

# **YOUR GROUP BENEFITS**

**PROVIDED BY**

**THE INTERNATIONAL  
BROTHERHOOD  
OF  
ELECTRICAL WORKERS  
LOCAL UNION 894  
WELFARE TRUST FUND**

inside front cover

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WELFARE TRUST FUND**

**CURRENT AS AT MAY 1, 2010**

## **TO ALL ELIGIBLE PLAN MEMBERS**

The IBEW Local Union 894 Welfare Plan was started in October 1959, pursuant to a Collective Agreement between the Local Union and signatory Contractors. Since 1959, the Benefits of the Welfare Plan have been changed and improved, as Government sponsored plans became available, and as subsequent Collective Agreements increased Employer Contributions to support the cost of the Plan.

In some cases, Federal and Provincial Legislation may require changes. Since the Trustees must conform to any legislation affecting this Benefit Plan, the Trustees must reserve the right to amend these Plans as and when necessary.

It is the sincere wish of the Board of Trustees that continued improvements in the Benefits provided through the Welfare Trust Fund may be achieved, always having regard for the maintenance of sound financial conditions. If the Plan encounters financial difficulty it is possible that Benefits could be reduced or eliminated entirely.

The purpose of this Booklet is to explain, as clearly as possible, each of the Benefits to which you may be entitled under the Plan. It also tells you how to file claims. Please read the following pages carefully, as it is important that you understand the Plan thoroughly in order for you and your covered Dependents to reap the full Benefits provided.

This Booklet is a guide to the Benefit Plan. If there is a dispute about coverage the contract of Insurance and the Plan Text will be used for the final determination of benefits.

## PRIVACY STATEMENT

The Plan is subject to the provisions of federal privacy legislation set out in the Personal Information and Electronic Documents Act (PIPEDA). The Plan may be subject to other legislation regarding the protection of personal information. The Board of Trustees has taken steps to ensure that personal information of Plan Members and their dependants is protected through the implementation of the Plan's Privacy Policies and Practices document, a copy of which is available from the Local Union Office. These Policies and Practices will be adhered to by the Plan's administration office, the Board of Trustees, the Plan's claims payers and insurers, and anyone else who has any responsibilities to the Plan.

Briefly, the Plan's Privacy Policies and Practices require that the Plan will collect, maintain, share and retain only the personal information that is necessary for the effective administration of the Plan, subject to obtaining consent from the Member and/or his dependants to do so. Access to personal information will be restricted to those who are required to use it. Personal information will only be shared if the other party has its own privacy policy. Personal information that is no longer needed will be destroyed.

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## IMPORTANT

This Booklet contains important information concerning your Group Benefit coverage. It should be kept in a safe place. This Booklet supersedes and replaces all previous communication material.

This Booklet summarizes the benefits and provisions of your Group Benefit Plan. It does not constitute the Group Policies and is not a contract of insurance, nor does it create or confer any contractual or other rights. Every effort has been made to ensure that the information is accurate. However, if there is any question as to interpretation, all rights with respect to a covered person will be governed solely by the Group Policies issued by The Manufacturers Life Insurance Company and RBC Life Insurance Company to the Board of Trustees of the IBEW Local Union 894 Welfare Trust Fund. The Prescription Drug Plan is self-funded and administered in accordance with the Plan Text.

A copy of certain Plan information may be obtained upon written request to the Plan Administration Office, who may make a reasonable charge for this service.

The Manufacturers Life Insurance Company and RBC Life Insurance Company are members of the Canadian Life and Health Insurance Compensation Corporation (Compcorp). Although these types of Policies are covered by the Consumer Protection Plan, you should obtain and read the Compcorp brochure to understand the limitation of that coverage.

To avoid any misunderstanding regarding the Benefits to which you as a Plan Member are entitled, we suggest the following:

1. Read the Booklet carefully. Develop a clear understanding of what Benefits the Plan provides and what expenses, or portion of expenses, are covered.

2. Think about lending this Booklet to your Dentist, Physician and/or paramedical professional (Psychologist, Physiotherapist, Podiatrist, Chiropractor, Osteopath). This enables them to tell you whether the service proposed may be eligible and what, if any, your costs will be.
3. Read and keep any newsletters or correspondence from the Plan as they may enhance, clarify or amend the Benefits, Pay Direct requirements or Dollar Bank draw downs etc. described in this Booklet.
4. Call the Plan Administration Office if any clarification is required.

# PART I

## GENERAL INFORMATION

### PLAN EFFECTIVE DATE

The Plan described in this Booklet is current as of May 1 , 2010

### ELIGIBILITY

All Active Members in Good Standing of IBEW Local Union 894, who are residing in Canada, and covered by provincial health care insurance, are eligible to participate in this Plan.

Pensioners in Good Standing of IBEW Local Union 894 who meet the eligibility criteria set out later in this Booklet are eligible for the Pensioner Life Insurance and some Major Medical Benefits, as well as for Prescription Drugs Benefit under the ClaimSecure Program, provided they make any Pay Direct remittances required by the Plan.

If you have Dependants residing in Canada, you may cover them as well. Your Spouse and your unmarried Children who are not employed full-time, are dependent upon you for support and are less than 22 years of age, including adopted, foster and step-children, are eligible. Unmarried Children over 22 years of age who are full-time students and dependent upon you for support are also eligible. You will be asked to apply for over age Dependant status on an annual basis.

Any functionally impaired Child may remain insured past Age 22. The Child, upon reaching Age 22, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

Your spouse must be legally married to you, or be your partner of the opposite sex, or of the same sex, who has been publicly represented as your spouse. You can only cover one spouse at a time.

If you and your spouse are not legally married, you must have cohabited for at least 12 consecutive months. Members may not cover ex spouses.

All Dependants must be covered by a Provincial medical program and must be residents of Canada.

### **EFFECTIVE DATE OF COVERAGE – ACTIVE MEMBERS**

Your Employer is required to make a Contribution for every hour of work. Every Contribution received by the Administrator is placed in your Dollar Bank until such time that you have earned 3 months of Contributions. Your Coverage, as well as that of your Dependants, is effective on the first day of the calendar month immediately following the month in which you earn your 1,050th Contributory Dollar. This is your Effective Date. Each month, \$350.00 is deducted from your Dollar Bank to maintain Coverage. Any Dollars contributed in excess of \$350.00 each month remain in your Dollar Bank and are used to maintain your Coverage. You can build up your Dollar Bank to a Maximum of \$4,200.00 - that is, up to one year's Coverage.

If you have accumulated \$1,050.00 in your Dollar Bank, you are covered on the first day of the calendar month immediately following the 1,050th Contributory Dollar even if you are totally disabled or laid off.

However, if you are Totally Disabled prior to your Effective Date you will not be eligible for Disability Benefits.

If you are initially covered as a Single Member, and later acquire

a Dependant, your Dependant must be enrolled in the Plan. You must advise the Administrator, as soon as possible, of your change in status. Claims for unlisted Dependants will be held, unpaid, until you file a new Application Card confirming your Dependants.

If one of your Dependants is hospitalized (other than a new-born infant) on your Effective Date, coverage for that Dependant will commence on the day following his/her discharge from hospital. Once you are insured for Dependant coverage, additional Dependants will be insured from the date eligible, regardless of hospital confinement.

### **TERMINATION DATE OF COVERAGE – ACTIVE MEMBERS**

Coverage for you and your Dependants will remain in effect as long as you have at least \$350.00 in your Dollar Bank. Your coverage is terminated at the end of that calendar month in which you have less than \$350.00, or if your association with Local Union 894 has terminated. However, Members in Good Standing of the Local Union may maintain Benefits through the Pay Direct Programme or the Extended Benefit Programme, as described below. Upon retirement, you may continue Active Members' coverage except for Weekly Disability Income, Long Term Disability, Survivor Income and Emergency Travel Assistance Benefits until your Dollar Bank is below \$350.00. At that point you may qualify for the "Early Retiree Benefit Plan" or the "Benefits for Pensioners" described later in this Booklet.

### **PAY DIRECT PROGRAMME – ACTIVE MEMBERS**

Any Member in Good Standing of the Local Union whose Dollar Bank is less than \$350.00 will be notified that his coverage is going to expire. The Member will be given the option of making Pay Direct Payments to maintain Full Benefits Coverage or the Alternate Pay Direct Plan described below. The current monthly

Pay Direct amount for Full Benefits Coverage is \$275 plus applicable taxes. These Payments may be made directly to the Administrator for a maximum of twelve (12) months.

Pay Direct Payments for Full Benefits Coverage, as well as for the Pay Direct plans described below, must be received by the Administrator no later than the due date stated on the Pay Direct letter. You may not let your Pay Direct coverage lapse for any period of time as you will not be permitted to reinstate it at a later date. Retired Members do not qualify for this Programme.

### **ALTERNATIVE PAY DIRECT PLAN – ACTIVE MEMBERS**

When first notified that your coverage is going to expire, instead of Paying Direct for Full Benefits Coverage, you will have a one-time option of choosing the “Alternative Pay Direct Plan” which includes coverage for Life Insurance and the Pay Direct Drug Plan only, at a cost of \$125.00 per month plus applicable taxes. It is important to be aware that if you choose the Alternative Pay Direct Plan you cannot subsequently switch to Full Benefits Coverage, nor to the Reduced Benefits package described below.

Members who choose the Alternative Pay Direct Plan may Pay Direct for a total of 24 months.

### **PAY DIRECT COVERAGE EXTENDED BEYOND ONE YEAR – ACTIVE MEMBERS**

Once your first 12 month Pay Direct period on Full Benefits Coverage is completed, you will have the option of purchasing a further 12 months of Reduced Benefits. This package includes the following:

Health Care Benefits, including Major Medical, Vision Care and Outside Canada Coverage (does not include Emergency Travel Assistance), the Pay Direct Drug Plan and Dental.

The current monthly Pay Direct amount for the Reduced Benefits package is \$190 plus applicable taxes. You must sign an agreement at the Union Office to purchase this coverage.

### **EXTENDED BENEFIT PROGRAMME – ACTIVE MEMBERS**

The Extended Benefit Programme provides for the continuance of all Welfare Plan Benefits, provided that the Member immediately contacts the Local Union Office to confirm that he is unable to work due to a non-WSIB compensable disability.

Members who qualify for this Benefit will be reported by the Local Union Office to the Administrator. The Local Union Office will place the Plan Member's name on a Special Administration Report. Eligibility for the continuance of Benefits is determined by the provision of satisfactory Evidence of Disability, such as must be provided by the Member in order to receive Weekly Indemnity or Long Term Disability Benefits from the Plan. The Member will remain covered by the Extended Benefit Programme at no cost to himself for a maximum of 12 months, or until such earlier time as the Trustees no longer consider the Plan Member eligible, which would include having evidence that the Plan Member is no longer disabled, has retired, has terminated association with Local Union 894, or has returned to work. At the end of the twelve months, and provided the Member remains disabled and has a sufficient Dollar Bank, \$220 will be deducted from his Dollar Bank each month and his coverage will continue.

