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Unifor Local 112 Health and Welfare Plan

Full-Time and Part-Time Employees
Plan Booklet

January 1, 2026

Benefits provided through:
Millworkers Health & Welfare Plan (Unifor) Fund

Contents

Introduction

Dear UNIFOR Hospitality Worker,

This booklet provides a general description of the Health and Welfare Plan for eligible Unifor 112 full-time and part-time Members working at participating hotels ("the Plan"). The Plan is provided through the Millworkers Health & Welfare Plan (Unifor) Fund with the following providers administering and/or underwriting the benefits: The McAteer Group, The Manufacturer Life Insurance Company (Manulife), and Co-operators Life.

If you work for any of the following participating Employers, you enjoy the best health and welfare plan in Toronto's hospitality industry. As of February 2026, the Employers that participate in the Plan and contribute towards the benefits as described in this booklet are:

- The Anndore House
- Delta Hotels by Marriott Toronto Airport & Conference Centre
- Delta Hotels by Marriott Toronto Mississauga
- Hyatt Regency Toronto
- Pan Pacific Toronto
- Royal Canadian Legion
- W Hotel Toronto

This booklet contains important information and should be kept in a safe place known to you and your family. It is strictly a summary document and, as such, the legal contracts and policies issued by the insurance companies are the governing documents in all cases. If there are variations between the information in this booklet and the provisions of the policies, the terms and conditions of the policies will prevail.

The Trustees are constantly attempting to provide benefits under the Plan to the Members in the most cost-effective manner. For some benefits, such as Dental, Weekly Indemnity and some portions of the Extended Health Benefits, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act. If you have any questions about your benefits, please contact the Plan Administrator:

The McAteer Group
45 McIntosh Drive
Markham, ON L3R 8C7
Toll Free: 1-800-263-3564
Email: questions@millworkersuniforbenefits.org

Sincerely,

Trustees of the
Millworkers Health & Welfare Plan (Unifor) Fund

Joining and Leaving the Plan

Joining the Plan

In order to join the Plan and become a Member, you must:

- Be a full-time or part-time employee at a workplace which is part of the Plan
- Be a permanent resident of Canada
- Be under 70 years of age
- Complete the necessary enrolment forms

Who is covered for benefits

This plan covers you and your eligible Dependants.

Your eligible Dependants include any of the following persons:

1. Your spouse, who is a person to whom you are legally married, or with whom you have lived continually in a common-law relationship for at least 1 full year (6 months for Dependent Life Insurance and other benefits provided by Co-operators Life) and publicly represent as your spouse
2. Any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your spouse
3. Any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 26 (under age 25 for Dependent Life Insurance and other benefits provided by Co-operators Life) and also in full-time attendance at a recognized college, university, trade school or similar educational facility and financially dependent on you or your spouse
4. Any unmarried disabled child of any age who is living with and is financially dependent on you and/or your spouse and is incapable of self-sustaining employment.

You must be prepared to prove that an individual claimed as a Dependent falls within the listed requirements. The following additional conditions apply:

- No person will be considered a Dependent if they reside outside of Canada on a permanent or temporary basis or if they are a full-time member of the armed forces.
- Only one person may qualify as your spouse at any one time.
- For full-time students age 21 and over, you must confirm full-time school enrollment to The McAteer Group **each school year** and provide proof of such upon request.
- Disabled status is subject to approval by the Plan Administrator. The Dependent must become disabled while covered as a Dependent under clause 2 or 3 above.

Benefit Card

A Benefit Card will be mailed directly to your home address once you become eligible.

Determining Eligibility for Benefits

The Plan operates on an hour bank system. An hour bank system banks your hours contributed to the Plan, and a set amount is deducted every month from your bank to maintain your coverage. The rules of the hour bank system determine whether you are eligible for benefits each month:

1. The Plan maintains a record of your "contributory hours". A "contributory hour" is an hour on which your employer pays contributions to the Plan under the terms of your collective agreement. Your employer reports these hours to the Plan.
2. Your employer begins reporting and paying for these contributory hours monthly **only after you have completed your probationary period**.
3. Your employer also reports whether you are a full-time or a part-time employee.
4. If you work for more than one employer that participates in the Plan, your contributory hours from all those employers count toward your eligibility.
5. To receive payment from the Plan, you must be eligible for benefits in the month in which a covered expense occurs or in which a disability begins. An expense occurs on the date of service or treatment, or the date of purchase of the supply.

6. You will be eligible for benefits for the first time on the first day of the month following the month the Plan has received:

    - **3 months** of contributory hours for full-time Members
    - **9 months** of contributory hours for part-time Members

7. These hours have to total at least:

    - **120 hours for full-time Members**
    - **64 hours for part-time Members**

8. After you have been eligible for the first time, you will be eligible for benefits in any month in which your hour bank balance on the first day of the previous month is at least as much as the required monthly cover charge. The required monthly cover charge is:

    - **120 hours for full-time Members**
    - **64 hours for part-time Members**

9. On the first day of each month, if you have sufficient hours for coverage, the required cover charge will automatically be deducted from your hour bank balance (regardless of whether you have a claim or not).

10. If your hour bank balance is below the required monthly cover charge on the first day of a particular month, then no hours will be deducted, and your benefits will stop on the first day of the next month. However, you will again be eligible for benefits when your hour bank balance reaches the required monthly cover charge on the first day of the previous month.

11. Hours which are not deducted will remain in your hour bank, subject to the following accumulated maximums, which are equivalent to 3 months of cover charge:

    - **360 hours for full-time Members**
    - **192 hours for part-time Members**

Hour bank Example – Full-time Member
George has been a full-time member of the Plan for one year. Below is an example of how the Hour bank rules are applied for George.

Date and Activity	Hour bank Balance	Notes
March 31 – Balance	160 hours	Hours worked to end of February
April 1 – deduct 120 hours	40 hours	George will have coverage in May
April – 60 hours contributed	100 hours	Represents hours worked in March
May 1 – no deduction	100 hours	George will NOT have coverage in June
May – 90 hours contributed	190 hours	Represents hours worked in April
June 1 – deduct 120 hours	70 hours	George will have coverage in July
June – 120 hours contributed	190 hours	Represents hours worked in June
If George maintains a balance of at least 120 hours in his hour bank while he is working, he will be eligible for benefits every month.		

Hour bank Example – Part-time Member		
Maria has been a part-time member of the Plan for two years. Below is an example of how the Hour bank rules are applied for Maria.		
Date and Activity	**Hour bank Balance**	**Notes**
March 31 – Balance	**80 hours**	**Hours worked to end of February**
April 1 – deduct 64 hours	**16 hours**	**Maria will have coverage in May**
April – 34 hours contributed	**50 hours**	**Represents hours worked in March**
May 1 – no deduction	**50 hours**	**Maria will NOT have coverage in June**
May – 65 hours contributed	**115 hours**	**Represents hours worked in April**
June 1 – deduct 64 hours	**51 hours**	**Maria will have coverage in July**
June – 50 hours contributed	**101 hours**	**Represents hours worked in May**
If Maria maintains a balance of at least 64 hours in her hour bank while she is working, she will be eligible for benefits every month.		

