.

Dollar Bank
Your Dollar Bank is the account of the hourly contributions made by your employer on your behalf. Along with four other eligibility requirements, the balance in this account determines your eligibility for benefits.

Definition: Monthly Deduction is the accumulated work hours required to be eligible for benefits. A monthly deduction is not equivalent to an actual month of work, it may take some plan members longer than others to accumulate the same number of hours and, to manage the Trust Fund, the Trustees may change the number of work hours that constitute a monthly deduction. Contact the Administrative Agent if you want to review the employer contributions made on your behalf.

You initially become eligible for coverage when you accumulate three monthly deductions in your Dollar Bank. Your coverage is effective on the first day of the month following that accumulation. For example, if you achieve the required accumulation of hours worked in June, your coverage will be effective on July 1.

You will continue to be eligible for benefits as long as your Dollar Bank contains at least one monthly deduction. If in any month the balance in your Dollar Bank exceeds one monthly deduction, the excess will remain in your account for future deductions up to twelve monthly deductions.

If you accumulate more than twelve monthly deductions, these funds will be transferred to the general reserve of the Trust Fund. This reserve is used for multiple purposes such as supporting coverage for disabled and Retired Members.

The Trust Fund has been designed by the Board of Trustees to provide you with benefits during times you are working and with assistance during times of unemployment and disability. If in any month the balance in your Dollar Bank is insufficient to cover one monthly deduction, provisions are available: Fund Assistance and Direct Payments.

Fund Assistance for Disabled Members (Under Age Sixty-Five)
To be eligible for Fund Assistance, you must remain a member in good standing of your local union and be under age sixty-five.

If you are absent from work due to an illness or injury, your Dollar Bank will be frozen and coverage will be maintained for up to twelve months if you are receiving one of the following benefits:

- Weekly Wage Replacement benefits, commonly known as Short Term Disability (STD) and Weekly Indemnity (WI), through The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund,
- Long Term Disability (LTD) benefits through The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund,
- *Workplace Safety & Insurance Board (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. It is your responsibility to contact the plan administrator to confirm your continuing coverage.

You may be eligible to continue Fund Assistance beyond the initial twelve-month period if you are totally and permanently disabled.

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.

Fund Assistance for Disabled Members (Over Age Sixty-Five)
Effective January 1, 2017, if you turn age sixty-five 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 fifty-two weeks.

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

Direct Payment
To be eligible for Direct Payment, you must remain a member in good standing of your local union, be under age sixty-five, and have exhausted your Fund Assistance options.

If in any month your Dollar Bank does not contain a full monthly deduction, you may be eligible to make Direct Payment for your benefit coverage. You may make Direct Payment for up to twelve months if your termination of employment is due to disability or lay-off or three months if your termination of employment is voluntary.

All benefits are continued by Direct Payments except Weekly Wage Replacement and LTD.

Retiree Coverage
You may make Direct Payment for a full package of benefits if you notify the Administrative Agent within thirty-one days of your retirement or within thirty-one days of depleting your Dollar Bank and meet several other requirements.

For eligibility requirements and a summary of benefits, obtain a separate brochure from the Administrative Agent or the Trust Fund's website.

Definition (for Retiree Coverage only): Retirement is the date a person starts to collect a pension benefit from any pension plan.

TERMINATION OF MEMBER COVERAGE

On termination of your coverage, you may have the option to convert a portion of your Life benefits to an individual life insurance policy. Details appear in the "Life" section of this booklet.

Your insurance will be discontinued on the earliest of the following dates:

- The date the insurance contract is cancelled or terminated,
- The date you cease to be a member in good standing of the union,
- The last day of the month following the month in which your Dollar Bank does not contain a full monthly deduction,
- The date you retire (except as explained under "Retiree Coverage" in this section),
- The last day of the month following the month in which you have exhausted the benefit extensions provided through the "Fund Assistance for Disabled Members" provision,
- The last day of any month in which you have made the maximum number of contributions through the "Direct Payment" provision,
- The first of the month following the month in which you reach the benefit age limit which appears in the "Summary of Benefits" section of this booklet, or
- The date you cease to be in the classification of persons who may be eligible for coverage by the Trust Fund.

REINSTATEMENT OF MEMBER COVERAGE

Your coverage will be reinstated after a period of termination when you accumulate 240 hours in your Dollar Bank. Your coverage is effective on the first day of the month following that accumulation. For example, if you achieve the required accumulation of hours worked in June, your coverage will be effective on July 1.

If you have been out of benefit for twelve consecutive months, your coverage will be reinstated when you satisfy the "Eligibility Requirements".

DEPENDENT ELIGIBILITY

A Dependent is eligible for benefits if:

- You are eligible for benefits,
- He/she lives in Canada,
- He/she is insured by a provincial health plan,
- He/she conforms to the definition of Dependent Spouse or Dependent Child,
- He/she is named on the most recent Member Information Card on file with the Administrative Agent,
- He/she is over fourteen days of age for the Hospital Cash Benefit, and
- He/she has been given a final release by a physician if he/she was confined for medical treatment in an institution or at home on the date his/her coverage would otherwise become effective.

Definition: Dependent Spouse means:

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

A former spouse is not eligible for coverage unless insurance protection for some of the benefits available under this plan is mandated by court order.

File a new Member Information Card every time your marital status changes.

Definition: Dependent Child means:

- Your unmarried child (over fourteen days of age for the Hospital Cash Benefit only) and under twenty-one years of age provided he/she is not working more than thirty hours a week,
- Your unmarried child under twenty-five 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 your child reaches age twenty-one), and

- 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.

Note: Dependent child coverage is extended for drugs to age twenty-six, if a full-time student and a resident of Quebec.

File a new Member Information Card every time your Dependent status changes.

Continuing Coverage for Children Who Are Functionally Impaired
Extended Health, Dental, Dependent Life, Emergency Travel Medical and Hospital Cash coverage will continue beyond the date an unmarried child reaches the limiting age for coverage, provided proof is submitted to the insurer within thirty-one days after such date that such child:

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

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

Continuing Coverage If an Eligible Member Dies
Extended Health and Dental coverage for eligible Dependents may continue without premium payment for a maximum of twenty-four months.