Maintenance of Benefits in the Extended Benefits Programme is available only to Welfare Plan Members who are eligible for Benefits in the month immediately prior to their Disability. The Extended Benefit Programme will commence the maintenance

of Benefits on the first day of the month following 30 days of continuous Disability. During the 30 days following the onset of Disability the Plan Member is responsible for the maintenance of his Benefits through the Pay Direct Programme if he does not have sufficient Dollars in his Dollar Bank to continue Welfare Plan Coverage.

If unemployment is due to illness there will be no maximum to the number of times that the Plan Member may be covered by the Extended Benefit Programme. However, no Plan Member may be covered by the Extended Benefit Programme at no cost to himself for more than twelve (12) months for any one period of continuous Disability.

Plan Members may be removed from the Extended Benefit Programme because:

1. The Plan Member has not provided "Satisfactory Evidence of Disability", or
2. The Plan Member has left Local Union 894, or
3. The Plan Member has returned to work with a Contributing Employer, or
4. The Plan Member has been added to the Unemployment List of the Local Union Office as Available for Work, or
5. The Plan Member has reached the maximum 12 months allowed under the Programme at no cost to himself and has exhausted his Dollar Bank, or
6. The Plan Member has retired. Retired Members do not qualify for this Programme.

### **"Satisfactory Evidence of Disability":**

Plan Members under consideration for the Extended Benefit Programme will be required to provide a completed Attending Physician Statement which will be reviewed by the Claims Administrator appointed by the Trustees. Evidence of Disability will be requested as often as is necessary to ensure that the Plan Member is disabled. In the event that the Claims Administrator determines that the Plan Member is no longer disabled, Benefits under the Extended Benefit Programme will cease immediately. In the event of a disagreement between the Claims Administrator's assessment of Disability and the Member, the Plan Member will be asked to consent to an Independent Medical Exam by a Physician designated by the Board of Trustees. The decision of the Independent Physician will be final. The Board of Trustees will pay the cost of the Independent Medical Exam but will not be responsible for the cost to the Plan Member of providing any other evidence of Disability.

### **Membership in Local Union 894:**

The Plan Member's Membership in Local Union 894 will be determined by the Local Union Office.

Members disabled due to a disability which is compensable by Workplace Safety and Insurance Board (WSIB) or other Workers' Compensation plans are not eligible for the Extended Benefit Programme.

### **Return to Work with a Contributing Employer:**

The Plan Member's return to work with a Contributing Employer will be determined by the Plan Administrator.

## **Cost of the Extended Benefit Programme:**

The cost of the Extended Benefit Programme is paid by the Welfare Trust Fund's reserves. The continuation of this Programme is contingent upon the ability of the Trust Fund to pay the cost of this Benefit. The Trustees will review, on an ongoing basis, the cost of the Extended Benefit Programme and it may be terminated, or the Trustees may require that the Plan Member pay a greater portion of the Cost, if the circumstances warrant such an action.

## **EXTENDED BENEFIT PROGRAMME EXTENSION OF COVERAGE – ACTIVE MEMBERS**

Once you have exhausted your entitlement under the Extended Benefit Programme as described above, you will have the option of purchasing a further 12 months of reduced Extended Benefits while you remain disabled and eligible as described above. This package includes the following:

Health Care Benefits, including Major Medical, Vision Care, Outside Canada Coverage (does not include Emergency Travel Assistance), the Pay Direct Drug Plan and Dental

The current monthly Pay Direct amount for this package is \$115 plus applicable taxes.

## **REINSTATEMENT**

If your Coverage is terminated because you have less than \$350.00 in your Dollar Bank you will again be covered by the Welfare Plan on the first of the month following the date on which you have worked sufficient Hours to produce \$700.00, provided you are a Member in Good Standing of Local Union 894. For example, if you are terminated and have \$100.00 in your Dollar Bank, and bank your 600th dollar on March 10th, you will again be covered by the Welfare Plan on April 1st.

The Administrator will continue to maintain the terminated Member's Dollar Bank unless there is a period of six consecutive months in which no Contributions are received. In such a case, the Member's Dollar Bank is erased. Upon becoming re-employed, the Member must satisfy the original eligibility requirement of \$1,050.00.

## **MEMBERS IN RECEIPT OF A WORKPLACE SAFETY AND INSURANCE BOARD BENEFIT**

If you become disabled due to a disability that is compensable by the Workplace Safety and Insurance Board (WSIB), your Welfare Benefits will be continued for you for up to 12 months following the date of the injury.

If you cease to be in receipt of a Workplace Safety and Insurance Board benefit before the expiry of the twelve (12) month period, Welfare Plan Benefits will no longer be maintained for you. If you do not have sufficient Dollars in your Dollar Bank to be eligible for Active Member Benefits, you have the option of maintaining your Coverage through the Pay Direct Programme provided you are and remain a Member in Good Standing of Local Union 894.

To ensure your Dollar Bank is credited correctly the Administrator must receive proper notification from your Employer outlining all necessary details of the injury.

## PAY DIRECT PLANS

| PLAN NAME | WHO CAN BE COVERED  | BENEFITS COVERED   |
|-----------|---|--|
| A         | Active Members<br>– One Year  | Active Member Weekly Indemnity, Long Term Disability, Life Insurance, Accidental Death & Dismemberment, Survivor Income Benefit, Emergency Travel Assistance, Supplementary Health, Vision Care, Prescription Drugs, Semi-Private Hospital, Dental |
| AA        | Active Members<br>Alternative Plan<br>Up to 24 Months                 | Active Member Life Insurance and Prescription Drugs  |
| B         | Active Members<br>– Second Year                                       | Active Member Supplementary Health, Vision Care, Prescription Drugs, Semi-Private Hospital, Dental   |
| C         | Extended Benefits<br>For Sick And<br>Disabled Members<br>– First Year | Active Member Life Insurance, Accidental Death & Dismemberment, Survivor Income, Emergency Travel Assistance, Supplementary Health, Vision Care, Prescription Drugs, Semi-Private Hospital, Dental   |
| D         | Disabled Members<br>– Second Year                                     | Active Member Supplementary Health, Vision Care, Prescription Drugs, Semi-Private Hospital, Dental. Also Life Insurance, Survivor Income Benefit and Accidental Death & Dismemberment if approved for Waiver of Premium.                           |
| E         | Early Retirees<br>(see Section III)                                   | Active Member Life Insurance, Survivor Income, Supplementary Health, Vision Care, Prescription Drugs, Semi-Private Hospital, Dental  |
| F         | Pensioners<br>(see Section IV)  | \$3,000 Life Insurance, Pensioner Supplementary Health, Prescription Drugs, Semi-Private Hospital  |

## PART II

### BENEFITS FOR ACTIVE MEMBERS

#### DEATH & ACCIDENT PROTECTION

#### GROUP TERM LIFE INSURANCE BENEFIT FOR ELIGIBLE ACTIVE MEMBERS AND EARLY RETIREES

If you should die, regardless of the cause, \$50,000 will be paid to your Beneficiary. Payment of Benefit and changes in Beneficiary designation are subject to applicable government legislation. If there is no Beneficiary the Benefit is payable to your Estate.

#### Waiver Of Premium:

If you should become Totally Disabled prior to age 65 and remain disabled for at least 6 months, your Life Insurance coverage will remain in force, without payment of Premiums. You must notify Manulife Financial within 12 months of the last active day at work and must furnish satisfactory proof within 18 months of the last active working day.

As long as you continue to be disabled prior to age 65, Premiums for this Benefit will be waived. The Insurance will remain in force until the time it would normally have ceased if you were not Totally Disabled.

"**Totally Disabled**" means your inability to work in any business or occupation, for wages or profit, due to bodily injury or sickness and is determined by the Plan's Insurer.

## SURVIVOR BENEFIT FOR ELIGIBLE ACTIVE MEMBERS AND EARLY RETIREES

The Survivor Benefit is designed to help provide your Eligible Survivors with financial security in the event of your death. However, if your Survivor predeceases you or does not satisfy the definition of Survivor at the time of your death, no Benefit is payable.

### Eligible Survivors:

Your Eligible Survivors are your Spouse and Children defined as follows:

1. The term "**Spouse**" means the person under age 65 who is:
  - a) Legally married to you, or your partner of the opposite sex or of the same sex who has been publicly represented as your Spouse. If you and your Spouse are not legally married, you must have cohabited for at least 12 consecutive months; and
  - b) You must reside in the same country as your Spouse; and
  - c) You must have appointed your Spouse as your Beneficiary.
2. The term "**Children**" means any Child who is:
  - a) an unmarried Child (including adopted, foster and step-children) of yours, or of your Spouse, and
  - b) dependent upon you for support and maintenance, and
  - c) less than 22 years of age, and
  - d) while you were alive, resided in the same country as you.
3. The term "**Orphan**" means a Child as defined above, who has lost both parents through death.

### Amount Of Benefit:

If you should die, regardless of the cause, a Monthly Benefit will be payable as follows:

|                         |                 |
|-------------------------|-----------------|
| Spouse's Benefit .....  | \$200 per month |
| Children's Benefit..... | \$100 per month |
| Orphan's Benefit .....  | \$100 per month |

### Commencement Of Benefit Payments:

The first payment is made on the first of the month following the month in which the Member dies. Subsequent payments are made on the first day of each month.

### Payment Of Benefit:

#### Spouse's Benefit

The Spouse's Benefit is normally paid to your Surviving Spouse whom you designate as your Beneficiary.

The last payment for the Spouse is made on the first of the month in which the Spouse:

1. Dies, or
2. Reaches age 65.

#### Children's Benefit

This benefit is payable in addition to the Spouse's Benefit above, if you have a Spouse. Upon the death of an insured Member with a dependent Child or Children, the Policy provides that a total benefit of \$100 a month will be paid for the benefit of the Child or Children. The benefit ceases when there are no surviving unmarried Children under the age of 22. A Child age 18 or over will directly receive their portion of the \$100 per month.

For Children less than 18 years old, the Children's Benefit will be paid to your Spouse provided your Spouse has been designated as Beneficiary, has custody and provides principal support of the Child. If your Spouse dies, or if there is no Spouse appointed as Beneficiary, or if your Spouse does not have custody and does not provide principal support of the Child, the Benefit will be paid to the person or institution appearing, in the Insurer's opinion, to have assumed principal support and custody of that Child.

If the total Children's Benefit is not payable to the Spouse, the Children's Benefit will be divided equally among all Children.

The last Benefit payment for the Children is made on the first of the month in which the last surviving Child:

1. dies, or
2. marries, or
3. no longer satisfies the definition of dependent child.