Change in Status (Full-time vs Part-time)

To be considered a full-time employee, at least one employer must report your status as full-time along with your contributory hours.

A change in status will take effect on the first of the month following the month in which the change is reported. Since a change in your status is reported to the Plan along with monthly contributory hours, there could be a

lag before you see an impact on your coverage. For example, if your status changes from part-time to full-time in September, those hours will not be reported until October, so the change will be effective November 1.

If your status changes from full-time to part-time, then you will no longer be eligible for full-time benefits, unless you have sufficient hours in your hour bank to continue full-time coverage.

If your status changes from part-time to full-time, then you will become eligible for full-time benefits as described above. However, if you were previously covered for part-time benefits and you don't have enough hours in your hour bank for full-time benefits, then your part-time benefits will be continued (assuming you have sufficient hours for part-time coverage) until your hour bank balance is sufficient to cover the full-time hour bank deduction.

Termination of Benefits

The hour bank rules determine your eligibility for benefits on a month-to-month basis. In addition, **all** coverage for you and your Dependants will **end on the earliest of the following:**

1. The date which your employer is no longer required to contribute to the Plan on your behalf
2. The date on which your Union Membership terminates
3. The date on which you become a full-time member of the armed forces
4. The date on which your employer fails to make a required contribution to the Plan
5. The date on which the Plan is terminated
6. For Dependants, the date a Dependent ceases to be an eligible Dependent.

For certain benefits only, coverage will also end when you reach the maximum insurable age. For such benefits, the maximum insurable age or "Termination Age" is shown in the **Schedule of Benefits**. For most benefits, there is no termination age.

In some cases, you may be eligible to convert your group insurance to an individual plan after termination. Details are available in the **General Information** section.

Exceptions

If your coverage is ending under Item 1 above only, some benefits may be continued under certain circumstances as described below.

Hour Bank Balance Remaining

Your Life, Extended Health and Dental coverage may continue for up to three months:

	Hour bank Balance	
	Full-time Members	Part-time Members
0 months	Less than 120 hours	Less than 64 hours
1 month	120 to 239 hours	64 to 127 hours
2 months	240 to 359 hours	128 to 191 hours
3 months	360 hours	192 hours

Retiree Dental

If you retire with a pension and meet certain eligibility criteria, you may qualify for continuation of dental benefits for up to one year. If you qualify, benefits will be extended to you only. Your Dependants will not be eligible for retiree dental benefits.

Retiree dental benefits will not include coverage for the initial placement of crowns, bridges or dental implants after your retirement date.

Disability

Your Extended Health and Dental coverage may continue while you are receiving Workplace Safety and Insurance Board (WSIB) loss of earnings (LOE) benefits or otherwise considered totally disabled under the terms of this Plan, but in no event longer than:

- The number of months you have already been eligible for benefits under this Plan, or
- Twelve months from your date of disability, whichever is lesser.

You must be eligible for benefits in the month your disability commenced, and your coverage is subject to all other terms of this Plan. In order for your benefits under this Plan to continue while you are receiving WSIB benefits, **you must inform The McAteer Group of your WSIB claim and provide the required proof of claim on an ongoing basis.**

You may also be eligible for continuation of Life Insurance, Critical Illness and/or Accidental Death and Dismemberment Insurance while you are receiving Workplace Safety and Insurance Board (WSIB) loss of earnings (LOE) benefits or otherwise considered totally disabled under the terms of this Plan. Please refer to the Total Disability Waiver of Premium section under each the relevant benefit details later in this booklet.

Schedule of Benefits

The information in this section – for full-time and part-time Members – must be read in conjunction with the details provided under each benefit section. Extended Health Care and Dental benefits, in particular, have specific maximums that will apply to various benefits.

Full-Time Members

BENEFITS		AMOUNTS
Overall Deductible		$25 per family, per calendar year (not applicable to drugs, hospital, or vision benefits)
Life Insurance (see page 45 for details)	Member Life	$60,000 – reduced to $30,000 at age 70 and $15,000 at age 75
	Dependant Life	Spouse -$10,000 Dependent Child - $5,000
Prescription Drugs (see page 21 for details)		95% reimbursement with no deductible, subject to mandatory generic pricing, $7 dispensing fee cap, maximum $5,000 per person per calendar year
Dental (see page 30 for details)	Deductible	No deductible
	Basic Services	100% reimbursement, subject to Provincial Fee Guide

	Major Restorative Services*	100% reimbursement, subject to Ontario Dental Association Fee Guide *Must have 12 months of continuous service with Participating Employer to be eligible for Major Dental
	Orthodontia	50% reimbursement, to $3,000 lifetime maximum, for dependants up to age 18 only
	Post-Retirement	Retired Members age 60 or over 12 months dental coverage
Vision Care (see page 22 for details)	Benefit Amount	100% reimbursement up to $400 every 24 months for persons 18 or older, every 12 months for persons under age 18.
	Eye Exams	100% reimbursement for one eye exam every 24 months.
Paramedical (see page 22 for details)	Chiropodist/Podiatrist	100% reimbursement, $350 maximum
	Psychologist/Psychotherapist/Social Worker	80% reimbursement, $350 combined maximum
	Other eligible paramedical practitioners	80% reimbursement, $350 maximum per practitioner Eligible practitioners include: acupuncturist, audiologist, chiropractor (and 1 chiropractic x-ray combined), massage practitioner, naturopath, osteopath (and 1

		osteopathic x-ray combined), speech language pathologist
Orthotics & Orthopedic Shoes (see page 23 for details)		100% reimbursement up to $400 (combined) every 24 months
Medical Supplies and Prosthetics (see page 23 for details)		80% reimbursement. Subject to reasonable & customary amounts.
Hospitalization (see page 25 for details)		100% reimbursement, semi-private hospital room accommodation
Member Accidental Death & Dismemberment (see page 49 for details)		$60,000 Reduced to $30,000 at age 70 Reduced $15,000 at age 75
Critical Illness (see page 47 for details)		$5,000, list of 25 eligible conditions
Wage Indemnity* (Short Term Disability) (see page 38 for details)		Payable from 1st day accident, 2nd day illness Weeks 1-2 - Plan pays 75% of average weekly earnings, to maximum of $524 Weeks 3-6 - Plan pays 60% of average weekly earnings, to maximum of $524 Weeks 7-32 - Paid by Employment Insurance **Must have 12 months of continuous service with Participating Employer to be eligible for Wage Indemnity*

Maternity / Parental / Compassionate Leave Top Up* (see page 41 for details)	Up to $100/week top up provided during periods member is receiving Employment Insurance benefits for maternity/parental leave (for up to 25 weeks) or for compassionate care leave (for up to 6 weeks) **Must have 12 months of continuous service with Participating Employer to be eligible for Maternity/Parental/Compassionate Leave Top Up benefits.*

Part-Time Members

BENEFITS		AMOUNTS
Overall Deductible		$25 per family, per calendar year (not applicable to drugs, hospital, or vision benefits)
Dependant Coverage		Dependants of part-time Members are eligible for prescription drugs, dental benefits, and eye exams only
Life Insurance (see page 45 for details)	Member Life	$30,000 – reduced to $15,000 at age 65
	Dependant Life	Spouse -$5,000 Dependent Child - $2,500

