Unifor Local 112
Health and Welfare Plan

Standard Plan Benefits
Full-time and Part-time Employees

Benefits provided through**:**

Millworkers Health & Welfare Plan (Unifor) Fund

June 1, 2025

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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), Blue Cross Life Insurance Company of Canada, 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 2023, 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.

This booklet describes the benefits in place as of a certain date. The Trustees reserve the right to amend or terminate any of the benefits provided under the Plan.

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 Dependents.

Your eligible Dependents 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 Administrator. The Dependent must become disabled while covered as a Dependent under Clause 2 or 3 above.

Identification (ID) Cards

A Benefits ID 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. 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 **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 be reporting your status as full-time along with your contributory hours.

A change in status will impact benefits on the first of the month following the month 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 cover charge.

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 Dependents 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 Dependents, 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 on 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 Dependents 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 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.

Extended Health Care (Members and Dependents*)

Calendar Year Deductible**	$25 per family
Reimbursement for Eligible In-Province Expenses	
• Hospital Room Accommodation, Chiropodists, Podiatrist, Orthotics, Orthopedic Shoes, Vision Care and Eye Exams	100%
• Prescription Drugs (subject to $5,000 annual maximum and $7 maximum dispensing fee)	95%
• All Other Eligible In-Province Expenses	80%
Reimbursement for Eligible Out-of-Province Expenses	
• Emergency Expenses	100%
• Non-emergency Expenses	Same as In-Province
Lifetime Maximum	$100,000 per person

* Part-time Members are eligible for prescription drugs, chiropodists, podiatrist, orthotics, orthopedic shoes, vision care and eye exams only. Dependents of part-time Members are eligible for prescription drugs and eye exams only.

** The Deductible does not apply to hospital room, prescription drugs, or vision benefits

Dental (Members and Dependents)

	Basic Services	Dental Implants*	Other Major Services*	Orthodontic Services**
Reimbursement	100%	50%	100%	50%
Overall Maximum	Unlimited	$1,500 / year	Unlimited	$3,000 lifetime

* To be eligible for Major Services, you must be a full-time Member with one year of continuous service

** Orthodontic coverage is available to full-time Members' Dependent Children under age 18 only (part-time Member Dependents are not eligible)

Wage Loss Replacement (Full-time Members only*)

Maternity or Parental Leave**			
• Maximum Weekly Benefit	$100		
• Maximum Benefit Period	25 weeks		
Compassionate Care Leave**			
• Maximum Weekly Benefit	$100		
• Maximum Benefit Period	6 weeks		
Disability			
• Commencement of Benefits	First day for accident, second day for illness		
• Maximum Benefit Period	32 weeks, including EI period		
	Weeks 1-2	**Weeks 3-6**	**Weeks 7-32**
• Percentage of Average Weekly Earnings	75%	60%	EI***
• Maximum Weekly Benefit	$524	$524	EI***

** To be eligible for Wage Loss benefits, you must be a full-time Member with one year of continuous service

** You must be in receipt of EI benefits to qualify for maternity, parental or compassionate care benefits

*** You are expected to apply for Employment Insurance sick benefits during weeks 7-32

Basic Life and Dependent Life Insurance

	Amount of Insurance	
	Full-time	**Part-time**
Member		
• Under age 65	$60,000	$30,000
• Age 65-69	$60,000	$15,000
• Age 70-74	$30,000	$15,000
• Age 75+	$15,000	$15,000
Spouse	$10,000	$5,000
Dependent Child (from birth)	$5,000	$2,500

Accidental Death & Dismemberment (Members Only)

Principal Sum	Equal to Member Basic Life Benefit

Critical Illness (Full-time Members only)

Amount of Insurance	$5,000
Partial Benefit	20% of the Amount of Insurance
Termination Age	Age 70

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 for any service and/or supply included in this booklet as a benefit that:

- is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth;
- was ordered or referred by a Physician, Dentist, or a Primary healthcare nurse practitioner (PHCNP), unless otherwise specified in the benefit description;
- is not a cost normally paid (in whole or part) or provided by a government plan or any other Provider of health coverage;
- is incurred while your coverage is valid (an expense is "incurred" on the date the service is provided or the supply is received); and
- is provided by a Practitioner or Provider approved by the Administrator.

An eligible expense does not include any payment to a pharmacy or a 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.

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 Dependent.

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 licence 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
- provides24-hour a day nursing service by registered or graduate nurses
- has a staff of one or more licenced 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 a 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 name 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.

Coordination of Benefits

If you or your Dependents are also covered by another plan, your benefit payments will be co-ordinated between the plans based on the rules of the *Canadian Life and Health Insurance Association* guidelines:

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.

2. 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.

3. Dependent 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.

4. 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.

5. 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 to which plan(s) you should submit a claim.

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.

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.

Conversion to an Individual Plan

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

Basic Life Insurance and Critical Illness

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 Dependent 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 offense under the Criminal Code of Canada or similar law of any other country
- false pretences 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 record 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

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

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 Dependent's behalf after coverage is terminated under the Plan. You agree to reimburse the Plan for these payments within 30 days of receipt of notice of the overpayment.

Third Party Liability

If you and/or your insured Dependent become totally disabled due to an injury or sickness or become eligible for reimbursement of insured medical or dental expenses as a result of an injury or sickness for which a third party is, or may legally become liable, you or your Dependent must sign and submit a reimbursement agreement before any benefits will be paid. The reimbursement agreement outlines the terms for reimbursing the Plan when you settle the claim with the third party. To continue to qualify for any future benefits, it is important that you and/or your Dependent obtain written consent from the Plan before settling any claim with the third party.

