SHEET METAL WORKERS' INTERNATIONAL ASSOCIATION

LOCAL UNION 562

EMPLOYEE BENEFIT TRUST

Dear Retired Member:

This booklet provides you with a summary of the more important provisions of the Group Insurance program available to you. It is not a contract of Insurance. Full details of the program are contained in the Group Policy issued by Manulife Financial. All rights with respect to the benefits of the plan will be governed solely by that Group Policy. Contact your Plan Administrator, Union Benefits, if you require additional information.

Please remember to direct all inquiries regarding your Health and Welfare plan to Union Benefits and not to Manulife Financial.

Note: When the male pronoun is used, it is understood it also applies to female members.

Sincerely Yours,

THE BOARD OF TRUSTEES

Chris McLaughlin
Bill Riedel
James Villeneuve
Rob Weiler
Gary Gagnier

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SUMMARY OF BENEFITS

Retired Members

Life Insurance	**$10,000**
Supplementary Health Care	Provides coverage for you and your dependents ▪ Eligible expenses are reimbursed at 100% with the exception of smoking cessation and ED drugs which are reimbursed at 50% ▪ There is a deductible of $10 per member, $10 for all dependents combined per calendar year
Prescription Drugs	The plan pays for drugs that legally require a prescription
Vision Care	The plan pays $200 per person in any period of 24 consecutive months
Eye Exams	The plan pays $50 per person in any period of 24 consecutive months
Private Duty Nursing	The plan pays $10,000 lifetime with benefit restoration / reinstatement.
Paramedical Practitioners	Services of a licensed Chiropractor, Osteopath, Massage Therapist, Physiotherapist, Naturopath or Podiatrist/Chiropodist up to $300 per practitioner, per individual, per calendar year. Licensed Speech Therapists and Psychologists are covered up to $200 per practitioner per year.
Hearing Aids	The plan pays $400 per person in any 60 consecutive months
Out-of-Province - Emergency	You are covered when traveling outside the province of residence. Lifetime maximum is $1,000,000.
Dental Care	Provides coverage for you and your eligible dependents ▪ There is a deductible of $10 per member, $10 for all dependents combined per calendar year ▪ A pre-assessment is required for any treatment over $400 ▪ Eligible expenses are reimbursed based on the Ontario Dental Association fee guide that is 1 year behind the current fee schedule.
Basic Services	The plan reimburses 100% of eligible expenses for basic (routine) services and dentures.
Orthodontic Services	The plan reimburses 60% of eligible expenses for children under 19
Maximum	The maximum payable in a calendar year for basic services and dentures is $2,000. For Orthodontics, it is a lifetime maximum of $2,000.

For Full Details of the above Summary of Benefits, please review the corresponding pages in this booklet.

Eligibility

At retirement, coverage can be continued on a reduced schedule of benefits, using the credits remaining in your dollar bank. If you choose not to continue in the Plan, your remaining "dollar bank" will be refunded. If you choose the refund of credits, you will not be permitted to re-enroll.

To qualify for the reduced schedule of benefits, you must be:

- a member of S.M.W.I.A. Local 562
- eligible in the Plan on the date of retirement and receiving a Local 562 Pension

If you have chosen to continue in the Plan and have used up your dollar bank credits, you can continue your coverage on a pay direct basis. The pay direct amount will be 50% of the cost of the premium.

The following options are available:

Life Insurance
Life Insurance plus Supplementary Health Care
Life Insurance plus Dental
Life Insurance plus Dental and Supplementary Health Care

If you then return to work, employer contributions received can be used to continue the reduced schedule of benefits. After these credits have been exhausted, you may then resume pay direct payments

When you retire, the Administrator, Union Benefits, will send you an election form that will allow you to make your benefit selection.

If you do not return the form within 60 days and you have funds in your dollar bank, Union Benefits will determine your coverage level based on the benefits you had in force just prior to retirement.

If you do not have funds in your dollar bank and do not make pay direct payments, Union Benefits will terminate your coverage and **you will not be eligible to reinstate it**.