TERMINATION OF DEPENDENT COVERAGE

Your Dependent's insurance will be discontinued on the earliest of the following dates:

- The date your coverage terminates,
- The date your Dependent ceases to be eligible,
- The date your Widow remarries, or
- The date the insurance contract or coverage is cancelled or terminated.

ENROLMENT

Claims cannot be paid on behalf of you or your eligible Dependents unless a completed Member Information Card is on file. You may obtain the card from the Administrative Agent or your union office.

File a new Member Information Card every time:

- You want to change your Beneficiary,
- You want a new Dependent to be eligible for coverage by the Trust Fund or one to be removed, and
- Your marital status changes.

MAINTAIN ACCURATE COVERAGE

The Member Information Card asks you to list your current Dependents' names and birth dates exactly as they appear on their provincial health cards. Avoid nicknames.

Within thirty days of any changes to your Dependent or marital status, you should file a new Member Information Card with the Administrative Agent. This information is important to ensure uninterrupted coverage and avoidance of any delays in the assessment of claims.

Until directed otherwise by a new Member Information Card, claims will be processed according to the most recent Member Information Card on file. For example, claims for a second spouse will not be paid until a new Member Information Card replaces the first spouse as an eligible Dependent. Only one spouse is eligible for coverage by the Trust Fund at a time.

Send written notification of address change as soon as possible.

NAME A BENEFICIARY

The Member Information Card asks you to name a Beneficiary, subject to governing law, for Life and Accidental Death & Dismemberment benefits. If you have not named a Beneficiary or if the Beneficiary on file has died, benefits are payable to your estate.

You may change your named Beneficiary, subject to governing law, by filing a new Member Information Card with the Administrative Agent. Your card 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.

SUMMARY OF BENEFITS

Definition: 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.

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

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

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

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

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

Definition: 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.

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

Definition: 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.

EXTENDED HEALTH For Eligible Members and their Dependents	
Percentage payable	80% except where noted
Deductible	NIL
PRESCRIPTION DRUGS (Prescription Drug Card)	
Percentage payable	100% with a $6.50 dispensing fee maximum
Vaccines	Covered
Anti-smoking aids	$500 lifetime maximum, unless otherwise required by law
PARAMEDICAL	
Reimbursement paid at 80% 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 podiatrist, chiropractor, and osteopath	$500 per calendar year per practitioner, including x-rays
chiropodist, acupuncturist, clinical psychologist, naturopath, physiotherapist, massage therapist, and speech therapist	$500 per calendar year per practitioner
MAJOR MEDICAL	
Ambulance service	Local ambulance, air ambulance limited to economy airfare
Out-of-hospital nursing	$10,000 every 3 years (pre-approval required)
Accidental dental	Covered within 12 months of the accident (treatment must begin within 60 days)
Durable medical equipment and supplies such as:	
Transcutaneous nerve simulators	$700 lifetime maximum
Breast prostheses	Every 2 calendar years
Surgical stockings	2 pairs per calendar year
Surgical brassieres	2 per calendar year
Wigs	$700 lifetime maximum
Glucose meter	50% to $350 lifetime maximum
HEARING AIDS	
	$500 every 3 years

EXTENDED HEALTH continued
For Eligible Members and their Dependents

ORTHOPAEDIC SHOES or ORTHOTICS	
Custom-made orthopaedic shoes or orthotics	1 pair per calendar year up to $500

VISION CARE	
Percentage payable	100%
Adults – one pair of lenses & frames or contact lenses or prescription sunglasses, or prescription safety glasses (for Members only), including 1 eye examination and retinal scanning for claimants between the ages of 19 and 64	$400 every 24 months
Dependent children under age 18 – one pair of lenses & frames or contact lenses	$400 every 12 months
Disposable contact lenses	$100 every 6 months or 4 times within any 24-month period

EMERGENCY TRAVEL MEDICAL
For Eligible Members and their Dependents
Terminates at Age 80

Lifetime maximum under age 70	$5,000,000
Lifetime maximum ages 70 to 74	$1,000,000
Lifetime maximum ages 75 to 80	$500,000

Limited to trips of 90 consecutive days. Internal maximums may apply.

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 more than 3 consecutive days.

DENTAL
For Eligible Members and their Dependents

Reimbursement is based on the general practitioner's provincial fee guide of your home province for the year recognized by the Trust Fund at the time the service is rendered.

Percentage payable	
Diagnostic & preventative	100%
Minor restorative	80%
Endodontic & periodontic	80%
Oral surgery	80%
Dentures	80%
Major restorative	50%
Prosthodontics fixed	50%
Prosthodontics removable	50%
Orthodontic (for Dependent children under age 21)	50%

Deductible	NIL
Lifetime maximum	$2,000 for orthodontic
Calendar year maximum	$3,000 per individual for all procedures

DIAGNOSTIC AND PREVENTATIVE	
Complete oral examination	Once every 3 years
Recall or specific examination	Once every 9 months
Full-mouth & panoramic x-rays	Once every 3 years
Intra-oral x-rays	15 films every 3 years
Polishing and fluoride application	Once every 9 months
Oral hygiene instruction	Once every 12 months for Dependent children under age 15
Pit and fissure sealants on bicuspids and permanent molars	Once every 5 years
Scaling	8 units per calendar year (combined with periodontal root planning)
Occlusal equilibration	8 units per calendar year

DENTURES	
Relines/rebases/repairs	Once every 36 months
Replacements	When the existing appliance is at least 5 years old and unserviceable

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 if hospitalized
Benefit amount	60% of salary to the 2018 EI maximum of $547 per week
Benefit period	52 weeks (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, reduces 50% at age 65
Covers only specific conditions.	

LIFE For Eligible Members	
Active 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

EXTENDED HEALTH

The benefits in this section apply to eligible Members, their eligible Dependents and Widow. Extended Health benefits cease upon reaching any limiting age or in accordance with the “Termination of Member Coverage” provision, whichever is earlier.

