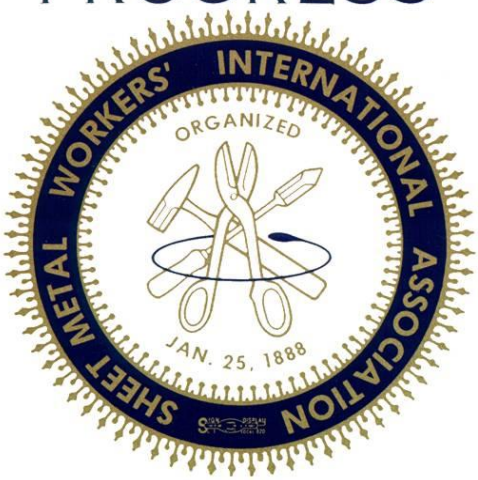
S.M.W.I.A. LOCAL 537

EMPLOYEE BENEFIT PLAN

PROGRESS



PROTECTION

FOR ACTIVE SHEET METAL MEMBERS AND THEIR DEPENDENTS

Effective Date: May 1, 2016

Group Contract No: 64N40

LOCAL 537
SHEET METAL WORKER'S INTERNATIONAL ASSOCIATION

LOCAL UNION 537

EMPLOYEE BENEFIT TRUST

Dear Member:

This booklet describes the main features of the Group Benefit program available to you and every effort has been made to ensure that the information is accurate however it is not a contract of insurance. This booklet is not an official document and does not grant or confer any contractual rights. The final determination of any terms, conditions or provisions which may arise shall be governed by the provisions of the official Plan Text and the Trust Agreement.

The Trustees hope that their efforts in developing a sound program of protection for members and their families will be of real value to all concerned. We urge you to study this booklet carefully in order to understand the benefits and your rights thereto.

The Trustees appointed as Administrator and Consultant, **Union Benefits**, to attend to the day-to-day administration of the Fund under the overall direction of the Trustees. Contact your Plan Administrator, **Union Benefits**, if you want any additional information at **1-800-265-2568.**

Full details of the benefits insured with SSQ are contained in the Group Policy # 64N40 issued by (SSQ, Life Insurance Company Inc. or "SSQ"). All rights with respect to these benefits of the plan will be governed solely by that Group Policy. Benefits detailed in the SSQ Group Policy # 64N40 are the Life, Accidental Death and Dismemberment, Short Term Disability, Long Term Disability and Medical Care benefits. These benefits are detailed in the booklet

Benefits that are self-funded and the Employee and Family Assistance Program (EFAP) provided by Shepell-fgi are detailed in this booklet.

The Emergency Travel Insurance and Assistance Benefit is insured by SSQ. Details of this benefit are provided in this booklet.

This booklet is for your reference. Please read it carefully and keep it for future use.

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

Sincerely Yours,

THE BOARD OF TRUSTEES

Randy Cook
Scott McQueen
Peter Kwiatkowski
Mark Stanley
Yasar Raja

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SUMMARY OF BENEFITS

Benefit	Benefit Amount	Description
Member Life	$30,000	Payable to your designated beneficiary Reduces at retirement to $20,000
Accidental Death and Dismemberment	$30,000	Loss benefits are payable to the member. Death benefits are payable to your designated beneficiary. Terminates at age 70 or earlier retirement
Short Term Disability (STD)	EIC maximum per week	STD benefits are payable for a maximum of 26 weeks of benefit, integrated with the Employment Insurance Sickness Benefits. Benefits are payable from: • the 1st day if your disability is due to an accidental injury • the 1st day if you are hospitalized • the 8th day if your disability is due to an illness
Taxability Status		STD benefit payments are considered a taxable benefit for Income Tax purposes. Terminates at age 65 or earlier retirement.
Long Term Disability (LTD)	$1,400 per month	LTD benefits are payable after 26 weeks of STD have been paid To qualify for LTD, you must be "totally disabled". You are considered "totally disabled" during the qualifying period and the next 24 months of a period of disability if you are unable, solely because of illness or accidental bodily injury, to work at your own occupation. After 24 months and during the same period of disability, you are totally disabled only if you are unable, solely because of illness or accidental bodily injury, to work at any reasonable occupation.
Waiver of Premium		Once you have qualified for LTD benefit payments, your Member Life, AD&D, STD and LTD premiums are waived. Your application for LTD benefits will also be used to approve the waiver of premium benefit
Taxability Status		LTD benefit payments are considered a taxable benefit for Income Tax purposes Terminates at age 65 or earlier retirement
Employee and Family Assistance Program **Provided by Shepell·fgi**		Voluntary, confidential short-term counseling and advisory services available 24/7/365 to you and your family. Terminates at retirement

Benefit	Reimbursement	Maximum and Description
Medical Care	100%	Lifetime maximum per person is unlimited
Deductible		Nil
Prescription Drugs	100%	The drug card pays for medically necessary drugs that legally require a prescription (no over-the-counter drugs) The maximum dispensing fee paid by the plan is $8.00 Smoking cessation limited to $600 per lifetime, and Fertility Drugs are limited to $2,400 per lifetime Erectile Dysfunction Drugs limited to $1,000 per calendar year
Paramedical Services	100%	$500 per practitioner per calendar year, for physiotherapist, speech therapist, osteopath, chiropractor, podiatrist/chiropodist, massage therapist/kinesiologist, naturopath, acupuncturist or clinical psychologist
Orthotics	100%	$350 maximum per person per calendar year
Custom made orthopedic shoes	100%	$400 maximum per person per calendar year Must be prescribed by: Medical Practitioner or Specialist-MD, Podiatrist – DPM, Chiropodist-D CH or D Pod M Must be dispensed by: 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, Chiropractor-D.C. May continue coverage in retirement on a pay direct basis
Vision Care (self-funded)		
Eyeglasses, contact lenses or laser eye surgery	100%	$300 per person every 2 calendar years
Eye exam	100%	$75 per person every 2 calendar years when not covered under a provincial plan May continue coverage in retirement on a pay direct basis
Emergency Travel and Assistance Insured by SSQ	100%	Coverage for medical emergencies when travelling outside your province of residence, for a maximum period of 90 days. Terminates at the end of the year you are age 71 or earlier retirement
Dental Care (self-funded)		Reimbursement is based on the Dental Association Fee Guide that is 1 year behind the current fee schedule A pre-determination assessment is required for any treatment over $800
Deductible		Nil
Basic Services	100%	$2,000 per calendar year maximum per person for basic, major restorative and orthodontic services combined
Major Restorative	50%	
Orthodontics	50%	For dependent children under age 19. Lifetime maximum of $2,000 per child. May continue coverage in retirement on a pay direct basis

To access the website, www.unionbenefits.ca, use Username: m537 and Password: 537rewards

ELIGIBILITY

How do I become eligible?

Provided you are employed under the conditions and jurisdictions of S.M.W.I.A. Local 537, 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. 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 the full cost of the premium for your status group as specified on the out-of-benefit notice.

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-direct payments be accepted.

How long can I continue benefits on a pay-direct basis?

You can continue all benefits through pay-direct to age 65 or earlier retirement. 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 one (1) months' premium. Neither initial eligibility nor reinstatement to eligibility will be permitted by "pay-direct" payments

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.

At the end of each year, the union office will calculate the premium required to pay for full coverage for 12 months. If the amount in your dollar bank exceeds the amount required to fund 12 months of full coverage, you are eligible for a refund of the excess credits which is paid out once a year. You will receive a T4A for income tax purposes as this is a taxable benefit.

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, 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:

- Short Term Disability and Long Term Disability benefits terminate at age 65.
- Accidental Death & Dismemberment (AD&D) terminates at age 70 and the Emergency Travel Insurance and Assistance benefit terminates at the end of the year following your 71st birthday.
- You can elect to continue the Life Insurance, AD&D (under age 70), Medical Care, Emergency Travel Insurance and Assistance benefit (under age 71), Vision Care and Dental Care benefits.

If you have funds in your dollar bank, the premium for the Life Insurance, AD&D, Medical Care, Emergency Travel Insurance and Assistance benefit, Vision Care and Dental Care 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 (under age 70), Medical Care, Emergency Travel Insurance and Assistance benefit (under age 71), Vision Care 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 my spouse has coverage through their employer?

If you have comparable coverage through your spouse for medical care and/or dental care, you can opt out of these benefits provided you supply Union Benefits with the proper form providing proof of your spouse's coverage.

You must notify Union Benefits 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 537 plan for medical care, vision care and dental care benefits. If you opt out of medical care, vision care and dental care 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, Short Term Disability and Long Term Disability.

The amount that is deducted from your dollar bank will depend on the benefits you have selected. You can choose:

- Basic Benefits Only (Life, Accidental Death & Dismemberment, STD and LTD)
- Basic Benefits plus Medical Care
- Basic Benefits plus Dental Care

The actual amount deducted will fluctuate as premiums increase or decrease.

Definition of Dependent

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

- Each child from birth. 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 or 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. In the event of divorce, legal separation, or discontinuance of cohabitation, you may elect to continue membership of the former spouse or to provide notice to the Union office to terminate coverage for the spouse. At no time will coverage for more than one spouse be provided under the same policy.
- No dependent 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 in 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). If the dependent is confined at home, confinement will mean they are unable to carry on any substantial part of the regular and customary duties or activities of a person in good health and of the same age and gender. In this case, the dependent becomes eligible when they are able to carry on the substantial part of their regular and customary duties or activities.

If you marry, enter into a common law relationship or have new dependent children, you must add them to your group insurance coverage within 31 days. To do this, you need to contact the union office and update your Member Information Card. You also need to advise the union office, in writing, when a previously eligible dependent no longer qualifies.

If you do not notify Union Benefits within 31 days, you may be required to provide evidence of insurability.

What should I do if my address or my dependent status changes?