### **Orphan's Benefit**

The Orphan's Benefit will be paid directly to any Child who is at least 18 years old.

For Orphans less than 18 years old, the Orphan's Benefit will be paid to the person or institution appearing, in the Insurer's opinion, to have assumed principal support and custody of that Orphan.

The Orphan's Benefit will be divided equally among all Orphans.

The last Benefit payment for the Orphans is made on the first of the month in which the last Surviving Orphan:

1. dies, or
2. marries, or
3. no longer satisfies the definition of dependent Child.

### **Waiver Of Premium:**

In the event of the plan Member's Total Disability, the same conditions as set out under "Waiver of Premium" for Group Term Life Insurance will also apply to the Survivor Benefit.

### **BASIC ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE FOR ELIGIBLE ACTIVE MEMBERS UNDER AGE 70**

#### **The Plan:**

You are insured against the perils described in the Loss Schedule. Your protection is world-wide, 24 hours a day, on or off the job. Benefits are payable regardless of any other benefits that you may receive from any insurance company other than the Company, or any other organization.

#### **Definition:**

"The Company" means RBC Life Insurance Company.

#### **Who Is Eligible:**

You are eligible if you are a member of the Policyholder under age 70 who meets the Dollar Bank eligibility rules set by the Trustees.

**Purpose of the Benefit:**

This Benefit provides a lump sum cash payment in the case of accidental death or dismemberment occurring anywhere in the world – 365 days a year – 24 hours per day – on or off the job.

**Principal Sum:**

The Principal Sum is \$35,000.

**Termination:**

All benefits terminate on the earlier of the day you reach age 70 or the day you retire.

**When Is This Plan Effective:**

You are insured from the first of the month following completion of your applicable waiting period. If there is no waiting period, your coverage is effective immediately.

**Loss Schedule:**

If an accident causes a loss payable under this schedule within one year from the date of the accident, the Insurer pays the amount shown. Only one benefit (the larger one) is paid if more than one loss occurs in the same accident.

**For Loss of:**

**Percentage of Principal Sum**

|  |         |
|--|---------|
| Life .....   | 100%    |
| Both Hands or Both Feet.....   | 100%    |
| Sight of Both Eyes .....   | 100%    |
| One Hand and One Foot.....   | 100%    |
| One Hand or Foot and Sight of One Eye .....  | 100%    |
| Speech and Hearing in Both Ears .....  | 100%    |
| One Leg or One Arm.....  | 75%     |
| Either Hand or Foot .....  | 66 2/3% |
| Speech or Hearing in Both Ears .....   | 66 2/3% |
| Sight of One Eye .....   | 66 2/3% |
| Thumb and Index Finger of the Same Hand .....  | 33 1/3% |
| Hearing in One Ear .....   | 16 2/3% |
| All Toes of One Foot.....  | 12 1/2% |
| Quadriplegia<br>(Total and Irreversible Paralysis of All four limbs) .....                                 | 100%    |
| Paraplegia<br>(Total and Irreversible Paralysis of Both lower limbs) ....                                  | 100%    |
| Hemiplegia (Total and Irreversible Paralysis of<br>One arm and one leg on the same side of the body) ..... | 100%    |

**For Loss of Use of:**

|                           |         |
|---------------------------|---------|
| Both Hands or Arms .....  | 100%    |
| One Arm or One Leg.....   | 75%     |
| One Hand or One Foot..... | 66 2/3% |

"Loss" means, with regard to:

**Hands and Feet:**

Actual severance through or above the wrist or ankle joint;

**Eyes:**

Entire and irrecoverable loss of sight;

**Leg or Arm:**

Actual severance through or above the knee or elbow joint;

**Thumb and Index Finger:**

Actual severance through or above the metacarpophalangeal joints;

**Speech and Hearing:**

Entire and irrecoverable loss;

**Toes:**

Actual severance through or above the metatarsophalangeal joints;

**Quadriplegia, Paraplegia, Hemiplegia:**

Complete and irreversible paralysis of such limbs.

“Loss of Use” means: Must be total, irrecoverable and continuous for 12 months, after which the benefit is payable, provided the nerve damage is determined to be permanent.

**Exposure and Disappearance:**

If loss results from unavoidable exposure to the elements and indemnity is otherwise payable hereunder, such loss is payable under the terms of the policy.

If your body is not found within one year after the date of the disappearance, sinking or wrecking of the vehicle in which you are an occupant at the time of the accident and under such circumstances as would otherwise be covered hereunder, it is presumed that you suffered loss of life resulting from bodily injury caused by an accident at the time of such disappearance, sinking or wrecking.

**Waiver Of Premium:**

If you become totally disabled from an accident or sickness and waiver of premium is approved under your applicable Group Life Insurance Plan, premiums under this plan are waived while total disability continues, until the earlier of your attainment of age 65, your eligibility terminates, the policy is terminated or if you fail to provide the Insurer upon request, proof of continued total disability.

**Repatriation:**

If you lose your life as a result of a covered accident occurring at least 100 kilometres from your principal city of residence, the Insurer pays up to \$5,000 for the preparation and transportation of your body back to your principal city of residence.

**Rehabilitation:**

If you receive benefits for a loss described in the Loss Schedule and you require special training to allow you to work in an occupation that you would not have engaged in except for the injuries you sustained, the Insurer will pay for your training, considering the expenses are reasonable and necessary (other than travelling, clothing and ordinary living expenses), up to \$5,000, occurring within two years from the date of the accident.

**Family Transportation:**

If while on a trip, you sustain an injury and as a result, are confined as an in-patient in a Hospital, are under the Regular Care and Attendance of a physician or surgeon and require the personal attendance of a Member of the Immediate Family as recommended by the attending physician or surgeon, the Insurer will pay the expense incurred by the family member for transportation to your bedside by the most direct route by a

licensed common carrier, but not to exceed an amount of \$1,000 as the result of any one accident.

**"Hospital"** means an institution licensed as a hospital, which is open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with twenty-four (24) hour nursing service. Hospital will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home or convalescent hospital.

**"Member of the Immediate Family"** means your spouse or common-law spouse, parents, grandparents, children over age 18, brother or sister.

**"Regular Care and Attendance"** means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

#### **To Whom Benefits Are Paid:**

Your accidental death benefit is paid to the beneficiary designated and in effect at the time of payment, or to your estate if no such designation is made. Any other benefits are paid to you (those described in the Loss Schedule are paid as a percentage of the Principal Sum).

#### **Exclusions:**

The insurance does not cover losses caused in any way from suicide or any suicide attempt; self-inflicted injuries; nuclear war or war between a country of North America and/or the states of the former Soviet Union, China, France or the United Kingdom; full-time active service in the armed forces of any country; travelling as a pilot or crew member of any aircraft or travel in the Policyholder's owned or leased aircraft.

#### **Claim Procedures:**

To make a claim under this plan, written notice of the accident must be given to the Insurer within 30 days of the date of the accident and written proof must be submitted within 90 days of the date of the accident. The Insurer provides the necessary claim forms as well as instructions covering other requirements that may aid in a prompt handling of the claim.

If the Insurer does not receive the required notice and proof of loss, the claim may not be considered after the 90 day period has expired, unless there is good reason for the delay. In no event is a claim considered after one year from the date of the accident if the Insurer was not notified and the necessary forms not completed and submitted to the Insurer.

#### **Disclaimer:**

This booklet is a summary of the principal features of the plan and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Master Policy GSR 13029, underwritten by RBC Life Insurance Company.

#### **DISABILITY INCOME FOR ELIGIBLE ACTIVE MEMBERS**

#### **WEEKLY INDEMNITY BENEFIT FOR ELIGIBLE ACTIVE MEMBERS**

If you are Totally Disabled, unable to work, and under the continuing care of a physician, you may receive a weekly income of \$500.00 per week.

**"Totally Disabled"** means the inability to work at your own occupation, for wages or profit, due to bodily injury or disease and is determined by the Plan's Insurer.

Your weekly benefit will be reduced by any income you are eligible to receive from the following sources:

1. Any plan of automobile insurance providing income replacement indemnity, which has been approved as an acceptable limitation by the Human Resources and Development Commission; and
2. Earnings or payments from any Employer; and
3. Earnings recovered through a legally enforceable cause of action against some other person or corporation (in accordance with provisions under Third Party Liability).

#### **Commencement Of Benefits:**

Your Benefits will commence on the earlier of:

1. The 8th day of a Disability caused by sickness.
2. The 1st day of a Disability due to an accident.

#### **Integration with Employment Insurance (EI) Sickness Benefits:**

Weekly Indemnity Benefits are integrated with the Sickness Benefit under Employment Insurance (EI). EI Sickness Benefits are paid after two weeks of disability (the waiting period) and are paid to a maximum of 15 weeks. The Plan will pay benefits during the EI waiting period and will resume payments when EI Sickness Benefits have ceased, providing that you are still Totally Disabled.

If you qualify for Sickness Benefits under EI but are not eligible to receive the full 15 weeks, or if you do not qualify for EI sickness benefits but are Totally Disabled, the Plan will pay you Benefits as long as you remain disabled, for a maximum disability period of 52 weeks.

If you become Totally Disabled, you must immediately apply for EI Sickness Benefits. At the same time, apply for your Weekly Indemnity Benefit from this Plan. If you are denied EI Sickness Benefits, or do not receive the full 15 weeks of benefit, notify the Administrator and send the Administrator a copy of the Letter of Denial and/or your final payment notice from EI.

You must apply for Weekly Indemnity Benefits within 90 days of the commencement of your disability. If you are still Totally Disabled when your Weekly Indemnity Benefit ceases, you may apply for Long Term Disability Benefits.

#### **Maximum Benefit Period:**

During any one period of Disability, your Weekly Indemnity (WI) Benefits will continue until you recover, or have received a combined maximum of 52 weeks of payments from EI and WI, whichever is earlier.

#### **Cessation Of Benefit Payments:**

Your Weekly Indemnity Benefit Payments will cease on the earliest of the following events:

1. The date you are no longer Totally Disabled; or
2. The date you have received Weekly Indemnity Benefit payments for 52 weeks; or
3. The date you retire; or
4. The date you fail to undergo, when requested by the Insurer, medical, psychiatric, psychological, educational and/or vocational examinations by examiners selected by the Insurer; or

5. The date you refuse to complete and return a Reimbursement Agreement or Direction Form or comply with the terms of a signed Reimbursement Agreement or Direction Form, when requested, in accordance with the provisions under Third Party Liability; or
6. The date you die.

