SHEET METAL WORKERS' INTERNATIONAL ASSOCIATION

LOCAL UNION 562

EMPLOYEE BENEFIT TRUST

Dear 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
Gary Gagnier
Rob Weiler

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SUMMARY OF BENEFITS

Active Members

Member Life Insurance	**$25,000**
Accidental Death and Dismemberment	**$25,000**

Weekly Disability — **$426 per week**

Benefits are integrated with the Employment Insurance Sickness Benefits and are payable to you from:

- the 1st day if your disability is due to an accidental injury
- the 4th day if your disability is due to an illness

Benefits are payable for a maximum of 26 weeks and terminate at age 65.

Long Term Disability — **$1,200 per month**

Benefits are payable to you following a 26 week waiting period but are not payable beyond age 65.

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 $300 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 and denture services 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.

Emergency Travel Assist (ETA)	This benefit covers you and your family while traveling outside your province of residence or outside the country for up to 90 days. The insurer is E.T.F.S. and a separate booklet was issued detailing this coverage.

How do I become eligible?

Provided you are employed under the conditions and jurisdictions of S.M.W.I.A. Local 562, are a resident of Canada and are covered under a Provincial Health Plan, you will become eligible for benefits on the 1st day of the second month following the period in which contributing employers have made contributions on your behalf equal to the value of three months' premium.

How do I remain eligible?

Provided you are a member in good standing you remain eligible for the period of time required to use up the contributions that have been made on your behalf. The employer contributions are deposited into your dollar bank and the premium for your benefit coverage is deducted from your dollar bank one month at a time.

You are "out of benefit" when your dollar bank balance is less than the amount required to pay one monthly premium. The plan administrator, Union Benefits, will notify you in writing that you are going out of benefit. The notification will advise you that you can then make self contributions to the Benefit Trust to maintain your benefit coverage and the amount that you are required to pay. This method of continuing benefits is referred to as pay-direct.

You may only make pay-direct payments one month at a time. The self-contribution rate will be 50% of the cost of the premium for your status group as specified on the out-of-benefit notice from the Administrator.

Pay-direct contributions will not be permitted for "inactive members" who are working away from the trade.

If you elect to continue benefits on a pay-direct basis, you must submit payment to Union Benefits within 10 days of receiving the notification or your benefit coverage will cease. Under no circumstances will retroactive pay-directs be permitted.

How long can I continue benefits on a Pay-Direct Basis?

You can continue all benefits through pay-direct to age 65. At age 65, pay-directs may continue but on a reduced schedule of benefits.

If my benefit coverage ends, how can it be reinstated?

If your coverage terminates for any reason and you want to re-establish coverage, you will be reinstated on the first day of the second month following any period for which you had employer contributions that equal the value of two months' premium.

Neither initial eligibility nor reinstatement to eligibility will be permitted by "pay-direct" payments. If you do not reinstate within 10 months of going "out-of-benefit", your welfare account will be reduced to zero.

How much can I accumulate in my dollar bank?

The maximum amount you are permitted to accumulate in your dollar bank will be 12 times the actual monthly premium cost for full benefits. Credits in excess of this amount will be transferred into the reserves of the Trust Fund.

Termination of Insurance

Your coverage will terminate when the policy terminates or when your Welfare Account is less than the required monthly draw and you fail to make the required pay-direct payment to the Fund.

What if my spouse has coverage through their employer?

If you have comparable coverage through your spouse for supplementary health care and dental, you can only opt out of these benefits if you supply the administrator, Union Benefits, with the proper form providing proof of your spouse's coverage.

You must notify the Administrator's Office if your alternate coverage is no longer in effect and provide them with a reinstatement form so you can opt back in to the Local 562 plan for supplementary health care and dental benefits. If you opt out of supplementary health care and dental and subsequently opt back in, you must remain in the plan for a minimum of 24 months.

You **cannot** opt out of the Basic Benefits, which include Life Insurance, Accidental Death and Dismemberment, Weekly Disability and Long Term Disability coverage.

What happens if I am still working at age 65 and have not retired?

If you are still an active member, have not retired and have maintained your benefit coverage up to age 65, you will be given the opportunity to continue some of the coverage that you had prior to age 65.

Just prior to your 65th birthday, the plan administrator, Union Benefits will send you an election form. This form will identify the coverage that continues automatically and which benefits are available on a contributory basis. The form must be returned prior to your 65th birthday to ensure that the coverage you want is continued. The following is a summary of the automatic and voluntary coverage available as well as a list of the benefits that terminate at age 65:

- Weekly Disability and Long Term Disability benefits terminate at age 65.
- You can elect to continue the Life Insurance, Accidental Death & Dismemberment, Supplementary Health Care, Emergency Travel and Dental benefits.