Complete a new Member Information Card which can be obtained from the website or Union Benefits. You must notify Union Benefits within 31 days of any change in your address or family status such as:

- Change of address;
- Change in marital status;
- Establishment of a common-law relationship;
- Birth or adoption of a child;
- Change of beneficiary for any reason, including your beneficiary's death;
- A Dependent Child becoming disabled; or
- A Dependent Child commencing full-time attendance at a post-secondary school.

Co-ordination of Benefits (for Medical Care, Emergency Travel Insurance and Assistance Benefit, Vision Care and Dental Care Benefits)

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. The order is determined as follows:

1) Benefits will be payable first from a group policy which does not have a provision to coordinate benefits, then subsequently in accordance with the rules of this and other group policies which do have coordination of benefits.
2) Among the policies having coordination of benefits, priority will be determined in the following order:
   Members:
   a) The plan where you are covered as a member.
   b) If you are eligible for member coverage under more than one plan, priority goes to:
      - the plan where you are an active, full-time member,
      - the plan where you are an active, part-time member,
      - the plan where you are a retiree.

   Dependents:
   <u>Spouse</u>
   c) The plan where the spouse is covered as a member.
   d) The plan where the spouse is covered as a dependent.
   <u>Dependent Children</u>
   e) The plan of the parent with the earlier birthdate (month/day) in the calendar year.
   f) The plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birthdate.
   g) In situations where parents are separated/divorced, then the following order applies,
      - the plan of the parent with custody of the child,
      - the plan of the spouse of the parent with custody of the child,
      - the plan of the parent not having custody of the child,
      - the plan of the spouse to the parent above.

If priority cannot be established according to the above rules, 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.

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 for Short Term Disability and 6 months for Long Term Disability after the return to active work.

Change in Government Sponsored Plans

The medical, dental and hospital benefits (if applicable) under this Group Benefit Plan are provided in conjunction with Government sponsored Provincial Programs. In the event coverage under any provincial plan is modified, suspended or discontinued, the group insurance plan will not automatically assume responsibility for any services or products previously covered under the provincial programs.

Contributing Employers

The Contributing Employers are those Employers who are carrying on business in the jurisdiction of Local 537 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.

File and Personal Information

In order to maintain the confidentiality of information concerning the persons it insures, SSQ, Life Insurance Company Inc. opens an insurance file to hold personal information about the application for insurance and any insurance claims made.

With the exception of certain cases provided for under applicable legislation, access to insured persons' files is restricted to those employees, legal agents and service providers who must consult these files for the purpose of contract management, inquiries or underwriting, in addition to any other person you may authorize. SSQ keeps these insurance files in its offices.

All persons insured with SSQ have the right to consult the information contained in their file and, if necessary, to have any errors or inaccuracies corrected, free of charge, by making a written request to the attention of SSQ's Personal Information Protection Officer at the following address: SSQ, Life Insurance Company Inc., 110 Sheppard Avenue East, Suite 500, Toronto, ON M2N 6Y8. However, SSQ may charge fees for transcribing, reproducing or sending this information. The person making the request for information will be informed beforehand of the approximate amount that will be charged.

Legal Agents and Service Providers

SSQ may exchange information of a personal and confidential nature with its legal agents and service providers only for the purpose of allowing them to carry out the tasks they are assigned, in particular, for processing most prescription drug claims. SSQ's legal agents and service providers must comply with SSQ's Personal Information Protection Policy.

When you enrol in a group insurance plan, and also when you make a claim (e.g. electronic Dental Care claims submission), you are actually giving your consent that the insurer and its legal agents and service providers may use your personal information for the above-mentioned purposes. It is understood that not giving this consent would compromise the management of your insurance coverage and the quality of the services SSQ can offer you.

For more information, consult the SSQ Personal Information Protection Policy available at www.ssq.ca.

Member Contributions

If you are required to contribute towards the premium cost of benefit coverage, your contribution will be first used towards the cost of Life and Accidental Death and Dismemberment Insurance coverage and then applied towards the cost of any other applicable benefits.

Reciprocal Agreements

The Trustees of the SMWIA Local 537 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 537 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 537 Employee Benefit Trust is yours.

Time Limit for Submitting Claims

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

For Medical Care, Vision Care and Dental Care Claims

- Twelve (12) months after the date of the service

For Life Insurance and Accidental Death & Dismemberment Claims

- Twelve (12) months following the date of death
- Twelve (12) months after the date of the loss for AD&D benefits

For Short Term Disability (STD):

- Six months after the date of disability

For Long Term Disability (LTD):

- Six months after the end of the LTD qualifying period
- 90 days after the date the disability recurs
- 90 days after the Insurer's request for additional information
- 12 months to submit all required documents if the claim is declined or payment of benefit is terminated
- If your application is declined or payment of benefits is terminated, you have ninety (90) days to file an appeal and twelve (12) months in which to provide additional proof justifying your entitlement to benefits.

For Waiver of Premiums:

- If no claim for disability insurance benefits is filed, applications for waiver of premium must be submitted in writing.
- All claims for Waiver of Premium must be submitted within twelve (12) months of the date of disability.
- If your application has been declined or your waiver of premium has been interrupted, you have ninety (90) days to file an appeal and twelve (12) months to provide additional proof justifying your continued entitlement to a waiver.
- For an application for waiver of premium to be approved, all required documents must be submitted no later than 18 months following the start of your total disability.

In the event that the policy or a benefit terminates, all claims must be submitted within 90 days of the date of termination.

Third-Party Liability and Subrogation

You must notify SSQ of any notice served to, or legal action taken against a third party or any judgment, claim or settlement related to an event which may result in entitlement to benefits under the insurance plan.

If you are entitled to receive financial compensation from a third party with respect to which benefits are payable under the contract, you will be required to reimburse SSQ the amount of any benefits overpaid.

SSQ is subrogated to all rights of the insured against a third party liable for damage that results in an entitlement to payment of benefits under the terms of the contract, up to the limitation of the amounts paid by SSQ. Should SSQ decide to exercise its right of subrogation, the insured may be required to sign a letter of subrogation drafted by SSQ.

What Income Tax is Payable?

Under current legislation, you do not have to pay any taxes on the contributions made to the Plan by the contributing employers. You will receive a T4-A tax slip from the Administrator for the portion of the contribution representing the cost of your Life and Accidental Death & Dismemberment Insurance. Taxes will not be deducted from payments under this Plan but will have to be paid by you when you file your income tax return for the year. T4-A tax slips will be issued to you annually reflecting the taxable benefits you received for the calendar year. Medical expenses reimbursed under the Plan cannot be claimed as deductible expenses when filing your income tax return.

Please note that in addition to any Dollar Bank Refund, Short Term Disability and Long Term Disability benefit payments are taxable income which you will need to report on your income tax return.

Termination of Insurance

Your coverage will terminate when your dollar bank is less than the required monthly draw and you fail to make the required pay direct payment to the Fund.

Coverage for Disabled Members

Disabled members, who are receiving Long Term Disability (LTD) benefits or Workers' Safety and Insurance Board (WSIB) benefits, will have their benefits continued with the cost of the premium being subsidized by 50%. For disabled members receiving LTD benefits, the cost of the premium is subsidized by the S.M.W.I.A. Local 537 Benefit Trust Fund, after the member has exhausted his benefit dollar bank. For disabled members receiving WSIB benefits, the cost of the premium for the first twelve months of disability will be subsidized by the Bill 162 Fund. If WSIB benefits continue beyond twelve months, the cost of the premium is subsidized by 50% by the S.M.W.I.A. Local 537 Benefit Trust, after the member has exhausted his dollar bank.

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

Medical Care, Emergency Travel Insurance and Assistance benefit and Vision Care only
Dental Care only
Medical Care, Emergency Travel Insurance and Assistance benefit, Vision Care and Dental Care

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

Disabled members, who are receiving Long Term Disability (LTD) benefits or have been in receipt of Workers' Safety and Insurance Board (WSIB) benefits for a minimum of six months, may have the premium cost for their Life, Accidental Death & Dismemberment, STD and LTD insurance coverages waived. This Waiver of Premium will continue while the LTD or WSIB benefit is in effect, but not beyond 65 years of age. The amount of insurance is the amount in force on the member's date of disability.

Surviving Dependent Coverage

Provision has been made to continue benefits for the spouses and dependent children of deceased members as follows:

If you are an active member of the Plan, your eligible dependents, at no cost to them, will be provided with the Medical Care (includes Emergency Travel Insurance and Assistance Benefit and Vision Care) and/or Dental Care benefits in place prior to death, for a period of two years from your date of death. For example, if you had elected not to continue the Dental Care benefit, this benefit would not be available to your eligible dependents.

After 2 years has elapsed, benefits can be continued on a pay direct basis. You will be given the opportunity to select which benefits you want to continue on a pay direct basis. The rates are subject to change. After the initial selection, coverage can be decreased but not increased.

These benefits would terminate after 2 years if no pay direct payment is made or the earlier of the effective date of coverage with another Insurer, the contract termination date, or 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.

Bill 162 – Workplace Safety and Insurance Board (WSIB)

Effective January 1, 1990, the Trust Fund is responsible for payments to the Health and Welfare fund, and the Pension fund, if you have suffered a loss-of-time accident and are covered through Workplace Safety and Insurance Board. This benefit is provided for a period of twelve months following the date of injury or up to the date you are no longer receiving Workplace Safety & Insurance Board benefits. This benefit is paid by the Trust Fund.

You must notify Union Benefits to receive this benefit. A copy of the acceptance of claim letter must be provided, as well as copies of payment statements (submitted monthly), for confirmation. If your WSIB benefits continue for a period of at least six months, you must submit a Waiver of Premium request to Union Benefits.

Bereavement Pay – For Sheet Metal Workers Only

This benefit is available to active sheet metal members who have contributed to the Bereavement Fund for at least 1 year.

