UBC BUILT
ATLANTIC CANADA
REGIONAL COUNCIL

Atlantic Canada Regional Council of Carpenters, Millwrights and Allied Workers Employee Life and Health Trust Fund

OFFICE STAFF BOOKLET

April 1, 2025

ABOUT THIS BENEFIT BOOKLET

This booklet provides a summary of the key facts about your Life and Health Trust (ELHT) Plan. It has been published and distributed to eligible members with valid address information on file with the Plan Administrator, Manion Wilkins & Associates Ltd. (Manion). This booklet is also available online. Between booklet publications, plan changes are announced by newsletter or communiqué. Every attempt is made to provide up-to-date and accurate information on an ongoing basis. However, changes may occur to the benefit plans from time to time that are not reflected in the latest booklet, newsletter or communiqué.

A complete description of the plans is contained in the legal documents that govern the plans, including the trust document, master group insurance policies, the ELHT Plan text documents. These documents are available for review in one of Manion's offices. If there are any differences between the information contained herein or in a newsletter or communiqué and the legal plan documents, the terms of the legal documents will apply.

The Board of Trustees of the Atlantic Canada Regional Council of Carpenters, Millwrights and Allied Workers Employee Life and Health Trust Fund, referred to as the "Trustees", and Manion make no warranty, guarantee, or promise, expressed or implied, concerning the content of any benefit plan booklet, newsletter or communiqué.

Please note that a new release of a booklet, newsletter or communiqué reflecting changes in the Plan may be printed and distributed or uploaded for online access at any time and without prior notification to Members and beneficiaries.

The Trustees recommend that members or beneficiaries contact Manion for confirmation of benefit levels and coverage before relying on the information contained within any booklet, newsletter or communiqué.

Updates included in this booklet version:

1) Effective March 1, 2025: The Plan has terminated the Inkblot Mental Health Support Program.
2) Effective April 1, 2025:
   a) The Plan does not pay any dispensing fee for drug prescription or refill.
   b) Mandatory generic drug substitution applies that the Plan will pay brand name drugs if the Physician prescribes "No Substitution".
   c) Services of massage therapists and chiropractors for Dependents are limited to a combined maximum of $500 per calendar year per person, subject to the overall maximum of $1,500 per calendar year for all practitioners combined.
   d) Drug Step Therapy is introduced for medical conditions related to high blood pressure, cholesterol, diabetes, and acid reflux.

TABLE OF CONTENTS

	Page
If You Need Information, Contact Manion	I-1
Policy / Plan / Registration Numbers	I-1
Online Services - myManion	I-2
Who manages the Fund and the Plan	I-4
Joining the Plan	I-5
Checklists	I-6
ELHT Plan	**W-1**
Summary of Benefits	W-1
How to File Claims – ELHT Plan	**G-1**
Health and Dental Claim Submission Time Limit	G-3
Submission of Health and Dental claims	G-3
Coordination of Benefits	G-5
Direct Deposit recommended for benefit Payments	G-6
ELHT Plan Eligibility	**G-7**
Date Insurance Becomes Effective	G-7
Dependent Eligibility	G-7
Keeping your Benefits	G-8
Continuation of ELHT Plan Coverages	G-8
Termination of Coverage – ELHT Plan	G-9
Other Important Information	G-10
Description of Benefits	**B-1**
Life Insurance	B-1
Accidental Death and Dismemberment	B-3
Long Term Disability Benefit	B-9
Critical Illness Benefit	B-15
Health Benefit	B-16
Dental Benefit	B-25
Emergency Out Of Province Medical Coverage	B-28
Member and Family Assistance Program (MFAP)	B-32
General Definitions	**D-1**
Disclaimer	

IF YOU NEED INFORMATION, CONTACT MANION

➢ Contacting the Plan Administrator – Manion

For enrollment, health and dental claims, and general inquiries:

MANION WILKINS & ASSOCIATES LTD. (Manion)
500 – 21 Four Seasons Place
Etobicoke, Ontario M9B 0A5

Contact Centre:	416-234-3511
Telephone Toll-free:	1-866-532-8999
Email Inquiry:	askus@mymanion.com
Fax Claims:	416-234-2071
Email Claims:	claim@manionwilkins.com
Website:	www.manionwilkins.com
Online Services:	www.mymanion.com

Office Hours are:
Mon – Fri: 8:30 a.m. – 5:00 p.m. (Eastern)

Contact Centre is open:
Mon – Fri: 8:00 a.m. – 7:00 p.m. (Eastern)

For life, critical illness and disability claims related questions and inquiries:

Manion Life & Disability Claims Department

Claims Administrator:	416-234-3633
Telephone Toll-free:	1-800-263-5621 (select 6 from the menu)
Email Inquiry/Disability Claims:	disability@manionwilkins.com
Email Inquiry or Life and AD&D Claim Notification:	lifeclaims@manionwilkins.com
Fax to Disability Department:	416-234-0127

Office Hours are:
Mon – Fri: 8:30 a.m. - 5:00 p.m. (Eastern)

➢ Policy / Plan / Registration Numbers

ELHT Plan
- The Trust Fund provides Health and Dental benefits under Plan No. 22717.
- Life Insurance, Dependent Life Insurance, and Long Term Disability benefit are underwritten by Medavie Blue Cross under Policy No. 10616.
- Accidental Death & Dismemberment Insurance is underwritten by Zurich Insurance Company Ltd. under Policy No. 8621773.
- Critical Illness are underwritten by Industrial Alliance Insurance & Financial Services under Policy No. 100009815.
- Emergency Out of Province Medical Coverage is underwritten by AIG Insurance Company of Canada under Policy No. CMG 9428757.
- Member and Family Assistance Program is provided by MembersHealth.

➢ Online Services - myManion

The Board of Trustees in conjunction with Manion offers you access to myManion, an online service where you can review your personal benefit information 24-hours-a-day at www.mymanion.com. In addition to the myManion online services (Portal), your account information is available 24/7 through your iPhone, iPad and similar android devices. The "myManion" App is available for FREE from the Apple App Store and Google Play Store.

myManion Portal www.mymanion.com and Mobile App

When you first became an eligible plan member, you would have been provided with your unique username (ID) and a temporary password for you to enroll yourself and your Dependents, if any, in the benefit plan; follow the prompts: create your own password and fill in the necessary information.

SCAN ME

Once you have successfully completed your enrollment, login using your username (ID) and password, or using biometrics login (face ID or fingerprint ID) via Mobile App, the Home Menu will direct you to the menus for your claims or benefits. From this Menu, you can:

- quickly access your digital Benefit Card and Emergency Travel Card under the « My Benefits » menu via the Mobile App, or add these cards to the Apple or Google Wallet without the need to login;
- retrieve your user ID by following the prompts at "Login";
- click the « My Profile » tile to:
  - reset your password and set your password hint;
  - view and verify your personal and Dependent information;
  - update « Contact Info » including mailing address, telephone number and email address;
  - set up/update « Banking Info » menu for the direct deposit program that provides secure and timely reimbursement of submitted health and dental claims;
  - update your « Communication Preferences » menu to receive electronic notification of Message centre alerts, Eligibility notices and Statements by email or text-SMS;
  - assign your « Authorized Contacts ». An Authorized Contact is an individual you assign who can contact Manion on your behalf to discuss the details of your benefit plan. You can assign an Authorized Contact through your online account, myManion, or by contacting Manion. You will be asked to set up a 4-digit numerical PIN code for your Authorized Contact;
  - view and update your « Beneficiaries » for life benefits;
- submit claims easily by using the « Submit Claim » menu under the « My Claims » tile and following the prompts. Please ensure that you provide all the information required and that it is entered accurately. You must also upload clear photographs or copies of receipts when requested and you must be enrolled for direct deposit. Alternatively, eligible vision care and paramedical claims can be filed electronically by your health practitioner(s) and you can check the « Health Practitioner Lookup » menu if your health practitioner is enrolled on the Telus eClaims Service – Refer to page G-2;
- view the status, explanation of benefits and history of submitted health and dental claims under the « Claims History » menu;

- click the « My Benefits » tile to:
  - check your benefit coverage details under the « Check Coverage » menu;
  - access claim forms, the booklet, brochures, newsletters and communiqué updates under the « Forms and Booklets » menu;
- access message centre that provides news and updates on your benefits, self-pay notices and terminations etc. You will also see the critical message banner .! Click here to review your messages for critical information. from the Home Menu. .To receive electronic notification of Message Centre Alerts and Eligibility Notices, select « My Communication Preferences » under the « My Profile » pop-up menu, « Update Change Preference » to email or text-SMS, « Submit Changes »;
- view your work history and the ELHT Plan contributions submitted on your behalf by your Contributing Employer(s) under the « My Work History » menu;
- access or print copies of statements prepared annually by Manion under the « View Documents » menu of « My Dashboard » including, as applicable, T4A for taxable life insurance premiums paid plus any taxable benefits paid during the tax year. You can « Update » « My Communication Preferences » by clicking your name for the « My Profile » pop-up menu to select paper or electronic statements.
- access the « My Message Centre » tile that provides important information, notifications and updates on your benefits, self-pay notices and terminations etc. You will also see the critical message banner .! Click here to review your messages for critical information. from the Home Menu. To receive electronic notification of Message Centre Alerts by email or text-SMS, update your « Communication Preferences » under the « My Profile » tile;
- click the « My Dashboard » tile to:
  - view your work history and ELHT Plan contributions submitted on your behalf by your Contributing Employer(s) under the « Work History » menu;
  - access copies of T4A for taxable life insurance premiums paid plus any taxable benefits paid during the tax year under the « View Documents » menu:

WHO MANAGES THE FUND AND THE PLAN

➢ Board of Trustees

The Trust Fund/Plan are managed by a Board of Trustees consisting of representatives of the Union, the Association and the Participating Employers. The Trustees are the "Administrator" and ultimately are responsible for the oversight, management and administration of the Trust Funds and Plan as defined by the Trust Agreements and legislation. As the "Administrator" the Trustees have a duty of care and owe fiduciary duties to the plan beneficiaries as outlined in the Trust Agreements and all applicable laws and regulations.

The Trustees are:

Union Trustees	Management Trustees
James Dawson	Geoff Colter
Mike Noseworthy	George Dalton
Colin Porter	Ken Dean
Jeff Richardson	Durck deWinter
Debbie Romero (Chair)	Bronwyn Dunphy
Jody Sewell	Kyle MacDonald
Noel Wall	Matthew Mallam
Mike Williams	Ray Phillippo
Joe Wilson	Jeremy Tucker

Under the oversight of the Trustees:

The Trustees delegate some of their responsibilities to professional service providers who are subject to the same duty of care as the Trustees.

➢ Third Party Administrator and Plan Consultant

Manion Wilkins and Associates Ltd.:

- provides plan administration, plan consulting, and runs the day-to-day operations (collections, eligibility, benefit payments);
- informs/reports on plan issues and legislation/industry developments;
- produces member communications; and
- monitors and accounts for all operations, including financial status and investment performance.

➢ Insurance Companies

Medavie Blue Cross, Zurich Insurance Company of Canada, AIG Insurance Company of Canada, Industrial Alliance Insurance & Financial Services, and MembersHealth provide insured benefit coverage to protect Members and their Dependents against the risk of a loss within the rules of the policies.

➢ Joining the Plan

Eligibility and coverage require that all Members:

- ☐ enroll in the ACRC Employee Life and ELHT Plan by filing ***a completed Member Information Card (MIC).*** The completed MIC confirms that you are a Member of a Participating Local Union and provide personal data and beneficiary designation(s) required to administer your benefits within the guidelines of the Plan; **OR**

  enroll **online** at the Enrolment Welcome Page through the myManion Portal at www.mymanion.com or via the Mobile App by filing your personal data, Dependent information, beneficiary designation(s), authorized contacts, banking information and confirm with your electronic signature.

- ☐ complete the Coordination of Benefits (COB) section of the MIC for the ELHT Plan if you or any of your Dependents have insurance coverage elsewhere (refer to page G-**Error! Bookmark not defined.** for details). You can also manage your « Coordination of Benefits » under the « My Profile » menu at myManion. Failure to provide COB information will result delays in claims payment for your Dependents.

- ☐ advise Manion of all changes to your status by direct update or by completing the downloaded forms via myManion:
  - for marital status and/or name change;
  - for authorized contact update;
  - for addition or deletion of Dependents;
  - for life insurance beneficiary update;
  - for spouse update;
  - for managing supporting documents or proofs under the « Submit Documents » menu under the « My Benefits » tile at myManion;
  - if you receive a document from Manion and you notice an error in any of your information, such as your date of birth or name.

- ☐ change your address and banking information online under the « My Profile » tile via myManion, by letter or by phone through your Local Union office. You will be required to provide identification.

Your Life Insurance continues for thirty-one (31) days following the termination of your coverage. During this thirty-one (31) day period you may be eligible to convert the amount of your Life Insurance to an individual whole life or a convertible one-year term plan or a term to age 65 plan without submitting evidence of health. The premium rate will be determined by your age and class of risk at the time of conversion. This is referred to as the Conversion Privilege**.** To take advantage of this option, it is your responsibility to contact Manion as soon as possible because the required application form and the initial premium payment must be submitted to the Insurance Company within 31 days of the date your benefit coverage under this Plan terminates. (For example, if your insurance coverage terminates on the last day of February, to convert the life insurance, the Insurance Company must receive the required application and premium by March 31st.) For more information, refer to the Conversion Privilege sections of this booklet.

CHECKLISTS

➢ Checklist, if you become disabled

- ☐ Advise your Local Union Office and the Life & Disability Claims Department at Manion.
- ☐ Is your disability work related?
  a) If yes, apply for the provincial Workers' Compensation Board (WCB) and advise the Life & Disability Claims Department at Manion.
  b) If no, apply for Employment Insurance (EI) disability benefits.
- ☐ Advise the Disability Department at Manion if you remain disabled after 34 weeks of receiving EI disability/sickness benefits.
- ☐ Manion will assist you including providing the forms to apply for:
  a) Accidental Death & Dismemberment (AD&D) – loss due to an accident.
  b) Critical Illness (CI) – if you suffer a covered disease/ illness.
  c) Long Term disability (LTD) – **apply even if you are applying for WCB and/or Canadian Pension Plan** (CPP).
  d) Waiver of Premium (WOP) – apply within 12 months if disability is prolonged.
- ☐ Contact Service Canada and apply for CPP Disability Benefits. For eligibility, forms and application procedure, visit http://www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-disability-benefit/apply.html.
- ☐ Ensure that Manion is provided with copies of all information related to your claim for WSIB or CPP disability benefits including decision letter and annual proof of amount being received.

