INSULATORS LOCAL 95 BENEFIT FUND

UNION MEMBERS

BENEFITS INFORMATION BOOKLET
November 2025

Visit us online at
www.insulators95benefits.com

CUSTOMER SERVICE

The Trust Fund's Administrative Agent, Benefit Plan Administrators Limited (BPA), is available to assist you.

Trust Fund's Website

- Do you want up-to-date information regarding your benefits?
- Do you need a claim form?

✓ Visit www.insulators95benefits.com

Claims Call Centre

- Do you have questions about any of the benefits described in this booklet?
- Do you need a standard claim form?
- Do you want to follow up on a claim?

✓ Phone 1-800-867-5615 or email claims@bpagroup.com

Plan Administrator

- Do you want to review the employer contributions received on your behalf?
- Do you need a (new) Member Information Card?
- Do you need a replacement Benefit Card?

✓ Phone 1-800-867-5615 or email administration@bpagroup.com

All phone and email messages will be returned no later than the end of the next business day.

Administrative Agent
Benefit Plan Administrators Limited (BPA)

P.O. Box 3071, Station "A"
Mississauga, Ontario L5A 3A4

Phone Number: 905-275-6466
Toll-Free Number: 1-800-867-5615
Fax Number: 905-275-6462

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INTRODUCTION

A MESSAGE FROM THE BOARD

This booklet describes the conditions of eligibility, coverage and claims procedures under the Insulators Local 95 Benefit Fund, which for descriptive ease is referred to in this booklet as the Trust Fund. The Board of Trustees is solely responsible for establishing the eligibility rules of the Trust Fund. Please read this booklet carefully.

This booklet also contains a description of the M.H. (Mike) Nicols Scholarship Plan.

Effort has been made to ensure that the coverage descriptions in this booklet are consistent with the group insurance policies issued by the insurance companies and with related government health coverages. However, this booklet is not, in itself, a legal contract, so it follows that the terms and conditions of the insurance policies, and of the governing legislation, take precedence in case of dispute. Any amendment to the governing documents is effective without notice to you. Possession of this booklet does not guarantee entitlement to the benefits described herein.

Your Collective Agreement stipulates the contributions made to the Trust Fund, and thus determines your classification under this Trust Fund. Your benefits may change from time to time depending on the terms of the Collective Agreement negotiated between your Union and your Employer(s), who contribute to this Trust Fund.

Should you require additional information on the benefits or your current classification, please contact your Trust Fund's Administrative Agent, Benefit Plan Administrators Limited.

The Trustees hope that the benefit coverage, provided by the Trust Fund, is of real value to you and your Eligible Dependents.

The Board of Trustees

THE BENEFIT TRUST FUND

HOW IT WORKS

The benefits provided by the Trust Fund are combinations of those purchased from insurance companies, and those provided directly by the Trust Fund. These benefits are funded with contributions made by your Employer on your behalf. The contributions are made to the Trust Fund as a result of a Collective Bargaining Agreement. The Board of Trustees looks after the Trust Fund.

The Trustees are responsible for the design of the benefit package provided by the Trust Fund and for the allocation of the contributions made to the Trust Fund. To help carry out their duties, the Trustees have appointed various people such as accountants, consultants and lawyers to provide them with professional advice. The Trustees meet with these advisors from time to time to review matters that arise in the running of the Trust Fund. The Trustees make all decisions that are necessary at these meetings by taking a vote amongst themselves. The Trust Fund's Administrative Agent who is Benefit Plan Administrators Limited performs the daily administrative functions of the Trust Fund.

The Trustees expect that the benefits provided by the Trust Fund will be continued indefinitely, but necessarily reserve the right to amend or terminate the benefit coverage described herein in whole, or in part, without prior notice and in their sole discretion.

GENERAL INFORMATION

The benefits described in this booklet may be revised from time to time or discontinued without prior notice and at the sole discretion of the Board of Trustees. The intent of this booklet is to give you details of your Trust Fund and the insurance benefits provided by the Fund. This booklet is not a legal contract and does not confer any contractual rights. Should any discrepancy arise between the wording used in this booklet and in the master policy, the master policy wording will take precedence. The information contained in this booklet is important and we suggest it be kept in a safe place.

LEGAL ACTIONS

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

APPEALS

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

BENEFIT LIMITATION FOR OVERPAYMENT

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after the Insurance Carrier sends you a notice of the overpayment, or within a longer period if agreed to in writing by the Insurance Carrier. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit the Insurance Carrier's right to use other legal means to recover the overpayment.

ON THE IMPORTANCE OF BEING REGISTERED

It is absolutely essential that you complete an information card, which you can obtain from the Administrative Agent. On this card, you name the Beneficiary/Beneficiaries to whom your Life Insurance should be paid, in the event of your death. Members should list all Dependents who are eligible for Health and Dental Care Benefits.

If you have already completed an information card and you have no desire to change your Beneficiary/Beneficiaries, it is not necessary for you to complete another card. You may change your named Beneficiary/Beneficiaries, subject to Provincial Law, by written request, filed with the Administrative Agent. The change will take effect as of the date such request was executed, but without prejudice to the Insurance Company for any payment(s) made before such request is received at its Head Office.

Please be sure to fully complete and sign the card, and return it to the Administrative Agent. It is extremely important that a completed card be on file, since claims cannot be paid on your behalf, or on behalf of your Eligible Dependents, unless a card is on file.

After your insurance becomes effective, it is necessary for you to notify the Administrative Agent of any change in your Dependent or marital status. This information is necessary so that your coverage can be adjusted accordingly.

YOUR PRIVACY

The Trustees and the Administrative Agent are required to collect personal information about you, your Dependents and Beneficiaries, in order to administer your benefits. The personal information you share with the Trustees and the Administrative Agent stays confidential and is used only to determine your benefit entitlements under the Trust Fund. The Administrative Agent will however, provide personal information to other parties such as insurance carriers to determine benefit entitlements when payments are made to you or your Dependents, or as required by law. Your employment history may be shared with your Local Union for the purpose of monitoring the contributions required to be made under the terms of the Collective Agreement. The insurance carriers and your Local Union are also required by law to respect the confidentiality of any such information.

If you need more information regarding the Privacy Policy of the Trust Fund, you may contact the Administrative Agent's office.

PRIVACY OFFICER
P.O. Box 3071, Station A
Mississauga, Ontario L5A 3A4

Email: privacy_officer@bpagroup.com

SUMMARY OF BENEFITS

EXTENDED HEALTH CARE For Eligible Members Under Age 71 & Dependents	
Percentage payable	100% except where noted
Deductible	NIL
Maximum aggregate amount	Unlimited except where noted
Physician administration fees	Covered
PRESCRIPTION DRUGS	
Percentage payable	100% with a $6.50 dispensing fee maximum
Prescription drug maximum	$1,000,000 per lifetime
Vaccines	Covered
Medical cannabis	$1,000 per calendar year for each Member and eligible Dependent, when prescribed by a physician
Sensors for flash glucose monitoring machines (such as for FreeStyle Libre)	Covered if insulin-dependent (monitors are covered under Major Medical)
PRESCRIPTION DRUG SAVINGS PROGRAM	
Reduced fees on prescription medication with participating providers.	
PARAMEDICAL	
Regulated or licensed: chiropodist/podiatrist, chiropractor, osteopath, naturopath, dietician/nutritionist, clinical psychologist, psychotherapist, social worker, physiotherapist, speech therapist, and registered massage therapist	$50 per visit per practitioner to a maximum of $500 per calendar year per practitioner, including x-rays
MAJOR MEDICAL	
Ambulance service	Local ambulance, including emergency air ambulance within Canada, in excess of the amount payable under OHIP
Out-of-hospital nursing	$10,000 per calendar year
Convalescent hospital	Semi-private room & board rate
Accidental dental	Covered within 6 months of the accident

EXTENDED HEALTH CARE continued
For Eligible Members Under Age 71 & Dependents

MAJOR MEDICAL continued

Durable medical equipment & supplies such as:

Breast prosthesis	1 per lifetime
Surgical brassieres	1 per lifetime
Custom-made compression hose	2 pairs per calendar year
Stump socks	2 pairs per calendar year
Wigs	1 per lifetime
Glucometer	1 per lifetime

HEARING AIDS

$500 every 5 years (repairs and batteries are not covered)

FOOT CARE

Custom-made orthotics	$500 every 3 years

VISION CARE

Percentage payable	100% except where noted
Eye examination	$50 covered as part of below-noted Vision Care maximum
Adults – One pair of prescribed lenses & frames, or contact lenses (including disposables), or sunglasses, or safety glasses (for Members only)	$500 every 24 months
Dependent children under age 18 – One pair of prescribed lenses & frames, or contact lenses (including disposables), or sunglasses	$500 every 12 months
Bifocal, hardex and photochromic lenses, tints 1 and 2, tinting levels 1 and 2, and scratch resistance coating	Covered under above-noted Vision Care maximum
Laser eye surgery	50% to a maximum of $1,000 per lifetime
Visual training	$100 every 12 months

EXPEDITED ACCESS TO HEALTHCARE
For Eligible Members & Dependents

Expedited access to diagnostic scans and specialist consultations. Diagnostic scans will be booked and performed within 72 hours on average, and you will see specialists within weeks not months.

ON-DEMAND MEDICAL VIRTUAL CARE (vCare)
For Eligible Members & Dependents

Online access to healthcare providers via secure text and video chat with personalized medical support 24/7 across Canada. Fill and refill prescriptions, specialist referrals and lab requisitions.

MEMBER & FAMILY ASSISTANCE PROGRAM (LifeJourney)
For Eligible Members & Dependents

Online compassionate care for your mental health, financial and legal assistance, nutritional consultations. Available 24/7 for a wide range of challenges LifeJourney works with vCare to have all your wellness resources – primary care and MFAP in one convenient place through your vCare account.

MENTAL WELLNESS (QuikCare & mHealth)
For Eligible Members & Dependents

Online psychological treatment and care. The program provides Cognitive Behavioural Therapy (CBT) with a psychologist for a range of psychological conditions including anxiety, addiction, depression, stress, and substance abuse.

INDIVIDUAL FINANCIAL SERVICES
For Eligible Members & Dependents

Personalized financial planning and advisory services to complement your group benefits at no additional cost to you.

PRE-RETIREMENT COUNSELLING
For Eligible Members

Planning for retirement years.

DENTAL CARE
For Eligible Members Under Age 71 & Dependents

Reimbursement is based on the general practitioner's provincial fee guide of your home province for the year recognized by the Trust Fund at the time the service is rendered.

Percentage payable	
Basic and preventive procedures (including endodontic, periodontic and oral surgery)	100%
Major procedures	50%
Bridges & crowns	50%
Dentures	50%
Orthodontic (for Dependent children under age 18)	50%
Deductible	NIL
Lifetime maximum for orthodontic	$2,000
Calendar year maximum	$2,000 per individual

DENTAL CARE continued For Eligible Members Under Age 71 & Dependents	
LIMITS	
Complete oral examination	Once every 24 months
Recall or specific examination	Once every 9 months
Polishing and fluoride application	Once every 6 months
Full mouth x-ray	Once every 24 months
Bitewing x-ray	Once every 6 months
Study cast	Once every 12 months
Periodontal scaling or root planing	8 units per calendar year
Pit and fissure sealants	Once per tooth for Dependent children under age 18 only
Bridge and crown replacement	Once every 5 years
Denture relines/rebases/repairs	Once every 24 months

ACCIDENTAL DEATH & DISMEMBERMENT For Eligible Members Under Age 70 & Dependents	
Member	$100,000
Spouse	$50,000
Dependent child	$15,000

HOSPITAL CASH For Eligible Members Under Age 70 & Dependents	
First 20 days of hospitalization	$225 per day
Next 100 days thereafter	$150 per day
Benefit maximum	$19,500

EMERGENCY TRAVEL MEDICAL For Eligible Members Under Age 80 & Dependents	
Lifetime Maximum under age 75	$5,000,000
Lifetime Maximum ages 75 to 80	$1,000,000

Limited to trips of 90 consecutive days.

WEEKLY WAGE REPLACEMENT For Eligible Members Under Age 70	
This is non-occupational (not work related) coverage.	
Waiting period	1 week, or from date of recall to work if later.
Benefit amount	$695 per week
Benefit period	104 weeks including 26-week EI period
Benefit offset	85% all source maximum and CPP/QPP disability benefits from 27th week of claim

This is a taxable benefit.

LONG TERM DISABILITY For Eligible Members Under Age 60	
Waiting period	106 weeks
Benefit amount	$1,600 per month
Benefit period	To the earlier of age 60 or retirement
Benefit offset	85% all source maximum and other employment income
Disability definition	Any occupation
This is a taxable benefit.	

CRITICAL ILLNESS For Eligible Members Under Age 70	
Principal sum	$20,000
Covers only specific conditions.	

LIFE INSURANCE For Eligible Members Under Age 71	
Under age 65	$100,000
Over age 65, under age 71	$20,000

RETIREE LIFE CERTIFICATE After Age 65	
Retirement on or after July 1, 1977 & before January 1, 2009	Up to $10,000
Retirement after January 1, 2009	Up to $5,000

VOLUNTARY INSURANCE For Eligible Members & Dependents
Insurance coverage available for purchase to complement existing group benefits such as Life, AD&D, Critical Illness, and additional emergency travel medical benefits including coverage beyond the 90-day trip duration, if required.

GENERAL PROVISIONS

MEMBER ELIGIBILITY

To qualify for coverage, you and your Eligible Dependents must be insured under a Provincial Health Plan. Participation is not allowed beyond age 71. You must also maintain your membership in good standing with Insulators Local 95. The Trust Fund's Administrative Agent keeps an account for you of the hourly contributions made by your Employer(s) on your behalf. The balance in this account determines your eligibility for benefits. Each month, a deduction is taken from your account to "pay" for your benefits. From time to time, the Trustees will alter the amount of the monthly deductions when required to prudently manage the Trust Fund.

You become eligible for coverage under the Trust Fund when you have accumulated three monthly deductions in your account. Your coverage for all benefits except Long Term Disability (LTD) becomes effective on the first day of the second month following that accumulation. LTD coverage becomes effective after you have accumulated 4,000 working hours for a contributing Employer. Your coverage continues for each month your account contains the required monthly deduction. The maximum account balance is 12 monthly deductions. Retirees may run out their accounts but cannot accumulate additional contributions after retirement.

If you are absent from work because of disability due to illness or injury on the date of your coverage or any increase in your coverage would otherwise become effective, such coverage will not become effective until the date you return to active full-time work for 1 full day.

Example: You begin your employment March 15th and contributions are received as follows:

Contributions for March:	-½ monthly deduction
Contributions for April:	-1 monthly deduction
Contributions for May:	-1 monthly deduction
Sub-total:	2½ months deduction

At this time, you are not eligible for benefits.

Contributions for June:	-1 monthly deduction
Total:	3½ months deduction

You have now accumulated the three months deductions and are eligible for benefits effective August 1st, the first of the second month following the required accumulation.

NOTE: The above example is based on a regular work month of 120 hours. Any hours worked in excess of that amount, such as overtime, may entitle you to benefits earlier than shown in the example. When you do not work continuously during the month, your eligibility for benefits may be delayed.