Once you have made your benefit selection, you can reduce or discontinue coverage but you cannot increase your benefit coverage.

SPECIAL BENEFITS

Widow's Benefits

Provision has been made to provide benefits for the widows and dependent children of deceased members on a "benefit selection" basis.

Payment of the benefits selected will first be made by using any funds remaining in the deceased member's dollar bank and then through pay-direct payments, based on 50% of the total premium payable for Supplementary health care and Dental. The rates are subject to change.

The following options are available and a description of the benefits is included in the Summary of Benefits for Active Members:

- Supplementary Health Care only
- Dental only
- Supplementary Health Care and Dental

These benefits will continue to be available on a pay-direct basis only to remarriage or entering into a common law relationship, whichever occurs first. Under no circumstances will benefits be available to children of the deceased member's spouse born later than ten months after the death of the member.

After the initial selection, the surviving spouse may elect to discontinue all or part of the chosen benefit coverage but will not be permitted to improve coverage.

NON-INSURANCE BENEFITS

Ontario Drug Benefit Plan – $100 Deductible

Retirees may submit prescription receipts for up to the $100 deductible for yourself and your spouse to Union Benefits, once per year, for reimbursement. Invoices are paid directly from the Health and Welfare surplus. These payments will remain effective, provided there are surplus funds remaining in the Health and Welfare Plan. The one-year payment period is August 1st to July 31st.

Doctor's Notes

Effective March 1, 2009, the Trust Fund will reimburse members for two (2) Doctor's Notes. The maximum amount that will be paid to the member for these Doctor's Notes is $50 in a calendar year.

GENERAL PROVISIONS

Co-ordination of Benefits

(for Supplementary Health Care and Dental benefits)

This plan has been designed to help you meet the cost of disease or injury. Since it is not intended that you receive benefits greater than the actual expenses incurred, any coverage you have under other "plans" will be taken into account in determining the amount of benefit payable under this plan, that is, the benefits under this plan will be coordinated with the benefits of the other plans.

If you have coverage through another plan, benefits under all plans are adjusted so that the combined payment does not exceed 100% of the total allowable expense. The way in which this is done is to determine which plan pays first and which plan pays next.

Benefits will be paid first from a group policy, which does not have a provision to coordinate benefits.

The order of payment under the co-ordination of benefits provision is determined as follows:

a) The first payor is the plan that covers the person as an insured member.
b) The first payor for dependent children is determined by the parent whose birthday occurs first in the year (not who is oldest)
c) If priority cannot be determined under (a) or (b) above, the benefits will be paid under both plans in a ratio proportionate to the amounts that would have been paid under each plan had there been coverage under just that plan.

When priority has been established, send claims to the first insurer. If the full amount is not paid, the claim can then be sent to the alternate insurer, along with the detailed statement showing the amount that has been paid. For the purpose of coordination of benefits, the Insurer has the right to receive and release information of benefits and, if necessary, collect any overpayments made by it.

Definition of Dependent

Dependents will include only the following persons who are residents of Canada and covered under a Provincial Health Plan:

- A dependent child will include the children of the marriage, legally adopted children and stepchildren. To be considered a dependent, the child must be unmarried, not employed on a regular and full-time basis, and under 21 years of age.

- A child aged 21 to 24 inclusive will be considered a dependent if in full-time attendance at an accredited school, college or university. A student whose normal residence is in Canada, except when attending school outside Canada, will also be considered a dependent. Written proof of full-time student status must be provided each term.

- Any functionally impaired child who was insured as a dependent shall remain insured beyond any limiting age for dependents. For the purposes of insurance, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act of Canada. Medical documentation must be provided.

- Your spouse, includes a person married to you as a result of a valid civil or religious ceremony and excludes a person you are divorced from or have been separated from for more than a 12 month period. Spouse also includes a person who has had a common law relationship with you for a minimum period of 12 consecutive months immediately prior to the date a claim arose. You must be able to satisfy the insurer of the existence of the common law relationship. To qualify, the common law relationship must include continuous cohabitation and public representation of married status.

