IUPAT Local 177 Welfare Trust fund

HEALTH & WELFARE Benefits

JULY 1, 2023

IUPAT Local 177 Welfare Trust Fund

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MEMBER AND FAMILY ASSISTANCE PROGRAM

Homewood Health Inc.

IMPORTANT

This document contains essential information concerning Group Insurance Coverage and should be kept in a safe place. This booklet supersedes and replaces all previous communication material.

Although this booklet provides a general explanation of the group insurance program, it does not change or modify the terms of the insurance contracts. Every effort has been made to ensure that the information presented here is accurate. If there is any conflict between this summary and the insurance contracts, the terms and conditions of the insurance contracts will govern. All rights and benefits can be determined only by referring to the insurance contracts and the rules and regulations of the Trustees.

Member Assistance Program is governed by the Homewood Health Inc. Agreement and the Life, Dependent Life and Weekly Disability (are governed by Beneva Group Policy 38B90). The Extended Health and Dental Care Benefits are self-insured by the IUPAT Local 177 Welfare Trust Fund. These documents are available for examination at the Plan Administrators office.

Policy Numbers:

Life, Dependent Life, Weekly Disability, Out of Country Travel – Policy 38B90

Extended Health Care – Group No. 59315

Prescription Drug – Group No. 59315

Dental – Group No. 59315

Change of Address

If you have a change of address, it is important that you notify the Administrator, Ellement immediately by completing a Change of Address form or by updating your address via the Painters Portal.

To All Eligible Participants:

*This booklet presents a summary description of your plan benefits provided by the **IUPAT Local 177 Welfare Trust Fund**. While it is our hope that you and your family will enjoy good health, it is comforting to know these benefits are available when you need them.*

*This booklet explains how you become a Plan participant, describes the benefits that are provided and when you can receive them, tells you when Plan coverage ends, and lets you know your options for continuing Plan coverage. We urge you to read it carefully so that you gain a thorough understanding of the benefits that are available to you. Please share it with your family too, so that they will be aware of the benefits available to them. The benefits described in this booklet are those in effect as of **July 1, 2023**. They were current at the time of publication but can be changed at any time by the Board of Trustees.*

Although we have tried to explain the Benefit Plan in plain, straightforward language, you may still come across words and phrases that have special meanings in the Plan. To help you understand them, we have included definitions of those terms. In explaining the Plan in simple language, we have made every effort to be accurate. However, if there is any conflict between this booklet and the Group Policies and Agreement, the Group Policies and Agreement will govern.

Because of the ever-changing economic environment, the benefits provided in this booklet cannot be guaranteed for the future. To protect the Fund, the Trustees have the right to amend, delete, add or change the Plan's benefits and eligibility rules as they apply to all current and future members and retirees, including the right to add or delete benefits, monetary or otherwise, as circumstances may warrant.

If at any time you have any questions about the benefits provided by the Fund or would like assistance in filing a claim, please do not hesitate to contact the Plan Administrator; a member of the staff will be pleased to assist you.

Sincerely,

Board of Trustees

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IMPORTANT:

To avoid delays, always include your Full Name and Certificate Number, your Employer Name and your Group Number on any claim forms or correspondence submitted.

ABOUT THIS PLAN

The IUPAT Local 177 Welfare Trust Fund is governed by the Board of Trustees.

Contributions are made to the Fund by the employers who are signatory to the Collective Agreement with the International Union of Painters and Allied Trades. Such employers are called “Contributing Employers” in this Booklet.

An account is kept by your Plan Administrator for each member, showing the hours reported monthly by the Contributing Employer. This account is called the Hour Bank Account.

To enroll in the Plan, you must fully complete the Registration Form. The information contained on this form provides the Administrator with a record of your personal data, which forms an especially important basis of your file. You must report changes to your marital status, dependent information and/or your beneficiary designation by completing the appropriate form, which can be obtained from the Painters website.

ABOUT THE HOUR BANK

When You Become Covered Initially

You and your eligible dependents will become covered on the first day of the second month following accumulation of 300 hours in your Hour Bank Account, provided you are actively at work or available for work on the day you would ordinarily become covered.

Should you not be working, or available for work, on the day your coverage would ordinarily start, insurance for you and your dependents will be delayed until you return to work or are available for work. A member must accumulate these 300 hours in the six-month period from the date of the first contribution, if the 300 hours are not accumulated within the specified six-month period, all hours are forfeited.

Reinstatement

If your coverage has previously terminated, you will again be covered on the first day of the second month in which you have accumulated 200 hours in your Hour Bank Account, provided your period of termination did not exceed six months. If you were not covered through the Plan for more than six months, you must meet the initial eligibility rule of 300 hours prior to becoming eligible for coverage.

Should you not be working, or available for work, on the day your coverage would ordinarily become reinstated, coverage for you and your dependents will be delayed until you return to or are available for work.

Maximum Accumulation
The number of hours in your Hour Bank Account may never exceed 1,200 hours (enough to provide 12 months of coverage, even if you acquire no hours during that period). Hours more than 1,200 will be credited to the reserves of the Welfare Trust Fund.

Monthly Deduction
Each month, 100 hours will be deducted from your Hour Bank Account to provide benefit coverage.

Self-Pay Option
If you have less than 100 hours in your Hour Bank Account, you can make direct payments to the Fund to maintain your coverage, provided you are a member in good standing with the Union and are registered with the Union and available for work and are not working or employed by any employer who carries out any work that falls within the jurisdiction of the Union and who does not contribute to the Benefit Trust Fund under the terms of a Collective Agreement.

Once your Hour Bank Account is exhausted, the Trustees have initiated a provision enabling members to make self-payments to continue their benefit coverage for up to three (3) months.

Ellement will send you a Self-Pay Notice. The amount of this Self-Pay Notice is determined by the Board of Trustees and may change from time to time.

Apprentices While Attending Required Schooling
Coverage will be maintained while a member is attending required schooling. No deductions will be made from the member's Hour Bank Account (Hour Bank is frozen) during this period. The period will commence on the first of the month coinciding with or immediately following the date of the required schooling, and end with the month that the schooling ends. You must notify Ellement in writing of your required attendance at school and provide the necessary proof of attendance to qualify for this extension of coverage.

Continuation of Coverage While Disabled
No deductions will be made from a member's Hour Bank Account (Hour Bank is frozen) in any calendar month while the member is disabled and in receipt of Workers' Compensation Benefits (WCB), Employment Insurance Sickness Benefits (EI Sickness) or Weekly Disability Benefits through the IUPAT Local 177 Welfare Trust Fund. The maximum period an Hour Bank Account may be frozen for a disabled member is twelve (12) months. The period will commence as of the date the member advises Ellement in writing and submits the satisfactory proof of disability.

PLAN DESCRIPTIONS

Division	101 201	Active Employees With Less Than 1 Year of Service (To age 70)
Division	102 202 301	Active Employees With More Than 1 Year of Service (To age 70)
Division	103 302	Active Employees (70-74 years of age)
Division	303	Retiree Self Payment Only (To age 65)

ACTIVE MEMBERS COVERAGE SUMMARIES

ALL ACTIVE EMPLOYEES WITH LESS THAN 1 YEAR OF SERVICE (the earlier of age 70 or retirement) Division 101 and 201

BENEFIT	DESCRIPTION
Member Life Insurance	$75,000, reduces by 50% at age 65
Dependent Life Insurance	Spouse: $15,000 and Dependent Child: $7,500
Weekly Disability	189 days elimination period. Equivalent of EI Sickness Maximum for 25 weeks of disability;
Co-Insurance	Accidental Dental – 100% All Other Eligible Expenses – 90%
Supplementary Health	In Province Hospital – 100% reimbursement with the difference between the ward and semi-private rate, unlimited maximum. Nursing Care - $25,000 for a maximum of 12 months per condition Ambulance – Unlimited Paramedical Practitioners - $500 per person, per practitioner each calendar year Convalescent/Rehabilitation Hospital - $25 per day up to 180 days of confinement for all periods of treatment of an illness due to the same or related cases. Hearing Aid Maximum - $600 per person every 36 consecutive months
Vision	100% reimbursement up to $500 per person once every 24 months (for prescription glasses and/or contact lenses). Contact lenses for special conditions are eligible up to $400 per person once every 24-month period. Laser Eye Surgery - $300 per person once every 24 months
Eye Exams	One per adult and overage dependent children to a maximum of $100 per 24 months (12-month period for a dependent child under the age of 18)
Travel Insurance and Assistance	$5,000,000 per trip including Trip Cancellation of $5,000 per trip, 180 days trip duration
Prescription Drug	$50,000 maximum per calendar year, per individual
(Drug Plan Formulary as defined by TELUS Adjudicare)	Deductible – Equal to the Dispensing Fee Generic drug substitution – reimbursement will be made for the cost of the lowest priced equivalent drug unless your physician has written that there is to be no substitution of the prescribed drug. - 1st Tier 90%of eligible drugs under the Alberta Provincial Formulary - 2nd Tier 75% of the balance of drugs not eligible under the Alberta Provincial Formulary but covered under a regular prescription plan Drug coverage includes: - All eligible prescription drugs including oral contraceptives, bearing a Drug Identification Number - Preventative Immunization vaccines and toxoids are covered - This plan includes the Special Authorization Program
Member Assistance Program	Short term counselling with a maximum of 4 sessions per covered person per year (For members and eligible dependents); Substance Abuse Expert/Substance Abuse Professional Assessments (For Members Only)

Dental Care **All Active Employees with less than 1 year of Service** Reimbursement based on 2016 Dental Fee Schedule for General Practitioners in the Member's Province of Residence	90% of Basic and Preventative Treatment, Endodontics, Periodontics - 90% for the first 6 units of scaling/root planing and 50% for all subsequent units. 60% Major Restorative Treatment 50% Orthodontic Treatment for dependent children under 18 only up to $1,000 lifetime Basic, Major, Endodontics, Periodontics combined maximum of $1,500 per calendar year