Your account balance is allowed to build to a maximum equal to 12 monthly deductions, which represents the equivalent of 12 months' coverage. If you have credits in excess of 12 months, the credits are transferred to the general reserve of the Trust Fund. This reserve is used for the following purposes:

- to pay for increased costs of benefits;
- to maintain coverage if you become disabled;
- to subsidize coverage should you become unemployed;
- to provide improved or additional benefits;
- to pay for the administrative and operating costs of the Trust Fund.

CHANGE OF YOUR STATUS

As advised in the booklet section entitled On the Importance of Being Registered, it is your responsibility to notify the Administrative Agent of any change of your status (married, separated, divorced, new dependents, etc.) to ensure that proper coverage for you and your Eligible Dependents is maintained, including a change in beneficiary if applicable.

DEPENDENT ELIGIBILITY

Your Dependents becomes eligible for coverage when you become eligible or, if acquired later, upon becoming your Dependent. To qualify for coverage your Eligible Dependents must be insured under a Provincial Health Plan. Newborn Children are eligible for all coverage from birth, provided you advise the Administrative Agent within 31 days of the birth. All dependents must be listed on the Dependent section of your Member Information Card and this Card must be filed with the Administrative Agent.

You must be a Member of the Trust Fund and eligible for benefits in order for your Dependents to be covered.

Coverage or any increase in coverage, for your Eligible Dependent who is confined for medical treatment in any institution or at home on the date such coverage would otherwise become effective, will not become effective until he/she has been given a final release by the physician from all such confinement. This shall not postpone the effective date for a child born while the Member's Dependents are insured under the Trust Fund.

Dependent means a spouse or unmarried child who is under 21 years of age (under 25 years if regularly attending school and solely dependent upon the Member for support).

Spouse means a person married to the Member as a result of a valid religious or civil marriage ceremony; except that, a person living with the Member in a common-law relationship for a minimum period of 12 consecutive months will be deemed to be the Member's Spouse, if such person is publicly represented as the Member's Spouse. It follows therefore, that to change the covered common law spouse requires a 12-month period where no spouse is covered. Spouse includes persons of the same or opposite sex who are under the age of 71.

Child means:

- Your unmarried children under 21 years of age provided they are not employed on a regular full-time basis ,or
- Your unmarried children under 25 years of age provided they are not employed on a regular full-time basis and they are in full-time attendance at a university or similar institution. Annual proof of student registration is required after the child attains age 21, or
- Your legally adopted children, stepchildren, foster children, or children of your common-law spouse, provided your spouse or common-law spouse lives with you and has custody of the child, and provided they meet the requirements set out above.

The term **Dependent** does not include:

- any child who is working more than 30 hours per week, unless he/she is a full-time student, and
- any person who is not a resident of Canada or the United States.

NOTE: You may be required to submit proof that your Dependent Children are not working on a full-time basis, or that they are in full-time attendance at a university or similar institution.

CONTINUATION OF COVERAGE FOR FUNCTIONALLY IMPAIRED CHILDREN

Extended Health Care and Dental Care coverage will continue beyond the date an unmarried child attains the limiting age for coverage, provided such child:

- is incapable of self-sustaining employment by reason of functional impairment,
- became so incapacitated prior to attainment of the limiting age, and
- is wholly Dependent upon you for support and maintenance.

Thereafter, such proof must be submitted to the Insurance Company, as required.

MAINTAINING COVERAGE

Your insurance continues automatically provided at least one monthly deduction remains in your account.

DIRECT PAYMENT

As mentioned above, your insurance continues automatically as long as you have a balance of at least one monthly deduction in your account. However, if at the end of any month, you have less than one deduction, you may continue your coverage for all benefits, by making a payment directly to the Trust Fund. You are allowed to make these direct payments for 12 months. An extension beyond the 12-month limit may be granted providing you are in good standing with the Union, and have not refused work at the trade within the territorial jurisdiction of the Union. Direct payments are not permitted beyond retirement or age 65.

You may be eligible for financial assistance to maintain direct payments, however such assistance only applies to Health and Dental Care Benefits, as well as Life Insurance.

Should you elect to retire and your coverage is in effect at the time of retirement, the benefits provided under the Insulators Local 95 Benefit Fund, except Weekly Wage Replacement and Long Term Disability Benefits, may be continued.

The Life Insurance Benefit reduces at the earlier of retirement or age 65. At first, the balance in your hour bank account will be used to provide your benefits and when that is depleted you may elect to continue the benefits on a Self-Pay basis until you attain age 65.

Should you decide to return to work, you may continue to make Self-Pays beyond age 65, but only for so long as you continue working. There can be no break in coverage; your benefits must be continuous, and you must begin your self-payments within 30 days of the depletion of your Hour Bank. Retirees do not accumulate contributions in an hour bank after retirement.

Retirees who return to work after receiving their Retiree Life Certificate and elect to make Self-Pays will be entitled to no other Life Insurance Benefit above their Life Certificate.

DISABILITY FUND ASSISTANCE

Should you become disabled **and be unable to work**, your Trustees have arranged for the Trust Fund to assist you by maintaining coverage for benefits, for you and your Eligible Dependents. All benefits may be continued by the Trust Fund, provided you are in receipt of Weekly Wage Replacement Benefits, Long Term Disability Income, Workplace Safety and Insurance (WSIB) Benefits, Employment Insurance (EI) Disability Income, or Salary Continuance Benefits from a Motor Vehicle Accident Insurance.

Proof of your disability will be required on a monthly basis (contact the Administrative Agent for further details).

The Trust Fund will continue to maintain benefit coverage for up to a continuous period of 24 months, provided you are totally disabled from your “own” occupation, thereafter Disability Fund Assistance continues provided you are prevented from performing “any” occupation. To be considered disabled from any occupation, you will be in receipt of CPP Disability Benefits, or approved for Waiver of Life Insurance Premiums by the Insurance Carrier. In no event will Disability Fund Assistance continue beyond your attainment of age 65.

TERMINATION OF COVERAGE

Your benefit coverage, and that of your Eligible Dependents, will cease under this Trust Fund:

- The first day of any month in which you have less than one deduction in your account, or
- The last day of any month in which you have made the maximum number of contributions under the Direct Payments option, or
- The last day of any month in which you cease to qualify under the Fund Assistance provisions, or
- The first of the month following the month in which you attain the benefit age limit which may be set out in the Description of Benefits of this booklet, or
- The date you cease to be in a class of persons who may be insured under this policy, or
- The date the Group Master Policy is cancelled or terminated.

On termination of your coverage you may have the option to convert a portion of your Life Insurance coverage to an individual Life Insurance Policy. For more details please refer to the Description of Benefits, Life Insurance, Conversion Privilege sections of this booklet.

In the event that you are disabled, or if you die, some benefits may be extended to you or your Dependents. Please refer to the specific benefit description sections under the Description of Benefits in this booklet.

Coverage for your Dependents will terminate on the date such Dependent ceases to meet the dependent eligibility requirements.

NOTE: Should you elect to work beyond age 65, you may continue coverage until the end of the month in which you turn 71, with the following exceptions:

- Long Term Disability terminates at age 60;
- Life Insurance reduces at age 65;
- Accidental Death & Dismemberment, Hospital Cash, Weekly Wage Replacement, and Critical Illness terminate at age 70;
- Emergency Travel Medical terminates at age 80.

REINSTATEMENT OF COVERAGE

If your coverage under this Trust Fund ceases because you have insufficient credits, and you have not retired, your coverage will be reinstated when you have accumulated one monthly deduction in your account. Your coverage is effective on the first day of the second month following that accumulation.

If you have been out of benefit coverage for six consecutive months, you will be treated as a new member and the Member Eligibility provisions will apply.

DEFINITIONS FOR THE PURPOSE OF THIS TRUST FUND

Convalescent/Rehabilitation Hospital or Nursing Home: To be recognized as a Convalescent/Rehabilitation Hospital or Licensed Nursing Home, for insurance purposes, an institution must have a transfer arrangement with one or more hospitals and regularly provide skilled 24-hour nursing care during the convalescent or rehabilitation stage of an injury or disease, and its charges for ward care for the individual are reimbursed under a Provincial Hospital plan. Unless they fully meet this definition, institutions for rest, the aged, custodial care, drug addicts, or for the care of pulmonary tuberculosis, or mental illness do not qualify as Convalescent/Rehabilitation Hospitals, or Licensed Nursing Homes.

Earnings: For purposes of determining the amount of wage replacement benefits, Earnings shall mean the amount of money, based on the number of hours in the regular work week, as per the Collective Agreement multiplied by the hourly rate in the wage rate classification to which you belong. This shall not include overtime, bonuses or commissions.

Hospital: To be recognized as a Hospital for insurance purposes, an institution must keep patients regularly overnight, have full therapeutic facilities for the care of the injured, sick or chronically ill and be continuously staffed by licensed physicians, who are doctors of medicine, and by registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term Hospital, as used in this policy, shall not include a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged or an institution used primarily for the confinement or treatment of alcoholism or drug addiction, tuberculosis or mental illness.

Other Health Practitioner: Other Health Practitioners shall mean any of the following licensed, certified or registered health practitioners practicing within the scope of his/her profession: Audiologist, Chiropodist/Podiatrist (from at least a three-year podiatry program), Denturist, Chiropractor, Osteopath, Optometrist, Dietician/Nutritionist, Naturopath, licensed Clinical Psychologist/Psychotherapist/Social Worker, Physiotherapist, Speech Therapist, or Registered Massage Therapist. A Psychologist is considered licensed if certified or registered by the jurisdiction in which he/she practices.

Non-Occupational: With respect to injury, shall mean an injury that does not arise in the course of any employment for wage or profit. With respect to disease, Non-Occupational shall mean a disease where a person is not entitled to receive benefits under any Workplace Safety and Insurance Act or similar legislation.

Physician: The term Physician shall mean a duly qualified person who is legally licensed to practice medicine.

Retired: Shall mean in receipt of a pension from the Insulators Local 95 Pension Plan.

Retirement: The date you commence collecting a pension benefit under the Insulators Local 95 Pension Plan.

Surgeon: The term Surgeon shall mean a duly qualified person who is legally licensed to practice medicine.

EXTENDED HEALTH CARE

The benefits described in this section apply to both the Eligible Members under the age of 71 and their Eligible Dependents.

The Extended Health Care Benefit is designed to provide valuable supplementary protection but not to duplicate the Provincial Hospital and Medical Care Plans under which an individual is or could be protected. Therefore, the Extended Health Care Insurance excludes: 1) services and supplies to the extent benefits can be obtained for them under a provincial plan by fulfilling the requirements of that plan, and 2) services and supplies where private insurance is prohibited. Additional exclusions are detailed in the section entitled Exclusions. You should read the Covered Expenses with these Exclusions in mind. Before incurring any major expenses, you may submit details to the Claims Office that will inform you what benefits, if any, are available under the Trust Fund.

Charges for medically necessary eligible services or supplies will be limited to the reasonable and customary cost for the expense up to any maximums specified in the Summary of Benefits.

Reasonable and customary means charges for services of the level usually furnished for cases of the nature and severity of the case being treated and are in accordance with representative fee practices and prices in the area.

COVERED EXPENSES

This insurance applies to expenses you are required to pay for the treatment of pregnancies and non-occupational accidents and sicknesses. The supplies or services must be medically necessary and prescribed by a physician, or other qualified medical practitioner deemed appropriate by the Insurance Carrier. A medical expense shall be deemed incurred as of the date the service or supply is furnished to you, and you must be covered on that date for the expense to be considered.

PRESCRIPTION DRUG SAVINGS PROGRAM

The Prescription Drug Savings Program lets you take advantage of reduced fees on prescription medication and avoids the hassle of shopping around for lower fees every time you fill a prescription.

As a plan member, by filling your prescriptions with participating providers, you will have access to lower dispensing fees, lower ingredients cost and exclusive perks from each provider. Over the long-term these savings will be invested back into the benefit fund, making sure Eligible Members and Dependents can get the best benefit coverage possible.

Some of the participating stores are Food Basics, Metro, Rexall, Pharma Plus, and Sobeys.

The insurance will pay the following covered expenses incurred by you or an Eligible Dependent up to the limits described below and set out in the Summary of Benefits.

Prescription Drugs:

- **Drugs** and medicines including injectables which are medically necessary, legally require a written prescription from a physician in order to be purchased, and are dispensed by a licensed pharmacist, or physician legally authorized to dispense such drugs, plus drugs that regardless of their legal status are not normally sold except by prescription. These drugs must be prescriptive, restrictive, controlled or narcotic in nature. Included are preventive immunization vaccines and toxoids, diabetic supplies such as sensors for flash glucose monitoring machines, and oral contraceptives and contraceptive appliances such as intrauterine devices (IUD's), rings and patches. Ontario pharmacists can also prescribe medications for minor ailments.

  The maximum single purchase of drugs that will be considered is the amount that can reasonably be used within 100 days of the date of purchase.

  Cannabis for medical purposes when:
  - prescribed to treat one of the following 6 conditions: Anorexia, nausea/vomiting from chemotherapy, neuropathic pain (chronic), palliative care, spasticity, and spinal cord injury,
  - a valid authorization has been issued by a Clinical Cannabis Physician,
  - a valid prior authorization has been approved,

- a registration with Heath Canada under the Access to Cannabis for Medical Purposes Regulations has been completed,
- the product is purchased from a Licensed Producer in the province of Ontario,
- all other requirements under the Cannabis Act and Cannabis Regulations have been complied with.

Eligible Members and Dependents are not required to use any particular Licensed Medical Cannabis Provider. However, the plan has arranged preferred pricing, free consultation and electronic claim reimbursement through your existing Benefit Card, with Starseed Medicinal Inc. (Starseed). Currently, only claims submitted utilizing Starseed as a provider may be paid directly through your Benefit Card. Once Starseed receives the prior authorization approval, an electronic claim submission will be made from Starseed for reimbursement by the plan, in accordance with the eligibility provisions and benefit maximums. Claims related to all other medical cannabis providers must be submitted by mail to the Claims Office and include a product identification number (PIN).

The limitations that apply to coverage for drugs and drug supplies apply with equal force to coverage for medical cannabis, except that cannabis for medical purposes does not require a drug identification number (DIN) as defined by the Food and Drugs Act, Canada.

Not eligible for reimbursement: Any drug not approved by the Food and Drugs Act, Canada. Proprietary or patent medicines (off-the-shelf preparations), dietary or health food, Nicorettes and similar anti-smoking related prescriptions, etc, erectile dysfunction drugs, fertility drugs, unless prescribed for other than fertility purposes, nutritional products and charges for the administration of drugs, whether or not a prescription is given for medical reasons.

For eligible plan Members over age 65, the first $100 of eligible prescription drug expenses in the program year will be covered by the plan, satisfying the Member's annual Ontario Drug Benefit (ODB) deductible. After the annual ODB deductible has been satisfied, the plan will cover the per-prescription co-payment amount of up to $6.11 charged by the pharmacy for eligible ODB prescriptions. However, the plan does not cover drugs that are eligible under the ODB plan.

NOTE: The Trustees reserve the right to modify the drug formularies and definition at any time in the future, in order to deliver the benefit in a contemporary fashion.

Paramedical:

- **Health Practitioner** charges, including x-ray charges, for a properly Accredited Chiropodist/Podiatrist, Chiropractor, Osteopath, Dietician/Nutritionist, Naturopath, Licensed Clinical Psychologist, Psychotherapist, Social Worker, Physiotherapist, Speech Therapist, or Registered Massage Therapist, acting within the scope of their licences.

