A Summary Description For

Plan Benefits

Laborers' Health & Welfare Trust Fund Of Western Canada

January 1, 2017

Laborers' Health & Welfare Trust Fund of Western Canada

10154 108 Street, NW
Edmonton, Alberta
Canada, T5J 1L3

Telephone: ***780-453-2303***
Toll Free: **1-800-661-7369**
Fax: **780-452-5388**
| www.fasadmin.com | info@fasadmin.com |

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Homewood Health Inc.

Auditors

Mowbrey Gil LLP

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Funds Administrative Service Inc.

IMPORTANT

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

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

The hourly costs shown in this booklet for the four Plan options are for illustrative purposes only. While the hourly costs were current at the date shown on the cover page, it is possible and likely that the hourly costs will increase in the future. Should the Board increase or decrease the hourly costs at a future date, the hourly rates adopted by the Board will apply regardless of the rates shown in this booklet,

Member Assistance Program and Substance Abuse Assessments are governed by the Homewood Health Inc. Agreement and all other benefits (except Health Care Expense Option) are governed by Group Policy 38 B 00-1 (Life Benefit and Accidental Death & Dismemberment) and Policy 38 B 00-2 (Weekly Disability, Supplementary Health and Dental Care Benefits), issued by SSQ, Life Insurance Company Inc. to Laborers' Health & Welfare Trust Fund of Western Canada. These documents are available for examination at the Fund Office.

CHANGE OF ADDRESS

If you have a change of address, it is important that you notify the Fund Office immediately by completing a new Registration Form.

To All Eligible Participants:

This booklet presents a summary description of your plan benefits and the Increased Coverage Options, provided by the ***Laborers' Health & Welfare Trust Fund of Western Canada****. While it is our hope that you and your family will enjoy good health, it is comforting to know these benefits are available when you need them.*

This booklet explains how you become a Plan participant, describes the benefits that are provided and when you can receive them, tells you when Plan coverage ends, and lets you know your options for continuing Plan coverage. We urge you to read it carefully so that you gain a thorough understanding of the benefits that are available to you. Please share it with your family too, so that they will be aware of the benefits available to them. The benefits described in this booklet are those in effect as of January 1, 2017. They were current at the time of publication but can be changed at any time by the Board of Trustees.

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

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

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

Sincerely,

Board of Trustees

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ACTIVE MEMBERS COVERAGE SUMMARIES

PLAN 1 SUMMARY

BENEFIT	DESCRIPTION
Member Life Insurance	$30,000
Accidental Death and Dismemberment	$15,000
Weekly Disability	$537 per week for 52 weeks of disability; payable from 1st day of an Accident and 8th day of a Sickness; integrated with Employment Insurance sickness and accident benefits
Supplementary Health	80% of prescription generic drugs; maximum of one hearing aid per ear, reimbursement will be made for 100% of the first $750 of expenses plus 50% of the balance, with maximum reimbursement of $2,500 per hearing aid every 24 months; one eye exam every 24 months, up to $80; 100% of all other covered expenses; lifetime maximums of $30,000 private nursing, $100,000 overall
Safety Glasses	$400 for prescription safety glasses every 12 consecutive months (members only)
Travel Insurance and Assistance	$5,000,000 per trip
Trip Cancellation	$5,000 per trip
Member Assistance Program	Short term counselling with a maximum of 6 hours per covered person per year; Substance Abuse Expert/Substance Abuse Professional Assessments (For Members Only)
Dental Care	50% of Routine Services based on 2016 Dental Fee Schedules; $750 maximum benefit per person per calendar year
Hour Bank	Maximum of six (6) months of coverage

Additional health and dental related expenses may be eligible for reimbursement from a member's Health Care Expense Option (HCEO) account balance.

ACTIVE MEMBERS COVERAGE SUMMARIES

PLAN 2 SUMMARY

BENEFIT	DESCRIPTION
Member Life Insurance	$100,000
Dependent Life Insurance	Spouse $20,000; Each Child $16,000
Accidental Death and Dismemberment	$50,000
Weekly Disability	$537 per week for 52 weeks of disability; payable from 1st day of an Accident and 8th day of a Sickness; integrated with Employment Insurance sickness and accident benefits
Supplementary Health	80% of prescription generic drugs; maximum of one hearing aid per ear, reimbursement will be made for 100% of the first $750 of expenses plus 50% of the balance, with maximum reimbursement of $2,500 per hearing aid every 24 months; one eye exam every 24 months, up to $80; 100% of all other covered expenses; lifetime maximums of $30,000 private nursing, $100,000 overall
Safety Glasses	$400 for prescription safety glasses every 12 consecutive months (members only)
Vision Care	Maximum benefit of $500 per person every 24 months; 60% reimbursement of laser eye surgery with a $1,500 lifetime maximum
Travel Insurance and Assistance	$5,000,000 per trip
Trip Cancellation	$5,000 per trip
Member Assistance Program	Short term counselling with a maximum of 6 hours per covered person per year; Substance Abuse Expert/Substance Abuse Professional Assessments (For Members Only)
Dental Care	100% of Routine Services; 75% of Major Restorative Services; based on 2016 Dental Fee Schedules; $3,500 maximum benefit per person per calendar year for Routine and Major Restorative combined; 50% Orthodontia for dependent children and for adults, with $2,000 lifetime maximum benefit per person
Hour Bank	Maximum of six (6) months of coverage

Additional health and dental related expenses may be eligible for reimbursement from a member's Health Care Expense Option (HCEO) account balance.

ACTIVE MEMBERS COVERAGE SUMMARIES

PLAN 3 SUMMARY

BENEFIT	DESCRIPTION
Member Life Insurance	$100,000
Dependent Life Insurance	Spouse $30,000; Each Child $20,000
Accidental Death and Dismemberment	$50,000
Weekly Disability	$537 per week for 52 weeks of disability; payable from 1st day of an Accident and 8th day of a Sickness; integrated with Employment Insurance sickness and accident benefits
Supplementary Health	Semi-private hospital; 100% of prescription generic drugs; maximum of one hearing aid per ear, reimbursement will be made for 100% of the first $750 of expenses plus 50% of the balance, with maximum reimbursement of $2,500 per hearing aid every 24 months; one eye exam every 24 months, up to $80; 100% of all other covered expenses; lifetime maximums of $30,000 private nursing, $100,000 overall
Safety Glasses	$400 for prescription safety glasses every 12 consecutive months (members only)
Vision Care	Maximum benefit of $500 per person every 24 months; 60% reimbursement of laser eye surgery with a $1,500 lifetime maximum
Travel Insurance and Assistance	$5,000,000 per trip
Trip Cancellation	$5,000 per trip
Member Assistance Program	Short term counselling with a maximum of 6 hours covered person per year; Substance Abuse Expert/Substance Abuse Professional Assessments (For Members Only)
Dental Care	100% of Routine Services; 80% of Major Restorative Services; based on 2016 Dental Fee Schedules; $3,500 combined maximum benefit per person per calendar year for Routine and Major Restorative combined; 80% Orthodontia for dependent children, 50% for adults only, with $3,000 lifetime maximum benefit per person
Hour Bank	Maximum of six (6) months of coverage

Additional health and dental related expenses may be eligible for reimbursement from a member's Health Care Expense Option (HCEO) account balance.

ACTIVE MEMBERS COVERAGE SUMMARIES

PLAN 4 SUMMARY

BENEFIT	DESCRIPTION
Member Life Insurance	$100,000
Dependent Life Insurance	Spouse $30,000; Each Child $20,000
Accidental Death and Dismemberment	$50,000
Weekly Disability	$537 per week for 52 weeks of disability; payable from 1st day of an Accident and 8th day of a Sickness; integrated with Employment Insurance sickness and accident benefits
Supplementary Health	Semi-private hospital; 100% of prescription generic drugs; maximum of one hearing aid per ear, reimbursement will be made for 100% of the first $750 of expenses plus 50% of the balance, with maximum reimbursement of $2,500 per hearing aid every 24 months; one eye exam every 24 months, up to $80; 100% of all other covered expenses; lifetime maximums of $30,000 private nursing, $100,000 overall
Safety Glasses	$400 for prescription safety glasses every 12 consecutive months (members only)
Vision Care	Maximum benefit of $500 per person every 24 months; 60% reimbursement of laser eye surgery with a $1,500 lifetime maximum
Travel Insurance and Assistance	$5,000,000 per trip
Trip Cancellation	$5,000 per trip
Member Assistance Program	Short term counselling with a maximum of 6 hours covered person per year; Substance Abuse Expert/Substance Abuse Professional Assessments (For Members Only)
Dental Care	100% of Routine Services; 80% of Major Restorative Services; based on 2016 Dental Fee Schedules; $3,500 combined maximum benefit per person per calendar year for Routine and Major Restorative combined; 80% Orthodontia for dependent children, 50% for adults only, with $3,000 lifetime maximum benefit per person
Hour Bank	Maximum of nine (9) months coverage

Additional health and dental related expenses may be eligible for reimbursement from a member's Health Care Expense Option (HCEO) account balance.

RETIRED MEMBERS SUMMARY

Benefit	Description
Member Life Insurance	$5,000
Member Assistance Program	Short term counselling with a maximum of 6 hours per covered person per year

UNION MEMBER BURIAL BENEFIT

Benefit	Description
Burial Benefit Amount	$5,000

ELIGIBILITY RULES – ACTIVE MEMBERS

MEMBER ELIGIBILITY

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

- ❑ reside in Canada,
- ❑ are a member of a Local Union which is participating in the Laborers' Health & Welfare Trust Fund of Western Canada,
- ❑ are employed in Alberta, Saskatchewan or British Columbia,
- ❑ work for a *contributing employer,*
- ❑ have provincial healthcare, and
- ❑ work the required number of hours for eligibility as described later.