This benefit pays an active sheet metal member $300 for lost wages following the death of an immediate family member, if the member has

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

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

This benefit does not apply to Roofers or Production Workers.

LIFE INSURANCE (Members Only)

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

Amount of Insurance

The amount of your life insurance coverage is **$30,000**.

Conversion Privilege

If your insurance under this benefit ends or reduces while the contract is in force, you are entitled to convert all or part of your group life insurance coverage to individual life insurance without having to prove your insurability. To exercise the conversion privilege, you must apply in writing to SSQ no later than 31 days after the day you cease to belong to the group insured.

You can opt for one of the following types of individual insurance:

a) A life insurance that is comparable to your group insurance as to the amount and duration, but that does not exceed $400,000 for all of your group life insurance benefits combined, including the ones you were insured for as a spouse or child, where applicable

b) A one-year term life insurance that can be converted into the insurance described in item a) above

Individual life insurance policies issued after having exercised the conversion privilege do not provide for a premium waiver.

If you should die during the 31-day period in which you could have exercised your conversion privilege and your group insurance coverage has not already been converted, the amount of life insurance you were eligible to convert shall be payable under the group insurance contract.

In all cases described above, the premium for the first year of the individual insurance cannot exceed the premium for a one-year term insurance. Except for this first-year premium, the premiums must be level for the term of the individual policy. The individual policy premiums are based on the rates in force for individual insurance, in accordance with your gender, and your age and smoking status on the date you cease to belong to the group insured, and in accordance with the particulars that applied to your group life insurance. SSQ must receive the first premium for individual life insurance within 31 days following the date you cease to belong to the group insured.

Waiver of Premium Benefit

If, while insured under this coverage, you become totally disabled, as defined under the Definition of Total Disability in the Long Term Disability section, and qualify for Long Term Disability benefits before attaining age 65, the Insurer will waive the payment of your Life Insurance premiums.

In order to qualify for the waiver of premium benefit, you must notify the Insurer within 12 months of the last active day at work and must furnish due proof of disability, satisfactory to the Insurer, within 18 months of that last active working day.

The waiver of premium also applies to Workplace Safety and Insurance Board (WSIB) claimants. If the disability is approved as a permanent WSIB claim and you have been in receipt of benefits for a minimum period of 6 months, you will be required to complete an application for Waiver of Premium. The application will be submitted to the Insurer to approve the waiver of the premiums for the Life, Dependent Life, Accidental Death and Dismemberment, STD and LTD coverages. In other words, payment will not be required for these benefits as long as you remain disabled as described in this section.

Premiums will be waived starting with the date the required proof is approved by the Insurer. Premiums will not be waived beyond the earlier of:

- your attainment of age 65;
- the date you cease to be totally disabled; or
- the date you retire.

From time to time, the Insurer will have the right to require proof of continuance of your total disability. You may be required to be examined by a medical examiner designated by the Insurer, at the Insurer's expense.

No benefits will be provided under this benefit if you fail to submit proof of disability when required.

The amount of Life insurance for which premiums will first be waived will be the amount in force on the date of disability. If the amount of insurance would have reduced at a later date based on the Summary of Benefits in force on your date of disability, then the amount of insurance for which premiums are being waived will be reduced in a like manner.

If you die while insurance is being continued in accordance with this provision, the amount of insurance that the Insurer will pay will be the amount of insurance for which premiums are being waived at the time of death.

No further benefit will be provided under this provision if you:

1) cease to be totally disabled; or
2) fail to submit proof of continuance of disability when required; or
3) fail to be examined by a qualified physician when required; or
4) attain age 65.

Compassionate Assistance Benefit

If you are totally disabled and terminally ill and the prognosis is death within the next 12 months, you may be eligible for an advance on the Life Insurance benefit equal to 50% of your insured amount up to a maximum of $50,000. Premium payments for the full Life insurance amount must continue to be paid.

ACCIDENTAL DEATH AND DISMEMBERMENT (Members Only)

100% of your Accidental Death and Dismemberment Benefit is payable in the event of your death from an accident, 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. You should review your beneficiary designation to be sure that it reflects your current intent.

The amount of the Principal Sum is $30,000. When injury results in any of the following losses within 365 days after the date of the accident, the following will be paid:

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%

"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 Union Benefits 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 waive the payment of your Accidental Death and Dismemberment insurance premiums.

Your entitlement to Waiver of Premium Benefit ceases the date your Waiver of Premium for Life Insurance ceases.

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
In the event of your death due to an accident for which an amount is payable under this 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 for which an amount is payable under this benefit, 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 under this benefit 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 for which an amount is payable under this benefit 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 $5,000. "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. This plan does not cover a period of hospitalization which is less than five days.

Education Benefit (Applicable to Member coverage only)

In the event of your accidental death for which an amount is payable under this benefit, 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, limitations and restrictions

This benefit does not cover any loss that is attributable, directly or indirectly, in whole or in part, to any of the following causes:

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;
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%);

Benefit Amount

The benefit amount is **equal to the EIC maximum per week**. Benefits are integrated with Employment Insurance (E.I.) Sickness Benefits and are payable to you from:

- 1st day if your disability is due to an accidental injury
- 1st day if you are hospitalized
- 8th day if your disability is due to an illness

Benefits will be payable while you are totally disabled by a non-occupational injury or illness. Totally disabled means that you are incapacitated to the extent that you are not able to perform any and every duty of your occupation or employment. The disability must commence while you are insured under this coverage. No more than one benefit will be payable during any period of disability whether you are disabled by one or more causes.

Hospitalization is defined as Admission to hospital for a minimum duration of 24 hours, or for day surgery.

Non-occupational, with respect to injury, is defined as an injury which does not arise in the course of any employment for wage or profit. With respect to illness, is defined as an illness where a person is not entitled to any benefits under the Workers' Safety and Insurance Board benefits.

Integration with EI Sickness Benefits

If you qualify for sickness benefits from Employment Insurance (E.I.), the Short Term Disability (STD) benefit will be suspended when E.I. begins.

If you continue to be disabled after exhaustion of your E.I. benefits (maximum 15 weeks), the STD benefit will resume for a maximum period of protection of 26 weeks of benefit payments, including the period covered by E.I. benefits.

If you do not qualify for E.I. sickness benefits, the STD will be payable as long as you remain disabled up to a maximum period of 26 weeks.

It is necessary that you make application to both the Plan and E.I. at the commencement of your disability in order to maintain continuous benefits. If you are not eligible for E.I. sickness benefits, rejection of the claim must be forwarded to Union Benefit.

NOTE: *Benefits will not be paid if your claim to E.I. is rejected because of your failure to apply for E.I. benefits on a timely basis.*

In no event will benefits be paid prior to the date of first treatment by a doctor.

The rate of payment is that which is in effect immediately prior to the onset of your disability. This amount will not increase if there is a benefit improvement.

Maximum Duration of Benefit

The benefit is payable to a maximum of **26 weeks per disability**.

Continuous Period of Disability

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

All Source Maximum

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 100% of your gross pre-disability weekly earnings. If your total income exceeds 100% of your pre-disability earnings, your Short Term Disability benefit will be reduced accordingly.

Other Income Benefits

The plan includes the following as other income:

a) Any compensation or payment received from an employer, including severance payments and vacation pay

b) Disability benefits payable under any applicable legislation respecting automobile accidents, the Canada or Quebec Pension Plan, any other group insurance contract or any other legislation

c) Parental benefits payable under any legislation; under this contract, maternity and paternity benefits, and benefits payable for family or parental reasons, are all considered parental benefits

If the income or benefits are normally payable in a lump sum, the weekly equivalent of this lump sum amount is included in the calculation of each benefit payment.

For benefit calculation purposes, amounts payable for dependents and indexation of sources of income are not taken into account.

Extension of Benefits

If the contract or short term disability benefit terminates and you become totally disabled prior to such termination, the Insurer continues to be liable as though the provision remained in force.
If the same disability recurs within six continuous months after termination of this benefit, the Insurer will continue to pay benefits to you but only for the remainder of the original maximum benefit period. The date of disability must have occurred before the termination of this benefit. The Insurer will not be liable for benefits after termination of either the contract or Short Term Disability benefit once a replacing Insurer is bound contractually or as a matter of law.

Exclusions and Limitations

No benefit will be payable:

1) for the portion of a period of disability during which you are not under the continuous care of a physician, except if your total disability, as defined in this benefit description, is a condition that is declared stable by a physician, to the satisfaction of Union Benefits;

2) for the portion of a period of disability during which you are

   a) imprisoned in a penal institution; or

   b) confined in a hospital, or similar institution, as a result of criminal proceedings;

3) during any leave of absence (including maternity or parental leave);

4) for a disability which commences on or after the date a strike begins, subject to any provincial Employment or Labour Standards Act;

5) for aesthetic or cosmetic treatments;

6) for a period during which you hold a position or perform work, for which you may be entitled to receive any income.

This benefit does not cover:

1) disabilities for which you fail to undergo, when requested to do so by Union Benefits, any examination with a health care professional or any treatment or program likely to favour recovery of your health;
2) disabilities that are attributable, directly or indirectly, in whole or in part, to any of the following causes:
   i) a criminal act that you commit or attempt to commit;
   ii) your active participation in a riot or insurrection;
   iii) war, whether declared or undeclared;
   iv) your active service in the armed forces;
   v) intentional self-inflicted injuries, regardless of whether you are deemed to be sane or insane at the time.

LONG TERM DISABILITY (Members Only)

Introduction

Long Term Disability (LTD) insurance is income replacement insurance which provides you a monthly income if you become so totally disabled by accidental bodily injury or illness while insured under this plan that you can no longer work for your living. The Short Term Disability Insurance plan will protect you against the loss of your income for a few weeks or months. Long Term Disability Insurance covers you for those total disabilities that may last for years.

Qualifying Disability Period

The qualifying disability period starts when you first become totally disabled and ends after 26 weeks provided the disability is continuous and you are under age 65.