  No amount will be paid for any Health Practitioner services until any applicable Provincial Health Plan benefit is exhausted, unless permitted by law.

Major Medical:

- **Convalescent/Rehabilitation Hospital** (within Home Province) daily room and board in excess of ward, provided the individual is admitted to the Convalescent Hospital immediately following a minimum 14 consecutive day confinement in a Hospital. The confinement must be for the continued care of the same condition for which the patient was hospitalised. All confinements in a Convalescent Hospital will be considered as one period of disability unless confinements are separated by at least 90 days. Disability must commence prior to age 65.

  A definition of a Convalescent/Rehabilitation Hospital is included in the General Provisions section of this booklet.

- **Ambulance** service charges, including emergency air ambulance service within Canada, in excess of the amount payable under the insured person's Provincial Health Plan. The services must be required to transport the person from the place of injury (or where illness struck) to the nearest hospital where treatment is available, or directly from that hospital to the nearest hospital for needed specialized treatment not available at the first hospital, or from hospital to a convalescent/rehabilitation hospital.

- **Out-of-Hospital Nursing** services of a Registered Nurse (R.N.), a Certified/Licensed Nursing Assistant (C.N.A., R.N.A., R.P.N., L.P.N. or L.N.A.), or a Member of the Victorian Order of Nurses (V.O.N.) while you or an Eligible Dependent are not confined to a hospital. The nursing service must have been ordered by a physician as medically necessary and requiring the specialized training of a registered nurse. The nurse must not ordinarily reside in the Member's home or be a member of the family. Charges for services that are mainly custodial or assist the individual with the functions of daily living, or for personal counseling are not covered. Coverage is subject to obtaining prior approval.

- **Dental Care for Accidental Injury**: customary charges for necessary dental care by a licensed dentist or oral surgeon for the prompt repair of sound natural teeth when required for a non-accidental injury, external to the mouth, which occurs while insured. The dental work must be completed within six months of the accident or treatment of a fractured jaw to be a covered medical expense.

- **Oxygen** and its administration.

- **Durable Medical Equipment and Supplies**: charges for the rental of or, at the option of the insurer, the purchase of durable medical equipment of the type and model adequate for the insured person's medical needs based on the nature and severity of the disability, such as but not limited to:
  - Hospital beds, wheelchairs, iron lung, and canes;

- Rigid or semi-rigid braces for back, neck, arm or leg and non-dental prosthesis, such as artificial limbs and eyes, surgical corsets, crutches, casts, splints, and trusses, when required for a medical condition which has been arrested or corrected by surgery, including replacement if required because of a change in physical condition;
- Breast prosthesis;
- Purchase of surgical brassieres when required following a mastectomy;
- Custom-made compression hose, excluding elastic stockings;
- Stump socks;
- Wigs; and
- Glucometer and flash glucose monitoring machines.

Not eligible for reimbursement: Any items of personal comfort, convenience, exercise, safety, self-help or environmental control items, or items which may also be used for non-medical reasons, such as, but not limited to heating pads or lamps, communication aids, air conditioners or cleaners, and whirlpool baths or saunas.

Before incurring any major expenses, you are encouraged to submit details to the Claims Office to determine to what extent benefits are payable. In any event, a letter will be required from a licensed physician describing the nature of the disability and the type, medical need and estimated duration of any required durable medical equipment.

- **Hearing Aid** charges, excluding replacement, repairs, or batteries, when provided by a certified, Clinical Audiologist.

- **Foot Care** charges for orthotics, for each occurrence, by either a Physician or Chiropodist/Podiatrist, and must be dispensed by a Physician, Chiropodist/Podiatrist, Orthotist or Pedorthist. **Custom-made orthotics prescribed or dispensed by a Chiropractor are not covered by this plan**. Charges for orthotics which have been specially designed and molded for the insured person and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

- a diagnosis, including list of symptoms and the primary complaint,
- a description of the physical findings from the clinical examination,
- a brief description of the gait abnormality associated with the diagnosis, and
- confirmation that the product has been custom-made.

NOTE: The Ontario Assistive Devices Program may provide partial reimbursement for certain expenses listed above, such as prosthetic devices, respiratory equipment, hearing aids, wheelchairs, hospital beds, etc. Further information regarding this program may be obtained by calling 1-800-268-6021.

EXCLUSIONS

No benefits are payable under this Trust Fund for charges for care, services or supplies:

- that were furnished without the recommendation and approval of a physician acting within the scope of his license;
- that are not medically necessary, such as but not limited to, charges for a surgical procedure or treatment performed primarily for beautification, or charges for Hospital confinement for such surgical procedure or treatment;
- if payment is prohibited by law;
- that an insured person may obtain as a benefit under any governmental plan or law;
- for occupational injury or disease covered by Workplace Safety and Insurance Act or similar legislation;
- for which no charge would have been made in the absence of this insurance;
- for dental work, except as provided under the Dental Care for Accidental Injury;
- for any drugs or services that are not approved by Health and Welfare Canada, or are experimental or limited in use whether or not so approved;
- for experimental procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
- for health examinations that are requested by a third party;

- for broken appointments, travel, communication costs, filling in of forms or physician's supplies;
- which are incurred outside the Member's home province, unless the Member is either temporarily out-of-province on business or vacation or for furthering education, and the supplies are necessary as the result of an emergency or unexpected sudden illness, or requires reasonable and customary treatment that is not readily available in the Member's home province and must be obtained elsewhere (Before incurring any non-emergency expenses outside Canada, it is strongly suggested that you submit a treatment plan to confirm any payable amount);
- for treatment of injuries arising from a Motor Vehicle Accident (NOTE: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if the services or supplies being claimed are not eligible or the financial commitment is complete, and a letter from your automobile insurance carrier will be required);
- which were considered an insured service of any provincial government plan at the time this benefit was issued and subsequently were modified, suspended or discontinued.

No amount will be paid for any charge incurred that results from or is contributed by:

- war, whether declared or not,
- insurrection, rebellion or participation in a riot or civil commotion,
- purposely self-inflicted injury, or
- the insured person's commission of, or attempt to commit, an assault or a criminal offence.

CO-ORDINATION OF EXTENDED HEALTH CARE BENEFITS

This Trust Fund has been designed to help you meet the cost of disease or injury. Since it is not intended that you receive benefits greater than the actual expenses incurred, any health care coverage you have under other plans will be taken into account in determining the amount of benefit payable under this Trust Fund, that is, the benefits under this Trust Fund will be coordinated with the benefits of the other plans.

Plan means any contract of group insurance or other arrangement for Members of a group (whether on an insured basis or not), prepaid health care coverage, or student accident insurance.

Specifically, this Trust Fund will pay either its regular benefits in full, or a reduced amount which, when added to the benefits available under the other plan, or plans, will equal 100% of Allowable Expenses.

Allowable Expense means any necessary, reasonable and customary expense, incurred while eligible for benefits under this Trust Fund, part or all of which would be payable under any of the plans, but not any expenses contained in the list of Exclusions.

The manner in which this is done determines which plan pays first (and thus where to submit the claim first) and which plan(s) pays next. The plan that does not have a co-ordination of benefits provision pays before the plan that does (most, if not all, insurance company plans have such a provision).

For any person who is covered under more than one plan, benefits will be payable first under the plan where he/she is the insured member and secondarily where he/she is covered as a dependent.

Dependent Children are covered first by the parent whose birthday comes first in the year, and any unpaid balance can then be submitted to the other parent's plan.

If priority cannot be established in the above manner, the benefits shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

To implement this provision, the Trust Fund and the insurer may:

- Subject to the consent of the covered person, if required by law, obtain from or release to any other person, corporation or organization any information deemed to be needed, or
- Pay to or recover from any person, corporation or organization any excess payment; any payment so made will be deemed to be benefits paid and, to the extent of such payments, will fully discharge the Trust Fund and the insurer from all liability under this benefit.

EXTENSION OF BENEFITS DUE TO DISABILITY

If you or a covered Dependent are totally disabled when your coverage terminates, the Extended Health Care Benefit may continue for the disabled person, in respect of the disabling illness, for a specified period of time, as provided by the insurance policy. The specified period of time can be determined by contacting the Administrative Agent.

Generally, the Extended Health Care Benefit will continue until the earliest of the following dates:

- the end of the next calendar year following the year in which the insurance of the disabled person terminated,
- the date on which the total disability ceases,
- (90 days after the termination of the Insurance Policy, or
- the end of a period following termination of coverage, equal to that period during which the disabled person was last covered under this provision.

SURVIVOR EXTENSION OF BENEFITS

Your surviving Spouse and surviving Dependent Children, including any child conceived before and born after your death, will be insured under the Extended Health Care Benefit on the later of the following dates:

- the date of your death, or
- if disabled on the date of your death, the date the survivor is no longer entitled to benefits under Extension of Extended Health Care Benefits.

The Extended Health Care Benefits in force at the time of your death will not be affected by any increase, decrease or by termination of the Survivor Benefit or Group Policy.

The Survivor Benefit terminates the earlier of:

- the date of death of the surviving Spouse/Dependent,
- the date which is two years from the date of your death,
- the date your Spouse remarries,
- the date on which the surviving Child ceases to qualify as a Dependent, or
- the date your Dependents become insured under another group policy providing similar benefits.

In the event that an eligible survivor is totally disabled and under the care of a physician on the date the Survivors' Health Benefit terminated, and if prior to termination, covered expenses are incurred with regard to the disabling condition, coverage will be continued for the disabling condition during the continuance of total disability to the later of:

- 90 days after the date on which the Survivor Health Benefit terminated, or
- the date the eligible survivor is discharged from an in-patient Hospital confinement, which commenced within the 90-day period following the date the Survivor Health benefit terminated.

Totally Disabled (for a Dependent) means the Dependent is incapacitated to the extent that the Dependent is not able to perform all the usual and customary duties or activities of a person in good health and of the same age.

Any extended benefits payable are subject to the provisions and limitations of the Trust Fund. This extension is provided under the terms of the insurance policy at no additional premium cost and terminates if the policy or benefit is terminated.

HOW TO FILE EXTENDED HEALTH CLAIMS

Benefit Card

You and your spouse will be provided with a Benefit Card which may be used for all covered prescription drug and health care practitioner services. Every time you have a prescription filled or a health care practitioner service performed, present your Benefit Card to the pharmacist or health care practitioner who will electronically submit a claim on your or your eligible Dependents' behalf. Immediately, your claim will be processed and you will be notified of which expenses are reimbursable. You may use any pharmacy or health care practitioner office in Canada that will accept your card.

BPA eClaims App or Website

You can submit your claims online with the BPA eClaims mobile app and website. To get started, all you need to do is register. You can do so by downloading the app to your phone or by accessing BPA eClaims from our website.

To download the mobile app to your phone or tablet, go to the App Store (iPhone) or Google Play (Android) and search “BPA eClaims”. To access BPA eClaims from your computer, visit our website at www.bpaeclaims.ca.

To register your account, you will need your Benefit Card. You will be asked to provide your Group Number, which consists of the first six digits of your Benefit Card number, as well as your Certificate Number, which consists of the second set of ten digits of your Benefit Card number.

How to submit an online claim:

- ✓ When you log in, click on submit a claim and choose a claim type (such as health).
- ✓ Select the patient you are claiming for (yourself, spouse or child), and the provider (such as the pharmacist or health care practitioner). If you are submitting a claim involving coordination of benefits, enter the amount already paid for by your primary insurance under the first payor. If you are submitting for multiple services from the same provider or visit, you will be prompted to add another service.
- ✓ Upload your detailed itemized receipt showing payment. If you are submitting a claim using your phone, take a picture and upload each receipt. If you are submitting from your computer, scan and upload each receipt.
- ✓ Once you have ensured the information you entered is correct, click to submit the claim. You will be able to check the history status of your claim and you will be notified once it has been paid or if it has been declined.

BPA eClaims QR Code:

Paper Claim Form by Mail or Email

Paper claim forms may be obtained from the Trust Fund’s Administrative Agent office or website.

Before submitting the claim form, ensure that all questions, have been answered, that you have signed your name and clearly identified yourself by full name, return mailing address and your Employer and Union. If the claim is for your Dependent, provide the Dependent's first name, date of birth and relationship to you. Faulty or missing information will only result in a delay in processing your claim.

When you are sure that all of the above has been completed, forward the form and all attachments to the Claims Office by mail or email. Your benefit cheque will be mailed directly to you. Assignment of benefits is not permitted and all cheques will be made payable to you as the Eligible Member.

Each expense should be listed separately, by insured individual, on the appropriate claim form. Submit claims together with originals of bills or receipts, no more than once a month or every two to three months if bills are small. Claiming more frequently for small amounts ties up service for everyone and delays payment on larger claims where there is a real need for timely benefits.

Bills and receipts must be complete. Each bill, or receipt, other than for drugs, must show the:

- ✓ patient's full name,
- ✓ date(s) the service was rendered or purchase made,
- ✓ nature of the sickness or injury,
- ✓ itemized charges, and
- ✓ physician's written recommendation.

Each drug or medicine bill or receipt must show the:

- ✓ patient's full name,
- ✓ prescription number, name of medication, quantity, and strength,
- ✓ date of purchase, dispensing fee (not applicable to Medical Cannabis or Quebec Members) and the total charge for each item, and
- ✓ drug identification number (DIN).

NOTE: Failure to list drug expenses separately will result in your form being returned to you for proper completion.

Cash register receipts or labels from containers are not acceptable documentation.

PROOF OF LOSS

Written proof stating the occurrence, character and extent of loss must be submitted for each benefit to the Administrative Agent within 12 months after the date of the loss, but not more than 3 months after the date coverage terminates, for Extended Health Care Benefits.

VISION CARE

The benefits described in this section apply to Eligible Members up to age 71 and their Eligible Dependents.

All lenses must be prescribed by an optometrist or an ophthalmologist and must be for the correction of visual defects.

The Trust Fund covers reasonable and necessary Vision Care expenses up to the limit specified in the Summary of Benefits for the following:

- One eye examination performed by a licensed ophthalmologist or optometrist when not covered by a provincial government plan, and
- One pair of lenses and frames, including bifocals, hardex photochromic, tints one and two, tinting levels one and two, and scratch resistance coating, when prescribed by a licensed ophthalmologist or optometrist, or
- One pair of contact lenses, including disposable contact lenses, when prescribed by a licensed ophthalmologist or optometrist, or
- One pair of sunglasses when prescribed by a licensed ophthalmologist or optometrist, or
- One pair of safety glasses when prescribed by a licensed ophthalmologist or optometrist (for Members only), and
- Visual training by an ophthalmologist or optometrist, and
- Laser eye surgery (Members are encouraged to research the credentials and experience of the laser eye surgeons before selecting their service provider).

The purpose of the Vision Care Benefit is to help meet actual expenses. Benefits under this plan will be coordinated with any benefits received under other plans, in order that you will not receive more than your actual expenses.

The usual Co-ordination of Benefits provisions as previously described in the Extended Health Care section of this booklet will apply. The Survivor Extension of Benefits also applies as described in the Extended Health Care section of the booklet.

EXCLUSIONS

The following expenses will not be reimbursed:

- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits;
- Services and supplies received principally for cosmetic purposes;
- Artificial eyes (see Durable Medical Equipment and Supplies under Extended Health Care), and any coating or tinting not noted as being covered;
- Replacement of lenses or frames or contact lenses, due to loss, breakage or theft;
- Prescription safety glasses purchased for a Dependent.