  Note: Separation is considered to have taken place on the date that you and your spouse no longer reside together at the same address. Coverage for a separated spouse would end if they married or entered into another common-law relationship.

- No individual will be covered during military service.

Changes to your Dependents

If you marry, enter into a common law relationship or have new dependent children, you must add them to your group insurance coverage within 30 days. To do this, you need to contact the plan administrator and update your Member Information Card. You also need to advise the plan administrator, in writing, when a previously eligible dependent no longer qualifies.

Time Limitations

Written proof stating the occurrence, character and extent of loss must be submitted to the Insurance Company within six months of the date of death for Life Insurance Benefits

And to the Administrator within twelve months after the date of the loss, but not more than six months after the date insurance terminates, for Supplementary health care and Dental Care Benefits.

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

LIFE INSURANCE (MEMBERS ONLY)

(See Summary of Benefits)

The Life Insurance is payable in the event of your death from any cause at any time or place while you are insured. Payment will be made in a lump sum to the named beneficiary or beneficiaries designated by you. The beneficiary or beneficiaries may be changed whenever you wish in accordance with Provincial Laws.

Conversion Privilege

(a) If your life insurance, or any amount of such insurance, ceases because of termination of employment, or termination of membership in the classes of employees eligible for insurance, or because of age, pension or retirement, you may, by written application without evidence of health and upon payment of the first premium within 31 days thereafter, convert such amount if you have not passed your 65th birthday, or 50% of such amount if you have passed your 65th birthday, or a lesser amount at your option, but not less than the minimum amount issued by the Insurance Company and not more than $200,000, to individual life insurance, without disability or other supplementary benefits. You may select the individual policy from any one of the forms, other than term insurance, then issued by the Insurance Company except that if you have not passed your 65th birthday you may select an individual policy of term insurance for

- a period of not longer than one year and may, before the expiry date of such individual policy, convert, without evidence of health, the full amount of such policy or, at your option, a lesser amount but not less than the minimum amount for which the Insurance Company will issue such individual policy, to any other type of policy to which you were entitled; or

- the period ending on the policy anniversary nearest your 65th birthday. The individual policy will take effect upon the expiry of the 31 day conversion period, and the premiums will be at the Insurance Company's regular rate for the type of policy selected according to your attained age and the class of risk to which you then belong.

(b) If your life insurance is terminated because of the group policy being discontinued or amended, and if immediately prior to the date of discontinuance or amendment you had been insured for at least five continuous years, you will be entitled to the same conversion privilege as described in paragraph (a) above except that the amount of insurance under the individual policy shall not exceed the amount determined as follows:

- if you have not passed your 65th birthday; the amount of your life insurance which terminated but not more than three times the current annual maximum pensionable earnings as established under the Canada Pension Plan, less the amount of any group life insurance for which you are or become eligible within 31 days after such termination, whether issued by the Insurance Company or by any other insurer; and

- if you have not passed your 65th birthday; 50% of the amount of your life insurance which terminated, less the amount of any group life insurance for which you are or become eligible within 31 days after such termination, whether issued by the Insurance Company or by any other insurer, or $2,000., whichever is less.

(c) If you die during the 31 day period during which you are entitled to an individual policy in accordance with paragraph (a) or (b) above, and before the individual policy takes effect, the amount of life insurance available to you under the individual policy shall be payable as a claim under the group policy whether or not application for the individual policy has been made.

SUPPLEMENTARY HEALTH CARE (MEMBERS AND DEPENDENTS)

Description of Benefits

The Plan applies to expenses for the treatment of non-occupational injuries and diseases or for pregnancy incurred by you and your dependents. Expenses are considered to be incurred at the time the service is provided, the treatment is received or the purchase is made.

The Plan is designed to provide valuable supplementary protection but not to duplicate or take the place of benefits available through the Ontario Health Insurance Plan under which you or your dependent could be protected. Therefore, the Group Plan excludes care and services to the extent that benefits can be obtained for them under the Provincial Plan. Of course, the Plan cannot provide any benefits which are prohibited by law.