If the disability is not continuous, the days you are disabled will be accumulated to satisfy the qualifying disability period provided:

1) no interruption is longer than 2 weeks;
2) the disabilities arise from the same or related illness or injury.

The qualifying disability period will be the greater of 26 weeks prior to age 65, or the duration of Short Term Disability Benefit, if applicable.

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 illness 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 ta period of total disability. Thereafter, during the same period of disability, you are totally disabled only if you are unable, solely because of illness 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.

Benefit Amount

The amount of income is **$1,400 per month**. Benefits are payable to you following a **26 week** waiting period.

Maximum Duration of Benefit

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 illness which caused such disability, whichever occurs later.

Accident is defined as an unintentional, sudden, unforeseen and unpredictable event resulting, directly and independently of any other cause, in bodily injury.

Illness is defined as a disease, deterioration of health or bodily disorder, as diagnosed by a physician. For the purposes of the contract, this term is also used to refer to pregnancy-related complications and organ donations and any related complications.

Non-occupational, with respect to injury, is defined as an injury which does not arise in the course of any employment for wage or profit. With respect to illness, is defined as an illness where a person is not entitled to any benefits under the Workers' Safety and Insurance Board benefits.

Total disability resulting from an accident is defined as a disability resulting exclusively from an accident that begins within 90 days of the date of the accident.

Benefit in Event of Total Disability

If you become totally disabled before age 65 because of a non-occupational illness or an accidental injury, the Insurer will pay a monthly benefit during the applicable benefit period. The amount of the monthly benefit will be the Benefit Amount less any income and benefits payable under Reductions of Coverage, subject to the All Source Maximum of 80% of gross pre-disability earnings. Due proof must be submitted to the Insurer that you became totally disabled while insured under this coverage and have been continuously disabled for the qualifying disability period.
The benefit for a period which is less than a full calendar month will be based on the number of days applicable to the month in which the gross monthly benefit is calculated, less any Reductions of Coverage, multiplied by the number of days in said month.

Reductions of Coverage

The amount of the gross benefit will be reduced by the amount of any income or benefit payable under any Workplace Safety and Insurance Act or similar law.

You must apply for all benefits or income for which you may be or may become eligible.

If you are receiving any income or benefit payable under any government plan or program for an injury or illness totally unrelated to the injury or illness that caused the current disability, the Insurer will not reduce the gross monthly benefit by that amount.

All Source Maximum

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. If your total income exceeds 80% of your gross pre-disability earnings, your Long Term Disability benefit will be reduced accordingly.

Other Income Benefits

The plan counts as other income benefits:

1. wages or retirement benefits payable from any employer or employer's pension or retirement plan, including earnings received under an approved program of rehabilitation or from a Different or Lesser Paid Occupation as described herein;
2. any income or benefit payable under any Workplace Safety and Insurance Act or similar law;
3. any payments received from the Canada or Quebec Pension Plan, excluding payments made in respect of dependent children;
4. any income or benefit payable under any other plan or program of any government or of any subdivision or agency of the government, including any plan or program established pursuant to a provincial automobile act;
5. unemployment benefits payable under any legislation;
6. any other plan or program provided to you by or through any employer. Such plan or program includes any permanent and total disability benefit of group life insurance for which you could have elected to apply;
7. Distributions from profit sharing plans by reason of your disability or retirement.

Benefits During Program of Rehabilitation

The Insurer may recommend that a program of rehabilitation be appropriate for you if you are eligible for Long Term Disability Benefits. The Insurer will notify you in writing of its approval of the program, and the extent, if any, of its support during such program.

Any of the following may be eligible for consideration as a rehabilitation program:
1) your regular occupation on a part-time basis;
2) a formal vocational training program; or
3) any other training program deemed suitable by the Insurer.

Long Term Disability benefits will continue to be payable to you while participating in a rehabilitation program approved by the Insurer for up to 24 consecutive months.
Expenses incurred by you in connection with the program and for which you have received prior approval from the Insurer will be reimbursed by the Insurer provided that, in the Insurer's opinion, they are reasonable and customary. Expenses which are payable through government programs or a third party insurer will not be reimbursed by the Insurer.

The gross Long Term Disability benefit amount less reductions will be further reduced by 50% of any earnings received from employment under the rehabilitation program. If your total income from this plan and other income benefits exceeds 100% of your gross pre-disability earnings, your Long Term Disability Benefit will be reduced accordingly.

Your involvement in a rehabilitation program will cease on the earliest of the following dates:

- the date you cease to be Totally Disabled;
- the date you complete the rehabilitation program; or
- the date it is determined by the Insurer that you are not participating in the rehabilitation program to the extent previously agreed upon by you and Insurer.

Return to a Different and Lesser Paid Occupation

If a disabled member, eligible for full benefits, elects a different and lesser paid occupation not related to the Program of Rehabilitation described above, the gross benefit less reductions will be further reduced by 50% of the earnings from the lesser paid occupation elected. If your total income from this plan and other income benefits exceeds 80% of your gross pre-disability earnings, your Long Term Disability Benefit will be reduced accordingly.

Continuous Period of Disability

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.

Monthly Rate of Basic Earnings

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;
- the date you retire.

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.

Extension of Benefits

If the contract or Long Term Disability Income benefit terminates and you are totally disabled at such termination, the Insurer continues to be liable as though the coverage remained in force.
If the same disability recurs within six consecutive months after termination of this benefit, the Insurer will continue to pay benefits to you but only for the remainder of the original maximum benefit period. The date of disability must have occurred before the termination of this benefit. The Insurer will not be liable for benefits after termination of either the contract or Long Term Disability income benefit once a replacing Insurer is bound contractually or as a matter of law.

Waiver of Premium

For each member who is receiving Long Term Disability benefits, the Insurer will waive the payment of premiums for the Long Term Disability, Life, Accidental Death and Dismemberment and Short Term Disability insurance coverages. Premiums will be waived beginning with the premium for the first full policy month for which benefits became payable and continuing for each full policy month for which benefits are payable.

Appeal Procedure

If you appeal the denial/termination of a Long Term Disability claim, you must submit to the Insurer a written notice of appeal. The notice must be submitted to the Insurer within 90 days of the date of the Insurer's denial/termination notice. Medical or other supportive documentation must be submitted to the Insurer within twelve months of the date of the denial/termination notice. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.

If the above provision is in conflict with the applicable law of your province of residence, the provision will be deemed amended to conform with the minimum requirements of that law.

Exclusions and Limitations

No benefit will be payable:

1) for any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program recommended by said physician;
2) for any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;
3) for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addiction, unless you are participating in a recognized substance withdrawal program;

4) for disability resulting from injury or illness which occurred while you were on active duty in the armed forces of any country, state or international organization or for disability resulting from war or act of war, whether declared or undeclared;

5) for the portion of a period of disability during which you are

   a) imprisoned in a penal institution; or

   b) confined in a hospital, or similar institution, as a result of criminal proceedings;

6) during any leave of absence (including maternity or parental leave);

7) for a disability which commences on or after the date a strike begins, subject to any provincial Employment or Labour Standards Act;

8) to an insured individual who refuses to participate in a rehabilitation program which is deemed appropriate by the Insurer or the attending physician.

This benefit does not cover:

9) disabilities for which you fail to undergo, when requested to do so by SSQ, any examination with a health care professional or any treatment or program likely to favour recovery of your health;

10) disabilities that are attributable, directly or indirectly, in whole or in part, to any of the following causes:

   a) a criminal act that you commit or attempt to commit;

   b) your active participation in a riot or insurrection;

   c) war, whether declared or undeclared;

   d) your active service in the armed forces;

   e) aesthetic or cosmetic treatments;

   f) intentional self-inflicted injuries, regardless of whether you are deemed to be sane or insane at the time.

Canadian Residency Requirement

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

i) you have previously notified and received approval in writing from the Insurer, and;

ii) you remain under the regular care of a licensed physician deemed appropriate by the Insurer, and;

iii) proof of the ongoing disability can be determined on evidence satisfactory to the Insurer in English or French within 30 days of request.

Description of Benefits

The Plan applies to expenses for the treatment of non-occupational accidents and sickness incurred by you and your eligible dependents. The Plan is designed to provide valuable supplementary protection but not to duplicate or take the place of benefits available through your Provincial Health 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.

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 reasonable and customary 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 illness. Expenses are considered to be incurred at the time the service is provided, the treatment received or the purchase is made.

If you incur covered Medical Care expenses during any calendar year, this plan pays you 100% for all eligible expenses.

Deductible

The deductible is that portion of the eligible expenses, which you are required to pay in any year before you receive benefits. The Deductible is nil.

Lifetime Maximum Benefit

The total lifetime benefit payable in respect of you or your dependents is unlimited.

Prescription Drugs

NOTE: This plan has a "DRUG CARD". Please use your drug card every time you are purchasing prescription drugs.

The drug card covers reasonable and customary charges incurred for medically necessary drugs and medicines, which are dispensed by a licensed pharmacist or physician and are prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of an illness or injury and are either:

a) drugs which require a physician's prescription in accordance with the Food and Drug Acts, Canada, or
b) other specified drugs and medicines which have been identified by the Insurer as covered expenses and are by convention not dispensed without a physician's prescription, or
c) injectable preparations identified by the Insurer, allergy serums, and diabetic preparations and supplies.

Reimbursement of drug expenses under the plan will be based on the cost of the generic equivalent drugs as indicated below:

- reimbursement will be based on the cost of the generic drug, regardless of whether you purchase the name brand drug or generic drug;
- if there is no generic equivalent for the drug you need, reimbursement will be based on the cost of the name brand drug; and
- if your physician (M.D.) writes the brand name on the script and specifies 'no substitution' permitted, reimbursement will be based on the cost of the brand name drug.

No benefit will be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase. For members over age 65, the plan will pay the deductible and dispensing fees not paid by the provincial drug plan.