If you have funds in your dollar bank, the premium for the Life Insurance, AD&D, Supplementary Health Care, Emergency Travel and Dental will be drawn from your dollar bank. If you have exhausted your dollar bank, you can still continue these benefits but on a pay-direct basis.

- If you do not notify Union Benefits of your choice and you have funds in your dollar bank, the **default** option will be to continue the Life Insurance, AD&D, Supplementary Health Care, Emergency Travel and Dental Care benefits.
- If you do not notify Union Benefits of your choice and you do **not** have funds in your dollar bank, your coverage will terminate and you will not be entitled to Retiree benefits when you retire.

What if I Leave Local 562

If you have terminated your membership with Local 562, you may apply for a refund of any remaining credits in your dollar bank. Upon completion and approval of the application, you will remain covered for benefits for 3 months if there are sufficient credits in your dollar bank. After an additional 3 months waiting period, the dollar bank balance will be refunded to you less a $30 withdrawal fee and applicable taxes.

SPECIAL BENEFITS

Disabled Members

Coverage Available to Members on Long Term Disability

If you are receiving Long Term Disability (LTD) benefits from the plan, you will have Supplementary health care and Dental benefits continued with the cost of the premium being subsidized by 50%. The subsidized premium becomes effective after you have exhausted your dollar bank.

Continuation of benefits is on a selection basis and the following options are available:

Supplementary Health Care only
Dental only
Supplementary Health Care and Dental

Life Insurance for disabled members will be provided at no cost when you are approved for LTD benefits provided you have been approved for waiver of premium. Your Accidental Death and Dismemberment Insurance will also be waived when you qualify for waiver of premium under your Life Insurance coverage. This waiver of premium will continue while the LTD benefit is in effect but not beyond 65 years of age. The amount of Life Insurance continued on your behalf will be the amount that was in effect on the date of disability.

After your initial selection, you may elect to discontinue part or all coverage, but you cannot improve your coverage.

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

Bereavement Pay

This benefit pays an active member for lost wages up to an amount equal to the current Weekly Disability daily rate, for up to four days, following the death of an immediate family member.

The immediate family includes: Father, Mother, Spouse, Child, Step-Parent, Step-Child, Mother-in-law, Father-in-law, Daughter-in-law, Son-in-law, Brother, Sister or Immediate Grandparents.

An application form must be completed to apply for this benefit.

Jury Duty

Any eligible active member who is called for Jury Duty shall be reimbursed for time spent on a jury, an amount equal to the current Weekly Disability daily rate, less the amount paid to the member by the court.

An application form must be completed. Proof of attendance and the court's payment must be provided.

Bill 162 – Workplace Safety & Insurance Board

Effective January 1, 1990, the Trust Fund is responsible for payments to the Health and Welfare fund, and the Pension fund, for those members who have suffered a loss-of-time accident and are covered through Workplace Safety and Insurance Benefits.

This benefit is provided for a maximum period of twelve months following the date of injury or up to the date you are no longer receiving Workplace Safety & Insurance Board benefits.

You must notify the Administrator’s Office to receive this benefit. A copy of the Form 7 (Injury Report) and acceptance of claim letter must be provided, as well as copies of payment statements (submitted monthly), for confirmation.

Ontario Drug Benefit Plan – $100 Deductible

If you are still active and your spouse is over age 65, you may submit prescription receipts for up to the $100 deductible for 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

At or available for work

You will be considered actively at work if you are working for a contributing employer or available for work as determined by your name appearing on the out-of-work list of the Union.

If you have become disabled, and an increase in benefits takes place after your date of disability, you will not be entitled to the increased benefit until you are no longer disabled and have returned to work for at least one full day, or are available for work for at least one full day.

The increased benefit would not apply if you became disabled from the same or related causes, within two weeks if you were receiving Weekly Sick Pay benefits and six months if you were receiving Long Term Disability benefits, after the return to active work.

Contributing Employer

The Contributing Employers are those Employers who are carrying on business in the jurisdiction of Local 562 and with whom the Union has a Collective Agreement, either individual or collective, which stipulates that such Employers shall now or hereafter make contributions into a fund to provide health and welfare benefits for those of their employees subject to the Collective Agreement.