- WOP claims must be submitted within 12 months after the date you cease active work due to Total Disability (you must notify Manion/the Insurer(s) within 12 months of the last day of active work).
- LTD claims must be submitted to Medavie Blue Cross within 12 months from the end of the Qualifying Period.
- The definition of "totally disabled" for the purpose of continuing payment of LTD benefits changes after you have received 24 monthly payments.

➢ Checklist for government benefits, when you are retiring

6 months prior to your date of retirement:

- ☐ If you are age 60 or older, you can apply for your Canada Pension Plan (CPP) Retirement Benefits by signing in or registering for a My Service Canada Account (MSCA). You can apply online by going to www.Canada.ca (services / benefits / public pensions / CPP Retirement Pension). If you are not able to apply online, you will need to complete the Application for a Canada Pension Plan Retirement Pension and include certified true copies of the required documentation, and mail them or bring them to the Service Canada Centre closest to you. Mailing addresses are provided on the form.
- ☐ Service Canada implemented a process to automatically enroll you to receive the Old Age Security (OAS) pension commencing one month after you turn age 65. If you are automatically enrolled, Service Canada will send you a notification letter the month after you turned 64. If you did not receive such a letter from Service Canada informing you that you were selected for automatic enrollment, you must apply in writing for the OAS pension. Complete and mail the Application for the Old Age Security Pension form, or bring it to the Service Canada Centre closest to you. Mailing addresses are provided on the form.
- ☐ Service Canada implemented a process to automatically enroll you to receive the Guaranteed Income Supplement (GIS). If you are a low-income senior, you will automatically be considered for the GIS based on your income tax filings. Benefits will commence for low-income seniors beginning one month after they turn 65.
- ☐ Familiarize yourself with other provincial supplements and government programs for seniors to determine if you are eligible.

➢ Checklist, upon death of your Spouse, Beneficiary or Dependent

- ☐ Notify your Local Union office and the Life & Disability Claims Department at Manion.
- ☐ Apply for Dependent Life Insurance benefit, if applicable.
- ☐ Update any change in marital status, and/or Dependents online under the « Dependents » menu of « My Profile » tile via myManion.
- ☐ Advise Manion of any change in marital status and/or Dependents by completing the downloaded forms via myManion. You can update your « Beneficiaries » for life insurance under the « My Profile » tile via myManion.

➢ Checklist, upon Member's death

Spouse, beneficiary or executor of estate should:

- ☐ Advise the Member's Local Union Office and the Life & Disability Claims Department at Manion of the date of death.
- ☐ Contact Service Canada to obtain information and forms to apply for survivor and death benefits under the Canada Pension Plan and the Spouse's Allowance under the Old Age Security Plan, if applicable.
- ☐ When received from Manion,
  a) complete an Application for Life Insurance;
  b) if death is accidental, complete an Application for Accidental Death & Dismemberment Insurance.
- ☐ If the Member was in-benefit under the ELHT Plan at the date of death, eligible Dependent(s) will have Health, Dental, Out of Province/Canada Medical Coverage, and Member and Family Assistance Program extended, without premium payment, up to a maximum of 24 months from the date of the Member's death.
- ☐ Be advised that the life insurance on the surviving Dependents will continue at no cost for 31 days after the Member dies. During this 31 day period, the Spouse has the right to convert the group Dependent Life Insurance coverage into an individual policy.
- ☐ **Manion's Personal Financial Consulting Department** is available to work with the surviving family members to obtain required insurance coverage once benefits under this ELHT Plan terminate. Contact Manion to learn more.

ELHT PLAN

Eligibility: You will be covered by the Plan on the first day of the month following three (3) months of coverage costs paid on your behalf by the Contributing Employer provided:

- you have successfully enrolled online (or filed the completed Member Information Card) to participate in the ACRC ELHT Plan; and
- you or your eligible Dependent(s) qualify for the benefit and coverage under the Plan and/or a benefit has not terminated.

➢ Summary of Benefits

Further details are discussed in the Description of Benefits – Section B.

Life Insurance *Pg. B-1*	$60,000
Waiver of premium	Up to age 65
Waiver qualifying period	6 months prior to attainment of age 65
Termination Age	The earlier of retirement, employment termination or lay-off
Accidental Death and Dismemberment *Pg B-3*	$75,000 Principal Sum – Schedule included ($25,000 when working toward initial eligibility)
Waiver of premium	Same as Life Insurance WOP
Termination Age	The earlier of age 75, retirement, employment termination or lay-off
Dependent Life Insurance *Pg. B-1*	Spouse: $10,000 Each Child: $10,000
Waiver of premium	Same as Life Insurance WOP
Termination Age	The earlier of retirement, employment termination or lay-off
Long Term Disability	*Pg. B-9*
Benefit amount	60% of first $2,250, 50% of next $2,250, plus 40% of the remaining monthly earnings up to a maximum benefit of $10,750 per month (includes annual Cost of Living Adjustment)
Non-evidence maximum	Evidence of good health is required for amounts in excess of $5,300
Qualifying period	37 weeks
Definition of Disability	Own occupation during the Qualifying period and the next 2 years, thereafter any occupation
Benefit reduction	WCB/CPP offset, all source limit up to 85%
Maximum benefit period	The earlier of retirement or age 65 (less qualifying period)
Taxability	Non-taxable benefits
Termination Age	The earlier of age 65, retirement, employment termination or lay-off
Critical Illness *Pg. B-15*	***Optional Coverage***
Maximum Benefit	$50,000
Termination Age	The earlier of age 70, retirement, employment termination or lay-off

Maximum Benefit Coverage (per covered person)	
Health Benefit *Pg. B-16*	**Maximum Benefit** (per covered person)
Overall Maximum	Unlimited lifetime benefit maximum
Deductible	Nil
Covered Percentage	100%
Termination Age	The earlier of retirement, employment termination or lay-off
Prescription Drugs – Mandatory generic substitution (unless brand name medically supported)	Certain drugs subject to limitations or prior authorization may apply. **Co-payment:** The Plan does not pay any dispensing fees.
Drug Step Therapy and Prior Authorization apply	Maintenance drugs are limited to one dispensing fee for each 90-day supply.
- vaccines	$500 per lifetime
- erectile dysfunction drug	$250 per calendar year
- fertility drugs	$2,500 per lifetime
- anti-obesity drugs	$1,000 per calendar year
- smoking cessation	$500 per lifetime
Vision Care – eyeglasses or contact lenses	$350 every 24 months including $75 eye exams (every 12 months for Children under age 18)
- Elective laser vision surgery	$800 per lifetime. Cataract eye surgery is not covered.
- Prescription safety glasses	$300 every 24 months (Member coverage only) ***Make sure the receipt clearly states that it is for prescription safety glasses.***
- Visual motor training	$150 per lifetime
Paramedical Services by Duly Licensed practitioners ★ Doctor's referral is required for Dependents.	**Spouse or Child:** Combined $500 per calendar year for massage therapist★ and chiropractor, subject to the overall maximum of $1,500 per calendar year for all eligible practitioners combined. **Employee:** $1,500 per calendar year for eligible practitioners combined: massage therapist★, chiropractor, acupuncturist, chiropodist, podiatrist, osteopath, naturopath, physiotherapist, speech therapist, dietician, clinical psychologist, and social worker (MSW)
Ambulance service including air ambulance	Reasonable and customary land ambulance, $1,000 per calendar year air ambulance, and $500 per calendar year for ambulance attendant
Accidental dental treatment	$5,000 per calendar year. Services must be completed within 180 days of date of accident.
Hearing aids	$2,000 per ear every 60 months
Private duty nursing	$10,000 per calendar year
Hospital	Semi-private accommodation

Maximum Benefit Coverage (per covered person)	
Health Benefit (Cont'd)	
Convalescent hospital	$20 per day to a max of 120 days per disability
Orthopedic shoes	$400 every 12 months (custom-made: page B-20)
Orthotics	$400 every 12 months (custom-made: page B-20)
Off-the-shelf orthopedic shoes/modifications	$400 every 12 months. Pre-approval by Manion prior to purchase is required.
Other medical services	Refer to the Health Benefit Description section
Dental Benefit *Pg. B-25* • Basic Services • Major Services • Orthodontics Deductible Fee Guide Plan Maximums • Basic and Major services • Orthodontics Termination Age	 100% 75% 50% (for Dependent Child under age 18) Nil Current provincial fee guide applicable in the province where services are rendered Combined $2,000 per calendar year (recall examinations – once every 6 months) $2,000 per lifetime (for each Child under age 18) The earlier of retirement, employment termination or lay-off
Emergency Out of Province Medical Coverage *Pg. B-28* Deductible Lifetime maximum Maximum duration Emergency phone no: Termination Age	Participants and Dependents under age 75 are covered at 100% for emergency medical expenses over the provincial health care benefits. Nil $5,000,000 for individuals under age 70; $2,000,000 for individuals of age 70 – 74 inclusive First 90 days per trip 1-877-204-2017 from U.S. & Canada 0-715-295-9967 (collect) outside U.S. & Canada age 75 or earlier retirement. Coverage ceases for the Participant as well as the Dependents. Coverage for a Spouse may terminate sooner if the Spouse attains age 75 before the Participant.
Member and Family Assistance Program (MFAP) *Pg. B-32*	MembersHealth Accountable Healthcare Program (AHP) offers personalized healthcare to you and your Dependents with access to a range of resources and support to help manage physical health, mental health and well-being. • 24/7/365 medical support: speak to AHP's doctors, specialists and surgeons within minutes; • Medical services; • Wellness and mental health support; • Patient care.

Benefit Coverage	
MFAP (Cont'd)	Access the care you need by booking an appointment: **Click** Online at www.membershealth.ca **Tap** MembersHealth mobile application available at iOS and android **Call** 24/7 on 1-800-484-0152 You will then receive an appointment confirmation by text or call. At the appointment time, the AHP doctors will contact you via video call.

HOW TO FILE CLAIMS – ELHT PLAN

Important: Enrol for Direct Deposit for benefit Payments for secure and timely health and dental claims reimbursement. You are encouraged to set up your direct deposit banking information and provide an email address under the « My Banking Info » menu – refer to page G-**Error! Bookmark not defined.** for details.

Claim forms may be obtained from Manion, your Local Union office, or online via the myManion Portal at www.mymanion.com or via the Mobile App.

ALL CLAIMS should clearly indicate the following:

a) Name of Plan: Atlantic Canada Regional Council Health and Wellness Trust Fund.
b) AIG policy no. for Emergency Out of Province Medical Coverage is CMG 9428757.
c) The Trust Fund provides Health and Dental benefits under Plan No. 22717.
d) Medavie Blue Cross policy no. for Life Insurance, Long Term Disability and Medical Second Opinion benefits is 10616.
e) Zurich Canada policy no. for AD&D is 8621773.
f) Industrial Alliance Insurance & Financial Services policy for Critical Illness benefit is 100009815.
g) Your name, address, Local Union No. and Certificate No.
h) If the claim is for your Dependent(s), provide Dependent's full name, date of birth and relationship to you.
i) If your Spouse has coverage under another plan (e.g. through your Spouse's employer), provide the policy number, name of the insurance company and the type of **INSURED BENEFITS** (i.e. health and/or dental).
j) Review the forms to be sure **ALL** information has been included and remember to **SIGN** and date all claim forms.

Notes:
- Please ensure that your address is correct on all claim forms before submitting them to Manion. Address changes will be made from claim forms in certain circumstances. You can also update your address online via the myManion Portal at www.mymanion.com or via the Mobile App.
- Claims that are NOT submitted within the deadlines will be denied. Refer to the time limit of claims submission under each benefit in the section.

➢ Prescription Drug Claims

Your Benefit Card provides your pharmacist with immediate confirmation of covered drug expenses. To fill a prescription for covered drug expenses:

a) present your Benefit Card (or digital card via the Mobile App or that you can add to your Apple or Google Wallet without the need to login) to the pharmacist at the time of purchase, and
b) pay any portion of each prescription that is not covered under this Plan.

When the pay direct option is not available for any reason, pay the pharmacist and submit a fully completed Health Care Claim Form along with the payment receipts to Manion's Claims Department for assessment, using the Mobile App, or through the myManion Portal, or by email, by fax or by post.

➢ Health Claims – Plan No. 22717

TELUS eClaims – Electronic filing of your ***vision care and paramedical claims*** allows your health practitioner(s) to file eligible claims for you and your family electronically to Manion for payment. This eliminates the need for mailing vision care or paramedical claims and speeds up reimbursement of eligible expenses. You can check the « Health Practitioner Lookup » menu if your health practitioner is enrolled on the TELUS eClaims service that they can electronically submit claims directly to Manion on your behalf. Simply show your Benefit Card (or the digital card using the Mobile App or adding the Card to the Apple or Google Wallet without the need to login) to your health practitioner for electronic submission of eligible services. When your benefit plan does not cover 100% of the expenses incurred, you or your eligible Dependent(s) will need to pay the difference to your health practitioners.

Electronic Filing of Health Claims – Submit claims easily using the myManion Portal or Mobile App – From the "Home" menu, go to the « My Claims » tile, then the « Submit Claim » menu, select the benefit type and follow the prompts. Please ensure that you provide and enter accurately all the information required. You must also upload clear photographs or copies of receipts when requested and you must be enrolled for direct deposit. ***We recommend that you keep your original receipts, the Physician's written referral and/or prescription for at least one year from the date of service.***

SCAN ME

Filing Health Claims by email or by fax – You may submit all Health and Coordination of Benefits claims by emailing them to claim@manionwilkins.com, or by fax to 416-234-2071, or by post (see address outlined on next page). If you are sending your claims by email or by fax, scan or take photographs of all the documents (signed claim form and receipts, such as the attending Physician's written referral or prescription, if applicable) and attach the scanned files or photographs to your claims. ***Please save your original receipts, Physician's written referral and/or prescription for at least one year from the date of service.***

➢ Dental Claims – Plan No. 22717

Electronic Filing via the Dental Office – Your Plan has the capability for electronic filing of dental claims. Tell your Dentist that your Plan accepts claims electronically. If your Dentist has access to this service, show the Dentist your Benefit Card which notes the plan number needed to verify that Manion does accept electronic filing of dental claims.

Once your dentist office submits your claim to Manion, the system will automatically verify eligibility and coverage amounts and will expedite reimbursement to you or your dentist, if applicable.

Online Filing of Dental Claims – When electronic filing is not an option, pay the Dentist and submit a fully-completed Dental Care Claim Form to Manion's Claims Department for assessment, using the Mobile App, via the myManion Portal, by email, by fax or by post.

➢ Health and Dental Claim Submission Time Limit

Claims that are not submitted to Manion within the required time period will be denied.