BENEFIT	DESCRIPTION
Member Life Insurance	$75,000, reduces by 50% at age 65
Dependent Life Insurance	Spouse: $15,000 and Dependent Child: $7,500
Weekly Disability	189 days elimination period. Equivalent to EI Sickness Maximum for 25 weeks of disability;
Co-Insurance	In Province Hospital Eligible Expense – 100% Accidental Dental – 100% All Other Eligible Expenses – 90%
Supplementary Health	In Province Hospital – the difference between the ward and semi-private rate, unlimited maximum. Nursing Care - $25,000 for a maximum of 12 months per condition Ambulance – Unlimited Paramedical Practitioners - $500 per person, per practitioner each calendar year Convalescent/Rehabilitation Hospital - $25 per day up to 180 days of confinement for all periods of treatment of an illness due to the same or related cases. Hearing Aid Maximum - $600 per person every 36 consecutive months
Vision	$500 per person once every 24 months (for prescription glasses and/or contact lenses). Contact lenses for special conditions are eligible up to $400 per person once every 24-month period. Laser Eye Surgery - $300 per person once every 24 months
Eye Exams	One per adult and overage dependent children to a maximum of $100 per 24 months (12-month period for a dependent child under the age of 18)
Travel Insurance and Assistance	$5,000,000 per trip including Trip Cancellation of $5,000 per trip, 180-day trip duration
Prescription Drug **(Formulary & Maximums: Drug Formulary as defined by TELUS Adjudicare)**	$50,000 maximum per calendar year, per individual Deductible – equal to the Dispensing Fee Generic drug substitution – reimbursement will be made for the cost of the lowest priced equivalent drug unless your physician has written that there is to be no substitution of the prescribed drug. 1st Tier 90% of the eligible drugs under the Alberta Provincial Formulary 2nd Tier 75% of the balance of drugs not eligible under the Alberta Provincial Formulary but covered under a regular prescription plan - Drug coverage includes: - All eligible prescription drugs including oral contraceptives, bearing a Drug Identification Number - Preventative Immunization vaccines and toxoids are covered - This plan includes the Special Authorization Program
Member Assistance Program	Short term counselling with a maximum of 4 sessions per covered person per year (For members and eligible dependents); Substance Abuse Expert/Substance Abuse Professional Assessments (For Members Only)

Dental Care **All Active Employees with more than 1 year of service** Reimbursement based on 2016 Dental Fee Schedule for General Practitioners in the Member's Province of Residence	90% of Basic and Preventative Treatment, Endodontics, Periodontics - 90% for the first 6 units of scaling/root planing and 50% for all subsequent units. 75% Major Restorative Treatment 50% Orthodontic Treatment for dependent children under 18 only up to $2,000 lifetime. Basic, Major, Endodontics, Periodontics combined maximum of $2,500 per calendar year

BENEFIT	DESCRIPTION
Maximum	$2,000 per person, per calendar year for supplementary health (excluding prescription drugs)
Co-Insurance	Accidental Dental – 100% All other Eligible Expenses – 90%
Supplementary Health	In Province Hospital 100% – The difference between the ward and semi-private rate, unlimited maximum Ambulance – Unlimited Paramedical Practitioners - $500 per person, per practitioner each calendar year Convalescent/Rehabilitation Hospital - $25 per day up to 180 days of confinement for all periods of treatment of an illness due to the same or related cases Hearing Aid Maximum - $600 per person every 36 consecutive months
Vision	100% reimbursement for Prescription Glasses & Contact Lenses up to $500 per individual, once in any 24-month period. Contact Lenses for Special Conditions - $400 per individual, once in any 24-month period. Laser Eye Surgery - $300 per individual once in any 24-month period
Eye Exams	One per adult and overage dependent children to a maximum of $100 per 24 months (12-month period for a dependent child under the age of 18)
Prescription Drug **(Drug Plan Formulary as defined by TELUS Adjudicare)**	Deductible – Equal to the Dispensing Fee - Generic drug substitution – reimbursement will be made for the cost of the lowest priced equivalent drug unless your physician has written that there is to be no substitution of the prescribed drug. - 1st Tier 90% of the eligible drugs under the Alberta Provincial Formulary - 2nd Tier 75% of the balance of drugs not eligible under the Alberta Provincial Formulary but covered under a regular prescription plan Drug coverage includes: - All eligible prescription drugs including oral contraceptives, bearing a Drug Identification Number - $8,000 overall maximum per person, per calendar year. - Preventative Immunization vaccines and toxoids are covered - This plan includes the Special Authorization Program
Dental Care Reimbursement based on 2016 Dental Fee Schedule for General Practitioners in the Member's Province of Residence	90% of Basic and Preventative Treatment, Endodontics, Periodontics - 90% for the first 6 units of scaling/root planing and 50% for all subsequent units. 75% Major Restorative Treatment Basic, Major, Endodontics, Periodontics combined maximum of $2,500 per calendar year

RETIRED MEMBERS COVERAGE SUMMARY
RETIREES SELF-PAYMENT ONLY

(Coverage terminates at age 65) Division 303

BENEFIT	DESCRIPTION
Overall Maximum	$2,000 per person, per calendar year for supplementary health (excluding prescription drugs)
Co-Insurance	7 Accidental Dental – 100% All Other Eligible Expenses – 90%
Supplementary Health	In Province Hospital – 100%, The difference between the ward and semi-private rate, unlimited maximum Ambulance – Unlimited Paramedical Practitioners - $500 per person, per practitioner each calendar year Convalescent/Rehabilitation Hospital - $25 per day up to 180 days of confinement for all periods of treatment of an illness due to the same or related cases. Hearing Aid Maximum - $600 per person every 36 consecutive months
Vision	100% reimbursement for Prescription Glasses & Contact Lenses up to $500 per individual, once in any 24-month period. Contact Lenses for Special Conditions - $400 per individual, once in any 24-month period. Laser Eye Surgery - $300 per individual, once in any 24-month period
Eye Exams	One per adult and overage dependent children to a maximum of $100 per 24 months (12-month period for a dependent child under the age of 18)
Prescription Drug **(Drug Plan Formulary as defined by TELUS Adjudicare)**	Deductible – Equal to the Dispensing Fee Generic drug substitution – reimbursement will be made for the cost of the lowest priced equivalent drug unless your physician has written that there is to be no substitution of the prescribed drug. - - 1st Tier 90% of the eligible drugs under the Alberta Provincial Formulary - 2nd Tier 75% of the balance of drugs not eligible under the Alberta Provincial Formulary but covered under a regular prescription plan - Drug coverage includes: - All eligible prescription drugs including oral contraceptives, bearing a Drug Identification Number - $8,000 overall maximum per person, per calendar year - Preventative Immunization vaccines and toxoids are covered - This plan includes the Special Authorization Program

MEMBER ELIGIBILITY

You may become eligible for coverage under the Plan if you:

- ❑ reside in Canada,
- ❑ are a member of a Local Union which is participating in the IUPAT Local 177 Welfare Trust Fund
- ❑ are a permanent employee,
- ❑ work for a *contributing employer,*
- ❑ have provincial healthcare, and
- ❑ work the required number of hours for eligibility as described later.

A contributing employer is any employer who is signatory to the Collective Agreement with the International Union of Painters and Allied Trades.

DEPENDENT ELIGIBILITY

Your eligible dependents are:

1. Residents of Canada

2. Your spouse, where spouse means either:

   (a) a person who, at the time in question, is legally married to you, by virtue of a religious or civil ceremony. You can only cover one spouse at a time.

   (b) if there is no person to whom sub-clause (a) above applies, then a person who is living with you at the time an expense is incurred, who is publicly represented as your spouse, who has been living with you for at least one continuous year and who meets the other conditions set out in this subparagraph (b) being:

      i) to establish that your spouse has been living with you for at least one year, you must complete the Declaration of Common-Law Spouse section on the reverse side of the Registration Form, naming your spouse as a dependent. This form must then be on file in the Plan Administrator's office for a period of one year before your common-law spouse is eligible for benefits;

      ii) if you have a spouse as defined in subparagraph (b) above, but that person has not been registered with the Plan Administrator for at least one year, you can have the Declaration of Common-Law Spouse signed by a Commissioner of Oaths. This will eliminate the one-year Plan Administrators filing requirement and your spouse then becomes eligible for benefits the date the form is received in the Plan Administrators office; however, your spousal relationship must still have existed for at least one year before the claim expense was incurred;

      iii) to be valid, the Registration Form must be signed by you and received by Ellement; and

      iv) you cannot include on the Registration Form more than one person who is or may be a "spouse". A designation by you of a new spouse will only take effect on the later of the date that the Registration Form is received by the

Administrator and when there is no other person who has been designated by you as a "spouse" within one year preceding the date of the receipt of that designation of a new spouse by the Administrator.

3. Your unmarried children under the age of 18 who are dependent upon you for maintenance and support and are not employed on a regular and full-time basis;

4. Your unmarried children aged 18 and over but under the age of 25 who are dependent upon you for maintenance and support and are not employed on a regular and full-time basis, and are attending school at an accredited college or university on a full-time basis;

5. Your unmarried children over the age of 18 who are physically or mentally incapable of self-support and became so while dependent upon you for maintenance and support and while not employed on a regular and full-time basis, and while covered as a dependent under 3 or 4 above. In these cases, you must notify the Plan Administrator 31 days of the date the child attains the limiting age.

The word "children" means, in addition to your own or lawfully adopted child, any stepchild, or other child, who depends upon you for maintenance and support, and is not employed on a regular and full-time basis, and lives with you in a regular parent-child relationship.

Children of your spouse must also be included on the Registration Form and become eligible when your spouse does.

Effective Date Of Coverage

Coverage for you and your dependents will become effective on the date on which you qualify for coverage in accordance with the rules described in the following section – except that no payments are made for services rendered or costs incurred prior to that date.

Initial Eligibility

Hours you work for contributing employers, for which contributions have been received, will be credited to your hour bank account. You become eligible for benefits after accumulating a minimum of 300 hours in a six (6) month period from the date of your first contribution. The month after you complete the required number of hours is a waiting period. Coverage will begin on the first day of the month following the waiting period.

Limited coverage may be available should a member die, or become disabled due to an accident, during this waiting period. Contact the Plan Administrator for details. No benefit payments will be made for services received before that date.

If you are not actively at work or available for work on the date your coverage would normally become effective, coverage will begin on the next date you are actively at work or available for work for full pay.

Here is an example of how the Plan's initial eligibility rules work:

> John began work for a contributing employer in March and by the end of May, he had accumulated 400 hours in his hour bank account. Since John met the 300 hours requirement in six consecutive months, the month of June was his waiting period. John's coverage started on July 1, the first of the month following the waiting period.