Each Contributing Employer will contribute, in respect of each employee, at the rate stipulated in the pertinent Collective Agreements in effect from time to time.

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.

When your Dependents become Eligible

Your spouse and unmarried children become eligible for dependent's benefits on the same date that you become eligible. You must enroll your dependents with the plan administrator by completing a Member Information Card. Dependents confined to hospital at the time they would normally become eligible will become eligible when they are discharged from the hospital (does not apply to newborn infants). No person will be eligible for dependent benefits if they are covered as a member under the Plan.

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.

Reciprocal Agreements

The Trustees of the SMWIA Local 562 Employee Benefit Trust make every effort to implement the regular flow of monies for members who are working in another jurisdiction through the signing of Reciprocal Agreements. However, if you are working out of the jurisdiction of Local 562 and the Local Union where you are working is either (a) slow in returning contributions, or (b) does not return contributions, then the responsibility of maintaining coverage in the SMWIA Local Union 562 Employee Benefit Trust is yours.

Extension of Benefits

If you or one of your insured dependents are totally disabled at the time insurance terminates, supplementary health care benefits will be extended for the disabled individual during the uninterrupted continuance of such disability for a maximum of three months beyond the date on which insurance terminates, but in no event, beyond the date the disabled person becomes covered under any other group-type plan providing similar benefits.

An individual will be considered to be totally disabled at the time insurance terminates if:

- **a member** – is unable because of disease or injury to engage in his regular occupation and is not working for any kind of compensation.
- **a dependent** – is prevented because of disease or injury from engaging in substantially all of the normal activities of a person of like age and gender in good health.

Maternity Benefits will not be extended for expenses incurred after insurance has terminated. Any extended benefits payable are subject to the provisions and limitations of the plan.

Time Limitations

Written proof stating the occurrence, character and extent of loss must be submitted for each benefit to the Insurance Company within:

- Six months after the date of death for Life Insurance Benefits.
- Six months after the date of the loss for Accidental Death and Dismemberment Benefits.
- Six months after the end of the qualifying period for Long Term Disability Insurance.

And to the Administrator within:

- Six months after the start of disability for the Weekly Disability Benefits.
- 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.

Waiver of Premium

If you become totally and permanently disabled, as defined under the Definition of Disability in the Long term Disability section, while insured and before age 65 and remain so disabled for six months, your Life Insurance will remain in force up to age 65 as long as you remain so disabled provided proofs of disability are furnished as required. The first proof must be filed with the Insurance Company within 24 months following the date you cease active work. Subsequent proofs of disability must be furnished each year thereafter.

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.

ACCIDENTAL DEATH AND DISMEMBERMENT (MEMBERS ONLY)

(See Summary of Benefits)

This coverage is equal to the amount of Life Insurance and terminates at retirement.

Description of Benefits

When injury results in any of the following losses within 365 days after the date of the accident, the plan will pay:

For Loss of	Percentage of Principal Sum
Life	100%
Both hands or both feet	100%
Both arms or both legs	100%
Sight of both eyes	100%
Sight of one eye	66 2/3%
Speech, or Hearing of both ears	66 2/3%
Hearing in one ear	33 1/3%
All toes of one foot	25%
For Loss or Loss of Use of	
One Arm or One Leg	75%
One Hand or One Foot	66 2/3%
Thumb and Index Finger or at Least Four Fingers of One Hand	33 1/3%
For Total Paralysis of	
Both upper and Lower Limbs (Quadriplegia)	200%
Both Lower Limbs (Paraplegia)	200%
Upper and Lower Limbs of One Side of the Body (Hemiplegia)	200%

“Principal Sum” means the amount of insurance indicated in the Summary of Benefits.

"Loss" as used above with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and finger means the complete severance at or above the metacarpophalangeal joint; as used with reference to toe means the complete severance at or above the metatarsalphalangeal joint; and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as used above with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing.

"Loss" as used above with reference to quadriplegia, paraplegia and hemiplegia means the complete and irreversible paralysis of such limbs.

"Loss" as used above with reference to loss of use means the total and irrecoverable loss of use provided the loss is continuous for twelve consecutive months and such loss of use is determined to be permanent at the end of the period.

Indemnity provided under this section for all losses sustained by any one insured individual as the result of one accident shall not exceed the following:

(a) The Principal Sum for all losses except quadriplegia, paraplegia and hemiplegia.
(b) Two Times the Principal Sum, or the Principal Sum if Loss of Life occurs within 90 days after the date of the accident with respect to quadriplegia, paraplegia and hemiplegia.