HOW TO FILE VISION CARE CLAIMS

Benefit Card

You and your spouse will be provided with a Benefit Card which may be used for all covered vision care services. Every time you have a vision care service performed, present your Benefit Card to the vision care office who will electronically submit a claim on your or your eligible Dependents' behalf. Immediately, your claim will be processed and you will be notified of which expenses are reimbursable. You may use any vision care office in Canada that will accept your card.

BPA eClaims App or Website

You can submit your claims online with the BPA eClaims mobile app and website. To get started, all you need to do is register. You can do so by downloading the app to your phone or by accessing BPA eClaims from our website.

To download the mobile app to your phone or tablet, go to the App Store (iPhone) or Google Play (Android) and search "BPA eClaims". To access BPA eClaims from your computer, visit our website at www.bpaeclaims.ca.

To register your account, you will need your Benefit Card. You will be asked to provide your Group Number, which consists of the first six digits of your Benefit Card number, as well as your Certificate Number, which consists of the second set of ten digits of your Benefit Card number.

How to submit an online claim:

- ✓ When you log in, click on submit a claim and choose a claim type (such as vision).
- ✓ Select the patient you are claiming for (yourself, spouse or child), and the provider (such as the vision care office). If you are submitting a claim involving coordination of benefits, enter the amount already paid for by your primary insurance under the first payor. If you are submitting for multiple services from the same provider or visit, you will be prompted to add another service.
- ✓ Upload your detailed itemized receipt showing payment. If you are submitting a claim using your phone, take a picture and upload each receipt. If you are submitting from your computer, scan and upload each receipt.
- ✓ Once you have ensured the information you entered is correct, click to submit the claim. You will be able to check the history status of your claim and you will be notified once it has been paid or if it has been declined.

BPA eClaims QR Code:

Paper Claim Form by Mail or Email

A properly completed Vision Care claim form including the optometrist's prescription is required for each claimant. Paid receipt of purchase must be attached.

Each Vision Care claim must show the:

- ✓ patient's full name,
- ✓ charge for lenses,
- ✓ charge for frames,
- ✓ charge for miscellaneous items, and
- ✓ optometrist's prescription.

PROOF OF LOSS

Written proof stating the occurrence, character and extent of loss must be submitted to the Administrative Agent within 12 months after the date of the loss, but not more than 3 months after the date coverage terminates, for Vision Care Benefits.

EXPEDITED ACCESS TO HEALTHCARE

The benefits described in this section apply to Eligible Members and their Eligible Dependents.

Canadian medical specialists are limited to how many new patients they are able to diagnose each month, due to budgetary constraints with the Canadian Healthcare system. This creates average wait times of over eight months to see a specialist and over three months for a diagnostic scan.

The QuikCare Platinum Expedited Access to Healthcare Program is designed to assist you so you can focus on taking care of your wellbeing. It assists in the alleviating the pain and worrying and returning you to a healthier life.

HOW THE PROGRAM WORKS

The program provides a unique healthcare benefit by allowing those who are placed on a medical wait list, immediate access to diagnostic scans (MRI/CT Scans) and specialist consultations with the cost fully covered. It will give you peace of mind knowing diagnostic scans will be booked and performed within seventy-two hours and you will see specialists within weeks not months.

All that is required for you or your Eligible Dependents to rapidly access expedited health care treatment is a diagnostic requisition form or a specialist referral from your physician. QuikCare will liaise with you to attain the required documentation and utilize a network of specialists and diagnostic imaging services to coordinate and pay for the required services. Fees for diagnostic testing and specialist consultations are paid by QuikCare directly to health care providers. You **do not** have to pay for your health care treatment and then seek reimbursement.

COVERED SPECIALISTS	
• Cardiologist	• Neurosurgeon
• Gastroenterologist	• Ophthalmologist
• General surgeon	• Rheumatologist
• Neurologist	• Urologist

COVERED SERVICES	
• CT Scan	• MRI
• Ear, Nose & Throat	• Orthopedics

HOW TO USE THE PROGRAM

Once you receive a physician's diagnostic requisition or a physician's referral letter for a specialist, simply call the QuikCare Platinum Dedicated Helpline, which is available twenty-four hours a day, seven days a week, at the following toll-free number:

- ✓ **Toll-free number 1-844-900-8357**

You must call the helpline in advance of receiving a diagnostic procedure or specialist consultation and obtain approval from the Case Management Team in order to have your expedited health care arranged and paid for.

The Case Management Team will coordinate with you or your Eligible Dependents to acquire the required documentation and assist you in every step.

QuikCare will then arrange the required expedited health care and will advise you or your Eligible Dependents of the appointment time and location.

Following the scan or specialist appointment, the Case Management Team will contact you and ensure the results are sent to your physician and to arrange any further treatment

ON-DEMAND MEDICAL VIRTUAL CARE

The benefits described in this section apply to Eligible Members and their Eligible Dependents.

The On-Demand Medical Virtual Care or vCare platform is designed to address your healthcare needs via secure text and video chat, anytime and wherever you are.

This online platform provides you and your family with 24/7, personalized medical support wherever you are in Canada. You can connect instantly with Canadian healthcare providers via secure text and video chat for your primary health questions and concerns.

vCare features:

- Unlimited virtual consultations via secure text and video chat, 24/7;
- Convenient primary and mental health-care support;
- Fill and refill prescriptions, specialist referrals, and lab requisitions;
- Coverage for you and your eligible Dependents;
- Virtual follow-ups with no appointments required;
- Health records on the platform, with updates sent to your family doctor with your consent.

When to use vCare:
Avoid visits to walk-in clinics or emergency rooms for non-emergency issues such as:

- Infections, rashes and skin irritations;
- Anxiety and depression;
- Stomach and digestive issues;
- Cough, cold and flu;
- Weight loss counselling and smoking cessation;
- And much more.

Please note: Specific cases will require an in-person medical appointment at the discretion of our healthcare providers. Our clinicians cannot complete Workers' Compensation forms or sick notes for more than three days. This service is not for emergencies.

To begin your registration process, you will need to visit:

- ✓ **www.vcareregistration.com**

You will be required to enter the following information when registering:

- Email;
- Province of residence;
- Policy number;
- Certificate number;
- Create password.

As a first-time user of vCare, you will have to register your account. In this step, you will need your Benefit Card. In this registration process, you will be asked to provide your:

- Policy Number which consists of the first six digits on your Benefit Card;
- Certificate Number which consists of the second set of ten digits on your Benefit Card.

After registration, you will be prompted to download the Telus Health Virtual Care app from the App Store or Google Play. After downloading, all you need to do is enter your email address and password you created during the registration process to access vCare.

vCare QR Code:

MEMBER AND FAMILY ASSISTANCE PROGRAM

The benefits described in this section apply to Eligible Members and their Eligible Dependents.

LifeJourney is a new way to approach the Member & Family Assistance Program (MFAP). It is a single, integrated virtual service that provides you with 24/7 access to immediate, compassionate care.

With LifeJourney, Active Members and their eligible Dependents have access to resources to help with a wide range of challenges such as financial and legal assistance, mental health support, nutritional consultations, and virtual care.

Some of the resources provided include:

- Allied health professionals
- Case management
- Diagnoses
- Forms
- Lab work requests
- Mental health
- Prescriptions
- Specialist referrals

HOW TO USE THE PROGRAM

LifeJourney works with vCare to have all your wellness resources – primary care and MFAP – in one convenient place. Once you activate your vCare account, you will have access to your extended LifeJourney resources. Best of all is that your Eligible Dependents also have access to vCare and LifeJourney so that the whole family can stay healthy and well.

To get started, you will need to register at: **www.vcareregistration.com** (please see the On-Demand Medical Virtual Care/vCare section in this booklet for the registration process)

HOW THE PROGRAM WORKS

While LifeJourney is a digital platform, you will be guided by a Care Advocate at every step of your journey. Your Care Advocate will help you find the right resources and put together a personalized treatment plan to help you reach your health and wellness goals.

vCare QR Code (to access LifeJourney):

MENTAL WELLNESS

The benefits described in this section apply to Eligible Members and their Eligible Dependents.

One of the biggest issues today facing Members and their Eligible Dependents is mental health. Currently, 1 in 4 Canadians leave work due to anxiety, stress or depression. Mental illness is one of the top drivers for short and long-term disability claims.

QUIKCARE CONFIDENTIAL MENTAL HEALTH PROGRAM

The QuikCare Confidential Mental Health Program has been designed to improve functioning well-being. Eligible Members and Dependents struggling with mental health can benefit from assistance that enables them to deal with life's challenges. This is achieved by utilizing a specialized psychological method with a strong focus on getting better and living a healthier life.

How the program works

The program provides Cognitive Behavioral Therapy (CBT) with a psychologist for a range of psychological conditions including anxiety, addiction, depression, stress and substance abuse. By ensuring rapid access to CBT, Eligible Members and Dependents get effective psychological treatment that will improve and sustain their overall mental health.

CBT is delivered virtually in the form of digital therapy sessions in the comfort and privacy of the Members' own home for up to 12 weeks. Members feel supported, get the care they need digitally, and become mentally stronger. The confidential evidence-based treatment alleviates the social stigma associated with mental health care. Should more intensive therapy or psychiatric intervention be needed, escalation can be facilitated.

What is CBT and how does it help?
CBT is a short-term therapy with long term benefits that is structured and focused on providing individuals with skills to help manage their emotions, thoughts and behaviours. CBT can help individuals to change how they think ("cognitive") and what they do ("behaviour"). CBT focuses on the "here and now" problems instead of focusing on the "root causes" of distress or symptoms, which may have originated in the distant past. CBT uses a skills-oriented approach to problem solving that will help Members find ways to improve their state of mind and help them to develop techniques so they can avoid problems in the future.

Results show that CBT based treatment consistently increased the Member's well-being. CBT is effective alone or in combination with medication for the treatment of mood, anxiety and several other psychological disorders. CBT enhances the Member's resilience which equips them to adapt and cope with negative situations and adversity such as workplace and financial worries, relationship issues or health problems.

How to use the program

Once you receive a physician's referral for psychological intervention, simply call the confidential QuikCare Helpline at the following toll-free number:

- ✓ **Toll-free number 1-844-900-8357 (this number is not an emergency crisis line)**

On this call, key contact details and eligibility information will be collected. Within 1 business day, QuikCare will contact you to discuss needs, outcome goals and next steps, and to obtain required documentation (referral letter and medical release). QuikCare Mental Wellness Cognitive Behavioral Therapy is then arranged, and details are shared with you. Within 3 business days of treatment approval, QuikCare will follow-up to ensure you were able to initiate Cognitive Behavioral Therapy, or to provide assistance if required. QuikCare will conduct ongoing monitoring for any potential 'red flags' for escalation and care path adjustments, as well as outcome measuring at the end of the 12 weeks treatment to compare initial goals and treatment outcomes.

VIRTUAL MENTAL HEALTHCARE

The BPA mHealth online platform provides Eligible Members and Dependents the resources they need to support their mental wellness, from the comfort of their own home on a computer or handheld device. It includes the Virtual Mental Health Program in the form of Cognitive Behavioral Therapy (CBT), a Mental Health Assessment Tool, and a Mental Health Knowledge Forum and Library.

Mental Health Assessment Tool

While no automated tool can replace the opinion of a medical professional, the Mental Health Assessment Tool can help assess any mental health problems you may have and provide support. It can offer valuable insight into any mental health issues you may be experiencing, along with suggestions on helpful steps you can take to improve your mental wellbeing. The results can be downloaded and shared with your primary care physician or your mental health counsellors. Your responses will be confidential and secure. Specific cases will require in-person counselling at the discretion of our healthcare provider. It is designed for adults over the age of 17 and is not for emergencies.

Mental Health Knowledge Forum and Library

You will find helpful articles and a variety of resources on topics like stress management, work/life balance, mindfulness meditation and more, as well as strategies for managing anxiety, mood disorders and living a healthy, well-balanced life.

How to use the platform

To access mHealth from your computer, visit our website at **www.bpamhealth.com** and follow the steps to register. For access to resources when you are on the go, be sure to download the app available on the App Store or Google Play.

mHealth QR Code:

INDIVIDUAL FINANCIAL SERVICES

The benefits described in this section apply to Eligible Members and their Eligible Dependents.

Your group coverage provides excellent, comprehensive protection tailored to the general needs of the group. However, to ensure you and your family are fully covered in the event of an unexpected death or illness, it is important to consider additional coverage options that cater specifically to your unique circumstances.

The Individual Financial Services (IFS) Program provides personalized financial planning and advisory support to complement your group benefits and help you achieve your financial goals. The Program offers tailored advice on retirement planning, investment strategies, savings plans, and life and living benefit insurance. Through one-on-one consultations and educational programs, IFS empower you to make informed decisions about your financial security. The services are free and included in your plan at no additional cost to you.

Schedule an online or in-person meeting with an advisor and discover ways to save on your coverage!

Financial Services and Insurance Coverage

- Tax-Free Savings Accounts (TFSAs) for flexible savings with tax advantages;
- Registered Education Savings Plans (RESPs) for saving for education expenses;
- Critical illness insurance for financial protection in the event of a critical illness diagnosis, with the use of claim payout at your discretion;
- Travel insurance for unexpected medical expenses while travelling abroad, with the possibility of extending your trip duration coverage;
- Term and whole life insurance even for those with existing health issues;
- And much more!

How IFS Can Help

- Purchasing property: Save on mortgage insurance.
- Having children or expecting a newborn: Protect your family's income in case of a parent's unexpected passing.
- Planning for retirement or a significant project: Secure your financial future.
- Experiencing a family loss: Cover final expenses.
- Making a substantial purchase: Safeguard your investment against unforeseen events.
- Changing jobs or experiencing job loss: Adjust or retain group coverage based on your new situation.
- Getting married or divorced: Plan for the financial impact of this change.
- Starting a business: Ensure business continuity in the event of a partner's unexpected passing.

Please note that the Individual Financial Services available from BPA ("IFS") is not offered as part of the Insulators Local 95 Benefit Fund or paid for by the Trustees of the Insulators Local 95 Benefit Fund (the "Trustees"). The Trustees are not liable for any losses incurred by Members or their Eligible Dependents connected with advice received through IFS.

HOW TO USE THE PROGRAM

You may schedule a meeting by:

- ✓ **calling 1-866-617-5777 (Extension 1550),**
- ✓ **emailing ifs@bpagroup.com,**
- ✓ **visiting www.calendly.com/d/cmgx-rr2-f95, or**
- ✓ **scanning the QR Code below**

PRE-RETIREMENT COUNSELLING

Pre-Retirement counselling offers Members an opportunity to plan for their years of retirement and is available to Members who choose it, on the following topics:

1) Financial Concerns
- Your Pension Plan
- Registered Retirement Savings Plans (RRSPs)
- Annuities and Registered Retirement Income Funds (RIFFs)
- Government Benefits
- Budgets
- Housing
- Wills
- Taxation Issues

2) Lifestyle Concerns
- Health, Wellness, Nutrition
- Time application - Leisure, Boredom,
- Loneliness, Hobbies
- Personal Relationships
- Relocation

3) Personal Resources
- Your Worth
- Working in Retirement

4) Retirement Check List

Pre-Retirement counselling seminars will be held in different areas of the province and all members over 45 years of age will be notified in advance of the locations, dates and times. Attendance will be on a first come, first serve basis.