Continuation of Eligibility

After you meet the Plan's initial eligibility requirements, all hours that you work for contributing employers are credited to your *hour bank account*. For each month of coverage under the Plan, 100 hours will be deducted from your hour bank account. You will be allowed to accumulate excess hours in your hour bank account up to a maximum of 1,200 hours (twelve months of coverage).

In general, you continue to be eligible for Plan coverage if your hour bank account contains at least 100 hours of work credit. See the Coverage Reinstatement section regarding forfeiture of hours.

Continuation of Eligibility While Disabled

If you are an eligible member who becomes disabled and receives disability benefits from one of the sources listed below for any calendar month, no deduction will be made from your hour bank account for Plan coverage for that month. In other words, even though your Plan coverage will continue, your hour bank account will be "frozen." For any one continuous period of disability, the maximum period that your Plan coverage will continue with your hour bank account "frozen" is twelve (12) consecutive months.

The Plan will freeze your hour bank account if you are receiving:

- ❑ Workers' Compensation Benefits,
- ❑ IUPAT Local 177 Welfare Trust Fund Weekly Disability Benefits, or
- ❑ Employment Insurance (E.I.) Sickness and Accident benefits.

If you receive any of the above benefits, you must notify the Plan Administrator immediately of the duration of your disability so that your hour bank account may be frozen for the period, as described above. Request for Freezing of Hours forms may be obtained at your Plan Administrator's office.

Termination of Eligibility

Plan coverage for you and your eligible dependents will end on the earliest of the following:

- ❑ the end of the second month following the month in which work credits in your hour bank account fall below 100 hours after deduction of 100 hours for that month,
- ❑ the end of the month for which the required premium payment was made on your behalf,
- ❑ the date you enter the armed forces on a full-time basis
- ❑ the date you or your dependents no longer have provincial health care coverage, or
- ❑ the date the Plan terminates.

Coverage Reinstatement

If your coverage has previously terminated, you will again be covered on the first day of the second month in which you have accumulated 200 hours in your Hour Bank Account, provided your period of termination did not exceed six months. If you were not covered through the Plan for more than six months, you must meet the initial eligibility rule of 300 hours prior to becoming eligible for coverage.

Extension of Coverage by Self-Payment

Self-payments are designed for members who have run out their hour bank and have no benefit coverage for the following month. If your hour bank account falls below 100 hours, you will receive

a notice that your coverage will terminate. Provided you are a member in good standing with the Union at the time your coverage terminates (and this is verified by your Local Union), you will be provided with a one-time option to continue your coverage by making self-payments on a month-to-month basis.

- ❑ to continue the coverage level you are currently covered for excluding coverage for Weekly Disability.

You may continue Plan coverage through self-payment for up to a maximum of three (3) consecutive months.

WHEN SELF-PAYMENT IS DUE

Self-payments are due in advance of the month for which coverage is desired; however, the following grace periods will be applied:

- ❑ the first payment must be made by the last day of the month for which that self-payment applies,
- ❑ second and subsequent self-payments must be made by the 7th calendar day of each month.

All payments must be made on a continuous, uninterrupted basis. If there is an interruption, you cannot re-start self-payments later.

Contact the Ellement for further information about the amount of self-payment and other requirements that must be met. Upon receipt of the self-payment notice you can log into the member's portal and request to make self-payments.

DECEASED MEMBERS – LENGTH OF DEPENDENT COVERAGE

If you should die while your dependents are insured and you are eligible for coverage through your hour bank. Plan coverage applicable at the time of your death shall continue for your already insured dependents until the earlier of the following:

- ❑ 12 calendar months immediately following the date of your death, or
- ❑ the date your hour bank account runs out.
- ❑ the date on which the Spouse remarries;
- ❑ the date on which this Benefit terminates.

EXTENSION OF SUPPLEMENTARY HEALTH BENEFITS AND HOSPITAL BENEFITS DURING DISABILITY

If you or one of your covered dependents are totally disabled on the date your coverage ends, the level of your Supplementary Health Benefits in effect at that time will be continued for the disabled person. This extension of coverage will continue for the disabled person for as long as that disability continues, but not beyond:

- ❑ 12 months for Supplementary Health and 90 days for Hospital Benefits,
- ❑ the date the maximum benefit has been paid, or
- ❑ the date that person becomes covered under any other Group Plan, whichever occurs first.

To qualify for this extended coverage, totally disabled means:

- for you, that you cannot, because of illness or injury, engage in your regular occupation and you are not working for pay or profit
- for an insured dependent, that such person cannot, because of illness or injury, engage in most of the normal activities of a person of the same age and sex

Payments will be made for pregnancy-related eligible expenses if you or your dependent are pregnant on the date coverage would normally end for a reason other than the termination of the plan.

ELIGIBILITY RULES FOR ASSOCIATE EMPLOYEES

This Plan allows for Associate employees who reside in Canada to become eligible for coverage under the Plan:

- an employee of certain other employers for whom coverage under this Plan has been approved by the Trustees, or
- 100 hours of contributions is required every month of coverage
- Associate cannot make self-payments
- Hours cannot be frozen if an Associate is attending trade school

These employees may become and remain eligible provided they meet prescribed eligibility rules. The Board of Trustees reserves the right to amend these rules at any time and to request proof that all conditions and requirements are being met. Full information concerning the participation of associate employees can be obtained by contacting the Plan Administrator.

Effective January 1, 2008, the Trust Fund introduced to all eligible Members of the Benefit Plan (the "Plan") of the Trust Fund Early Retiree Health Benefit Program (the "Program"). The Board of Trustees expressly reserves the right to amend these Eligibility Rules from time to time and expressly reserves the right, as set out in the Trust Agreement, to change the benefits provided by the Program and to terminate the Program. Subject to the foregoing, the Eligibility Rules are as follows:

1. If at the time that a Member's Hour Bank with the Plan ends, or a Member's eligibility to make self-payments to the Plan. The Member is (a)

    - Under the age of 65 years; and
    - Is in receipt of a Pension, or will be entitled to be in receipt of Pension within 3 months from the End of Eligibility, from the IUPAT Local 177 Pension Plan, such Member is eligible to join the Program subject to the other provisions of the Eligibility Rules;
    - At the End of Plan Eligibility, the Member must be in good standing with the IUPAT Local 177 and must remain in good standing on an uninterrupted basis with IUPAT Local 177 from the End of Eligibility and while such Member participates in the Program.

2. Within prescribed time period from the End of Eligibility (and as such prescribed period is determined by the Board of Trustees from time to time), a Member must elect to participate in the Program by delivering to the Administrator of the Plan the required election form to participate in the Program and must complete such other documents as may be required by the Trustees from time to time. Currently, the time period to make such an election is 14 days from the End of Eligibility;

3. To be eligible for the Program, the Member must also have been either working or available for work within the jurisdiction of IUPAT Local 177, during the 12 months immediately preceding the End of Eligibility;

4. To be eligible for the Program, the Member must have been covered for benefits as an active Member of the Plan without interruption during the 12 months immediately preceding the End of Eligibility;

5. The Member must make the required self-payments required for the Program to the Administrator's office on an uninterrupted basis. The monthly contributions must be paid by way of postdated cheques or automatic withdrawal payments, with the first payment having been received by the Administrator within 14 days of the End of Eligibility;

6. Continued Eligibility for the Program is subject to IUPAT Local 177's verification of eligibility based on the Local's Retiree Member Rules.

7. The benefits to be provided under the Program, and the contribution rates for such Program, shall be determined by the Board of Trustees from time to time.

8. A Member of the Program, subject to the other conditions of these Eligibility Rules, will remain eligible for coverage until the last day of the month in which the Member reaches the age 65 years. A Member will cease to be eligible for the continuing coverage for the Program if:

    a) The Member does not remain in good standing with IUPAT Local 177 as a retired Member for a period of more than 30 days;

b) The Member fails to pay a contribution when due, and such default continues for a period of 14 days from the due date;

c) The Member gives written notice to the Administrator that the Member does not wish to continue to participate in the Program, in which case such coverage will end at the later of:

i. The end of the month in which such notice was received by the Administrator; and

ii. The date under which the eligibility in the Program ends under any of the other provisions of the Eligibility Rules or under any of the provisions of the Group Insurance Policy for the Program;

d) Upon the Member regaining eligibility for benefits in the Plan as an active Member of the Plan.

9. Except for a Member who becomes an active Member of the Plan after joining the Program, a Member whose participation in the Program ends by reason of any of the provision of these Eligibility Rules is not eligible to rejoin the Program or to commence to receive benefits in the Program for a second time.

BENEFITS

The Life Insurance benefit is payable to your beneficiary in the event of your death from any cause at any time or place while you are insured under the Plan. Coverage terminates when you retire or reach age 70. Benefits reduce to 50% when you reach age 65. If applicable, the optional life insurance protection chosen by the participant, taking into consideration the reductions in protection stipulated in the said table.

The Life Insurance benefit amount payable is: ***$75,000***

If you are an Active member and you should die during the one-month period immediately preceding the date your eligibility commences or is reinstated (that is, during the waiting period), a Life Insurance benefit will be paid to your beneficiary.

The portion of premiums paid on your behalf for your level of Life Insurance coverage is a taxable amount. A T4-A will be issued from the Plan.

WHO CAN BE YOUR BENEFICIARY?

You may designate anyone you wish as beneficiary for your member Life Insurance benefit by filling in the information requested on your Registration Form.

You may change your beneficiary at any time (subject to the applicable laws of your province of residence) by completing a new Registration Form and submitting it to the Plan Administrator. Any payment made in good faith to your estate or your estate's representative, or to the person known by the Plan Administrator as the designated beneficiary at the time of payment, shall be full discharge of the liability of BENEVA for such payment under this benefit.

Optional Life Insurance - Evidence of insurability

Additional insurance protection for the participant is subject to the acceptance of evidence of insurability deemed satisfactory by the Insurer.

If a participant, in the judgment of the Insurer, constitutes a higher risk, the Insurer may, at its discretion, either refuse the application for additional insurance or accept it subject to the payment of premiums in addition to those stipulated for this benefit.

A. Restriction - Suicide

If a participant commits suicide, whether sane or insane, and has been protected for less than 12 months by the optional life insurance protection or the previous optional life insurance protection which was replaced by this policy, the Insurer will refund the premiums collected for this participant for the optional life insurance coverage in lieu of paying the amount of optional life insurance.