Your Accidental Death And Dismemberment Plan Also Includes The Following Benefits Which Are Briefly Described. Please Contact Your Plan Administrator For Complete Details And Limitations:

Aggregate Limit

$5,000,000 per accident for all insured individuals.

Waiver of Premium Benefit

If while insured for this coverage, you become disabled and qualify for the Waiver of Premium Benefit under your life insurance coverage, the Insurer will also waive the payment of your accidental death and dismemberment insurance premiums.

Your entitlement to Waiver of Premium Benefit ceases on the earlier of a) the date your Waiver of Premium for Life Insurance ceases, or b) the date the policy or this coverage terminates.

Aircraft Coverage
Coverage while riding as a passenger but not as a pilot or member of the crew.

Exposure and Disappearance
Loss due to unavoidable exposure to the elements. Loss of life resulting from bodily injury caused by an accident at the time of a disappearance, sinking or wrecking.

Repatriation Benefit

The Insurer will pay the reasonable and customary expenses incurred for the transportation of the body of the deceased insured individual to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased, subject to a maximum of $10,000.

Occupational Training Benefit (Applicable to Member coverage only)

In the event of your accidental death, the Insurer will pay the reasonable and customary expenses incurred within three years following the date of the member's accident for a spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, subject to a maximum of $10,000.

Rehabilitation Benefit (Applicable to Member coverage only)

In the event you sustain an accidental injury which results in a loss payable and such injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, the Insurer will pay the reasonable and customary expenses incurred for such training subject to a maximum of $10,000 for any one accident.

Family Transportation Benefit

In the event you sustain an accidental injury and are confined in a hospital located more than 150 kilometres from your normal place of residence, the Insurer will pay the reasonable expenses incurred by all members of your immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to the confined insured individual, subject to a maximum of $1,000.

"Immediate family" means a person at least eighteen years of age who is the spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the member.

Seat Belt Benefit

In the event you sustain an accidental injury payable under this benefit, the amount of Principal Sum will be increased by 10% if, at the time of the accident, you were:

(1) wearing a properly fastened seat belt; and
(2) driving or riding in a vehicle driven by a driver who was neither intoxicated nor under the influence of drugs, unless taken as prescribed by a physician, at the time of the accident. Intoxication and being under the influence of drugs is as defined by the local jurisdiction where the accident occurred.

Hospital Indemnity

A daily benefit (1/30th of 1% of your Principal Sum, maximum of $2,500 per month) will be payable if you are confined in a hospital for at least 5 days and under the care of a physician for an accidental injury payable under this benefit, subject to a maximum of 365 days per accident.

Education Benefit (Applicable to Member coverage only)

In the event of your accidental death, the Insurer will pay the Education Benefit stated below for each of your dependent children who are enrolled as full-time students in an institution for higher learning within 365 days following date of your death.

The Education Benefit is equal to the reasonable and customary expenses actually incurred, subject to the lesser of 5% of your Principal Sum or $5,000, for each school year the dependent child described above continues his education on a full-time basis in an institution for higher learning, but not to exceed 4 school years, which must run consecutively, with respect to any one dependent child.

"Institution for higher learning" includes any university, college, CEGEP or trade school.

Exclusions

This plan does not cover a period of hospitalization which is less than five days with respect to the "HOSPITAL INDEMNITY" benefit nor any loss, fatal or non-fatal, caused or contributed to by:

1) self-destruction or self-inflicted injury, whether the insured individual be sane or insane; or;
2) declared or undeclared war or any act thereof;
3) riding as a passenger or otherwise in any vehicle or device for aerial navigation other than as provided in the part entitled "AIRCRAFT COVERAGE";
4) committing, attempting, or provoking, an assault or criminal offence; or
5) an accident which occurs while the insured individual is operating a motor vehicle or any other form of motorized transportation and the blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%).

WEEKLY DISABILITY BENEFITS (MEMBERS ONLY)

(Integrated with Employment Insurance Sickness Benefits)

The plan pays you a weekly benefit for disability absences during which you are prevented from working as a result of a non-occupational accidental bodily injury or disease, including pregnancy related conditions. Your benefit will commence on the first day of disability due to accidental injury and on the fourth day of disability due to disease or pregnancy and is payable for a maximum of twenty-six weeks during any one period of disability. The maximum weekly benefit is the greater of the amount shown in the Summary of Benefits or the E.I. benefit maximum at the start of your disability but in no case will it exceed 70% of your average weekly earnings.

