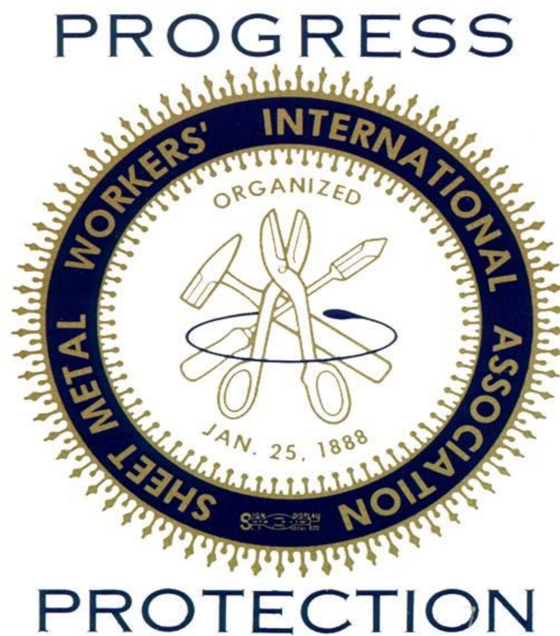
S.M.W.I.A. LOCAL 537

EMPLOYEE BENEFIT PLAN



FOR RETIRED 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 and Medical Care benefits. These benefits are detailed in the booklet

Benefits that are self-funded are also detailed 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

TABLE OF CONTENTS

SUMMARY OF BENEFITS **1**

ELIGIBILITY **2**

Eligibility 2

Definition of Dependent 2

When Your Dependents Become Eligible 2

Co-ordination of Benefits (for Medical Care, Group Travel Medical Emergency, Vision Care and Dental Care Benefits) 3

GENERAL PROVISIONS **4**

Time Limit for Submitting Claims 4

What Income Tax is Payable? 5

Termination of Insurance 5

SPECIAL BENEFITS **6**

Surviving Dependent Coverage 6

Out of Country Insurance Premium Rebate 6

LIFE INSURANCE (MEMBERS ONLY) **7**

MEDICAL CARE (MEMBERS AND DEPENDENTS) **8**

VISION CARE – SELF-FUNDED (MEMBERS AND DEPENDENTS) **13**

DENTAL CARE – SELF-FUNDED (MEMBERS AND DEPENDENTS) **14**

HOW TO CLAIM **19**

SUMMARY OF BENEFITS

Benefit	**Benefit Amount**	**Description**
Member Life	$20,000	Payable to your designated beneficiary Coverage may continue in retirement on a pay direct basis
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) $8.00 maximum dispensing fee paid by the plan Smoking cessation limited to $600 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.* *Coverage may continue 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 Coverage may continue in retirement on a pay direct basis
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. Coverage may continue in retirement on a pay direct basis

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

Eligibility

At retirement, coverage can be continued on a reduced schedule of benefits, using the credits remaining in your dollar bank. Once your dollar bank is exhausted, you can continue benefits on a self-contribution basis.

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

- a member of S.M.W.I.A. Local 537
- eligible in the Plan on the date of retirement and receiving a Local 537 Pension

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, 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:

   Spouse

   c) The plan where the spouse is covered as a member.
   d) The plan where the spouse is covered as a dependent.

   Dependent Children

   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.

GENERAL PROVISIONS

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.

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 Insurance coverage and then applied towards the cost of any other applicable benefits.

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

- Twelve (12) months following the date of death

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 Insurance. 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.

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.

SPECIAL BENEFITS

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, 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.

Out of Country Insurance Premium Rebate

Retired members may purchase their own Out of Country coverage through whatever Agency they feel best suits their needs and may submit paid coverage invoices to Union Benefits for reimbursement to a maximum of $250 per family per calendar year.

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 **$20,000**.

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.

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.

MEDICAL CARE (Members and Dependents)

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.

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

<u>Electronic claim submission</u> – 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.

<u>Paper claim submission</u> – 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 <u>dated and signed by you, the member,</u> 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

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