Each participant will receive a Retirees Handbook entitled "Lifestyle Planning" which is used during the seminar and can be used by you and your family at home. This handbook will be updated as changes occur.

DENTAL CARE

The Dental Benefits described in this section apply to Eligible Members up to age 71 and their Eligible Dependents. The insurance covers work included in a comprehensive list of dental expenses, which appears later. Many dental conditions can properly be treated in more than one way. This Trust Fund is designed to help pay your dental expenses but not on the basis of treatment that is more expensive than necessary for good dental care. Thus, if a condition is being treated for which two or more services included in the list are suitable under customary dental practices, the benefit under the Trust Fund will be based on the least expensive of the services.

If a dental service is performed that isn't in the list, but the list contains one or more other services that under customary dental practices are suitable for the condition being treated, then for the purpose of the Trust Fund, the least expensive of the suitable services listed will be considered to have been performed. See Charges Not Eligible for Dental Insurance later in this section of the booklet for additional exclusions.

The final choice of treatment is always between the patient and the dentist. You are financially responsible to your dentist for cost of the dental work performed. This Trust Fund will reimburse you to the limits described herein.

FREE CHOICE OF DENTIST

You may choose any licensed dentist or licensed denturist practicing within the scope of his/her profession.

PRE-DETERMINATION OF BENEFITS

Pre-determination of Benefits permits the review of the proposed treatment in advance and allows for a solution of any questions before, rather than after, the work has been done. Additionally, both you and the dentist will know in advance what the Trust Fund will allow assuming you, or the Dependent, remain covered.

A treatment plan is strongly recommended when dental work is expected to exceed $500.00.

A treatment plan is the dentist's report that itemizes the dentist's recommended services, shows the dentist's charge for each service, and is accompanied by supporting X-rays, or a letter of expertise.

The treatment plan will be returned to the dentist, with a copy to you, showing the estimated benefits.

WHAT AN ELIGIBLE CHARGE IS

An eligible charge is one the dentist makes to you for a covered dental service furnished to you or a covered dependent, provided the service is included in the list of Covered Dental Expenses and not listed under Exclusions.

All expenses are assessed on a reasonable and customary basis. Lab fees may be cut back accordingly.

A charge is considered incurred on the date the service is received, rather than on the date the charge is made. In the case of root canal therapy, crowns, dentures or bridgework, which may require multiple appointments, the date the expense is incurred will be the date the service is finally completed. For dentures or bridgework, this date will be the date the prosthetic device is installed. For crowns, this will be the date the permanent crown is installed and for root canal therapy, this will be the date the canal is closed.

TERMINATION OF BENEFITS

No benefits for covered dental expenses will be paid for expenses incurred after the policy terminates, or after the individual's coverage terminates.

COVERED DENTAL EXPENSES

The percentage payable and the calendar year maximum are specified in the Summary of Benefits. Charges for reasonable and customary services and supplies specified below shall be considered covered expenses when incurred by you or a covered dependent.

Percentage Payable is the maximum percentage of the allowed expense for which the Trust Fund will reimburse you.

Calendar Year Maximum is the maximum amount the Trust Fund will allow any one individual for Dental Care Benefits in a single calendar year.

Eligible expenses include Basic and Preventive Treatment, Endodontics, Periodontics, Oral Surgery, Major Restorative and Prosthodontics. An expense is eligible to the extent that coverage is not prohibited by provincial health insurance plans or because of other limitations described below or in the Summary of Benefits.

Basic Procedures:

- oral examinations including cleaning of teeth;
- topical application of sodium or stannous fluoride;
- dental x-rays: single diagnostic x-rays, and complete series (Panorex);
- consultations;
- extractions;
- oral surgery including excision of impacted teeth;
- amalgam, acrylic, silicate or composite fillings;
- retentive pins;
- anaesthesia where reasonably and customarily required in connection with other covered procedures;
- occlusal equilibration;
- periodontal scaling;
- treatment of periodontal and other diseases of gums and tissues of the mouth;
- caries, trauma and pain control;
- emergency endodontic procedures and root canal therapy;
- prefabricated full coverage restorations for primary teeth;
- stainless steel crown restorations on primary teeth;
- space maintainers for missing primary teeth and habit breaking appliances;
- pit and fissure sealants for a dependent child under the age of 18 only, once per tooth;
- study casts;
- relining and rebasing of existing dentures.

Major Procedures:

- crowns, other than stainless steel;

- crowns used to restore natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filing. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration;
- replacement of existing crowns 5 years or older;
- repairs to dentures;
- initial installation of partial or full removable dentures, if required because of the extraction of additional natural teeth while insured under the Trust Fund;
- replacement of existing partial or full removable denture(s) providing:
    - it is required because of the extraction of additional natural teeth while insured under the Trust Fund and the existing appliance could not have been made serviceable, only the expense for the portion of the replacement appliance replacing the additional teeth extracted is covered,
    - the existing appliance is at least 5 years old and cannot be made serviceable, or
    - the existing appliance is replaced as a result of the initial placement of an opposing denture.

NOTE: A temporary appliance is considered to be permanent if not replaced within 12 months from the date the temporary appliance was inserted. Replacement of lost or stolen dentures, duplication of dentures and personalization or characterization of dentures is not covered.

- initial installation of fixed bridgework, providing it is required because of the extraction of additional natural teeth while insured under the Trust Fund;
- bridge repairs and recementation;
- replacement of existing fixed bridgework providing:
    - it is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this Trust Fund, or
    - the existing fixed prosthetic device is at least 5 years old and cannot be made serviceable.

NOTE: A temporary bridge is considered to be permanent if not replaced within 12 months from the date the temporary bridge was inserted.

ORTHODONTIC TREATMENT

Orthodontic treatment includes the diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as straightening of the teeth. These include active space maintainers, or orthodontic appliances for the purpose of repositioning or moving the teeth. Expenses are covered at the percentage and to the maximum shown in the Summary of Benefits. This benefit is only available to Eligible Dependent Children under the age of 18.

A pre-treatment plan is always required for this benefit. Treatment will generally extend over a two or three-year time span. The Claims Office will respond to the pre-treatment plan with an explanation of how the monthly reimbursement process will work for the duration of the orthodontic treatment. Claim payment is on a reimbursement basis, subject to the submission of paid receipts.

CHARGES NOT ELIGIBLE FOR DENTAL INSURANCE

Payment will not be made for any dental procedure required due to an injury or dental disease for which you, or your Dependent, were advised to receive treatment or for which treatment first began before the effective date for that dental procedure.

The following items are not considered as covered expenses:

- oral hygiene instruction;
- replacement of a lost or stolen prosthetic device;
- services and supplies that are partially or wholly cosmetic in nature;
- supplies or services which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
- charges for completion of claim forms, broken appointments, counselling, travel, communication costs or for advice by telephone;
- charges for protective athletic appliances;
- expenses incurred as a result of intentionally self-inflicted injuries (while sane or insane) or as a result of committing or attempting to commit a criminal offence;

- expenses for treatment required as a result of war, (declared or not) or participation in a riot, insurrection or civil commotion;
- expenses for services or treatment that are payable by Workplace Safety & Insurance Act (or similar legislation) or any government plan, or which are received without charge or which a government health plan prohibits being paid;
- services or supplies for implantology, including tooth implantation, transplantation and surgical insertion of fabricated implants;
- services or supplies in connection with any procedures excluded as an eligible expense;
- any Hospital charges for board and room or related services and supplies;
- any dental examinations required by a third party;
- services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury or disease;
- any charges which would not normally have been made but for the presence of this insurance or for which you or your Dependent are not obligated to pay;
- dental treatment which is primarily experimental or for dietary planning, congenital or developmental malformation;
- any dental procedure required due to teeth extracted, missing or fractured before the effective date of your coverage for that procedure except as specifically stated for appliance replacement above;
- treatment of injuries arising from a Motor Vehicle Accident (NOTE: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if the services or supplies being claimed are not eligible or the financial commitment is complete, and a letter from your automobile insurance carrier will be required);
- accidental injuries covered by the Extended Health Care provisions of this Trust Fund.

CO-ORDINATION OF DENTAL CARE BENEFITS

This Trust Fund has been designed to help you meet the cost of disease or injury. Since it is not intended that you receive benefits greater than the actual expenses incurred, any dental care coverage you have under other plans will be taken into account in determining the amount of benefit payable under this plan, that is, the benefits under this Trust Fund will be coordinated with the benefits of the other plans.

Plan means any contract of group insurance or other arrangement for members of a group (whether on an insured basis or not), prepaid dental care coverage, or student accident insurance.
Specifically, this Trust Fund will pay either its regular benefits in full, or a reduced amount which, when added to the benefits available under the other plan, or plans, will equal 100% of Allowable Expenses.

Allowable Expense means any necessary, reasonable and customary expense, incurred while eligible for benefits under this Trust Fund, part or all of which would be payable under any of the plans, but not any expenses contained in the list of Exclusions.

The manner in which this is done determines which plan pays first (and thus where to submit the claim first) and which plan(s) pays next. The plan that does not have a co-ordination of benefits provision pays before the plan that does (most, if not all, insurance company plans have such a provision).

For any person who is covered under more than one plan, benefits will be payable first under the plan where he/she is the Insured Member and secondarily where he/she is covered as a dependent.

Dependent Children are covered first by the parent whose birthday comes first in the year, and any unpaid balance can then be submitted to the other parent's plan.

If priority cannot be established in the above manner, the benefits shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

To implement this provision, the Trust Fund and the insurer may:

- Subject to the consent of the covered person, if required by law, obtain from or release to any other person, corporation or organization any information deemed to be needed, or
- Pay to or recover from any person, corporation or organization any excess payment; any payment so made will be deemed to be benefits paid and, to the extent of such payments, will fully discharge the Trust Fund and the insurer from all liability under this benefit.

SURVIVOR EXTENSION OF BENEFITS

Your surviving Spouse and surviving Dependent Children, including any child conceived before and born after your death, will be insured under the Dental Care Benefit on the later of the following dates:

- the date of your death, or
- if disabled on the date of your death, the date the survivor is no longer entitled to benefits under Extension of Dental Care Benefits.

The Dental Care Benefits in force at the time of your death will not be affected by any increase, decrease or by termination of the Survivor Benefit or Group Policy.

The Survivor Benefit terminates the earlier of:

- the date of death of the surviving Spouse/Dependent,
- the date which is two years from the date of your death,
- the date your Spouse remarries,
- the date on which the surviving Child ceases to qualify as a Dependent, or
- the date your Dependents become insured under another group policy providing similar benefits.

Any extended benefits payable are subject to the provisions and limitations of the Trust Fund. This extension is provided under the terms of the Trust Fund and terminates if the Trust Fund or benefit is terminated.

HOW TO FILE DENTAL CARE CLAIMS

Benefit Card

You and your spouse will be provided with a Benefit Card which may be used for all dental care services. Every time you have a dental service performed, present your Benefit Card to the dental office who will electronically submit a claim on your or your eligible Dependents' behalf. Immediately, your claim will be processed and you will be notified of which expenses are reimbursable. You may use any dental office in Canada that will accept your card.

BPA eClaims App or Website

You can submit your claims online with the BPA eClaims mobile app and website. To get started, all you need to do is register. You can do so by downloading the app to your phone or by accessing BPA eClaims from our website.

To download the mobile app to your phone or tablet, go to the App Store (iPhone) or Google Play (Android) and search "BPA eClaims". To access BPA eClaims from your computer, visit our website at www.bpaeclaims.ca.

To register your account, you will need your Benefit Card. You will be asked to provide your Group Number, which consists of the first six digits of your Benefit Card number, as well as your Certificate Number, which consists of the second set of ten digits of your Benefit Card number.

How to submit an online claim:

- ✓ When you log in, click on submit a claim and choose a claim type (such as dental).
- ✓ Select the patient you are claiming for (yourself, spouse or child), and the provider (such as the dentist). If you are submitting a claim involving coordination of benefits, enter the amount already paid for by your primary insurance under the first payor. If you are submitting for multiple services from the same provider or visit, you will be prompted to add another service.
- ✓ Upload your detailed itemized receipt showing payment. If you are submitting a claim using your phone, take a picture and upload each receipt. If you are submitting from your computer, scan and upload each receipt.

- ✓ Once you have ensured the information you entered is correct, click to submit the claim. You will be able to check the history status of your claim and you will be notified once it has been paid or if it has been declined.

BPA eClaims QR Code:

Paper Claim Form by Mail or Email

Paper claim forms may be obtained from the Trust Fund's Administrative Agent office or website. Your dentist's office will also have a supply of generic dental claim forms that are acceptable.

Before submitting the claim form, ensure that all questions, have been answered, that you have signed your name and clearly identified yourself by full name, return mailing address and your Employer and Union. If the claim is for your Dependent, provide the Dependent's first name, date of birth and relationship to you. Faulty or missing information will only result in a delay in processing your claim.

When you are sure that all of the above has been completed, forward the form to the Claims Office by mail or email. Your benefit cheque will be mailed directly to you, or if you wish you may assign benefits to be paid directly to your dentist.

PROOF OF LOSS

Written proof stating the occurrence, character and extent of loss must be submitted for each benefit to the Administrative Agent within 12 months after the date of the loss, but not more than 3 months after the date coverage terminates, for Dental Care Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT

The benefits described in this section apply to Eligible Members under age 70 and their Eligible Dependents.

PRINCIPAL SUMS

All Eligible Members are covered for a principal sum of $100,000.00. Their Eligible Spouse is covered for a principal sum of $50,000.00, and each Eligible Dependent Child is covered for a principal sum of $15,000.00.

Member means a Member eligible for benefits under Insulators Local 95 Benefit Fund.

Insured Person means a Member, Spouse and/or Dependent Child insured under the policy. Spouse and Dependent Child are defined under the General Provisions section of this booklet.

Activities of Daily Living means the following six activities:

- Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
- Transferring: moving between a bed and a chair, or a bed and a wheelchair;
- Dressing: putting on and taking off all necessary items of clothing;
- Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene;
- Eating: performing all major tasks of getting food into the body;
- Bathing: washing in either a tub or shower, including the task of getting in and out of the tub or shower.

Brain Death means the permanent, irreversible, cessation of electrical activity in both the upper brain and brain stem as certified by a qualified physician.

Dependent Parent means a parent or grandparent of either the Eligible Member or the Spouse, who is dependent upon the Member or the Spouse for support, maintenance and care.

Hospital means an incorporated or licensed Hospital having accommodation for resident bed patients, a laboratory, a registered graduate nurse always on duty and an operating room where surgical operations are performed by a legally qualified physician or surgeon, but in no event shall this include a convalescent or nursing home or home for the aged or health spa.

Immediate Family Member means the insured person's spouse, child including adopted children and step-children, parent including stepparent, legal guardian, parent-in-law, brother or sister including stepbrothers or stepsisters, grandparents, grandchildren, daughter-in-law son-in-law, brother-in-law and sister-in-law.

Injury means bodily injury which is sustained as a direct result of an unintended and unanticipated accident, provided such accident is external to the body and occurs while insured under LAMP.