NOTE:

- The maximum dispensing fee paid by the plan is $8.00 per prescription.
- Smoking Cessation Aids are covered subject to a lifetime maximum of $600 per individual.
- Fertility drugs are covered to a lifetime maximum of $2,400 per individual.
- Erectile dysfunction drugs are covered, subject to a maximum benefit of $1,000 per individual per calendar year.

Charges which exceed these limitations will not be covered.

Extended Health Expenses

1) Charges for the services of a certified, registered or licensed physiotherapist, speech therapist, osteopath, chiropractor, podiatrist/chiropodist, massage therapist/kinesiologist, naturopath, acupuncturist or clinical psychologist when operating within their field of expertise, subject to a maximum benefit of $500 in any calendar year per specialty per insured individual. X-rays are covered, subject to a maximum benefit of $50 per calendar year for chiropractor, osteopath, naturopath and podiatrist/chiropodist. The difference between the amount billed by the Practitioner and the amount paid by the Provincial Plan is not a covered expense.

2) Charges for orthotics which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment limited $350 per calendar year. Custom made orthopedic shoes are limited to a maximum of $400 per 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
Chiropractor-D.C.

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

(Orthotics dispensed by a physiotherapist for example are <u>not</u> eligible for reimbursement)

3) Diabetic preparations and supplies.

4) Charges for a convalescent care facility when admitted immediately following a minimum of three consecutive days of hospital confinement. Reimbursement is limited to a maximum benefit of $20 per day for 180 days for each period of disability. Confinement must be for the continued care of the same condition for which the individual was hospitalized and must begin prior to the individual's 65th birthday.

5) Charges for 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 illness to the nearest hospital with adequate facilities. No other expenses in connection with travel are included.

6) Charges for the services (excluding custodial care) of a Registered Nurse (R.N.) or Nursing Assistant (R.N.A. or L.P.N.) while the patient is not confined to a hospital; provided the nurse does not ordinarily reside in the home of the member and is not a relative of the member or of the member's spouse. Reimbursement will be limited to a lifetime maximum benefit of $50,000 person. These charges will be considered eligible expenses only if recommended by a physician and if medically necessary. For the purposes of this policy, custodial care is defined as assistance with daily living or tasks which a layperson could perform.

7) Charges for necessary dental treatment required as the result of an accidental injury to natural teeth provided the accident occurred while insured under this coverage. Only such charges directly related to the accidental injury and approved by the Insurer are considered a covered medical expense. Dental treatment must be completed within twelve months of the date of the accident. Dental accident coverage is limited to $5,000 per accident and an estimate must be submitted for prior approval.

8) Charges for rental (or, at the Insurer's option, purchase) of braces, crutches, Continuous Positive Airway Pressure (CPAP) and purchase of prostheses.

9) Anaesthesia, Oxygen, Blood, Blood Products.

10) Rental of Iron Lung or Other Durable Medical or Surgical Equipment limited to $500 per calendar year.

11) Diabetic Equipment limited to $700 every 5 consecutive calendar years.

12) Transcutaneous Electrical Nerve Stimulator (TENS Machine) limited to $300 every 5 consecutive calendar years when prescribed by a physician.

13) 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.

14) Intrauterine Device (IUD) limited to $75 every 24 consecutive months.

15) Surgical Elastic Stockings limited to 2 pairs per calendar year when prescribed by a physician.

16) Prostheses limited to $200 per calendar year for breast prostheses and $300 per calendar year for repairs or adjustments to medical aids and prostheses.

17) Charges for laboratory tests and x-rays not covered by any provincial government plan.

18) Charges for the purchase of hearing aids (excluding the cost of batteries) subject to the maximum of $500 per person per 5 consecutive years.

19) Charges for speech aids program are limited to a lifetime maximum of $500.

Outside Canada Referral Expenses

This benefit is limited to a lifetime maximum benefit of $1,000,000 and terminates at age 65. If an insured is referred by a physician to a hospital outside Canada for medically necessary treatment which is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada, and which is eligible for reimbursement in whole or in part by a provincial medical plan, the following expenses in excess of any provincial government plan allowance are covered:

- reasonable and customary charges for semi-private accommodation;
- reasonable and customary charges for the services of a physician;
- reasonable and customary charges for hospital services and supplies furnished during hospitalization;
- reasonable and customary charges for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

Out of Province Referral Expenses (Inside Canada)

If an insured is referred by a physician to a hospital outside the insured's province of residence but inside Canada for medically necessary treatment which is unavailable in the insured's province of residence and for which there is no medically sufficient alternate treatment available in the insured's province of residence, and which is eligible for reimbursement in whole or in part by a provincial medical plan, the following expenses in excess of any government plan allowance are covered:

- reasonable and customary charges for ward accommodation;
- reasonable and customary charges for the services of a physician;
- reasonable and customary charges for hospital services and supplies furnished during hospitalization;
- reasonable and customary charges for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

Hospital is defined as an institution operated pursuant to law for the care and treatment of sick and injured persons. The hospital must be continuously staffed and supervised by licensed physicians and registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term hospital, as used in this policy, shall not include a rest home, nursing home, rehabilitation hospital, chronic care facility, health spa, a place for custodial care, a home for the aged or an institution used primarily for the confinement or treatment of alcoholism or drug addiction, tuberculosis or mental illness.

Convalescent/rehabilitation hospital is a place that has a transfer arrangement with hospitals; provides inpatient nursing care (that meets minimum Provincial regulations) for the convalescent / rehabilitation stage of an injury or illness; and is approved as a convalescent / rehabilitation hospital for payment of the ward rate under the Provincial Health Plan.

Assistive Devices Programme

The Ontario Ministry of Health introduced the Assistive Devices Programme to help people who have long-term physical disabilities get needed equipment and supplies.

In some cases, the Assistive Devices Programme pays up to 75% of the cost of items such as artificial limbs, orthopaedic braces and breathing aids. Claims for this type of equipment should first be submitted to the Assistive Devices Programme and the unpaid balance to the benefit plan.

Exclusions

The following items are not considered as eligible expenses:

1. in connection with a illness other than a non-occupational illness 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. which are considered an insured service of any provincial government plan at the time this policy / benefit was issued and subsequently modified, suspended or discontinued;

6. for general health examinations and examinations required for use of a third party;
7. for care, treatment, services or supplies which are not recommended and approved by a physician who is attending the covered family member;
8. for a surgical procedure or treatment performed for beautification, including hospitalization;
9. for care, treatment, services or supplies which are not necessary for the treatment of the injury, illness or pregnancy nor to the extent that any charges for care, treatment, services or supplies are unreasonable;
10. 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;
11. incurred for care, treatment, services or supplies as a result of any group or employer-sponsored treatment, inoculation or examination;
12. for medical treatment or surgical procedure by a physician other than as specifically provided under outside Canada or out of province expenses in the Medical Care Expense section;
13. for transport or travel, other than as specifically provided under Medical Care Expenses;
14. not specified in the foregoing list of eligible expenses;
15. for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his license;
16. which are not medically necessary to the care and treatment of any existing or suspected injury, illness or pregnancy;
17. which are from an occupational injury or illness covered by any Workplace Safety and Insurance law or similar legislation;
18. which would not normally have been incurred but for the presence of this insurance or for which the member or dependent is not legally obligated to pay;
19. which the Insurer is not permitted, by any law or regulation, to cover;
20. for dental work where a third party is responsible for payment of such charges;
21. for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
22. for services or supplies resulting from any intentionally self-inflicted wound;
23. for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare - Canada or are experimental or limited in use whether or not so approved;
24. for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
25. made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies;
26. for accommodation in a Canadian hospital.

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.

EMERGENCY TRAVEL INSURANCE AND ASSISTANCE PROGRAM

For information before you travel, to obtain approval before incurring or paying any eligible expenses, or to request assistance, contact SSQ's travel assistance service at one of the numbers below:

From Canada or the United States: 1 866 438-5498
From elsewhere in the world: 418 651-2266 (collect call)
When calling - Please identify that your benefits are administered by Union Benefits and then provide the SSQ Contract Number on the front of your Card.

Description

The Emergency Travel and Assistance benefit provides coverage for medically necessary expenses due to a sudden or unexpected injury or illness while you are travelling outside your province of residence.

To be considered eligible for any expenses under the Emergency Travel and Assistance coverage, you must be eligible for and participating in the Medical Care benefit.

Coverage period

Trip duration of 90 days

Expenses covered

The percentage of reimbursement applicable to the following eligible expenses is 100%.

Coverage under this benefit is limited to the period while individuals are outside their province of residence. In the event that the insured dies during the coverage period, or suffers accidental injury or a sudden and unexpected illness during such period, emergency expenses incurred by or for the insured as described below are eligible, up to the maximum reimbursement of $5,000,000.

The Emergency Travel and Assistance benefit only covers reasonable and customary eligible expenses in excess of those reimbursed under the provincial health and hospitalization plans of the insured's province of residence. The coverage period for your plan is 90 days, however, if you are planning a trip that is scheduled to last more than 90 days you must contact SSQ in advance for information about applicable conditions.

In the following cases, approval must be requested as soon as possible from SSQ's travel assistance service, either by the insured or by any other adult able to do so:

- hospitalization,
- medical care,
- transportation by ambulance.

In the following cases, insureds must obtain prior approval from SSQ's travel assistance service:

- treatment provided by a nurse, chiropractor, podiatrist, physiotherapist or dentist;
- repatriation;
- medical escort;
- living expenses and transportation of a close relative of the insured;
- transportation of the insured's body if deceased; return of a vehicle;
- expenses described under the "Services, products and articles" section.

For any expenses to be considered eligible, the services must be obtained from an individual who does not reside with the insured and is neither a close relative nor a travel companion of the insured.