Health and Dental claims are to be submitted **within 18 months of incurring the expense.**

➢ Submission of Health and Dental claims

You can submit all claims of the above benefits to Manion ***online, by email***; you must save the original receipts for at least one year from the date of service. When submitting paper claims to Manion ***by post***, attach only original bills and receipts (Photocopies are not acceptable) and send them to:

Manion Wilkins & Associates Ltd.
Claims Department
626 – 21 Four Seasons Place, Etobicoke, ON M9B 0A6
Contact Centre: 416-234-3511 or Toll Free: 1-866-532-8999
Fax Claims: 416-234-2071
Email Claims: claim@manionwilkins.com
View/Submit Claims: www.mymanion.com

➢ Emergency Out of Province Medical Claims – AIG Policy No. CMG 9428757

If you require emergency medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately. If circumstances prevent you from calling Global Excel Management Inc. right away, you should contact them as soon as you can and ***your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.*** Global Excel Management Inc. will help ensure that you receive the medical care you need and, if possible, will make claims payment arrangements directly with the hospital or service provider. Telephone Global Excel Management Inc. at the following numbers:

From U.S. & Canada 1-877-207-5018
Outside U.S. and Canada 1-819-566-3940 (collect)

Give the operator the following:

- The Insured Participant's name and the patient's name, location and the details of the emergency
- Policy Number: **CMG 9428757**

If you are not able to contact Global Excel Management Inc. before being billed for the charges, or if your medical needs are minor in nature (i.e., costing less than $500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip. To make a claim for out-of-pocket expenses, contact a Global Excel Management Inc. operator who will send you a claim form. When you complete the form, provide the patient's name and provincial health plan number and your certificate number. Be sure to attach detailed statements and original receipts showing the services rendered and the charges for each service.

Mail your completed claim form and attachments to:

Global Excel Management Inc.
73 Queen Street Lennoxville, QC, J1M 1J3

Please make sure you obtain your medical records, statements or detailed receipts at the time of treatment and/or discharge, to submit with your claim. All claims must be submitted to Global Excel Management Inc. as soon as possible, and ***no later than 90 days after the expense was incurred.***

➢ Long Term Disability Claims - Medavie Blue Cross Policy 10616

If you are disabled for longer than 37 weeks prior to age 65, you may be entitled to a monthly payment under the Long Term Disability Benefit.

The LTD claim forms are available from the Disability Department at Manion. You must complete and submit the LTD Claim Form within the required time period to the Disability Department at Manion. In order to avoid delays in payment, please ensure that all required information is provided.

If you are imprisoned in a penal institution or confined in a hospital or similar institution due to a disability as a result of criminal proceedings, the police report must be provided to Manion. If you are disabled due to an accident which occurred while you were operating a motor vehicle, the Motor Vehicle Accident report must be provided to Manion.

For Long Term Disability claims related questions/inquiries:

Manion Life & Disability Claims Department

Disability Claims Administrator:	416-234-3633
Telephone Toll-free:	1-800-263-5621 (select 6 from menu)
Email Inquiry/Disability Claims:	disability@manionwilkins.com
Fax to Disability Department:	416-234-0127

- It is important that you apply for LTD benefits after 23 weeks of disability whether or not you are applying for Workplace Safety & Insurance Board (WSIB) benefits or any other form of disability income. You must also apply for Canada Pension Plan disability benefits.
- Application for LTD benefits is also considered as an application for waiver of premium benefit for Life and if applicable, Dependent Life Insurance – refer to pages B-2.
- Apply for waiver of premium benefit for AD&D Insurance.

A claim for Long Term Disability benefit must be submitted to Medavie Blue Cross ***within 12 months following the expiry of the Qualifying Disability Period.***

➢ Critical Illness Claim – iA Financial Group Policy no. 100009815

Claim forms may be obtained from Manion, your Local Union office, or online via the myManion Portal at www.mymanion.com or via the Mobile App.

The Insurer must receive notice of any claim for a Critical Illness Insurance benefit as soon as possible after the date of the occurrence of the covered condition or surgery, but in any event ***within one year of the date of the occurrence of the covered condition or surgery***, unless specified otherwise under the Critical Illness Insurance benefit.

For Life, AD&D and Critical Illness claims related questions and inquiries:

Claims Administrator:	416-234-3633
Telephone Toll-free:	1-800-263-5621 (select 6 from menu)
Email Inquiry and Claim Notification:	lifeclaims@manionwilkins.com
Fax Number:	416-234-0127

➢ Life Claim and Application for Waiver of Premium upon Total Disability – Medavie Blue Cross Policy no. 10616

Life Claims – Manion should be immediately notified of the death of an insured person. The appropriate death claim forms will then be sent to the beneficiary for completion. The fully completed life claim has to be submitted to Medavie Blue Cross through Manion ***within 12 months of the death of the insured person.***

In order to qualify for the **Waiver of Premium Benefit for Life Insurance**, the Member must notify Medavie Blue Cross and furnish due proof of disability, satisfactory to the Insurer, ***within 12 months of that last active working day.***

➢ Accidental Death and Dismemberment Claim – Zurich Canada Policy no. 8621773

Manion should be immediately notified of an accidental death or dismemberment of an insured person. Please contact the Disability Department of Manion for inquiries and the proper claim form. The insured or the beneficiary, or someone on your behalf, must give written notice of the Covered Loss to the Insurer ***within 90 days of the Covered Loss***.

COORDINATION OF BENEFITS

Applicable to Health and Dental Benefits Only

➢ If You are Covered under Another Plan

When your Spouse has health or dental coverages for themselves, you and/or your Dependent Child(ren), the details must be provided to your Plan and Manion. The Coordination of Benefits provision (COB) ensures that you and your family receive maximum reimbursement of eligible health and dental expenses incurred. ***You must provide the details and complete the « Coordination of Benefits » menu under the « My Benefits » tile through myManion.*** Failure to provide coordination of benefits information will result delays in claims payment for you and your Dependents.

➢ Coordinating Claims with your Spouse's plan

if you and/or your Dependents are covered under this Plan for health benefits or dental benefits and are also covered under other group plans (including your Spouse's plan, school/student, or accident insurance) that provide similar coverage, applicable claim will be coordinated so that benefits payable from all plans will not exceed 100% of the eligible charges incurred. You will need to check to see if your Spouse's plan has rules that permit claiming from more than one plan. Then, submit your claims in the order as shown on next page.

If you (or your Spouse) are covered by 2 or more plans, claims should be submitted in this order – to the plan where you (or your Spouse):
1) are an active, full-time member,
2) are an active, part-time member,
3) are a retired member.

Be sure to keep copies of all original receipts for submission to your Spouse's plan.

Coordinating claims with your Spouse's plan	When you receive treatment	When your Spouse receives treatment
	1) Claim first to your ACRC Plan. 2) Claim for anything left unpaid to your Spouse's plan. Within the rules of your Spouse's plan, it will pay up to 100% of the amount not covered by the ACRC Plan.	1) Spouse first makes claim to the Spouse's own plan. 2) Spouse claims for anything unpaid to the ACRC Plan. Within rules of your Plan, Manion will pay up to 100% of the amount not covered by your Spouse's plan.
Coordinating claims for your Child(ren	**If you are living with your Child's other parent**	**If you are separated or divorced**
	1) Claim first to the plan of the parent whose birthday comes earlier in the calendar year. 2) Claim for anything left unpaid to the plan of the parent whose birthday comes later in the calendar year. If your Spouse was born in February and you were born in November, then your Spouse's plan would be the first payor of the claims for your Dependent Child(ren). If both parents have the same date of birth, the plan of the parent whose first name begins with the earlier letter in the alphabet would be the first payor.	Make claims for each Child in this order: 1) To the plan of the parent with custody. 2) To the plan of the current Spouse of the parent with custody. 3) To the plan of the parent without custody. 4) To the plan of the current Spouse of the parent without custody.

Further information regarding the rules of coordinating benefit payments can be obtained from Manion.

DIRECT DEPOSIT RECOMMENDED FOR BENEFIT PAYMENTS

For added security and timely payments, Health and Dental benefit payments can be made by direct deposit. The Trustees recommend you instruct Manion to deposit your benefit payments directly into your bank account. To enroll in this service, access your online account through myManion, click the « My Profile » tile and fill in the « Banking Info » menu.

ELHT PLAN ELIGIBILITY

➢ Date Insurance Becomes Effective

The insurance of an eligible Participant shall become effective for the Employee on the first day of the month following three (3) months of coverage costs paid to the Trust Fund and the Office Staff has successfully enrolled online to the ELHT Plan with Manion.

You shall have to be Actively At Work on the date your coverage becomes effective. Should you not be working on the day your benefit coverage would ordinarily start, the benefit coverage for you and your Dependents will be delayed until you return to work or are available for work.

ELHT Plan Beneficiary

You can designate any person or persons as a beneficiary(ies) or change a named beneficiary, in writing, to receive the death benefit payable under the Participant Life Insurance and AD&D Insurance. If you do not designate a beneficiary, any death benefit that becomes payable under the group policy due to your death will be paid to your estate. If your beneficiary is a minor child, please indicate the person (or company) to whom benefits should be paid and held in Trust until the beneficiary reaches the age of majority.

For example, instead of: Child Smith, please indicate William Smith, in Trust for Child Smith; or ABC Trust Company, in Trust for Child Smith. The Insurer(s) will not be responsible for the sufficiency or validity of the beneficiary designation or change of beneficiary. The policies contain a provision removing or restricting your right to designate persons to whom or for whose benefit insurance money is to be payable.

➢ Dependent Eligibility

Registering your Dependents for coverage

- Coverage for your Spouse and Dependent Child(ren) is not automatic. You must notify Manion in writing to add dependent coverage within 31 days of marriage or the birth of a child, by completing a Member Information Change (MIC) form. Eligible "Dependent Children" is defined in the General Definitions section – see page D-2.
- Manion has to be notified as soon as the common-law relationship is established. Eligibility coverage of a common-law spouse is outlined under "Spouse" of General Definitions section – see page D-1.
- You must be covered in order for your Dependents to be covered.
- Dependents ***do not*** include any person permanently living outside of Canada (this does not apply to a student whose normal residence is in Canada and is attending school outside Canada).
- If your Dependent is hospitalized at the time when your coverage becomes effective, coverage for that Dependent will not become effective until the day following final discharge from the hospital.
- No one will be eligible as a Dependent while covered as a Member or such Dependent commences active duty in armed forces of any country, state or international organization.

KEEPING YOUR BENEFITS

➢ Continuation of ELHT Plan Coverages after the Participant's Death

When the in-benefit Member dies, Health and Dental benefits, Emergency Out of Province Medical Coverage (subject to age limitations), and Member and Family Assistance Program for eligible Dependents shall continue, without premium payment, up to a maximum of 24 months from the date of death.

➢ Continuation of ELHT Plan Coverages during a Temporary Interruption of Work

If you are on a leave of absence

While you are on a legislated job-protected leave as defined under the Employment Standards Act, the Employer must continue to make employer-portion of contributions on your behalf for the benefit coverage of the ELHT Plan as required by the Collective Agreement or any other applicable legislation. The Employment Standards Act recognizes maternity and parental leaves. The prerequisite for entitlement to these ongoing contributions during maternity or parental leave, subject to the Employment Standards Act of each province. The availability and pre-requisite for entitlement to employer's contributions for other legislated job-protected leaves may vary, subject to the Employment Standards Act of each province.

If you are receiving disability benefit payments

The Trust Fund will extend coverage for all benefits, provided appropriate monthly contribution remittances are received by the Trust Fund. Coverage will cease at the earlier of the date of recovery, attainment of the 24 month maximum period if the appropriate monthly contribution remittance is not received within the allowable time or the disabled Participant reaches age 65.

Proof of your disability must be submitted within 6 months of disability. You will also be required to provide proof of your ongoing total disability on an annual basis. Acceptable Proof of Continuous Disability includes full CPP disability benefits.

Note: Office Staff MUST apply for Long Term Disability benefits within 34 weeks of their date of disability and for CPP disability benefits within 12 months of the date of their disability.

TERMINATION OF COVERAGE – ELHT PLAN

The following terms and conditions also apply in the case of the partial cancellation of coverages owing to the cancellation of one or more benefits.

For Active Participants

Your benefit coverage will terminate on the earliest of the following dates:

- the date you cease to be a member of any eligible class;
- the date your class is termination from the Plan;
- the date you are no longer a full-time resident of Canada;
- the date you are no longer covered by a Canadian provincial healthcare plan;
- the date you commence active duty in armed forces of any country, state or international organization;
- the date you retire;
- the date you die;
- the date you attain the termination age as outlined in the "Summary of Benefits";
- the date the Group Master Policy is cancelled or terminated.

For Eligible Dependents

A Dependent's coverage terminates on the earliest of the following dates:

- the date the Participant ceases to be covered under the Group Master Policy;
- the date the dependent ceases to be a Dependent as defined in the General Definitions section in the booklet on page D-**Error! Bookmark not defined.**;
- the date the dependent is no longer a full-time resident of Canada;
- the date the dependent is no longer covered by a Canadian provincial healthcare plan;
- the date the dependent attains the termination age as outlined in the "Summary of Benefits";
- the date the surviving Spouse re-marries after the Member's death (surviving Children will continue to be covered by self-payments);
- the date the dependent commences active duty in armed forces of any country, state or international organization;
- the date Dependent coverage is terminated under this Plan.

A Dependent's coverage can be continued following the death of a Member as detailed under the previous section entitled "Continuation of ELHT Plan Coverages after the Participant's Death" on page G-8.

OTHER IMPORTANT INFORMATION

Change in ELHT Plan Coverages

If your ELHT Plan benefits change because of an amendment to the Plan, or because of a change in your age, status in the Plan, earnings, dependent status, etc., the new benefits become effective on the date the change affecting your benefits occurred. When a change results in increased benefits you must be at work or available for work to be eligible for the increased benefits. If you are not Actively at Work or available for work on the date the increased benefits would otherwise become effective, the change will not become effective until you return to work or become available for work.

For example: Member Life Insurance amount was $50,000 when you were disabled and unavailable for work. During your disability, if the Plan increases the Life Insurance amount to $60,000, you would not be eligible for the new increase of $10,000 if you continued to be disabled. You would become eligible for the increased Life Insurance amount only when you recover and you returned to work or become available for work.

Increased benefits for a Dependent confined at home or in a hospital on the date the new benefits would otherwise become effective do not become effective until the Dependent is released from home or hospital. In any case, payment for services and supplies received before the date of an increase in benefits will always be based on plan benefits in effect before the change.

Tax on Benefits

The *Income Tax Act* and its regulations require that the premiums paid by the Trust Fund for your ***Life, Dependent Life, Accidental Death and Dismemberment Insurance, and Critical Illness Benefit*** be included in your annual taxable income. Your T4A is available electronically in the « View Documents » menu under the « My Dashboard » tile the myManion Portal and via the Mobile App.

Note: Life and Accidental Death and Dismemberment Insurance premiums are not taxable for months in which you self-pay.