After the deductible has been satisfied, as stated in the Summary of Benefits, benefits will be paid for all eligible expenses which you or your dependents may incur during the rest of the calendar year.

Eligible Expenses

This section should be read in conjunction with the section entitled "Exclusions". Before incurring any major expenses you may submit details to the Claim Department which will inform you what benefits, if any, are available under the plan.

Covered Expenses included under the plan are the charges which you are required to pay for the following services and supplies received while you are insured, for the treatment of non-occupational injuries and diseases, vision care or for pregnancy.

Drugs and Medicines including vaccinations, and immunizations, injectables, serums and oral contraceptives obtainable only upon a physician's prescription and dispensed through a registered pharmacist. Also included are needles, syringes, and diagnostic aids for diabetes. (A Glucometer will be considered only if the individual is insulin dependent. This device must be prescribed by a physician). Smoking cessation aids (Habitrol, Zyban, etc.) which require a physician's prescription, are subject to a lifetime maximum of $400 for a first course of treatment and a maximum of $200, payable at 50%, will be reimbursed for a second course of treatment. Reimbursement of the cost of Fertility Drugs is subject to a lifetime maximum of $6,000. Erectile Dysfunction Drugs (Viagra, Cialis etc.) which legally require a doctor's written prescription will be reimbursed on a 50% co-insurance basis to a maximum of $250 in a calendar year.

Co-payments introduced by the Ontario Government, for drugs covered under the Ontario Drug Benefit, are not payable.

Professional Ambulance Service including air and rail ambulances when used to transport the individual from the place where he is injured by an accident or stricken by a disease to the nearest hospital with adequate facilities. No other expenses in connection with travel are included.

Out-Patient Hospital Services and Supplies in connection with:

- use of examination or operating room,
- drugs, dressings or casts,
- anesthesia in connection with the performance of a surgical procedure, but not charges made by a resident physician or intern of a hospital.

Registered Graduate Nurse (R.N.) while the patient is not confined to a hospital. The nursing service must have been ordered by a physician as medically necessary and requiring the specialized training of a registered nurse. The nurse must not ordinarily reside in the employee's home or be a member of the family. Pre-approval must be obtained from the benefit office.

Speech Therapy by a person duly qualified and registered and legally engaged in the practice of speech therapy but not more than $200 per calendar year.

Out-of-Province/Canada Emergency Treatment as described below incurred in connection with emergency treatment while the individual is outside the province/country in which he normally resides. Coverage for students studying abroad will begin from the date they leave the province up to the policy limitation.

- Charges by a general practitioner or specialist in excess of the amount allowed under the Provincial Hospital and Medical Plans in the individual's normal province of residence, provided such charges are reasonable and customary in the area in which they were incurred.

- Charges for hospital confinement including ancillary or miscellaneous expenses for ward accommodation in excess of the allowance payable by the Provincial Hospital Plan in the individual's normal province of residence. No charges will be considered unless all or part of the daily charge is payable under such Provincial Hospital Plan.

- Economy airfare for the patient's return to the province of residence, when ordered by the attending physician.

NOTE: You will be required to pay any medical expenses initially. Upon returning home, you would submit hospital charges, doctor's fees, etc., first to the provincial plan (OHIP) for their consideration. Then, you would submit to your group plan with a copy of the provincial plan payment statement for consideration of the balance. Prescription receipts are to be sent to your group plan as usual.

Rental of Iron Lung or Other Durable Medical or Surgical Equipment.

Treatments by a Provincially Licensed Chiropractor, Osteopath, Naturopath or Podiatrist/Chiropodist up to a maximum benefit of $300, per specialty, per calendar year, per individual; charges for x-rays are covered subject to one x-ray per calendar year per specialty, for each individual. Consideration is made only after the provincial health plan no longer pays any portion of the treatment cost. **The difference between the amount billed by the Practitioner and the amount paid by the provincial plan is not payable.**

Physiotherapy by a person duly qualified and registered and legally engaged in the practice of physiotherapy, provided such services, by duration and type, have been prescribed by a physician.