In addition, Weekly Indemnity Benefits will not be payable for:

1. A disability for which you are entitled to benefits under the Workplace Safety and Insurance Board or other Workers' Compensation plan. You must always report such an injury to the Union Office. The Union Office will advise you as to other reports that you need to complete;
2. Any time when you are on vacation and receiving pay;
3. For any disability resulting from intentionally self-inflicted injuries, whether you are sane or insane;
4. For any disability resulting from voluntary participation in war, riot or insurrection;
5. For the portion of a period of disability during which you are (a) imprisoned in a penal institution; or (b) confined in a hospital, or similar institution, as a result of criminal proceedings;
6. During any leave of absence (including maternity leave);
7. For a disability which commences on or after the date a strike begins while the strike is in progress, subject to any provincial Employment or Labour Standards Act; however, you may fulfill your Qualifying Disability Period starting on the date of disability.

8. Cosmetic surgery or treatment, when so classified by the Insurer, unless such surgery or treatment is for a non-occupational accidental injury and commenced within 90 days of an accident.

### **Third Party Liability:**

If you have a cause of action against a third party for income lost as a result of your Disability, the Weekly Indemnity Benefit will be payable as specified. However, prior to the commencement of payments, you will be required to complete a Reimbursement Agreement/Direction Form, agreeing to reimburse the Insurer. The amount to be reimbursed will not exceed the amount of Benefits paid by the Insurer.

Full details concerning terms and calculation of reimbursement are set out in the Agreement.

### **Recurrent Disabilities:**

Once you have been Totally Disabled and have received Benefits under this Plan, a later disability will be defined as recurrent when it is separated from the previous disability by less than two weeks of full-time active employment.

A disability will be considered to be recurrent if it results from an injury or sickness which is directly related to the causes of the immediately preceding disability.

If any period of disability is classified as "recurrent", it will be treated as a continuation of the previous disability. You will not have to re-satisfy any qualifying periods which may apply. Payments will continue for the remainder of the Maximum Benefit Period.

## LONG TERM DISABILITY BENEFIT FOR ELIGIBLE ACTIVE MEMBERS UNDER AGE 65

The Long Term Disability Benefit helps to provide income security should you become Totally Disabled and remain so over a long period of time. In order to receive this Benefit you must remain under the continuing care of a Physician.

Your Benefit will be \$2,000 per month.

This amount will be reduced by other income you may be entitled to receive from all of the following sources:

1. Disability Benefits payable under the Canada/Quebec Pension Plan (CPP/QPP), excluding benefits payable on behalf of your Dependants.
2. Earnings or payments from any Employer.
3. Disability Benefits payable under any other group, association or franchise insurance plan.
4. Disability and income replacement benefits payable under any government plan (excluding Employment Insurance Benefits).
5. Benefits payable under the Workplace Safety and Insurance Board Act or any Workers' Compensation Act.
6. Retirement or Pension Benefits provided by an Employer, Union and/or a government.
7. Income replacement indemnity payable under any plan of automobile insurance.

8. Earnings recovered through a legally enforceable cause of action against some other person or corporation (in accordance with provisions under Third Party Liability).

The Long Term Disability Benefit will be further reduced by any amount by which such Benefit, plus the income from all sources just outlined (including Canada/Quebec Pension Plan Benefits payable to you on behalf of Dependants), exceeds 80% of your gross pre-disability earnings.

The amount of Benefit payable by the Insurer will not be affected by changes in your Canada or Quebec Pension Plan benefit unless the changes result from:

1. A correction due to an error made when your award was originally determined.
2. A change of 10% or more in the benefit formula under the government plan.

### Public Pension Plans:

Your Monthly Benefit will not be reduced by disability benefits payable under a public pension plan (CPP/QPP) until actual determination of the award has been made, if at the time you submit your Long Term Disability Claim, you sign an agreement to reimburse the Insurer.

Otherwise, CPP/QPP benefits which have not been determined by the time your Benefit is payable will be estimated and deducted from your Monthly Long Term Disability Benefit. Adjustments to correct such payments will be made after the award has been determined.

### **Third Party Liability:**

If you have a cause of action against a Third Party for income lost as a result of your Disability, the Long Term Disability Benefit will be payable as specified. However, prior to the commencement of payments, you will be required to complete a Reimbursement Agreement/Direction Form, agreeing to reimburse the Insurer. The amount to be reimbursed will not exceed the amount of Benefits paid by the Insurer.

Full details concerning terms and calculation of reimbursement are set out in the Agreement.

### **Commencement Of Benefits:**

Benefits begin after a qualifying period of 52 weeks of continuous Total Disability, provided Proof of Disability is submitted within 6 months following the qualifying period. While receiving Benefits, further proof of Total Disability may be required.

### **Cessation Of Benefit Payments:**

Your Monthly Long Term Disability Payments will cease on the earliest of the following events:

1. The date you are no longer Totally Disabled; or
2. The date you reach Age 65. However, should you complete the 52 week qualifying period after your 64th birthday but prior to your 65th birthday, a total of 12 monthly payments will be made.
3. For any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for

any portion of a period of disability during which you do not participate in the treatment program recommended by said physician.

4. The date you fail to undergo medical, psychiatric or psychological treatment or participate in a rehabilitation program for alcoholism, drug addiction or substance abuse treatment program when recommended by the Insurer.
5. The date you are incarcerated in a prison or mental institution by authority of a criminal court.
6. The date you refuse to complete and return a Reimbursement Agreement/Direction Form or comply with the terms of a signed Reimbursement Agreement/Direction Form, when requested, in accordance with the provisions under Third Party Liability.
7. For any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;
8. For any disability resulting from participation in the commission of a criminal offence;
9. For a disability which commences on or after the date a strike begins while the strike is in progress, subject to any provincial Employment or Labour Standards Act; however, you may fulfill your Qualifying Disability Period starting on the date of disability;
10. For any period of disability during which you fail to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending physician or on the advice of independent medical opinion.

11. The date you die.

### Definition of “Totally Disabled”:

“Totally Disabled” means you are wholly and continuously disabled due to illness or bodily injury and, as a result, you are not physically or mentally fit to perform the essential duties of your normal occupation during the qualifying period and the succeeding 24 months. After this time, you will still be considered Totally Disabled provided you are unable to perform the essential duties of your normal occupation and any other occupation:

1. For which you are, or may become suited, by education, training and/or experience. If you must hold a government permit or license to perform your duties you will not be considered Totally Disabled solely because such permit or license has been withdrawn or not renewed.
2. For which the current monthly earnings are 75% or more of the current monthly earnings for your normal occupation.

Confinement is not normally required. However, you must be under the regular care of a Physician, and be prepared to attempt rehabilitative employment, or participate in a rehabilitation program considered appropriate by the Insurer.

### Rehabilitation:

Long Term Disability Benefits are designed to be paid during periods when you are disabled and cannot work. Often however, there will be a time when, although you are not yet fully recovered, you can work at some type of job and possibly earn an income.

Therefore, you will be encouraged to participate in a rehabilitation program developed by the Insurer's Rehabilitation Counsellors in consultation with your Physician and Employer.

In order to participate in a rehabilitation program not developed by the Insurer, the program must be approved by the Insurer.

Income from employment is normally used to reduce Long Term Disability Benefits. In the case of Rehabilitation, for a maximum of 24 months, only half of these earnings will be used to reduce your Long Term Disability payments.

**Note:** If at any time, the income you receive from rehabilitation employment equals 75% or more of the current monthly earnings of your normal occupation, your Long Term Disability Benefit payments will cease. Otherwise, while in rehabilitation your income from all sources cannot be greater than 100% of your gross earnings prior to your disability.

### Waiver Of Premium:

Premiums are due and payable during the 52 week Qualifying Period. However, once the Qualifying Period has been satisfied, Premiums falling due will be waived while you are receiving Long Term Disability Benefits, or would be receiving a Benefit were it not for the offsets described above.

### Recurrent Disabilities:

If you cease to be Totally Disabled at any time during the Qualifying Period and become Totally Disabled again, due to the same cause, within two weeks, the Qualifying Period will be extended by the number of days during which you cease to be Totally Disabled.

Once you have been Totally Disabled and have received Benefits under this Plan, a later disability will be defined as recurrent when it is separated from the previous one by less than six months of full-time employment.

A disability will be considered to be recurrent if it results from an injury or sickness which is directly related to the causes of the immediately preceding disability.

Once you are receiving Long Term Disability Benefits, any period of disability which is classified as "recurrent" will be treated as a continuation of the previous disability. You will not have to re-satisfy the 52 week Qualifying Period, and Benefits will begin again immediately.

#### **Disability Income - Exceptions And Limitations:**

Disability Income is not payable for the following:

1. A Disability caused by self-inflicted injuries or illness.
2. A Disability resulting from insurrection, war, service in the armed forces of any country, or participation in a riot.

Complications due to pregnancy are covered. However, any disability due to any cause will not be eligible for Benefits at any time when you are on pregnancy leave of absence or could be placed on such leave by your Employer in accordance with relevant government legislation or the leave agreed upon by you and your Employer.

## **HEALTH CARE BENEFITS FOR ELIGIBLE MEMBERS AND DEPENDANTS**

### **Payment of Benefits:**

This Benefit pays 100% of all Eligible Expenses which are in excess of the Deductible. The Annual Maximum for each Covered Person is \$50,000. The Annual Maximum does not apply to the Emergency Travel Assistance Benefits for Active Members and their Dependants.

All Referral Expenses incurred outside Canada are subject to a Lifetime Maximum of \$1,000,000 per Covered Person.

Early retirees and their dependants will not be eligible for Emergency Travel Assistance. Pensioners and their Dependants will not be eligible for Paramedical, Convalescent Care, Chronic Care, Vision Care and Outside Canada Coverage, Orthotics, nor Emergency Travel Assistance. Please refer to Parts III and IV of this Booklet.

### **Deductible:**

There is a \$10 Deductible, applied to each Covered Person once each Calendar Year, to the Eligible Expenses incurred during that year. The maximum Deductible per Family per year is \$20. Any Family Member can contribute any amount toward satisfying the Family Deductible.

"Deductible" means the amount of out-of-pocket Expenses for which you are responsible, prior to consideration of payment of Benefits.

In the case of a common accident which involves at least 2 Members of your Family, covered under the same certificate, only the Individual Deductible will be applied (once each Calendar Year) to all Eligible Expenses in connection with the accident.

## MAJOR MEDICAL BENEFIT FOR ELIGIBLE MEMBERS AND COVERED DEPENDANTS

### Eligible Expenses:

Eligible Expenses must be reasonable and customary and (except for Expense #1) recommended as medically necessary by a Physician. Payment will be based on reasonable and customary charges in the area in which treatment is rendered.

The following is a list of the items currently eligible for payment under the Group Plan. However, should your Provincial Health Plan include any of these items, coverage under this Plan will automatically adjust in accordance with the approved legislation.

1. Professional services of the following licensed, certified or registered Paramedical Practitioners (when operating within their recognized fields) up to a total payment of \$500 per year per Person, for all Practitioners combined:

Physiotherapist, Psychologist, Podiatrist, Chiropractor, Osteopath, and Speech Therapist.