Loss when used with reference to:

- **"Quadriplegia", "Paraplegia",** and **"Hemiplegia"** means the complete and irreversible paralysis of such limbs;
- **"Hand"** or **"Foot"** means the complete severance through and above the wrist or ankle joint but below the elbow or knee joint;
- **"Arm"** or **"Leg"** means the complete severance through or above the elbow or knee joint;
- **"Thumb and Index Finger"** means the complete severance through or above the first phalange;
- **"Fingers"** means the complete severance through or above the first phalange of all four fingers of one hand;
- **"Toes"** means the complete severance of both phalanges of all the toes of one foot;
- **"The Entire Sight of One Eye"** means the total and irreversible loss of sight such that corrected visual acuity must be 20/200 or less in such eye;
- **"The Entire Sight of Both Eyes"** means the total and irrecoverable loss of sight in both eyes such that corrected visual acuity must be 20/20 or less and the field of vision must be less than 20 degrees in both eyes. A physician certified in ophthalmology must clinically confirm the diagnosis in writing;

- **"Hearing in One Ear"** means the diagnosis of permanent loss of hearing in one ear with an auditory threshold of more than 90 decibels. A physician certified in otolaryngology must confirm the diagnosis in writing;
- **"Hearing"** means the diagnosis of permanent loss of hearing in both ears, with an auditory threshold of more than 90 decibels in each ear. A physician certified in otolaryngology must confirm the diagnosis in writing;
- **"Speech"** means the complete and irrecoverable Loss of the ability to utter intelligible sounds;
- **"Loss of Use"** means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

Loss when used herein may also include Loss of Life.

Permanent and Total Disability means injury which prevents the Eligible Member or Spouse from performing at least two of the six activities of daily living, without assistance from another person for the rest of their life. The disability must be determined, as of 12 months after the date of injury, to be total, permanent, and irreversible and certified to be such by a physician acceptable to the Insurance Company. The Member's or Spouse's inability to actually obtain employment is not a criterion to qualify for the Permanent and Total Disability Benefit.

Private Passenger Type Automobile is any means of transportation not operated for commercial purposes, designed to carry passengers and that is pulled, propelled or fueled in any way, including cars, trucks, motorcycles, snowmobiles or boats.

ACCIDENTAL DEATH AND SPECIFIC LOSS SCHEDULES

When an Eligible Member or their Spouse receive injuries resulting in any of the following losses within 365 days of the accident, benefits will be payable for:

Schedule for Loss of:	Percentage of Principal Sum
brain death	200%
quadriplegia, paraplegia, hemiplegia	200%
life	100%

Schedule for Loss of (continued):	Percentage of Principal Sum
both hands, or both feet, or one hand and one foot	100%
entire sight of both eyes	100%
one hand and entire sight of one eye, or one foot and entire sight of one eye	100%
speech and hearing in both ears	100%
use of both arms or both hands or both legs or both feet	100%
one arm, or one leg, or use of one arm, or one leg	80%
one hand, or one foot, or use of one hand, or one foot	75%
entire sight of one eye	75%
speech **or** hearing in both ears	75%
thumb and index finger of the same hand	33 ⅓%
use of thumb and index finger of the same hand	33 ⅓%
four fingers of the same hand	33 ⅓%
hearing in one ear	66 ⅔%
thumb of either hand	25%
all toes of the same foot	25%
one to three fingers of either hand	16 ⅔%

When an Eligible Child receives injuries resulting in any of the following losses within 365 days of the accident, benefits will be payable for:

Schedule for Loss of:	Percentage of Principal Sum
brain death	1,000%
both hands, or both feet, or one hand and one foot	1,000%
entire sight of both eyes	1,000%
one hand and entire sight of one eye, or one foot and entire sight of one eye	1,000%
speech and hearing in both ears	1,000%
use of both arms or both hands or both legs or both feet	1,000%
quadriplegia, paraplegia, hemiplegia	1,000%

Schedule for Loss of (continued):	Percentage of Principal Sum
life	100%
one arm, or one leg, or use of one arm, or one leg	80%
one hand, or one foot, or use of one hand, or one foot	75%
entire sight of one eye	75%
speech **or** hearing in both ears	75%
thumb and index finger of the same hand	33 ⅓%
use of thumb and index finger of the same hand	33 ⅓%
four fingers of the same hand	33 ⅓%
hearing in one ear	66 ⅔%
thumb of either hand	25%
all toes of the same foot	25%
one to three fingers of either hand	16 ⅔%

If more than one loss is sustained as the result of any one accident, only one benefit shall be payable, the largest.

The amount specified for losses of (a) both hands, both feet or both eyes, (b) one hand and one foot, (c) one hand and one eye, (d) one foot and one eye, (e) use of both arms, both hands, both legs or both feet, (f) speech and hearing, (g) thumb and index finger or at least four fingers of one hand and (h) all toes of one foot is payable only when such double Loss occurs as a result of the same accident.

The maximum payable for all losses sustained by an insured person as a result of the same accident shall not exceed the principal sum, except as noted for brain death, paraplegia, hemiplegia, or quadriplegia, or for children as noted in above table.

DISAPPEARANCE

If the body of an insured person has not been found within one year of the forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then, for the purposes of this benefit such insured person shall, in the absence of any evidence to the contrary, be deemed to have suffered loss of life.

PERMANENT AND TOTAL DISABILITY BENEFIT

When an Eligible Member or Spouse receive injuries resulting in permanent and total disability within 365 days of an accident, the principal sum will be paid less any amount paid or payable under the Loss Schedule for the same accident.

REHABILITATION BENEFIT

When injuries result in a payment being made under the Loss Schedule, the Insurer will pay the reasonable and necessary expenses actually incurred up to a limit of $15,000.00, for the occupational training of the insured person provided:

- such training is required because of such injuries and in order for the insured person to be qualified to engage in an occupation in which he/she would not have been engaged except for having suffered such injuries, and
- the training expenses are incurred within two years from the date of the accident.

No payment will be made for ordinary living, travelling or clothing expenses.

HOME ALTERATION AND VEHICLE MODIFICATION

When injuries result in a payment being made under the Loss Schedule, and these injuries result in and necessitate the use of a wheelchair for the insured person to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred for:

- the one-time cost of alterations to the injured insured person's residence to make it wheel-chair accessible and habitable, and
- the lesser of:
  - the one-time cost of modifications necessary to a motor vehicle, owned by the injured insured person, and
  - the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Insurer.

Benefit payments herein will not be paid unless:

- home alterations are made on behalf of the insured person and carried out by an experienced individual in such alterations and recommended by a registered organization, providing support and assistance to wheel-chair users, and

- vehicle modifications are made on behalf of the insured person and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities in the insured person's province of residence.

The maximum payable under Home Alteration and Vehicle Modification resulting from any one accident is $15,000.00 per insured person.

PARENTAL CARE BENEFIT

If an insured person suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Loss Schedule, the Insurer will pay a Parental Care Benefit for an Eligible Dependent Parent.

A Dependent Parent is eligible if, at the time of the accident:

- he/she is resident in a licensed nursing care facility,
- he/she is enrolled in a home health care program,
- he/she is living in the insured person's residence, or
- he/she is receiving support and care provided by the insured person as evidenced by cancelled cheques, Income Tax Returns showing the Parent as a Dependent, or other similar forms of proof.

The maximum amount payable for the Parental Care Benefit for all injuries resulting from any one accident is the lesser of 10% of the insured person's principal sum or $5,000.00.

FAMILY TRANSPORTATION

When injuries covered by this policy result in an insured person being confined to a hospital, more than 100 Kilometres from his/her permanent place of residence, the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of one member of the Immediate Family to such hospital if:

- confinement to hospital occurs within 365 days of the accident causing the injury, and
- reimbursement of expenses are limited to the cost of one economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such Immediate Family Member.

The maximum amount payable for Family Transportation for all injuries resulting from any one accident is $15,000.00 per insured person.

REPATRIATION BENEFIT

If an insured person suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Loss Schedule, and:

- such loss of life occurs more than 50 kilometres from his/her permanent city of residence, and
- such loss of life occurs within 365 days of the date of the accident causing the injury,

the Insurer will pay the actual expenses incurred for preparing the deceased insured person for burial or cremation and shipment of the body to the city of residence of the deceased insured person.

The maximum amount payable for Repatriation is $15,000.00 per insured person.

IDENTIFICATION BENEFIT

If an insured person suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Loss Schedule, and the insured person's body requires identification, the Insurer will pay the reasonable and necessary expenses actually incurred by one member of the Immediate Family for:

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

This benefit is payable only if the body is located not less than 150 kilometres from the said Immediate Family Member's normal place of residence and the identification of the body is requested by the police or similar law enforcement agency having authority over such matters.

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

The benefit is payable only once in connection with injuries and losses suffered by any one insured person, regardless of the number of policies providing coverage for this benefit for such insured person, that may be issued by the Insurer. The maximum amount payable for Identification Benefit is $10,000.00, per insured person.

SEAT BELT RIDER

If an insured person suffers injury resulting in Loss of Life for which the Insurer has paid the benefit set out in the Loss Schedule, the Insurer shall pay an additional amount equal to 10% of the insured person's principal sum if the injury causing the loss of life results while he/she is a passenger or driver of a Private Passenger Type Automobile and his/her seat belt is properly fastened.

The actual use of the seat belt must be verified and be evidenced in the official report of accident or certified by the investigating officer.

BEREAVEMENT BENEFIT

If an Eligible Member suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Loss Schedule, the Insurer will pay the reasonable and necessary expenses actually incurred for grief counselling provided that:

- the counselling is for the Spouse and/or Dependent Children,
- such expenses are incurred within 365 days of the date of the accident causing loss of life, and
- such grief counselling is provided by a therapist or counsellor who is licensed, registered or certified to provide such treatment and who is not a member of the Member's Immediate Family.

The Insurer will pay the person who has incurred the actual expense. The maximum amount payable for this benefit is $1,000.00.

DAY CARE BENEFIT

If an insured person suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Loss Schedule, the Insurer will pay to the legal guardian of any surviving Dependent Child of the insured person, an amount equal to the lesser of:

- the actual annual cost charged by a commercial and licensed day care centre,
- 5% of the Insured's principal sum, or
- $5,000.00 per year.

The benefit is payable annually for a maximum of four consecutive payments per Dependent Child:

- and only for such Dependent Child who at the date of the insured person's loss of life is under age 13,
- provided such Dependent Child is enrolled in a commercial and licensed day care centre no later than 90 days following the insured person's loss of life, and
- provided that the Dependent Child continues his/her enrolment in a commercial and licensed day care centre.

SPECIAL EDUCATION BENEFIT

If an Eligible Member suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Loss Schedule, the Insurer will reimburse the annual tuition, not including room and board, charged by an institution of higher learning per school year for each Dependent Child of that Member up to the lesser of the following amounts:

- $5,000.00 per school year, or
- 5% of the Member's principal sum.

The Special Education Benefit is payable annually up to a maximum of four consecutive payments per Dependent Child:

- only for such Dependent Child who is, at the time of the Member's loss of life, enrolled as a full-time student in an institution of higher learning beyond the 12th grade level, and
- only while such Dependent Child continues his/her continuous enrolment in an institution of higher learning.

The Insurer will reimburse the person who has incurred the actual tuition expenses.

If, at the time of loss, the Member has no covered Dependent(s) eligible for the Special Education Benefit, an additional amount of $2,500.00 will be paid to the designated Beneficiary.

SPOUSAL OCCUPATIONAL TRAINING BENEFIT

If a Member suffers injury resulting in loss of life for which the Insurer has paid the benefit set out in the Loss Schedule, the Insurer will pay to the Member's Spouse the actual cost incurred for a professional or trades training program in which such Spouse enrols for the purpose of obtaining an independent source of support and maintenance, provided such cost is incurred not later than 36 months after the Member's loss of life.

The maximum payable hereunder is $15,000.00.

SERIOUS ILLNESS BENEFIT

If, while coverage is in effect and coverage has been in effect on the Member for a period of not less than 90 days, the Member is then diagnosed with any one of the Covered Illnesses listed below and the Member satisfies the following conditions:

- has been hospitalised as an in-patient continuously for at least 48 hours as a consequence of the Covered Serious Illness,
- survives for a period of at least 30 days after the diagnosis has been made, and
- the Member is under age 65 at the time of diagnosis,

then the Insurer will pay a benefit of $10,000.00. The Insurer shall only be obligated to pay this benefit once per Member even though the Member may be diagnosed with more than one of the Covered Serious Illnesses.

Covered Serious Illnesses

- Major burns
- Major organ failure requiring transplant
- Major organ transplant
- Motor neuron disease
- Multiple sclerosis
- Necrotizing fasciitis
- Parkinson's disease

BURNS, LACERATIONS AND SURGICAL PROCEDURES INDEMNITY BENEFIT

If an insured person suffers injury resulting in the destruction of his/her skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid (3rd degree burn or worse), by means of exposure to fire, heat, caustics, electricity or radiation, the Insurer will pay up to $25,000.00 per insured person, based on a percentage of the insured person's principal sum, provided that the insured person survives for a period of at least 30 days after the date of the accident causing the burn.

The Insurer will pay depending on the area of the body which is burned and determined in accordance with the following table:

Body Part	(A) Body Classification	(B) Maximum % for that Body Part
Face, neck, head	11	99%
Torso (front or back)	2	36%
Either lower leg (below knee)	3	27%
Hand & forearm	5	22.5%
Either upper arm	3	13.5%
Either thigh	1	9%

The amount of the benefit is determined by multiplying the Body Classification (A) by the actual percentage of the insured person's Body Part that is burned and then multiplying the resulting percentage (not to exceed the Maximum Percentage for that Body Part (B) by the principal sum for such insured person.

The maximum amount payable for this burn benefit for all Injuries resulting from any one accident is $25,000.00 per insured person.

For Lacerations Requiring Suturing	
Over five inches in length	$300.00
Between two to five inches in length	$100.00
Less than two inches in length	$50.00

For Surgical Procedures Requiring General Anaesthesia	
External and internal injuries requiring a general anaesthesia	$500.00
Arthroscopy	$100.00

FRACTURE BENEFIT

If an insured person sustains injury resulting in a fracture or dislocation listed in the following Fracture Table, the Insurer shall pay the amount specified in the Fracture Table, provided that such fracture or dislocation occurs within 30 days after the date of accident causing it and such injury requires surgical treatment from a physician.

The maximum amount payable for this Fracture Benefit is $5,000.00 per insured person for all Injuries resulting from any one accident. Only one indemnity, the largest, shall be payable as the result of any one accident.

Fracture Table	
Cranium* (depressed fracture)	$5,000.00
Spine (two or more vertebrae)	$5,000.00
Pelvis	$3,000.00
Cranium* (other compound)	$2,000.00
Spine (one vertebra)	$2,000.00
Thigh (femur)	$1,650.00
Upper jaw (maxilla)	$1,650.00
Knee cap (patella)	$1,350.00
Leg (tibia or fibula)	$1,250.00
Shoulder blade (scapula)	$1,250.00
Ankle (Pott's fracture)	$1,250.00
Wrist (Colle's fracture)	$1,250.00
Forearm (compound or comminuted)	$1,150.00
Spine (compression Fracture)	$1,000.00
Arm, between elbow and shoulder	$850.00
Sacrum or Coccyx	$850.00
Sternum	$850.00
Forearm (not compound)	$600.00
Collar bone (clavicle)	$600.00
Nose	$600.00
Ribs, two or more	$500.00

Fracture Table (continued)	
Facial bones	$400.00
Lower jaw (mandible)	$400.00
One hand (one or more metacarpal)	$400.00
One foot (one or more metatarsal)	$400.00
One rib	$250.00
Heel bone	$250.00
Any bone not specified above	$250.00

*** Cranium (as used in this policy)** means the vault of the skull consisting of the following bones: frontal, parietals, occipital, temporals, sphenoid and ethmoid.