If you qualify for Disability benefits from the Employment Insurance, the Fund's benefit will be suspended when E.I. benefits begin. If you continue to be disabled after exhaustion of your E.I. benefits (maximum 15 weeks), the Fund will resume its payments to you for a maximum period of 26 weeks, including the period covered by E.I. benefits. A copy of your "Last Payment" E.I. cheque stub will be needed, as well as an updated medical report.

If you do not qualify for E.I. benefits, the Fund's benefit will be payable as long you remain disabled, up to a maximum of 26 weeks. Written proof of E.I.'s denial must be provided.

NOTE: Be sure to apply for Employment Insurance Accident and Sickness Benefits immediately upon becoming disabled.

All disability absences will be considered as having occurred during a single period of disability unless acceptable evidence is furnished that:

(a) the causes of the latest disability absence cannot be connected with the causes of any of the prior disability absences and the latest disability absence occurs after return to active work on full time for at least one day, or

(b) a connection with prior disability absences can be established but that, between the last of the previous disability absences which are connected and the latest one, you have returned to active work on full time for at least two consecutive weeks.

Benefits are only payable for:

(a) Those days on which you are under the care of a legally qualified physician. A period of care will be considered to have started when you have been seen and treated personally by the physician.
(b) Those days on which you are not performing work for compensation or profit.
(c) Those days to which you are not entitled to benefits under the Quebec Automobile Insurance Act.
(d) The period of disability absence during which benefits are not payable under the Employment Insurance Act.

The disability absence must commence while insurance is in force

If you are entitled to pregnancy leave of absence, no benefits are payable for the period during which you would be away from work on pregnancy leave of absence.

LONG TERM DISABILITY INSURANCE (MEMBERS ONLY)

Introduction

Long Term Disability insurance is income insurance which guarantees you a monthly income if you become so totally disabled by accidental bodily injury or disease while insured under this plan that you can no longer work for your living. The ordinary disability insurance plan will protect you against the loss of your income only for a few weeks or months. Long Term Disability insurance covers you for those total disabilities that last for years.

Definition of Total Disability

You will be considered "totally disabled" during the qualifying period and the next 24 months of a period of disability if you are unable, solely because of disease or accidental bodily injury, to work at your own occupation. Your own occupation means the type of work in which you are engaged and is not limited to the actual job you are performing prior to the start of a period of total disability. Thereafter, during the same period of disability, you are totally disabled only if you are unable, solely because of disease or accidental bodily injury, to work at any reasonable occupation. A reasonable occupation means any gainful activity for which you are, or may reasonably become fitted by education, training or experience, other than work under an Approved Rehabilitation Program.

Maximum Period of Payment

You will be eligible for your first payment from the plan after you have completed the qualifying period, which is the first six months of a period of total disability. However, you will not receive an income payment if you reach age 65 before you complete the qualifying period. After completing the qualifying period, you will be eligible for income payments during the continuance of a period of total disability until you reach age 65, unless the period of total disability ceases.

A period of total disability commences on the first day you are totally disabled or 31 days prior to the date you were then first seen and treated personally by a physician in connection with the injury or disease which caused such disability, whichever occurs later.

Amount of Monthly Income

Refer to the Summary of Benefits for the current monthly payment. The Long Term Disability plan will pay this amount less 50% of earnings, if any, received in connection with an approved rehabilitation program and will pay all of this guarantee if you are receiving no other income benefits.

If you are receiving other income benefits, your income from this plan will be limited so that the total income from this plan and other income benefits will not exceed 80% of your gross pre-disability monthly rate of basic earnings, but in no event will the amount payable under this plan exceed the guarantee.

Other Income Benefits

The plan counts as other income benefits:

1. Income received from any employer or from any occupation for compensation or profit (including income received in connection with an Approved Rehabilitation Program).

2. Disability, retirement or unemployment benefits provided for under any law of a government. Examples of these are Workplace Safety & Insurance benefits and disability and retirement benefits under the Canada or Quebec Pension Plan.

3. Disability, retirement or unemployment benefits provided under any group insurance or pension plan or any other arrangement of coverage for individuals in a group (whether or not insured).

4. Distributions from profit sharing plans by reason of your disability or retirement.

Benefits payable to you or to your spouse, children and dependents by reason of your disability or retirement are included as other income benefits. However, disability or retirement benefits at the level at which you were receiving them prior to the commencement of the period of total disability are not included as other income benefits. Any increase in the amount of Canada or Quebec Pension Plan benefits by reason of a change in the Consumer Price Index or other method of determining cost of living increases, after the commencement of the period of total disability, shall not be included as other income benefits.