**Note:** The services of a Physiotherapist require the written prescription of a Medical Doctor. The Plan does not cover Physiotherapy required as a result of a motor vehicle accident.

Benefits are not payable until the provincial health plan has paid its Yearly Maximum. Check with the Administration Office if you require further details.

This expense is not available to Pensioners nor their Covered Dependants.

2. Diagnostic procedures, including Prostate Specific Antigen (PSA) tests, radiology, blood transfusions and oxygen (including the equipment necessary for its administration).
3. Services of a Registered Nurse (R.N.), while the patient is not confined to a hospital, provided the services are certified as medically necessary and ordered by a Physician.

If an R.N. is not available when needed, medically required nursing services of a Registered Nursing Assistant or a Licensed Practical Nurse will be eligible. However, any such nurse must not ordinarily reside in the Patient's home. Services of a nurse who is the Spouse, Child, brother, sister, or parent of the Member or the Member's Spouse, will not be covered.

4. Transportation by a licensed ground ambulance to and from the nearest medical facility for immediate treatment.
5. If medically necessary and approved by the Insurer in advance, transportation by any form of licensed ambulance (including air ambulance) or any vehicle used for public transportation :

a) transfer to the nearest appropriate medical facility or hospital for necessary treatment, and/or;

b) medical evacuation for admission to Hospital in the Province where the patient normally resides.

Ground transportation to and from the Hospital and airport at the point of departure and arrival is also eligible, if approved by the Insurer, in advance.

6. Necessary dental treatment required as a result of an accidental injury to natural teeth. Dental treatment must be completed within 6 months of the accident, and your coverage, as well as the Policy, must still be in force. Payment will be made based on the least expensive procedure which will provide a professionally adequate result.
7. Purchase of trusses, braces, crutches and artificial limbs or eyes.
8. Orthopaedic shoes which are attached to and form part of a brace. If the shoes are not part of a brace, two pairs are eligible annually. Maximum of \$400 per calendar year. To qualify, the shoes must be custom made, prescribed by a Physician, Podiatrist or Chiropodist, supported by a statement of diagnosis, related symptoms and physical findings, as well as a description of the abnormal walking pattern associated with the medical condition, and dispensed by a certified Podiatrist, Chiropodist, Pedorthist, Orthotist or Physician.
9. Elastic support stockings, up to \$25 per Calendar Year.
10. Custom made orthotics. One pair per Calendar Year, to a maximum of \$400. To qualify, orthotics are subject to the same requirements that apply to Orthopaedic shoes, as described in #8 above.
11. Rental, or at the Insurer's option, purchase of a wheelchair, hospital bed or respirator/ ventilator.
12. Room, board and normal nursing care provided in a licensed nursing home or clinic (for convalescent or chronic care, but excluding custodial care), up to \$20 per day. This expense is not available to Pensioners nor their Covered Dependants.

13. Hospital charges incurred as an out-patient for necessary medical or surgical treatment (excluding Physicians' fees, and special nurses' fees).
14. Semi-Private hospital room.
15. Professional services of a Physician (where this coverage is permitted by law).
16. Diabetic Supplies, (insulin, needles, syringes) including glucometers; Diabetic pumps (require the prior approval of the Insurer.)
17. Hearing Aids to a maximum of \$500.00 in 60 consecutive months.

**VISION CARE BENEFIT FOR ELIGIBLE ACTIVE MEMBERS, EARLY RETIREES AND COVERED DEPENDANTS (Not Subject to the Deductible)**

18. Frames, lenses and the fitting of prescription glasses, including prescription sunglasses, up to an overall Maximum of \$225 per person in any 24 consecutive months.

Vision care expenses are eligible when recommended by a Physician (including an ophthalmologist) or an optometrist.

19. Expenses for eye examinations are limited to a maximum benefit of \$50 per person in any period of 24 consecutive months.

## OUTSIDE CANADA AND OUTSIDE PROVINCE COVERAGE FOR ELIGIBLE ACTIVE MEMBERS AND DEPENDANTS

### Outside Canada Emergency

Active Members and their Dependants are eligible for the Emergency Travel Assistance benefits described in the next section. In the event of an emergency, if you are eligible for Emergency Travel Assistance benefits, you must immediately call the applicable Mondial Assistance (formerly known as World Access Canada Inc.) phone number set out under “Claims Procedures”. In the event of a medical emergency, if you are not eligible for Emergency Travel Assistance benefits the Claims Payment Administrator will provide information on how to submit claims.

The following items will be considered to be eligible expenses:

#### 20. In-patient Hospital charges for the following:

- a) the difference between the room and board benefit payable by the Provincial Hospital Plan and the actual cost of ward accommodation, and
- b) medically necessary hospital services and supplies furnished during Hospital confinement.

#### 21. Hospital charges for medical and surgical treatment incurred by a person on an out-patient basis.

#### 22. Physician's charges for professional services.

### Outside Canada Referral

Only insured individuals under age 65 are eligible and expenses are limited to a \$1,000,000 lifetime maximum.

Referrals must be made by a physician to a hospital outside Canada for medically necessary treatment which is not available in Canada and for which there is no medically sufficient alternative treatment available in the insured's Province of Residence. The expenses must be eligible under a provincial medical plan. Expenses paid are in excess of any provincial plan allowance based on reasonable and customary charges.

### Out of Province Referral (Inside Canada)

Referral must be made by a physician to a hospital outside the insured's Province of Residence for medically necessary treatment which is not available in the insured's province of residence where there is not medically sufficient alternative treatment available in the insured's Province of Residence, and which is eligible in whole or in part by a provincial medical plan. Expenses paid are in excess of any provincial plan allowance based on reasonable and customary charges.

Expenses for Out of Province Referral are not subject to a maximum.

## OUTSIDE CANADA AND OUTSIDE PROVINCE COVERAGE FOR ELIGIBLE EARLY RETIREES AND DEPENDANTS:

### Outside Canada Expenses

Only insured individuals under age 65 are eligible for the charges listed below and expenses are limited to a \$1,000,000 lifetime maximum.

**Note:** Coverage is limited to a period of 60 days from the date the insured leaves the Province of Residence.

If, while travelling outside Canada, hospitalization or medical treatment is required due to emergency and non-elective

reasons, expenses in excess of any provincial government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by a provincial medical plan. Expenses paid are in excess of any provincial plan allowance based on reasonable and customary charges.

If an insured is referred by a physician to a hospital outside Canada for medically necessary treatment which is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada, and which is eligible for reimbursement in whole or in part by any provincial medical plan. Expenses paid are in excess of any provincial plan allowance based on reasonable and customary charges

#### **Out of Province Expenses (Inside Canada)**

If, while travelling outside the insured's Province of Residence but inside Canada, hospitalization or medical treatment is required due to emergency and non-elective reasons, expenses in excess of any government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by a provincial medical plan. Expenses paid are in excess of any provincial plan allowance based on reasonable and customary charges.

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

#### **FOR ACTIVE MEMBERS, EARLY RETIREES AND ELIGIBLE DEPENDANTS:**

Expenses Incurred outside Canada (for both emergency and non-emergency treatment) will be considered for reimbursement in the same manner as those incurred in Canada as described under "Eligible Expenses" for the following items:

- Health Care Facilities (room and board in excess of ward accommodation)
- Medical Transportation Services
- Medical Supplies and Services
- Dental Services
- Professional Services (other than Physicians' Services)
- Vision Care.

#### **EMERGENCY TRAVEL ASSISTANCE FOR ELIGIBLE ACTIVE MEMBERS AND DEPENDANTS**

The Insurer has arranged for Emergency Travel Assistance to be administered by Mondial Assistance (formerly known as World Access Canada Inc.), an international company specializing in travel assistance through a world-wide network of professionals.

Mondial Assistance Access will, in good faith, make every effort to provide the following services for you or your Covered Dependant in an emergency which arises while traveling (but not working) while outside your normal Province of Residence.

In all cases, if you require emergency assistance out of Canada, you must call the numbers for Mondial Assistance set out under "Claims Procedures" later in this section of the Booklet. Mondial Assistance, the Insurer's administrator for this Benefit, will assist you.

**Note:** Coverage is limited to a period of 60 days from the date the insured leaves the Province of Residence.

## **EMERGENCY MEDICAL ASSISTANCE FOR ELIGIBLE ACTIVE MEMBERS AND DEPENDANTS**

In the event of an emergency which occurs while a Claimant is traveling, vacationing or otherwise temporarily residing outside Canada, the following items will be considered as Eligible Expenses, in addition to those set out under “Outside Canada Emergency” earlier in this Booklet:

### **24 Hour Access:**

Multilingual assistance by telephone (call collect hotline), telex and facsimile services.

### **Medical Referral:**

Referral service to local Physician, Dentist, Pharmacist or appropriate medical facility.

### **Medical Care Monitoring:**

If hospitalized, the care and services rendered to the Patient will be monitored by Mondial Assistance medical staff who will maintain contact, as frequently as necessary, with the Patient, the attending Physician, the Patient's personal Physician and Family.

### **Emergency Transportation:**

Emergency transportation to the nearest appropriate medical care facility and if medically necessary from the medical care facility to a hospital in Canada. Upon written recommendation of a physician, such charges shall include a medical attendant

if necessary who is neither a resident in the member's home nor a relative of the member or the member's spouse.

### **Hospital/Medical Payment Service:**

Payment of local Hospital charges, medical transportation charges and medical fees when a deposit or payment in full for services rendered is required will be arranged and/or co-ordinated on behalf of the Patient. The coverage that such Person is entitled to under any government plan of insurance and Eligible Expenses under this Plan will be taken into account.

If such payments are subsequently determined to be in excess of the amount of Benefits to which the patient is entitled under this Plan, the Insurer shall have the right to recover the excess amount by assignment of government plan benefits and/or by refund from you.

For services requiring payment of \$200 or less, please make payment and keep the receipts. Your government health plan and the Insurer will reimburse you for the Eligible Expenses upon your return.

### **Return of Dependant Children:**

If Dependant Children are left unattended while traveling with you or your Spouse when one of you is hospitalized for medical reasons, one-way economy transportation will be arranged and the extra cost over and above any allowance available under prepaid travel arrangements will be paid for the return of such Children. The most direct route to their normal place of Residence in Canada will be used.

If necessary, round-trip economy transportation will also be arranged and paid for a qualified escort to accompany the Children.

### **Visit of a Family Member:**

If while traveling alone, you or one of your Dependants should become hospitalized outside your normal Province of Residence and the expected period of hospitalization is more than 7 days, round-trip economy transportation by the most direct route to the Hospital will be arranged and paid for one Member of the immediate Family (a Spouse, Parent, Child, brother or sister, or a person who normally resides with you).

Similarly if you or one of your dependents should die round trip economy transportation will be arranged and paid for one member of the immediate family, if necessary, to identify the deceased prior to release of the body.