Extended Health Care Benefits

Your Extended Health Care (EHC) benefits are designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax-supported agency. Benefits are provided through The McAteer Group as Administrator for the Millworkers Health & Welfare Plan (Unifor) Fund.

Part-time Member Extended Health Care benefits are limited to: prescription drugs, chiropodists, podiatrist, orthotics, orthopedic shoes, vision care and eye exams.

Dependents of part-time Members are eligible for prescription drugs and eye exams only.

In-Province/Territory Eligible Expenses

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician, Dentist, or Primary healthcare nurse practitioner. Reimbursement percentage and general plan maximums are outlined in the **Schedule of Benefits** section. Unless otherwise indicated, the maximums shown are on a per person basis.

Hospital

The additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital 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.

Emergency ambulance

Charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient. Air transport will be covered when time is critical, and the patient's physical condition prevents the use of another means of transport.

Emergency transport from one hospital to another, only when the original hospital has inadequate facilities.

Charges for an attendant when medically necessary.

Drugs

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

Dispensing fees up to $7.00 per prescription are eligible.

The per person calendar year maximum for drugs is $5,000. Members or dependents 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.

Practitioners

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 following practitioners:

- acupuncturist: $350
- audiologist: $350
- chiropractor and 1 chiropractic x-ray combined $350
- massage practitioner $350
- naturopath $350
- osteopath and 1 osteopathic x-ray combined $350
- physiotherapist $350
- podiatrist and chiropodist combined $350
- psychologist $350

- psychotherapist and social worker combined $350
- speech language pathologist $350

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.

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.

Medical aids and supplies

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
- orthopedic shoes and orthotics to a combined maximum in a 24 month period of $400

- 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 of 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

- 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.

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 in a 12 month period for Dependents under age 18, and
- $400 in a 24 month period for Dependents age 18 and over.

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

NOTE: For part-time members, Vision Care benefits are **not** available to dependents.

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.

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.

Out-of-Province Non-Emergency Eligible Expenses

The Plan will reimburse you (and your Dependents) 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 Eligible Expenses

Emergency Medical Travel Insurance provides coverage for eligible active employees under the age of 80 and their eligible dependents 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.

- Coverage Period: 90 days per trip
- Maximum: $100,000 per insured person, per trip
- Maximum Age: 79
- Policy Number: DAT00013334

If you have an emergency, you must call Global Excel immediately before seeking treatment. They are available 24 hours a day, 7 days a week. Your Manulife-Global Excel Assistance Card provides instant information on how to contact Global Excel. Call the emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to Global Excel.

You must notify Global Excel before obtaining emergency treatment, so that they may confirm coverage and provide pre-approval of treatment. If it is medically impossible for you to call prior to obtaining emergency treatment, call or have someone call on your behalf as soon as possible. If you do not contact Global Excel prior to seeking treatment, the medical treatment you receive may not be covered by this insurance.

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. Pre-existing medical condition exclusions may apply to medical conditions and/or symptoms that existed before your trip. In the event of a claim, your medical history will be reviewed after a claim has been reported.

Eligible expenses are covered only if incurred within 90 days of the date you or your Dependent left your province of residence. You and your Dependents are required to provide proof of the date of departure and return date to your province of residence, when requested by Manulife or Global Excel.

Below is an example of Eligible emergency expenses, all of which may be subject to certain limitations

- Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
- Emergency air transportation when approved and arranged in advance by Global Excel.
- The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital.
- Services of a Physician and laboratory and x-ray services.
- Prescription drugs in sufficient quantity to alleviate an acute medical condition.
- Other emergency services and/or supplies.

In emergencies which occur while you (and your Dependents) are travelling, during the first 90 days after you initially leave your province of residence, Global Excel will coordinate the following services:

- locate the nearest appropriate medical care
- obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians
- investigate, arrange and coordinate medical evacuations and related transportation needs
- arrange and coordinate the repatriation of remains

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.

Submitting EHC Claims

Electronic Claims

When submitting an electronic claim online or through the mobile app you must keep original receipts and documentation to support the claim for 12 months from the date you submit the claim. If the claim is selected for review, you must submit the original receipts and supporting documentation electronically or by mail within 21 calendar days.

The Administrator must receive an electronic claim within 12 months from the date the expense was incurred.

Pay Direct Claims

Provided your pharmacy is connected to the Administrator's electronic processing system, the Plan will pay them directly for prescription drugs covered under your EHC plan. Simply show the pharmacist your Benefits ID card; they will charge you only for amounts not covered by the Plan.

Some health practitioners (opticians, physiotherapists, massage practitioners, etc.) may also be able to submit your claim direct to the Administrator. Ask your practitioner if they'll submit your claim electronically for you, so you pay only what's not covered by the Plan.

Paper Claims

Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:

- Obtain a claim form from the Plan website at www.millworkersuniforbenefits.org.

- Follow the instructions on the claim form. To avoid delay in payment, include original receipts and all other requested information with your claim. (Receipt photocopies are acceptable only when accompanied by a claims payment statement from another carrier).
- You can mail the completed form and receipts to the Administrator
- The Administrator must receive the original claim form and original receipts.
- The Administrator suggests you submit claims within 90 days from the date the expense was incurred. However, the Administrator must receive your claim within 12 months from the date the expense was incurred. If not, your claim will not be paid under any circumstances.

Because the Administrator does not return receipts after the claim is processed, you should keep a photocopy of the receipts that you submit. You will receive a remittance statement for your records each time you submit a claim.

If you (and your Dependents) are eligible to claim certain benefits under more than one plan, please review the **Coordination of Benefits** section under **General Information**.

Certain medical expenses are covered under the provincial plans. If you submit your claim to the Plan before you submit your claim to the provincial plans, the Administrator will deduct what the provincial plans would normally pay from your claim.