The Extended Health benefit is designed to provide valuable supplementary protection, not to duplicate coverage by any provincial government plan. Therefore, Extended Health benefits exclude (1) services and supplies to the extent benefits can be obtained for them under a provincial government 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 limitations in mind. Before incurring any major expenses you may submit details to the Administrative Agent that will inform you of what benefits, if any, are available under the Plan.

Reimbursable expenses are for the treatment of pregnancies and accidents and sicknesses that are non-occupational. The charges will only be considered reimbursable 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 insurer. A medical expense shall be deemed incurred as of the date the service or supply is provided, and you must be eligible for benefits on that date for the expense to be considered.

PRESCRIPTION DRUGS

Prescription Drug Card

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.

An Assure Claims check is done before a prescription is dispensed. Depending on the outcome of these checks, the pharmacist may refuse to dispense the prescribed drug.

Covered Prescription Drug Expenses
To be considered for reimbursement, a drug must be:

- Medically necessary,
- Legally require a prescription from a physician or other professional authorized by provincial legislation to be purchased,
- Dispensed by a pharmacist or physician legally authorized to dispense such drugs and prescriptive, restrictive, controlled or narcotic in nature[1], and
- Provided in Canada.

The following are some reimbursable prescription drug expenses:

- Life-sustaining Drugs;
- Injectable medications;
- Oral and non-oral contraceptives and contraceptive appliances, such as intrauterine devices (IUD's), rings and patches;
- Anti-obesity Drugs;
- Vaccines;
- Diabetic supplies, including charges for standard syringes, needles and diagnostic aids, requires for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered).

A dispensing fee charge up to $6.50 is reimbursable. To avoid any out-of-pocket expense, you should review your current dispensing fee charges with your pharmacist as fees vary among pharmacies.

To avoid additional dispensing fees, you should also consider purchasing a ninety-day supply of drugs that you take regularly on a long-term basis.

[1] Warning: Even if a person is taking opioids such as oxycodone or morphine as prescribed by a physician, he/she may become addicted. The coverage of prescribed opioids may be monitored and restricted to a thirty-day supply.

The maximum single purchase of drugs that will be considered is the amount that would reasonably be consumed within thirty-four days, except for certain maintenance drugs that would reasonably be consumed or used within one hundred days of the date of purchase. Purchasing generic drug equivalents whenever possible will help the Trust Fund contain costs.

In Canada, a generic drug has the same active chemical ingredients as the brand name drug, so generic substitution is simply the substitution of a less expensive drug for the originally prescribed brand name drug. This can be done by the pharmacist without the consent of your physician and is the normal practice of many pharmacists for a limited number of drugs.

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 blood letting 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, contraceptive implants or appliances, except for intrauterine devices (IUD's), rings and patches;
- 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;

- Fertility drugs, whether or not prescribed for a medical reason;
- Drugs used to treat erectile dysfunction;
- Drugs or drug supplies not listed in the *Liste de médicaments* 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 twenty-five and you are a resident of Quebec.

Note: If you are age sixty-five 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 sixty-day period immediately following:

- the date you reach age sixty-five, or
- the date you become a resident of Quebec, within the meaning of the Health Insurance Act, Quebec, if you are age sixty-five 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*[2].

PARAMEDICAL

The following paramedical expenses are reimbursable (refer to the "Summary of Benefits" for maximums where applicable):

[2] The Ontario Drug Benefit (ODB) and the Trillium Drug Program (TDP) provide provincially funded benefits to residents of Ontario. They are listed in the "Government Benefits" section.

- The paramedical services of a regulated or licensed acupuncturist, chiropodist/podiatrist, chiropractor, clinical psychologist, speech therapist, naturopath, osteopath, physiotherapist and massage therapist. A physician must prescribe the services of a registered massage therapist and include the nature of the condition being treated and the estimated duration of therapy, and
- Diagnostic x-ray charges from a regulated or licensed podiatrist, chiropractor, or osteopath.

No amount is reimbursed for any paramedical services until any applicable provincial health plan benefit is exhausted.

MAJOR MEDICAL

The following major medical expenses are reimbursable (refer to the "Summary of Benefits" for limits where applicable):

Ambulance Service
Reimbursable expenses are for professional ambulance service, including emergency transportation by airline, to and from the nearest hospital qualified to provide the necessary treatment. Such emergency transportation by airline is subject to a maximum benefit equal to the economy airfare for the insured, and if medically required, a medical attendant who is neither a resident in your home nor a relative of your family.

Out-of-Hospital Nursing
Reimbursable expenses, if pre-approved by the insurer, are for the home services of a Registered Nurse (RN), registered nursing assistant (RNA) or a registered practical nurse (RPN) while you or an eligible Dependent is not confined to a hospital. The nurse must not ordinarily reside in your home or be a relative of your 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.

Coverage is subject to obtaining pre-approval. For pre-approval, you should ask your physician to submit a letter to the Administrative Agent. A physician's letter should contain the following information:

- ✓ A description of you or your eligible Dependent's current medical condition and prognosis,

- ✓ A list of the required nursing services and their frequency,
- ✓ An indication of the level of skill required to perform the required services, meaning those of a Registered Nurse (RN), registered nursing assistant (RNA) or registered practical nurse (RPN),
- ✓ The number of hours of care required per day or week, and
- ✓ An estimate of the length of time care will be required.

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.

Accidental Dental
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 begin within sixty days and be completed within twelve months of the accident to be a reimbursable medical expense.

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

Durable Medical Equipment and Supplies[3]
Reimbursable expenses are for the rental or purchase, if pre-approved by the insurer, of durable medical equipment of the type and model adequate for your medical needs based on the nature and severity of the disability. All medical equipment and supplies must be prescribed by a Physician.

Except for custom-made items such as prostheses, the insurer requires pre-approval of items such as hospital beds and wheelchairs. For pre-approval, you should ask your physician to submit a letter to the Administrative Agent. A physician's letter should contain the following information:

- ✓ The nature of the disability,
- ✓ The type of durable medical equipment required,

[3] The Assistive Devices Program (ADP), a provincially funded program available to residents of Ontario, is listed in the "Government Benefits" section.

- ✓ Why the equipment is needed, and
- ✓ The estimated duration of this need.