A contributing employer is any employer that is obligated or permitted to contribute to the Fund.

DEPENDENT ELIGIBILITY

Your eligible dependents are:

1. Your spouse, where spouse means either:

   (a) a person who, at of the time in question, is legally married to you, by virtue of a religious or civil ceremony and has not been living separate and apart from the member for more than 1 year;

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

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

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

iii) to be valid, the Registration Form must be signed by you and received by or filed with the Trustees or the Administrator; and

iv) you cannot include on the Registration Form more than one person who is or may be a "spouse". A designation by you of a new spouse will only take effect on the later of the date that the Registration Form is received by the Administrator and when there is no other person who has been designated by you as a "spouse" within one year preceding the date of the receipt of that designation of a new spouse by the Administrator.

2. Your unmarried children under the age of 21 who are dependent upon you for maintenance and support and are not employed on a regular and full-time basis;

3. Your unmarried children age 21 and over but under the age of 25 who are dependent upon you for maintenance and support and are not employed on a regular and full-time basis, and are attending school at an accredited college or university on a full-time basis;

4. Your unmarried children over the age of 21 who are physically or mentally incapable of self-support and became so while dependent upon you for maintenance and support and while not employed on a regular and full-time basis, and while covered as a dependent under 2 or 3 above.

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

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

Effective Date Of Coverage

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

Initial Eligibility

Hours you work for contributing employers, for which contributions have been received, will be credited to your hour bank account. You become eligible for benefits after accumulating a minimum of 315 hours in at least two but not more than six consecutive months. The month after you complete the required number of hours is a waiting period. Coverage will begin on the first day of the month following the waiting period.

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

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

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

> John began work for a contributing employer in March and by the end of May, he had accumulated 400 hours in his hour bank account. Since John met the 315 hours requirement in at least two but not more than six consecutive months, the month of June was his waiting period. John's coverage started on July 1, the first of the month following the waiting period.

CONTINUATION OF ELIGIBILITY

After you meet the Plan's initial eligibility requirements, all hours that you work for contributing employers are credited to your *hour bank account*. For each month of coverage under the Plan, 125 hours will be deducted from your hour bank account. You will be allowed to accumulate excess hours in your hour bank account up to a maximum of 750 hours (six months of coverage) for Plans 1,2, and 3. Employees in Plan 4 may accumulate up to 1,125 hours (nine months of coverage).

In general, you continue to be eligible for Plan coverage as long as your hour bank account contains at least 125 hours of work credit. See the Coverage Reinstatement section regarding forfeiture of hours.

CONTINUATION OF ELIGIBILITY WHILE DISABLED

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

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

- ❑ Workers' Compensation benefits,
- ❑ Laborers' Health & Welfare Trust Fund of Western Canada Weekly Disability Benefits, or
- ❑ Employment Insurance (E.I.) Sickness and Accident benefits.

If you receive any of the above benefits, you must notify the Fund Office immediately of the duration of your disability so that your hour bank account may be frozen for the period, as described above. Request for Freezing of Hours forms may be obtained at your Local Union office or the Fund Office.

Termination of Eligibility

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

- ❑ the end of the second month following the month in which work credits in your hour bank account fall below 125 hours after deduction of 125 hours for that month,
- ❑ the end of the month for which the required premium payment was made on your behalf,
- ❑ the date you enter the armed forces on a full-time basis
- ❑ the date you no longer have provincial health care coverage, or
- ❑ the date the Plan terminates.

Coverage Reinstatement

If your eligibility for Plan coverage ends, you will again become eligible if your hour bank account shows a total of at least 125 hours within the four-calendar-month period after your eligibility ended. Reinstatements will become effective on the first day of the second month following the month in which this requirement is met.

Limited coverage may be available should a member die, or become disabled due to an accident, during this period. Contact the Fund Office for details.

For example:

> Bill lost eligibility for coverage in April when his hour bank account fell to 30 hours of work credit. He earned 40 hours of work credit in May and 73 hours of work credit in June. At the end of June, Bill's hour bank account had a total of 143 hours of work credit. Bill's Plan coverage was reinstated as of August 1, the first day of the second month following the month in which his account reached at least 125 hours.

If you do not accumulate at least 125 hours of work credit in your hour bank account within four calendar months after coverage ends, any work credit in your account at that time will be forfeited. If you return to work for a contributing employer at a later time, you may become eligible for Plan coverage when you meet the Plan's initial eligibility requirements described earlier.

Extension of Coverage by Self-Payment

Self-payments are designed for members who have run out their hour bank and have no benefit coverage for the following month. If your hour bank account falls below 125 hours, you will receive a notice that your coverage will terminate. Provided you are a member in good standing with the Union at the time your coverage terminates (and this is verified by your Local Union), you will be provided with a one-time option to continue your coverage by making self-payments on a month-to-month basis.

When you first become eligible to make a self-payment you will have two choices of coverage level:

- ❑ to continue the coverage level you are currently covered for excluding coverage for Weekly Disability and the Health Care Expense Option, or
- ❑ to continue coverage for the Core Benefits only excluding coverage for Weekly Disability.

The amount of your self-payment is based on your coverage choice. You will not be permitted to change your self-payment option once your first self-payment has been made.

You may continue Plan coverage through self-payment for up to a maximum of six (6) consecutive months if you were eligible through hours prior to losing coverage under Plans 1, 2, and 3. If you were eligible through hours prior to losing coverage under Plan 4 then you can make up to a maximum of nine (9) consecutive self-payments provided you remain a member in good standing with the Union.

WHEN SELF-PAYMENT IS DUE

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

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

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

Contact the Fund Office for further information about the amount of self-payment and other requirements that must be met.

DECEASED MEMBERS – LENGTH OF DEPENDENT COVERAGE

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

- ❑ three calendar months immediately following the date of your death, or
- ❑ the date your hour bank account runs out.

EXTENSION OF CORE SUPPLEMENTARY HEALTH BENEFITS AND HOSPITAL BENEFITS DURING DISABILITY

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

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

whichever occurs first.

To qualify for this extended coverage, totally disabled means:

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

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

Participation of Non-Bargaining Employees

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

- a full-time salaried officer or employee of any applicable Local for whom coverage under this Plan has been approved by the Trustees,
- an employee of the Trustees for whom coverage under this Plan has been approved by them,
- an employee of certain other employers for whom coverage under this Plan has been approved by the Trustees, or
- an employee of the Trustees of any jointly trusted benefit Fund, sponsored or supported by a Union such as Training, Education or other similar Fund established and maintained to benefit employees, for whom coverage under this Plan has been approved by the Trustees.

Trustees of the Laborers' Health & Welfare Trust Fund of Western Canada may also become eligible for benefits under this Plan.

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

ELIGIBILITY RULES – RETIRED MEMBERS PLAN

MEMBER ELIGIBILITY

To be eligible for benefits under the Retired Members Plan the member must meet all of the following requirements:

He must be a member in good standing of a LIUNA Local (the "Union") on the date he retires from employment with participating employers (the date of his retirement);

1. He must have 10 continuous years as a member in good standing of the Union on the date of his retirement;

2. He must have been working, or available for work, under the jurisdiction of the Union for 12 continuous months as of the date of his retirement;

3. He must be in receipt of, or in the process of successfully applying for, a monthly retirement benefit commencing on his date of retirement from the Laborers' Pension Fund of Western Canada (the Pension Plan);

4. He must have 12 continuous months of coverage as a non-retired Member under the Fund as of the date of his retirement; and

5. The Union office must verify that he meets requirements 1, 2, and 3 above, on his date of retirement.

With respect to Number 4 above, members in receipt of a disability pension and members whose pension is commuted on their retirement date shall be eligible for the Retired Members Plan.

If a member does not elect to participate in the Retired Members Plan within 30 days of his effective date of coverage (as defined below), he will not be allowed to participate later.

ELIGIBLE DEPENDENTS

A Retired Member's eligible dependents are:

1. The Retired Member's spouse, where spouse means:

   (a) a person who, as of the time the expense is incurred, is legally married to the Retired Member, or

   (b) a person who is living with the Retired Member at the time an expense is incurred and who is publicly represented as the Retired Member's spouse, and who has been living with the Retired Member for at least one continuous year. To establish that the Retired Member's spouse has been living with the Retired Member for at least one year, the Retired Member must complete the Declaration of Common-Law Spouse section on the

reverse side of the Registration Form, naming the spouse as a dependent. This form must then be on file in the Fund Office for a period of one year before the Retired Member's common-law spouse is eligible for benefits.

If the Retired Member has a spouse, as defined above, but the spouse has not been registered with the Fund Office for at least one year, the Retired Member can have the Declaration of Common-Law Spouse signed by a Commissioner of Oaths. This will eliminate the one year Fund Office filing requirement and the spouse then becomes eligible for benefits the date the form is received in the Fund Office; however, the Retired Member's spousal relationship must still have existed for at least one year before the expense was incurred.

If more than one person qualifies as the Retired Member's spouse, the person the Retired Member designates on the Registration Form as the spouse will be the person the Plan recognizes as the spouse. To be valid, the Registration Form must be signed by the Retired Member and received by or filed with the Trustees or the Administrator. In the absence of the designation, the Plan will consider the person qualified under (a) in the above definition to be the Retired Member's spouse.