Dental Benefits

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

Benefits are paid based on dental services, financial limits and treatment frequencies in the applicable Dental Fee guide. Reasonable and customary limits are applied to fee items as applicable.

Reimbursement percentage shown in the **Schedule of Benefits** are 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
- anesthesia in conjunction with surgery – No calendar year maximum.

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 Dependents 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 Dental Claims

Present your Benefits ID card to your Dentist's office. It is important to ask if the Plan will cover the entire cost of your treatment. To avoid any misunderstanding, it is suggested that your Dentist submit an outline of the proposed services to the Administrator **before you start treatment.** This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.

Some dentists and specialists do charge above Ontario Dental Association's published fee guide, and you are responsible for extra charges if you choose to use these dentists and specialists. If you use the Teeth First Dental Network, the network ensures that all dentists and specialists to which you are referred charge rates within the Ontario Dental Association's published fee guide and do direct billing with The McAteer Group.

Before your Dentist starts treatment, please ask them how billing is made. The Plan may pay in either of two ways:

1. For pay direct claims, the Plan will pay the benefit amount to the Dentist directly for services provided following receipt of:
   - a claim form showing the services performed and the fee charged, signed by the patient and the dental Provider, or
   - an electronic claim showing the services performed and the fee charged.

2. If you have paid your Dentist directly, the Plan will reimburse you the benefit amount following receipt of:
   - a claim form signed by the patient that is either submitted with a receipt or is signed by the dental Provider showing the services performed and the fee charged, or
   - an electronic claim showing the services performed and the fee charged.

The Administrator suggests that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will the Plan pay any claim received later than **12 months** from the date the service is performed.

Separate claim forms are required for each member of your family who has received dental services. Be sure to include the following information on the claim form:

- name of the Dentist
- name and birthdate of the person receiving the dental care
- your policy and ID numbers (this information is on your Benefits ID card)
- your home mailing address
- whether you have coverage through another plan. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan).

Incomplete claims will be returned for clarification.

Orthodontic Claims Procedures

Receipts

Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.

Claiming deadlines

We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date). Reimbursement is made if the complete and correct claims information is received within 12 months of the due date. However, no benefit is payable for claims not received within **12 months** of the due date.

Treatment plan

Have your orthodontist complete a treatment plan before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.

If the payment schedule or treatment changes, a revised treatment plan must be submitted.

Your treatment plan will be retained on file by the Administrator. Without a treatment plan on file, claims cannot be paid for:

- your initial fee/down payment
- your monthly/quarterly fees
- one time appliance fees

Only claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

Monthly or quarterly fees
If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by the Administrator which are over 12 months old will not be reimbursed.

If you paid any amount to the Dentist before treatment is complete, the Plan will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.

As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

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 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.

The weekly benefit amount and the maximum benefit period are shown in the **Schedule of Benefits**.

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

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 McAteer Group 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

Leave top up benefits may be payable while you are receiving Employment Insurance maternity benefits, parental benefits, compassionate care benefits, or family caregiver benefits for children.

The weekly benefit amount and the maximum benefit period are shown in the **Schedule of Benefits**. 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.

Taxable Status

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

Exclusions for Wage Loss Claims

Benefits are not payable:

1. for any disability arising from any of the following:
   - result of a motor vehicle accident
   - self-inflicted injury or sickness caused by your own negligence
   - participation in a criminal offense
   - civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation
   - a pregnancy related sickness during any period of formal maternity and/or parental leave, or during any period in which Employment Insurance (EI) benefits are being paid
   - substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your Physician
   - medical or surgical care which is cosmetic, unless considered medically necessary

2. for any period of disability that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason

3. while you are
   - in a jail or penitentiary
   - on leave of absence or paid vacation
   - receiving or entitled to receive benefits for the same or related disability from Workplace Safety and Insurance Board (WSIB) or similar legislation

4. if you become disabled during a strike or lock-out at your place of employment; however, your right to benefits will be reinstated when the strike or lock-out ends.

Submitting a Wage Loss Claim

Disability Benefits

If you are unable to work due to disability, the following steps must be taken:

- Notify your Human Resources Department that you are unable to work and obtain a Wage Indemnity Claim Form, along with directions on how to complete the form.
- Complete, sign and date the appropriate sections of the form.
- Have your doctor complete and sign the physician's portion of the form. This is not required for claims that are 5 working days or less, unless requested by The McAteer Group.
- Have your Human Resources Department complete the Employer section and submit the completed forms to The McAteer Group.

The McAteer Group may request supplementary reports to update the medical information on file. The cost for completion of medical reports is your responsibility.

Leave Top Up Benefits

To apply for Leave Top Up Benefits, you must be receiving corresponding benefits from Employment Insurance (EI) and take the following steps:

- Contact your Human Resources Department to obtain a Leave Top Up Claim Form, along with directions on how to complete the form.
- Complete, sign and date the appropriate sections of the form.
- Have your Human Resources Department complete the Employer section and submit the completed forms 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.

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.

Basic Life Insurance

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

Benefit Amount

The amount of insurance shown in the **Schedule of Benefits** will be payable to your beneficiary upon your death.

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 Basic Life 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.

Dependent Life Insurance

Your Dependent Life Insurance benefits underwritten by Co-operators Life Insurance Company. This benefit provides life insurance coverage for your spouse and dependent children.

Benefit Amount

The amount of insurance shown in the **Schedule of Benefits** will be payable to you upon death of your eligible Dependent.

Total Disability Waiver of Premium

If premiums for your basic life insurance coverage are being waived, premiums for the dependent life benefit will also be waived, but only so long as this benefit and your employer's coverage under this benefit remains in force.