If a participant increases their amount of optional life insurance, the 12-month period mentioned above begins to run once again from the date the optional life insurance takes effect, but only for the increase of such amount.

THIS RESTRICTION ALSO APPLIES TO LIFE INSURANCE PROTECTION WHEN PARTICIPATION IN THE PARTICIPANT'S LIFE INSURANCE BENEFIT IS OPTIONAL OR WHEN THE AMOUNT VARIES DEPENDING ON THE CHOICE MADE BY THE PARTICIPANT OR WHEN THE EMPLOYEE'S APPLICATION IS RECEIVED BY THE INSURER AFTER THE PERIOD STIPULATED IN THE CLAUSE "EFFECTIVE DATE OF PROTECTION OF EMPLOYEES AND THEIR DEPENDANTS" HAS EXPIRED SO THAT EVIDENCE OF INSURABILITY MUST BE PROVIDED BY THE EMPLOYEE.

WAIVER OF PREMIUM FOR DISABILITY - DIVISIONS 101, 102, 201, 202, 301

If you become totally and permanently disabled while you are insured for Life Insurance coverage under the Plan, and before age 65, your Life Insurance will continue (even though you may lose eligibility for other benefits) for as long as you remain disabled, but not beyond your 65th birthday, subject to the following requirements:

1. You must be totally disabled for at least nine (9) months, and

2. Medical evidence must show that your disability is total and permanent, and

3. Written notice and proof of your disability must be given to the Insurance Company within 12 months following the date you cease active work due to disability. Subsequent proofs of disability must be furnished each year thereafter.

No increase in insurance may become effective during a period of disability.

Totally and permanently disabled as used above means that due to illness or injury, you are, and will continue to be, unable to perform any occupation for which you are, or may reasonably become, fitted by training, education or experience.

CONVERSION PRIVILEGE (NOT APPLICABLE TO RETIRED MEMBERS)

If your Life Insurance coverage terminates, you may be eligible to convert the terminated amount to an individual life insurance policy without a medical examination or health questionnaire being required. Contact the Plan Administrator for details concerning your eligibility to convert, as well as the type of policy you can convert to and the amount of coverage that you may convert. Written application together with the initial premium due must be submitted to BENEVA within 31 days of the date your Life Insurance coverage terminates.

EXTENDED BENEFITS (NOT APPLICABLE TO RETIRED MEMBERS)

If you should die within 31 days of the date your Life Insurance coverage terminates, the amount you could have converted will be paid as a death benefit under this Plan even if you did not apply for conversion.

BENEFITS

The Life Insurance benefit is payable to you in the event of the death of one of your eligible dependents from any cause, at any time or place, while insurance for that dependent is in force. Coverage for your dependents will end when you retire or reach age 65, whichever is earlier. If applicable, the optional life insurance on the spouse and dependent children chosen by the participant, considering the reductions in protection stipulated in the said table.

The Life Insurance benefit amount payable is:

Spouse	**Each Child**
$15,000	$7,500

WAIVER OF PREMIUM FOR DISABILITY

If your Life Insurance is continued by reason of total and permanent disability as provided in the Life Insurance for Members section, the Life Insurance then in effect for your dependents will also be continued.

CONVERSION OF DEPENDENTS' INSURANCE

If Dependent Life Insurance for your spouse or one of your dependent children terminates because your Member Life Insurance terminates, or because of your death, or because the individual no longer meets the contractual definition of spouse or that of dependent child, the person whose insurance terminates may be eligible to convert to an individual life insurance policy without a medical examination or health questionnaire being required. Contact the Plan Administrator for details concerning eligibility to convert, as well as the type of policy that can be converted to and the amount of coverage that can be converted. Written application together with the initial premium due must be submitted to BENEVA within 31 days of the date your spouse's/dependent's Life Insurance coverage terminates.

EXTENDED BENEFITS

If your spouse or dependent child dies within 31 days of the date the individual's Dependent Life Insurance terminated, the amount that could have been converted will be paid as a death benefit under this Plan even if the individual did not apply for conversion.

Evidence of insurability

Additional insurance protection for the spouse and dependent children is subject to the acceptance of evidence of insurability deemed satisfactory by the Insurer.

If an insured, in the judgment of the Insurer, constitutes a higher risk, the Insurer may, at its discretion, either refuse the application or accept it subject to the payment of premiums in addition to those stipulated for this benefit.

You will be paid a benefit, if while insured for Weekly Disability coverage, you become disabled due to a non-occupational bodily injury or sickness that prevents you from performing work for a contributing employer for pay or profit. Coverage terminates upon retirement or you reach age 70, whichever is earlier.

The amount of benefit is equal to the current Employment Insurance maximum for all Plan coverage Options.

WHEN WEEKLY DISABILITY BENEFITS ARE PAYABLE

Weekly Disability benefit payments begin once the elimination period of 189 days has been met. Benefit payments may continue for up to a maximum of 25 weeks if you remain disabled and are under the care of a physician. Contact Ellement as soon as you are off work to make an application.

Successive periods of total disability that are separated by less than one week of full-time employment or availability for full-time employment will be considered as one period of disability. However, if your subsequent disability is caused by an injury or sickness entirely unrelated to the cause of the previous disability and it begins after you return to or are available for work, it will be considered as a separate disability.

If any period of disability is classified as “recurrent” it will be treated as a continuation of the previous disability. This is significant because any maximums which apply may already be used up and any waiting period may already be satisfied.

WHAT IS NOT COVERED

Weekly Disability benefits are not payable for:

- ❑ any day on which you are not under the care of a physician or surgeon; no period of care shall be considered to have started until you have been seen and treated personally by a physician or surgeon;
- ❑ a disability caused by self-inflicted injury or illness;
- ❑ a disability resulting from insurrection, war, service in the armed forces of any country, or participation in a riot;
- ❑ a disability for which you are entitled to benefits under any Workers’ Compensation Act or Automobile Insurance Act;
- ❑ periods of disability when you are on vacation and receiving full pay;
- ❑ any period that you are undergoing cosmetic surgery or treatment, when so classified by the insurance company, unless such surgery or treatment is for accidental injury and began within 90 days of the accident causing the injury; or
- ❑ any day you do any kind of work for pay or profit.

HOW TO START RECEIVING DISABILITY BENEFITS

Be sure to apply to both the Plan Administrator and E.I. (Sickness Benefits) as soon as you become disabled. Disability claims must be reported to the Plan Administrator within 30 days after the date the disability began.

Third Party Liability

If you receive benefit payments under this Plan for loss of income for which there may be cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will enable BENEVA to be reimbursed for any amount(s), including interest, you recover from a third party for loss of income, or medical or dental expenses which, together with any amount(s) paid or payable under any of the benefits of this Plan, would exceed the amount you would otherwise be entitled to because of your disability.

When BENEVA is notified of payment by a third party of any judgment or settlement, further disability payments under this Plan will be interrupted until the amount set out in the Reimbursement Agreement has been reimbursed.

If a lump sum payment is made under judgment or settlement for loss of future income, no further disability benefits will be paid from this Plan until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

Extension of Benefits

If you are disabled on the date your coverage ends and that disability continues uninterrupted, Weekly Disability benefits will continue until the end of the benefit period under this Plan, or until your disability terminates, whichever occurs first.

For information before the insured person travels, to obtain approval before incurring or paying any eligible expenses, or to request assistance, BENEVA's travel assistance service may be contacted at one of the numbers below:

From Canada or the United States: 1 (866) 438-5498
From elsewhere in the world: 1 (418) 651 2266 (collect call)
The Contract Number specified on the insurance card must be provided when calling.

When contacting the travel insurance provider, you should have the following information available:

- ❑ Policy Number – 38B90
- ❑ Certificate Number
- ❑ Plan Name – IUPAT Local 177 Welfare Trust Fund
- ❑ Name of Third-Party Administrator – Ellement

1. Expenses Covered

The Percentage Payable applicable to the following eligible expenses is as specified in the Schedule.

In the event of the insured's death during a stay outside the province of residence, or if the insured suffers accidental injury or a sudden and unexpected illness during such stay, emergency expenses incurred by the insured as described below are eligible, up to the benefit maximum shown in the Schedule.

Travel Insurance only covers eligible expenses more than those reimbursed under the public health and hospitalization plans of the insured's province of residence. Insureds planning a trip scheduled to last more than 180 days must contact BENEVA in advance for information about applicable conditions.

In the following cases, approval must be requested as soon as possible from BENEVA'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 BENEVA'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 the expenses described below to be considered eligible, insureds must be covered under the public health and hospitalization plans of their province of residence.

In all cases, 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. 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 before the trip
  - A relapse is suffered before the trip
  - 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
- ❑ 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.

BENEVA'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.

(1) Hospitalization

Hospitalization expenses incurred due to treatment in a hospital.

(2) Physician fees

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

(3) 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.

(4) Chiropractor, podiatrist or physiotherapist fees

Professional fees of a chiropractor, podiatrist or physiotherapist.

(5) 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.

(6) Prescription drugs

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

(7) Transportation by ambulance

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

(8) 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.

(9) Transportation by plane of a medical escort

The cost of economy class return air fare 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.

(10) Living expenses and transportation of a close relative

The cost of accommodation and meals in a commercial establishment and the cost of economy class return transportation for a close relative between the place of residence and the hospital when the insured is hospitalized for at least 7 days. Eligible expenses, including transportation costs incurred to identify the deceased insured's body prior to return, 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 per trip

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.

(11) Transportation of the insured's body if deceased

The expenses of preparing and returning the remains of the insured by the most direct route home, 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.

(12) 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.

(13) 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

(14) Living expenses

The cost of accommodation and meals in a commercial establishment the insured must incur when obliged to postpone the return home 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 abroad, for all individuals covered.

(15) Travel Assistance services

This insurance provides access to certain travel assistance services when needed. These services may not be available in all countries and are subject to change by BENEVA 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

2. Exclusions, Limitations and Restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Health Care Insurance Benefit, the following exclusions apply to Travel Insurance.