2. The Retired Member's unmarried children under the age of 21 who are dependent upon the Retired Member for maintenance and support and are not employed on a regular and full-time basis, and

3. The Retired Member's unmarried children age 21 and over but under the age of 25 who are dependent upon the Retired Member for maintenance and support and are not employed on a regular and full-time basis, and are attending school **at an accredited college or university** on a full-time basis, and

4. The Retired Member's unmarried children over the age of 21 who are physically or mentally incapable of self-support and became so while dependent upon the Retired Member for maintenance and support and while not employed on a regular and full-time basis, and while covered as a dependent under 2 or 3 above.

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

Children of the Retired Member's spouse must also be included on the Registration Form, and become eligible when the Retired Member's spouse does.

If a dependent is confined for medical care or treatment in any institution or at home when coverage would normally start, the dependent will not be covered until given a final release by the doctor from all such confinement. However, this provision is not applicable to dependents who were covered as a non-retired Member's dependents as of the last day of non-retired Member coverage.

No one will be eligible as a dependent while covered as a non-retired or Retired Member or while in military service.

Required Contributions

Eligible Retired Members can become insured for Retired Members coverage by making monthly contributions at the required level and at the required time, as determined by the Board. The contributions are required on a monthly basis. **Failure to make the required contributions within the time requirements will result in coverage under the Retired Members' Benefit Plan being terminated, as provided for in the Termination of Eligibility provision below.**

When a Retiree initially becomes eligible to participate in the Retired Members Plan, the first payment for coverage must be made within 30 days of the effective date of coverage, as defined below. All subsequent payments for continued coverage must be made by the 15th day of the month for which coverage is applicable.

Effective Date of Coverage

The effective date of coverage under this Plan for any eligible Retired Member who retires on or after the Effective Date of the Plan, is the first day of the month immediately following the month in which non-retired Member coverage by the Laborers' Health & Welfare Trust Fund of Western Canada (the Fund) ceases.

The effective date of coverage for Eligible Dependents is the effective date of coverage for the Retired Member, except where specified otherwise in Eligible Dependents (as defined earlier).

Termination of Eligibility

Coverage as a Retired Member under this Plan will cease upon the earliest of:

1. The date the Retired Member ceases to be a member in good standing of the Union;

2. The date the Retired Member ceases to make the required monthly Plan contributions to the Fund Office;

3. The date coverage commences as a non-retired Member under the Fund, due to the Retired Member's re-employment with a participating employer;

4. The date the Retired Member is re-employed in the industry by a non-participating employer;

5. The date the Retired Member reaches age 75;

6. The date of the Retired Member's death.

Important: If a Retired Member's coverage terminates for any reason other than Number 3 above, his coverage cannot be reinstated.

As noted in Number 3 above, should a member become eligible for coverage as a Retired Member and subsequently become eligible as a non-retired Member under the Fund, his eligibility as a Retired Member will cease. If, after that, he terminates eligibility as a non-retired Member, he will again become eligible as a Retired Member provided he meets all of the Initial Eligibility rules, as set out in Section A (with respect to his date of re-retirement). Rule Number 3 of the Initial Eligibility rules will be adjusted to the number of months he was covered as a non-retired Member, if it was less than 12 months.

Changes In Eligibility Rules

The eligibility rules may be amended by the Board at any time without the necessity of prior notice being provided to those individuals affected thereby, including Retired Members covered by this Plan and those not yet eligible for coverage as of the effective date of any such amendment.

The Board expressly reserves the right to terminate any or all of the benefits or coverage provided for Retired Members and their dependents, and expressly reserves the right to provide different benefits to Retired Members or dependents than the benefits being provided to other members, participants, dependents, or beneficiaries of the Plan. The Board also expressly reserves the right to change the amount of contributions required to be made by all Retired Members from time to time.

UNION MEMBER BURIAL BENEFIT

The Union Member Burial Benefit amount is equal to $5,000. To be eligible for the Burial Benefit, the Union Member must meet all of the following requirements at the time of death:

1. Be under the age of 65

2. Have been eligible for benefits under the Plan on or after January 1, 1990

3. Not be eligible for Life Insurance benefits under the Plan

4. Be a member in good standing with the Local Union; and

5. Be believed to have an estate valued at less than $25,000 as reflected by a Statutory Declaration from the Business Manager of the Local Union where the member is in good standing

YOUR COVERAGE OPTIONS

ACTIVE MEMBERS

ELECTING YOUR LEVEL OF COVERAGE

When you meet the Plan's initial eligibility requirements, you must elect the coverage Option you want. The level of coverage available to you depends upon your employer's contribution rate. The contribution rate that applies to you is printed on your enrollment form. A summary of the coverage Options and the costs of the Options are also included on your enrolment form.

The chart found in Appendix A provides a summary of contribution rates and coverage default levels as of May 1, 2016. The contribution rates and cost for coverage options is subject to change at any time.

You will automatically be enrolled in the highest level of coverage which is available at your contribution rate (this is called your default level). If you do not want that level of coverage, you can elect a lower level of coverage and have the "surplus" contributions transferred to a Health Care Expense Option, set up in your name.

FOR EXAMPLE:

> Andy's employer contributed at a rate of $1.90 per hour. Andy would have automatically been enrolled in the Plan 3 coverage level, which cost $1.85 per hour. The $0.05 difference between the $1.90 contribution rate and the $1.85 cost is automatically transferred to his Health Care Expense Option.
>
> After referring to the summary charts of the coverage level provided by each Option, Andy decided that the Plan 2 coverage level would best meet his family's benefit needs. Therefore, he elected this coverage level (at a cost of $1.51 per hour) with $0.39 per hour ($1.90 - $1.51) to be transferred to his Health Care Expense Option.

WHEN THE COST IS LESS THAN YOUR EMPLOYER'S CONTRIBUTION RATE

As shown in the prior example, if the coverage level you are enrolled in costs less than your employer's contribution rate, the excess will be directed into a Health Care Expense Option, set up in your name. You may use the amount in your Health Care Expense Option to pay for eligible health care expenses that are not reimbursed from any other source. In this way, the full amount of the employer contributions made on your behalf is available to you to use for your health care expenses. For more information on the Health Care Expense Option, see the description included later.

How Long Your Election Remains in Effect

Your Initial Election

Your first election remains in effect from the date coverage begins until the next Plan re-enrollment, at the call of the Board of Trustees.

You will be advised of a Plan re-enrollment date and be provided with all of the necessary re-enrollment forms. Any election you make remains in effect until the next Plan re-enrollment date, unless you have a qualified family status change, or a change in contribution rate, both of which are discussed below.

Family Status Changes

You may change your coverage before the next Plan re-enrollment if you experience a *family status change.* A *family status change* is:

- ❑ adding a dependent through marriage, birth or adoption, or
- ❑ losing a dependent though divorce, death, or a child losing dependent status
- ❑ changes to a spouse's eligibility for coverage under a different Plan

If you have a change in family status after your initial enrollment, you must contact the Fund Office within 30 days after this event in order to make a change in your Plan coverage.

Once the Fund Office has received notification of your family status change, the Fund Office will forward a new Registration Form for you to complete. Any change in your coverage will become effective the first of the month following receipt of your new Registration Form by the Fund Office.

If you wait longer than 30 days to notify the Fund Office of a family status change, the next time you can change your *Plan* selection will be with the next Plan re-enrollment date.

WHAT HAPPENS IF YOUR CONTRIBUTION RATE CHANGES

The guidelines for a re-selection due to an increase or decrease in contribution rate are detailed below. A re-selection as a result of an increase or decrease in contribution rate is only permitted once per year.

CONTRIBUTION RATE INCREASES

If your contribution rate increases during the year, you may be eligible for a change in your coverage. However, you must satisfy a requalification period before you can re-select your Plan at the higher contribution rate. The requalification period to be permitted to re-select is the same as the initial eligibility rules – 315 hours in at least two (2) but not more than six (6) months.

Once the requalification eligibility requirements have been met, you will automatically be enrolled in the higher level of coverage available at your higher contribution rate, unless you elect a lower level of coverage. All hours in your bank will provide coverage at your re-selected coverage level.

When you are eligible to re-select, the Fund Office will forward a new Registration Form for you to complete. You must return the Registration Form within 30 days.

If you do not satisfy the requalification eligibility requirements to re-select your Plan, the additional contributions will be credited to your Health Care Expense Option. Added Health Care Expense Option contributions will increase the dollars that are available to cover eligible expenses that are not reimbursed by another source. If you do not have a Health Care Expense Option, then one will be started for you.

CONTRIBUTION RATE DECREASES

If your contribution rate decreases during the year, your *Plan* selection will remain in effect until your hour bank balance earned at your contribution rate runs out. At the end of this period, your coverage level may change.

If your new contribution rate is not sufficient to maintain your current level of coverage, then your coverage level will be reduced.

Before your hour bank runs out for your existing *Plan* selection, the Fund Office will forward a new *Plan* Registration Form for you to complete. You must return the *Plan* Registration Form within 30 days.

Any claims incurred before the effective date of a reduction in coverage level will remain eligible for payment (provided they would have been covered before the reduction).

MEMBER LIFE INSURANCE

ACTIVE AND RETIRED MEMBERS

BENEFITS

The Life Insurance benefit is payable to your beneficiary in the event of your death from any cause at any time or place while you are insured under the Plan. Coverage terminates at age seventy-five (75).

The Life Insurance benefit amount payable is:

Plan 1	: $30,000
Plan 2, 3 or 4	: $100,000
Retired Members	: $5,000

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

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

WHO CAN BE YOUR BENEFICIARY

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

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

WAIVER OF PREMIUM FOR DISABILITY (NOT APPLICABLE TO RETIRED MEMBERS)

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

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

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

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

disability. Subsequent proofs of disability must be furnished each year thereafter.