Insureds who already have a known disease or illness before the trip must ensure before departure that:

- Their health condition is good, and stable.
- They are able to carry out usual daily activities, and
- They are experiencing no symptoms that may reasonably suggest that any complications may arise or medical care may be required during the trip outside the province of residence

The insured's state of health is **considered unstable**, and its effects are **not** considered to be those of a sudden and unexpected illness, in the following cases:

- Symptoms worsen
- A relapse is suffered
- The disease or illness is in its terminal phase
- The disease or illness is chronic and shows signs that deterioration may occur or foreseeable complications may arise during the trip

SSQ's travel assistance service can clarify the term "sudden and unexpected illness" and confirm whether coverage may be limited in any way by the insured's condition.

Hospitalization
Hospitalization expenses incurred due to treatment in a hospital.

Physician fees
Professional fees of a physician for medical, surgical or anaesthetic care, other than fees for dental care.

Nursing fees
When prescribed by the attending physician, professional fees of a registered nurse for private nursing care provided exclusively in hospital. Eligible expenses for nursing fees may not exceed $5,000 per insured per trip.

Chiropractor, podiatrist or physiotherapist fees
Professional fees of a chiropractor, podiatrist or physiotherapist.

Dentist fees
Professional fees of a dentist for accidental injury to natural teeth. The accident must occur outside the insured's province of residence. Treatment must be received while the individual's insurance is in force. Eligible expenses for professional fees of a dentist may not exceed $1,000 per insured per trip.

Prescription drugs
Expenses for the purchase of drugs available only on prescription from a health care professional legally authorized to do so.

Transportation by ambulance
The cost of transportation by ambulance to the nearest hospital by a licensed ambulance service.

Repatriation of the insured
The cost of returning the insured to the province of residence for immediate hospitalization and the cost of transporting the insured to the nearest location where appropriate medical services are available. Benefits are limited to the cost of the most economical transport option, taking the insured's health condition into account.

Transportation by plane of a medical escort
The cost of economy class round-trip transportation by air for a medical escort who is neither a member of the insured's family nor a travel companion, when required by the air carrier or the attending physician of the insured.

Living expenses and transportation of a close relative
The cost of accommodation and meals in a commercial establishment and the cost of economy class round-trip transportation for one close relative between the place of residence and the hospital when the insured is hospitalized for at least 7 days or, in case of death, between the place of residence and the place where the deceased insured's body must be identified. Eligible expenses are subject to the following limits:

- Transportation: $2,500 per trip for all insured family members
- Accommodation and meals: $300 per day for all insured family members, up to a maximum of $2,400 for the whole duration of the stay

Eligible transportation expenses are limited to the cost of making the trip by the most economical means (bus, train or air). The attending physician must certify in writing that the visit was necessary.

In case of death of the insured, preparation and transportation of the body or burial or cremation on the spot
The expenses of preparing and returning the remains of the insured by the most direct route home, or burial or cremation on the spot, excluding expenses incurred for a coffin or funeral urn. Eligible expenses are limited to a total maximum of $10,000 for preparation of the body and transportation.

Return of vehicle
The cost of returning the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency. Eligible expenses are limited to a maximum of $2,000 per trip.

The vehicle must be returned by a recognized commercial agency. The insured must be incapable of doing so personally due to an illness or injury that is confirmed by the attending physician, and the insured's travel companions, if applicable, must also be unable to return the vehicle.

Services, products and articles
Expenses paid for the following medical services, products or articles:

- Rental of a wheelchair, hospital bed or respirator
- X-rays and laboratory analyses
- Purchase of trusses, corsets, crutches, splints, casts and other orthopaedic devices

Living expenses
The cost of accommodation and meals in a commercial establishment the insured must incur when obliged to modify the planned trip due to hospitalization of the insured, a family member or a travel companion.
The duration of hospitalization must be at least 24 hours. Eligible expenses are subject to a maximum of $300 per day, or $2,400 per trip outside the province of residence of the insured, for all individuals covered.

Travel assistance services
Your insurance provides access to certain travel assistance services when you need them. These services may not be available in all countries and are subject to change by SSQ without notice.
The following services are available:

a) Directing the insured to an appropriate clinic or hospital
b) Verifying medical insurance coverage to avoid, wherever possible, the insured having to pay for hospital care up front
c) Ensuring the proper follow-up of the insured's medical file

d) Coordinating the return and transport of the insured as soon as medically possible

e) Providing emergency support and coordinating settlement applications

f) Arranging the transportation of a family member to the bedside of the insured, to identify the insured's body if deceased and/or coordinate the repatriation of the deceased insured

g) Arranging for the return of insured persons to their home (return expenses not included)

h) Arranging for the return of the insured's personal vehicle if the insured is unable to do so due to illness or accident

i) Communicating with the insured's family or employer

j) Acting as an interpreter for emergency calls

k) Recommending a lawyer in the event of legal difficulties

Exclusions, limitations and restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Insurance plan, the following exclusions apply to Emergency Travel Insurance and Assistance benefit.

The following expenses are not eligible for reimbursement under the Emergency Travel Insurance benefit of this plan:

a) Expenses incurred as a result of the insured's refusal to be repatriated to the province of residence, upon SSQ's request

b) Expenses incurred by the insured outside the province of residence when such expenses could have been incurred in the province of residence, without danger to the insured's life or health. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a different quality than that available outside the province of residence does not constitute a danger to the insured's life or health

c) Expenses incurred in a location for which the Government of Canada issued a travel advisory not to stay in or not to travel to. This exclusion does not apply to insureds already present at the location in question at the time the Government of Canada issues a travel advisory, provided they then take the necessary measures to comply with the advisory as soon as possible

d) Expenses payable under any public plan

e) Expenses related to elective or non-emergency surgery or treatment

f) In the case of a trip taken for the purposes of obtaining or with the intention of receiving medical treatment, expenses incurred in relation to the medical condition for which the trip is taken, whether or not the trip is taken upon the recommendation of a physician

g) Expenses for chronic care incurred in a facility treating chronic illnesses

h) Expenses incurred for insureds in thermal spa facilities or extended care homes

i) Expenses incurred due to injury or death as a result of practicing any of the following activities or sports: glider planes, mountaineering, bungee jumping, parachuting skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance plan applies to.

j) Expenses related to an event occurring during the trip, or shortly thereafter, that insureds may reasonably have predicted due to their state of health at the start of the trip. This category of events includes pregnancy, miscarriage, childbirth and related complications, where such events occur within the 2 months preceding the normal expected date of delivery or thereafter

k) Hospital or medical expenses incurred for treatment for which no reimbursement is provided for under the provincial health or hospitalization plan of the insured's province of residence.

VISION CARE – SELF-FUNDED (Members and Dependents)

The vision care benefit is self-funded through the SMWIA Local 537 Health and Welfare Trust Fund. All claim payments will come from the Trust Fund.

Eligible Expenses

The plan covers the expenses listed below when prescribed by an ophthalmologist or an optometrist provided such expenses are considered reasonable and customary for the service provided in the area where the expenses are incurred.

Charges for vision care as follows:

- lenses and frames for eyeglasses, contact lenses or laser eye surgery not covered below up to a maximum of $300 every 2 calendar years.
- contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, provided visual acuity can be improved to at least 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses, of $200 every 2 calendar years.
- eye exams limited to $75 payable every 2 calendar years when not covered under a provincial plan.

DENTAL CARE – SELF-FUNDED (Members and Dependents)

The dental care benefit is self-funded through the SMWIA Local 537 Health and Welfare Trust Fund. All claim payments will come from the Trust Fund.

As the wording of this dental coverage is technically oriented, it is suggested that you take this booklet with you when you visit your dentist.

Description of Benefit

If you incur Covered Dental Expenses during any calendar year, this plan pays you:

- 100% for Basic (routine) services.
- 50% for Major Restorative services
- 50% for Orthodontics for eligible dependent children under the age of 19.

Maximum Benefit

- The maximum benefit for basic (routine) services, major restorative services and orthodontics services combined is limited to $2,000 per calendar year per person.
- The lifetime maximum benefit for orthodontics is $2,000. **A pre-treatment plan must be provided for pre-approval.**

Dental Fee Guide

Eligible expenses are reimbursed based on the Dental Association Fee Guide that is 1 year behind the fee schedule that is in effect in the province where the service is rendered on the date the charge is incurred.

Deductible

The deductible for a calendar year is that portion of the Eligible Expenses which you are required to pay each year before you receive benefits. The Deductible is nil.

Dental Claim Submission

Electronic claim submission – Applicable to Basic Services claims only

Your dentist can submit your basic dental claims electronically which means you will know while you are still in the dentist's office what your plan will pay. You do not have to sign and mail in a claim form, the claim has already been adjudicated.

Paper claim submission – Applicable to Basic Services (when the dentist cannot use electronic submission) and for All Major Restorative and Orthodontic claims

You may file your claim by completing the standard dental claim form provided by the dental office which must be dated and signed by you, the member, and returning it to Union Benefits.

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. These claims would not be eligible for electronic submission by the dentist.
- Any Pre-Determinations cannot be submitted electronically.

- Applicable commercial lab, drug and other expenses are eligible to a maximum of 60% of the allowable professional fee. Any applicable co-payment is then applied. Here is an example of the claim reimbursement calculation:

According to the dental fee guide for general practitioners in effect for your plan, the maximum payable for crowns is $663.00. The maximum amount that would be payable for commercial lab fees would be $663.00 x 60% = $397.80.

Dentist bill = $700 for crown and $400 for commercial lab fees = $1,100 billed.

Reimbursement would be calculated as follows:

$ 663.00	- Eligible for Crown
$ 397.80	- Eligible for Commercial Lab fees
$1,060.80	**- Total Eligible Amount**
x 50%	**- Co-insurance**
$ 530.40	**- Total reimbursement**

Alternate Benefits

In the event that more than one treatment is suitable for a dental condition, the least expensive treatment included under the coverage which will produce a professionally satisfactory result will be considered.