Health and Dental expenses that are not reimbursed to you by this Plan may be claimed as deductible expenses when filing your income tax return. A Claims History Report outlining what was submitted versus paid is available in « Claims History » menu under « My Claims » tile via myManion.

Note: Your T4A is also available electronically in the « View Documents » menu of « My Dashboard » tile through the myManion Portal and Mobile App.

Change in Government Sponsored Programs

The health and dental benefits under this Plan are provided in conjunction with government sponsored provincial programs. If coverage under any provincial program is modified, suspended or discontinued, this Plan will not automatically assume responsibility for any services or products previously covered under the provincial programs.

Future of the ELHT Plan

The Contributing Employers and the Union expect and intend to keep the ELHT Plan in force indefinitely. However, the Trustees may change or modify the Plan from time to time. ***Future benefit coverage is not guaranteed***.

If the Plan is discontinued, all moneys in the Trust Fund must first be used for the benefit of Members and their beneficiaries, and distribution will be made according to the terms of the Plan and Trust Document.

The Trustees have the authority to determine the nature, amount and duration of benefits provided by the ELHT Plan. Decisions made by the Trustees regarding changes to the benefits provided will be made with the intent of ensuring that the Plan remains sustainable. Any particular benefit payable at any particular time cannot be guaranteed for any specific period of time unless required by legislation. The Trustees reserve the right to amend, suspend, delete or terminate any benefit at any time.

Notice Regarding Privacy of Personal Information

When you apply for coverage, Manion and the Insurers set up a file, or series of files, with personal information relative to your participation in the Health Benefit Trust Fund and Plan. This includes all of the information concerning your enrollment, your benefits and your claims. The purpose of this file is to permit Manion to administer your benefits under the ELHT Plan. This includes the following:

- arranging insurance coverage where applicable
- claims adjudication, management and payment
- offering additional insurance products or services that Manion believe you would benefit from knowing about. Manion may also tailor offerings to you based on your demographics or other information, with the objective of meeting your specific needs
- internal and external audits
- income tax reporting purposes where applicable
- preparation of reports used by the plan sponsor (*Board of Trustees)* in the financial management of the plan

Your files are securely maintained in the offices of Manion, the actuary, the insurers and the custodian. Your personal information is used within these companies and shared, only to the extent required by law, with your plan sponsor, your Participating Local Union and the coverage provider(s) and financial institutions involved in caring for your Plan(s).

Only authorized persons have access to your file when required for coverage purposes. The information in your file is securely stored and is not shared with any other parties, unless you authorize Manion to release it to them, or the disclosure is required by law. You have the right to access the personal information in your file and, if necessary, have it corrected by submitting a written request to Manion or the insurers. Check https://www.manionwilkins.com/privacy/ to access Manion's privacy policy online. You may request to review the personal information Zurich maintains about you and make corrections by writing to: Privacy Officer, Zurich Insurance Company Ltd (Canadian Branch), 100 King Street West, Suite 5500, P.O. Box 290, Toronto, ON M5X 1C9 or by emailing privacy.zurich.canada@zurich.com.

Insurer's Right to Examination(s) of a Claimant

The Insurer(s), at its own expense, shall have the right and opportunity, whenever it deems necessary, to require a medical examination, by a Physician designated by it, of any person for whom a claim is submitted and to make an autopsy in case of death, where it is not forbidden by law. In addition, the Insurer reserves the right to obtain the report of any medical practitioner who has examined the person for whom a claim was submitted.

The Insurer(s), at its own expense and discretion, shall have the right and opportunity to conduct an examination under oath of any person who has submitted a claim or for whom a claim has been submitted under the group policy, whether or not a legal action has been commenced by the person under the group policy with respect to the claim.

Subrogation – Legal Right to Collect

If you or your Dependent has the right to recover damages from any person or organization with respect to which benefits are payable by the Insurer, you will be required to reimburse the Insurer in the amount of any benefits paid out of the damages recovered.

The term "**damages"** will include any lump sum or periodic payments received with respect to (i) past, present, or future loss of income, and (ii) any other benefits, otherwise payable by the Insurer.

If you or your Dependent receives a lump sum payment under judgment or settlement for benefits which would otherwise be payable by the Insurer, no further benefits will be paid by the Insurer until the benefits that would otherwise be payable equal the amount of the lump sum. If a claim for damages is settled before trial, you will be required to reimburse the Insurer the amount that reasonably reflects the loss of benefits that would otherwise be payable by the Insurer. You or your Dependent must notify Manion of any action commenced against a third party and of any judgment or settlement in the circumstances described above.

For benefits paid through the Plan Administrator, Manion also has the right to recover any payments in excess of the amount determined to be payable in accordance with the benefit maximums stated in the Plan.

➢ Misrepresentation

The Trustees have the power to terminate any person to past, present or future benefits and to take any further action they deem appropriate, including denying Membership in the Plan, to any person where the Member or persons claiming through the Member are found to be abusing the Plan or making false or improper claims under the Plan.

➢ Access to Plan Documents

Upon written request, copies of the Plan Documents may be obtained from Manion. There may be charges for this service.

You have the right to review or request a copy of any or all of the following items:

- The sections of the Group Policy and/or Plan Document that apply to you and your Dependents,
- Your application for group benefits, and
- Any evidence of insurability you submitted as part of your application for benefits.

Every action or proceeding against an Insurer for the recovery of insurance money payable under a group insurance contract of the Plan is absolutely barred unless commenced within the time set out in the *Insurance Act*, or other similar applicable legislation [e.g. *Limitations Act, 2002* (Ontario); Civil Code (Quebec)] in the covered person's province.

DESCRIPTION OF BENEFITS

➢ Life Insurance

Life Insurance is payable in the event of your death while you are insured as an active Participant.

The insurance amount is $60,000 and coverage terminates at the earlier of retirement, employment termination or lay-off.

In the event of your death, Life Insurance is payable to your beneficiary (the person you named on your Member Information Card for the ELHT Plan to receive the proceeds), provided you are covered and were at work or available for work.

Naming a Life Insurance Beneficiary

You should review your ELHT Plan beneficiary designation online to be sure that it reflects your current intent. Refer to page G-7 for more details.

Conversion Privilege if Coverage Ends

Your Life Insurance continues for 31 days following the termination of your coverage. During this 31-day period you may be eligible to convert the amount of your Life Insurance to an individual whole life or a convertible one-year term plan or a term to age 65 plan without submitting evidence of health. The premium rate will be determined by your age and class of risk at the time of conversion.

It is your responsibility to contact Manion as soon as possible because the required application form and the initial premium payment must be submitted to the Insurance Company within 31 days of the date your Life Insurance under this Plan terminates. For more information on the conversion privilege, please contact Manion for details. Provincial differences may exist.

Dependents of Active Participants

Life Insurance for the Spouse is payable at $10,000 and the insurance amount is $10,000 for each Dependent Child in the event of their death from any cause at any time or place while insured under this Plan. Dependent Life insurance terminates at the earlier of retirement, employment termination or lay-off.

Conversion Privilege of Dependent Life Insurance

The Dependent Life Insurance continues for 31 days following your death or your termination of coverage. During this 31-day period your Spouse's amount of Dependent Life Insurance may be converted to an individual whole life plan or a convertible one-year term plan or a term to age 65 plan without submitting evidence of health. The premium rate will be determined by your Spouse's age and class of risk at the time of conversion.

It is your responsibility to contact Manion as soon as possible because the required application form and the initial premium payment must be submitted to the Insurer within 31 days of the date your Dependent Life coverage under this Plan terminates.

Waiver of Life Insurance Premium if Totally Disabled

(For Active Participants under age 65)

If you become Totally Disabled for at least six consecutive months before age 65, your Life Insurance will be continued without payment of premiums until you cease to be totally disabled or you reach the age of 65, whichever occurs first.

Totally Disabled or Total Disability means disability resulting from Injury or Sickness which prevents engagement in an Insured Participant's regular occupation for 6 consecutive months. The availability of work will not be considered by the Insurer in assessing your disability. If you must hold a government permit or licence to perform your duties will not be considered Totally Disabled solely because such permit or licence has been withdrawn or not renewed.

The waiver of premiums ceases on the earliest of the following dates:

- you cease to meet this benefit's definition of Totally Disabled;
- you fail to submit medical proof of Total Disability when required;
- you fail to attend a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by the Insurer;
- your 65th birthday;
- you retire; or
- you die.

The waiver of premium for Dependent Life Insurance also terminates on the date the dependent is no longer an eligible Dependent defined in this Plan.

➢ Accidental Death and Dismemberment

This coverage provides 24 Hour **Accident** Protection anywhere in the world. It includes coverage for fatal and nonfatal accidents involving dismemberment, paralysis, loss of use of limbs, blindness, and loss of hearing.

This Insurance also provides valuable living benefits to help protect your family's financial security if you are injured or pass away due to an accident, such as home alteration and vehicle modification, rehabilitation, retraining, child and parent care benefits.

Who is Covered?

If you suffer an Injury resulting in a Covered Loss and you are covered under more than one Class, the Insurer will pay only one benefit, the largest benefit. The Principal Sum for the Participant is $75,000 and the Principal Sum when working toward initial eligibility is $25,000. Coverage will terminate at the earlier of age 75, retirement, employment termination or lay-off.

Covered Losses

Benefit Amount	Principal Sum
Loss of life	100%
Accidental dismemberment of:	
• Both hands or both feet	200%
• One hand and one foot	100%
• One hand or one foot plus the loss of sight of one eye	100%
• Sight of both eyes	100%
• Speech and hearing	100%
• Speech or hearing in both ears	75%
• One hand; one foot; or sight of one eye	75%
• Thumb and index finger of the same hand	33 1/3%
• Hearing in one ear	33 1/3%
Loss of use of:	
• Two limbs	200%
• One limb	75%
Plegia (total paralysis) of:	
• Quadriplegia (all 4 limbs)	200%
• Triplegia (3 limbs)	200%
• Paraplegia (both lower limbs)	200%
• Hemiplegia (upper and lower limbs on one side of the body)	200%
Covered Loss of:	
• Two limbs	200%
• Both hands or all fingers and thumbs of both hands	200%
• Sight of both eyes	100%
Aggregate limit of liability per covered accident is $1,250,000.	

Beneficiary Designation

In the event of accidental loss of life, benefits shall be payable as designated in writing by the insured Participant under the current group life insurance policy. In the absence of such designation, benefits will be payable to your estate. All other benefits shall be payable to you.

Waiver of Premium for Disability

If you become Totally Disabled before age 65, the Accidental Death & Dismemberment Insurance may be continued without payment of premiums in the same manner as Life Insurance.

What are You Covered for?

Benefits	Benefit Descriptions
CORE BENEFITS	
Accidental Death	If there is a loss of life as the result of a covered Injury, The Insurer will pay the applicable Principal Sum.
Accidental Dismemberment	The Insurer will pay the applicable benefit amount if you suffer an Injury listed in the Covered Losses.
Loss of Use	A benefit will be paid to the Insured if they suffer an Injury which results in total paralysis of one or two limbs which is considered to be permanent, complete, and irreversible.
Plegia	Benefits will be provided in the event you have sustained an Injury which has resulted in the permanent, complete and irreversible loss of voluntary movement that affects the motor function of one or more limbs for at least 12 consecutive months.
Accidental Dismemberment & Covered Loss of Use	If you suffer an Injury, which results in a Covered Loss within 365 days of the Accident, The Insurer will pay the benefit amount shown in the Covered Losses.
Aggregate Limit of Liability per Covered Accident is $1,250,000.	
In-Hospital Indemnity Benefit	When you suffer an Injury resulting in Covered Loss which requires you to be hospitalized for more than 7 consecutive days, this benefit provides additional financial help to pay for unforeseen expenses.
ADDITIONAL BENEFITS	
After School Care Benefit	This benefit helps to pay $6,000 for after school care for each dependent child under the age of 11, after your death.
Bedside Companion	If you are hospitalized at least 50 km away from your place of residence for 3 or more days due to an Injury resulting in a Covered Loss, The Insurer will cover the costs associated with having a companion at your bedside if required, including a round-trip economy transportation fare and up to $15,000 for meals and accommodation.
Carjacking Benefit	An additional benefit 10% of the Principal Sum to a maximum of $10,000 will be provided if you suffer an Injury or death, as a result of a carjacking while either operating a vehicle, getting in or out, or as a passenger.

Continuance of Coverage Benefit	Coverage will be extended for 12 months provided premiums are paid if the Insured is: on a temporary lay-off, temporarily absent from work due to short term disability, on leave of absence, or on maternity leave.
Conversion Benefit	On the date of cessation of your employment, you will have 31 days to convert this Group Accident Insurance to an Individual Accident Insurance.
Critical Burn Benefit	If you suffer an Injury due to a critical burn as determined by a Physician, on the surface of your body resulting from an Accident, an additional benefit will be payable for specified body areas as follows: Face and neck and head .....10% Both hands or both feet.....25% One hand and one foot .....25% One hand and the sight of one eye .....25% One foot and the sight of one eye .....25% One hand or one foot.....20% Thumb and index finger of same hand.....20% All other body parts.....20%
Day Care Benefit	A benefit which helps to pay $5,000 for day care costs after your death, for each dependent child under the age of 13 who are enrolled in an Accredited Child Care Facility.
Exposure and Disappearance Coverage	Benefits are payable if you suffer a Covered Loss due to unavoidable exposure to the weather resulting from a covered Accident. In addition, if the conveyance in which you are riding disappears, is wrecked, or sinks, and you are not found within 365 days of the event on a trip which is otherwise covered, The Insurer will presume that you lost your life as a result of Injury and benefits will be payable.
Higher Education Benefit	Benefit to help pay % of the Insured's Principal Sum, to a maximum of $5,000 for post-secondary costs for children enrolled full time in an accredited college, university, or trade school when an Accident results in your death. his amount will be paid annually for 4 consecutive years if the Dependent Child continues their education. Before this benefit is paid each year, the Dependent Child must present written proof, acceptable to Us, that the Child is attending an institution of higher learning on a full-time basis. The maximum amount payable under this benefit is $20,000.
Home Alteration & Vehicle Modification Benefit	When you are injured in an Accident, this benefit provides additional financial assistance and pays the lesser of 10% of Principal Sum or $10,000 to make any modifications to your home or vehicle if required.
Parent Care	If you were to pass away, as a result of an Accident, an additional benefit of $5,000 per Dependent parent or 5% of Principal Sum to a maximum of $10,000 for all Dependent parent(s) would be provided for the care of your dependent parent if you are their primary caregiver.