Treatment by a Person Duly Qualified and Registered and Legally Engaged in the Practice of Psychology but not more than $200 per calendar year. (Physicians charges in connection with psychoanalysis treatment {for Quebec residents only} if the individual is not confined in a hospital or similar institution are covered at 50%.)

Treatments by a Masseur who is duly qualified and registered and legally engaged in the practice of massage provided such services, by duration and type, have been prescribed by a physician but not more than $300 per calendar year per individual. A medical doctor's written referral is required each calendar year.

Artificial Limbs and Eyes, Crutches, Splints, Casts, Trusses and Braces for Back, Neck, Arm or Leg, including replacement due to a change in physical condition when prescribed or ordered by the attending physician.

Dental Work performed by a dentist for the prompt repair of sound natural teeth required as a result of a non-occupational, accidental injury, external to the mouth, if treatment takes place within twelve months of the accident. Reimbursement is limited to a maximum of $5,000 per accident.

Anaesthesia, Oxygen, Blood, Blood Products.

Diagnosis and Assessment but not Treatment by a Person Duly Qualified and Registered and Legally Engaged in the Practice of Psychology

Diagnostic Laboratory and X-Ray Expenses.

Hearing Aids purchased on the written recommendation of a physician certified as an audiologist up to the maximum stated in the Summary of Benefits. Any charges for batteries will be disregarded.

Orthotics that have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment will be limited to a maximum benefit of $200 per shoe. Custom made orthopaedic shoes are limited to the same maximum but are payable at 50%. The overall maximum benefit is $400 in any calendar year.

PLEASE NOTE:
Only the following prescribing providers will be accepted:
Medical Practitioner or Specialist-MD, Podiatrist – DPM, Chiropodist-D CH or D Pod M

Only the following dispensing providers will be accepted: Medical Practitioner or Specialist-MD, Orthotist-CO(c) or CPO(c), Pedorthist-C Ped(C) or C Ped MC, Podiatrist-DPM, Chiropodist-D CH or D Pod M

(orthotics prescribed or dispensed by a chiropractor or physiotherapist for example are <u>not</u> eligible for reimbursement)

A prescribing practitioner’s documentation of medical necessity is required each year. This must include a complete diagnosis or gait analysis.

Vision Care Expenses for the following supplies recommended by a legally qualified ophthalmologist or optometrist:

- lenses and frames, including repairs to such lenses or frames, and contact lenses, up to the maximum stated in the Summary of Benefits. Individuals who have Laser Eye Surgery can apply up to the maximum benefit towards the cost of the surgery. Reimbursement will be limited to the amount an individual has remaining in his Vision Care Benefit within his 24 month period.
- special eye glasses following an eye operation, but any charges in excess of $100 during the lifetime of an individual will be disregarded.
- one set of contact lenses medically required for visual acuity of 20/70, but any charges in excess of $150 during the lifetime of an individual will be disregarded.
- coverage of $50 payable in a 24 month period for basic refractive eye examinations; this does not include specialty type eye examinations (eg. IOL, retinal scanning, etc.)

No benefits are payable for:

- sunglasses or tinted glasses with a tint other than number one;
- anti-reflective coatings;
- replacement of lost contact lenses.

Restoration

On January 1 of each year, the amount which has been counted against the Maximum Nursing Benefit of an insured family member and not previously restored or reinstated will be automatically restored up to $1,000.

No evidence of good health is required for this automatic restoration but it is not available after insurance has terminated.

For example, if you receive $1,700 in Nursing Benefit payments in one calendar year, your Maximum will automatically be restored by $1,000 on next January 1, and by the remaining $700 on the following January 1, assuming no further benefits have become payable in the meantime.

Reinstatement

At any time that the Maximum Nursing Benefit of a family member is reduced by at least $1,000 on account of benefits which have been collected, reinstatement of the maximum may be requested provided the family member is then in good health. It will be necessary to submit medical evidence of the good health of such member to the Insurance Company at your own expense. The new maximum becomes effective on the date the Insurance Company acknowledges the evidence as satisfactory.