Treatment Plan/Pre-Determination

Before your dentist starts a course of treatment, he will, upon request, prepare a "treatment plan" – a written report describing his recommendations as to necessary treatment and cost.

You should submit a "treatment plan" to Union Benefits before treatment commences for all major restorative dental treatments such as crowns, bridges and dentures as well as for all other dental treatments where the course of treatment will cost more than $800 and for all orthodontic treatment. Union Benefits will then calculate the amount of dental benefits the plan would pay for the proposed treatment and will inform you.

Basic (Routine) Services – 100% Reimbursement

A) Each of the following procedures is covered twice in each calendar year provided that, for each service, a period of at least five consecutive months has elapsed since the last such service was rendered:
   - oral examinations
   - polishing of teeth (one unit)
   - bite-wing x-rays (2 every six months, up to 4 per year)
   - topical fluoride (one unit)

B) Diagnostic procedures including complete oral examinations (limited to once in 24 months), complete series of x-rays or equivalent (limited to once in 24 months), study casts (limited to once per year), consultations

C) Oral hygiene instruction (limited to one unit in a twelve-month period)

D) Scaling of teeth (limited along with periodontal root planing to a maximum of twelve units in a calendar year)

E) Passive space maintainers (those that do not move the teeth) for dependent children only

F) Basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, or synthetic restorations (fillings) or stainless steel crowns (for primary teeth); sedative dressings are covered

G) Extractions

H) Anaesthesia where reasonably and customarily required in connection with other covered procedures

I) Emergency endodontic procedures and root canal therapy

J) Periodontics including root planing (see scaling for limitation), acute infections, occlusal adjustment, provisional splinting, gingival curettage, gingivoplasty, gingivectomy or osseous surgery, mouth guards and special periodontal appliances (limited to two in two consecutive calendar years) and TMJ appliances

K) Routine oral surgical procedures such as surgical removal of impacted teeth, residual roots and associated post surgical care

L) Repairs, relining and rebasing of dentures, once every 2 calendar years.

Major Restorative Treatment – 50% Reimbursement

An estimate and x-rays (for crowns and bridges) must be provided for pre-approval of any major restorative treatment.

A) Procedures including inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. Replacement of existing inlays, onlays and crowns are covered only if the existing restoration was placed at least five years previously and is no longer serviceable. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration. The pre-existing condition limitation on teeth fractured prior to the insurance effective date applies.

B) The initial installation of partial or full dentures, subject to the pre-existing condition limitations on teeth missing, extracted or fractured prior to the effective date, and only after the individual has been insured for at least 12 consecutive months.

Replacement of existing dentures is not covered except if:

1) the replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan, or
2) the replacement is more than 12 months after the individual became insured under this coverage, and the existing denture is at least five years old and no longer serviceable.

Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

C) The initial installation of fixed prosthetic devices (bridges) subject to the pre-existing condition limitations on teeth missing, extracted or fractured prior to the effective date. Recementing and replacement of the facing or veneer of the fixed prosthetic appliance is covered.

The replacement of existing fixed prosthetic devices is not covered except if:

1) the replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan; or
2) the replacement is more than 12 months after the individual became insured under this coverage, and the existing fixed prosthetic device is at least five years old and no longer serviceable.

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.

Orthodontics – 50% Reimbursement

Orthodontic coverage is provided for each of your eligible dependents, provided they are under the age of 19 on the date the treatments started. The Plan will reimburse 50% of your expenses, to a lifetime maximum of $2,000 per eligible child for treatment provided by an orthodontist, for orthodontic appliances for the correction of Class I, Class II, or Class III malocclusions in relation to primary, mixed or permanent teeth.

Date Charge or Expense Incurred

A dental charge or expense will be considered to be incurred on the date the procedure or service is rendered or the supply is furnished.

In the case of root canal therapy, crowns and dentures or bridgework, which may require multiple appointments, the date the expense is incurred will be the date the service is finally completed. For dentures or bridgework, this date will be the date the prosthetic device is installed. For crowns, this will be the date the permanent crown is installed and for root canal therapy, this will be the date the canal is closed.

Exclusions and Limitations

In applying the following pre-existing condition exclusions, the effective date for a dental procedure means the earliest date from which the member (or dependent) has been continuously insured for the dental procedure under the terms of this policy.

Payments will not be made for any dental procedure required due to any injury or dental illness for which the member or dependent was advised to receive treatment or for which treatment first began before the effective date for that dental procedure. Payments will not be made for any dental procedure required due to teeth extracted, missing or fractured before the effective date for that procedure, except as specifically stated for appliance replacement under covered expenses.

No benefit will be payable for the initial installation (or addition) of prosthetic devices unless such installation (or addition) is required primarily due to teeth that were missing, extracted or fractured after the effective date for prosthetic devices.

The following items are not considered as covered expenses:

1) services or supplies that are primarily for cosmetic dentistry;
2) services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
3) services or supplies which were necessitated either wholly or partly, directly or indirectly as the result of committing, attempting, or provoking an assault or criminal offence, or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
4) miscellaneous charges such as for counselling, (instruction, except if included as an eligible expense), travel, broken appointments, communication costs or filling in of forms;
5) services or supplies resulting from any intentionally self-inflicted wound;
6) any services which are covered by any government plan or program; or for which no charge is made; or which the Insurer is not permitted by law to cover;
7) charges which were considered an insured service of any provincial government plan at the time this policy/benefit was issued and subsequently were modified, suspended or discontinued;
8) any hospital charges for board and room and related services and supplies;

9) any dental examinations required by a third party;
10) services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or illness;
11) any charges which would not normally have been made but for the presence of this insurance or for which the member or dependent is not legally obligated to pay;
12) services or supplies for or in connection with a procedure which is not listed as an eligible expense.
13) services or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

Your Employee and Family Assistance Program (EFAP) is provided by Shepell·fgi and a separate brochure is available on the Union Benefits website at www.unionbenefits.ca.

The following is a brief description of the services provided through this voluntary, confidential short-term counselling and advisory service. The services are available to you and your immediate family which includes spouse, children, mother, father, brother and sister. This program connects you and your family members to a network of dedicated professionals who are available to provide assistance 24/7/365. This network includes experienced counsellors, psychologists, social workers and other specialist.

About Shepell·fgi

For close to 30 years, Shepell·fgi has been recognized as Canada's pre-eminent EAP provider. The firm was founded with the mandate to help members and their families resolve the personal problems that can interfere with their lives and work. This vision has become a reality for over six million members and family members from the 6,000+ organizations around the world that have strengthened their workplace with Shepell·fgi's integrated and responsive EFAP services.

All Shepell·fgi programs deliver an exceptional quality of care and the highest professional standards in the industry, as demonstrated by ongoing accreditation by the Council on Accreditation (COA), National Quality Institute (NQI) and through our exemplary client retention rate of more than 98%.

What Does Your EFAP Include?

- **Short-term Professional Counselling** with a variety of delivery methods to best suit your comfort level and lifestyle;
- **Work/Life Services** providing help with legal, financial, family, nutritional concerns and more;
- Unlimited access to workhealthlife.com providing you and your family with 700+ expert health and wellness articles, online professional counselling options, online access to EFAP support services and more;
- **My EAP** mobile device application for on-the-go support. Free download at shepellfgi.com/myeap.

Your EFAP is Available 24/7/365 with Simple Access

- Call the Shepell·fgi Care Access Centre toll free at **1 800 387-4765;**
- Online Access (Canada only) via workhealthlife.com;
- E-Counselling via workhealthlife.com, shepellfgi.com or My EAP app;
- First Chat, online chat with a counsellor, via workhealthlife.com;
- For **crisis situations** requiring immediate attention call 911 or the Shepell·fgi Care Access Centre at **1 800 387-4765.**

In order to ensure an effective and immediate response to all situations, each of Shepell·fgi's Client Care Representatives brings strong educational qualifications (at minimum a bachelor's degree in the social sciences); excellent problem solving, communication and assessment skills; and is well suited to a collaborative team environment.

The Right Care at the Right Time

Shepell·fgi provides access to programs and services in a way that is different from all other EFAP providers—our intake, assessment and triage process is unique. Whether through the Care Access Centre or online, the intake process starts by identifying member risk and the level of urgency.

The process continues by moving the member into either the crisis stream or into a non-urgent evaluation of the presenting issue(s). If in crisis, an immediate warm transfer to a Master's level clinician takes place to ensure the safety of the member. For non-urgent situations, the primary issue will be identified and the

specific support service(s) will be initiated based on the member's learning preferences, work schedules and other lifestyle realities.

COUNSELLING SERVICES

It takes a great deal of courage for people to acknowledge that they need help. Shepell·fgi provides every opportunity for people to resolve their personal or work-related issues. The quality of their professional counselling staff is unsurpassed. The services described below are accessed by individuals through a confidential call to the Shepell·fgi Care Access Centre 24/7/365 or online via workhealthlife.com.

The counselling model is a solution-focused process that provides members with the level of care and length of counselling needed to effectively resolve their concerns. The counsellor network is a multi-disciplinary team of professionals who have master's degrees or PhDs in the fields of psychology, clinical social work or educational psychology. They will assess an individual's needs and together with them determine a goal to achieve through counselling.

Counselling Options

In-Person Counselling

- Counselling sessions are held in an office at a pre-determined appointment time

Telephonic Counselling

- Works well for individuals reluctant to access face-to-face services;
- Also good for those living in remote and rural locations.

E-Counselling

- Professional counselling service delivered via written email exchange;
- Counselling without rigidity of appointments; access anytime from anywhere!
- SSL-secure website maintains the highest level of security for all correspondence.