Repatriation of Remains & Identification Benefit	Repatriation of Remains: If you were to pass away due to an Injury while travelling at least 50 km away from their primary residence, The Insurer will pay the benefit for expenses to either: prepare the body and transport it back to the normal place of residence or cremate the body and return the ashes back to your province of residence, up to a maximum of $15,000. Identification Benefit: In the event that someone is legally required to identify the body of the Insured, and they must travel to the location where the Insured has passed away, The Insurer will provide payment up to a maximum of $15,000 for transportation, commercial accommodation and a subsistence allowance.
Rehabilitation Benefit	When you suffer an Injury under the Accidental Dismemberment, Covered Loss of Use, and Plegia Benefit, this additional benefit provides you with special training in the event you need to change occupations at the lesser of: i) the actual expenses that are incurred within 2 years from the date of the Accident for the Rehabilitation Training; ii) $15,000; or iii) 15% of the Principal Sum.
Seat Belt & Air Bag Benefit	When you suffer an Injury in an automobile Accident when properly wearing your seatbelt, which results in your death, an additional benefit will be paid at 20% of Principal Sum up to a maximum of $25,000. If the seat belt benefit is payable, The Insurer may pay an additional amount to the Principal Sum if you were driving or riding as a passenger with a manufacturer equipped airbag which inflated properly.
Spouse/Domestic Partner Retraining Benefit	An additional benefit at the lesser of 15% of Principal Sum or $15,000 will be provided to your surviving Spouse/domestic partner for the cost of any professional or trade training program should they need to make a career adjustment as the result of your Accidental death.
Therapeutic Counseling Benefit	If you suffer an Injury resulting in a Covered Loss under the Accidental Death and Dismemberment, Covered Loss and Plegia Benefit and require therapeutic counselling, the charges will be reimbursed to the person who incurs the expense up to $5,000 for any one Covered Accident.
Funeral Benefit	An additional funeral amount $5,000 will be paid in the event of the Accidental death of an Insured.
Disability Fitness Benefit	If an Injury is sustained which results in a Covered Loss, The Insurer will pay the reasonable and necessary expenses actually incurred up to a maximum of $5,000 for the purchase of any specially designed fitness training or athletic equipment for you which would otherwise, not have been required except for such Injury.

Workplace Modification & Accommodation Benefit	If you sustain an Injury resulting in a loss which necessitates the use of special adaptive equipment and/or workplace modifications in order to reasonably accommodate your return to Active full-time work with the Policyholder. The Insurer shall pay the Policyholder, upon your return to Active full-time work with the employer, the reasonable and necessary expenses actually incurred by your employer for such adaptive equipment and/or workplace modification up to a maximum of $5,000.
Continuation of Coverage Benefit	Coverage will be continued for 12 months, subject to the payment of premiums, if you are: a) Laid off on a temporary basis; b) temporarily absent from work due to short-term disability; c) on leave of absence; or d) on maternity leave. If you assume other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Exposure and Disappearance

If you were exposed to weather because of an Accident and this results in a Covered Loss, the Insurer will pay the Principal Sum, subject to the Plan terms.

If the conveyance in which you are riding disappears, is wrecked, or sinks, and you were not found within 365 days of the event, the Insurer will presume that you lost your life as a result of Injury. If travel in such conveyance was covered under the Plan terms, the Insurer will pay the Principal Sum, subject to all Policy terms. The Insurer has the right to recover the benefit if the Insurer finds that you survived the event. The General Exclusions and General Limitations below apply to this Hazard.

Definitions

The following terms, which appear in bold, are defined as follows:

Aggregate Limit of Liability means the total benefits The Insurer will pay for a Covered Accident or Covered Accidents set forth in the Schedule or Coverages Section or Endorsement. For purposes of the Aggregate Limit of Liability provision, Covered Accident or Covered Accidents will include a Covered Loss or Covered Losses arising out of a single event or related events or originating cause occurring within a [1] day period and includes a resulting Covered Loss or Covered Losses. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each Covered Person, The Insurer will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.

Coverage(s) means the event or events described in the Hazards of this Policy to which benefits and additional benefits apply.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a Covered Injury, and for which benefits are payable under this Policy.

Domestic Partner if used in this Policy, means the Spouse as defined in this policy.

Immediate Family Member means Spouse, Domestic Partner, parent, brother, sister, legal guardian, step-parent, grandparent, grandchild, natural or adopted child, step-child, step-brother, step-sister, aunt, uncle, niece, nephew, cousin or in-law.

Limb means an arm or a leg.

Exclusions

A loss will not be a Covered Loss if it is caused by, contributed to, or results from:

a) Suicide, any attempt at suicide, self-inflicted injury, or any attempt at self-inflicted injury.
b) War or any act of war, whether declared or undeclared.
c) Involvement in any type of active military service.
d) Illness or disease, regardless of how it was contracted; this includes treatment or complications following the surgical treatment of an illness or disease.
e) Participation in the commission or attempted commission of a crime, any felony, an assault, insurrection, or riot.
f) Parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity.
g) Being intoxicated while operating a motor vehicle.
h) Being under the influence of any prescription drug, narcotic or hallucinogen, unless such prescription drug, narcotic or hallucinogen was prescribed by a Physician and taken in accordance with the prescribed dosage.
i) Travel or flight in any aircraft except to the extent stated in the Coverage Section.
j) Release, whether Accidental or not, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release.
k) A cardiovascular event or stroke caused by exertion prior to or at the same time as an Accident.
l) Alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a licensed medical provider operating within the scope of their authority.
m) Medical treatment within Canada at a private hospital.

➢ Long Term Disability Benefit

If you are Totally Disabled due to an accidental bodily Injury or Sickness for longer than the Qualifying Period, you may be eligible Long Term Disability Benefit.

Qualifying Period

The Qualifying Period starts when you first become totally disabled and ends after 37 weeks provided the disability is continuous and you are under age 65. If the disability is not continuous, the days that you are disabled will be accumulated to satisfy the qualifying disability period provided:

- no interruption is longer than 2 weeks; and
- the disabilities arise from the same or related disease or injury.

Amount of Monthly Benefit

If you become Totally Disabled before age 65 because of a disease or accidental injury, the Insurer will pay a monthly benefit during the applicable benefit period.

The amount of the monthly benefit equals to 60% of first $2,250, 50% of next $2,250, plus 40% of the remaining monthly earnings up to a maximum benefit of $5,000 per month, ***less any income and benefits payable under any Workers' Compensation Law or similar law***, and subject to the All Source Maximum (where applicable). Proof must be submitted to the Insurer that you became totally disabled while insured and have been continuously disabled during the Qualifying Period.

This benefit is non-taxable to the receiving Participant.

The benefit for a period which is less than a full calendar month shall be 1/30th of the applicable Gross Monthly Benefit, less any Reductions of Coverage, multiplied by the number of days in said period.

Benefits will be payable for each month or partial month that such total disability continues beyond the applicable qualifying disability period. Benefits will not be payable for more than the applicable Maximum Benefit Period.

Coverage terminates at the earlier of age 65, retirement, employment termination or lay-off.

Total Disability Definition changes for LTD Benefit

During Qualifying Period and following 24 months – Own Occupation Totally Disabled shall mean you are incapacitated to the extent that you are not able to perform any and every duty of your occupation or employment.
After the above period of LTD benefit payment – Any Occupation Totally Disabled definition changes and shall mean you are incapacitated to the extent that you are not able to perform any and every duty ***of any occupation or employment*** for which you are qualified, or may reasonably become qualified, by education, training or experience, subject to the restrictions noted previously.

The availability of work will not be considered by the Insurer in accessing your disability. 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.

Maximum Benefit Period

The maximum benefit period shall be to age 65, the date that you are no longer disabled or upon retirement.

Benefits may be payable after your attainment of age 65 if you satisfy the qualifying disability period while age 64, in which case the maximum benefit period shall be twelve (12) consecutive months. In no event shall benefits be payable after your death, recovery, or attainment of age 66.

Recurrent Disability

If the plan was paying you Long Term Disability benefits and you return to work and become disabled again because of the same or a related condition within 6 months, your Long Term Disability benefits will be continued without another waiting period. If you have returned to active work for one full day and become disabled from a different and unrelated cause, you will begin a new period of disability. In either case, you will have to re-apply for disability payments by filling out a new claim form.

Benefit Reductions

Your monthly LTD benefit will be **directly** reduced by the total of the following amounts (if any) you receive, or are entitled to receive, due to the same or related disability:

- any Workplace Safety & Insurance Board benefits or similar coverage;
- any government plan, excluding Employment Insurance Benefits;
- any retirement or pension plan;
- any government motor vehicle automobile insurance plan or policy established pursuant to a provincial automobile insurance act., unless prohibited by law; and
- any income or benefit payable under any other plan or program provided to you by or through any employer, including severance payments and vacation pay. Such plan or program includes any permanent and total disability benefit or group life insurance for which you could have elected not to apply.

Your total monthly income while disabled cannot be more than 85% of your gross monthly earnings as of the date disability commenced. ***If total income from the sources listed below, plus this benefit, is more than 85%, your disability benefit will be further reduced accordingly*** (this is known as the All Source Maximum).

All Source Maximum

Your total monthly income while disabled cannot exceed eighty-five percent (85%) of net monthly earnings as of the date disability commences. If the total income exceeds eighty-five percent (85%), the Long Term Disability Income benefit will be reduced by the amount of such excess.

With respect to your participation in a Program of Rehabilitation, total monthly income while disabled cannot exceed 100% of net monthly earnings as of the date disability commences. If total income exceeds 100%, the Long Term Disability Income benefit will be reduced by the amount of such excess.

Total monthly income includes:

1) a) Long Term Disability benefits under this Plan;
   b) income or benefits specified under 2) and 3) below, including any income or benefit from a different or lesser paid occupation;
   c) with respect to your participation in a Program of Rehabilitation, income from the program of Rehabilitation;
2) Income payable to you under a Pension or Retirement Plan of the employer, or any plan or arrangement resulting in the payment of any salary, wage or other payment by the employer to you during the total disability;
3) Income or benefit payable under:
   a) any other plan or program provided to you by or through the Employer. Such plan or program includes any permanent and total disability benefit of Group Life Insurance for which you could have elected not to apply;
   b) any Workers' Compensation law or similar law;
   c) the Canada Pension Plan or Quebec Pension Plan primary benefits;
   d) any other plan or program of any government or of any subdivision or agency of the government, including any plan or program established pursuant to a provincial Automobile Insurance Act. The Insurer shall not reduce the monthly benefit in respect of benefits payable by the Employment Insurance Commission.

You must apply for all benefits or income for which you may be or may become eligible for under any of the preceding sources. If you are receiving any income or benefit payable under any government plan or program for an injury or disease totally unrelated to the injury or disease that caused the current disability, the Insurer shall not reduce the gross monthly benefit by that amount

Reduced Monthly Benefit

If you are eligible for full benefits and you elect a different and lesser paid occupation not related to the Program of Rehabilitation described below, the gross benefit less reductions shall be further reduced by fifty percent (50%) of the earnings from the lesser paid occupation elected, subject to the All Source Maximum described above.

Cost of Living Adjustment

The amount of monthly indemnity benefit payable will be adjusted on the first day of January of each year according to the Canadian Consumer Price Index.

Benefits during Program of Rehabilitation

The Insurer may recommend that a program of rehabilitation is appropriate for you. The Insurer will notify you in writing of its approval of the program and the extent, if any, of its support during such program. Any of the following may be eligible for consideration as a rehabilitation program:

- your regular occupation on a part-time basis;
- a formal vocational training program; or
- any other training program deemed suitable by the Insurer.

Long Term Disability benefits will continue to be payable to you when participating in a rehabilitation program approved by the Insurer for up to twenty-four (24) consecutive months.

Expenses incurred by you in connection with the program and for which you have received prior approval from the Insurer will be reimbursed by the Insurer provided that, in the Insurer's opinion, they are reasonable and customary. Expenses which are payable through government programs or a third party insurer shall not be reimbursed by the Insurer.

Reduced Monthly Benefit: The Gross Benefit less reductions will be further reduced by fifty percent (50%) of any earnings received from employment under the rehabilitation program, subject to the All Source Maximum on page B-10.

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

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

Waiver of Premium

The Insurer will waive the payment of premiums for the Long Term Disability Income for when you are receiving benefits under this coverage. Premiums will be waived beginning with the premium for the first full policy month for which benefits became payable and continuing for each full policy month for which benefits are payable.

Extension of Benefits

If the policy or Long Term Disability Income benefit terminates and you are totally disabled at such termination, the Insurer continues to be liable as though the coverage remained in force.

If a disability recurs within six (6) continuous months after termination of this benefit, the Insurer will continue to pay benefits to you but only for the remainder of the original maximum benefit period. Such disability must have been caused by an accident or sickness that occurred before termination. The Insurer shall not be liable for benefits after termination of either the contract or Long Term Disability Income benefit once a replacing Insurer is bound contractually or as a matter of law.

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will be subrogated to all rights of your recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You shall execute such documents as required by the Insurer.

In the event that you provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share *pro rata* in that amount.

Should you choose to settle the matter prior to judicial determination, you understand that the sum reached in settlement will be deemed to be full compensation for loss of income, and the Insurer's right of subrogation will apply.

The term "**compensation"** shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

Appeal Procedure

If you appeal the denial/termination of a Long Term Disability claim, you must submit a written notice of appeal to the Insurer. The notice must be submitted to the insurer within sixty (60) days of the date of the Insurer's denial/termination notice. Medical or other supportive documentation must be submitted to the Insurer within six (6) months of the date of the denial/termination notice. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.

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

Exclusions and Limitations

No benefits are payable to you for any total disability commencing within 6 months of your effective date of insurance if the disability is caused or contributed to by, or is a consequence of, a sickness or injury for which you received medical treatment or services or have taken prescribed medication at any time or times within 90 days before the effective date of insurance.

Benefits will not be payable under the following circumstances:

1) for any period of disability unless you are under/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 your Physician;
2) for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addition, unless you are participating in a recognized substance withdrawal program;
3) when you are on a leave of absence (including maternity leave). If you become Totally Disabled while on a leave of absence, the leave of absence will end on the day you are scheduled to return to work;
4) when you are receiving treatment by a therapist, unless such treatment is recommended by a Physician deemed appropriate by the Insurer;
5) when you are working in any occupation, except as provided for under the rehabilitation program;
6) when you are imprisoned in a penal institution or confined in a hospital, or similar institution, as a result of criminal proceedings;
7) when you became disabled, when such disability commenced on or after the date a strike begins, subject to any provincial Employment or Labour Standards Act, however, you can fulfill the qualifying disability period during a strike;
8) on the date you cease to meet the definition of Totally Disabled;
9) on the date you do not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by the Insurer;
10) when you refuse to participate in a rehabilitation program which is deemed appropriate by the Insurer.

Benefits will not be payable for any disability directly or indirectly related to:

- intentionally self-inflicted injuries or illnesses, or attempted self-destruction, whether you are deemed sane or insane;
- war (whether declared or undeclared), insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;
- injury or disease which occurred while you are on active duty in the armed forces of any country, state or international organization;
- medical or surgical care which is not Medically Necessary;
- the committing of, or attempt to commit, an assault or criminal offence;
- an accident which occurs while you are operating a motor vehicle and the blood contains more than the legislated legal blood alcohol limit in the jurisdiction where the accident occurred.