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

a) Expenses incurred because of the insured's refusal to be repatriated to the province of residence, upon BENEVA'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 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 practising any of the following activities or sports: gliding, hang-gliding, paragliding, 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 public health or hospitalization plan of the insured's province of residence

1. Reasons for Cancellation

For cancellation expenses to be considered eligible, the trip must be cancelled, extended or interrupted due to one of the following causes:

a) An illness or accident suffered by the insured, a travel companion, a business partner of the insured, or a member of the insured's family. The illness or accident must prevent the individual from performing his or her usual activities and must be sufficiently serious to justify or force the cancellation or interruption of the insured's trip

b) Death of the insured; the insured's spouse; the insured's or spouse's child; the insured's travel companion; or the insured's business partner

c) Death of a family member of any of the following individuals: the insured; the insured's spouse; the insured's child; the insured's travel companion. The funeral must be scheduled to take place during the planned trip or the preceding 14 days

d) Death, illness or accident suffered by a person for whom the insured is the legal guardian

e) Notwithstanding any other provision of the Plan, suicide or attempted suicide of the insured's travel companion or a member of the insured's family

f) Death of a person for whom the insured is the testamentary executor

g) Death or emergency hospitalization of the host at destination

h) The insured's or travel companion's summons for jury duty or subpoena to act as a witness in a case scheduled to be heard during the trip, provided the person involved has taken all necessary measures to have the hearing postponed. A summons or subpoena is not considered cause for cancellation or interruption of a trip when the person involved institutes legal proceedings or is a defendant in the case or is a police officer and has been subpoenaed as part of their regular duties

i) Quarantine of the insured, provided that quarantine ends 7 days or fewer before the scheduled date of departure, or occurs during the time of the trip

j) Hijacking of the airplane on which the insured is travelling

k) Damage rendering the principal residence of the insured or of the host at destination uninhabitable. The residence must remain uninhabitable 7 days or fewer before the scheduled date of departure, or the damage must occur during the time of the trip

l) Transfer of the insured, for the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required by the employer within the 30 days preceding the scheduled date of departure

m) Notwithstanding any other provision of the Plan, terrorism, war, whether declared or undeclared, or an epidemic in the location which the insured plans to travel to or leave, provided the Government of Canada issues an advisory not to travel to such location or one to leave such location. The advisory must be in force for the period of the planned trip or stay and have been issued after the insured has already

finalized the travel arrangements or when the insured was already staying in such location

n) Delay of the transportation used by the insured to reach the point of departure of the planned trip or to the point of departure of a scheduled connection after departure of the planned trip, provided that the means of transport used provides for scheduled arrival at the point of departure at least 3 hours prior to the time of departure or at least 2 hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by mechanical problems (except for a private automobile), a traffic accident, or an emergency road closure, each of the latter two causes requiring confirmation by a police report

o) Weather conditions such that:

- the departure of the public carrier used by the insured, at the point of departure of the planned trip, is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip or
- the insured is unable to make a scheduled connection after departure with another carrier, provided the scheduled connection after departure is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip

p) Damage occurring to a commercial establishment or to the location where a commercial activity is to be held. The damage must prevent the activity in question from taking place. A written cancellation notice must be issued by the organization officially responsible for the activity

q) Death or hospitalization of the person with whom the insured had arranged a business meeting or commercial activity. In such case, reimbursement is limited to transportation expenses and a maximum of 3 days' accommodation

2. Expenses Covered

To be eligible, expenses must be incurred by the insured following the cancellation, extension or interruption of a trip, provided such expenses are related to amounts paid in advance by the insured and that, at the time travel arrangements were finalized, the insured was not aware of any event that could reasonably lead to the cancellation, extension or interruption of the planned trip. Expenses must also be incurred for one of the specified eligible reasons for cancellation. Expenses are reimbursed in accordance with the provisions hereafter and up to the benefit maximum shown in the Schedule.

(1) In the event of cancellation prior to departure

In the event of cancellation prior to departure, the trip cancellation must be notified to the travel agent or carrier, as well as to the insurance carrier, at the latest 48 hours following the event causing cancellation. In the event that this period ends on a statutory holiday, notice of cancellation may be submitted on the next working day.

a) The non-refundable portion of prepaid travel expenses

b) Additional expenses incurred by the insured if the travel companion who was to share accommodation at destination must cancel due to one of the eligible reasons for cancellation and the insured decides to proceed with the trip as initially planned. Expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion had to cancel

c) The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if departure is delayed due to weather conditions and the insured decides not to proceed with the trip

(2) In the event of missed departure or if the trip must be interrupted temporarily

The additional cost of a one-way economy class ticket on a scheduled flight of a public carrier, by the most direct route to the initially planned trip destination. Departure must be missed due to a delay in the means of transportation used by the insured, subject to the conditions specified in the eligible reasons for cancellation. In the event of interruption of a trip, the interruption must be due to an illness or accident suffered by the insured or travel companion, subject to the conditions specified under the eligible reasons for cancellation.

(3) If the return is earlier or later than planned

a) The additional cost of a one-way economy class ticket, by the most direct route, for a return trip to the point of departure, by the means of transportation initially planned. If the initially planned means of transportation cannot be used, whether or not travel expenses have been prepaid, the expenses eligible will be equal to the fees charged by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the insured to return to the initial point of departure. These expenses must be pre-approved by BENEVA's travel assistance service

b) The unused and non-refundable portion of the ground portion of prepaid travel expenses

Restriction

If the insured's return is delayed by more than 7 days, the expenses incurred are eligible, provided the insured or the insured's travel companion was admitted to hospital as an in-patient for more than 48 hours within the seven-day period.

If travel expenses were not paid in advance, the expenses incurred by the insured are covered provided that before the scheduled date of departure, the insured was not aware of any event that could reasonably lead to the interruption of the planned trip.

(4) Round-trip transportation

The cost of transportation by the most economical means, following approval by BENEVA's travel assistance service, for the insured to return to the province of residence and then back to the trip destination, provided the return is due to one of the following reasons:

a) Death or hospitalization of a member of the insured's family, a person for whom the insured is the legal guardian or a person for whom the insured is the testamentary executor

b) A disaster that has made the principal residence of the insured uninhabitable or has caused significant damage to the insured's business establishment

3. Exclusions, Limitations and Restrictions

In addition to the exclusions, restrictions and limitations applicable to all benefits of the Health Care Insurance Benefit, the following exclusions apply to Trip Cancellation Insurance.

Trip Cancellation Insurance does not cover losses due to the following causes or to which such causes have contributed:

a) War, whether declared or not, an epidemic or an act of war or of terrorism, it being understood that this exclusion does not apply to the insured already present in a place at the time a war or an epidemic breaks out, or an act of war or of terrorism occurs, provided the insured takes the necessary measures to leave such place as soon as the Government of Canada issues an advisory to do so. This exclusion does not apply to insureds whose travel plans are finalized on or before the day the government advisory is issued

b) Active participation of the insured in a riot or insurrection, perpetration or attempted perpetration of a criminal act by the insured or the insured's travel companion or participation of the insured or the insured's travel companion in a criminal act

c) Abusive or excessive consumption of medication, drugs or alcohol and the ensuing consequences

d) Intentional self-inflicted injury by the insured or travel companion; suicide or attempted suicide, whether the individual is sane or insane

e) Participation in any of the following activities or sports: gliding, hang-gliding, paragliding, 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

f) The reason for which the trip is purchased, in the event that it is purchased for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, whether or not the trip is taken upon the recommendation of a physician

g) In the event that the trip is purchased to visit or be at the bedside of a person who is ill or has suffered an accident, change in medical condition or death of such person

h) A cause which, beyond any possible doubt, does not prevent the insured from proceeding with the trip

If notice of cancellation of a trip prior to departure is not provided within the time specified herein, the insurance carrier's liability is limited to the cancellation expenses stipulated in the travel contract that are applicable at the time such notice should have been given. However, this limitation will not apply if the insured and any adult accompanying the insured on the planned trip provide proof deemed satisfactory by the insurance carrier that they were totally incapable of doing so. In such case, the trip must be cancelled as soon as one of these persons is able to do so, and the insurance carrier's liability is limited to the applicable cancellation fees stipulated in the travel contract at the time of cancellation.

BENEFITS

The Extended Health Care Benefits help pay for certain medical services and supplies which are not covered by a provincial plan.

ELIGIBLE EXPENSES – DIVISIONS 101, 102, 103, 201, 202, 301, 302

The following services and supplies are covered by the Supplementary Health Benefits.

To be eligible for payment, eligible expenses must be reasonable, customary and considered to be medically necessary by a physician.

A service or supply is *medically necessary* if it is accepted by the medical profession as effective, appropriate and essential in the diagnosis or treatment of a sickness or injury that is based on recognized and accepted standards of care.

The Plan considers a *physician* to be a Doctor of Medicine (M.D.) duly licensed to practice medicine or any other practitioner recognized by the College of Physicians and Surgeons in the area in which the treatment is provided.

The Plan considers a *hospital* to be an institution operated according to law for the inpatient medical care of sick, injured and chronically ill persons, has a staff of licensed doctors (M.D.) and 24-hour nursing service by Registered Nurses (R.N.), and in Canada, is approved for payment of the ward rate under the Provincial Health plan.

Nursing Care (eligible for Divisions 101, 102, 201, 202, 301 **Only)** – Service of a Registered Nurse (R.N.), provided to a patient who is not confined to a hospital, up to a lifetime maximum benefit of $25,000 for a maximum of 12 months per condition. Nursing services of a Registered Nurse, Registered Nursing Assistant or a Licensed Practical Nurse will be eligible. The nurse providing care and the insured patient must not ordinarily reside in the same home. Services of a nurse who is the spouse, child, brother, sister, or parent of the employee or the employee's spouse will be ineligible. Prior approval from Ellement is required.

Services of Practitioners – Up to $500 per person per type of practitioner is payable each calendar year for professional services provided by the following licensed, certified or registered practitioners when they are operating within their recognized fields.

- *Speech Therapist*
- *Psychologist*
- *Physiotherapist*
- *Registered massage therapist*
- *Chiropractor.* In addition, one x-ray is provided per calendar year.
- *Services of podiatrist, chiropodist includes one x-ray per calendar year.* Coverage is payable from the first dollar.
- *Naturopath/Homeopath*
- *Registered dietician $180 for the initial assessment and $110 for subsequent visits to the maximum stated above.*
- *Osteopath*

  Provincial Paramedical Limitations:

Services of a Podiatrist. Reimbursement will only be provided for Eligible Expenses incurred after the annual maximum allowance under the provincial health plan has been exhausted. Proof the maximum has been met will be required.