Submitting a Dependent Life Claim

The time limit within which a dependent life insurance claim must be made is 180 days from the date of loss. You 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

The amount of insurance is shown in the Schedule of Benefits.

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 to you the amount indicated in the Schedule of Benefits, provided the following conditions have been satisfied:

- you have satisfied the criteria of a Critical Illness described under the Covered Conditions – Critical Illnesses;
- you have been Diagnosed with a Critical Illness prior to the termination age of the Critical Illness benefit as indicated in the Schedule of Benefits;
- the Date of Diagnosis must occur after your coverage under the Critical Illness benefit becomes effective and prior to the date the Policy terminates or the date your coverage under this benefit terminates;
- you are receiving and following Reasonable and Customary Treatment;
- you survive for the Survival Period and have not experienced irreversible cessation of all functions of the brain; and
- if your condition is Medically Diagnosed or treated outside of Canada, the benefit will be payable only if all of the following conditions are satisfied:
    - the complete medical records are made available to Co-operators Life promptly, and
    - based on these medical records, Co-operators Life is satisfied that:
        - the same Diagnosis would have been made if the Covered Condition had been Medically Diagnosed in Canada;

        - the same treatment, involving the particular surgical procedure, would have been advised if treatment had taken place in Canada;
        - the Physician or Specialist making the Diagnosis was licensed to practice in the jurisdiction in which the Diagnosis was made and had medical credentials at least equal to those required in Canada; and
    - if requested by Co-operators Life you must undergo an Independent Medical Examination by a Physician or Specialist appointed by Co-operators Life.

Upon payment under the Partial Benefit, the insurance will remain in effect and the Amount of Insurance will not be reduced by the Partial Benefit payment. Only one Partial Benefit claim will be paid under this provision.

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

Definitions for Critical Illness

Activities of Daily Living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath with or without the aid of assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food and drink that has already been prepared and made available, with or without the use of assistive devices.

Brain Death means an irreversible form of unconsciousness (irreversible coma) characterized by a complete loss of brain function while the heart continues to beat. The usual clinical criteria for brain death include the absence of reflex activity, movements and respiration. Pupils should be dilated and fixed.

Critical Illness means any of the Covered Conditions listed under Covered Conditions - Critical Illnesses.

Date of Diagnosis is the date the Critical Illness is first Diagnosed by a Physician or Specialist, unless otherwise specified under Covered Conditions - Critical Illnesses and subject to verification by an Independent Assessment, at the sole discretion of Co-operators Life.

Diagnosis or Diagnosed means the complete fulfilment of the definition of a Covered Condition specified under Covered Conditions - Critical Illnesses.

Independent Assessment means independent medical examinations, assessments or tests performed by one or more Physicians/Specialists as selected by Co-operators Life to confirm the Diagnosis of a Covered Condition.

Life Support means you are under the regular care of a Specialist for nutritional, respiratory or cardiovascular support when irreversible cessation of all functions of the brain, as confirmed by electroencephalogram (EEG) studies, has occurred.

Medically Diagnosed Condition or **Medically Diagnosed** shall mean a Sickness or an Injury which has been diagnosed according to a generally accepted classification system including but not limited to an x-ray, magnetic resonance imaging (MRI), bone scan, biopsy, x-ray computed tomography scan (CAT scan), psychometric testing including Minnesota multiphasic personality inventory-2 (MMPI-2), or a haematological or ultrasonic test.

Reasonable and Customary Treatment means systematic medical treatment that is:

- generally accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of the Medically Diagnosed Condition, and
- of a nature, intensity, frequency and duration essential to the diagnosis or management of the Medically Diagnosed Condition involved; and
- prescribed and rendered by a Physician or where considered appropriate by Co-operators Life, prescribed and rendered by a Specialist.

Surgery is the treatment of disorders of the body by incision or manipulation with surgical instruments.

Survival Period is the period starting on the Date of Diagnosis of the Critical Illness and ending 30 consecutive days immediately following the Date of Diagnosis of the Critical Illness, except where a longer period of time is provided specifically under Covered Conditions - Critical Illnesses, in which case, the number of days specified will apply. The Survival Period does not include the number of days you are on Life Support. You must be alive at the end of the Survival Period and must not have experienced irreversible cessation of all functions of the brain.

Specialist means a licensed medical practitioner who has been trained and specializes in a particular study or work and is registered by the College of Physicians and Surgeons in the Province or Territory in which the person is practicing and has been recognized with a designation in his/her area of speciality which is relevant to the Covered Critical Illness condition for which a benefit is being claimed. A Specialist does not include someone who is related to you. In the absence or unavailability of a Specialist, and only where approved by Co-operators Life, a condition may be Diagnosed by a qualified Physician. Specialist includes, but is not limited to; cardiologist, neurologist, nephrologists, oncologist, ophthalmologist and burn specialist.

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.

Covered Conditions - Critical Illnesses

Alzheimer's Disease - Dementia, including Alzheimer's Disease is defined as a definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

You must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

The Diagnosis must be made by a Specialist. No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium. Reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Aortic Surgery is the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist. The Date of Diagnosis is the date you undergo the surgery for the Covered Condition. No benefit will be payable for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia is a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following; marrow stimulating agents; immunosuppressive agents; bone marrow transplantation. The Diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis is a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of Diagnosis. The Diagnosis of Bacterial Meningitis must be made by a Specialist. No benefit will be payable under this condition for viral meningitis. The Survival Period is 90 days.

Benign Brain Tumour is a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficits. The Benign Brain Tumour must be Medically Diagnosed by a neurologist. No benefit will be available under this condition for pituitary adenomas less than 10 mm.