Prescription Drugs (see page 21 for details)	Reimbursement	95% reimbursement with no deductible, subject to mandatory generic pricing, $7 dispensing fee cap, maximum $5,000 per person per calendar year
Dental (see page 30 for details)	Deductible	No deductible
	Basic Services	100% reimbursement, subject to Provincial Fee Guide Includes diagnostics, preventive, restorative, endodontics, peridontics, prosthetic repairs, and surgical services
	Major Restorative Services	Not Covered
	Orthodontia	Not Covered
Vision Care (see page 22 for details)	Benefit Amount	100% reimbursement up to $400 every 24 months.
	Eye Exams	100% reimbursement for one eye exam every 24 months.
Paramedical (see page 22 for details)		100% reimbursement, $350 maximum for Chiropodist and Podiatrist only.
Orthotics & Orthopedic Shoes (see page 23 for details)		100% reimbursement up to $400 (combined) every 24 months
Member Accidental Death & Dismemberment (see page 49 for details)		$30,000 Reduced to $15,000 at age 65

General Information

Definitions

Deductible

means the initial portion of the Eligible expenses, which you must pay before the Plan will reimburse charges for any Eligible expense.

Dentist

means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, Dentist may also mean dental specialist, denturist, or dental hygienist, depending on the services each may provide.

Eligible expense

means a charge covered by the Plan, medically necessary, reasonable & customary in the circumstances. Such as:

Fee guide

means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed.

Markup

means the Plan's reasonable and customary level, as updated from time to time.

National drug special authorization formulary

is a list of eligible drugs, including:

- certain drugs that require the Administrator's prior approval before being eligible; and
- drugs that require approval by the applicable Government Plan before being eligible.

The Administrator reserves the right on an ongoing basis to add, delete, or amend the list of eligible drugs at their discretion.

Physician

means an individual who is duly qualified and legally licensed to practice medicine or surgery, or both, in the Province or Territory where the service is rendered and registered by the College of Physicians and Surgeons in the

Province or Territory in which the person is practicing. A Physician does not include someone who is residing with or related to you or your Dependant.

Practitioner

means a person currently licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. The Plan reserves the right to refuse the service, medical supply or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

Primary healthcare nurse practitioner

means a person duly qualified and licensed to deliver specific health care services in the jurisdiction where the services are provided and is acting within the scope of that license.

Provider

means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. The Plan reserves the right to refuse the service, medical supply or equipment from the Provider based on ineligibility, or based on the Provider's qualifications or conduct.

Hospital

means an establishment which:

- holds a license as a Hospital (if licensing is required in the jurisdiction)
- operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients
- provides a 24-hour a day nursing service by registered or graduate nurses
- has a staff of one or more licensed Physicians available at all times
- provides organized facilities for diagnosis and major medical surgical facilities

- is not primarily a clinic, nursing, rest or convalescent home or similar establishment
- is not, other than incidentally, a place for the treatment of alcohol or drug addiction

Injury
means bodily Injury which is sustained as a direct result of an unintended, unanticipated accident, provided such accident is external to the body and occurs while insurance under the Plan is in force.

Beneficiary Designation

Your designated beneficiary receives any benefits payable under the Basic Life benefit and Accidental Death & Dismemberment benefit in the event of your death. All other benefits will be payable to you as the Member. A beneficiary named under the basic life benefit is the beneficiary for all benefits under your Plan.

It is very important that you designate a beneficiary. You have the right to name a beneficiary at the time you apply for coverage, and you can change your beneficiary at any time, where permitted by law, by completing an Enrolment and Beneficiary Designation form available from your Employer or from The McAteer Group. If your beneficiary dies before you do or if you do not name a beneficiary, payment will be made to your estate. If your beneficiary is a minor, payment will be made to the named trustee or a public trustee (if you have not appointed a trustee for minor beneficiaries).

You should review any beneficiary designations under this Plan from time to time to ensure that they reflect your current intentions.

General Claiming Guidelines

All claims must be submitted in English.

No payment will be made if your claim is received after the time limits described in this booklet.

Your claim may be rejected if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled, or if any exclusion applies.

Conversion to an Individual Plan

If you are interested in applying for conversion, please contact The McAteer Group for an application.

Basic Life Insurance

If your insurance terminates on or before your 65th birthday, you may be able to convert your group life and/or critical illness insurance to an individual policy, without needing to provide evidence of good health. Your application for the individual policy and the first premium must be received by Co-operators Life within 31 days of the termination of your group insurance. If you die during this period, the amount of group life insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion. The conversion privilege is not available after your 65th birthday.

The amount of Critical Illness benefit converted will not exceed the amount you were insured for under the Plan. The maximum amount of group life insurance that can be converted cannot exceed the full amount of your basic life insurance benefit amounts less the amount of insurance you have or are eligible for under any group insurance contract issued by any insurance carrier on the date your converted policy becomes effective. However, in no event shall the amount of the individual policy exceed $200,000.

General Exclusions

The Plan will not be liable for any portion of an expense for which you or your Dependant is entitled to reimbursement:

- under any other group or individual benefit Plan or insurance policy, or
- due to the legal liability of any other party.

In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:

- intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
- active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat

- a direct or indirect attempt at, or commission of, an indictable offence under the Criminal Code of Canada or similar law of any other country
- false pretenses or fraudulent misrepresentation
- any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar Plan.

Access to Documents

As required by legislation, you have the right to request a copy of your enrollment form or application for insurance and any written statements or other records not otherwise part of the application that you provided as evidence of insurability. For insured benefits, on reasonable notice, you may also request a copy of the master policy, subject to certain limitations. The first copy will be provided at no cost to you, but a fee will be charged for subsequent copies. All requests for copies of documents should be directed to The McAteer Group.

Appeals

If a plan member disagrees with any benefits decision and wishes to appeal, they have the right to do so. Appeals must be made in writing to the Plan Administration Office. Please contact the Plan Administration Office for more details.

Legal Action

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against the Plan or an insurer for the recovery of insurance money payable under the Plan is absolutely barred unless commenced within the time set out in the *Insurance Act* or any other applicable legislation.

Right of Recovery

You are financially responsible for any benefits paid to you that were not payable under the policy, including any benefits paid on your or your Dependant's behalf after coverage is terminated under the Plan. You must reimburse the Plan for these payments within 30 days of receipt of notice of the overpayment.

Third Party Liability

The plan has the right to recover any and all disability income benefit payments made to a plan member if, or when another party is, or may be, legally liable to compensate the plan member directly for income lost due to the plan member's disabling condition.

"Third party" includes but is not limited to a plan member's (and/or any other) home or automobile insurer, as well as any individual, business, insurer, or Government agency from whom the plan member is or may be entitled to claim and/or receive financial compensation for the loss of income arising from full, or partial liability for the plan member's disabling condition.