- *Eye examinations performed by a licensed ophthalmologist or optometrist* that are not covered by your provincial health plan. Coverage is limited to one eye examination every 24 months (every 12 months for dependent children under age 18), up to a maximum benefit of $100 per person.

The practitioner providing care and the insured patient must not ordinarily reside in the same home. Services of a practitioner who is the spouse, child, brother, sister, or parent of the employee or the employee's spouse will be ineligible.

Ambulance Service provided by a licensed ground ambulance to a local hospital, and from home hospital to another hospital where specialized treatment is to be provided. The Plan also covers up to one round trip per person each year for emergency transportation by means of a licensed ambulance, air-ambulance or by any other vehicle normally used for public transportation, to the nearest hospital in which the required treatment can be provided.

Hospital Care – For the room and board charges specified below, 100% reimbursement of reasonable and customary charges which are not paid by the Government hospital plan, when a sickness or accident requires you or your dependent to be confined in a hospital.

If you or a covered dependent are confined in a licensed hospital, you will be reimbursed for:

- ❑ **Room and board charges** more than ward accommodations, up to the level of semi-private accommodation, and
- ❑ **The daily co-insurance** charge (if applicable).

If you are confined in a private room, payment will be based on the hospital's charge for semi-private room and board.

- A legally licensed institution which is operated for the care and treatment of sick and injured persons as In-patients, and which:
  a) Is eligible to receive payments under a provincial hospital plan;
  b) Provides organized facilities for diagnosis and major surgery;
  c) Provides 24-hour nursing service by registered nurses, and has a Physician in regular attendance;
  d) Is not primarily operated as a nursing home or a place for rest, or for the care and treatment of the aged, the blind and deaf, and
  e) Is not primarily operated as a place for the care and treatment of alcoholics, drug addicts, or the mentally ill.

For the purpose of this Plan, Chronic Care and Convalescent/Rehabilitation Facilities/beds are not considered under the Hospital Coverage.

Convalescent Rehabilitation Hospital – Semi-private accommodation in a licensed Convalescent or Rehabilitation Hospital provided the person was admitted within 14 days following a period as an In-patient in a Hospital – to a maximum specified in the Benefit Schedule.

Diagnostic Laboratory and X-Ray Expenses

Prescription Drugs (Generic Substitution) – Subject to the Deductible, Co-Insurance and Drug Formulary as specified in the Benefit Schedule, and provided through the Pay-Direct Drug card, all drugs are eligible if they;

- Bear a Drug Identification Number and are dispensed by a licensed pharmacist, and
- Can only be obtained by a written prescription from a Physician or Dentist for use in respect of an illness or injury, or by a qualified health professional if legislation permits them to prescribe those drugs, and
- Are not more than a 34-day supply (100-day supply for maintenance drugs) **Reimbursement will be made for the cost of the lowest priced equivalent drug, unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine.**

Special Authorization Drug Program – The plan covers drugs that are medically necessary. The Special Authorization (SA) program applies to several drugs for which prior approval is required before being covered by the plan. For a drug to be approved for coverage, the employee and doctor will need to complete a Special Authorization kit providing some medical information.

If the information provided meets the plan's medical criteria, then the prescription drug will be approved for coverage.

If claims are submitted for a listed drug that has not received Special Authorization, the claim will be declined and the SA form will need to be submitted.

Drug Limitations – The following are not eligible, unless otherwise stated in the Benefit Schedule:

- Proprietary or patent medicines,
- Experimental drugs,
- Obesity drugs,
- Fertility drugs,
- Erectile Dysfunction drugs,
- Dietary or health foods, vitamins, nutritional products, and
- Smoking cessation aids (which include, but are not limited to, nicotine patches and nicotine gum),
- Drugs that are administered intravenously,
- Drugs that are normally only administered in a hospital.

Eligible drugs that are covered under a provincially funded drug program, are limited to the provincial deductible and applicable co-insurance.

Medical Equipment and Supplies

Purchase but not the repair of a spinal brace or an artificial limb or eye where the loss of the limb or eye occurs while the person is covered under this Benefit; replacement is included when required due to physiological change. Purchase or rental but not the repair or replacement of a crutch or a custom made (rigid support) brace (not prescribed specifically for sporting activities).

Rental or purchase, of a wheelchair or hospital bed, to lifetime maximum of $2,000 each. Prior approval from the Plan Administrator is required, for which a written recommendation from the Physician must be submitted, stating the medical necessity for the item.

Purchase of colostomy, ileostomy or ureterostomy supplies.

Purchase of one glucometer per lifetime.

Purchase of Diabetic supplies, including disposable needles and reagent strips.

Injectable drugs and serums.

Purchase of breast prosthesis when required because of total or radical mastectomy which has been performed while the person is covered under the Benefit – to a maximum of $400 per person every 60 consecutive months.

Purchase of two surgical brassieres each calendar year when required because of total or radical mastectomy.

Purchase of two pairs of surgical stockings per person each calendar year.

ORTHOPEDIC SUPPLIES

Purchase of orthopedic supplies, shoes (and customized orthosis and arch support) and boots, one pair per person per calendar year, up to a combined maximum of $300 (not eligible for payment unless prescribed by a medical doctor for a diagnosed physical impairment. Medical doctors do not include Doctor of Chiropractic or chiropodists). This does not include off the shelf shoes that have been modified.

HEARING AIDS

Purchase of hearing aids where reimbursement will be made at 100% to a maximum benefit of $600 every 36 months of eligible expenses per person. On the written prescription of a licensed otolaryngologist. Repairs are not included.

OTHER ELIGIBLE EXPENSES

a) Oxygen, plasma, blood or blood substitutes and their administration

b) X-ray and diagnostic laboratory procedures and e-ray or radium therapy; such procedures do not include services received in a hospital.

c) Purchase of wigs required because of chemotherapy to a lifetime maximum of $100 per individual.

Emergency Dental Treatment for the repair of damage resulting directly from an accidental injury to natural teeth or the area outside the mouth, provided the treatment is received within 90 days of the accident and you are still eligible for coverage. Payment will be made based on the amount for the least expensive procedure which will provide a professionally adequate result. No reimbursement will be provided for treatment performed more than 2 years after the date of the accident.

Vision Care

The Plan's vision care benefit provides reimbursement for the purchase of prescription glasses or contact lenses, up to a maximum benefit of $500 per person every 24 consecutive months. Contact Lenses for Special Conditions - $400 per person every 24 consecutive months. Laser Eye Surgery - $300 per person every 24 consecutive months.

Benefits are provided for prescription lenses, prescription sunglasses prescribed by an ophthalmologist or an optometrist.

Off the shelf sunglasses or safety glasses are excluded.

Eye Exams – Eye examinations (including eye refractions) performed by a qualified ophthalmologist or licensed optometrist – to the maximum specified in the Benefit Schedule.

Medically Necessary Contact Lenses – Coverage for contact lenses is subject to Medical Necessity and will be paid according to the following:

- To correct extreme visual acuity problems that cannot be corrected to the 20/40 in the better eye with spectacle lenses;

- Following cataract surgery resulting in Aphakia;

- Keratoconus or other corneal irregularities.

CHARGES NOT COVERED UNDER SUPPLEMENTARY HEALTH BENEFITS

Limitations & Exclusions – No reimbursement will be made under this benefit for the following:

- Services or treatment which in whole or in part a government health plan prohibits from being paid, except to the extent that it permits excess reimbursement;
- Services, treatment or supplies which the individual received without charge;
- Services, treatment, or supplies that are experimental in nature;
- Drugs, services, treatment or supplies for the treatment of sexual dysfunction;
- Drugs, hormones, products and injections for the treatment of obesity;
- Services, treatment or supplies provided to the Member by the Employer;
- Services, treatment or supplies not included in the list of eligible expenses;
- Any services, treatment or supplies which are required as the result of a motor vehicle accident.

Eligible expenses which result directly or indirectly from the following:

- Intentionally self-inflicted injuries while sane or insane;
- Cosmetic treatment other than due to an accidental bodily injury which is caused solely by external, violent and accidental means, independently of all other causes and which is sustained while the individual is insured under the benefit;
- Committing or attempting to commit a criminal offence;
- Any cause for which payment is provided under any Worker's Compensation Act or similar legislation or under any other government plan;
- War, whether war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion.

Survivor Benefit – A Dependent, whose coverage under this plan would otherwise have ended because of the death of the Member, will continue to be covered under this benefit in accordance with the other provisions of this plan until the earliest of the following dates:

a) The end of the period of 12 months following the date of the death of the member;
b) The exhaustion of the deceased member's hour bank;
c) The date on which the Spouse remarries;
d) The date on which this Benefit terminates.

Covered dental expenses are charges for services and supplies provided by or under the supervision of a licensed, certified or registered oral surgeon or dentist. Eligible expenses are those which are recommended as necessary by a physician or dentist that are not more than the 2016 Suggested Dental Fee Schedule* in your province of residence. Dental treatments are considered eligible if performed by a dentist or denturist who practices within the scope of their license. Specialist fees are not reimbursable.

*"Suggested Dental Fee Schedule" means the Dental Association Fee Guide in your province of residence. If your province of residence is Alberta, "Suggested Dental Fee Schedule" means the Insurance Industry Reimbursement Guide.

DENTAL COVERAGE AT-A-GLANCE

Basic Treatment (Eligible Expenses) – Basic treatment excludes any services that are primarily for orthodontic treatment

1) Oral Examinations:
    - Complete oral examinations – limited to one in any 24-month period;
    - Specific and recall oral examinations – limited to one in any 6-month period;
    - Emergency examinations for evaluating acute pain and/or infection.
2) X-Rays:
    - Complete series of periapical films and panoramic film – each limited to one in any 24-month period;
    - Bitewing films and x-rays to diagnose a symptom or examine progress of a particular course of treatment other than temporomandibular joint film.
3) Laboratory Examinations
4) Consultations
5) Preventative:
    - Prophylaxis (light scaling and polishing for preventative purposes rather than therapeutic) limited to once in any 6-month period;
    - Topical application of fluoride and anti-cariogenic substances – limited to once in any 6-month period and for dependents under age 18 only;
    - Pit and fissure sealants covered on primary and adult teeth under age 18;
    - Space maintainers for missing primary teeth; not designed specifically for sporting activities;
    - Temporary dressing for the emergency relief of pain;
    - Occlusal equilibration;
    - Night guards.
6) Minor Restorative Services:
    - Non-bonded amalgam;
    - Acrylic, silicate or composite restorations (Composite filling apply to all teeth);
    - Pre-formed stainless steel and polycarbonate crowns.
7) Removal of erupted teeth and surgical removal of impacted teeth and residual roots.
8) Repair, rebasing and relining of partial or complete dentures, not including the replacement of teeth on a denture.
9) Local anesthesia and anesthesia required in relation to dental surgery.