Dislocation Table	
Hip	$2,100.00
Knee (with open primary repair)	$1,650.00
Shoulder (with open reduction)	$1,250.00
Wrist	$850.00
Ankle	$850.00
Elbow	$600.00
Bone of foot, other than toes	$400.00

The Insurer shall only be obligated to pay once for each dislocation benefit. Recurrent dislocations are not provided for under this policy.

WAIVER OF PREMIUM

In the event an Eligible Member becomes totally and permanently disabled and his/her waiver of premium claim is accepted and approved under the Trust Fund's current group life policy, then the Accidental Death and Dismemberment premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Insurer until one of the following occurs, whichever is earlier:

- the date the Member attains age 65,
- the date of the death or recovery of the Member,
- the date the Member is no longer eligible for total disability waiver of premium under the Trust Fund's group life policy, or
- the date this Policy is terminated.

SURVIVOR EXTENSION OF BENEFITS

Your surviving Spouse and surviving Dependent Children, including any child conceived before and born after your death, will be insured under this benefit on the date of your death. The Trust Fund will maintain premium payments on behalf of your surviving Dependents, to the earlier of:

- the date of death of the surviving Spouse/Dependent,
- the date which is two years from the date of your death,
- the date your Spouse remarries,
- the date on which the surviving Child ceases to qualify as a Dependent, or
- the date your Dependents become insured under another group policy providing similar benefits.

Any extended benefits payable are subject to the provisions and limitations of the Trust Fund.

EXCLUSIONS

No coverage shall be provided under the Accidental Death and Dismemberment Benefit and no payment shall be made for any loss or claim resulting from, or contributed to, in whole or in part by, or as a natural and probable consequence of any of the following excluded risks, even if the proximate or precipitating cause of the loss or claim is an accidental injury:

- suicide or any attempt thereat by the insured person while sane;
- self-inflicted injury or any attempt thereat by the insured person while sane or insane;
- declared or undeclared war or any act thereof;
- sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
- mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
- sustained while the insured person is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
- stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;
- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the insured person is:

  - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers,
  - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft, or
  - riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder.
- infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
- injury or Loss sustained while the insured person is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the insured person is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
- the commission or attempted commission by an insured person or injury incurred while an insured person is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed;
- an act, attempted act or omission taken or made by the insured person, or an act, attempted act or omission taken or made with the insured person's consent, for the purposes of interrupting the blood flow to the insured person's brain or to cause asphyxiation to the insured person whether with intent to cause harm or not;
- natural causes.

HOW TO CLAIM

Claim forms may be obtained from the Trust Fund's Administrative Agent. Before submitting the claim form, ensure that all questions have been answered and that you have clearly identified yourself by full name, return mailing address and Local Union. If the claim is for your Dependent, provide the Dependent's first name, date of birth and relationship to you.

When you are sure that all of the above has been completed, forward the form and any receipts, if applicable, to the Administrative Agent.

PROOF OF LOSS

Written notice of injury for which a claim under this benefit is made must be submitted to the Insurer, in care of the Trust Fund's Administrative Agent, Benefit Plan Administrators Limited, within 30 days after the occurrence or commencement of any loss covered by the policy. Proof of such injury must be given to Insurer within 90 days of the loss. Failure to give notice of proof shall not invalidate nor reduce any claim if it is shown that notice of proof was given as soon as reasonably possible.

HOSPITAL CASH

The benefits described in this section apply to Eligible Members under age 70 and their Eligible Dependents.

The Member will be paid the specified daily benefit of:

- $225.00 for the first 20 hospital days, and
- $150.00 for the next 100 hospital days,

while he/she or any Eligible Dependent is admitted as an in-patient in a hospital and under the care of a licensed physician. The benefit maximum is $19,500.00.

A hospital day will be recognized in accordance with the Hospital's billing practices. Such period of hospitalization must:

- be necessary because of injury, illness, or childbirth, and
- begin while insurance under the policy is in force with respect to such Member.

If any injury or illness requires more than one period of hospitalization, then the maximum benefit period of 120 days in a Hospital will be reinstated provided that at least 61 days has elapsed between such periods of hospitalization.

For injury or illness that begins while this coverage is in force, a benefit of 50% of the specified daily benefit will be paid for the number of days the insured person recovers at home, not to exceed the number of days that the insured person was hospitalized for the covered injury or illness to a maximum of 20 days, subject to a maximum of $2,250.00.

SURVIVOR EXTENSION OF BENEFITS

Your surviving Spouse and surviving Dependent Children, including any child conceived before and born after your death, will be insured under this benefit on the date of your death. The Trust Fund will maintain premium payments on behalf of your surviving Dependents, to the earlier of:

- the date of death of the surviving Spouse/Dependent,
- the date which is two years from the date of your death,
- the date your Spouse remarries,
- the date on which the surviving Child ceases to qualify as a Dependent, or

- the date your Dependents become insured under another group policy providing similar benefits.

Any extended benefits payable are subject to the provisions and limitations of the Trust Fund.

HOW TO CLAIM

Claim forms may be obtained from the Trust Fund's Administrative Agent. Before submitting the claim form, ensure that all questions have been answered and that you have clearly identified yourself by full name, return mailing address and Local Union. If the claim is for your Dependent, provide the Dependent's first name, date of birth and relationship to you.

When you are sure that all of the above has been completed, forward the form and any receipts, if applicable, to the Administrative Agent.

PROOF OF LOSS

Written notice of injury for which a claim under this benefit is made must be submitted to the Insurer, in care of the Trust Fund's Administrative Agent, Benefit Plan Administrators Limited, within 30 days after the occurrence or commencement of any loss covered by the policy. Proof of such injury must be given to Insurer within 90 days of the loss. Failure to give notice of proof shall not invalidate nor reduce any claim if it is shown that notice of proof was given as soon as reasonably possible.

EMERGENCY TRAVEL MEDICAL

The benefits described in this section apply to Eligible Members under age 80 and their Eligible Dependents.

Coverage under this provision is available on an emergency basis only. It provides benefits for covered losses resulting from injury or sickness occurring during the first 90 consecutive days of a trip outside of the province of residence, subject to the following exclusions, limitations and provisions. An Eligible Spouse and each Eligible Dependent Child is insured for the same coverage as the Eligible Member. In no event will coverage extend beyond age 80.

When injuries or sickness result in emergency hospital confinement or require emergency medical or therapeutic services as listed below, benefits will be paid to the maximum shown in the Summary of Benefits, for the actual expenses incurred outside the province of residence, that exceed the amount which is payable with respect to such expenses under any government hospitalization or medical care plan in Canada, or if an insured person is not covered under any such plan, to the extent they exceed any amount which would be payable with respect to such expenses under the government hospitalization or medical care plan if he/she were covered under any such plan.

Hospital means an incorporated or licensed Hospital having accommodation for resident bed patients, a laboratory, a registered graduate nurse always on duty and an operating room where surgical operations are performed by a legally qualified physician or surgeon, but in no event shall this include a convalescent or nursing home or home for the aged or health spa.

Emergency means medical treatment or surgery for an unforeseen sickness or injury which makes it necessary to receive immediate treatment from a physician or surgeon for the immediate relief of an acute symptom of which upon the advice of a physician or surgeon cannot be delayed until the insured person returns to his/her province of residence.

Medically Necessary means the services or supplies provided by a hospital, physician or surgeon, licensed dentist or other licensed provider that are required to identify or treat an insured person's Sickness or Injury and that are defined as follows:

- consistent with the symptom or diagnosis and treatment of the insured person's Sickness or Injury;
- appropriate with regard to standards of good medical practice;
- not solely for the convenience of the insured person, a physician or surgeon or other licensed provider;
- when applied to the care of an in-patient, it further means that the insured person's medical symptoms or conditions require that the services cannot be safely provided as an outpatient.

EMERGENCY HOSPITAL CONFINEMENT

If you are confined as a resident inpatient in a hospital, reimbursement will include those reasonable and customary charges made by the Hospital for services rendered and supplies provided, including semi-private accommodation, to the extent that they are medically necessary.

In the event that an insured person is confined to hospital at the end of his/her trip outside the province of residence and thus prevented from returning to the province of residence, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first covered expense was incurred.

EXTENDED COVERAGE AFTER TERMINATION

In the event of the delayed arrival of a common carrier or hospitalization of the insured person, this benefit will automatically be extended at no charge: 1) 24 hours in the event of a delayed common carrier, 2) the period of hospitalization plus 72 hours after the insured person is released from hospital.

EMERGENCY MEDICAL AND THERAPEUTIC SERVICES

Benefits are payable for reasonable and customable charges to the extent they are medically necessary, for the following:

- the services of a legally qualified physician or surgeon (other than an Immediate Family Member of the insured person);

- laboratory tests and x-ray examination ordered by a legally qualified physician for the purpose of diagnosis;
- the services of a registered graduate nurse (other than an Immediate Family Member of the insured person), up to a maximum of 50 nursing shifts at a fee, but not to exceed $100.00 per shift;
- rental of crutches or hospital type bed, or the cost of splints, canes, slings, trusses, braces or other approved prosthetic appliances;
- the services of a legally qualified Anaesthetist;
- drugs or medicines that require a legally qualified physician's written prescription;
- services of a chiropodist/podiatrist, chiropractor, osteopath, physiotherapist, or (other than an Immediate Family Member of the insured person) up to a maximum of $300.00 for each class of practitioner;
- expenses for accidental injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires treatment by a legally qualified dentist or dental surgeon within 30 days from the date of the accident, not to exceed in the aggregate the amount of $2,000.00 as the result of any one accident;
- out-patient services provided by a Hospital.

REPATRIATION BENEFIT

If an insured person suffers injury or sickness resulting in loss of life and:

- such loss of life occurs outside his/her province of residence, and
- such loss of life occurs within 365 days of the date of the accident causing the injury or sickness causing loss of life,

the Insurer will pay the actual expenses incurred for preparing the deceased insured person for burial or cremation and shipment of the body to the city of residence of the deceased insured person.

The maximum amount payable for Repatriation is $15,000.00 per insured person.

IDENTIFICATION BENEFIT

If an insured person suffers injury or sickness resulting in loss of life and the insured person's body requires identification, the Insurer will pay the reasonable and necessary expenses actually incurred by one member of the Immediate Family for:

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

This benefit is payable only if the body is located outside the said Immediate Family Member's normal province of residence and the identification of the body is requested by the police or similar law enforcement agency having authority over such matters.

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

The benefit is payable only once in connection with Injuries, sickness and losses suffered by any one insured person, regardless of the number of policies providing coverage for this benefit for such insured person, that may be issued by the Insurer.

The maximum amount payable for Identification Benefit is $10,000.00, per insured person.

TRIP INTERRUPTION BENEFIT

If your scheduled departure is delayed for at least 12 hours due to sickness or hospitalization as provided by the Plan, or due to sickness or hospitalization of your covered travelling companion, the Company will reimburse you up to a maximum of $500 for the extra cost of your one-way economy/charter air fare via the most cost-effective itinerary to your next scheduled travel destination or original departure point of the same trip.

The Company will also reimburse the additional and unplanned hotel and meal expenses, telephone calls and taxi fares up to a combined maximum of $300 per day to a maximum of 5 days.

In order to claim any of the above outlined expenses, original itemized invoices must be provided at time of claim.

The combined maximum amount payable for this benefit is $2,000 per insured person per incident.

AUTOMOBILE RETURN BENEFIT

If injury or sickness results in an insured person becoming totally disabled and unable to continue his/her trip, the Insurer will pay the actual expense incurred for a commercial agency to return the insured person's private or rental Vehicle used for the trip, to the insured person's place of residence or nearest rental agency, up to a maximum of $5,000.00.

OUT OF POCKET EXPENSES

The Insurer will pay up to $150.00 per day for reasonable and necessary commercial living expenses incurred by any insured person or their insured travel companion if an insured person becomes totally disabled and cannot continue their trip, up to a maximum benefit of $1,500.00.

FAMILY TRANSPORTATION

If an insured person suffers injury or sickness resulting in the insured person being confined to a hospital located outside his/her permanent province of residence, the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of one member of the Immediate Family to such hospital if:

- confinement to hospital occurs within 365 days of the accident causing the injury or sickness, and
- reimbursement of expenses are limited to the cost of one economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such Immediate Family Member, and incidental travel expenses up to a maximum of $250.00.

The maximum amount payable for Family Transportation for all injuries resulting from any one accident or sickness is $15,000.00 per insured person.

EMERGENCY MEDICAL ASSISTANCE BENEFIT

Obtaining the services you need is fast and easy. By calling the toll-free numbers provided below, you have access to multilingual operators 24 hours a day, 7 days a week. A Wallet Card showing these phone numbers and your policy number is available from the Administrative Agent's Office. **The Insurer must be notified within 48 hours from the time of the incident.**

EMERGENCY TRANSPORTATION

Ground Transportation

The Insurer will pay the reasonable and necessary charges for the use of a licensed ground ambulance to a maximum of $5,000.00 for any one injury or sickness.

Air Transportation

If an injury or sickness commencing during the course of a trip results in the medically necessary emergency air transportation of the insured person, the Insurer will pay benefits for covered expenses up to a maximum of $50,000.00. Air transportation must first be approved by the Insurer and it must be ordered by a legally licensed physician who certifies that the severity of the insured person's injury or sickness warrants the air transportation of the insured person and that such is medically necessary.

If due to the geographical area at the onset of the medical emergency an air ambulance is deemed necessary, the Insurer will pay the cost of a licensed air ambulance to transport the insured person to the nearest hospital or medical facility where appropriate medical treatment can be obtained.

Air transportation means:

- the insured person's medical condition warrants immediate transportation from the place where the insured person is injured or sick to the nearest hospital where appropriate medical treatment can be obtained,

- after being treated at a local hospital, the insured person's medical condition warrants transportation to the place where he/she resides (provided such residence is located in Canada) to obtain further medical treatment or to recover, or
- both of the above.

Covered expenses are only those reasonable and customary expenses, up to the maximum, for transportation, medical services and medical supplies which are medically necessary and incurred in connection with the air transportation of the insured person.

All transportation arrangements made for transporting the insured person must be the most direct and economical route. Expenses for special transportation must be recommended by the attending physician, or required by the standard regulations of the conveyance transporting the insured person. Expenses for medical supplies and services must be recommended by the attending physician.

Air transportation is any land, water or air conveyance required to transport the insured person during air transportation. Special transportation includes, but is not limited to, air ambulance, land ambulances, commercial airlines and private motor vehicles.