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

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

Conversion Privilege (Not Applicable To Retired members)

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

Extended Benefits (Not Applicable To Retired members)

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

DEPENDENT LIFE INSURANCE

ACTIVE MEMBERS

BENEFITS

The Life Insurance benefit is payable to you in the event of the death of one of your eligible dependents from any cause, at any time or place, while insurance for that dependent is in force.

The Life Insurance benefit amount payable is:

	Spouse	Each Child
Plan 2	$20,000	$16,000
Plan 3 or 4	$30,000	$20,000

WAIVER OF PREMIUM FOR DISABILITY

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

CONVERSION OF DEPENDENTS' INSURANCE

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

EXTENDED BENEFITS

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

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

ACTIVE MEMBERS

BENEFITS

If you sustain a bodily injury caused by an accident while insured, and if an insured loss occurs as a direct result within 365 days of the accident, an Accidental Death or Dismemberment (AD&D) benefit is payable.

Based on the loss incurred, the following will be paid:

Loss	Plan 1	Plan 2, 3 and 4
Life	$15,000	$50,000
Paraplegia, Quadriplegia or Hemiplegia	$30,000	$100,000
Both hands or feet	$15,000	$50,000
Sight of both eyes	$15,000	$50,000
Speech and Hearing	$15,000	$50,000
One hand and one foot	$15,000	$50,000
One hand and the sight of one eye	$15,000	$50,000
One foot and the sight of one eye	$15,000	$50,000
One arm or one leg	$11,250	$37,500
One hand, one foot, sight of one eye, speech or hearing	$10,000	$33,333
Thumb and index finger of either hand	$ 5,000	$16,666
Four fingers of either hand	$ 5,000	$16,666
Hearing in one ear	$ 5,000	$16,666
All toes of one foot	$ 3,750	$12,500

Only one of the amounts, the largest applicable loss, is payable for all losses resulting from one accident.

Payments for all losses will be made to you, except for loss of life which will be paid to your designated beneficiary.

"Loss" as used above means:

- ❑ complete severance of a hand or a foot at or above the wrist or ankle joint but below the elbow or knee joint;
- ❑ complete severance of an arm or a leg at or above the elbow or knee joint;

- ❑ complete severance of thumb and fingers at or above the metacarpophalangeal joint;
- ❑ complete severance of toes at or above the metatarsophalangeal joint;
- ❑ irrecoverable loss of the entire sight in an eye;
- ❑ the total and irrecoverable loss of the ability to speak;
- ❑ the total and irrecoverable loss of the ability to hear;
- ❑ for Quadriplegia, the permanent and irrecoverable paralysis of both upper and lower limbs;
- ❑ for Paraplegia, the permanent and irrecoverable paralysis of both lower limbs; and
- ❑ for Hemiplegia, the permanent and irrecoverable paralysis of upper and lower limbs of one side of the body.

AD&D coverage under the Plan is subject to an Aggregate Limit of Indemnity of $4,000,000 for all losses resulting from any one aircraft accident. This means that if an aircraft accident results in an accumulation of losses greater than $4,000,000, the amount payable for each insured person's loss will be reduced proportionately. The Plan will never pay more than $4,000,000 in benefits for death or loss resulting from one aircraft accident.

DAY CARE BENEFIT

In the event your death is as a direct result of an accident, a benefit is payable for the reasonable and necessary expenses actually incurred, subject to the lesser of a maximum of 5% of your Principal Sum or $5,000 for each year your Dependent Child described above is enrolled in a legally licensed Day Care Centre, but not to exceed four years, which must run consecutively with respect to any one Dependent Child.

FAMILY TRANSPORTATION BENEFIT

When, as a result of loss covered by this policy, you are confined as an inpatient in a hospital located from a point of not less than one hundred and fifty kilometers from your normal place of residence, the reasonable expenses actually incurred by all members of your immediate family for hotel accommodation and transportation by the most direct route to your location will be paid. The coverage payable is not to exceed the aggregate amount of $10,000 for all such expenses.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

In the event you sustain the loss of, or loss of use of, both feet or both legs, or become quadriplegic, paraplegic or hemiplegic and subsequently require the use of a wheelchair to be ambulatory, the cost of alterations to your principal residence and/or the cost of modifications to one motor vehicle utilized by you will be paid. Such modifications must be approved by licensing authorities where required, for the purpose of making them wheelchair accessible, to a maximum of $10,000.

SPOUSAL OCCUPATIONAL TRAINING BENEFIT

If your death is as a direct result of an accident sustained by you, the reasonable and necessary expenses incurred by your Spouse, to engage in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, will be paid. This amount is not to exceed the aggregate amount of $10,000 for all such expenses that are actually incurred within three years from the date of your accident.

REHABILITATION BENEFIT

If injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged, except for such injury the reasonable and necessary expense incurred for such training by you, within three years of the date of the accident, subject to a maximum amount of $10,000 as the result of any one accident, will be paid.

REPATRIATION BENEFIT

If injury results in your death within 365 days of the date of the accident, the actual expense incurred for preparing your body for burial or cremation, and the shipment of your body to your city of residence, will be made, subject to a maximum amount of $10,000.

SPECIAL EDUCATION BENEFIT

If injury results in your death, payment of 5% of your Principal Sum to a maximum of $5,000, in addition to all other benefits, will be made to your Dependent Child, who on the date of accident was enrolled as a full-time student in any institution of higher learning beyond the Secondary School level, but not to exceed four consecutive annual payments.

WHEN AD&D COVERAGE ENDS

In addition to the circumstances under which all Plan coverage ends, AD&D coverage ends when you reach age 70.

EXTENDED BENEFITS

If you should die during the one-month period immediately preceding the date your eligibility commences or is reinstated, that is, during the waiting period, and an accident is the sole cause of your death, an Accidental Death benefit will be paid to your beneficiary.

If you should die during the 31-day period after your coverage terminates, and an accident is the sole cause of your death, an Accidental Death benefit will be paid to your beneficiary.

What is Excluded from AD&D Coverage

This Plan does not cover any loss:

- ❑ resulting from suicide of self-inflicted injury,
- ❑ resulting from declared or undeclared war or any act of war,
- ❑ occurring while you are on full-time active service in the armed forces, or
- ❑ occurring while you are piloting or acting as a member of a crew in an aircraft, unless the aircraft is certified and fixed-wing and is being used for personal and/or recreational purposes. Personal and/or recreational purposes do not include carrying passengers for hire, use in connection with acrobatic or stunt flying, use in connection with crop dusting, hunting and other circumstances outlined in detail in the Insurance Contract.

Exposure and Disappearance

Loss due to exposure will be deemed to be accidental if the exposure was a direct result of an accident.

An Accidental Death benefit may be payable in the event of the disappearance of an insured person under circumstances indicating an accident, as detailed in the Insurance Contract.

Who Can Be Your Beneficiary

Your beneficiary for this benefit is the same person you named as beneficiary for your Member Life Insurance coverage. To the extent permitted by provincial laws, you may change your beneficiary at any time by completing a new Registration Form and submitting it to the Fund Office. The change will become effective on the date the Fund Office receives your new Registration Form.

WEEKLY DISABILITY BENEFIT

ACTIVE MEMBERS

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

The amount of benefit is $537 per week for all Plan coverage Options.

WHEN WEEKLY DISABILITY BENEFITS ARE PAYABLE

Weekly Disability benefit payments begin on the first day of disability caused by an accident and on the eighth day of disability caused by a sickness. Benefit payments may continue for up to a maximum of 52 weeks, as long as you remain disabled and are under the care of a physician.

HOW WEEKLY DISABILITY BENEFITS COORDINATE WITH E.I.'S ACCIDENT AND SICKNESS BENEFITS

If you are eligible for Accident and Sickness Benefits from Employment Insurance (E.I.), the Fund's benefits will be suspended when E.I. benefits begin (not later than 14 days after the date your disability begins).

If you are still disabled after using up all of your E.I. benefits (maximum 15 weeks), the Fund will resume benefit payments and will continue payments. As long as you remain disabled and under a physician's care, benefits will be paid up to a combined maximum of 52 weeks of payments, including the payments received from E.I.

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

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

WHAT IS NOT COVERED

Weekly Disability benefits are not payable for:

- ❑ any day on which you are not under the care of a physician or surgeon; no period of care shall be considered to have started until you have been seen and treated personally by a physician or surgeon;
- ❑ a disability caused by self-inflicted injury or illness;

- ❑ a disability resulting from insurrection, war, service in the armed forces of any country, or participation in a riot;
- ❑ a disability for which you are entitled to benefits under any Workers' Compensation Act or Automobile Insurance Act;
- ❑ periods of disability when you are on vacation and receiving full pay;
- ❑ any period that you are undergoing cosmetic surgery or treatment, when so classified by the insurance company, unless such surgery or treatment is for accidental injury and began within 90 days of the accident causing the injury; or
- ❑ any day you do any kind of work for pay or profit.

How To Start Receiving Disability Benefits

Be sure to apply to both the Fund Office and E.I. as soon as you become disabled. If you do not qualify for Employment Insurance Weekly Accident and Sickness benefits or Workers' Compensation benefits, contact the Fund Office immediately. Disability claims must be reported to the Fund Office within 180 days after the date the disability began.

Third Party Liability

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

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

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

Extension of Benefits

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

SUPPLEMENTARY HEALTH BENEFITS

ACTIVE MEMBERS AND THEIR DEPENDENTS

BENEFITS

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

Benefits for each covered person include:

- 100% of eligible expenses for Travel Insurance and Assistance, up to a lifetime maximum benefit of $5 million per person, and
- 100% of eligible expenses for Trip Cancellation Insurance, up to a maximum benefit of $5,000 per trip, and
- 100% of all other eligible expenses (except as otherwise noted) up to a lifetime maximum benefit of $100,000 per insured person.