Pre-approval of medical equipment and supplies is subject to all insurance contract provisions and eligibility for benefits on the date the item is purchased for the expense to be reimbursable.

Reimbursable expenses include but are not limited to the following durable medical equipment and supplies (refer to the "Summary of Benefits" for limits where applicable):

- Hospital beds, wheelchairs, canes, crutches and walkers;
- Rigid or semi-rigid braces for back, neck, arm or leg; non-dental prostheses such as artificial limbs and eyes; and a surgical corset including replacement if required because of a change in physical condition;
- Respiratory equipment including oxygen;
- Transcutaneous nerve simulators for the control of chronic pain;
- Splints, casts and catheters;
- Surgical stocking;
- Breast prostheses;
- Purchase of surgical brassieres when required following a mastectomy;
- Wigs;
- Glucometer, and flash glucose monitoring machines when insulin-dependent.

Expenses for the following durable medical equipment and supplies are not reimbursable:

- Items of personal comfort, convenience, exercise, safety, self-help or environmental control items, and
- 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.

HEARING AID

The purchase of a hearing aid is reimbursable when provided by a certified clinical audiologist. The dollar and time limit in the "Summary of Benefits" do not apply if you or an eligible Dependent sustains accidental damage to the natural ear. Repairs and batteries are not reimbursable.

ORTHOPAEDIC SHOES OR ORTHOTICS

Reimbursable expenses, up to the maximum specified in the "Summary of Benefits", are for orthopaedic shoes or orthotics which have been specially designed and molded for you or an eligible Dependent 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.

Orthopedic shoes and orthotic devices must be:

- ✓ Prescribed by a podiatrist or orthopedic surgeon,
- ✓ Dispensed by a physician, chiropodist/podiatrist, orthotist or pedorthist, and
- ✓ Claimed with an updated prescription every time.

Note: No other provider is acceptable to the insurer for reimbursement of orthopedic shoes or orthotics.

VISION CARE

The following vision care expenses are reimbursable (refer to the "Summary of Benefits" for maximums):

Adults

- One pair of glasses or contact lenses or prescription sunglasses or prescription safety glasses required to correct vision, when prescribed by a licensed ophthalmologist, optometrist or optician.

Dependent Children

- One pair of glasses or contact lenses required to correct vision, when prescribed by a licensed ophthalmologist, optometrist or optician.

The vision care maximum specified in the "Summary of Benefits" 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.

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 or stolen glasses, broken glasses or duplicate 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[4];
- 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,

[4] The "Government Benefits" section lists several provincially funded programs that provide benefits to residents of Ontario.

  - the diagnosis or treatment of infertility, and
  - contraception other than prescribed contraceptive drugs and products containing a contraceptive drug, 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[5];
- 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;

[5] The Workplace Safety and Insurance Board (WSIB), a provincially funded agency accessible by residents of Ontario, is listed in the "Government Benefits" section.

- Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society.

EMERGENCY TRAVEL MEDICAL

The benefits in this section apply to eligible Members and their eligible Dependents. Emergency Travel Medical benefits cease for the whole family when you reach age eighty or in accordance with the "Termination of Member Coverage" provision, whichever is earlier.

Each Canadian province and territory provides a health plan with comprehensive benefits for hospital confinement, the services of medical physicians and other health practitioners, and ambulance services. 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 your home province and require these services, your provincial government 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 your home province. Unfortunately, there is often a tremendous difference between the cost of these services outside your home province and the amount allowed by your provincial government plan, which you would have to pay were it not for this valuable benefit.

This benefit provides extensive coverage for many services rendered outside your home province. Such expenses are reimbursable provided that they are unexpected and of an emergency nature. If the purpose of your or your eligible Dependent's trip outside your home province is to obtain that medical treatment, expenses are not reimbursable.

PERIOD OF COVERAGE

You and your eligible Dependents are covered while outside your home province for such reasons as business or vacation up to the maximum number of consecutive days specified in the "Summary of Benefits".

WHAT TO DO IN A MEDICAL EMERGENCY

Call Global Excel Management Inc. immediately. Its operators are backed by a team of physicians and nurses who work closely with the physician looking after you or an eligible Dependent and, if necessary, your family physician to help ensure that you receive the medical care you need.

- U.S. and Canada **1-877-207-5018**
- Elsewhere (collect call) **1-819-566-3940**

You will be asked to provide the following information to the operator:

- ✓ Your name,
- ✓ Your location,
- ✓ The details of your emergency, and
- ✓ Your policy number which is SRG 9104748.

ADDITIONAL INFORMATION

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

MEMBER & FAMILY ASSISTANCE

The benefits in this section apply to eligible Members and their eligible Dependents. Access to the Member & Family Assistance Program (MFAP) ceases in accordance with the "Termination of Member Coverage" provision.

Almost everyone will, at some time in his/her life, have difficulty dealing with a personal issue. If a problem develops, a person's health, happiness, social life, family life and work performance may be impacted. The MFAP offers assistance in times of stress. The MFAP is a professional counselling and referral service provided through Homewood Health Incorporated (HHI), an independent third party.

The MFAP provides access to short-term counselling without service fees. If longer-term or specialized counselling is required, Homewood Health Incorporated (HHI) 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 by a provincial government plan or your Extended Health benefits; however, if fees are incurred for referral services, they become your responsibility.

PRIVACY AND CONFIDENTIALITY

The MFAP is a confidential service. This means that neither your employer nor the union will ever know if you or your eligible Dependents have used it:

- You contact HHI Ontario consultants directly,
- In-person counselling sessions are offered outside of normal business hours and located away from your worksite, and
- Names or individual information will never be released to the Board of Trustees, any union officials or any other person.

PROFESSIONAL COUNSELLORS

Counsellors are professionally accredited, experts in specialized areas and fluent in different languages. Assistance of the counsellor is intended to be short-term and focused on providing you with the tools and resources to address the cause of your stress.