No benefit will be payable if, within the first 90 days immediately following the later of, the date your insurance under this benefit became effective or the date of last reinstatement, you had any of the following:

- signs, symptoms or investigations, that lead to a Diagnosis of Benign Brain Tumour, covered or excluded under the Policy, regardless of when the Diagnosis is made, or
- a Diagnosis of Benign Brain Tumour, covered or excluded under the Policy

The medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be provided to Co-operators Life within 6 months of the date of the Diagnosis. If this information is not provided within this period, no benefit will be payable.

Blindness is a definite Diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or,
- the field of vision being less than 20 degrees in both eyes.

Blindness must be Medically Diagnosed by an Ophthalmologist.

Burns is a definite Diagnosis of third-degree burns over at least 20% of the body surface. Burns must be Medically Diagnosed by a Specialist.

Coma is a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Coma must be Medically Diagnosed by a Specialist.

No benefit will be available under this condition for:

- a medically induced coma;
- a Diagnosis of brain death, or
- a coma which results from alcohol or drug use.

Coronary Artery Bypass Surgery is the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). No benefit will be payable for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures. The surgery must be determined to be medically necessary and Medically Diagnosed by a cardiologist. The Date of Diagnosis is the date you undergo the surgery for the Covered Condition.

Deafness is a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. Deafness must be Medically Diagnosed by a Specialist.

Heart Valve Replacement or Repair is the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist. The Date of Diagnosis is the date you undergo the surgery for the Covered Condition. No benefit will be payable for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure (End Stage Renal Disease) is a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis; peritoneal dialysis or renal transplantation is initiated. Kidney Failure must be Medically Diagnosed by a Specialist.

Life-threatening Cancer - Cancer (Life-Threatening) is a definite Diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer must be made by a Specialist.

No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of your coverage under this benefit, or the date of last reinstatement of coverage, you have any of the following:

- signs, symptoms or investigations, that lead to a Diagnosis of Cancer, covered or excluded under the Policy, regardless of when the Diagnosis is made; or
- a Diagnosis of Cancer, covered or excluded under the Policy

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to Co-operators Life within 6 months of the date of the Diagnosis. If this information is not provided within this period, no benefit will be payable for any claim for cancer or, any critical illness caused by any cancer or its treatment.

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010. The term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Loss of Independent Existence is a definite Diagnosis of the total inability to perform, by oneself, at least two of the six Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis of Loss of Independent Existence must be made by a Specialist.

Loss of Limbs is a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The Diagnosis of Loss of Limbs must be made by a Specialist. The Date of Diagnosis is the date the limbs are severed.

Loss of Speech is a definite Diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The Diagnosis of Loss of Speech must be made by a Specialist. No benefit will payable for any psychiatric related causes.

Major Organ Transplant is a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, you must undergo a transplantation procedure as the recipient for transplantation of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The Date of Diagnosis is the date you undergo the surgery for the Covered Condition. The major organ failure must be Medically Diagnosed by a Specialist.

Major Organ Failure on Waiting List is a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, you must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant Surgery. For the purposes of the Survival Period, the Date of Diagnosis is the date of your enrollment in the transplant center. The major organ failure must be Medically Diagnosed by a Specialist.

Motor Neuron Disease is a definite Diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. Motor Neuron disease must be Medically Diagnosed by a neurologist.

Multiple Sclerosis is a definite Diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or

- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Multiple Sclerosis must be Medically Diagnosed by a neurologist.

Myocardial Infarction (Heart Attack) is a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Heart Attack must be Medically Diagnosed by a cardiologist.

No benefit will be available under this condition for:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty in the absence of new Q waves, or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Occupational HIV Infection is a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental Injury during the course of your normal occupation, which exposed you to HIV contaminated body fluids. The accidental Injury leading to the infection must have occurred after the effective date of your coverage under this benefit, or the date of last reinstatement of coverage.

Payment under this condition requires satisfaction of all of the following:

- The accidental Injury must be reported to Co-operators Life within 14 days of the accidental Injury;
- A serum HIV test must be taken within 14 days of the accidental Injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental Injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and,
- The accidental Injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

No benefit will be payable under this condition if:

- You have elected not to take any available licensed vaccine offering protection against HIV; or,
- A licensed cure for HIV infection has become available prior to the accidental Injury; or,
- HIV infection has occurred as a result of non-accidental Injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis is a definite Diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders is defined as a definite Diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. You must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Specified Atypical Parkinsonian Disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

No benefit will be payable under Parkinson's disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Parkinson's disease and Specified Atypical Parkinsonian Disorders Exclusion Period:

No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of, the effective date of your coverage under this benefit, or the date of last reinstatement, you have any of the following:
- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or
- a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to Co-operators Life within 6 months of the date of the Diagnosis. If this information is not provided within this period, no benefit will be payable for any claim for Parkinson's disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's disease or Specified Atypical Parkinsonian Disorders or its treatment.

Stroke or Cerebrovascular Accident (CVA) is a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source with acute onset of new neurological symptoms and new objective neurological deficits on clinical examination, both of which persist for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The Stroke must be Medically Diagnosed by a Specialist.

No benefit will be available under this condition for:

- Transient Ischemic Attacks; or,
- Intracerebral vascular events due to trauma; or,
- Lacunar infarcts which do not meet the definition of stroke as described above.

Covered Conditions Critical Illnesses - Partial Benefits

Coronary Angioplasty is the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be Diagnosed and determined to be medically necessary by a Specialist. The Date of Diagnosis is the date you undergo the procedure.