Endodontics (Eligible Expenses) – Endodontics is root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.

- Root canal therapy;
- Apexification;
- Apicoectomy;

- Retro filling;
- Root amputation;
- Hemisection;
- Vital pulpotomy

Periodontics (Eligible Expenses) – Periodontics is the treatment of bone and gum disease.

- Periodontal scaling/root planing not exceeding 6 units of time per calendar year (subsequent units covered at 50%).
- Definitive periodontal surgery:
  Definitive periodontal surgery includes local anesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post-surgical care. A surgical site is considered a sextant. The mouth is divided into 6 sextants. The allowance for fewer teeth may be prorated. Definitive periodontal surgery includes the following procedures:
    - Gingival curettage
    - Gingivoplasty
    - Gingivectomy
    - Flap approach
    - Grafts – pedicle; free soft tissue; lateral sliding; and rotated.

Related Periodontal Services:

- Provisional splinting
- Occlusal adjustment (8 Units per Calendar Year)
- Periodontal appliance
- Periodontal appliance adjustment or reline.

Oral Surgery (Eligible Expenses) – Oral surgery includes local anesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation. A surgical site will be considered a sextant unless specified as a quadrant.

1) Extraction of Erupted Tooth (Uncomplicated) – limited if additional teeth extracted in the same quadrant.
2) Extraction of Erupted Tooth (Complicated) – limited if additional teeth extracted in the same quadrant. Surgery requires surgical flap or sectioning of the tooth.
3) Extraction of Impacted Tooth (Soft Tissue Impact) – limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue and extraction of impacted tooth.
4) Extraction of Impacted Tooth (Partial Bone Impaction) – limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and either removal of bone or tooth or sectioning and removal of tooth.
5) Extraction of Impacted Tooth (Complete Bone Impaction) – limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and removal of bone and sectioning and removal of tooth.
6) Extraction of Residual Root – limited if additional teeth extracted in the same quadrant.
7) Surgical Exposure of Impacted Tooth – limited if additional teeth exposed in the same quadrant.
8) Alveoloplasty – includes remodeling, excision, removal and reduction of bone.
9) Other procedures.

Major Treatment (Eligible Expenses)

1) Metal inlay/onlay restorations.
2) Retentive pins in inlays and crowns.
3) Crowns (single restorations only), other than preformed stainless steel and polycarbonate crowns, for a tooth that is broken by caries or traumatic injury and cannot be filled by amalgam or composite. Replacement of an existing crown is included if such crown is at least 5 years old.

4) Prosthodontic Appliances (e.g. fixed bridgework, removable partial or complete dentures) other than dentures with precision or stress breaker attachments or precision attachments and telescoping crown unit for fixed bridgework as follows:
    - Construction and insertion of an initial permanent prosthodontic appliance if such appliance was necessary because of the extraction of at least one natural tooth while insured under this Benefit;
    - Replacement of an existing prosthodontic appliance with a permanent prosthodontic appliance
        - If such appliance was necessary because of the extraction of at least one natural tooth while insured under this Benefit, or
        - If the existing appliance is at least 5 years old, or
        - If the existing appliance is temporary and being replaced by a permanent appliance within 12 months of the date the temporary one was installed;
- Denture adjustments with minor adjustments limited to once in a six-month period.
- Repair of fixed bridgework.

5) Dental Implants but coverage is limited to the lowest cost of appropriate alternate covered treatment (such as a bridge or crown).

Orthodontic Treatment

Eligible for Divisions 101, 102, 201, 202, 301 only – If an individual, while insured under this benefit, incurs eligible expenses which are for necessary dental treatment which has as its objective the correction of malocclusion of the teeth, the Plan will provide reimbursement for such expenses, in accordance with the provisions of this policy and subject to any limitations of amount shown in the Benefit Schedule.

Limitations and Exclusions – Reimbursement will not be made for any portion of the charge that is over the suggested charge in the appropriate fee guide.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the locality where the services are provided. However, in no event will the total reimbursement of lab fees exceed 60% of the suggested fee in the appropriate fee guide for the particular dental treatment requiring the lab services.

No reimbursement will be made under this benefit for the following:

1) Any dental treatment which is for the cosmetic purposes when the form and function of the teeth are satisfactory an no pathological conditions exits;
2) Expenses incurred for nutritional counselling, oral hygiene and dental plaque control programs;
3) Any dental treatment rendered for the full mouth reconstructions, for vertical dimension correction, for the restoration of occlusion, for the correction of temporomandibular joint (TMJ) dysfunction or for the permanent splinting of teeth;
4) Charges levied by dentists for broken appointments, completion of claim forms or advice by telephone;
5) Expenses incurred for the replacement of dentures and appliances that are lost, mislaid, or stolen;
6) Any dental treatment which is not yet approved by the Canadian Dental Association or which is clearly experimental in nature;
7) Dental services, treatment or supplies which the individual received without charge or which a government health plan prohibits from being paid;
8) Any dental treatment rendered outside Canada except as specifically provided under the **Benefit Outside Canada** provision;
9) Any services, treatment or supplies provided to the Employee by the Employer;
10) Dental services and supplies not included in the list of eligible expenses;
11) Eligible expenses which result directly or indirectly from the following:
    a) Intentionally self-inflicted injuries while sane or insane;
    b) Committing or attempting to commit a criminal offence;

c) Any cause for which payment is provided under any Workers' Compensation Act of similar legislation of under any other government plan;
d) War, whether war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion.

12) Any services and supplies rendered for the treatment or correction of any congenital or developmental malformation.
13) Any services, treatment or supplies which are required as the result of a motor vehicle accident.

Co-ordination of Benefits – This Benefit is subject to the Co-ordination of Benefits provision of this policy.

Pre-Determination of Benefit – When the total cost of any proposed dental treatment is expected to exceed $500, the Employee or dependent should submit a detailed treatment plan within seven days after the plan is prepared by the dentist, to the Plan Administrator before commencement of treatment. The Plan Administrator will then advise the Member of the amount of reimbursement for which the Employee or dependent is eligible in accordance with the provisions of this policy. The treatment plan should outline the type of treatment to be provided, the anticipated dates of treatment, and the amounts to be charged for such treatment. The treatment plan submitted must be performed by the dentist who first presented the treatment, otherwise the Member or dependent will be required to submit a new treatment plan to the Plan Administrator for reassessment.

Proof of Claim – Written proof of a dental claim must be submitted to Ellement within 365 days of the date the expense was incurred.

The Plan Administrator reserves the right to require radiographs and other types of diagnostics such as specialist reports, periodontal charts and study models.

Payment of Orthodontic Claims – Notwithstanding anything to the contract, the **CLAIMS** section (provision) of this policy, the payment of orthodontic claims will be made on one of the following bases:

1) If a single charge is estimated for the entire course of treatment and the Member pays this charge to the orthodontist in prearranged installments over an estimated period of treatment, the Plan Administrator will reimburse the Member each time a bill or receipt is submitted to the Plan Administrator for any prearranged installment.
2) If a single charge is estimated for the entire course of treatment and the Member pays this charge to the orthodontist in one lump sum, the Plan Administrator will reimburse the Member monthly.
3) If in lieu of a single charge, a charge is made for each treatment as it is performed, the Plan Administrator will reimburse the Member as each charge is incurred.

Survivor Benefit – A Dependent, whose coverage under this plan would otherwise have ended because of the death of the Member, will continue to be covered under this benefit in accordance with the other provisions of this plan until the earliest of the following dates:

a) The end of the period of 12 months following the date of the death of the Member;
b) The exhaustion of the deceased member's hour bank;
c) The date on which the Spouse remarries;
d) The date on which this Benefit terminates.

TREATMENT PLAN

A Treatment Plan is a plan of dental treatment (including X-rays, if required) showing the patient's dental needs, a written description of the proposed treatment necessary in the professional judgment of the dentist, and the cost of the proposed treatment.

If you want to learn the amount the Plan will pay before you receive treatment, you should file a Treatment Plan with the Plan Administrator. Treatment Plans can be filed for any proposed dental treatment but should be filed when the total cost of the proposed dental work is expected to exceed $500. The Plan's response to the Treatment Plan identifies coverage and limitations for specific services and clarifies insurance percentages, specific limits and Dental Fee Schedule allowances before dental treatment begins. The Treatment Plan is not intended to limit you in your choice of dentist, to tell you or your dentist what treatment should be performed, to tell the dentist what fee to charge, or to guarantee reimbursement after coverage ends.

ALTERNATE COURSE OF TREATMENT

The IUPAT Local 177 Welfare Trust Fund reserves the right to provide reimbursement for the least expensive method of treatment that would provide a professionally adequate result. In cases where there are optional methods of dental treatment, benefits will be paid for the least expensive procedure consistent with proper dental care.

YOUR MEMBER ASSISTANCE PROGRAM

From time to time we all face difficult or stressful events in our lives. Most of the time, we handle these personal challenges well. Other times, our personal problems can become large enough that they begin to interfere with our effectiveness, happiness or safety, both at work and at home.

Your Member Assistance Program (MAP) provides confidential, professional counselling for a broad range of personal and family problems. While the program can be used for crisis intervention, the ideal time to use the program is before problems get out of hand.

WHAT BENEFITS ARE AVAILABLE TO ME?

Short Term Counselling for you and your dependents to a maximum of 4 sessions per family member per year from a professional counsellor either in person, over the phone, or through the internet site www.homewoodhealth.com.

WHAT DOES THE PROGRAM OFFER?

The MAP offers confidential, professional assessment, guidance, counselling (and referrals, when required) for personal and family difficulties such as:

• relationship and family problems	• work related stress or conflict
• separation/divorce/custody	• anger management
• difficulties with children	• eating disorders
• childcare and eldercare resources	• aging parents
• alcohol and drug dependencies	• sexual harassment and abuse
• gambling and other addictions	• grief and bereavement
• depression, stress, anxiety & other psychological disorders	• retirement planning

Referral to Legal and Financial Advisory Services – up to two hours in total per calendar year is available for certain legal and financial difficulties through the MFAP.