Extended Health Care Benefits

The plan will pay the reasonable and customary costs of medically necessary medical expenses incurred by active plan Members and their eligible dependants as outlined below. Any individual covered for medical benefits under this plan is required to be enrolled under the provincial health plan in their province of residence or its proxy, whether or not the individual is enrolled in a provincial plan or the required proxy. The plan will not pay any benefits for any services or supplies that are eligible for reimbursement under a provincial health or government plan.

Part-time Members

Part-time Member Extended Health Care benefits are limited to prescription drugs, chiropodists, podiatrists, orthotics, orthopedic shoes, vision care and eye exams. Dependants of part-time Members are eligible for prescription drugs and eye exams only.

Drugs

95% reimbursement with no deductible, subject to mandatory generic pricing, $7 dispensing fee cap, maximum $5,000 per person per calendar year.

Charges for drugs (listed in the National drug special authorization formulary) in a quantity the Administrator considers reasonable, and which are dispensed by a pharmacist, Physician, Dentist, or a Primary healthcare nurse practitioner, including:

- life-sustaining drugs
- insulin preparations, testing supplies, lancets, needles, and syringes for diabetics
- vitamin B12 for the treatment of pernicious anemia
- allergy serums when administered by a Physician or Primary healthcare nurse practitioner
- drugs which legally require a prescription, including, but not limited to:
    - contraceptives
    - drugs for smoking cessation to a calendar year maximum of $350
    - fertility drugs to a lifetime maximum of $2,000
    - vaccines
    - acetylsalicylic acid 81mg

Members or dependants who exceed this maximum can apply for additional drug coverage through the Ontario government's Trillium program.

Reimbursement for multi-source brand drugs will be cut back to the cost of the lowest-cost generic drug plus Markup. The ingredient cost of single-source brand drugs plus Markup is eligible.

If the Administrator receives written confirmation from the prescribing Physician, Dentist, or Primary healthcare nurse practitioner that there is a specific medical requirement that prevents the Member from taking the generic drug, the full ingredient cost of the multi-source brand drug plus Markup will be eligible.

Vision Care

Charges for the purchase of eyewear when prescribed by a Physician or legally authorized optical Provider, and/or repair of eyewear and charges for contact lens fittings when performed by a Physician or legally authorized optical Provider, to a maximum of:

- $400 every 24 months for persons 18 or older. 100% reimbursement.
- $400 every 12 months for persons under age 18. 100% reimbursement.

Charges for non-prescription eyewear and safety goggles (plain or prescription) are not covered.

For part-time Members, Vision Care benefits are not available to dependants.

Eye Examinations

Charges for 1 routine eye examination every 24 months up to the Administrator's reasonable and customary maximum when performed by a Physician or legally authorized optical provider, for persons between the ages of 20 and 64.

Part-time Members and their dependants are eligible for this benefit.

Paramedical

Professional services of the following Practitioners, subject to reasonable and customary limits per visit and up to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. The Plan does not require a doctor's note to access any of the listed practitioners. Practitioners must be registered and legally practice within the scope of their license.

- Chiropodist/Podiatrist
    - 100% reimbursement, $350 maximum
- Psychologist/Psychotherapist/Social Worker
    - 80% reimbursement, $350 combined maximum
- Other eligible paramedical practitioners
    - 80% reimbursement, $350 maximum per practitioner
    - Eligible practitioners include acupuncturist, audiologist, chiropractor (and 1 chiropractic x-ray combined), massage practitioner, naturopath, osteopath (and 1 osteopathic x-ray combined), speech language pathologist, physiotherapist

Only the services of a private duty nurse require referral by a Physician or Primary healthcare nurse practitioner.

- private duty care by a registered nurse for a person with an acute condition in the person's home, limited to a maximum of $5,000 in a 12 consecutive-month period.

Part-time Members are eligible for:

- 100% reimbursement, $350 maximum for Chiropodist and Podiatrist only.
- Dependants of part-time Members are excluded from this benefit.

Orthotics and Orthopedic Shoes

100% reimbursement. $400 per 24 months combined.

When prescribed by a Physician, podiatrist, chiropractor, or a Primary healthcare nurse practitioner as medically necessary, custom-made orthopedic shoes (including repairs) and modifications to stock item footwear. A custom-made orthopedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg when prescribed by a Physician, podiatrist, chiropractor, physiotherapist, or a Primary healthcare nurse practitioner as medically necessary for the patient, custom-made orthotics.

A custom-made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet.

Medical Supplies and Prosthetics

80% reimbursement. Subject to reasonable & customary amounts.

Charges for the following services and supplies provided by a medical supplier (as approved by the Administrator):

- Oxygen
- ostomy and ileostomy supplies
- intrauterine contraceptive devices (IUD's)
- aerochamber inhalers
- walkers, canes and cane tips, crutches, casts, and trusses
- splints and collars, rigid support braces and permanent prostheses (artificial eyes, limbs, and mastectomy forms), when prescribed by a Physician, physiotherapist, chiropractor, or a Primary healthcare nurse practitioner, as medically necessary. Myoelectrical limbs are excluded, but the Plan will pay the equivalent of a standard prosthesis

Charges for the following items to the maximum amounts indicated per calendar year:

- mastectomy brassieres, $250
- stump socks, $250
- surgical stockings, $250
- compression garments (30 mmHg and up)

- wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500
- hearing aids and repairs to a maximum of $500 in a 60-month period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

Standard durable medical equipment

Preauthorization is required from the Administrator for expenses in excess of $5,000.

Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis or required for a long-term disability, purchase of these items from a Provider may be considered.

Repairs to purchased items. Replacement of the item will be considered when it can no longer be made functional. A trade-in or return of replaced equipment may be requested.

Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.

Standard durable equipment includes:

- manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating the manual equivalent, otherwise the Plan will pay the manual equivalent
- medical heart monitors and cardiac screeners
- pacemakers
- blood glucose monitors
- speech processors and headsets when prescribed for profound deafness, subject to a 5 calendar year period
- bi-osteogen systems and growth guidance systems (when recommended by an orthopaedic surgeon)
- breathing machines and appliances, including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, regulators, and sleep apnea equipment

- insulin infusion pumps for diabetics – when basic methods are not feasible
- breast pumps
- transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
- transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

Hospital

The additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital is paid at the semi-private room rate to a maximum of $300 per day. The charges related to maternity will be covered at 100% of the semi-private accommodation rate.

These expenses will be covered to a maximum of 120 days for any one period of disability.

Charges for rental of a telephone, television, or similar equipment are not covered.

Ambulance

The Plan will pay charges in excess of the amount payable under the Insured Person's Basic Medical Plan for professional licensed ambulance service in an emergency including transportation by railroad, boat or airplane, or in acute emergency by air ambulance, from the place where the injury or sickness occurs to the nearest acute general hospital and return fare, including round trip fare for one attending person (doctor, nurse, first aid attendant), where necessary. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention, or transportation arranged at the patient's convenience, are not eligible expenses.

Dental Accident

Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics, and not by an object intentionally or unintentionally being placed in the mouth.

Benefits are paid based on eligible dental services and financial limits in the Fee Guide in the province/territory of service.

Prostate Specific Antigen (PSA) Testing

Charges for PSA testing when ordered by a physician.