REASONS TO USE THE PROGRAM

Homewood Health Incorporated (HHI) counsellors will help clients deal with a broad range of personal and work-related problems:

- Addictions
- Anxiety, depression or other psychological problems
- Conflict with a supervisor or co-worker
- Coping with chronic pain/illness
- Crisis such as the accidental death of a co-worker
- Dispute mediation
- Divorce/separation
- Family concerns
- Financial or legal difficulties
- Job performance concerns
- Loss of a loved one
- Marriage/relationship issues

HOW TO USE THE BENEFIT

The HHI Ontario counselling and referral service is available twenty-four hours a day. Call the Intake Coordinator at the following toll-free number:

- Toll-free number **1-866-462-8047**

You will be asked for your name and address, and HHI 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 HHI has confirmed that the counsellor is available, they will call you with his or 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 Homewood Health website at www.homeweb.ca and click on “Sign Up”. Then follow the instructions to “Create a Homeweb Account”.

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 seventy or in accordance with the “Termination of Member 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 at the WorldCare hub in Boston 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 thirty 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 WorldCare 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 or severe burns
- Major organ transplant
- 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 two second opinions in each year, up to a maximum of six 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 WorldCare at the following toll-free number:

- Toll-free number **1-877-676-6439**

ADDITIONAL INFORMATION

For more information, visit the WorldCare website at www.worldcare.com or contact the Administrative Agent.

HOSPITAL CASH

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

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

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

If any injury or illness requires more than one period of hospitalization, the maximum benefit period of one hundred and twenty days will be reinstated provided at least sixty-one days have elapsed since your or your eligible Dependent’s previous hospital discharge.

Please contact the Administrative Agent for:

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

DENTAL

The benefits in this section apply to eligible Members, their eligible Dependents and Widow. Orthodontics is only available for eligible Dependent children under age twenty-one. Dental benefits cease upon reaching any limiting age or in accordance with the “Termination of Member Coverage” provision, whichever is earlier.

Dental benefits are designed to provide valuable supplementary protection, but not to duplicate any provincial government plan coverage. This insurance applies to expenses you are required to pay for you and your eligible Dependents’ dental treatment.

Dental reimbursement is based on the general practitioner’s provincial fee guide of your home province 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.

Your Dental benefits will 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 two or more services included in the list of reimbursable expenses are suitable under customary dental practices, the benefit under this insurance contract will be based on the least expensive of the services.

If a dental service is performed that isn’t on the list of reimbursable basic or major procedures, 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 insurance contract, the least expensive of the suitable services listed will be considered to have been performed.

Reimbursable expenses are reasonable and customary expenses. For this reason, lab fees may be cut back. In the case of question, the insurer may ask for a copy of the lab bill.

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

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

An expense 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.

Definition (for Dental only): Predetermination of Benefits tells you how much the Trust Fund will reimburse you for dental work before the work is started. If the cost of services is expected to exceed $200, 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 ninety 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.

DIAGNOSTIC AND PREVENTATIVE

The following dental expenses are reimbursable (refer to the "Summary of Benefits" for maximums where applicable):

Diagnostic Services

- Oral examinations, complete oral exam and diagnosis;
- Single diagnostic x-rays and complete series or equivalent.

Preventive Therapy

- Scaling and polishing (prophylaxis);
- Topical application of sodium or stannous fluoride;
- Pit and fissure sealants on bicuspids and permanent molars;
- Passive space maintainers (those that do not move the teeth);
- Oral hygiene instruction for Dependent children under age 15 only.

MINOR RESTORATIVE

The following dental expenses are reimbursable (refer to the "Summary of Benefits" for maximums where applicable):

- Caries, trauma and pain control;
- Amalgam and tooth-coloured fillings used to restore the natural teeth to their normal functions and replacement fillings if the existing fillings are at least two years old;
- Retentive pins and prefabricated posts for fillings;
- Prefabricated crowns for primary teeth.

ENDODONTIC AND PERIODONTIC

The following dental expenses are reimbursable (refer to the "Summary of Benefits" for maximums where applicable):

- Treatment of the pulp chamber;
- Root canal therapy for permanent teeth and repeat treatment if the original therapy fails after the first eighteen months;
- Root planing, acute infections, occlusal adjustment and provisional splinting;
- Surgical services including gingival curettage, gingivoplasty, gingivectomy or osseous surgery.

ORAL SURGERY

The following dental expenses are reimbursable (refer to the "Summary of Benefits" for maximums where applicable):

- Extraction of teeth, including impacted teeth and residual roots;
- Routine oral surgery and associated post-operative care.

MAJOR RESTORATIVE

The Trust Fund covers those procedures, including inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth cannot be restored with a filling.

When the tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration.

Extensive restoration is covered provided the tooth was fractured after the effective date of coverage by the Trust Fund.

Replacement crowns and onlays are covered when the existing restoration is at least five years old and no longer serviceable.

DENTURES/REMOVABLE PROSTHODONTICS

Initial Installation
Initial installation of partial or full dentures is covered providing the appliance is required primarily due to teeth that were missing, extracted or fractured after the effective date of coverage by the Trust Fund.

Repairs, Relining and Rebasing
Denture adjustments, and repair or relining and rebasing of dentures are reimbursable.

Replacement
Replacement of existing dentures is covered providing the replacement:

- Is required because of extraction, loss or fracture of one or more sound, natural teeth after the effective date of coverage by the Trust Fund,

- Is required as a result of the initial placement of an opposing denture, or
- The existing appliance is at least five years old and no longer serviceable.

FIXED PROSTHODONTICS

The Trust Fund covers initial installation of fixed prosthetic appliances providing the appliance is required primarily due to teeth that were extracted or fractured after the effective date of coverage. Recementing and replacement of the facing of a fixed prosthetic device is also covered. Replacement of existing fixed prosthetic devices is covered providing the replacement:

- Is required because of extraction, loss or fracture of one or more sound, natural teeth after the effective date of coverage by the Trust Fund, or
- The existing appliance is at least five years old and no longer serviceable.

A temporary appliance is considered permanent if not replaced within twelve months of the date the temporary appliance was inserted.

ORTHODONTIC

Orthodontic services are only available to Dependent children under age twenty-one. Orthodontics is 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 retainers or orthodontic appliances for the purpose of repositioning or moving of the teeth.