Web site services available by Member registration at www.homewoodhealth.com include:

- **Childcare, Elder Care and Self Care Service** provides information about personal and family care providers in Canada.

- **The Health and Wellness Companion** is a program that allows you to store personal and family health information for secure and confidential access – anywhere, at any time; a comprehensive health library including a searchable drug database, answers to questions about diagnostic medical tests, medical terms, diseases and conditions and a health risk assessment that allows you to evaluate your current health and uncover potential health risks through a series of interactive health risk assessments

- **Interactive eLearning Courses** that offer you the convenience of self-paced, private and personalized learning experiences designed to improve your personal health and well-being and/or workplace effectiveness.

***VERY IMPORTANT:** When registering for any of these services online or when contacting Homewood Health Inc. by telephone, please indicate your company name as **IUPAT Local 177 Welfare Trust Fund.**

How Does The Program Work?

When you want to speak with someone, simply call the Homewood Health Inc. number listed below. Homewood Health Inc. staff will ask you for some basic registration information (to establish your eligibility for this benefit) and then help set up an initial appointment at a time and office location convenient for you. An experienced psychologist or counsellor will help assess your concerns and aid you in developing practical solutions.

Who Provides The Counselling?

Counselling will be provided by a registered psychologist or counsellor in the Homewood Human Solutions network. All Homewood Health Inc. counsellors have extensive experience helping individuals with their problems. If longer-term counselling, hospital treatment, or specialized services (such as medical, legal or financial help) are required, your counsellor will arrange an appropriate referral and follow-up with you.

What About Confidentiality?

Homewood Health Inc. counsellors are required by law to maintain the strictest confidentiality. No one who inquiries about or receives service under this Plan will be identified to anyone without your written approval.

Who Do I Contact?

To speak with someone confidentially, 24 hours a day, or to book an appointment, call the Homewood Health Inc. number nearest you.

English	1-800-663-1142
French	1-866-398-9505
TTY (Hearing Impaired)	1-888-384-1152
International (Collect)	1-604-689-1717

How Do I Become Covered Under The Plan?

When you work for a contributing employer, that employer reports the hours you work to the Plan Administrator. An hour bank reserve account is then established for you.

You must complete and return, to the Plan Administrator, a "Registration Form". Blank Registration Forms are available at your Local Union office or the Plan Administrators office.

What Is My Hour Bank Account?

This is an account kept by the Plan Administrator for each member who works for a contributing employer. These employers report the numbers of hours worked by the member to the Plan Administrator. The hours are placed in the member's hour bank account.

This is like a bank account with hours being deposited instead of dollars. To pay for coverage, a member has hours deducted or withdrawn from his account.

For example: If a member has 190 hours in his hour bank account at the beginning of the month, his account will operate as follows.

Month	Hour Bank Account Balance at Beginning of Month	Hours Reported in Month*	Hours Charged for Coverage	Hour Bank Account Balance
1	190 hrs.	136 hrs.	100 hrs.	226 hrs.
2	226	185	100	311
3	311	95	100	306
4	306	Nil	100	206
5	206	100	100	206
6	206	125	100	231

* *These hours were worked in the previous month. They are always reported a month later, i.e., after the end of the month worked.*

Is A Medical Examination Necessary To Get This Insurance?

No. All benefits for you and your dependents are available without any test of insurability.

When Do My Dependents Receive Coverage Under This Plan? What Are The Benefits For Which They Qualify?

Your dependents can become covered for Supplementary Health, Member Assistance Program, Dependent Life and Dental Care benefits (if elected) at the same time you become eligible according to the benefits outlined on the schedule of benefits for your applicable class.

What Happens If I Move From One Employer In The Industry To Another?

If your new employer is required to make contributions, your hour bank account will continue to be credited with hours reported.

Once I Am Covered, How Do I Know If I Have Sufficient Hours In My Hour Bank Account To Pay For My Coverage In Future Months?

The Plan Administrator will have the latest hour bank reserve account balances for each eligible employee. You are responsible for knowing what your hour bank account balance is at any time.

Do I Have To Be Under A Doctor's Care In Order To Qualify For Weekly Disability Benefits?

Yes. You must see a medical doctor as soon as possible if you have been injured or are sick enough to be unable to work. If you delay going to a doctor, your claim could be refused, reduced or delayed for further investigation.

Do I Have Health Care Coverage While Travelling Or Vacationing Outside Of My Province Or Country?

Yes, provided you are travelling or vacationing for a period of not more than 180 days. However, any expenses incurred outside of your Province or Country must first be submitted to your Provincial Health Care Plan for payment. The unpaid balance not covered by your Provincial Plan will be paid by the Fund according to the Fund's benefit provisions and up to a lifetime maximum benefit of $5 million. Individuals should contact the Travel Service Provider as soon as a medical emergency occurs to open a file.

What Can Dentists Charge For The Services They Provide?

Dentists may set their fees at any level they wish; however, reimbursement from the Fund is based on the applicable Suggested Dental Fee Schedule. If you feel the difference between the Fee Schedule and the dentist's fees is excessive, you should discuss this with your dentist prior to beginning treatment.

What is a Treatment Plan?

A Treatment Plan is a prepared statement by your dentist outlining the proposed treatment and the estimated cost. If the Treatment Plan is submitted to the Plan Administrator before treatment begins, your eligibility status will be confirmed and you and your dentist will be informed in advance of the amount that will be eligible for payment by the Fund when the treatment has been completed.

Are There Any Exclusions Under The Plan?

Yes. Not all types of expenses are covered. If in doubt, contact the Plan Administrator.

COORDINATION OF BENEFITS

This Plan includes a Coordination of Benefits provision. If you or your dependents are covered under more than one Group Health or Dental plan, this Plan will coordinate payment of benefits with the other plan or plans under which the person is covered. This provision ensures that, while claims may be made under all plans, the total reimbursement will not exceed the actual expenses incurred.

To coordinate payments, the insurance carrier must determine which *plan* pays first and which pays the difference.

Under the Coordination of Benefits provision, the term *plan* includes medical and dental care benefits under a law or governmental program, group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution above the high school level.

Benefits are coordinated with other plans as follows:

- ❑ The plan that does not have a Coordination of Benefits provision pays before the plan that does.
- ❑ The plan that covers the person as an employee or member pays before the plan that covers that person as a dependent.
- ❑ When coordinating benefits for a covered dependent child, the plan covering the parent with the earlier birthday (month and day) pays before the plan covering the parent with a later birthday.

How to File a Claim for Reimbursement

Log into your Painters profile to get everything you need to know about your coverage, how to submit claims, sign up for direct deposit and more. Visit www.paintersbenefits.ca

To assist you in filing a claim with the Plan Administrator, you will find below a step-by-step outline of the procedures that you should follow.

LIFE INSURANCE

- ❑ Your beneficiary should notify the Plan Administrator immediately to obtain the necessary claim form.
- ❑ An original death certificate should be submitted to the Plan Administrator as soon as it can be obtained.
- ❑ The Life Insurance benefit will be paid as soon as possible after satisfactory proof of death is furnished to the Plan Administrator.
- ❑ Written notice of claim must be made within 90 days after the date of death. Under the Disability Provision for Life Insurance, satisfactory proof of disability must be submitted within 12 months of the start of a disability and when requested thereafter.

Weekly Disability

- ❑ Apply to E.I. for Accident and Sickness benefits.
- ❑ Obtain a claim form from the website.
- ❑ Complete in detail the employee's portion of the Weekly Disability Benefits Statement form and then have your doctor complete their portion.
- ❑ Mail or submit through the Painters portal the form directly to the Plan Administrator.
- ❑ **Disability claims must be reported to the Plan Administrator within 30 days of the start of a total disability.**

Extended Health Benefits

The Prescription Drug, Dental and Extended Health benefits are processed through TELUS Adjudicare, which also handles the reimbursement of claims. The Pay Direct Benefit Card must be presented each time a claim is made with your dental office, pharmacy or health care provider.

Medical Benefits

- ❑ Obtain from your Local Union office or the Plan Administrator an Extended Health Care form.
- ❑ Using a separate form for each family member, itemize the bills for out-of-pocket expenses, for covered services and supplies.
- ❑ Attach receipts, making sure the receipts include (where applicable practitioners name, designation/registration number and address) the drug identification number, name of the medication, the date of purchase and charge for each item. Send the form to the Plan Administrator every 90 days (monthly for major bills). Drug store counter tapes are not acceptable.

Prescription Drug Benefit

- ❑ If you are using your TELUS Adjudicare card, provide your card to the pharmacist.
- ❑ If you are not using your TELUS Adjudicare card, you pay the full cost of all prescriptions and submit a claim using a Prescription Drug claim form or directly from the app from your account.

Hospital Benefits

- ❑ Request the Hospital Admitting Clerk to complete a standard hospital claim form.
- ❑ If you wish to have hospital payments paid directly to the hospital, complete the "assignment" portion of the claim form.
- ❑ Send the completed form or have the hospital send the completed form to the Plan Administrator.

Vision Care Expenses

- ❑ Obtain from your Local Union office or the Plan Administrator a Vision Care-Statement of Claim form.
- ❑ Using a separate form for each family member, itemize the bills.
- ❑ Attach original paid receipts and send them directly to the Plan Administrator. Photocopies and cash register tapes are not acceptable. You can also submit your claims electronically through your app.

- ❑ Your dental office can submit claims electronically, simply present your Benefit Card to them. TELUS Adjudicare 000034
- ❑ A separate claim form must be used for each individual.
- ❑ If you wish to have payments paid directly to the dentist, complete the "Assignment" portion of the claim form.
- ❑ Complete your portion of the form and send it directly to the Plan Administrator or you can submit the claim electronically through your app.
- ❑ The Plan Administrator will issue payment for the approved expenses.

Note: *For all Supplementary Health and Dental Care Benefits, when your insurance terminates for any reason, written proof of claim must be given to the Administrator within 90 days of the date of termination of insurance. Otherwise eligible expenses must be claimed WITHIN 12 MONTHS OF THE DATE THE EXPENSES WERE INCURRED.*

Be sure that you indicate your Group Number and Certificate Number and complete name and address on all correspondence sent to the Plan Administrator.