Chronic Lymphoma Leukemia (CLL), early stage Chronic Lymphocytic Leukemia is defined as a malignant proliferation of lymphocyte white blood cells. The Diagnosis of chronic lymphocytic leukemia must be made by an approved Specialist. The chronic lymphocytic leukemia must be classified as Rai stage 0 where there is an increase in blood lymphocytes but there is no enlargement of lymph nodes, liver or spleen, and there is no anemia or thrombocytopenia. No benefit will be payable for monoclonal B-cell lymphocytosis (MBL), lymphoma, or other causes of lymphocytosis. For purposes of the Policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Carcinoma in situ of breast, early stage ductal breast Carcinoma in situ is the presence of malignant breast cancer cells that remain within the cell group from which they arose, where cancer cells do not penetrate the basement membrane nor invade the surrounding tissues. The Diagnosis of ductal breast carcinoma in-situ must be confirmed with a valid pathology report by a certified pathologist and it must be classified as “Tis” according to the AJCC 7th Edition TNM staging method or FIGO Stage 0 of the Federation Internationale de Gynaecologie et d’Obstetrique staging system. Lobular breast carcinoma in-situ is excluded.

Malignant Melanoma, early stage Malignant Melanoma is an invasive malignant melanoma of the skin that is less than or equal to 1.0 mm in Breslow thickness, and is non-ulcerated and there is no spread to lymph nodes or distant metastases. There must be uncontrolled growth and spread of malignant melanoma cells that invade past the epidermis into the dermis of the skin. The Diagnosis must be confirmed with a valid pathology report and a report from an approved Specialist. No benefit will be payable for melanoma in-situ.

Prostate Cancer, early Stage Prostate Cancer is an invasive malignant prostate cancer that is characterized by the uncontrolled growth and spread of malignant prostate cancer cells that invade the prostate gland. The cancer must be confined to the prostate gland with no spread to lymph nodes or distant metastases, and classified as stage T1a or T1b by the AJCC 2010 Seventh Edition TNM Classification. The Diagnosis must be confirmed with a valid pathology report and a report from an approved Specialist. No benefit will be payable for any grade of Prostatic Intra-epithelial neoplasia (PIN) or prostate cancer in-situ.

Thyroid Cancer, early stage Thyroid Cancer is an invasive malignant papillary or follicular thyroid cancer that is characterized by the uncontrolled growth and spread of malignant thyroid cancer cells that invade the thyroid gland. The cancer must be confined to the thyroid gland with no spread to lymph nodes or distant metastases. The thyroid cancer must be 2.0 cm or less in greatest diameter in size and classified as stage T1 by the AJCC 2010 Seventh Edition TNM Classification. The Diagnosis must be confirmed with a valid pathology report and a report from an approved Specialist. No benefit will be payable for benign thyroid nodules.

Partial Benefits – Cancer exclusion

No benefit will be payable under the Partial Benefit if, within the first 90 days following the later of, the effective date of your coverage under this benefit, or the date of last reinstatement of coverage, you have any of the following:

- signs, symptoms or investigations, that lead to a Diagnosis of cancer, regardless of when the Diagnosis is made; or
- a Diagnosis of cancer.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to Co-operators Life within 6 months of the Date of Diagnosis. If this information is not provided within this period, no benefit will be payable for any claim for cancer or any Critical Illness caused by any cancer or its treatment.

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

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 from the date the illness was diagnosed.

Failure to furnish proof within this time will not invalidate nor 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

Accidental Death and Dismemberment (AD&D) benefits are underwritten by Blue Cross Life Insurance Company of Canada.

Your Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job.

If within one year from the date of the accident, an injury directly results in any of the specific losses listed in the Table of Losses, you or your beneficiary may be entitled to the benefits shown.

Table of Losses

For Loss of	**Percentage of the Principal Sum**
Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand or One Foot and the Entire Sight of One Eye	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
The Entire Sight of One Eye	75%
Thumb and Index Finger of the Same Hand	33-1/3%
Speech and Hearing	100%
Speech or Hearing	75%
Hearing in One Ear	66-2/3%
Four Fingers of One Hand	33-1/3%
All Toes of One Foot	25%
For Loss of Use of	
Both Arms or Both Hands	100%
One Hand or One Foot	75%
One Arm or One Leg	80%
For Paralysis	
Quadriplegia, Paraplegia or Hemiplegia	200%

The maximum amount payable as the result of any one accident is the Principal Sum, unless the loss is Quadriplegia, Paraplegia or Hemiplegia, in which case the maximum amount payable is the amount indicated for such Loss in the Table of Losses. This limitation does not apply to the Additional Benefits outlined below, which are subject to their own specific limits.

Additional Benefits

Subject to the conditions outlined below, if you suffer an Injury which qualifies for payment under the Table of Losses, additional benefits may be payable as described in this section.

Permanent and Total Disability

If you suffer Injury causing Permanent and Total Disability, the insurer will pay a benefit equal to 100% of the Principal Sum less any amounts under the Table of Losses which have been paid or which are payable you.

Rehabilitation Benefit

The insurer will pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training, provided that:

- such training is required because of a covered Injury and in order for you to be qualified to engage in an occupation in which you would not have been engaged except for having suffered such Injury
- the training expenses are incurred within three years from the date of the accident
- no payment will be made for ordinary living, travelling or clothing expenses.

Home Alteration and Vehicle Modification

If you suffer Injury which results in and necessitates the use of a wheelchair in order to be ambulatory, the insurer will pay the reasonable and necessary expenses incurred for:

- the one-time cost of alterations to your residence to make the residence wheel-chair accessible and habitable; and
- the lesser of:
    - the one-time cost of modifications necessary to a motor vehicle, owned by you, to make the vehicle accessible or drivable for you; and
    - the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Plan.

This benefit is payable only if:

- home alterations are made on your behalf and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and
- vehicle modifications are made on your behalf and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities in your province of residence.

The maximum amount payable for this benefit is $15,000.