  Each year, up to $1,000 will be automatically reinstated to each insured person's maximum amount available in benefits. However, the total will not exceed $100,000 per insured person.

  If your individual benefit payments (or any of your eligible dependents') amount to more than $1,000 you may apply to have your full maximum restored, subject to medical evidence of insurability that is satisfactory to SSQ.

ELIGIBLE EXPENSES – ALL PLANS

The following services and supplies are covered by the Supplementary Health Benefits under all Plan Options.

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

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

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

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

- **Nursing Care –** Service of a Registered Nurse (R.N.), provided to a patient who is not confined to a hospital, up to a lifetime maximum benefit of $30,000. If a R.N. is not available when needed, nursing services of a Registered Nursing Assistant or a Licensed Practical Nurse will be eligible.

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

- **Services of Practitioners –** Up to $400 per person per type of practitioner is payable each calendar year for professional services provided by the following licensed, certified or registered practitioners when they are operating within their recognized fields. The maximum benefit payable for eye examinations is an exception. These services are limited to $80 per person every 24 months. Where applicable, no payment can be made until the provincial plans have paid their yearly maximum.

  - *Psychologist or physiotherapist.*
  - *Registered massage therapist* on a doctor's written recommendation
  - *Chiropractor or naturopath.* In addition, up to $25 per calendar year is payable for required x-rays provided by a chiropractor.
  - *Services of a Christian Science healer* authorized as such on the register maintained and published by the First Church of Christ, Scientist, Boston, Massachusetts, U.S.A.
  - *Eye examinations performed by a licensed ophthalmologist or optometrist* that are not covered by your provincial health plan. Coverage is limited to one eye examination every 24 months, up to a maximum benefit of $80 per person.
  - *Services of podiatrist, chiropodist and acupuncturist.* Coverage is payable from first dollar.

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

- **Ambulance Service** provided by a licensed ground ambulance to and from a local hospital. The Plan also covers up to one round trip per person each year for emergency transportation by means of a licensed ambulance, air-ambulance or by any other vehicle normally used for public transportation, to the nearest hospital in which the required treatment can be provided. Prior approval of SSQ must be obtained. Licensed ground ambulance service to and from the points of departure and arrival is also considered eligible.

- **Hospital Care** (Within Canada) – ***For Plan 3 and Plan 4 only.*** Hospital charges for out-patient medical or surgical treatment (excluding physician's fees or special nurse's fees, laboratory service, physiotherapy and similar therapeutic procedures, electrocardiogram and other diagnostic procedures, and electric shock therapy and other therapeutic procedures).

  Eligible expenses also include room, board and normal nursing care provided in a licensed convalescent hospital in Canada (for convalescent or chronic care, but excluding custodial care) for semi-private accommodations up to a maximum of 120 days per disability period. To be covered, you must be admitted within seven days after being hospitalized for at least five consecutive days, and the confinement must be due to the same injury or sickness for which you were hospitalized.

- **Diagnostic Laboratory and X-Ray Expenses**

- **Prescription Drugs –** Charges for medically necessary drugs and medicines, including oral contraceptives prescribed by a licensed doctor (M.D.) or licensed dentist or other professional authorized by provincial legislation to prescribe drugs, and dispensed by a registered pharmacist or licensed doctor (M.D.), legally authorized to dispense such drugs, that regardless of their legal status are not normally obtainable except by a prescription from a licensed doctor (M.D.) or licensed dentist (except as noted below). Any other charges by a physician, such as professional fees, are not covered.

  Coverage is provided based on generic drugs and medicines. Full coverage of brand name drugs and medicines will only be provided if a generic equivalent does not exist. If a generic drug does exist and a brand name drug is purchased, you will be required to pay all expenses in excess of the full coverage amount of the generic equivalent.

  - Drugs for the treatment of erectile dysfunction are limited to $500 per insured person per calendar year.
  - Prescription and non-prescription smoking cessation products limited to $400 per insured person for the first course of treatment, and to 50% reimbursement up to $200 for the second course of treatment. No payment will be made for subsequent courses of treatment.
  - Drugs or medications for weight reduction are provided under restricted circumstances and are limited to $1,000 per insured person per lifetime.
  - Vaccinations are not eligible for reimbursement.

  The level of drug coverage provided varies by Plan as follows:

  Plans 1 and 2: 80% coverage

  Plans 3 and 4: 100% coverage, no deductible

The Annual prescription drug maximum effective July 1, 2016 is $12,000 for a single member and $20,000 for a member with family coverage**edical Supplies –** The Plan provides 100% reimbursement for the following supplies:

- Rental or, at SSQ's option, purchase of supplies, aids and appliances such as the following:
  - casts, plaster bandages, and surgical dressings,
  - radium or cobalt or radioactive isotopes,
  - blood or blood plasma,
  - wheelchairs, hospital beds, iron lungs or kidney dialysis equipment,
  - surgical supplies,
  - aids and appliances required because of an injury to organs or body parts, provided such injury was sustained in an accident which occurred while the patient was insured under this Plan.
- Purchase of orthopedic shoes and boots, one pair per person per calendar year, up to a maximum of $1,500 (not eligible for payment unless prescribed by a medical doctor for a diagnosed physical impairment. Medical doctors do not include doctors of chiropractic or chiropodists).
- Purchase of orthotic devices which have been specifically designed and fabricated for the covered individual, limited to one pair per calendar year, up to a maximum of $300, when prescribed by a medical doctor or podiatrist.
- Purchase of one hearing aid per ear where reimbursement will be made for 100% of the first $750 of expenses, plus 50% of the balance, with a maximum reimbursement of $2,500 per hearing aid per person in any 24 consecutive months.

❑ **Charges Incurred** for the treatment of plantar warts up to a maximum of $200 per calendar year.

❑ **Charges Incurred** due to a licensed doctor's (M.D.) fee to provide a note to explain an employee's absence from work when required for the employee's employer or to obtain disability benefits from the Fund. Eligible expenses are limited to $50 per note and $200 per calendar year.

❑ **Emergency Dental Treatment** for the repair of damage resulting directly from an accidental injury to natural teeth or the area outside the mouth, provided the treatment is received within 12 months of the accident and you are still eligible for coverage. Payment will be made based on the amount for the least expensive procedure which will provide a professionally adequate result.

❑ **Maternity Expenses –** Expenses incurred for pregnancy will be considered in the same manner as expenses incurred for any other condition.

Safety Glasses – All Plans

Reimbursement for the purchase of prescription safety glasses up to a maximum benefit of $400 per person every 12 consecutive months. This coverage is only available to Plan members and not to dependents.

Hospital Benefits – Plans 3 and 4

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

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

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

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

Vision Care – Plans 2, 3, and 4

The Plan's vision care benefit provides reimbursement for the purchase of prescription glasses or contact lenses, up to a maximum benefit of $500 per person every 24 consecutive months.

No benefits are provided for non-prescription lenses, prescription sunglasses, and anti-reflective coatings. Vision care expenses are eligible when prescribed by an ophthalmologist or an optometrist.

The vision care benefit also provides reimbursement of 60% of expenses incurred for laser eye surgery performed by a qualified ophthalmologist, up to a lifetime maximum benefit of $1,500 per person.

Charges not Covered Under Supplementary Health Benefits

Benefits are not payable for expenses incurred with respect to the following:

- self-inflicted injuries or illness while sane or insane,
- any injury or illness for which the insured person is entitled, in whole or in part, to indemnity or compensation under any Worker's Compensation Act.
- charges levied by a physician or dentist, or any other health practitioner, for time spent travelling, broken appointments, completion of claim forms, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication,

- ❑ cosmetic surgery or treatment (when determined as such by SSQ), unless the surgery or treatment is for accidental injuries and began within 90 days of an accident, and treatment is performed while the person is covered under this Benefit,
- ❑ injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot,
- ❑ services, treatments or supplies payable by, or covered only by a government plan. (However, where permitted to do so by law, reimbursement of the amount of an eligible expense over and above what is or would be payable by a government plan will be considered.),
- ❑ examinations required for the use of a third party,
- ❑ travel for health reasons,
- ❑ any charges for services, treatment or supplies for which there would be no charge except for the existence of insurance,
- ❑ expenses incurred outside Canada for hospital charges for ward accommodation, hospital services or supplies furnished during hospital confinement, or physicians' services which are incurred outside Canada on an elective basis or on the referral of a physician located in Canada,
- ❑ drugs, sera, injectables and supplies which are not approved by Health and Welfare Canada (Food and Drugs) or are experimental or limited in use whether or not so approved,
- ❑ drugs, sera, or injectable drugs, when administered in a hospital setting, whether on an inpatient or outpatient basis, except as provided under Travel Insurance.
- ❑ experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society, and
- ❑ confinement in a hospital or institution which is a place for drug addicts or alcoholics, a tuberculosis hospital or sanatorium, or a hospital or institution for the mentally ill.

TRAVEL INSURANCE AND ASSISTANCE

ACTIVE MEMBERS AND THEIR DEPENDENTS

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

From Canada or the United States: 1 (866) 438-5498

From elsewhere in the world: 1 (418) 651 2266 (collect call)

The Contract Number specified on the insurance card must be provided when calling.

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

- ❑ Policy Number
- ❑ Certificate Number
- ❑ Plan Name – Laborers' Health & Welfare Trust Fund of Western Canada
- ❑ Name of Third Party Administrator – Funds Administrative Service Inc.

1. <u>Expenses Covered</u>

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

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

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

In the following cases, approval must be requested as soon as possible from SSQ's travel assistance service, either by the insured or by any other adult able to do so: hospitalization, medical care, transportation by ambulance.