Ovarian Cancer Testing

Charges for CA 125 testing when ordered by a physician.

Exclusions for EHC Claims

The following are not included as Eligible expenses under your EHC plan:

1. except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians, Dentists, or Primary healthcare nurse practitioners, or any person who renders a professional health service in the patient's province/territory of residence
2. general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, infant food, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
3. except as specifically included in this booklet: anti-obesity drugs, sclerosing agents, contraceptives, drugs and supplies for smoking cessation, fertility drugs, and any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
4. allergy testing unless rendered by a naturopath

5. personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic, or experimental purposes, public ward accommodation, rest cures, and medical laboratory tests
6. charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English
7. any payment to a pharmacy, a Practitioner, Physician, Dentist, or Primary healthcare nurse practitioner (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan
8. that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits
9. expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
10. expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
11. charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the government plan in your province/territory of residence
12. expenses of a Dependent hospitalized at the time of enrolment
13. services performed by a Physician, Dentist, or a Primary healthcare nurse practitioner, who is related to or resides with you or your spouse
14. services, medical supplies or equipment rendered by a Provider or Practitioner not approved by the Administrator.
15. fees for ambulance services when an ambulance is called but not used

16. ambulance charges for work related illness or injury assessed by the Workplace Safety and Insurance Board (WSIB) to be your employer's responsibility
17. retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial plans
18. any other item not specifically included as a benefit.

Out-of-Province Non-Emergency Eligible Expenses

The Plan will reimburse you (and your Dependants) for non-emergency Eligible expenses incurred while travelling outside your province of residence, subject to the Deductible, in-province reimbursement percentage, and maximums. Any expenses payable or provided under a government plan will not be reimbursed.

Out-of-Province Emergency

Emergency Medical Travel Insurance provides coverage for eligible active employees under the age of 80 and their eligible dependants for certain expenses incurred **as a result of an emergency only** while travelling outside your province of residence. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other Provider of health coverage are not eligible. This travel insurance is underwritten by the Manufacturers Life Insurance Company (Manulife). Manulife has appointed Global Excel Management (Global Excel) as the provider of all assistance and claims services under this policy.

Before travelling, Members should contact Manulife and advise of their destination and travel plans, disclosing any pre-existing conditions as they can impact coverage. The Plan Administration Office can confirm eligibility for Members. Manulife – not the Plan Administration Office – can confirm if there are any limitations on coverage where and when travelling.

- Coverage Period: 90 days per trip
- Maximum: $100,000 per insured person, per trip
- Maximum Age: 79

Policy Number: DAT00013348

Phone Number: 1-833-685-2790 (From Canada/US)

Phone Number: + 519-735-9448 (From anywhere else)

Must be in a stable medical condition before travelling.

Out-of-Province/Canada Emergency Eligible Expenses

Reasonable and Customary charges for services and supplies required as a result of a medical emergency occurring while travelling if:

- you are, or your dependant is covered under a Basic Provincial Medical Plan; and
- treatment could not have been delayed until return to Canada.

When travelling outside your Province of residence, please carry the wallet card found at millworkersuniforbenefits.org/112-health.

Travel insurance is designed to cover losses arising from sudden or unforeseeable circumstances occurring while you are temporarily travelling outside your province or territory of residence. It is essential that you read and understand your Plan before travelling. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provisions of the Policy, the provisions of the Policy shall govern. The Plan has contracted Global Excel Management Inc. (called Global Excel) to provide medical assistance and claims services under the Policy.

Consult the ETA Booklet on this page millworkersuniforbenefits.org/112-health for more information.

Dental Benefits

The Dental Plan will cover you and your eligible Dependants. You must be prepared to prove that persons claimed as Dependants are actually dependant upon you. The Plan provides pay-direct claims processing using your benefit card – present your benefit card when you arrive at your dentist's office for your appointment.

Deductible	$25 per family, per calendar year
Basic Services	100% reimbursement, subject to Provincial Fee Guide

Major Restorative Services*	100% reimbursement, subject to Ontario Dental Association Fee Guide *Must have 12 months of continuous service with Participating Employer to be eligible for Major Dental
Orthodontia	50% reimbursement, to $3,000 lifetime maximum, for dependants up to age 18 only
Post-Retirement	Retired Members age 60 or over 12 months dental coverage

The reimbursement percentage shown is applied to the fees shown in the Fee guide as follows:

- for services performed in Ontario or outside Canada — the fees in the Ontario Fee guide
- for services performed in another province —the fees in the Fee guide in the province/territory of service

Fees in excess of the amount shown in the applicable Fee guide will be your responsibility.

Teeth First Dental Network

Teeth First Dental Network consists of a number of independent dental offices that have joined together to provide value-added, quality dental care. The Network includes approximately 12 offices in the Greater Toronto Area, with new offices added regularly.

The Teeth First Dental Network clinics are carefully selected and consistently follow the Teeth First Dental Set of Standards. These standards include a commitment to gentle and respectful patient care, maintaining a relaxing practice environment, offering flexibility and convenient hours to patients, and more. Dentists within the Teeth First Dental Network follow the Ontario Dental Association fee guidelines and direct-bill to the Plan on your behalf using your benefit card.

As a Plan Member, you are eligible to access dentists within the Teeth First Dental Network if you choose. A list of participating offices is available at **www.teethfirstdental.com/network**.

You will need to provide both a Teeth First card to access the network. You can print a copy of your Teeth First card by going to **www.teethfirstdental.com/network/unifor/**.

Dentists within the Teeth First Network also offer discounts on their fees, which can help reduce Plan costs and leave more funds available to provide other benefits.

Plan A – Basic Preventive & Restorative Services

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible expenses per person include, but are not limited to, the basic services shown below.

Diagnostic services

- examinations
    - complete oral – 1 in 24 consecutive months
    - complete periodontal- 1 in 24 consecutive months
    - recall – 2 per calendar year
    - specific – 2 per calendar year
    - consultations (as a separate appointment)
- x-rays
    - diagnostic
    - panoramic and complete mouth series – a combined limit of 1 in 24 consecutive months
    - bitewing – 2 per calendar year

All x-rays combined shall not exceed the dollar limit for a complete mouth series.

- diagnostic models – 1 set per calendar year

Preventive services

- scaling, root planning and gingival curettage - a combined limit of 14 units per calendar year
- polishing – 2 per calendar year
- topical application of fluoride – 2 per calendar year
- fixed space maintainers
- oral hygiene instruction - 2 per calendar year

- preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period.

Restorative services

- fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar maximum shown in the Fee guide per tooth in a 24 month period:
    - amalgam (silver coloured) fillings
    - composite (tooth coloured) fillings on all teeth
- metal prefabricated restorations on primary and permanent teeth – once per tooth in a 2 year period.

Endodontics

- for the treatment of diseases of the pulp chamber and pulp canal – 1 per tooth per lifetime
- root canals – 1 per tooth in 15 consecutive months.