➢ Critical Illness Benefit

You may apply for an optional amount of insurance of $50,000.

This insurance covers diseases such as cancer and stroke, but also other conditions such as paralysis, and loss of autonomy.

This benefit provides payment of a lump sum (non-taxable if you paid 100% of the premiums) that can be used to cover your financial commitments, treatment costs, medications, travel to medical appointments and other expenses incurred as a result of the illness.

Coverage terminates at the earlier of the Participant's age 70, retirement, employment termination or lay-off. Upon the death of the Participant while insured under this benefit, the Insurer undertakes to pay the beneficiary the sum insured at the time of the Participant's death, subject to the terms and conditions of this benefit and the group policy.

➢ Health Benefit

Your ELHT Plan coverage pays for the cost of Reasonable and Customary charges for the Medically Necessary services and supplies listed in this section. This coverage is available to you, your Spouse, and your other eligible Dependents, as long as you meet the coverage eligibility rules outlined in the "Eligibility" section. To be reimbursed quickly, you can submit your claims online or by email, please save the original receipts and Physician's prescription for at least one year from the date of service (see "How to File Health Claims" section for more details). Coverage terminates at the earlier of your retirement, employment termination or lay-off.

Eligible medical services or supplies incurred in Canada must be recommended by a Physician unless otherwise stated, and the charges must:

- exceed the amount payable under any government medical, health or hospital services plan or, if the person is not covered under such a plan, exceed the amount that would have been payable by the plan of the province in which the covered person resides;
- exceed the amount payable under any other coverage of the plan, any workers' compensation act, or similar law, or any other source, other than an individual policy issued by another company; and
- be those for which Manion is not prohibited by law from providing.

Eligible Expenses

Hospital accommodation

Charges, more than the hospital's public ward charge for accommodation and meals while in a hospital in Canada as an inpatient, up to the semi-private rate. Benefits are only payable if:

1) the accommodation was specifically elected by the patient;
2) hospital was recommended by the attending Physician;
3) the patient effectively receives curative treatment for illness, injury or for pregnancy.

Limitations:

- Charges for custodial or long-term care in a convalescent hospital, nursing home or similar institution will not be considered an eligible expense. Room charges for outpatient care, day surgery, private room, nursing home, chronic care facilities, home for the aged, and rest home will not be considered an eligible expense.
- Charges for the administrative fees charged by the hospital will not be considered an eligible expense.
- Private hospital will not be considered an eligible expense.

Prescription Drugs

Charges for drugs and medicines which are Medically Necessary for the treatment of an Illness or Injury. Such drugs must be prescribed by a person legally authorized by provincial legislation to prescribe drugs and dispensed by a licensed pharmacist or person legally authorized to dispense such drugs and medicines, for the treatment of an Illness or Injury.

Furthermore, such drugs and medicines must bear a valid Drug Identification Number (DIN) assigned by Health Canada and be included in the Compendium of Pharmaceuticals and Specialties.

Including:

- Oral contraceptives.
- Preventative vaccines, excluding Physician's fees, up to $500 per lifetime.
- Smoking cessation medication up to $500 per lifetime.
- Erectile dysfunction medication up to $250 per calendar year.
- Fertility drugs up to $500 per lifetime.
- Anti-obesity drugs up to $1,000 per calendar year.
- Viscosupplementation Injections (Orthovisc, Synvisc, Neovisc, Durolane, Euflexxa or any other viscosupplementation product) only if dispensed by a Physician, excluding Physician's fees or any other fees.

Co-payment: The Plan does not pay any dispensing fees charged by the pharmacies.

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

What Drugs/Medications are not Covered

- Drugs that do not bear a valid Drug Identification Number (DIN).
- Over the counter medications or drugs for which a prescription is not required by law (federal or provincial).
- Vitamins (injectable or oral) unless they legally require a prescription.
- Alcohol swabs.
- Medication which is provided and administered by a health care practitioner (unless they legally require a prescription).
- Drugs which are not considered medically necessary, e.g. cosmetic, unless they are approved under the Prescription Drug Plan – Prior Authorization Procedure (see below).
- Homeopathic medicines.
- Charges for drugs, sera, injectable drugs or supplies which are not approved by Health Canada or are experimental or Limited Use whether or not so approved.
- Drugs, biologicals and related preparations which are intended to be administered in Hospital on an in-patient or out-patient basis and are not intended for a covered person's use at home.

Prior Authorization Procedure

Your drug plan covers prescription drugs which are medically necessary and required in the treatment of an illness or injury. There are also other new or expensive drugs that may have the potential for misuse. Some of these drugs may have already been covered by the Plan and some may have been previously denied. Under the Prior Authorization Procedure, these drugs will be approved for payment only if your doctor completes the required documentation and they meet the clinical criteria established by Express Scripts Canada (ESC).

How Prior Authorization (PA) Works – When your pharmacist advises that the drug prescribed by your doctor requires PA, you can pay for your medication at this time if you wish, or wait until the PA process is complete. ***Note:*** You will need to complete and submit another authorization request form if you continue to use the PA drug beyond 12 months.

- ***If your PA drug is approved***, ESC will notify you and your pharmacist that it is approved. You will need to complete and submit the "Request For Prior Authorization" form. You can then have your prescription filled and your claim will be processed electronically.
- ***If not approved by phone***, you will need to complete and submit the "Request For Prior Authorization" form. You can call ESC and ask the form to be sent to you. There is a section that you must complete. You must then take the form to your Physician to complete.
- ***If your PA drug is denied***, ESC will notify you and your pharmacist by mail that the drug has been denied. You can then have your prescription filled at your own expense.

Drug Step Therapy

This plan also includes strategies like step therapy, meaning that more expensive drugs are only covered after proven, lower-cost drugs have failed. With a condition like high blood pressure, high cholesterol, diabetes, and acid reflux, this is a huge opportunity for savings, given that the most proven drugs cost much less than some other approved drugs.

Maintenance Drugs

Your Plan covers one dispensing fee every 90 days for maintenance medications. Many medications prescribed by doctors are maintenance medications. These are drugs which you or your eligible dependents have been taking for at least six months and which you or your dependents are required to take for a long period of time for a particular condition. Some examples of maintenance medications include blood pressure medication, birth control pills, heart medication, and thyroid pills.

Maintenance drugs can be identified by Manion at the time your claim is processed. The first time a claim is received for a maintenance medication that is not dispensed in a 90 day supply, you will be paid the eligible drug costs but the Plan will not to pay any dispensing fees. You should request a 90-day supply of your maintenance medication(s).

Mandatory Generic Substitution – unless brand name drugs are prescribed with words "No Substitution"

Prescription drugs are subject to a mandatory generic substitution. Generic substitution is the substitution of a less expensive drug for the originally prescribed brand name drug. This can be done by the pharmacist without the consent of your health care practitioner and is the normal practice of many pharmacists for a limited number of drugs. It does not mean your health care will be negatively impacted because in Canada the generic drug has the same active chemical ingredients as a brand name drug. ***Note:*** If, for any reason, your health care practitioner insists you receive a certain brand name medication, words "No Substitution" or "Dispense as Written" must be stated on the prescription. You will be reimbursed for the brand name drug according to the Plan rules once Manion receives proof that your health care practitioner has specified "***No Substitution" or "DAW***".

Pharmacy Network

You have the choice of purchasing your drugs anywhere you like. In order to assist you in choosing a lower cost pharmacy, a list of pharmacies and their current dispensing fees is available at Manion's website https://www.manionwilkins.com/resources/#reports. Scroll towards the end of the

webpage for the Dispensing Fee Reports. You will find the names and addresses of the pharmacies in your city indicating the average level of their dispensing fees charged. This list is updated periodically.

If You (or Your Spouse) are Age 65 or Older

In *Nova Scotia, Newfoundland and Labrador*, a private plan is the first payor, so the ELHT Plan will cover the eligible drug expenses. Please make sure your pharmacist processes your claim through the provincial plan. Any portion of a claim not covered by the covered person's provincial plan may be paid through this Plan's prescription drug benefits in conjunction with the Plan's rules. Any premium payment required to continue a covered person's provincial health plan coverage will not be reimbursed under this Plan.

Vision care

You and your eligible Dependents will be reimbursed the following maximum benefit amount when prescribed by an ophthalmologist or optometrist for each eligible family member based on the date of purchase.

- Eyeglasses or contact lenses, and eye examinations to a combined maximum of $350 in any 24-month period (12-month period for Children under the age of 18 years).
- Elective laser eye surgery for vision correction up to a maximum of $800 per lifetime. ***Note:*** Cataract surgeries are not covered.
- Prescription safety glasses, including the hardex treatment are eligible for ***active Participant coverage*** only, up to a maximum of $300 in any 24-month period. Dependents are not covered. ***Please ensure the receipt clearly states that it is for prescription safety glasses***.
- Visual training subject to a maximum of $150 per lifetime.

You ***will not*** be reimbursed for sunglasses (plain or prescription) or tinted glasses (with a tint other than number one), or for anti-reflective coating.

Convalescent care

Charges for licensed convalescent care facility services or supplies in excess of the Provincial Health Plan up to $20 per day for a maximum of 120 days per disability. Such confinement must be the result of a direct transfer from a hospital where confined for at least 3 consecutive days and for the continued care of the same condition.

Paramedical services – by Duly Licensed Practitioners

Professional charges are payable for treatment by Duly Licensed practitioners: massage therapist, chiropractor, physiotherapist, acupuncturist, podiatrist, chiropodist, osteopath, naturopath, speech therapist, dietitian, psychotherapist, clinical psychologist, or social worker (MSW)

- **Spouse or Child:** Combined $500 per calendar year per Covered Person for massage therapist★ and chiropractor, subject to the overall maximum of $1,500 per calendar year for all eligible practitioners combined.
  Note: ★ Doctor's written referral is required for Dependents.
- **Employee:** Combined maximum of $1,500 per calendar year per Employee for all eligible practitioners combined.

The amount payable is subject to the Reasonable and Customary limits set for each practitioner in the province where the services are provided.

Private duty nursing

Charges for the services of a registered nurse (RN), licensed practical nurse (LPN), or registered nursing assistant up to a maximum benefit of $10,000 per calendar year per covered person. Nursing will be considered eligible only if medically necessary and recommended by a Physician.

Charges for the following services are not covered:

a) Services provided primarily for custodial care, homemaking duties or supervision.
b) Services performed by a nursing practitioner who is an immediate family member or who lives with the patient. (An immediate family member means a person who is the Member, the Member's Spouse or Child, the Member's or Spouse's parent, or the Member's or Spouse's brother or sister.)
c) Service performed while the patient is confined in a hospital, nursing home, or similar institution.
d) Service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household.

Pre-determination of benefits: Manion suggests that a treatment plan be submitted with cost estimates before any private duty nursing services begin. Manion will then advise you of any coverage that will be provided.

Hearing aids

Charges for purchase of ***hearing aids***, excluding batteries, when provided by a certified, clinical audiologist, up to a maximum benefit of $2,000 per ear every 60 months per covered person.

Orthopedic shoes and orthotics

a) Charges for ***custom-made orthopaedic shoes*** *and* ***orthotics***, each up to a maximum of $400 every 12 months, recommended by a licensed doctor (MD), podiatrist or chiropodist; custom made and specifically designed and molded for the insured individual, dispensed by a certified podiatrist, chiropodist, pedorthist or orthotist and required to correct a diagnosed physical impairment. Recommendation must include the diagnosis, gait analysis, symptoms and chief complaints. No benefit will be provided if the orthopaedic shoes or orthotics are prescribed or dispensed by a practitioner other than those listed above.
b) Charges for **stock off-the-shelf orthopedic shoes** and **orthotics**, each up to a maximum of $400 every 12 months, must be prescribed and dispensed by a licensed doctor (MD), podiatrist or chiropodist. Department stores are not authorized providers. Prescriptions must include the diagnosis, gait analysis, symptoms and chief complaints. Invoices should detail the shoe make or model along with the covered person's name. Pre-fabricated footwear are considered based on the guidelines suggested by Pedorthic Association of Canada at https://pedorthic.ca/insurance-providers/orthopaedic-footwear/.

Note: To avoid misinterpretation of what is eligible and what may or may not qualify as a covered expense, ***it is strongly recommended*** that the covered individual submits an estimate to Manion ***for confirmation prior to the purchase.***

Other medical services and supplies

i) Purchase of external **prostheses** and standard artificial limbs (excluding myoelectric limbs). A maximum of one external breast prostheses per breast every 12 consecutive months. Artificial eyes including repair and replacement, stump socks, shoulder harnesses and voice prostheses.

ii) **Ambulance service** – Reasonable and customary charges for professional ground ambulance service. Emergency transportation by air, rail or water, to the nearest hospital qualified to provide the necessary treatment, up to a maximum of $1,000 per calendar year per covered person and, if medically required, a medical attendant at $500 per calendar year per covered person.

iii) **Diagnostic laboratory and x-ray procedures** which are defined as diagnostic testing of blood, urine or other bodily fluids and tissues and radiographic examinations performed in the covered person's province of residence are covered when coverage is not available under the provincial government plan. Includes allergy testing and materials associated with the testing.

iv) **Speech aids** to a maximum of $2,000 per lifetime.

v) **Accidental dental treatment** as a result of an accident up to $5,000 every 12 consecutive months. Services must be completed within 180 days of the date of the accident. Any expenses over $500 are subject to pre-approval.

vi) Custom molded **ear plugs** to a maximum of $75 every 24 months (Participant coverage only). Dependents are not covered.

vii) Charges for **wigs** as a result of chemotherapy treatment up to $200 per lifetime.

viii) Purchase of a **TENS** (transcutaneous nerve stimulator) machine for the control of chronic pain to a maximum of $700 per lifetime.

ix) Charges for **support stockings** up to a maximum of $250 per calendar year per covered person. To be eligible elastic support stockings must be recommended by a licensed doctor (MD) or podiatrist, provided they have a compression value of at least 20 to 30 mmHg pressure and are required to treat a diagnosed medical condition as determined by Manion.

Durable medical equipment

- **CPAP machines** up to $2,500 every 60 months, as well as an annual maximum of $300 for one mask. CPAP supplies are excluded.
- Charges for one **intermittent positive pressure breathing machine** per lifetime. Supplies are excluded.
- Charges for rental (or, at the Plan's option, purchase) of **mobility equipment**, subject to a maximum benefit of $10,000 every 60 consecutive months, as follows:
  - crutches, canes, walkers;
  - mechanical or hydraulic patient lifters - $2,000 every 60 months;
  - outdoor wheelchair ramps - $2,000 lifetime;
  - wheelchair, standard or where medically required electric – every 60 months, subject to pre-approval by Manion.