In the following cases, insureds must obtain prior approval from SSQ's travel assistance service: treatment provided by a nurse, chiropractor, podiatrist, physiotherapist or dentist; repatriation; medical escort; living expenses and transportation of a close relative of the insured; transportation of the insured's body if deceased; return of a vehicle; expenses described under the "Services, products and articles" section.

For the expenses described below to be considered eligible, insureds must be covered under the public health and hospitalization plans of their province of residence.

In all cases, services must be obtained from an individual who does not reside with the insured and is neither a close relative nor a travel companion of the insured.

Insureds who already have a known disease or illness before the trip must ensure before departure that:

- ❑ Their health condition is good, and stable. The insured's state of health is considered unstable, and its effects are not considered to be those of a sudden and unexpected illness, in the following cases:
  - Symptoms worsen before the trip
  - A relapse is suffered before the trip
  - The disease or illness is in its terminal phase
  - The disease or illness is chronic and shows signs that deterioration may occur or foreseeable complications may arise during the trip
- ❑ They are able to carry out usual daily activities

  and
- ❑ They are experiencing no symptoms that may reasonably suggest that any complications may arise or medical care may be required during the trip outside the province of residence.

SSQ's travel assistance service can clarify the term "sudden and unexpected illness" and confirm whether coverage may be limited in any way by the insured's condition.

(1) Hospitalization

Hospitalization expenses incurred due to treatment in a hospital.

(2) Physician fees

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

(3) Nursing fees

When prescribed by the attending physician, professional fees of a registered nurse for private nursing care provided exclusively in hospital. Eligible expenses for nursing fees may not exceed $5,000 per insured per trip.

(4) Chiropractor, podiatrist or physiotherapist fees

Professional fees of a chiropractor, podiatrist or physiotherapist.

(5) Dentist fees

Professional fees of a dentist for accidental injury to natural teeth. The accident must occur outside the insured's province of residence. Treatment must be received while the individual's insurance is in force. Eligible expenses for professional fees of a dentist may not exceed $1,000 per insured per trip.

(6) Prescription drugs

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

(7) Transportation by ambulance

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

(8) Repatriation of the insured

The cost of returning the insured to the province of residence for immediate hospitalization and the cost of transporting the insured to the nearest location where appropriate medical services are available. Benefits are limited to the cost of the most economical transport option, taking the insured’s health condition into account.

(9) Transportation by plane of a medical escort

The cost of economy class return air fare for a medical escort who is neither a member of the insured's family nor a travel companion, when required by the air carrier or the attending physician of the insured.

(10) Living expenses and transportation of a close relative

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

- Transportation: $2,500 per trip for all insured family members
- Accommodation and meals: $300 per day for all insured family members, up to a maximum of $2,400 per trip

Eligible transportation expenses are limited to the cost of making the trip by the most economical means (bus, train or air). The attending physician must certify in writing that the visit was necessary.

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

The expenses of preparing and returning the remains of the insured by the most direct route home, excluding expenses incurred for a coffin or funeral urn. Eligible expenses are limited to a total maximum of $10,000 for preparation of the body and transportation.

(12) Return of vehicle

The cost of returning the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency. Eligible expenses are limited to a maximum of $2,000 per trip.

The vehicle must be returned by a recognized commercial agency. The insured must be incapable of doing so personally due to an illness or injury that is confirmed by the attending physician, and the insured's travel companions, if applicable, must also be unable to return the vehicle.

(13) Services, products, and articles

Expenses paid for the following medical services, products or articles:

- Rental of a wheelchair, hospital bed or respirator
- X-rays and laboratory analyses
- Purchase of trusses, corsets, crutches, splints, casts and other orthopaedic devices

(14) Living expenses

The cost of accommodation and meals in a commercial establishment the insured must incur when obliged to postpone the return home due to hospitalization of the insured, a family member or a travel companion.

The duration of hospitalization must be at least 24 hours. Eligible expenses are subject to a maximum of $300 per day, or $2,400 per trip abroad, for all individuals covered.

(15) Travel Assistance services

This insurance provides access to certain travel assistance services when needed. These services may not be available in all countries and are subject to change by SSQ without notice. The following services are available:

a) Directing the insured to an appropriate clinic or hospital

b) Verifying medical insurance coverage to avoid, wherever possible, the insured having to pay for hospital care up front

c) Ensuring the proper follow-up of the insured's medical file

d) Coordinating the return and transport of the insured as soon as medically possible

e) Providing emergency support and coordinating settlement applications

f) Arranging the transportation of a family member to the bedside of the insured, to identify the insured's body if deceased and/or coordinate the repatriation of the deceased insured

g) Arranging for the return of insured persons to their home (return expenses not included)

h) Arranging for the return of the insured's personal vehicle if the insured is unable to do so due to illness or accident

i) Communicating with the insured's family or employer

j) Acting as an interpreter for emergency calls

k) Recommending a lawyer in the event of legal difficulties

2. Exclusions, Limitations and Restrictions

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

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

a) Expenses incurred as a result of the insured's refusal to be repatriated to the province of residence, upon SSQ's request

b) Expenses incurred by the insured outside the province of residence when such expenses could have been incurred in the province of residence, without danger to the insured's life or health. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a different quality than that available outside the province of residence does not constitute a danger to the insured's life or health

c) Expenses incurred in a location for which the Government of Canada issued a travel advisory not to stay in or not to travel to. This exclusion does not apply to insureds already present at the location in question at the time the Government of Canada issues a travel advisory, provided they then take the necessary measures to comply with the advisory as soon as possible

d) Expenses payable under any public plan

e) Expenses related to elective or non-emergency surgery or treatment

f) In the case of a trip taken for the purposes of obtaining or with the intention of receiving medical treatment, expenses incurred in relation to the medical condition for which the trip is taken, whether or not the trip is taken upon the recommendation of a physician

g) Expenses for chronic care incurred in a facility treating chronic illnesses

h) Expenses incurred for insureds in thermal spa facilities or extended care homes

i) Expenses incurred due to injury or death as a result of practising any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance Plan applies to

j) Expenses related to an event occurring during the trip, or shortly thereafter, that insureds may reasonably have predicted due to their state of health at the start of the trip. This category of events includes pregnancy, miscarriage, childbirth and related complications, where such events occur within the 2 months preceding the normal expected date of delivery or thereafter

k) Hospital or medical expenses incurred for treatment for which no reimbursement is provided for under the public health or hospitalization plan of the insured's province of residence

TRIP CANCELLATION INSURANCE

Active Members and Their Dependents

1. Reasons for Cancellation

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

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

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

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

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

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

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

g) Death or emergency hospitalization of the host at destination

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

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

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

k) Damage rendering the principal residence of the insured or of the host at destination uninhabitable. The residence must remain uninhabitable

7 days or fewer before the scheduled date of departure, or the damage must occur during the time of the trip

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

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

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

o) Weather conditions such that:

- the departure of the public carrier used by the insured, at the point of departure of the planned trip, is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip

or

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

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

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

2. Expenses Covered

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

(1) In the event of cancellation prior to departure

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

a) The non-refundable portion of prepaid travel expenses

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

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

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

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

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

a) The additional cost of a one-way economy class ticket, by the most direct route, for a return trip to the point of departure, by the means of transportation initially planned. If the initially-planned means of transportation cannot be used, whether or not travel expenses have been prepaid, the expenses eligible will be equal to the fees charged

by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the insured to return to the initial point of departure. These expenses must be pre-approved by SSQ's travel assistance service

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

Restriction

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

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

(4) Round-trip transportation

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

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

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

3. Exclusions, Limitations and Restrictions

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

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

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

insureds whose travel plans are finalized on or before the day the government advisory is issued

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

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

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

e) Participation in any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting, skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance Plan applies to

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

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

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

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

MEMBER ASSISTANCE PROGRAM (MAP)

Active and Retired Members and Their Dependents

YOUR MEMBER ASSISTANCE PROGRAM

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

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

WHAT BENEFITS ARE AVAILABLE TO ME?

you and your dependents can receive short term counselling to a maximum of 6 hours per family member per year from a professional counsellor either in person, over the phone, or through the internet site www.homewoodhealth.com.

WHAT DOES THE PROGRAM OFFER?

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

- ❑ emotional or physical problems
- ❑ marital or family problems
- ❑ stress
- ❑ work-related problems
- ❑ financial and legal difficulties
- ❑ child and elder care
- ❑ sexual harassment or abuse
- ❑ alcohol or drug dependencies
- ❑ gambling
- ❑ bereavement

How Does The Program Work?

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

Who Provides The Counselling?

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

What About Confidentiality?

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

Who Do I Contact?

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

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

SUBSTANCE ABUSE ASSESSMENTS

ACTIVE MEMBERS ONLY

Through Homewood Health Inc., the Plan provides Substance Abuse Expert/Substance Professional Assessments (SAE/SAP Assessments) services to the standards outlined in the "Canadian Model for Providing a Safe Workplace Alcohol and Drug Guidelines and Work Rule" (Canadian Model). These SAE/SAP Assessments are available to Active members (but not to dependents) covered under the Laborers' Health & Welfare Trust Fund of Western Canada at the time the Assessment is performed. The Assessment must be required for work related purposes, and the Assessment must not be available to the member under other circumstances. Coverage is provided on the following basis:

- ❑ The member must be eligible for benefit coverage under the Benefit Plan at the time the Assessment is performed.
- ❑ A maximum of four (4) Assessments per member per year will be provided.
- ❑ The Assessment performed by Homewood Health will reflect either harmful use, abuse, or dependency as noted below.
    - a) Harmful Use - Members who are assessed as this category will receive no additional benefits than are otherwise provided under the Plan.
    - b) Abuse - Members who are assessed as this category will be eligible to receive up to 30 additional visits or counseling sessions through Homewood Human Solutions. The member must be eligible for benefit coverage under the Benefit Plan at the time the additional sessions commence.
    - c) Dependency - Members who are assessed at this category will be eligible to receive both of the following:
        - i) up to 30 additional visits or counseling sessions through Homewood Human Solutions (the member must be eligible for benefit coverage under the Benefit Plan at the time the additional sessions commence), and
        - ii) access to an expedited admission to a treatment facility benefit, with a limit of one per lifetime, as reflected below.