Periodontics

- for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
    - occlusal adjustment and recontouring – a combined limit of 8 units per calendar year.
    - scaling, root planning and gingival curettage – a combined limit of 14 units per calendar year
    - osseous surgery – 6 services in a 60 month period
    - bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

Prosthetic repairs

- removal, repairs, and recementation of fixed appliances are limited to a combined limit of 4 units per calendar year
- rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 36 consecutive month period
- tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
- gold foil – only when used to repair existing gold restorations.

Surgical services

- extractions
- other routine oral surgical procedures
- general anesthesia required in relation to oral surgery.

Plan B – Major Restorative Services

You are eligible for Major Restorative Services only if you are a full-time member with at least one year of continuous service with a participating employer.

You are eligible for Plan B services when your Dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

Mounted x-rays and/or diagnostic casts may be required for claim approval.

Plan B services include, but are not limited to, the following:

Prosthodontic Services

- removable
    - complete upper and lower dentures
    - partial upper and lower dentures
- fixed bridge

Restorative Services

- inlays and onlays
- veneers
- crowns and related services
- implants (reimbursed at 50% to a maximum of $1,500 per calendar year).

Limitations

- Only 1 major restorative service involving the same tooth will be covered in a 5 year period.
- Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
- No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
- Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined by the Administrator. Where other material would suffice, you

will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage **for Dependent children under age 18 only**. Plan C covers orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Note: This benefit is available for eligible Dependants of full-time Members only.

Limitations

- The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
- No benefit is payable for the replacement of appliances which are lost or stolen.
- Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
- Treatment performed solely for splinting is not covered.

Emergency Treatment Outside Your Province/Territory of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province of residence, you require emergency dental care. You will be reimbursed according to the applicable Fee guide. This will not apply to the services of a dental hygienist.

Exclusions for Dental Claims

The following are not Eligible expenses under your dental plan:

1. items not listed in and fees in excess of those listed in the applicable Fee guide
2. charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
3. procedures performed for congenital malformations or for purely cosmetic reasons

4. charges for drugs, pantographic tracings, and grafts
5. anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
6. charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
7. incomplete or temporary procedures
8. recent duplication of services by the same or different Dentist
9. any extra procedure which would normally be included in the basic service performed
10. services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
11. any item not specifically included as a benefit
12. travel expenses incurred to obtain dental treatment.

Submitting Claims

Your health service providers should submit claims on your behalf at the time of payment. Prescription drug claims must be submitted by the pharmacy. Please show your benefit card to your pharmacist and any other healthcare practitioners so that they can submit your claims directly to the plan.

Members can submit health claims through the Claims Payment Service.

Register for the service by going to millworkers.onlineclaimsaccess.net/en/login or clicking the claims payment service link on the Plan's website.

Electronic payments will be made to your bank account.

You may also download the free app to submit claims through your mobile device if your provider did not submit your claim for you. Search "My Health Benefits" in the App Store or Google Play.

In the event that eligible prescription drugs are prescribed and dispensed outside of Canada, the receipts can be submitted to the Plan Administration Office. Claim forms are available on the plan website. Your fully completed

claim form and receipts can be emailed to claims@millworkersuniforbenefits.org or faxed to 905-946-2535, or mailed to:

Millworkers Health and Welfare Plan

45 McIntosh Drive

Markham, ON L3R 8C7

All claims must be received by the Plan within 12 months of the service date to be considered for payment.

Coordination of Benefits

If you or your Dependants are also covered by another Plan, your benefit payments will be coordinated between the Plans based on the following:

1. The Member is always the primary claimant. Your own claims should be submitted to this Plan first. Any unpaid balance may then be sent to the other Plan.

1. The spouse is always the secondary claimant. If your spouse has medical coverage, their medical claims should be sent to their other insurance Plan first. Any unpaid balance may then be sent to this Plan.

2. Dependant children are always covered primarily under the parent who has the earliest birthdate in the year (month and day). Submit your children's claims to that Plan first.

3. In situations of separation or divorce, the following order applies:

   the Plan of the parent with custody of the child
   the Plan of the spouse of the parent with custody of the child
   the Plan of the parent not having custody of the child
   the Plan of the spouse of the parent not having custody of the child.

4. Total reimbursement shall never exceed 100% of the eligible expenses.

When you submit a claim, please give details if you are covered by another Plan or if you have received other payments. If you have sent your original receipts to another Plan first, you may submit duplicate receipts and an explanation of benefits ("EOB") from the other Plan. Contact The McAteer Group if you are unsure which Plan(s) you should submit a claim to.

When coordinating benefit payments, the Plan will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the eligible expense was incurred.

If the Member or Dependant is also covered under the Spouse's plan or under any other group plan which provides similar benefits, payment will be coordinated and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the eligible expense (for dental, the fee guide applies).

The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.

The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:

- the amount that would have been payable had it been the primary carrier, or
- 100% of all eligible expenses reduced by all other benefits payable for the same expenses by the primary carrier.

If the other plan does not contain a coordination of benefits clause, payment under that plan must be made before the Plan will pay under this provision.

Extended health care plans with dental accident coverage determine benefits before dental plans.

If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.

When the Plan has paid benefits to the Member to the limit of the Pharmacare deductible, the Plan will pay their portion of the eligible expenses based on the plan's reimbursement percentage.

The Member will provide the information required to implement this provision. It is the Member's responsibility to present a copy of the original claim form and the remittance statement or cheque stub when making a further claim under this provision.

Wage Loss Replacement Benefits

You are eligible for Wage Loss Replacement Benefits only if you are a full-time member with at least one year of continuous service with a participating employer.

This benefit provides protection against loss of income for short periods of time if you become totally disabled and are prevented from performing work of any kind solely as a result of a-non-occupational accident or illness. Benefits are also available to supplement your income from Employment Insurance when you are receiving compassionate care benefits, family caregiver benefits for children, maternity benefits or parental benefits.

Benefits are provided through the Millworkers Health & Welfare Plan (Unifor) Fund.

Disability Benefits

Benefit

The Plan will pay wage loss benefits when you are totally disabled and prevented from working as a result of an accident or illness for which WSIB benefits are not payable.

If you have an accident, benefits commence on the first day of work that you miss. If you have an illness, benefits start on the second day of work you miss.

Benefits are integrated with E.I. sick benefits, and are paid as follows:

Weeks 1-2 - Plan pays 75% of average weekly earnings, to a maximum of $524

Weeks 3-6 - Plan pays 60% of average weekly earnings, to a maximum of $524

Weeks 7-32 - Paid by Employment Insurance

Certification of a total disability period beyond a 5-day period must be made by a Physician.

Members whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Plan Member qualifies for full coverage under the Plan.

If you are eligible for E.I. sick benefits, benefits from the Plan will cease during the period you are eligible to collect E.I. If you are still disabled after reaching the maximum duration of E.I. sick benefit payments, or if you are not eligible for E.I., or only partially eligible, the Plan will continue benefits for up to a maximum of 32 weeks including the E.I. sick benefit payments.

Claims must be filed for E.I. sick benefits at the same time you apply for Weekly Indemnity benefits with the Plan.

Average Weekly Earnings

For purposes of calculating your disability benefits, your average weekly earnings are calculated as your hourly rate of pay on your date of disability multiplied by the average number of hours reported per week to the Plan by your employer over the preceding five months.