### **Trip Interruption/Delay:**

If a trip is interrupted or delayed due to hospitalization of a Covered Person outside the normal Province of Residence, one-way economy transportation will be arranged and the extra cost over and above any allowance available under pre-paid travel arrangements will be paid to enable each Covered Person to rejoin the trip or return home by the most direct route.

### **Vehicle Return:**

If a covered person is unable to operate their owned or rented vehicle due to sickness, injury or death while traveling outside their normal Province of Residence, arrangement and payment up to a maximum of \$4,500 (Canadian) will be made for return of the vehicle to their normal place of residence or nearest appropriate rental agency.

### **Accommodation and Meals:**

Under these circumstances, reimbursement will be made for the cost of commercial accommodation and meals, subject to a maximum benefit of \$150.00 (Canadian) per person per day to a maximum benefit of \$300.00 per day for 7 days.

### **NON-MEDICAL ASSISTANCE FOR ELIGIBLE ACTIVE MEMBERS AND DEPENDANTS**

#### **Repatriation:**

If you or one of your Covered Dependants should die while traveling outside your normal Province of Residence, all necessary authorizations will be obtained and arrangements will be made for repatriation of the deceased's body.

The costs of preparation and transportation of the body to the first resting place (including but not restricted to a funeral home or the place of interment) in proximity to the deceased's normal place of Residence will be paid, subject to a Maximum Payment of \$3,000 (Canadian).

This Benefit does not cover the cost of a burial coffin.

#### **Lost Document and Ticket Replacement:**

In the event of theft or loss, assistance in the replacement of the necessary tickets and/or travel documents.

#### **Legal Referral:**

Referral service to a local legal advisor and assistance in arranging for a cash advance from funds available from personal credit cards, or Family and friends to post bail and pay legal fees.

## Telephone Interpretation Services:

In an emergency, telephone interpretation services in most major languages.

## Message Service:

A telephone message service will be provided through the Mondial Assistance operations centre for messages to/from Family, friends or business associates which may be left by/for you or one of your Dependants, while traveling. The centre will hold messages for 15 days.

Expenses for Emergency Travel Assistance are not subject to a maximum.

## CLAIMS PROCEDURES

For Emergency Travel Assistance, proof of claim for reimbursement of any expenses must be submitted to Mondial Assistance. For details, refer to the Administration Office.

In an Emergency Contact Mondial Assistance:

Canada and the United States, call toll free  
1-877-252-9857

Elsewhere, call collect  
1-519-742-8073 or fax 1-519-742-2581

**Carry your Mondial Assistance (formerly known as World Access Canada Inc.) Card with you when you are traveling.**

## Exceptions and Limitations:

Emergency Travel Assistance Coverage is limited to a maximum period of 60 days beginning with the first day of a trip provided you and your Dependants remain Canadian Residents and continue to be covered by a provincial government health plan. However, any Covered Person who is in Hospital on the 60th day shall continue beyond such limit until discharged from Hospital.

No Coverage is provided for charges or services resulting from:

1. Travel for health reasons or referral treatment outside Canada, whether or not such travel is recommended by a Physician.
2. Confinement in a chronic care or psychiatric Hospital, or a nursing home, home for the aged or health spa.

Neither the Insurer nor Mondial Assistance shall be liable in any manner whatsoever, if conditions, events or factors beyond their control delay, interfere with or prevent the provision of any service.

Furthermore, neither the Insurer nor Mondial Assistance is responsible for the availability, quality or results of any medical treatment received by you or one of your Dependants, or the failure to receive medical treatment or services for any reason.

Services are not provided in Afghanistan, Burma, El Salvador, Iran, Iraq, Cambodia, Laos, Libya, Nicaragua, North Korea, South Yemen, Vietnam and such other countries as Mondial Assistance may designate from time-to-time. Please call before you travel to ensure you are covered by the Plan and that you can access Mondial Assistance.

## **PAY DIRECT DRUG PLAN FOR ELIGIBLE ACTIVE MEMBERS, EARLY RETIREES, PENSIONERS AND COVERED DEPENDANTS**

### **YOU AND YOUR CLAIMSECURE PLAN**

As a Member of the ClaimSecure system of pay-direct plans, you are entitled to the following:

1. A drug program which incorporates product selection (generic substitution) for all legally substitutable drugs, which by law or convention require a Physician's or dentist's prescription.
2. Insulin supplies (i.e. needles, syringes and diagnostic tests), but excludes swabs, lancets and rubbing alcohol.
3. All injectables including serums, vaccines and injectable vitamins. (Excluding DIN 933336, Vitamin B6/B12 Dr. Bernstein's Diet)
4. Extemporaneous compounds prepared by a pharmacist.

#### **Exclusions:**

Any drug or medication which may be purchased without a prescription. This further excludes over-the-counter (OTC) products whether prescribed or not.

As a further guide, the ClaimSecure Plan excludes in part:

- Vitamins (except injectable vitamins)
- Patented Medicines and G.P. Products
- first aid and surgical supplies
- atomizers, vaporizers
- salt and sugar substitutes
- infant formula, dietary foods and aids

- contact lens care products
- diagnostic aids and laboratory tests (these are revealed under the Major Medical Benefit)
- contraceptives other than oral
- lozenges, mouthwash, toothpastes and cosmetics
- non-medicated shampoos, skin cleaners, skin protectors, emollients and soaps
- any benefit provided by a government plan.

#### **Generic Drugs:**

Product selection means your pharmacist will fill your prescription, where available, with an approved generic drug. Generic drugs contain the same amounts of the same active ingredients in the same dosage form as that directed by your prescription and must meet government standards for quality including effectiveness, potency, purity and safety. The Generic Program enables you to obtain prescribed drug products of quality at a reasonable cost

#### **How The Plan Works:**

The ClaimSecure card is recognized and accepted by pharmacies across Canada. To fill a prescription, present the Physician's prescription, along with your identification card, to the pharmacist. The Plan will pay the Pharmacist \$5.00 towards the Pharmacy's Dispensing Fee. You are required to pay the portion of the Dispensing Fee over \$5.00 plus 10% of the ingredient cost of your Prescription Drug.

#### **Where There Is No ClaimSecure Pharmacist In The Area:**

There may be certain circumstances where you are required to pay for the cost of your prescription. In such circumstances, it will be necessary for you to keep the receipt for the total amount paid and submit a claim for reimbursement. Claims

forms are available from your Administrator or from the ClaimSecure website ([www.claimsecure.com](http://www.claimsecure.com)). Attach all original receipts and send them to ClaimSecure at the address shown on your form. ClaimSecure will promptly process your claim and issue payment to you in accordance with terms of your plan.

### **Maternity Expenses:**

Expenses incurred due to pregnancy will be considered in the same manner as expenses incurred due to any other condition.

## **CLAIMSECURE MANAGED FORMULARY**

### **Plan Definition – Plan 7 (Brand Plan) or 7G (Generic Plan)**

This formulary will include most drugs, requiring a prescription by law, that were launched in Canada prior March 1, 2002, with the exception of the following:

- Smoking cessation drugs
- Fertility drugs
- Hair growth or hair inhibitory drugs (i.e. Propecia, Minoxidil, Vaniqa)
- Preventative Vaccines
- Anti-obesity drugs
- Anabolic steroids
- Sexual function medications (including erectile dysfunction drugs)
- Lancets

All new drugs launched in Canada after March 1, 2002 will be evaluated using the following criteria:

Drugs eligible for inclusion in the formulary:

- Generic version of a brand-name drug that is currently covered under the formulary

- Drugs that have similar efficacy and safety profiles and are equal or lower in cost compared to drugs currently covered under the formulary

Drugs eligible through special authorization:

- Drugs that have better efficacy and/or safety profiles, although their costs may be significantly higher compared to existing therapies covered under the formulary
- Drugs that are used for disease conditions that have no existing therapy and may have the potential for widespread use outside their approved indications

Drugs not eligible for inclusion in the formulary:

- Drugs administered in a hospital
- Drugs that are more expensive and do not have either better or similar safety and efficacy profiles compared to drugs currently covered under the formulary

## **SPECIAL AUTHORIZATION PROGRAM AND PROCEDURES**

ClaimSecure has developed this service, which is similar to the Pre-determination service under the Dental Plan, to ensure that certain drugs or categories of drugs are being prescribed appropriately and the Plan is not paying for expensive drugs when equally effective less expensive drugs are available.

Under the Special Authorization Program, the first purchase of a Special Authorization drug by a covered Member or dependant will be rejected at the point of purchase, and the pharmacy will receive an on-line real-time message indicating that the drug “requires Special Authorization”. This does not mean the drug will not be covered, but rather that the Member must follow the Special Authorization Procedures in order to have the drug approved for payment in the future.

### **Example Drugs Listed under the Special Authorization Program:**

- Erectile Dysfunction drugs (e.g. Viagra, Cialis);
- Drugs used for multiple purposes (e.g. Botox);
- Anti-obesity drugs (e.g. Meridia, Xenical);
- Enbrel, Remicade, Kineret, Pegatron.

### **Drugs That May Be Included in the Special Authorization Program:**

- Drugs that are used for disease conditions that have no existing therapy and may have potential for widespread use outside of their approved indications;
- Drugs that have better efficacy and/or safety profiles, although their costs may be significantly higher compared to existing therapies covered under the Plan;
- Drugs that have special provincial government coverage available in some circumstances.

### **Special Authorization Procedure:**

The Plan Member obtains a Special Authorization Request Form by calling ClaimSecure's toll-free number 1-877-479-3784 (1-877-4RX-DRUG) or by going to ClaimSecure's Internet website, [http://www.claimsecure.com/en/forms\\_member.asp](http://www.claimsecure.com/en/forms_member.asp) - Special. The Plan Member must submit the appropriate Special Authorization Request Form to his/her physician to have it completed. It is then forwarded, either by mail or by fax (1-866-466-1366) to ClaimSecure Clinical Services Department, along with any other relevant documentation. ClaimSecure will evaluate and determine the request for approval or rejection. ClaimSecure will inform the patient in writing whether the application has been approved or rejected, via mail within 10 business days from the date of receipt of the completed Form and supporting documentation.

### **Special Authorization Services:**

Special authorization application(s)/request(s) will be evaluated to determine if applicant(s) meets the clinical criteria for the requested drug. If additional information is required for the evaluation(s), ClaimSecure will contact the prescribing physician(s) directly or inform the patient(s) in writing via regular mail. If an application has been approved, authorizations will be entered into ClaimSecure's system to permit subsequent automatic electronic adjudications.

### **DENTAL BENEFIT FOR ELIGIBLE ACTIVE MEMBERS, EARLY RETIREES AND COVERED DEPENDANTS**

The Dental Benefit will reimburse you for all eligible expenses up to a maximum of \$1,500 per covered person, per Calendar Year.