Text-Based Self-Help Counselling

- Contain an integrated set of easy-to-use, practical articles, tip sheets and reference materials;
- Convenient self-directed counselling provides ultimate flexibility and privacy;
- Current topics: *Parenting School-Age Children (6-12), Parenting Teens, Enriching Your Career, Managing Workplace Stress, Enhancing Your Relationship, Separation and Divorce, Eating for Health.*

Video Counselling

- Real-time, professional counselling delivered via the Internet using a webcam and Internet software;
- A solution for those living in remote, rural and northern locations;
- Video Counselling software ensures absolute security and confidentiality.

First Chat

- Instant connection to a professional counsellor for immediate issue exploration;
- Providing ultimate convenience ideal for those most comfortable with real-time online communication ;
- First Chat software provides the utmost security and confidentiality.

Specialized Counselling Services

Career Counselling

Career counsellors help individuals address a wide range of personal and workplace issues. They offer a fresh perspective and help work with the individual to assess interests and skill sets. The program can help develop strategies that may lead to enhanced work satisfaction and performance. Career counsellors use a

variety of career management tools, resources, approaches and support to help individuals make more informed career decisions and to help them better manage career transitions.

Online Smoking Cessation Program

The Stop Smoking Centre online program is designed to move the member through the cessation process in an interactive and personalized way. Enhanced tools and customized exercises bring users closer to their goal of quitting. Unique features include:

- Nicotine Dependency Test and Quit Meter tracking money saved and life gained!
- Professional and peer support via the 'quit buddy' network 24/7/365;
- Users earn rewards as they overcome hurdles and reach milestones.

Online Stress Management Program

Fifty years of stress management research tells us that stress management works! A comprehensive, expertly developed program that features proven techniques presented in an engaging and interactive online real-time environment to help people manage stress and make meaningful changes in their lives. Based on a detailed individual stress assessment, this online program provides users with:

- Convenient anytime, anywhere access via the Internet to work at their own pace;
- Expert resources and modules to learn techniques, set goals, complete actions and measure their results in real-time;
- Interactive features including email reminders and goal alerts, three-month goal-calendar overview, private digital journal and more!

Online Enhancing Your Relationship Program

Shepell·fgi has collaborated with clinical experts in the field of intimate relationships to develop a comprehensive program featuring evidence-based best practices to help both individuals and couples achieve greater overall understanding of and satisfaction in their intimate relationships; all conveniently online.

- Online program provides users with convenient anytime, anywhere access via the Internet to work at their own pace with ensured privacy;
- The key principles of healthy relationships are explored through expert articles, videos and an additional Resource Guide;
- Order expert-approved books online too in paperback or e-book format;
- Interactive quizzes, exercises and activities addressing a wide variety of relationship dynamics keep users engaged and learning in real-time.

Online Separation and Divorce Program

Shepell·fgi has collaborated with clinical, legal and financial experts in the area of separation and divorce to develop an online solution that incorporates best practices to help individuals and families better manage and respond to the various challenges inherent in pursuing a separation or divorce. Users can work at their own pace with ensured privacy with convenient anytime, anywhere access via the Internet.

- **Expert articles and videos** that explore the emotional, parenting, legal and financial impacts of separation and divorce with ability to bookmark favourites. The **Resource Guide** offers a comprehensive selection of additional print and online resources;
- **Interactive exercises** starting with goal setting followed by problem identification and solution building and leading to action planning, all designed to help the user move forward successfully;

- **Activities and helpful features** including ability to bookmark favourite materials, order books online in paperback or e-book format, online feedback form.

Online Financial Planning Service
Convenient access to financial education, resources and tools. Users can create a financial action plan tailored to their personal situation or browse information and learn at their own pace.

WORK/LIFE SERVICES

In an increasingly fast-paced world, members are finding it more challenging to take care of themselves while balancing their responsibilities at work with their obligations at home. They struggle to make time for their priorities; often allowing their health and well-being to become an afterthought. Shepell·fgi's Work/Life Services provide timely, professional assistance and support to help members manage all of life's complexities.

Shepell·fgi's Work/Life Services are available to both members and their families. The programs focus on reducing/eliminating the time a member would normally spend seeking information and support resources in the areas of service listed below. As a result, members are better able to focus on their responsibilities —spending less time searching for solutions to their personal or health-related issues.

The Work/Life Services are designed to help members navigate the daily demands of their work, personal and family lives to ensure they achieve adequate balance. Additionally, they offer physical health focused support programs which provide members with a starting point to improve their overall health. Members connect with our professional consultation services to receive personalized information and resources that address their specific concern.

These programs may provide follow-up resource and information packages customized to suit the user's needs and may include reference books on specific topics, relevant tip sheets, information about community programs and forms/contact numbers for further support from government departments, social service agencies, community resources and professional service providers.

Family Support Services

This program helps with issues faced throughout an individual's family and personal life (includes planning a family, pregnancy, parenting, life transitions and aging). Members will be referred to a Family Support Specialist who researches the employee's needs and offers possible solutions.

The program includes telephone assessment, consultation, resources, support and advice on a full range of issues faced by individuals, parents, families, teens and young adults. Shepell·fgi researches provider locations, current availability, fees and when appropriate, recommends a community resource and prepares a package with options that may include: parenting classes, daycare, schools, after-school programs, palliative care, seniors accommodations/nursing homes and caregiver support.

This service addresses topics such as: Planning a Family, Expectant/New Parenting, Childcare, Special Needs, Support for Fathers, Practical Parenting, Parenting Toddlers, Adolescent Issues, University/College Decisions, Homecare Support, Eldercare, Compassionate Care and Bereavement.

Financial Support Services

The Financial Support Service provides information and options to help members take control of their financial lives. When required, Shepell·fgi also facilitate referrals to licensed professionals for more extensive services such as financial planning or debt repayment planning.

The service is designed to provide consultation and general advice. For some, this advice is crucial to help them make informed decisions about financial matters, especially during major life events such as marriage, divorce, retirement or the transition from school to work. For others, problems such as a history of poor financial habits, gambling and addictions, or the breakdown of a relationship result in the need for financial advice and support.

Financial professionals provide information and recommendations primarily over the telephone (or in-person if required). Areas of focus include:

- Debt and credit (general overview, preparing a budget)
- Tax issues
- Budgeting
- Retirement/Life transitions
- Divorce (financial issues)
- Investments (general information—no investment advice)
- Real estate/mortgages

This service does not provide advice about specific investment products, authorize loans or prepare tax returns.

Legal Support Services

The Legal Support Service provides information and clarification concerning how the law applies to a specific situation. It will recommend options on possible courses of action and where necessary, refer members to qualified lawyers for ongoing legal advice. Most members requiring legal assistance do not want or need to retain a lawyer. Their concerns can be resolved using the program. The service provides general advice on topics such as the ones below:

- Real estate
- Separation and divorce
- Bankruptcy
- Contracts
- Landlord and tenant issues
- Summons, warrants and subpoenas
- Consumer protection

This service will not assist with work-related or employer-directed issues. Also excluded is legal consultation addressing immigration and tax law. Costs for services provided by referrals are the responsibility of the member.

Naturopathic Services

The Naturopathic Service provides another option to help members make better choices through a natural and holistic approach to the maintenance of good health. The individual is seen as a whole person (physical, mental and emotional aspects) and symptoms of disease are seen as warning signs of the improper functioning of body and lifestyle habits.

Members consult with a **Naturopathic Doctor** and receive customized health and wellness information and materials on choices related to physiology, diet, lifestyle, and mental-emotional well-being, including illness prevention strategies. The program encompasses four key themes: Sleeping Healthy, Aging Well, Stress-Free Living and Workplace Wellness. The program uses a naturopathic approach to address some of the most common health concerns that lead to significant lost productivity.

The program offers help to:

- Address sleep difficulties
- Take steps to age well
- Improve digestion
- Boost energy levels
- Recognize mind-body connections
- Make good food choices
- Understand midlife changes
- Manage stress
- Balance work and personal life
- Learn how the workplace affects health
- Live well as a shift worker
- Deal with jet lag
- Build the immune system

Nutrition Support Services

Maintaining a healthy, well-balanced diet can be a challenge. The nutritional consultation is designed to assist in improving overall employee health. The program is delivered by **Registered Dieticians** using a short-term model designed to provide solutions to non-complex problems. For example, individuals who are diagnosed with a medical condition that requires management of diet may call and discuss with a dietician their food preferences and work with the RD to ensure a plan is put in place that not only satisfies the health requirements but also satisfies the taste needs of individuals. The program is delivered using a five-step consultation model that can take between 2-3 hours (not delivered all at once, requires a few telephone appointments).

Fitness Coach Connects

Fitness Coach Connects is our new interactive program that incorporates best practices to help you and your family members understand and improve your physical health. By participating in this program, you are taking an important step in improving your health through education, behaviour change and fitness.

HOW TO CLAIM

When you have a claim, the required forms can be obtained from your Plan Administrator, Union Benefits. The claim forms can also be downloaded from the Union Benefit website, www.unionbenefits.ca by logging on as "I am a member" with Username: m537 and Password: 537rewards.

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

- your full name and address
- your local
- your SSQ Group Policy Number is 64N40
- your Autoben Policy Number is 15729

ALL Claim forms must be signed by the member, not by the member's insured dependents.

- Medical claim forms must be fully completed as outlined on the form.
- Vision claims forms must be fully completed as outlined on the form.
- Dental claims for basic services can be submitted electronically by the dentist (contact Union Benefits for electronic submission information).
- Dental claims for major restorative services must be submitted on a paper claim form with a copy of the commercial lab invoice attached.
- Dental predeterminations must be submitted in paper form (cannot be submitted electronically).
- If a claim is being submitted on a paper basis, the standard dental claim form provided by the dental office must be dated and signed by the member.
- 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, ON N2V 2C9

Telephone (519) 725-8818
Toll Free 1-800-265-2568

Benefit Claims - ext 4033 or 4032
Pension - ext 4040
Member Services - ext 4037 or 4036

FAX (519) 725-9362