In submitting a claim for LTD benefits, you must advise the Insurance Company of the amount of all other income benefits payable. Further, you must submit evidence satisfactory to the Insurance Company that you and your spouse, children and dependents have made proper application, and reapplication where appropriate, for other income benefits payable by reason of disability and for any retirement benefits which may be applied for on an unreduced basis. You do not need to apply for retirement benefits available only on a reduced basis or disability benefits under life insurance programs if payment reduces the amount of life insurance, but such benefits will be counted as other income benefits if received.

For the purpose of this plan, the Insurance Company shall have the right to determine other income benefits as follows:

- Any periodic payments shall be allocated to monthly periods.
- Any single sum payment, including any periodic payments which an individual could have elected to receive in a single sum, shall be allocated to sixty monthly periods.
- Any periodic or single sum payment received pursuant to a retroactive award shall be allocated retroactively.

Monthly Rate of Basic Earnings

This is defined by the Plan with respect to any period of total disability as follows:

The gross monthly pre-disability earnings of a member will be calculated by multiplying 40 hours times the base rate in effect before the start of the disability, times 52, divided by 12.

Further, no change in the rate of basic earnings which is determined after the date a period of total disability begins will be considered in calculating the monthly rate of basic earnings for that period of total disability.

Cessation of Benefits

A period of total disability ceases on the earliest to occur of the following:

- when you are no longer totally disabled;
- when you commence work at a reasonable occupation;
- when you fail to furnish proof of the continuance of total disability or refuse to be examined by a physician;
- when you cease to be under the care of a physician;
- when you cease to be receiving accepted standard professional treatment for the condition being treated and, where appropriate, treatment by a relevant and certified specialist;
- the end of the calendar month in which you attain age 65;
- the date of your death.

Successive Periods of Disability Rule

Successive periods of total disability due to the same or related causes which are separated by less than six months will be considered as one continuous period of total disability. This rule applies both during the qualifying period and after you have actually become eligible for income payments from the plan.

Rehabilitation Provision

If you recover sufficiently to work again at any occupation, you may be able to do so without jeopardizing your total disability status. However, in order to remain eligible for income benefits from the plan, such work must be approved in writing by the Insurance Company as an Approved Rehabilitation Program, the amount of monthly income shown in the Summary of Benefits will be reduced by 50% of the earnings received in connection with the rehabilitation program. Working under an Approved Rehabilitation Program is to your advantage as you will receive a greater total income than if you had not made the effort to rehabilitate yourself.

Exclusions and Limitations

Certain disabilities are beyond the scope of Long Term Disability. Therefore, you are not insured against the loss of your earnings if your disability results from any one of the following causes:

1. war (whether declared or not), insurrection, rebellion, or participation in a riot or civil commotion;
2. your commission of, or your attempt to commit, an assault or criminal offense;
3. intentionally self-inflicted injuries;
4. chronic alcoholism or use of narcotics, barbiturates or hallucinogenic substances unless you are receiving active treatment in accordance with accepted professional standards;
5. a pre-existing condition as described below.

Pregnancy or Parental Leave

If you are entitled to pregnancy or parental leave of absence, you are not insured for the period during which you would be away from work on pregnancy or parental leave of absence.

Pre-existing Conditions

Further, you are not insured against a period of disability (including all separate periods considered as one) which commences during the first twelve months you are insured, if the disability is caused, directly or indirectly, by a disease or injury for which you received treatment or services or took drugs or medicines, which were prescribed or recommended by a physician during the three-month period just before your insurance went into effect. If your insurance terminates for any reason and you later become reinsured for Long Term Disability Benefits, this pre- existing condition limitation will again apply for twelve months.

Extended Insurance

If your Long Term Disability insurance terminates during a period of total disability, you will continue to be eligible for monthly income benefits during the continuance of that period of total disability.

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 now have Emergency Travel Assist coverage through E.T.F.S. and with that coverage you were issued Emergency Travel Assist (ETA) cards. Please be sure to take your ETA Card with you whenever you are going to be outside your province of residence. Your first call in an Emergency should be to the number listed on that card.

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 not 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 (including 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
Employer Contributions - ext 27
Pension - ext 35
Group Benefits - ext 28 or 32
Group Claims - ext 28 or 32
Disability Benefits - ext 24
Life Claims – ext 24

FAX (519) 725-9362
Toll Free - 1-800-265-2568