The pre-existing condition limitation does not apply to orthodontic procedures. Predetermination of benefits, which is defined earlier in this section, is required for all orthodontic procedures.

Claim payment is on a reimbursement basis, subject to the submission of paid receipts. If you choose to pay your dentist in advance, your payments will be amortized over the period of the Treatment Plan and reimbursed on a monthly basis as the treatment progresses.

Monthly reimbursement will terminate on your eligible Dependent's twenty-first birthday, or upon the "Termination of Member Coverage" provision if earlier, regardless of whether the treatment is complete.

TERMINATION OF BENEFITS

No amount will be reimbursed for expenses incurred after the insurance contract or your coverage terminates, even when approved with a Treatment Plan.

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 thirty 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 ninety days of termination will be considered as incurred prior to termination, provided the dependent is under age twenty-one.

Note: 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.

LIMITATIONS

The following charges are not reimbursable:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction 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 sixty 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;
- 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.

Definition (for Weekly Wage Replacement only): Disabled 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.

WAITING PERIOD

The Weekly Wage Replacement benefit is subject to a waiting period before payments commence:

- If you become disabled due to illness, benefits are payable from the eighth day you become disabled (pregnancy-related disability is treated as an illness),
- If you become disabled due to an accident, benefits are payable from the first day you become disabled, and
- If you are admitted as an in-patient for a minimum of twenty-four hours, benefits are payable from the first day of hospitalization.

Definition (for Weekly Wage Replacement only): In-patient means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

BENEFIT PERIOD

The maximum payment period considered by this STD Benefit is fifty-two weeks. You must be under the active and ongoing care of a physician for the full benefit period, including any period of EI payments. Payments do not begin prior to the date you see a physician.

THREE-PART CLAIM FORM

For illness, there is no benefit for seven days. As soon as you realize you may be off work for longer than seven days, contact the Administrative Agent and a three-part claim form will be forwarded to you for completion.

For accident, there is no waiting period. Contact the Administrative Agent as soon as possible to provide notice of claim and a three-part claim form will be forwarded to you for completion.

For hospitalization, there is no waiting period. Contact the Administrative Agent as soon as possible to provide notice of claim and a three-part claim form will be forwarded to you for completion.

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.

BENEFIT REDUCTIONS

Your Weekly Wage Replacement benefit 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.

SUCCESSIVE DISABILITIES

Successive disabilities separated by less than two 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 providing 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 two weeks.

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.

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.

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;
- 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 occurred in Ontario or Quebec;
- Fees charged by a physician to complete claim forms and provide copies of medical reports.

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.

LONG TERM DISABILITY

The benefits described in this section apply to eligible Members only. LTD benefits cease when you reach age sixty-five, retire or in accordance with the “Termination of Member Coverage” provision, whichever is earlier.

The Trust Fund has been designed by the Board of Trustees to provide you with assistance during times of disability. While you are disabled, you may continue to receive other benefits: Fund Assistance is described under the “Eligibility” section and premium waivers are described under the “Life” and “Accidental Death & Dismemberment” sections.

Definition (for Long Term Disability only): Totally Disabled means you are incapacitated during the qualifying period and the next twenty-four 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 twenty-four-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.

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.

BENEFIT PERIOD

Before payments can commence, the LTD benefit is subject to a fifty-two-week waiting period or the duration of the Weekly Wage Replacement benefit, whichever is greater, **plus any applicable EI period**.

The LTD benefit period continues to the earlier of five years, retirement, reaching age sixty-five or your recovery from disability.

Contact the Administrative Agent to initiate your claim. 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.

ALL SOURCE MAXIMUM

Under the LTD benefit, your total income each month must not exceed eighty-five percent 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, or
- 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 workweek 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

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.

RECURRENT AND NEW DISABILITIES

If you return to active work full-time and are totally disabled again from the same or related causes within six months, the second period of disability will be considered a continuation of the first disability.

If you return to work full-time and after one full day are totally disabled again from an entirely unrelated cause, you will have to file a new claim, in which case new waiting and benefit periods will start.

VOCATIONAL REHABILITATION

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to your own occupation 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.

REIMBURSEMENT

This procedure ensures that the insurer hasn't compensated you for lost income that you have recovered or will be recovering from another source. You may file a claim against a third party for causing you to become totally disabled to compensate for lost income.

If you receive compensation from the third party (by way of judgment or settlement), then it will be applied first to reimburse the insurer up to an amount equal to the total amount of LTD Disability benefits received by you to the date of such judgement or settlement.

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.

CANADIAN RESIDENCY REQUIREMENT

No LTD benefits are payable for any twelve-month period in which you do not reside in Canada for at least six months.

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 ninety 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, and
    - 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 twelve-month period in which you do not live in Canada for at least six 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.

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

The benefits described in this section apply to eligible Members only. Critical Illness benefits cease when you reach age seventy, retire or in accordance with the “Termination of Member Coverage” provision, 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 may use it in any way that will meet your particular needs.

You are eligible for a flat amount which is referred to as the principal sum. The principal sum reduces by fifty percent at age sixty-five. A Second Event 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 thirty 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, and
- Once one-hundred percent of the principal sum has been paid, coverage terminates and no further benefits are payable, except as described under Second Event benefit.

COVERED CRITICAL ILLNESSES

All covered critical illnesses must be diagnosed after the eligible Member’s effective date of coverage by the Trust Fund.

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.

Stroke must be diagnosed by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.

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

COVERED SERIOUS ILLNESSES*	
• Alzheimer's disease	• Loss of speech
• Aortic surgery	• Loss of hearing in both ears
• Aplastic anemia	• Major organ transplant
• Benign brain tumour	• Motor neuron disease
• Coma	• Multiple sclerosis
• Coronary artery bypass graft	• Non-life-threatening cancer (partial payment)
• Heart attack	• Occupational HIV infection
• Heart valve replacement	• Paralysis - Quadriplegia, paraplegia and hemiplegia
• Kidney (renal) failure	• Parkinson's disease
• Life-threatening cancer	• Severe burn
• Loss of independent existence	• Stroke
• Loss of sight in both eyes	

*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 twenty-five percent of the principal sum for the following non-life-threatening conditions:

- Malignant melanoma to a depth of 0.75 mm or less, excluding malignant melanoma in situ,

- Basal or squamous cell carcinoma that has spread beyond the deepest layer of skin and has not metastasized,
- Stage A colon cancer,
- Carcinoma in situ,
- Early prostate cancer diagnosed as T1a or T1b, and
- Any tumour in the presence of any human immunodeficiency (HIV).