- Should a Homewood Health Substance Abuse Expert (SAE) or Substance Abuse Professional (SAP) determine that it is clinically deemed appropriate and necessary for a member to have immediate access to treatment in an in-patient substance abuse facility, that is not immediately available through government funded access, then Homewood Health will work with the member to locate a facility that may provide accelerated admission. The funding for this expedited admission will be provided by the Trust Fund (through the Administrator) on the following basis:

- The expense must be incurred for a facility approved by Homewood Health.

- Treatment will only be provided to members on the approval and recommendation of an SAE or SAP with Homewood Health.

- Authorization for expenses will be provided for only one course of in-patient treatment per lifetime, subject to a maximum of $7,500.

- The member must be eligible for benefit coverage under the Benefit Plan at the time of admission to a treatment facility.

DENTAL CARE BENEFITS

ACTIVE MEMBERS AND THEIR DEPENDENTS

BENEFITS

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

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

DENTAL COVERAGE AT-A-GLANCE

The following chart provides a quick overview of the level of coverage for these Options with dental. All reimbursements are based on 2016 Fee Schedules.

Option	What Is Covered?	Maximum Benefit
Plan 1	• 50% of Routine Services	• $750 per person per calendar year
Plan 2	• 100% of Routine Services and 75% of Major Restorative Services	• $3,500 per person per calendar year
	• 50% of Orthodontia for dependent children and adults	• $2,000 per person per lifetime
Plan 3 and 4	• 100% of Routine Services and 80% of Major Restorative Services	• $3,500 per person per calendar year
	• 80% of Orthodontia for dependent children under age 19; 50% for adults	• $3,000 per person per lifetime

Treatment Plan

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

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

Alternate Course of Treatment

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

Covered Routine Services – All Plans

- ❑ oral examinations, prophylaxis (light scaling and polishing of teeth), and bite-wing X-rays, up to once every six months,
- ❑ full mouth series of X-rays, once every three years,
- ❑ extractions and simple alveolectomy (incision into tooth socket) at time of tooth extraction,
- ❑ topical application of an anti-cariogenic agent,
- ❑ surgical extraction of impacted teeth,
- ❑ surgical removal of tumours, cysts, neoplasms plus the incision and drainage of an abscess,
- ❑ amalgam, silicate, acrylic, and composite restorations,
- ❑ provision of space maintainers and prefabricated full coverage restorations of primary teeth,
- ❑ diagnostic X-rays and laboratory procedures required in relation to dental surgery,
- ❑ general anesthesia or conscious sedation required in connection with any covered dental service,
- ❑ injection of antibiotic drugs by the attending dentist,
- ❑ endodontic treatment (i.e., the treatment of diseases of the dental pulp),

- ❑ periodontal treatment (i.e., the treatment of the tissues and bones supporting the teeth, including surgery, provisional splinting, and occlusal equilibration),
- ❑ relining or rebasing of an existing denture,
- ❑ creation of an initial denture, including adjustments to dentures during the six months following initial installation,
- ❑ replacement of an existing denture, subject to the following limitations:
  - if the existing denture was reimbursed under the Plan, it must be at least three years old and cannot be made serviceable, or
  - if the existing denture is temporary, only if it is replaced with a permanent denture and takes place within 12 months of when the temporary appliance was installed, and
- ❑ addition of teeth to an existing denture (if the existing denture was reimbursed under the Plan, it must be at least three years old.)

COVERED MAJOR RESTORATIVE SERVICES – PLANS 2, 3, AND 4

Plans 2, 3, and 4 provide coverage for the following major restorative services:

- ❑ dental implants, but coverage is limited to the lowest cost of appropriate alternate covered treatment (such as a bridge or crown),
- ❑ inlays, onlays, gold fillings and crowns (including precision attachments for dentures),
- ❑ repairing or recementing an existing crown or inlay,
- ❑ repairing or cementing of an existing bridge,
- ❑ creation of an initial bridge,
- ❑ replacement of an existing bridge, only under the circumstances set out below
  - if the existing bridge is at least five years old and cannot be made serviceable, or
  - if the existing bridge is temporary and is replaced with a permanent bridge and takes place within 12 months of when the temporary appliance was installed, and
- ❑ addition of teeth to an existing bridge if the existing bridge is at least five years old.

COVERED ORTHODONTIC SERVICES – PLANS 2, 3, 4

Plans 2, 3, and 4 provide coverage for orthodontia services for you and your covered dependents. Eligible expenses are charges for an orthodontic procedure that:

- ❑ is in an Orthodontic Treatment Plan that has been reviewed by the Fund Office before treatment has started and returned to the dentist showing estimated benefits, and

- ❑ is required for the correction of malocclusion.

An *Orthodontic Treatment Plan* is a report on a form satisfactory to SSQ that, among other things, describes the recommended treatment, gives the estimated charge, and is accompanied by cephalometric X-rays, study models and other supporting evidence.

Charges Not Covered Under Dental Care Benefits

Benefits are not payable for expenses incurred with respect to the following:

- ❑ self-inflicted injuries or illness while sane or insane,
- ❑ any injury or illness for which the insured person is entitled, in whole or in part, to indemnity or compensation under any Workers' Compensation Act,
- ❑ charges levied by a physician or dentist for time spent travelling, broken appointments, completion of claim forms, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication,
- ❑ cosmetic surgery or treatment (when determined as such by SSQ), unless the surgery or treatment is for accidental injuries and began within 90 days of an accident, and treatment is performed while the person is covered under this Benefit,
- ❑ injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot,
- ❑ services, treatments or supplies payable by, or covered only by, a government plan. (However, where permitted to do so by law, reimbursement of the amount of an eligible expense over and above what is or would be payable by a government plan will be considered.),
- ❑ examinations required for the use of a third party,
- ❑ dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union,
- ❑ replacement of an existing appliance which has been lost, mislaid or stolen,
- ❑ services and supplies received for full mouth reconstruction, for a vertical dimension correction or for a correction to temporomandibular joint dysfunction,
- ❑ any charges for services, treatment or supplies for which there would be no charge except for the existence of insurance,
- ❑ root canal therapy if the pulp chamber was opened prior to the date the person became insured under this Benefit, and
- ❑ pit and fissure sealants.

Extension of Dental Care Benefits

In most cases no dental benefits are payable for expenses incurred after the date coverage ends, even if a Treatment Plan has been filed and benefits have been determined payable prior to the date coverage terminates. However, dental benefits are payable if:

- an impression for a denture, bridge, crown or inlay was taken prior to the date coverage ended and the denture, bridge, crown or inlay was installed or modified within 60 days after coverage ended,
- a tooth was prepared prior to the date coverage ended and the crown, bridge or gold restoration was installed within 60 days after coverage ended,
- the insured person was to undergo root canal therapy and the pulp chamber was opened prior to the date coverage ended and treatment was received within 60 days after coverage ended, and
- the insured person was to undergo orthodontic treatment and the initial orthodontic appliance was installed prior to the date coverage ended and treatment was received within three months after coverage ended.

HEALTH CARE EXPENSE OPTION

ACTIVE MEMBERS

If the total cost of your *Plan* election is a lower cost per hour than your negotiated hourly contribution rate, your excess contributions will be credited to a Heath Care Expense Option (HCEO) established in your name.

GENERAL OVERVIEW OF THE HEALTH CARE EXPENSE OPTION

Contributions directed to a Health Care Expense Option are set aside so that you may reimburse yourself for certain health-related expenses that are not covered by the *Laborers' Plan* or by your Provincial Health Plan. Generally, any expense that would be considered an allowable medical expense on your income tax return is eligible for reimbursement. These include charges such as co-payment amounts, orthodontia, vision care, hearing aids and many other expenses.

The money credited to your Health Care Expense Option is not taxed either when it is deposited or when you receive your reimbursement. That means that you pay for your eligible expenses with pre-tax dollars. Reimbursements you received from the HCEO do not have to be claimed as income for tax purposes. On the other hand, expenses which are reimbursed from your HCEO cannot also be claimed as deductions on your tax return.

FOR EXAMPLE:

> George participated in the Plan at the negotiated contribution rate of $1.10¢ per hour. He was enrolled in Plan 1. Therefore, he had 7¢ per hour surplus which was contributed to a Health Care Expense Option on his behalf. If George worked 125 hours in the month of May, $8.75 would be deposited into his Health Care Expense Option account.
>
> *On the other hand:*
>
> Joseph participated in the Plan at the negotiated contribution rate of $2.06 per hour. He was eligible to be enrolled in Plan 4. Joseph decided that the coverage available under Plan 3 was all the coverage he needed. Because Plan 3 has a total cost of $1.85 per hour, a 21¢ per hour surplus ($2.06 - 1.85 = 21¢) was contributed to a Health Care Expense Option established in Joseph's name. If Joseph worked 100 hours in the month of June, $21.00 would be deposited into his Health Care Expense Option account.
>
> George and Joseph may use the contributions in their Health Care Expense Option to reimburse themselves for eligible health-related expenses which are not covered under the plans for which they are eligible.