Your hourly rate of pay is the greater of:

- your hourly wage rate as set in the collective agreement, or
- the minimum base rate for disability benefits at your employer on the date you became disabled and as set by the Trustees.

Partial Weeks

Benefits for partial weeks are prorated based on a 5-day work week. No benefits will be payable for days on which you would not normally be paid if you were not totally disabled.

Coordination with Other Income Sources

Your wage loss payment will be coordinated with benefits received from other sources so that the total benefits received, for the same disability, will not exceed your normal take home pay on the date you became disabled.

Recurrent Disability

A recurrent disability will be considered part of the prior disability if, after receiving wage loss benefits, you return to work for less than 2 weeks. Once you have resumed work on a full-time basis and have been at work for 2 consecutive weeks, any subsequent injury or sickness will be considered a new disability.

Termination of Benefit Payments

Your benefit payments will cease on the earliest date one or more of the following occurs:

- you are no longer disabled
- you are no longer receiving continuing medical care and treatment from your Physician
- you are no longer following the treatment recommended for your disability
- you fail to submit satisfactory proof of continuing disability as required by the Plan
- you refuse a medical examination by a Physician chosen by the Plan
- you perform any work or compensation for profit
- the end of the maximum benefit period indicated in the Schedule of Benefits
- you retire

Leave Top Up Benefits

The Plan provides up to $100/week top-up provided during periods the member is receiving Employment Insurance benefits for maternity/parental leave (for up to 25 weeks) or for compassionate care leave (for up to 6 weeks).

Your combined benefit from this Plan and Employment Insurance cannot exceed more than 100% of your normal weekly earnings.

You cannot collect leave top-up at the same time as disability benefits.To apply for Leave Top Up Benefits, you must be receiving corresponding benefits from Employment Insurance (EI) and take the following steps:

- obtain a Leave Top Up Claim Form from the Plan Administration Office, or the Plan website Help completing the form is available.
- Complete, sign and date the appropriate sections of the form.
- Have your Human Resources Department complete the Employer section and submit the completed form to The McAteer Group.
- Provide The McAteer Group with a copy of documentation from EI confirming the start date, end date and weekly amount of your EI payments.

Taxable Status

Any wage loss replacement benefits you receive from the Plan are considered taxable.

Submitting a Wage Loss Claim

Disability Benefits

Take the following steps as soon as possible after you have become disabled:

1. Contact your doctor immediately upon becoming disabled. You must be seen and treated during the time of your disability.
2. Obtain a claim form from the Union office, shop steward or the Administrator's office and note instructions concerning an E.I. sick claim.
3. Complete the form where indicated.
4. The Union must complete the Authorization at the very bottom of the page.
5. Have your doctor complete the physician's portion of the form.
6. Send the completed form to the Plan Administration Office without delay.

Claim cheques will be sent directly to your home address.

Claims for disability must be submitted no later than 30 days after your total disability begins.

Benefits will only be paid when a Member is under the full-time care of a physician and/or surgeon. Where there is any doubt as to the validity of a claim, the Plan reserves the right to obtain a second medical opinion from a physician and/or surgeon of their choice.

Proof of Claim

You are required to prove your entitlement to benefits under the Plan. You must provide information required to prove your entitlement to benefits and must also authorize us to obtain information from other sources for this purpose (if required). Where applicable, from time to time, the Plan will ask you to provide us with proof of your total disability. Whenever the Plan requests information or authorizations, it must be submitted within the time limit requested. If not submitted within this time, you will not be entitled to benefits. Expenses incurred for providing this information will be your responsibility.

Deadlines

The Plan must receive your claim within 90 days of your last day worked. Failure to submit a claim within this limit may invalidate your claim.

Incomplete claim forms will cause a delay in the payment of your benefits.

Third Party Liability

The Plan will not pay benefits to the Member where a Member becomes Totally Disabled because of an injury or sickness in respect of which

a) a third party may be, directly or indirectly, either in whole or in part, liable to the Member, such as in the case of a motor vehicle-related accident or injury, or

b) the Member has a claim for benefits under workers compensation legislation;

Recurrence of Former Ailments

The Member will not receive benefits for more than

26 weeks as a result of disability due to any one ailment. However, a new waiting period and benefit duration period will start if the Member returns to active full-time work for:

a) A period of 2 weeks before the Member again becomes disabled because of the same or related cause, or

b) One full day before the Member again becomes disabled because of a different or unrelated cause.

Exclusions and Limitations

No benefit will be paid for periods of disability:

- arising from a motor vehicle-related accident or injury where ICBC or a third party may be, directly or indirectly, either in whole or in part, liable to the Member;
- arising from occupational accident or illness, as these are covered by the WCB Act;
- arising from your commission of or attempt to commit an assault or criminal offense;

- arising from self-inflicted injuries or sickness;
- substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician;
- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a Member of any armed service;
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from E.I., or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence;
- during which the insured is receiving or eligible to receive E.I. benefits;
- if you become disabled during a strike or lockout at your place of employment; however, your rights to benefits will be reinstated when the strike or lockout ends.

Termination of Benefit

Your benefit payments will cease on the earliest date one or more of the following occurs:

- you are no longer disabled
- you are no longer receiving continuing medical care or treatment from your physician;
- you fail to submit satisfactory proof of continuing disability as required by the Plan;
- you refuse a medical examination by a physician chosen by the Plan;
- you are no longer following the treatment recommended for your disability;

- you leave the province, state or country where you normally work and live, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan as medically necessary. If you normally reside outside Canada, such treatment must be approved by the Plan.
- you perform any work for compensation or profit;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire;
- you reach age 65; or
- you die.

Life Insurance

Your Basic Life Insurance benefits are underwritten by Co-operators Life Insurance Company. The amount of insurance is payable to the beneficiary designated by you, should your death occur from any cause while you are insured under the group policy. If you do not designate a beneficiary, the insurance will be payable to your estate.

Benefit Amount

Full-time

Member Life	$60,000 – reduced to $30,000 at age 70 and $15,000 at age 75
Dependant Life	Spouse -$10,000 Dependent Child - $5,000

Part-time

Member Life	$30,000 – reduced to $15,000 at age 65

Dependant Life	Spouse -$5,000 Dependent Child - $2,500

Total Disability Waiver of Premium

If you become Totally Disabled for more than six months prior to age 65, the amount of your life insurance will continue without payment of premiums, while you remain Totally Disabled. Satisfactory proof of Total Disability must be submitted to within 12 months from the date of Total Disability and thereafter, upon request by the insurer. Your life insurance coverage and waiver will terminate when you reach age 65 or recover, whichever occurs first.

It is your responsibility to apply for waiver of premium. Forms and more information are available from The McAteer Group.

If you don't apply or if your waiver of premium claim is not accepted, then your Basic Life Insurance coverage will end unless you go back to work at a participating employer.

Living Assistance Benefit

The living assistance benefit is available to you as an advance payment of your basic life insurance to help meet your medical or other health and welfare expenses if you become terminally ill and have been approved for the total disability life waiver of premium prior to age 65.