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.

SECOND EVENT 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 ninety days and are then diagnosed with a heart attack, stroke or coronary artery bypass graft, Alzheimer's disease, coma, loss of sight, loss of speech, loss of hearing, motor neuron disease, multiple sclerosis, Parkinson's disease, quadriplegia, paraplegia, hemiplegia or severe burn, then a Second Event benefit equal to the principal sum will be payable. The Second Event benefit is subject to you surviving thirty days after the diagnosis of the second event.

If you are diagnosed with heart attack, stroke or coronary artery bypass graft for which the principal sum has been paid and you have thereafter been actively at work for at least ninety days and are then diagnosed with cancer, Alzheimer's disease, coma, loss of sight, loss of speech, loss of hearing, motor neuron disease, multiple sclerosis, Parkinson's disease, quadriplegia, paraplegia, hemiplegia, or severe burn, then a Second Event benefit equal to the principal sum will be payable. The Second Event benefit is subject to you surviving thirty days after the diagnosis of the second event.

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

DIAGNOSTIC REQUIREMENTS

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' diagnoses. The decision of the third physician will be final.

Definition (for Critical Illness only): Diagnosis 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 AND LIMITATIONS

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

- Any illness not specifically listed as a covered critical illness,
- Commission of or attempt to commit a felony,
- Declared or undeclared war, or any act of declared or undeclared war,
- Voluntary participation in any riot or civil insurrection, and
- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.

LIFE

The benefits in this section apply to eligible Members and their eligible Dependents. Life Benefits cease in accordance with the "Termination of Member Coverage" provision. The amount of your Life Benefit is specified in the "Summary of Benefits".

MEMBER LIFE

Your Life Benefit is payable to your Beneficiary on your death from any cause at any time. 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 Life will also apply to Accidental Death & Dismemberment.

You may change your named Beneficiary, subject to governing law, by filing a new Member Information Card with the Administrative Agent. Your card 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.

DEPENDENT LIFE

If an eligible Dependent dies, the amount of Dependent Life Insurance mentioned in the "Summary of Benefits" is payable to you. If you die, the insurance will be paid to your estate.

Dependent Life Insurance benefits terminate when the Eligible Member Life Benefit terminates.

INDIVIDUAL POLICY OPTION

If Life benefit coverage for you or your Dependent spouse terminates or reduces, you or your Dependent spouse may be eligible to convert the terminated amount to an individual life insurance policy without a medical examination or health questionnaire being required.

The application for the individual policy and the first monthly premium must be received by the insurer within thirty-one days of the termination or reduction of the life benefit.

If you or your Dependent spouse dies within thirty-one days of the date life insurance terminates, the amount that could have been converted to an individual life insurance policy will be paid as a death benefit, even if no application for conversion was made.

If your Dependent child's insurance terminates and if you reside in the province of Quebec, you may be eligible to convert the terminated insurance as outlined above.

Contact the Administrative Agent for details. Provincial differences may exist.

PREMIUM WAIVER

If you are disabled, payment of premiums for Life benefits may be waived. The insurer will consider your application for a premium waiver if

- You were eligible for coverage by the Trust Fund on the date you became totally disabled,
- You have been totally and continuously disabled for at least six consecutive months. During these six months, your coverage must have been maintained,
- You are under age sixty-five,
- You notify the Administrative Agent of the last date you were actively at work within twelve months of that date,
- You provide proof of your total disability satisfactory to the insurer within eighteen months of your last active working day and periodically thereafter as requested, and
- You report for a medical examination by a physician of the insurer's choice if requested.

Definition (for waiver of premium for Life benefits only): Totally Disabled means that because of an illness or injury, you are incapacitated to the extent that you are unable to engage in any business or occupation and perform in any work for compensation or profit.

Payment of premiums will continue to be waived until the earliest of the following occurs:

- You do not submit proof of continuance of total disability when required,
- You fail to be examined by a physician if requested,
- You return to active employment with your employer. Beyond this date, your coverage will only continue if your employer makes premium payments,
- You reach age sixty-five, or
- You cease to be totally disabled.

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 seventy or in accordance with the “Termination of Member Coverage” provision, whichever is earlier.

Unlike other benefits that only cover what government benefits do not, Accidental Death & Dismemberment 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 one year from the date of the accident.

This coverage applies twenty-four hours a day, three hundred sixty-five 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 eligible Member 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 Accidental Death & Dismemberment will also apply to Life.

You may change your named Beneficiary, subject to governing law, by filing a new Member Information Card with the Administrative Agent. Your card 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 one 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 three hundred percent or three times the principle sum for total paralysis. If more than one loss listed on the “Loss Schedule” results from a single accident within one 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	33 ⅓%
Four fingers of the same hand	33 ⅓%
Hearing in one ear	33 ⅓%
Thumb of either hand	25%
All toes of the same foot	25%
One finger of either hand	16 ⅔%

LOSS SCHEDULE CONTINUED	
Loss of Use of	**Maximum % of Principal Sum Payable**
Both arms, both hands, both feet or both legs	200%
One arm or one leg	75%
One hand or one foot	75%
Thumb and index finger of the same hand	33 ⅓%
Total Paralysis of	
Both upper and lower limbs (quadriplegia)	300%
Both lower limbs (paraplegia)	300%
Upper and lower limbs of one side of the body (hemiplegia)	300%

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”. For more information about these benefits, contact the Administrative Agent.

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	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
Bereavement	$1,000	Loss of life
Identification	$10,000	Loss of life
Cosmetic disfigurement	$25,000	Third-degree burn in a non-occupational accident
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 one 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.

Definition (for AD&D only): Loss 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 four 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.