How the Health Care Expense Option Works

As mentioned, excess contributions are credited directly to your own Health Care Expense Option. You cannot contribute directly to the account.

When you have an eligible health care expense, you pay it. Next, you submit your claim for reimbursement under any applicable insurance plan. Any amount that is not paid by the insurance Plan can then be submitted for reimbursement from the Health Care Expense Option. Reimbursements will be paid to you directly; they cannot be paid to providers of care.

Health Care Expense Option claims can be submitted to the Fund Office at any time, however, reimbursement will only be processed four times per year.

What Happens to Balances Remaining in the Option at the End of the Plan Year

Any balance remaining in your Health Care Expense Option after December 31 can be carried forward. However, the Income Tax Act requires that no more than two years of contributions can be credited to the Plan at any time. In addition, any balance remaining in your option when you lose eligibility is forfeited.

For example:

> James had $100 in his Health Care Expense Option on December 31, 2015 and submitted eligible claims totaling $60. He received a reimbursement cheque for $60 and a $40 balance was carried forward to the next year.
>
> During the 2016 year, James had $120 credited to his Health Care Expense Option but had no eligible expenses to submit. Only $120 will be carried forward to the 2017 Plan year. The $40 cannot be carried forward a second time.

Eligible Expenses

The following is a sample list of expenses which may be reimbursed from your Health Care Expense Option account balance.

Generally, any expense that would be considered an allowable medical expense on your income tax return is eligible for reimbursement. Reimbursements can be made for expenses incurred on your behalf, or on behalf of your spouse or any dependent children, provided your dependents are listed as eligible on the Fund Office records.

In addition to deductible and co-payment amounts, the expenses covered by the account could include the following items:

A visit to a Dentist, Pharmacist, Nurse, Optometrist or Medical Practitioner – the following are considered Medical Practitioners:

Osteopath
Chiropractor
Naturopath
Registered Massage Therapist
Therapeutist (or Therapist)
Physiotherapists
Chiropodist (or Podiatrist)
Christian Science Practitioner
Psychoanalyst
Psychologist
Speech-Language Pathologist or Audiologist
Occupational Therapist
Acupuncturist
Dental Hygienist
Practical Nurse or Christian Science Nurse

Prescribed Medical Device and Equipment

- Wig
- Device or equipment designed for use by someone suffering from a severe chronic respiratory ailment or a severe immune system disregulation (does not include an air conditioner, humidifier, dehumidifier, heat pump or heat or air exchanger)
- Device or equipment to pace or monitor the heart of someone who suffers from heart disease
- External breast prosthesis
- Device designed to be attached to an infant diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant stops breathing
- Infusion pump, including disposable peripherals
- Orthopedic shoe or boot or an insert for a shoe
- Walking devices
- Air or Water Filter or Purifier
- Needle or Syringe

Miscellaneous Items

- Products required because of incontinence (i.e. adult diapers and disposable briefs, catheters, catheter trays, tubing)
- Eyeglasses (frames & lenses, contact lens, laser eye surgery)
- Guide and hearing-ear dogs
- Drugs, medications and other preparations or substances
- Dentures
- Rehabilitative therapy
- Premiums to private health services plan
- Cost of insulin and sugar-content test-tapes/tablets for diabetics
- Birth control pills
- Facilities – including Nursing Homes
- Special Schools, Institutions or other places for care of the handicapped

Please note that this is not a complete list of eligible expenses and may be subject to change if the Canada Revenue Agency guidelines for acceptable expenses for reimbursement from a Health Care Expense Option account are revised.

QUESTIONS AND ANSWERS

How Do I Become Covered Under The Plan?

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

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

What Is My Hour Bank Account?

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

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

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

Month	Hour Bank Account Balance at Beginning of Month	Hours Reported in Month*	Hours Charged for Coverage	Hour Bank Account Balance
1	190 hrs	136 hrs	125 hrs	201 hrs
2	201	185	125	261
3	261	95	125	231
4	231	Nil	125	106
5	106	100	125	81
6	81	125	125	81

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

Is A Medical Examination Necessary To Get This Insurance?

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

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

Your dependents can become covered for Supplementary Health, Member Assistance Program, Dependent Life and Dental Care benefits (if elected) at the same time you become eligible.

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

If your new employer is required to make contributions, your hour bank account will continue to be credited with hours reported. Your benefits are portable within the industry in Alberta, Saskatchewan, and British Columbia.

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

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

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

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

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

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

What Can Dentists Charge For The Services They Provide?

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

What is a Treatment Plan?

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

Are There Any Exclusions Under The Plan?

Yes. Not all types of expenses are covered. If in doubt, contact the Fund Office.

COORDINATION OF BENEFITS AND HOW TO FILE A CLAIM

Coordination of Benefits

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

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

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

Benefits are coordinated with other plans as follows:

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

How to File a Claim for Reimbursement

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

Life Insurance

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

Accidental Death and Dismemberment

- ❑ You or your beneficiary should notify the Fund Office immediately to obtain the necessary claim form.
- ❑ An original Medical Examiner's Report should be submitted to the Fund Office as soon as it can be obtained.
- ❑ The Accidental Death and Dismemberment benefits will be paid as soon as proof of such loss has been verified by the Fund Office.
- ❑ **A claim for this benefit must be made within 12 months of the date of loss.**

Weekly Disability

- ❑ Apply to E.I. for Accident and Sickness benefits.
- ❑ Obtain a claim form from your Local Union office or the Fund Office.
- ❑ Complete in detail the employee's portion of the Weekly Disability Benefits Statement form and then have your doctor complete his or her portion.
- ❑ Mail the form directly to the Fund Office.
- ❑ **Disability claims must be reported to the Fund Office within 180 days of the start of a total disability.**

Health Care Expense Option

- ❑ Complete a Health Care Expense Account Claim Form, available from the Fund Office.
- ❑ Attach your original bill or receipt clearly indicating:
  - the person receiving the service,
  - the type of service or supply,
  - the name and address of the person providing the service or supply,
  - the amount charged, and
  - the date the service was provided.
- ❑ If you are submitting a request for expenses partially paid or not paid by the Plan, be sure to include the "explanation of benefits" statement from this Plan or any other plan for which you are eligible to receive reimbursement (i.e., your spouse's plan) explaining the non-payment or partial payment.
- ❑ Submit the Claims Form and the supporting documentation, such as the bill or receipt, to the Fund Office. Keep a copy of everything you send to the Fund Office for your own records.
- ❑ If you submit a request for reimbursement which is more than the amount in your Health Care Expense account Option you will receive a cheque for the amount in your Health Care Expense account Option.

- **Reimbursement from the Health Care Expense Option will be processed four times per year.**

Supplementary Health Benefits

Medical Benefits

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

Prescription Drug Benefit

- If you are using your ClaimSecure drug card, provide your card to the pharmacist. You pay 20% of the remaining cost of each prescription for Plan 1 and 2. If you are enrolled in Plan 3 or 4, you will not need to pay the 20%.
- If you are not using your ClaimSecure drug card, you pay the full cost of all prescriptions and submit a claim using a ClaimSecure Claims Transmittal Form, available from the Fund Office.

Hospital Benefits

- Request the Hospital Admitting Clerk to complete a standard hospital claim form.
- If you wish to have hospital payments paid directly to the hospital, complete the “assignment” portion of the claim form.
- Send the completed form or have the hospital send the completed form to the Fund Office.

Vision Care Expenses

- Obtain from your Local Union office or the Fund Office a Vision Care-Statement of Claim form.
- Using a separate form for each family member, itemize the bills.
- Attach original paid receipts and send them directly to the Fund Office. Photocopies and cash register tapes are not acceptable.

Dental Care Expenses

- When you or your dependents have incurred covered dental expenses, obtain a Dental Care Statement form from your Local Union office or the Fund Office and have the dentist complete his or her portion.
- A separate claim form must be used for each individual.

- ❑ Complete your portion of the form and send it directly to the Fund Office.
- ❑ If you wish to have payments paid directly to the dentist, complete the "Assignment" portion of the claim form.
- ❑ The Fund Office will issue a cheque for the approved expenses and mail the cheque to you or your dentist, as is appropriate.

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

Be sure that you indicate your Social Insurance Number and complete name and address on all correspondence sent to the Fund Office.

SEND ALL COMPLETED CLAIM FORMS
TO THE FUND OFFICE

Funds Administrative Service Inc.

10154 108 Street, NW

Edmonton, Alberta T5J 1L3

APPENDIX A

ELECTING YOUR LEVEL OF COVERAGE

When you meet the Plan's initial eligibility requirements, you must elect the coverage Option you want. The level of coverage available to you depends upon your employer's contribution rate. The contribution rate that applies to you is printed on your enrollment form. A summary of the coverage Options and the costs of the Options are also included on your enrolment form.

You will automatically be enrolled in the highest level of coverage which is available at your contribution rate (this is called your default level). If you do not want that level of coverage, you can elect a lower level of coverage and have the "surplus" contributions transferred to a Health Care Expense Option, set up in your name.

If Your Contribution Rate is:	Your Default Level is:
$1.03	Plan 1
$1.24	Plan 1 plus $0.21 to HCEO
$1.57	Plan 2 plus $0.06 to HCEO
$1.85	Plan 3
$1.96	Plan 4
$2.06	Plan 4 plus $0.10 to HCEO

The default levels shown in the table above are included for illustrative purposes only. While the hourly costs for the Plan levels were current at the date shown on the cover page, it is possible and likely that the hourly costs will increase in the future. Should the Board increase or decrease the hourly costs at a future date, the default levels will change based on the hourly rates adopted by the Board regardless of the default levels shown in the table above.