### **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.

In order for you and your Dentist to learn in advance how much the Plan will pay and how much you will have to pay, it is recommended that a Treatment Plan be filed with the Claims Administrator. This should be done when the total cost of the proposed dental work is expected to exceed \$500. The Claims Administrator will identify coverage and limitations for specific services and will also clarify the insured percentage and specified limits and the Dental Fee Guide allowance, before treatment commences.

## Eligible Expenses:

Eligible expenses are those which are recommended as necessary by a Physician or Dentist, and are not in excess of the 2008 Ontario Dental Association Suggested Fee Guide, General Practitioners or the minimum fee specified in the Denturist Fee Guide used in 2008, in the Province of Ontario.

Dental treatments are considered eligible if performed by a Dentist or Denturist who practices within the scope of his or her license.

Several dental procedures are covered by Provincial Health Plans up to certain maximums. If the Dentist or Dental Surgeon chooses to charge more than the amount payable by the Provincial Plan, legislation in some Provinces does not permit the excess charges to be eligible under this Plan.

Situations may arise where alternate methods of treatment may be available. It is solely up to you and your dentist to decide which method will be used. As the basis for determining the amount to be paid, the Insurer reserves the right to pay for the least expensive method of treatment that will provide a professionally adequate result.

Only those treatments listed below are eligible:

1. The following services will be eligible for payment:
  - a) Oral examinations – once every six months. Initial or complete oral examinations are allowed once in every 24 months.
  - b) Preventive recall packages – once every six months.
2. Bite-wing x-rays, once every 12 months.

3. One unit of Prophylaxis (light scaling) and one unit of polishing, per 12 month period. One topical application of an anti-carcinogenic agent is covered every 12 month period. One unit is equal to 15 minutes of time.
4. Full mouth series of x-rays, once every 24 months.
5. Simple alveolectomy (incision into tooth socket) at time of tooth extraction.
6. Surgical extractions, including extractions of impacted teeth.
7. Surgical removal of tumors, cysts, neoplasms, plus the incision and drainage of an abscess.
8. Amalgam, silicate, acrylic and composite fillings.
9. Provision of space maintainers for missing primary teeth, and provision of habit breaking appliances for dependent children only.
10. Study casts are covered once per calendar year;
11. Diagnostic x-ray and laboratory procedures required in relation in dental surgery.
12. General anaesthetic required in relation to dental surgery.
13. Consultation required by the attending dentist.
14. Relining, rebasing or the repair of an existing denture or existing bridge.
15. Endodontic Treatment (i.e. the treatment of diseases of the dental pulp including root canal therapy).

16. Periodontic Treatment (i.e. the treatment of the tissues and bones supporting the teeth including surgery, provisional splinting, occlusal equilibration not exceeding 8 units of time per calendar year, and periodontal scaling/root planing not exceeding 16 units of time per calendar year).

17. Crowns and repair of crowns only.

### **HEALTH, EMERGENCY TRAVEL ASSISTANCE, AND DENTAL CARE EXPENSES NOT COVERED**

No payment will be made for expenses resulting from:

1. Intentionally self-inflicted injuries or illness while sane or insane.
2. Any injury or illness for which the insured person is entitled to indemnity or compensation under the Workplace Safety and Insurance Board or any Workers' Compensation Act.
3. Charges levied by a physician or dentist for time spent traveling, broken appointments, transportation costs, from rental charges or for advice given by telephone or other means of telecommunication.
4. Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot.
5. Services, treatments or supplies, eligible under this Plan and payable under any provincial health care plan, whether or not the claimant is covered under such a plan. The Insurer will only consider that amount of an eligible

expense which is over and above the amount that would be payable by the provincial health care plan.

6. General health examinations and examinations required for the use of a third party.
7. Travel for health reasons.
8. Dental treatment received from a dental or medical department maintained by an Employer, an Association, or a Labour Union.
9. The replacement of an existing dental appliance which has been lost, mislaid or stolen.
10. Dental services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for a correction to temporal mandibular joint dysfunction.
11. Any charges for services, treatment or supplies for which there would be no charge except for the existence of insurance.
12. Charges for medical treatment or surgical procedure by a physician other than as specifically provided under outside Canada or out of province expenses in the Major Medical section.
13. Drugs, sera, injectables and supplies which are not approved by Health & Welfare-Canada (Food and Drugs) or are experimental or limited in use whether or not so approved.
14. Experimental Medical procedures or treatment methods not approved by the Provincial Medical Association or the appropriate medical specialty society.

15. Charges for services or supplies which are furnished without the recommendation and approval of a Physician acting within the scope of his license.
16. Services or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.
17. Charges in connection with childbirth and medical complications resulting from childbirth when the delivery takes place after the beginning of the 32nd week of pregnancy.
18. Charges for a surgical procedure or treatment performed primarily for beautification or charges for hospital confinement for such surgical procedure or treatment.
19. Charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy.
20. Services or supplies that are primarily for cosmetic dentistry.
21. Any hospital charges for board and room and related services and supplies currently covered by any provincial government plan.

## TERMINATION OF INSURANCE

Insurance for you and your covered Dependents will cease on the earliest of the following events:

For Active Members:

1. At the end of the month in which your Dollar Bank Balance is less than \$350.00
2. For Weekly Indemnity, Long Term Disability and Emergency Travel Assistance, on the date you retire.
3. On the date you reach age 65 for Long Term Disability and the Waiver of Premium provisions under the Life Insurance, Survivor Income and Accidental Death and Dismemberment benefits.
4. On the date you reach age 70 for the Accidental Death and Dismemberment benefit.

For Early Retirees:

1. On the date you reach age 65.

For Active Members, Early Retirees and Pensioners:

1. On the date you die.
2. If you enter the armed forces on a full-time basis.
3. At the end of the last month for which you made a Pay Direct payment if such a payment is required to continue your benefits.
4. Termination of the Policy or coverage on the Group, Division, or Class to which you belong.

5. On the date you are no longer a Member in Good Standing with Local Union 894.

### Life Insurance Conversion Option:

If your individual coverage terminates or reduces, but the Policy continues, you may convert your Group Life Insurance to an Individual Life Insurance Policy. This amount must be equal to or less than your Group Term Life Insurance amount. The Individual Life Insurance Policy will be issued without proof of satisfactory health provided the completed application form, along with the necessary premium, is mailed to the Insurer within 31 days of the date of termination.

The types of policies available for conversion are:

1. Non-convertible term insurance to age 65
2. A permanent plan that the Insurer offers to the public at the time of conversion; or
3. One-year non-renewable term insurance which may be converted while it is in force to any plan described above.

The conversion policy will not include disability, double indemnity, dismemberment or accidental death provisions.

If you die during the 31 day period in which you are eligible to make application for conversion, the amount of your Group Life Insurance available for this purpose will be payable to your Beneficiary or Estate, whether or not you applied for conversion.

Certain conversion rights are also available on policy termination. Details on conversion may be obtained from the Administrator or the Group Administration Department at the Insurer's Home Office. The Insurer can be contacted at (416) 687-4513. The Policy Number is 961216.

## EXTENSION OF BENEFITS

### Disability Income

If you are Totally Disabled on the date of termination of insurance for any reason, and such disability continues uninterrupted, you will be eligible to receive Weekly Indemnity Benefits for such disability, until the date you are no longer Totally Disabled, or the date on which the maximum Weekly Indemnity Benefit is received, whichever is earlier.

Long Term Disability Benefits will extend beyond your termination date, provided you became Totally Disabled while you were still insured. Subject to the Maximum Benefit Period, Benefits will continue to be paid according to the contract provisions, regardless of the subsequent termination of the Group Policy. The Insurer reserves the right to require that while you are in receipt of Long Term Disability Benefits, you furnish proof of the continuance of Total Disability, and submit to an examination by the Insurer's medical advisors when requested.

### Health Care

If you, a Member, Dependant, or Pensioner is Totally Disabled when your Major Medical, Vision Care and Outside Canada Coverage, terminates, the aforementioned Healthcare benefits for such disability will be payable, as long as you remain Totally Disabled, up to a maximum period of 365 days after termination.

**“Totally Disabled”** for Active Members means wholly and continuously disabled and that you are unable to earn an income due to an accident or sickness.

**“Totally Disabled”** for Pensioners, means wholly and continuously disabled by sickness or accidental bodily injury which prevents one from engaging in duties or activities (household or otherwise)

which could be considered normal for a person of the same age and sex.

“**Totally Disabled**” for Dependants means the dependant is incapacitated to the extent that the dependent is not able to perform all of the usual and customary duties or activities of a person in good health and of the same age.

If one of your covered Dependants is hospitalized when your insurance terminates, then benefits will be payable in the same manner as your own, or until your Dependant is discharged from the hospital, whichever is earlier.

Payment will be made for pregnancy related eligible expenses if you or your covered Dependant are pregnant on the date coverage would normally cease.

Extension of the Major Medical, Vision Care and Outside Canada Coverage, will cease if the Policy should terminate and if the Plan terminates this benefit.

### **Dental Care**

In most cases no Dental Benefits are payable for expenses incurred after the date your insurance terminates, even if a Treatment Plan has been filed and Benefits have been determined by the Insurer prior to the date your insurance terminates.

### **When The Member Dies**

Major Medical, Vision Care, Outside Canada Coverage, Pay Direct Drug Plan and Dental Care Benefits will continue for your Dependants in the event of your death, until your Dollar Bank is exhausted, and then for a maximum of 12 additional months, or to the date the Policy or Benefit terminates, whichever is earlier.

## **PART III**

### **EARLY RETIREE BENEFIT PLAN**

The Health and Welfare Plan’s Board of Trustees have decided the criteria to qualify as an Early Retiree as follows:

- At least age 55 and younger than age 65
- Retired from the Trade but still a Member in Good Standing of Local Union 894
- Has 26,000 contributory hours to his credit in the Welfare Plan
- No lapse in coverage

The Early Retiree will not be allowed to engage in employment in the trade within the jurisdiction of the IBEW.

The Early Retiree package includes the following benefits, as currently provided for an Active Member:

- Life Insurance
- Survivor Benefit
- Major Medical (including Semi-Private Accommodation)
- Vision Care
- Dental
- Outside Canada and Out of Province Coverage
- Pay Direct Drug Plan

The Benefits excluded from the Early Retiree Plan are:

- Long Term Disability
- Weekly Indemnity Benefits
- Emergency Travel Assistance
- Accidental Death and Dismemberment

# PART IV

## BENEFITS FOR PENSIONERS

The current monthly Pay Direct amount for this package is \$253 plus applicable taxes. As with the Pay Direct Programme, you may not let your coverage lapse. You must sign an agreement at the Union Office before the purchase of this coverage. Coverage terminates in any event when you reach age 65.

### When The Early Retiree Dies

Major Medical, Vision Care, Outside Canada Coverage, Pay Direct Drug Plan and Dental Care Benefits will continue for your Dependents in the event of your death for a maximum of 12 months, or to the date the Policy or Benefit terminates, whichever is earlier.