Exclusions

No benefits are payable for charges:

1. in connection with a disease other than a non-occupational disease or an injury other than a non-occupational injury;

2. that would not have been made if no insurance existed or that no individual with respect to whom insurance under this policy relates is legally obligated to pay;

3. for care, treatment, services or supplies which are furnished or paid for, or with respect to which benefits are provided, under any law of government (national or otherwise) by reason of the past or present service of any person in the armed forces of a government;

4. for care, treatment, services or supplies other than those referred to in item (3) above, which are paid for, or with respect to which benefits are provided, under any law of a government (national or otherwise) except where such payments are made or such benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents;

5. for care, treatment, services or supplies which are not recommended and approved by a physician who is attending the covered family member;

6. for care, treatment, services or supplies which are not necessary for the treatment of the injury, disease or pregnancy nor to the extent that any charges for care, treatment, services or supplies are unreasonable;

7. for care, treatment, services or supplies rendered with respect to any individual while he is not a covered family member except as otherwise specifically provided;

8. incurred for care, treatment, services or supplies as a result of any group or employer-sponsored treatment, inoculation or examination;

9. hospital board and room, within the individual's home province.

No benefits are payable under this policy to the extent that the provision of such benefits is prohibited by any applicable law of the jurisdiction in which the individual resides at the time the claim is incurred.

DENTAL CARE BENEFITS (MEMBERS AND DEPENDENTS)

Description of Benefit

If you incur Covered Dental Expenses in a calendar year, this plan pays you 100% of such expenses, up to the applicable Fee Guide maximum, after the deductible has been satisfied, for basics and dentures. **An estimate must be submitted for pre-approval of dentures**.

The maximum benefit for these Covered Dental Expenses incurred in a calendar year for each insured family member is shown in the Summary of Benefits.

Orthodontic treatment is covered at 60% co-insurance for eligible dependent children under age nineteen. The lifetime maximum for this benefit is shown in the Summary of Benefits. **A pre-treatment plan must be provided for pre-approval.**

Eligible Expenses

Covered Dental Expenses included under the plan are the charges which you are required to pay for the following services and supplies up to the amount specified in the Ontario Dental Association Schedule of Fees for the year stated in the Summary of Benefits.

- Oral examinations, polishing of teeth, but not more than once in any period of six consecutive months
- Tests and lab examination
- Complete series of periapical films but not more than once in any five-year period
- Topical application of sodium or stannous fluoride limited to dependent children under age 16
- Dental x-rays
- Extractions
- Oral surgery, including excision of impacted teeth, but excluding periodontal surgery
- Fillings; Pit and fissure sealants (where such application is necessary for the maintenance of sound dental health)
- Anaesthetics administered in connection with oral surgery or other covered dental services
- Occlusal equilibration (limited to eight units per calendar year)
- Occlusal guards in connection with periodontal treatment or bruxism
- Treatment of periodontal and other diseases of the gums and tissues of the mouth, excluding surgery, post surgical treatment and appliances – limited to twelve units of periodontal scaling and root planing, for all procedures combined, in a calendar year
- Endodontic treatment, including root canal therapy – limited to once only for a tooth
- Space maintainers, prefabricated full coverage restorations for primary teeth
- Injections of antibiotic drugs by the attending dentist
- Initial installation of partial or full removable dentures to replace one or more natural teeth extracted while the individual is insured and adjustments to such dentures, but separate charges for adjustments will only be included if they are incurred more than three months after the initial installation
- Replacement of an existing partial or full removable denture by a new denture or the addition of teeth to an existing partial removable denture to replace extracted natural teeth, but only if evidence satisfactory to the Insurance Company is presented that:
    a. the replacement or addition of teeth is required to replace one or more additional natural teeth extracted after the existing denture was installed and while the individual is insured.
    b. the existing denture was installed at least five years prior to its replacement and that the existing denture cannot be made serviceable.
    c. the existing denture is an immediate temporary denture replacing one or more natural teeth extracted while the individual is insured and replacement by a permanent denture is required and takes place within twelve months from the date of installation of the immediate temporary denture.
- Repair or recementing of dentures or relining of dentures, limited to once per 24-month period.
- Orthodontic treatment including correction of malocclusion for covered dependent children under age nineteen.