Your employer must approve your application for this benefit and Co-operators Life will confirm that your medically diagnosed condition meets the program's requirements before approving payment. The amount of money available as a living benefit payment is 50% of your basic life insurance benefit, to a maximum of $50,000.

Submitting a Life Insurance Claim

The time limit within which a group life insurance claim must be made is 180 days from the date of loss. Your beneficiary must contact The McAteer Group who will provide claim forms and assistance with the claim process.

Critical Illness Insurance

Your Critical Illness benefits are underwritten by Co-operators Life Insurance Company.

You are eligible for Critical Illness Insurance only if you are a full-time member.

Amount of Insurance

$5,000.

Critical Illness for Members

If, while coverage is in effect, you, for the first time in your lifetime:

- are Medically Diagnosed with life-threatening cancer, Aplastic Anemia, Bacterial Meningitis, Loss of Independent Existence, Loss of Limbs, Loss of Speech, Paralysis, Occupational HIV, Multiple Sclerosis, Motor Neuron Disease, Alzheimer's Disease, Parkinson's Disease or a Benign Brain Tumour, or
- suffer a Heart Attack (Myocardial Infarction), Stroke, Kidney Failure, Coma, Deafness, Burns, or Major Organ Failure, or
- become Blind, or
- undergo Aortic Surgery, Coronary Artery Bypass Surgery, Heart Valve Replacement or a Major Organ Transplant or
- a Partial Benefit condition (meaning Coronary Angioplasty, Chronic Lymphoma Leukemia (CLL), Carcinoma in situ of breast, Malignant Melanoma, Prostate Cancer or Thyroid Cancer)

and you survive the Survival Period, then Co-operators Life will pay the premium, provided certain conditions have been met. The McAteer Group can explain this to you.

Once a full Critical Illness benefit is paid, coverage will terminate, and no further insurance is available for you under this Provision.

Independent Medical Assessment

It is a condition precedent to the payment of a Critical Illness Benefit that you shall, if required by Co-operators Life, undergo an Independent Assessment by one or more Physicians/Specialists chosen by Co-operators Life.

Total Disability Waiver of Premium

If premiums for your Basic Life Insurance coverage under the Policy are being waived, then premiums for your Critical Illness coverage will also be waived but only so long as this benefit and the Plan's coverage under this benefit remains in force.

Exclusions for Critical Illness Claims

No Critical Illness Benefit will be paid if your condition, either directly or indirectly, was caused by, was contributed to by, or resulted from, or was in any manner associated with one or more of the following:

1. attempted suicide or self-inflicted Injury or Sickness, regardless of mental state, or
2. committing or attempting to commit a criminal offense or provoking an assault, or
3. a situation where the Critical Illness results from Injuries sustained in, or directly or indirectly from, a Vehicle accident where you were driving the Vehicle involved in the accident and had either:
    - alcohol in your blood in excess of 80 milligrams of alcohol per 100 millilitres of blood; or
    - your ability to operate the Vehicle impaired by drugs or alcohol or a combination of the two; or
    - any poison gas or fumes, voluntarily or otherwise taken, administered, absorbed or inhaled, or
    - the use of alcohol or the use of any medication or drugs, voluntary or otherwise taken, administered, absorbed or inhaled, other than taken as prescribed by a Physician, or
4. insurrection, riot, hostilities of any kind, or war (whether war be declared or not) or active service in the armed forces of any country.
5. treatment for injury or illness caused by activities such as hunting, mountaineering, professional sports, racing of any kind, scuba diving, aerial sports, hang gliding, ballooning, and aviation other than as a fare paying passenger in a commercial licensed aircraft.

6. medical care which is not medically necessary or which is of a cosmetic nature. The donation of an organ or tissue will be considered as necessary medical care.

No Critical Illness Benefit will be paid where you fail to seek Reasonable and Customary Treatment in order to circumvent the waiting period or other conditions and restrictions applying to this benefit.

Submitting a Critical Illness Claim and More Information

You must contact The McAteer Group who will provide claim forms and assistance with the claim process.

Your critical illness claim form must be submitted within 3 months of the date the illness was diagnosed.

Failure to furnish proof within this time will not invalidate or reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months from the date of diagnosis.

Accidental Death and Dismemberment Insurance

Your AD&D benefit is provided by AIG Insurance Company of Canada.

If you suffer any of the losses listed below in the Schedule of Losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is covered?	Benefit Amount
Member, age 69 and below	$60,000
Member, age 70-74	$30,000
Member, age 75 and above	$15,000

Schedule of Losses

Loss of Life	The Principal Sum

Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm or One Leg	80% of the Principal Sum
Loss of One Hand or One Foot	75% of the Principal Sum
Loss of The Entire Sight of One Eye	75% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	33% of the Principal Sum
Loss of Speech or Hearing	75% of the Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Hearing in One Ear	66.7% of the Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	Two Times The Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two Times The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two Times The Principal Sum

How to Make a Claim

In the event of a claim, claim forms can be obtained here: millworkersuniforbenefits.org/112-health.

Written notice of claim to the Company must be given no later than 30 days from the date of the accident. Within 90 days from the date of the accident, proof of claim must be submitted to the Company. Proof may include a

certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from a legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed above will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and in no event later than one year from the date of the accident or the Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

More Details

For more details on your AD&D benefit, please visit the Plan website at millworkersuniforbenefits.org/112-health.

Respecting Your Privacy

The Plan, including the Administrator and all insurance providers, is committed to maintaining the security of your personal information. This is a top priority.

When you apply for coverage or benefits, the Plan must gather personal information about you, your spouse or dependants. We may also need to collect information, including medical information, about you from sources such as insurance companies, doctors and health care providers, the government and governmental agencies, and your employer.

We use this personal information for the purposes of providing group benefit plan administration services and insurance products to you, including:

- determining your eligibility for benefits
- administering and adjudicating your benefits
- determining the cost and financially managing these programs,
- meeting regulatory or contractual requirements with respect to the benefits and related services provided to you.

Access to your personal information is restricted to those employees and representatives who are responsible for the administration and servicing of the Plan, or any other person whom you authorize. Your personal

information will not be used or disclosed without your consent, except where authorized by law.

You are entitled to consult the information contained in our file and, if applicable, to have it corrected. The medical information not collected directly from you may only be released directly through your physician. To access the information that we have about you or to ask us to correct information, you can contact us at:

The McAteer Group
45 McIntosh Drive
Markham, ON L3R 8C7
Toll Free: 1-800-263-3564
Email: questions@millworkersuniforbenefits.org

Contact Information

Out of Province Emergency

Policy Number: DAT00013338
Phone Number: 1-833-685-2790 (From Canada/US)
Phone Number: + 519-735-9448 (From anywhere else)

Benefit insured by Manulife. Global Excel is the claims service provider.

Plan Administration Office

For questions regarding your claims or coverage details or for general assistance, please contact the Plan Administration Office:

The McAteer Group
45 McIntosh Drive
Markham, ON L3R 8C7

Toll Free: 1-800-263-3564
Email: questions@millworkersuniforbenefits.org

9:00 A.M. to 5:00 P.M.