A Pensioner is a Plan Member who has:

1. reached the age of 65;
2. depleted his Hour Bank below the normal Welfare Plan Eligibility Requirements for Active coverage;
3. is in receipt of a Monthly Pension from the International Brotherhood of Electrical Workers, or if due to the lack of sufficient Service, has not met the Vesting Requirements of the International Pension Plan;
4. has ceased to work in the Trade;
5. is and remains a Member in Good Standing of Local Union 894.

To qualify for Pensioner benefits on a non-Pay Direct basis, the Pensioner must have 50,000 contributory hours to his credit in the Welfare Plan. Included in the 50,000 hours will be a one time credit of 1,500 hours per year for each year the Member's Union initiation date with IBEW Local Union 894 precedes January 1, 1988, provided the Pensioner was in Good Standing in any year for which the credit is given.

“Contributory hours” are hours for which contributions have been made to the Welfare Plan under the terms of a collective agreement or participation agreement.

For Pensioners who do not have 50,000 contributory hours to their credit (including the one-time credit of 1,500 hours per year

for each year the Member's Union initiation date with IBEW Local Union 894 precedes January 1, 1988), but satisfy all other criteria listed above, the following rules will apply:

Members of IBEW Local 894 who have less than 15,000 contributory hours earned during their Membership with Local Union 894 will not be eligible for the Retired Member Benefit Plan.

Members who have at least 15,000 contributory hours, but less than 50,000 contributory hours earned during their Membership with Local Union 894 will be eligible to participate in the Retired Member Benefit Plan, but must pay for all or part of the cost of the Benefits provided. The current full monthly amount for this package is \$120 plus applicable taxes. The formula used to calculate a Pensioner's Pay Direct cost will be based on contributory hours earned and remitted to the Plan. A Pensioner with 15,000 contributory hours to his credit will pay the full cost. Pensioners with more contributory hours to their credit will pay proportionately less as their hours approach 50,000.

The trustees always reserve the right to amend the Pay Direct requirements of the Plan.

## **GROUP TERM LIFE INSURANCE**

In the event of death, payment will be made in a lump sum to the Beneficiary designated by you. The Beneficiary may be changed whenever you wish in accordance with Provincial Laws. The amount of the lump sum Death Benefit is:

All Pensioners - \$3,000.

## **MEDICAL-SURGICAL-HOSPITAL BENEFITS FOR ELIGIBLE PENSIONERS AND DEPENDANTS**

Pensioners and their Spouses who are age 65 are eligible for Ontario Health Care Benefits through Government assistance.

## **MAJOR MEDICAL BENEFIT FOR ELIGIBLE PENSIONERS AND DEPENDANTS**

Pensioners and their covered Dependants are eligible for certain Major Medical Benefits. Please refer to pages describing the Benefits earlier in this Booklet.

## **PAY DIRECT DRUG PLAN FOR ELIGIBLE PENSIONERS AND DEPENDANTS**

Pensioners and their covered Dependants are eligible for the same Pay Direct Drug Plan Benefit as are Active Members. Please refer to pages describing the Benefits earlier in this Booklet.

At age 65 you will also apply for the Ontario Drug Benefit Plan. In the event that the Ontario Benefit Plan does not cover a particular prescription drug, you may submit your receipt to ClaimSecure for consideration.

## **When The Pensioner Dies**

Pensioner Major Medical (including Semi-Private Hospital Accommodation) and Pensioner Pay Direct Drug Plan will continue for your Dependants in the event of your death for a maximum of 12 months, or to the date the Policy or Benefit terminates, whichever is earlier.

# PART V

## ADMINISTRATION

### CLAIMS PROCEDURES

#### Life Coverage:

Claim forms are available from the Administration Office. Proof of death should be submitted as soon as reasonably possible and within 15 months of the date of death.

#### Accidental Death And Dismemberment:

Claim forms are available from the Administration Office. You must provide written notice of your accident within 30 days of the accident. A Claim must be filed within 90 days of the accident.

Your accidental death benefit will be paid to the Beneficiary designated under the Group Term Life Insurance Benefit. If you have not named a Beneficiary the Benefit will be paid to your Estate. Any other Benefits are paid to you and are described in the Loss Schedule as a percentage of the Principal Sum.

#### Disability Income:

Claim forms are available from the Administration Office. You must complete certain portions of the form. Your doctor must complete the Attending Physician's statement.

For further information on submission of claims, contact the Administration Office.

In order to be considered for payment, Weekly Indemnity claims must be submitted within 90 days of the commencement of total disability. Long Term Disability claims must be submitted no later than 6 months following the qualifying period.

### **Health Care:**

Once the Deductible is satisfied, you may submit claims at any time. However, in order to minimize administrative costs, we strongly recommend that you accumulate receipts for a series of treatments.

If Major Medical expenses are incurred, obtain a claim form from the Administrator or download a form from IBEW 894 website. ([www.ibew894.org](http://www.ibew894.org))

In order to be considered for payment, Health claims must be submitted within 15 months of the date the expense was incurred.

Some original receipts in support of claims will not be returned, but will be retained by the Claims Administrator. Others will be marked "paid" and returned to you with your claim payment.

For all Health Care Benefits, when your insurance terminates for any reason, written proof of claim must be given to the Insurer within 90 days of the date of termination of insurance.

### **Dental Care:**

If Dental expenses are incurred, obtain a claim form from the Administrator; have your Dentist complete the form and ensure that your portion is also completed.

Dental claims must be submitted within 15 months of the date the expense was incurred.

For further information on submission of claims, contact the Administrator.

For all Dental Care Benefits, when your insurance terminates for any reason, written proof of claim must be given to the Insurer within 90 days of the date of termination of insurance.

### **Coordination Of Benefits:**

This Plan includes a Coordination of Benefits Provision. This provision operates in the event that you, or your Spouse, are covered under more than one Group Health, Emergency Travel Assistance or Dental Plan. If a person who is covered for Health Care Coverage, Emergency Travel Assistance or Dental Coverage under the Local 894 Welfare Plan, is also covered under another plan which provides similar Coverage, claims will be coordinated and/or reduced so that Benefits payable from all Plans will not exceed 100% of the Eligible Charge incurred.

If a person is eligible to receive Benefits under this Plan and the same or similar Benefits under another plan, payment will be determined as follows:

- The plan which does not contain a Coordination of Benefits Provision will pay before the plan which does.
- If the other plan(s) contains a Coordination of Benefits Provision, priority will be given to the plan(s) in the following order:
  1. The Plan where the person is covered as a Member. However, if a person is a Member of two or more Plans, priority will be given as follows:
    - a) the plan where the member is covered as an active Full-time Employee,

b) the plan where the member is covered as an active Part-time Employee,

c) the plan where the member is covered as Retiree.

2. The plan where the person is covered as a Dependant Spouse.

3. The plan where the person is covered as a Dependant Child. However, if a person is covered as a Dependant Child under two or more plans, priority will be given as follows:

a) the plan of the parent with the earlier birth date (month/day) in the Calendar Year.

b) the plan of the parent whose name begins with the earlier letter in the alphabet, if the parents have the same birth date.

An exception to this rule occurs if the parents are separated/ divorced, in which case priority will be given as follows:

i) the plan of the parent with custody of the Child,

ii) the plan of the spouse of the parent with custody of the Child,

iii) the plan of the parent not having custody of the Child,

iv) the plan of the spouse of the parent in (iii) above.

4. Health plans with dental accident coverage will determine benefits before dental plans, where a person may be able to claim under both plans.

5. If priority cannot be established using the above priorities, the Benefits will be prorated in proportion to the amounts that would have been paid under each plan had there been Coverage under just that plan.

When you file a claim you must consent that the Insurer has the right to release to or obtain from any company, organization or person, information which in the opinion of the Insurer is necessary to the application and implementation of the Coordination of Benefits Provision. If you do not provide such consent claims which may be subject to Co-ordination of Benefits cannot be paid.

If payments which should have been made under this Plan by the terms of this Coordination of Benefits Provision have been made under any other plan, the Insurer will have the right to pay to any company or organization the amount necessary to satisfy the intent of this Coordination of Benefits Provision. The amounts paid in this manner will be considered Benefits paid under this Plan and the Insurer will be fully discharged from liability to the extent of the payments made.

If payments have been made by the Insurer under this Plan which are in excess of the maximum amount of payment necessary to satisfy the intent of this Coordination of Benefits Provision, the Insurer will have the right to recover any such excess from any company or organization or person to or for whom such payments were made.

When eligible expenses are incurred, claims should be submitted to the first payer in the normal manner. When the first payer provides for partial reimbursement, expenses can then be submitted to the second payer for a total reimbursement by all payers of up to 100% of the expense.

When submitting under the second payer, include any information and payment details provided by the first payer.

## Medical Information Bureau (MIB)

MIB Group, Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Manulife Financial or its re-insurers may periodically report information to the MIB. If you apply to receive life, disability or health insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB upon request will supply the other insurer with the information on file.

Manulife Financial or its re-insurers may also release information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. All information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek correction. Their address is: MIB, 330 University Ave., Suite 501, Toronto, Ontario M5G 1R7. Tel: (416) 597-0590.

If you have any questions, contact the Administrator.

## ADMINISTRATION OFFICE

The IBEW Local Union 894 Office handles the day to day administration of the Plan and can assist you in explaining the Plan, obtaining claim forms etc.

You may Call: (905) 623-9324

Or Write: 380 Lake Road  
Unit 3  
Bowmanville, Ontario  
L1C 4P8

Website: [www.ibew894.org](http://www.ibew894.org)

## THE CLAIMS PAYMENT ADMINISTRATOR

Employee Benefit Plan Services handles the payment of claims and can assist you in Claims Payments etc.

You May Call: 1-800-263-3564 (Toll Free in Canada),  
or (905) 946-9700

Or Write: Employee Benefit Plan Services  
45 McIntosh Drive  
Markham, Ontario  
L3R 8C7

Please be sure to identify yourself as a Plan Member of IBEW Local 894 and include your home address.

## **THE CONSULTANT**

J.J. McAteer & Associates Incorporated  
45 McIntosh Drive, Markham, Ontario L3R 8C7

## **THE AUDITOR**

HS & Partners  
110-5925 Airport Road, Airway Centre,  
Mississauga, Ontario L4V 1W1

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## **POLICY AND CONTRACT NUMBERS**

Group Term Life Insurance, Survivor Income Benefit, Weekly Indemnity, Long Term Disability, and Health Emergency Travel Assistance and Dental:

### **The Manufacturers Life Insurance Company:**

Policy Number – 961216

### **Accidental Death & Dismemberment Insurance:**

RBC Life Insurance Company  
Policy Number – GSR 13029

### **Prescription Drug Plan (self-funded):**

ClaimSecure  
Group Number 5881

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