- **Medical Equipment**, rental or purchase, when approved by Manion, limited to the cost of the device or item that adequately meets the patient's fundamental medical needs, as follows:
  - splints (excluding dental splints), casts, braces (containing rigid material), and cervical collars;
  - intra-uterine contraceptive devices (subject to insertion by a doctor): $200 every 24 months;
  - insulin and ostomy supplies – unlimited;
  - insulin pumps - $6,500 maximum every 60 months;
  - insulin jet injector - $1,000 lifetime;
  - glucometer – one every 48 months;
  - standard hospital bed (electric excluded);
  - extremity pump for lymphedema - $1,500 lifetime;
  - speech aids - $2,000 lifetime;
  - aerochambers;
  - surgical brassieres – maximum two per calendar year;
  - bed rails;
  - colostomy and ileostomy supplies;
  - custom made burn garments and pressure supports for lymphedema;
  - head halters/traction apparatus/trapeze bars;
  - surgical shoes, boots, cast covers purchased after foot surgery for temporary use;
  - urethral catheters;
  - mist tents and nebulizers;
  - oxygen and the equipment needed for its administration;
  - apnea monitors for respiratory dysrhythmias.

Assistive Devices Programs

Each province has program(s) to help people who have long-term physical disabilities get needed equipment and supplies.

The Assistive Technology Program of **Nova Scotia** Health Authority provides assessments, devices, training and research opportunities as is necessary to support the goals of the NS residents with disabilities. The Rehabilitation & Supportive Services include assessment and developing a care plan to help obtain orthotics, pedorthics, prosthetics and mobility devices etc. A written referral from a recognized health professional is required. For details of the program, visit https://www.cdha.nshealth.ca/rehabilitation-supportive-care-services/assistive-technology.

The Special Assistance Program is a provincial program of **Newfoundland and Labrador** which provides basic medical supplies and equipment to assist with activities of daily living for persons with disabilities who meet the eligibility criteria for the program. Benefits of the program include medical supplies (such as dressings, catheters and incontinent supplies), oxygen and related equipment and supplies, orthotics such as braces and burn garments, and equipment such as wheelchairs, commodes or walkers. Contact the regional health authority at https://www.gov.nl.ca/hcs/department/contact/#disabilities_services for more information on accessing this service.

Prince Edward Island's AccessAbility Supports (AAS) Program provides support to eligible PEI residents for technical aids or assistive devices to improve their ability to perform activities of daily living and instrumental activities of daily living. For general inquiries, call (902) 620-3777, toll-free 1 (866) 594-3777 or visit https://www.princeedwardisland.ca/en/information/social-development-and-housing/accessability-supports to contact the Department of Social Development and Seniors.

Exclusions

The following items are not considered eligible expenses. No benefit is payable for any expense which is directly or indirectly related to:

- charges which are considered a covered service of any provincial government plan;
- charges for general health examinations, eye examinations and examinations required for use of third party;
- charges for medical or surgical care which is cosmetic;
- charges for medical treatment or surgical procedure by a Physician or Specialist other than as provided under Out-of-Province expenses.
- charges for transport or travel, other than as specifically provided under eligible expenses;
- charges for services or supplies which are furnished without the recommendation and approval of a Physician acting within the scope of their license;
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;
- charges which are from an occupational injury or disease covered by any Workplace Safety & Insurance Board law or similar legislation;
- charges which would not normally have been incurred but for the presence of this insurance or for which you or your Dependent are not legally obligated to pay;
- charges which the Trust Fund is not permitted, by any law or regulation, to cover;
- charges for dental work where a third party is responsible for payment for such charges;
- charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind, or injury/illness due to service in any armed forces;
- charges for services or supplies resulting from any intentionally self-inflicted wound, unless medical evidence establishes that the injuries are related to a mental health illness;
- charges for injuries resulting directly or indirectly from the committing of or attempt to commit an assault or criminal offence;
- charges for injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the insured person's blood contained more than the legislated legal blood alcohol limit in the jurisdiction where the accident occurred;
- charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
- charges made by a Physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies;

- any hospital accommodation expenses in Canada or abroad;
- charges for any services or supplies provided by an individual who ordinarily reside in the home of the patient or is an Immediate Family member or is a relative of the Member;
- charges not specified in the foregoing list of eligible health expenses.

➢ Dental Benefit

Your dental plan has been designed to help you and your Dependents maintain good dental health. Should you or your Dependents, while covered under this coverage and as a result of a non-occupational injury or a non-occupational dental disease, incur any of the eligible expenses listed in the "List of Covered Items", you will be reimbursed as described in the following sections. Covered expenses will be based on reasonable and customary charges for the services and supplies provided.

The dental plan covers:

- 100% of Basic Services
- 75% of Major Services
- 50% of Orthodontics (Dependent Children under age 18 only)

Reimbursement

The Plan pays the amount of eligible expenses based on the current dental fee guide applicable in the province where services are rendered. If treatment is given outside Canada, payments will be made to the extent that the charges are reasonable and customary but will not, in any case, exceed the maximums specified in the current dental fee guide applicable in the province of residence.

The plan covers you and each of your Dependents up to the following maxima:

- Basic and Major Services Calendar Year Maximum.....combined $2,000
- Orthodontic Lifetime Maximum (per Dependent Child) $2,000

For information on claim submission, see the "How to File Dental Claims" section on page G-2. Coverage terminates at the earlier of retirement, employment termination or lay-off.

Charge incurred

When a covered dental procedure requires multiple appointments to complete, the charge will be considered to have been incurred on the date the procedure was completed, subject to any Limitations or Exclusions in this Coverage.

Materials to be furnished

In order to determine the eligible charges, Manion may ask for pre-treatment x-rays and other diagnostic and evaluative materials. If they are not given, Manion will determine eligible charges on the basis of the information which is available. This may reduce, or eliminate, the benefits which otherwise would have been payable.

Laboratory Fees

Reimbursement of laboratory fees will be subject to a maximum of 60% of the current Fee Guide applicable in the province of residence for the particular dental treatment requiring the laboratory services.

For Expenses Over $500

For your protection, ***where a proposed course of dental treatment will exceed $500, ask your Dentist to submit a treatment plan in advance***. Manion will advise you what will be covered by the plan and conditions that apply in a "Pre-Treatment Statement". This statement will be sent to you. Provided you remain in-benefit, the conditions of this pre-treatment statement remain in force for 90 days.

Alternate Benefits

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, Manion reserves the right to determine eligible expenses on the basis of an alternate benefit, i.e. coverage is limited to the cost of the lowest priced alternate course of treatment.

List of Covered Items

Basic Services (Preventative and Restorative) – 100%

1) Recall oral examinations: 1 examination every 6 consecutive months. Polishing and topical application of fluoride: twice every 12 consecutive months. Scaling and Root Planing combined: 10 units every 12 consecutive months.
2) Complete oral examination: once every 36 months.
3) Specific oral examination & Emergency examination: 2 examinations every 12 consecutive months.
4) Dental x-rays: One complete series or panoramic x-ray during any 36 month period. One Bitewing set during any 12 month period.
5) Oral Hygiene instruction: 1 per lifetime.
6) Extractions & residual root removal; Frenectomy; Surgical excision, exposure & incision; Alveoplasty, in conjunction with extractions.
7) Fillings: amalgam, porcelain or plastic and replacement after 12 months.
8) Anesthetics and injections of antibiotic drugs.
9) Treatment of periodontal and other diseases of the gums and tissues of the mouth. Periodontal appliances & maintenance: one appliance per arch every 36 consecutive months;
10) Occlusal equilibration: 4 units every 12 consecutive months.
11) Space maintainers & maintenance of space maintainers.
12) Endodontic treatment including root canal therapy.
13) Denture rebase: 1 per arch every 36 consecutive months; Denture reline: 1 per arch every 36 consecutive months; Denture repairs.

Major Services – 75%

1) Crowns, if teeth cannot be restored satisfactorily by the use of a filling material, and gold inlays, if no other material is satisfactory.
2) Replacement of crowns provided a period of at least 60 months has elapsed since the last date on which the crowns were provided.
3) Initial installation of fixed bridgework. (Please see Exclusions and Limitations regarding pre-existing extractions.)
4) Alteration of or, replacement of fixed bridgework, when existing one cannot be serviceable and when necessitated as a result of an additional extraction when the charge for replacement is incurred and a period of at least 5 years has elapsed since the last date on which bridgework was provided or replaced.
5) Initial placement of dentures. (Please see Exclusions and Limitations regarding pre-existing extractions.)
6) Replacement of dentures provided the existing dentures cannot be made serviceable and a period of at least 5 years has elapsed since the last date on which dentures were provided or replaced.
7) Implant dental surgery and related oral services such as abutment insertion, ridge augmentation, bone preservation; implant periodontal surgery; and subsequent implant retained appliance.

Orthodontics – 50%

Only Dependent Children are covered for this benefit up to the date of completion ***provided treatment commenced prior to attainment of age 18***. The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids. These include active space retainers, or orthodontic appliances, those for the purpose of repositioning or moving of the teeth. A treatment plan prepared by the attending Orthodontist must be submitted to Manion for approval. Orthodontic services are payable over the course of the treatment plan, typically 18 to 24 months.

Exclusions and Limitations

Payment will not be made for any dental procedure in respect of teeth extracted, lost, or fractured before you or your Dependent became insured for that procedure except for appliance replacement as specifically stated under List of Covered Items.

No benefit is payable for any expense which is directly or indirectly related to:

- services or supplies that are primarily for cosmetic dentistry;
- services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of their license;
- services or supplies which were necessitated as the result of committing, attempting, or provoking an assault or criminal offence;
- a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
- self-inflicted injuries or illness, unless medical evidence establishes that the injuries are related to a mental health illness;
- miscellaneous charges such as for counseling or instruction, travel, broken appointments, communication costs or filling in of forms;
- any services which are covered by any government plan or program; or for which no charge is made; or which Manion is not permitted by law to cover;
- any dental examinations required by a third party;
- services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease;
- any charges which would not normally have been made but for the presence of this insurance or for which you or your Dependent is not legally obligated to pay;
- services or supplies in connection with any procedures excluded as eligible expenses, including equilibration of dentures;
- charges for dentures that have been lost, mislaid or stolen;
- treatment rendered for a full mouth reconstruction, for a vertical dimension, or for a correction of temporomandibular joint dysfunction;
- services or supplies provided by a person who normally resides with the Covered Person or who is related to the Covered Person by blood or marriage;
- services or supplies for or in connection with a procedure which is not listed as an eligible expense.

➢ Emergency Out Of Province Medical Coverage

For Participants and their Dependents

Emergency Out of Province Medical Coverage is provided by AIG Insurance Company of Canada **for covered persons under age 75**. This Plan covers losses resulting from medical emergencies only.

Important Notes: Expenses related to baggage and personal item loss, trip cancellation, trip interruption are generally not covered under this policy (for example, non-medical expenses such as hotel stays, meals or airfare, or at least a minimal extent where applicable). Travellers seeking the above types of coverage should arrange it independently (e.g. through their travel agent).

It is your responsibility to ensure that the Assistance Company has been contacted prior to receiving treatment or incurring any expenses related to any medical emergency. Failure to do so may limit benefits under this Plan.

The brochure explaining the details of the benefit may be obtained online via myManion. The digital « Emergency Travel Card » is also available under « My Benefits » tile via the Mobile App that can be added to the Apple or Google Wallet without the need to login. They include all of the information you need to make a claim, including the toll-free emergency assistance numbers you can call in case of a medical emergency when travelling outside your province of residence.

Period of Coverage

All active Participants and their Dependents are covered while outside their province of residence for such reasons as business or vacation. Expenses incurred by you are not covered in the event that you had left the province for the purpose of obtaining medical treatment, (except as indicated under the Referral Services benefit).

Trips are limited to a maximum of 90 consecutive days.

Emergency Coverage for Hospital, Medical and Therapeutic Services

If an Insured Person suffers a Sickness or Injury that results in an Emergency stay in a Hospital, including semi-private accommodation, or Emergency medical or therapeutic services outlined in the brochure, which can be obtained online via the myManion Portal or via the Mobile App, the Insurer will pay benefits, for the period this contract is in force, not to exceed a lifetime maximum of $5,000,000 for each Insured Person under the age of 70 and a lifetime maximum of $2,000,000 for each Insured Person age 70 to age 74 inclusive, for the actual expenses an Insured Person incurs outside of their province of residence that exceeds the amount which is payable with respect to such expenses under their governmental health insurance plan, or if the Insured Person is not covered under any such plan, to the extent that the actual expenses exceed any amount which would be payable with respect to such expenses under the governmental health insurance plan if the Insured Person was covered under any such plan.

Hospital Confinement

Benefits are payable for confinement as a resident in-patient in a hospital, including semi-private accommodation and charges made by the hospital for services and supplies rendered by such hospital and provided for use during such confinement.

In the event that you are confined to hospital at the end of your trip outside Canada and thus prevented from returning to Canada, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first insured expense was incurred.

Medical and Therapeutic Services

Benefits are payable for:

a) the services of a legally qualified physician or surgeon (other than an insured person);
b) laboratory tests and X-ray examination by a legally qualified Doctor of Medicine for the purpose of diagnosis;
c) the services of a registered graduate nurse (other than a relative by blood or marriage), up to a maximum of 50 nursing shifts at the usual and customary fee, but not more than $100 per shift;
d) rental of crutches or hospital type bed, or the cost of splints, canes, slings, trusses, braces or other approved prosthetic appliances;
e) the services of a legally qualified anaesthetist;
f) drugs or medicines that require a legally qualified physician's written prescription;
g) services of a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist (other than a relative) up to a maximum of $300 per practitioner;
h) expenses for accidental injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires treatment by a legally qualified dentist or dental surgeon within 30 days from the date of the accident, not to exceed in the aggregate the amount of $2,000 as the result of any one accident;
i) expenses for the relief of dental pain, other than pain caused by an accident, initiated within 48 hours of the onset and completed no later than 90 days after initial treatment, not to exceed $500; and
j) out-patient services provided by a hospital.