Services and supplies, in the case of each Dental Expense, must have been rendered and dispensed by a legally qualified dentist except that:

- polishing or scaling of teeth may be performed by a licensed dental hygienist if such treatment is rendered under the supervision and direction of such dentist.
- installation, adjustments, repairs and relining of complete dentures may be made by a denturist or a dental mechanic legally practicing within the scope of his license, but any charges in excess of the amount specified for such services and supplies in the denturist's or dental mechanic's tariff of the Province where such services and supplies are received will be disregarded.

If alternate services may be performed for the treatment of a dental condition, the amount included as a Covered Expense will be the amount specified for the least expensive service or supply which, as determined by the Insurance Company, will produce a professionally adequate result.

Predetermination of Benefits

If dental expenses in connection with a course of treatment planned by a dentist for a covered family member will exceed $400, the proposed course of treatment must be filed with and approved by the Insurance Company prior to the commencement of treatment. Failure to file and obtain approval may result in benefits for the course of treatment in a lesser amount than would otherwise have been payable, because of the difficulty of determining the necessity for the types of services involved after they have been rendered. After reviewing the proposed course of treatment, the Insurance Company will notify you of the estimated payment. **Pre-approval must be obtained for dentures or orthodontic treatment.**

Please note: Any dental procedures which include commercial lab charges require that a copy of the commercial lab invoice be provided when submitting the dental claim form for reimbursement.

Exclusions

No benefits are payable for:

1. any dental procedure which is included under any other Medical Plan provided by any employer or government

2. bridgework (including crowns, onlays and inlays forming the abutments) and gold fillings

3. fixed prosthetic devices (such as bridges and crowns)

4. services and supplies that are partially or wholly cosmetic in nature, except covered expenses necessary for the prompt repair of a non-occupational injury

5. supplies which were first prescribed or recommended prior to the date on which the individual would otherwise become insured hereunder for reimbursement in respect of such supplies

6. charges for completion of claim forms

7. charges for oral hygiene instruction, nutritional counselling or protective athletic appliances

8. the initial installation of dentures when such charges are incurred for replacement of teeth, all of which were extracted while the individual was not insured

9. dentures, and the fitting thereof, which were ordered while the individual was insured, but are finally installed or delivered to the individual more than ninety days after termination of insurance

10. replacement of a lost or stolen denture or personalization or characterization of dentures

11. charges for appointments broken without notice

12. services and supplies rendered for a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction

13. any hospital charges in connection with injuries or disease of a dental nature

14. services or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.

HOW TO CLAIM

When you have a claim you should contact your Plan Administrator who will supply you with the proper forms with instructions for completion.

In order to quickly process your claim, all forms must clearly indicate the following:

  - your full name and address
  - your local
  - your Group Policy Number (3935)

- **Claim forms must be signed by the member, not by the member's insured dependents**.
- Supplementary Health Expense claim forms must be fully completed as outlined on the form.
  - Dental claim forms must be completed by the dental office.
  - The member must complete all of Part 2 and sign where indicated. If payment is to be sent directly to the dental office, **please ensure the member signs the appropriate area.**
- If your dental office prefers to use their own forms it is not necessary to include the Manulife Financial form, provided the member fully completes Parts 2 and 3 of the standard forms, and signs where necessary.
- All forms completed incorrectly will be returned for proper completion.

***All claims should be forwarded to the Plan Administrator*:**

UNION BENEFITS
151 Frobisher Drive, Suite E220
Waterloo, Ontario
N2V 2C9

PHONE (519) 725-8818
Pay-directs - ext 27
Pension - ext 35
Group Benefits - ext 28 or 32
Group Claims - ext 28 or 32
Life Claims – ext 24

FAX (519) 725-9362
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