Workplace Modification and Accommodation Benefits

If you suffer Injury which results in and necessitates the use of special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to work with your Employer, the insurer will pay to your Employer, upon your return to active full-time work

with the Employer, the reasonable and necessary expenses actually incurred by the Employer for such adaptive equipment and/or workplace modification provided:

- the Employer agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs;
- the Employer acknowledges in writing that the performance of the essential duties of your job may be altered;
- the proposed special adaptive equipment and/or workplace modification have been approved in advance of an expense being incurred by the Employer for such equipment or modification.

The maximum amount payable for this benefit is $5,000.

Pyschological Therapy

If you sustain Injury and subsequently as a result of such Injury and Loss and within two years from the date of such Injury, you require Psychological Therapy as prescribed by a Physician, the insurer will pay the reasonable and customary expenses for Psychological Therapy.

"Reasonable and Customary" means the lesser of:

- usual charge made by Physicians or other health care providers for a given service or supply; or
- the charge determined to be the prevailing charge made by Physicians or other health care providers for a given service or supply in the geographical area where it is furnished; or
- the amount negotiated by the insurer and the health care provider.

"Psychological Therapy" means treatment or counselling by a therapist or counsellor, who is licenced, registered, or certified to provide such treatment, whether such treatment is on an out-patient basis or provided while a patient at a medical facility licenced to provide such treatment.

The maximum amount payable for this benefit is $5,000.

In-Hospital Benefit

If you suffer Injury resulting in a Loss (other than Loss of Life) and as a consequence of such Loss you are, pursuant to the instructions of a Physician, confined to a Hospital for more than five consecutive overnight stays, the insurer will pay:

- for a period of confinement in Hospital of more than 30 consecutive overnight stays, 1% of the Principal Sum; or
- for a period of confinement of 30 consecutive overnight stays or less, 1/30 of the amount determined in accordance with the point above for each overnight stay in Hospital.

Benefits are retroactive to the first overnight stay of confinement in Hospital.

The maximum amount payable for this benefit is $2,500 per month for no more than a total of 12 months of confinement for any one accident.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than three months, are considered one period of confinement.

Family Transportation

When injuries covered by the policy result in you being confined to a Hospital outside 100 Km from your permanent place of residence and within 365 days of the accident, the insurer will pay the reasonable and necessary expenses actually incurred for transportation of one immediate family member to such Hospital.

The term "member of the immediate family" means a person who is related to the you in any of the following ways: spouse, child, parent, grandparent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law, or daughter-in-law.

Reimbursement of expenses is limited to the cost of one economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation, but not to exceed the amount of $15,000.

Repatriation Benefit

When injuries covered by this policy result in loss of life outside 50 Km from your permanent city of residence and within 365 days of the date of the accident, the insurer will pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of $15,000.

Identification Benefit

If you suffer Injury causing Loss of Life for which a benefit is paid or payable hereunder and body identification is required, the insurer will pay to one Immediate Family member, the reasonable and necessary expenses actually incurred by such Immediate Family member for:

- commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of three consecutive nights)
- transportation by the most direct route to such location.

This benefit is payable only if the body of the deceased is located at least 150 kilometres from the Immediate Family member’s normal place of residence and the identification of the body is requested by the police or a similar law enforcement agency.

Payment will not be made for ordinary living, travelling or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the licence for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometre travelled.

The maximum amount payable for this benefit is five thousand dollars $5,000.

Seat Belt Benefit

If you suffer Injury resulting in Loss of Life, the insurer will pay an additional amount equal to 10% of the Principal Sum if Injury causing the Loss of Life results while you are a passenger or driver of a private passenger type automobile and your seat belt is properly fastened. The actual use of the seat belt must be verified and be evidenced in the official report of accident or certified by the investigating officer.

Day Care Benefit

If indemnity becomes payable under the policy for accidental loss of life, the insurer will pay an amount equal to the lessor of the following amounts:

- the actual annual cost charged by a commercial and licenced day care centre; or
- 5% of the Principal Sum; or
- $5,000 per year.

This benefit is payable annually for a maximum of four consecutive payments per Dependent Child who at the date of your Loss of Life is under age 13 and who is enrolled in a commercial and licenced day care centre no later than 90 days following such loss, provided that the Dependent Child continues his or her enrollment in a commercial and licenced day care centre.

Dependent Child Educational Benefit

If indemnity becomes payable for the accidental loss of life, the insurer will pay the lesser of the following amounts to or on behalf of any Dependent child who, at the date of accident, was enrolled as a full time student in any institution of higher learning (including, but is not limited to, any university, private post secondary college or trade school, and any College of General and Vocational Education) beyond the 12th grade level up to the lesser of the following amounts:

- the actual annual tuition, exclusive of room and board, charged by such institution per school year
- $10,000 per school year; or
- 5% of the Principal Sum.

This benefit is payable annually up to a maximum of four consecutive payments only for such Dependent Child who continues his or her continuous enrollment in an institution of higher learning.

Spousal Educational Benefit

If indemnity becomes payable for the accidental loss of life, the insurer will pay to your spouse the actual cost incurred for a professional or trades training program in which such spouse enrolls for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than 30 months after your Loss of Life.

The maximum amount payable for this benefit is fifteen thousand dollars $15,000.

Funeral Expense

If indemnity becomes payable for the accidental loss of life, the insurer will reimburse the person who has incurred the actual expenses pertaining to your cremation, burial or funeral expenses. The maximum amount payable for this benefit is $5,000.

Bereavement Benefit

If indemnity becomes payable for the accidental loss of life, the insurer will pay the reasonable and necessary expenses actually incurred for grief counselling provided that:

- the counselling is for your spouse and/or Dependent children;
- such expenses are incurred within 365 days of the date of the accident causing Loss of Life; and
- such grief counselling is provided by a therapist or counsellor who is licenced, registered or certified to provide such treatment and who is not a member of your Immediate Family.