Additional Benefits

The following benefits are covered subject to maximum limitations and restrictions as outlined in the brochure:

- Automobile return benefit
- Repatriation benefit
- Identification benefit
- Trip Interruption benefit
- Family transportation benefit
- Return transportation for travelling companion
- Return and escort of Dependent Children under age
- Referral services
- Emergency transportation benefit (ground transportation or air transportation)

Emergency Travel Assistance

Travel Assistance is provided by Global Excel Management Inc. with centres worldwide that will:

- help you locate the most appropriate medical facility for the Insured Person
- confirm coverage with AIG Insurance Company of Canada and assure the Hospital that the Insured Person is covered
- guarantee payment for hospitalization, if necessary
- arrange for admission to a Hospital
- provide translation services
- contact your own doctor for recommendations, when required
- contact your family and employer, when required
- arrange for/co-ordinate emergency medical evacuation
- co-ordinate the Insured Person's return home

Exclusions and Limitations

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

a) Injuries received while the Insured Person is participating in any manoeuvres or training exercises of the armed forces, national guard or organized reserve corps of any country or international authority;
b) pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of an unexpected pregnancy complication occurring before the end of the seventh month;
c) Sickness or Injury where the trip is undertaken for the purpose of securing medical treatment or advice for such Sickness or Injury;
d) dental surgery or cosmetic surgery unless such surgery is a result of a covered Injury;
e) emotional or mental disorders unless the Insured Person is confined to a Hospital;
f) Sickness or Injury due to participation in professional sports;
g) treatment or services that contravene any GHIP plan in Canada;
h) expenses incurred on an elective (non-emergency) basis;
i) loss or injury as a result of suicide or any attempt at suicide while sane or insane;
j) an act of declared or undeclared war, civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority;
k) any services or supplies provided by an Insured Person or one of the Insured Person's immediate family members;
l) any service, treatment, surgery not required for the immediate relief of acute pain or suffering or which is not medically necessary;
m) any treatment or surgery which reasonably could be delayed until the Insured Person returns to their province of residence; and
n) anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to the Insured Person prior to departure.

All expenses must be incurred on a non-elective emergency basis and are in excess of any individual, group or provincial medical plan.

Extended Coverage after Termination

In the event of the delayed arrival of your common carrier hospitalization this Plan will automatically be extended at no charge:

1) 24 hours in the event of a delayed common carrier;
2) The period of hospitalization plus 24 hours after you are released from hospital.

Termination of Emergency Out of Province Medical Coverage

An Insured Person's coverage ends on the earliest of:

3) the date the Plan is terminated;
4) the premium due date if premiums are not paid when due by the Trust Fund;
5) the date the member no longer satisfies the definition of an Insured Participant or, for an eligible Dependent, the date such dependent no longer satisfies the definition of Spouse or Dependent Child, as applicable;
6) the first day of the month following the date the Participant no longer belongs to an eligible class of members.

When an Insured Participant attains age 75, retires or when Health Benefit terminates, this Out of Province coverage ceases for such Participant as well as the Participant's eligible Dependents. Coverage for a Spouse may terminate sooner if the Spouse attains age 75 before the Insured Member. Similarly, coverage for a Dependent Child will cease once the child no longer satisfies the applicable criteria provided within the definition of Dependent Child.

➢ Member and Family Assistance Program (MFAP)

For Participants and their Dependents

MembersHealth Accountable Healthcare Program (AHP)

Accountable Healthcare Program offers personalized healthcare to you and your Dependents for all conditions, ranging from acute to complex. AHP's team of doctors, specialists, and surgeons promptly assess, diagnose, and implement care plans using evidence-based clinical practices, case reviews, and consultations to achieve optimal healthcare outcomes.

With AHP, you will get access to a range of resources and support to help you manage your physical health, mental health and well being. Everyone is guaranteed confidentiality within the limits of the law. You will not be identified to anybody – including your Employer and Manion.

The brochure may be obtained online under the « Forms and Booklets » menu through myManion and from the « My Mental Health » tile you can review your provider information and access the phone number to talk to a Mental Health Specialist.

Program Highlights:

- Members and Dependents can speak directly with AHP's doctors, specialists, and surgeons 24/7/365, within minutes.
- Unlimited appointments for Members and Dependents.
- Access to AHP's doctors from anywhere in the world.

24/7/365 Medical Support:

- Speak to one of AHP's success care professionals at any time of the day or night, including weekends and holidays.
- Tailored referrals to specialists and surgeons – AHP's care team actively works to shorten your wait time based on your local specialist.
- Immediate Mental health support - for crisis situations, you can speak to AHP's therapists in minutes.
- Referral to a therapist for ongoing support - for a set of counseling sessions.

Medical Services:

- Prescriptions are conveniently sent to a pharmacy of your choice.
- Diagnostics and labs ordered on your call for a seamless process.
- No fee doctor's notes (as medically required) conveniently emailed to you.
- Assistance with locating a family doctor.
- Second opinion service – AHP will provide expert medical opinions on your current diagnosis.
- Referrals for Specialists.

Wellness and Mental Health Support:

- Anxiety, stress, & depression.
- Marital & family.
- Addiction support - including expert assessment and treatment.
- Diversity and inclusion.
- Crisis management & trauma-related services.

- Life coaching.
- Nutrition support - healthy eating, weight management and more.
- Legal support - family, immigration, and more.
- Financial support - debt, planning, and more.

Patient Care:

- Personal touch with follow-up calls/texts 24-48 hours post-doctor visit to see how you are feeling.
- Access to AHP's doctors from anywhere in the world.
- Personal care managers dedicated to each member to help you navigate the healthcare system.

How it Works

Access the care you need by booking an appointment:

Click Online at www.membershealth.ca
Tap MembersHealth mobile application available at iOS and android
Call 24/7 on 1-800-484-0152

You will then receive an appointment confirmation by text or call. At the appointment time, the AHP doctors will contact you via video call.

GENERAL DEFINITIONS

The following definitions apply throughout this booklet unless a term is defined differently within a specific coverage for the purpose of that coverage.

Accident shall mean an unexpected or unforeseen happening or event involving an external force, causing loss or injury, independently of all other causes.

Actively at Work shall mean a Participant who is working for a Contributing Employer or is available for work as determined by whose name appearing on the out-of-work list of the Union.

Age shall mean the age of a covered person on the person's birthday, at the time of calculation of premiums or benefits, or at the time an event provided for under this plan occurs.

Contributing Employer, Participating Employer or Employer shall mean an employer who is a party to, or bound by, the Collective Agreement or as may be defined in the Collective Agreement, and who is required or permitted to make payments to the Trust Fund for the purpose of providing coverage for the Participants, of such Employer, who are eligible to be covered under the Trust Plan.

Convalescent Care Institution must be on the list of recognized provincial facilities and ward care must have been paid by the Provincial Health Plan. Convalescent care shall mean an active treatment for rehabilitation for a condition that will significantly improve as a result of convalescent care; and that immediately follows 3 or more days of confinement for acute care. Palliative Care shall mean the treatment for the relief of pain in the final stages of a terminal condition. Such facility **cannot be** used primarily as a:

- rest facility for the aged,
- facility for drug or alcohol rehabilitation or therapy,
- facility for mental illness, or
- facility for custodial care.

Covered Percentage shall mean the percentage of eligible charges shown in the Summary of Benefits, which will be reimbursed under a coverage after satisfaction of the deductible.

Covered Person shall mean an individual who is covered as an employee or a qualified dependent under this plan.

Deductible shall mean the amount of eligible charges shown in the Summary of Coverages, which must be paid by or on behalf of a covered person in any calendar year before reimbursement will be made under a coverage.

Dentist shall mean a doctor of dentistry, or a person licensed to practice dentistry in the place where the services are provided.

Dependents shall mean your eligible dependents include your Spouse and dependent Children identified as follows.

Spouse

- A person married to the Participant as a result of a valid civil or religious ceremony (excluding a person divorced or separated from the Member whether or not there is a court order or a legal separation agreement).
- You must cohabit with your common-law spouse or same-sex spouse for at

least 12 consecutive months in order for this spouse to be eligible for dental, health and dependent life benefits. The relationship should include continuous cohabitation and public representation of married status.

- Only one Spouse will be eligible for insurance under this Policy, and will be as indicated on your application for insurance under this Plan. Where this information is not contained on your application, the person who qualifies last under this Plan's definition of Spouse will be the eligible Spouse.

Dependent Children

- Your children younger than 21 years of age are eligible, provided the child is unmarried, is not employed on a regular and full-time basis and is dependent on you for support. Dependent children from age 21 and younger than 25 years of age must be in attendance at an accredited school, college or university on a full-time basis and wholly dependent on you for support and maintenance, to remain an eligible dependent. Proof of school attendance is required annually. You are able to manage the school proofs under the « Submit Documents » menu of the « My Benefits » tile via myManion.

  The coverage of a Dependent Child who is incapacitated due to a mental or physical handicap on the date the child reaches the age when such child would no longer eligible for coverage as described above, will be continued under the Plan. A child is considered incapacitated if such child is incapable of engaging in any substantially gainful activity, unmarried, and dependent on you for support, maintenance and care, due to a mental or physical disability. To continue a child's coverage, proof that incapacity existed while covered as a Dependent Child should be provided to Manion within 31 days after coverage would otherwise terminate. Contact Manion for the ***Extension of Coverage for Incapacitated Dependent Child Application Form***. Additional proof will be required from time to time and can be managed under the « Submit Documents » menu of the « My Benefits » tile via myManion.

  Stepchildren and legally adopted children may be included the same as your own children, provided they are living with you, depend on you for support and maintenance and are eligible for a deduction under the *Income Tax Act (Canada)*. Foster children are covered as Dependents but not eligible for Dependent Life Insurance.

Drug shall mean a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Duly Licensed shall mean licensed, certified or registered to practice the profession by the appropriate regulatory authority in the jurisdiction in which the care or services are rendered, or where such author*ity does not exist, ha*ving a certificate of competency from the professional body that establishes standards of competence and conduct for that profession.

Eligible Dependent shall mean your Spouse and Dependent Child(ren) who are covered under the Canadian provincial healthcare plan.

Hospital shall mean a legally licensed institution which is operated for the care and treatment of sick and injured persons as in-patients, and which:

a) is eligible to receive payments under a provincial hospital plan;
b) provides organized facilities for diagnosis and major surgery;
c) provides 24-hour nursing service by registered graduate nurses and supervised by licensed Physicians in regular attendance;

d) is not primarily a clinic, nursing, rest or convalescent home, rehabilitation hospital, chronic care facility, health spa, or a place for custodial care, a home for the care and treatment of the aged, the blind or deaf; and
e) is not primarily operated as a place for the care and treatment of alcoholics, drug addicts, tuberculosis or the mentally ill, unless the institution is eligible to receive payments under a provincial hospital plan.

Illness/Sickness shall mean any disorder of the body or mind diagnosed by a physician, including any complications resulting from a pregnancy.

Immediate Family Member shall mean a person who is the Spouse, parent, grandparent, Child, brother, sister, son-in-law, daughter-in-law, parent-in-law, brother-in-law, or sister-in-law of the Covered Person.

Injury (a) with respect to Accidental Death and Dismemberment Insurance, shall mean a bodily injury caused by an accident; (b) with respect to all other coverages, shall mean a bodily injury caused by external violent and accidental means.

Leave of Absence shall mean a period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Employer and the Employee. Leave of absence also includes Maternity and Parental Leave of Absence, and other legislated job-protected leaves. See https://www.canada.ca/en/services/benefits/ei/ei-maternity-parental.html for details and examples.

Maternity Leave of Absence shall mean the period of formal maternity leave to which a Member is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits. For the purposes of this Plan, Maternity Leave of Absence will be deemed to commence on the earlier of:

a) the date fixed by mutual agreement between the Employee and the Employer; and
b) the date the child is born or the child is placed for adoption.

Parental Leave of Absence shall mean the period of formal child care leave to which a Member is entitled by legislation governing the Employer.

Medically Necessary shall mean the service or supply is ordered by a physician and is commonly and customarily recognized throughout the Canadian medical profession as appropriate and required in the treatment of the patient's diagnosed sickness, injury or condition. The service or supply must not be educational, experimental or investigational in nature, nor provided primarily for the purpose of medical or other research.

Natural teeth shall mean teeth whether or not restored, but shall not mean removable or fixed prosthetic devices.

Nonoccupational, with respect to injury, shall mean an injury which does not arise in the course of any employment for wage or profit. With respect to disease, nonoccupational shall mean a disease where a person is not entitled to any benefits under the Workers' Compensation law or similar legislation.

Participant shall mean a person who:

a) resides in Canada; and
b) is working within the jurisdiction of the Union or available for work on the date benefit coverage commences; and
c) has benefit contributions made on their behalf by the Contributing Employer to the trust Fund; and

d) is "in-benefit" for the ELHT Plan. ***In-benefit*** shall mean the person is Actively at Work towards initial eligibility for Accidental Death and Dismemberment Insurance; and has satisfied all of the eligibility requirements applicable under the ELHT Plan for all other coverages; and
e) is eligible for coverage in the Office Staff category under the Health ELHT Plan.

Physician shall mean a Doctor of Medicine (MD) who is duly licensed to prescribe and administer any drugs or to perform surgical procedures in a place where the services are provided.

Plan shall mean Atlantic Canada Regional Council of Carpenters, Millwrights and Allied Workers Employee Life and Health Plan (referred as herein the "ELHT Plan" or the "Plan").

Plan Administrator shall mean Manion Wilkins & Associates Ltd.

Provincial Plan refers to any plan that provides hospital, medical, or dental benefits established by the government in the province where the covered person lives and which is governed by the Canada Health Act.

Qualifying Period shall mean a period of continuous Total Disability, starting with the first day of Total Disability, which must be completed by the Member in order to qualify for Long Term Disability benefit.

Reasonable and Customary shall mean a charge made by the provider of health care, services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.

Totally Disabled and Total Disability:

- **With respect to Waiver of Premium benefit for Life, Dependent Life and AD&D Insurance:** Totally Disabled shall mean disability resulting from Injury or Sickness which prevents engagement in an Insured Participant's regular occupation for 6 consecutive months.
- **With respect to Long Term Disability benefit:** Totally Disabled, during the 6-month qualifying period and the following 24 months, shall mean you are incapacitated to the extent that you are not able to perform any and every duty of your occupation or employment; thereafter, Totally Disabled definition changes and shall mean you are incapacitated to the extent that you are not able to perform any and every duty of ***any occupation or employment*** for which you are qualified, or may reasonably become qualified, by education, training or experience, subject to the restrictions noted previously.

Trust Fund shall mean Atlantic Canada Regional Council of Carpenters, Millwrights and Allied Workers Employee Life and Health Trust Fund (referred herein as the "Trust Fund" or the "ELHT Fund" or the "Fund").

Union shall mean any Local Unions or regional council subordinates to or directly affiliated with the Atlantic Canada Regional Council of Carpenters, Millwrights and Allied Workers (referred herein as "ACRC").

DISCLAIMER

The Trustees have the authority to determine the nature, amount and duration of benefits to be provided through the ACRC ELHT Plan. Decisions made by the Trustees about changes to the benefits will be made with the intent of ensuring that the Trust Funds remain in a “healthy financial position” without accumulating “excessive assets.”

Any particular benefit that is provided at a particular time cannot be guaranteed for any specific period of time unless required by legislation. The Trustees reserve the right to amend, suspend, delete or terminate any benefit at any time.