Definition (for AD&D only): Loss of Use 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 twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to the insurer to be permanent.

Definition (for AD&D only): Brain Death means irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain, even though the heart is still beating.

Definition (for AD&D only): Loss 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 Accidental Death & Dismemberment 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 that 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,
- Fire fighting, 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.

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

Obtain a Claim Form
You may obtain claim forms from the Administrative Agent, your union office or the Trust Fund's website. For dental claims, generic claim forms that are available at your dentist's office are also acceptable.

The Trust Fund does not reimburse physician's fees. Any charges by physician's or suppliers to complete claims forms or provide additional supportive information are not reimbursable.

Submit your Claim
Assignment of benefits for dental is accepted, if the dentist allows it. This means that the dentist will submit a claim on your behalf. While you may assign benefits directly to the dentist, electronically submitted claims are not eligible for consideration.

If any of the following information is missing on the claim form, your claim will be delayed:

- ✓ Name of your Trust Fund,
- ✓ Your first and last name,
- ✓ Your birth date,
- ✓ Your Identification Number,
- ✓ Your full mailing address,
- ✓ The patient's name and birth date,
- ✓ The dentist's signature on an original claim form and
- ✓ Your signature.

Where relevant, the following information should be attached to the claim form:

- ✓ Original receipts or paid invoices for the item or service being claimed. The receipt should show the patient's full name and full details of the charges. Cash register receipts or labels from containers are not acceptable,
- ✓ For vision care, this means charges for lenses, frames and miscellaneous items,

- ✓ For medical services and supplies, proof of payment is required. Accepted are copies of cheques, or debit/credit card receipts, or in the case of a cash payment, a signed statement from the provider of the service,
- ✓ The physician's referral where required, and/or
- ✓ The Explanation of Benefits (EOB) that you received from the other plan if you are coordinating benefits (coordination of benefits is explained below).

Mail the form and all attachments directly to the Administrative Agent:

The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund
c/o Benefit Plan Administrators Limited
P.O. Box 3071, Station A
Mississauga, Ontario L5A 3A4

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.

Definition: 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).

Definition: 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, Emergency Travel Medical, 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.

Emergency Travel Medical Claims
If you require emergency travel medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately:

- U.S. and Canada **1-877-207-5018**
- Elsewhere (collect call) **1-819-566-3940**

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 a Global Excel Management operator. Give the operator your name and your policy number: SRG 9104748. 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:

- ✓ Medical records, statements or detailed receipts received at the time of treatment and/or discharge.

Mail your completed form and attachments to:

Global Excel Management Inc.
73 Queen Street
Lennoxville, QC J1M 1J3

Global Excel Management Inc. will then coordinate with the provincial plan reimbursement of those approved, reimbursable expenses.

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

- Call toll-free **1-866-462-8047**

WorldCare Second Opinion
The second opinion may be requested by calling the number below and identifying yourself as a member of The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund.

- Call toll free **1-877-676-6439**

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 a LTD claim form by approximately fourteen 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 a 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**: twelve months after the date the expense was incurred;
- **Dental**: twelve months after the date a service is received;
- **Hospital Cash**: ninety days after the date of hospitalization;
- **Emergency Travel Medical**: ninety days after emergency treatment and/or services were provided;
- **Weekly Wage Replacement**: within six months after the termination of the first month following the waiting period;
- **Long Term Disability**: within six months after the termination of the first month following the waiting period;
- **Critical Illness**: twelve months after the date of diagnosis;
- **Life**: twelve months after death;

- **Waiver of Premium for Life Benefits**: eighteen months of your last day at work because of total disability;
- **Accidental Death & Dismemberment**: twelve months after death or accident.

Documented proof of loss is due within ninety 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 five 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 three 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 or 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. The following seven programs are available to Ontario residents:

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 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) Program

- ✓ ODB pays first if you are an Ontario resident age sixty-five or over. Then, the Trust Fund will cover the deductible and any eligible drugs that are not included on the ODB Formulary.
- ✓ Ontario Disability Support Program (ODSP) recipients may also claim ODB benefits.
- ✓ Speak to your pharmacist 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 your household income after taxes.
- ✓ Begin the application process for TDP benefits by calling 1-800-575-5386 or 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 and/or medical supplies.

- ✓ 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 calling 1-800-268-6021 or speaking to the health care professional who has provided your diagnosis.

Employment Insurance (EI)

- ✓ Apply for temporary financial assistance through EI if you are unable to work because of 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 six-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 or her name appearing on the Union Out-Of-Work List and satisfies the eligibility requirements of The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund described in the "Eligibility" section of this booklet.

Administrative Agent performs the daily administrative functions of the Trust Fund. When you contact the Administrative Agent, you are communicating with a staff member of Benefit Plan Administrators Limited (BPA).

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 detail 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, commonly known as Short Term Disability (STD) or Weekly Indemnity (WI), through The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund,
- Long Term Disability (LTD) benefits through The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund,
- Workplace Safety & Insurance Board (WSIB) benefits;
- Motor Vehicle Insurance Disability benefits, or
- Canada Pension Plan (CPP) Disability Benefits.

Dollar Bank is the account of the hourly contributions made by your employer on your behalf. Along with four other eligibility requirements, the balance in this account determines your eligibility for 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 Member is a person who has satisfied the Member eligibility requirements of The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund described in the "Eligibility" section of this booklet.

Eligible Dependent is a person who has satisfied the Dependent eligibility requirements of The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund described in the "Eligibility" section of this booklet.

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, the date of delivery, 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 (RPA).

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/she practises to prescribe and administer any drugs and to perform surgical procedures.

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 twenty-four-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 and Toronto Ready-Mix Producers' Benefit Plan Trust Fund.

You refers to members who have satisfied the eligibility requirements of The Teamsters and Toronto Ready-Mix Producers' Benefit Plan Trust Fund described in the "Eligibility" section of this booklet.

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
P.O. Box 3071, Station A
Mississauga, Ontario L5A 3A4

Email: privacy_officer@bpagroup.com
Telephone: 905-275-6466
Toll Free: 1 -800-867-5615
Fax: 905-275-6462

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 thirty 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.