The insurer will pay the person who has incurred the actual expense.

The maximum amount payable for this benefit, is one $1,000.

Serious Illness Benefit (Non-Cancer)

If you have been insured under this contract for not less than 90 consecutive days following which you are diagnosed with any one of the Covered Serious Illnesses defined below, the insurer will pay 10% of the Principal Sum, up to the maximum amount payable for this benefit, provided that you:

- have been confined to a Hospital as an in-patient continuously for at least 48 hours as a consequence of the Covered Serious Illness;
- survive for a period of at least 30 days after the diagnosis has been made; and
- are under the age of 65 at the time of the diagnosis.

The maximum amount payable for this benefit $5,000. The Plan will only pay this benefit once even if you are diagnosed with more than one such Covered Serious Illness.

The Covered Serious Illnesses are:

- **Major Burns** which means the Diagnosis by a plastic surgeon of a third degree burn covering at least 20% of the surface area of the body
- **Multiple Sclerosis** which means an unequivocal diagnosis by a neurologist of at least two episodes of well defined neurological abnormalities lasting for a continuous period of at least six months and confirmed by modern imaging techniques of the Insured Employee.
- **Necrotizing fasciitis** which means an unequivocal diagnosis of insidiously advancing soft tissue infection of the deeper layers of skin and subcutaneous tissues (fascia).
- **Parkinson's Disease** which means the Diagnosis by a neurologist of primary idiopathic Parkinson's Disease which is characterized by the clinical manifestation of two or more of: a) tremor; b) rigidity; c) Bradykinesia. All other types of Parkinsonism are excluded.

- **Major Organ Failure Requiring Transplant** which means the irreversible failure of the heart, liver, both lungs or both kidneys requiring receipt of a transplant of that organ, resulting in the Insured Employee being accepted into a recognized transplant program in Canada. The Insured Employee must survive at least 30 days following the date of enrollment into the transplant program.
- **Motor Neuron Disease** which means an unequivocal diagnosis of amyotrophic lateral sclerosis (Lou Gehrig's Disease), primary lateral sclerosis, progressive bulbar palsy, or pseudo-bulbar palsy. Other variations of motor neuron disease are specifically excluded.
- **Major Organ Transplant** which means the undergoing of a surgery, as a recipient by transplant of at least one of the following organs or tissues; heart, liver, lung, or kidney.

Definitions for AD&D

Loss when used:

With Reference to	Means
Quadriplegia, Paraplegia, Hemiplegia	the complete and irreversible paralysis of such limbs
Hand or Foot	the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint
Arm or Leg	the complete severance through or above the elbow or knee joint
Thumb and Index Finger	the complete severance through or above the first phalange
Fingers	the complete severance through or above the first phalange of all four fingers of one hand
Toes	the complete severance of both phalanges of all the toes of one foot
The Entire Sight of One Eye	the total and irrecoverable Loss of sight such that corrected visual acuity must be 20/200 or less in such eye
The Entire Sight of Both Eyes	the total and irrecoverable Loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes
Hearing in One Ear	the diagnosis of permanent Loss of hearing in one ear, with an auditory threshold of more than 90 decibels
Hearing	the diagnosis of permanent Loss of hearing in both ears, with an auditory threshold of more than 90 decibels in each ear
Speech	complete and irrecoverable Loss of the ability to utter intelligible sounds

Loss when used herein may also include "Loss of Life".

Loss of Use means the total and irrecoverable Loss of use provided the Loss is continuous for 12 consecutive months and such Loss of use is determined to be permanent.

Total Disability Waiver of Premium

If premiums for your Basic Life Insurance coverage under the Policy are being waived, then premiums for your Accidental Death and Dismemberment 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 AD&D Claims

No coverage will be provided under this contract and no payment will be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

1. suicide or any attempt thereat by the Insured Employee while sane;
2. self inflicted Injury or any attempt thereat by the Insured Employee while sane or insane;
3. declared or undeclared war or any act thereof;
4. sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
5. mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
6. injury sustained while the Insured Employee is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
7. stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;
8. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Employee is:
    - riding as a passenger in any aircraft not intended or licenced for the transportation of passengers; or
    - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    - riding as a passenger in an aircraft that is owned or leased by the Employer or Union.
9. infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
10. injury or Loss sustained while the Insured Employee is on full-time active duty in the armed forces or organized reserve corps of any country or international authority;
11. injury or Loss sustained while the Insured Employee is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while his or her blood alcohol is over 80 milligrams in 100 millilitres of blood;

12. injury or Loss sustained while the Insured Employee is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licenced Physician;
13. the commission or attempted commission by an Insured Employee or Injury incurred while an Insured Employee is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
14. an act, attempted act or omission taken or made by the Insured Employee, or an act, attempted act or omission taken or made with the Insured Employee's consent, for the purposes of interrupting the blood flow to the Insured Employee's brain or to cause asphyxiation to the Insured Employee whether with intent to cause harm or not; and
15. natural causes.

Notwithstanding the foregoing, exclusions 4, 7 and 9 above do not apply to the serious illness benefit provided for in Section 0 of this contract.

Submitting an AD&D Claim

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

Notice of claim must be submitted within 30 days Your accidental death and dismemberment claim form and proof of claim must be submitted within 90 days from the date of the accident, or the Injury, or the diagnosis of Covered Serious Illness.

Failure to furnish proof within this time will not invalidate nor 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 the accident, or the Injury, or the diagnosis of Covered Serious Illness.

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 dependents. 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

The Plan Administration Office

For questions regarding your claims or coverage details or for general assistance, 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