EXCLUSIONS

There is no coverage under this policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks:

- injuries received while the insured person is participating in any manoeuvres or training exercises of the armed forces, national guard or organized reserve corps of any country or international authority;
- pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of an unexpected pregnancy complication of which occur before the end of the seventh month;
- sickness or injury where the trip is undertaken for the purpose of securing medical treatment or advice for such Sickness or injury;

- dental surgery or cosmetic surgery unless such surgery is a result of a covered injury;
- emotional or mental disorders unless the insured person is confined in a hospital;
- sickness or injury due to participation in professional sports;
- treatment or services that contravene any Government Health Insurance Plan in Canada;
- expenses incurred on an elective (non-emergency) basis;
- suicide or any attempt at suicide while sane or insane;
- intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury, while sane or insane;
- an act of declared or undeclared war, civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority;
- any services or supplies provided by an insured person or an Immediate Family Member of the insured person;
- a sickness or injury that, at the time of departure, might reasonably be expected to require an insured person to undergo treatment, surgery or hospitalization;
- any service, treatment, surgery or stay in Hospital not required for the immediate relief of acute pain or suffering or which is not medically necessary;
- any treatment or surgery which reasonably could be delayed until the insured person returns to his/her province of residence;
- anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to the insured person prior to departure;
- that portion, if any, of any expenses for treatment, advice or hospitalization which are not Reasonable and Customary.

EXTENDED COVERAGE AFTER TERMINATION

In the event of a delayed arrival of a common carrier or a stay in hospital of the insured person, coverage will automatically be extended for that insured person at no charge for:

- 24 hours in the event of a delayed common carrier,
- The period of the medically necessary stay in hospital plus 24 hours after the insured person is released from hospital.

SURVIVOR EXTENSION OF BENEFITS

Your surviving Spouse and surviving Dependent Children, including any child conceived before and born after your death, will be insured under this benefit on the date of your death. The Trust Fund will maintain premium payments on behalf of your surviving Dependents, to the earlier of:

- the date of death of the surviving Spouse/Dependent,
- the date which is two years from the date of your death,
- the date your Spouse remarries,
- the date on which the surviving Child ceases to qualify as a Dependent, or
- the date your Dependents become insured under another group policy providing similar benefits.

Any extended benefits payable are subject to the provisions and limitations of the Trust Fund.

WHAT TO DO IN CASE OF AN EMERGENCY

Call AIG Insurance Company of Canada immediately in the event of a serious medical emergency. Their operators are backed by a team of emergency care professionals – physicians and nurses who work closely with the physician looking after you and, if necessary, your family or Company Physician, to help insure that you receive the medical care you need.

Telephone the Coordination Center at one of the following numbers:

- ✓ **Canada & U. S. A. at 1-877-204-2017**
- ✓ **Elsewhere (Collect Call) at 0-715-295-9967**

When injuries covered by this policy occur, failure to notify AIG Insurance Company of Canada within 48 hours from the time of the incident could result in limitation of the claims payment.

HOW TO CLAIM

Claim forms may be obtained from the Trust Fund's Administrative Agent. Before submitting the claim form, ensure that all questions have been answered and that you have clearly identified yourself by full name, return mailing address and Local Union. If the claim is for your Dependent, provide the Dependent's first name, date of birth and relationship to you.

When you are sure that all of the above has been completed, forward the form and any receipts, if applicable, to the Administrative Agent.

PROOF OF LOSS

Written notice of injury for which a claim under this benefit is made must be submitted to the Insurer, in care of the Trust Fund's Administrative Agent, Benefit Plan Administrators Limited, within 30 days after the occurrence or commencement of any loss covered by the policy. Proof of such injury must be given to Insurer within 90 days of the loss. Failure to give notice of proof shall not invalidate nor reduce any claim if it is shown that notice of proof was given as soon as reasonably possible.

MANAGED DISABILITY CARE PROGRAM

The Board of Trustees has employed the services of Benefit Plan Administrators Limited (BPA) to assist with the adjudication of your Short and Long Term Disability (LTD) claims.

The BPA Health Management Services team is available to assist you when you are medically unable to work. They will work with you to determine if you should be making a claim for Employment Insurance (EI) Disability Benefits, followed by Short Term Wage Replacement Benefits, if necessary LTD Benefits. They will help you in completing the necessary paperwork and keep you and your Employer updated on the progress of your claim.

If you are disabled on the job, you should continue to apply for benefits directly from the Workplace Safety and Insurance Board (WSIB).

The BPA Health Management Services can be reached at:

- ✓ **1-800-867-5615**

WEEKLY WAGE REPLACEMENT

The Trust Fund pays an Eligible Member a weekly benefit for disability absences during which you are prevented from performing your usual job duties solely as a result of a non-occupational accidental bodily injury or disease, including pregnancy related conditions. Your disability absence must commence while you are covered under the Trust Fund. If you are laid off at the time your disability commences, the benefit period will not start until you are recalled to work. You do not need to be confined at home. You must be under the continuous care of a physician throughout the entire period of your disability. Eligibility for this benefit terminates at the earlier of retirement or age 70. This benefit does not apply to Dependents.

In no event will benefits commence prior to the date you are seen by a physician.

Total Disability (under Weekly Wage Replacement) means you will be considered totally disabled if you are unable to work at your own occupation, solely as a result of a non-occupational injury or disease.

Your **own occupation** means the type of work in which you were engaged and is not limited to the actual job you were performing prior to the start of a period of total disability.

PERIOD OF PAYMENT

The Weekly Wage Replacement Benefit is integrated with Employment Insurance Sickness Benefits (EI). Your benefits under this Trust Fund will be reduced by the number of full or partial weeks for which you are entitled to EI Benefits, whether you apply for them or not. If you do not qualify for EI Sickness Benefits, payments will be made under this Trust Fund, however you must submit proof of your disqualification by EI. The maximum benefit period provided by the wage replacement plan is 104 weeks, inclusive of EI Benefits.

This Short Term Disability Wage Replacement Benefit is subject to a one-week waiting period before payments commence. The waiting period is taken from the date of your first consultation with a physician who determines you are totally disabled and unable to perform your usual job duties. No benefits are payable for the next 26 weeks, unless you prove your disqualification for EI Benefits. If your disability continues beyond the one-week waiting period and the 26-week EI period, you may claim benefits from this Trust Fund.

BENEFIT AMOUNT

The amount of your weekly benefit is specified in the Summary of Benefits at the beginning of this booklet.

Wage Replacement Benefits will be reduced by the amount of Primary Canada/Quebec Pension Plan Disability Benefits which are payable to you from the 27th week of your disability claim.

It is your responsibility to promptly claim CPP/QPP Benefits and to advise the Administrative Agent of the status of your application. Failure to do so will result in the suspension of your benefits.

In addition to the benefit reduction for CPP/QPP, your benefit under this coverage will also be directly reduced by any income or benefit payable under:

- any other plan or program provided to you by your Employer;
- any plan or program of any government or of any subdivision or agency of the government.

Your total weekly income from all sources cannot exceed 85% of your normal gross weekly earnings as of the date disability commences, except as allowed under the Rehabilitation provision.

If your weekly payments under the Weekly Wage Replacement Benefit, together with any other income to which you may be entitled under any other group disability program, total more than 85% of your normal gross weekly earnings, payments under this Weekly Wage Replacement Benefit will be reduced so that your weekly payments, together with all other disability payments or compensations as described above, will not exceed 85% of your normal gross weekly earnings.

TAX STATUS

This benefit is taxable and Income Tax will be withheld from your cheques. You will be mailed a T4A for all paid amounts by the end of February of the following year.

REHABILITATION PROVISION

You may be required to participate in an approved rehabilitation program designed to favour your return to work, if considered justified by the Claims Adjudicator.

If the Claims Adjudicator determines you should participate in a rehabilitation program, your Weekly Wage Replacement Benefit will not be reduced by any remuneration you receive under an approved rehabilitation program, unless your total income from all sources exceeds 100% of your weekly pre-disability earnings. In that event, your Wage Replacement Benefit will be reduced by the amount in excess of 100%.

Failure to participate in a recommended rehabilitation program can result in suspension or termination of your Weekly Wage Replacement Benefit payments.

SUCCESSIVE DISABILITIES

Successive disabilities separated by less than two weeks of active, full-time work will be considered one disability, unless the subsequent disability is due to an entirely different and unrelated cause.

Disabilities arising from different and unrelated causes will be considered as a new disability, provided they commence after you return to full-time work for at least one full day. Disabilities arising from the same or a related cause will be considered as a new disability provided you returned to regular, full-time work for a period of at least two weeks.

EXCLUSIONS AND LIMITATIONS

No benefits are payable for:

- any day on which you are not under the care of a legally qualified 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;

- any day you are performing work of any kind, anywhere, for compensation or profit;
- during any leave of absence (including Maternity/Paternity Leave);
- any day you are receiving Disability Benefits, Early Retirement, or Retirement Benefits under any Employer or Union sponsored pension plan;
- any day you are entitled to receive Employment Insurance Sickness Benefits;
- any day you are entitled to receive reimbursement under any Workplace Safety and Insurance Act or similar legislation;
- any disability due to or associated with treatment rendered for cosmetic purposes;
- any portion of a period of disability resulting from substance abuse, including alcoholism and drug addiction, unless you are participating in a recognized substance withdrawal program;
- any injury caused or contributed to by a Motor Vehicle Accident which occurs in Ontario or Quebec;
- for any disability resulting from intentionally self-inflicted injuries, whether you are sane or insane;
- for any disability resulting from voluntary participation in war, riot or insurrection;
- for the portion of a period of disability during which you are imprisoned in a penal institution or confined in a hospital or similar institution as a result of criminal proceedings.

TERMINATION OF COVERAGE

Your Weekly Wage Replacement Benefits terminate at the earlier of retirement or age 70.

SUBROGATION

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

In the event that you can provide proof to the Trust Fund that you have not recovered full compensation for loss of income, the Trust Fund shall determine the proportion of damages actually recovered and share proportionately in that amount.

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

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

HOW TO FILE WEEKLY WAGE REPLACEMENTS CLAIMS

Claim forms are available from the Administrative Agent. If you are claiming for Weekly Wage Replacement Benefits, a specific form must be used. This form consists of the following sections:

- ✓ Attending Physician's Statement,
- ✓ Member Statement of Claim, and
- ✓ Employer Section.

Your physician must complete the "Attending Physician's Statement" portion of the form. Make sure your physician clearly indicates the diagnosis, date(s) of service and type(s) of service rendered, and an estimated return to work date. Your physician must complete the form **after** you stop working. Forms completed in anticipation of medical treatments are not acceptable.

Remember! You must be under the continuous personal care of a physician to qualify for Weekly Wage Replacement Benefits.

You and your Employer must also complete your sections of the form before it is returned to the Claims Adjudicator. To avoid delay in payment, please make certain that all required information has been provided. Once the claim has been approved, your benefit cheque will be mailed directly to you.

It is **important** to note that you will be required to regularly provide medical evidence from your attending physician. This medical evidence must be sufficient to establish and maintain your inability to perform the usual functions of your job. You must be under the continuous care of a medical physician for the full 106-week period, which includes the waiting period and any period during which you received EI Benefits; and your treatment must be appropriate to the diagnosis indicated. Alternative or experimental treatments are not recognized by this Trust Fund.

Reminder! Your benefits will be reduced by CPP/QPP Disability Benefits from the 27th week of disability. If you do not advise the Claims Adjudicator of the status of your CPP application, your benefits may be suspended until you do.

If it appears that you will continue to be disabled after 104 weeks of receiving Wage Replacement Benefits, at approximately 98 weeks, the Administrative Agent will send you the appropriate forms for completion (with instructions), so that you may apply for benefits under the Long Term Disability Benefit portion of the Trust Fund.

PROOF OF LOSS

Written proof stating the occurrence, character and extent of loss must be submitted to the Claims Adjudicator within 90 days after the termination of the period for which the Insurer is liable. Failure to provide such proof within the time required shall not invalidate nor reduce the claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

The Trust Fund shall have the right and opportunity to independently examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pending and payment period, if any, of such claim.

LONG TERM DISABILITY

Long Term Disability (LTD) Benefits are Wage Replacement Benefits, which provide you a monthly income if you become totally disabled by a non-occupational accidental bodily injury or illness and can no longer work for your living while covered under this Trust Fund and under the age of 60.

LTD Insurance covers you for those total disabilities that last beyond the period covered by the Short Term Weekly Wage Replacement Plan. This benefit applies to Eligible Members under age 60, provided you have worked for contributing Employers for a minimum of 4,000 hours. It does not apply to Dependents, Members age 60 or older, or Retirees.

Total Disability (under Long Term Disability) means after the qualifying period, you will be considered totally disabled for the LTD Benefit only if you are incapacitated to the extent that solely because of a non-occupational illness or accidental bodily injury, you are unable to work at any occupation or employment for which you are, or may reasonably become, qualified by education, training or experience. Such disability must result from a medically determinable physical or mental impairment.

MAXIMUM PERIOD OF PAYMENT

You will be eligible for your first income payment from the Trust Fund after you have completed the qualifying period, which is the first 106 weeks of a period of total disability, or the duration of the Weekly Wage Replacement Benefit, whichever is greater. However, you will not receive an income payment if you reach age 60 before you complete the qualifying period.

After completing the qualifying period, you will be eligible for income payments during the continuance of a period of total disability up until attainment of age 60. At age 60, you are entitled to apply for an Early Retirement Pension under the Insulators Local 95 Pension Plan.

A period of total disability is considered to cease:

- when you commence work at a reasonable occupation;
- when you fail to furnish proof of the continuance of total disability or refuse to be examined by a physician;

- when you cease to be under the care of a physician;
- the date of your death.

AMOUNT OF MONTHLY INCOME

The LTD Benefit will be payable monthly to the maximum amount specified in the Summary of Benefits, less any income received from any Employer or from any occupation for compensation or profit, except as allowed under the Rehabilitation provision. Benefits are paid monthly at the end of the month.

Your LTD Benefit will not be reduced by Canada Disability Pension Plan or Quebec Pension Plan Benefits, or by any benefits received from the Insulators Local 95 Pension Plan, unless your total monthly income exceeds 85% of your earnings prior to disability.

Your total monthly income from all sources cannot exceed 85% of your normal gross monthly earnings as of the date disability commences, except as allowed under the Rehabilitation provision. If your monthly payments under the LTD Benefit, together with any other income, disability benefits or pension to which you may be entitled under any other group disability program or pension plan, total more than 85% of your normal gross monthly earnings; payments under this LTD Benefit will be reduced so that your monthly payments together with all other compensations as described above, will not exceed 85% of your normal gross monthly Earnings.

Your normal gross monthly earnings will be determined from the hourly rate in effect for your normal workweek as determined from the Collective Agreement in effect when your disability commenced.

Normal gross monthly earnings do not include overtime pay, bonuses, or any other extra compensation. A retroactive change in the rate of earnings shall be deemed to be effective on the date of the determination of the change in the rate of earnings.

REHABILITATION PROVISION

If considered justified by the Claims Adjudicator, you will be required to participate in an approved rehabilitation program designed to favour your return to work. The rehabilitation program may be modified or interrupted if the Claims Adjudicator deems it necessary and justified.

The Claims Adjudicator will review your case file to determine what kind of rehabilitation program, if any, would be best for you. If your case file indicates rehabilitation would be beneficial, the Trust Fund will provide the necessary resources and support to help you recover your health and functional autonomy to a level enabling you to return to work.

The rehabilitation program resources may include, among others:

- Psychological consultation;
- Employment counselling;
- Changes to your workstation, job description or work schedule.

Your (LTD) Benefit will not be reduced by any remuneration you receive under an approved rehabilitation program unless your total income from all sources exceeds 100% of your monthly pre-disability earnings. In that event, your LTD Benefit will be reduced by the amount in excess of 100%.

Failure to participate in the rehabilitation program will result in suspension or termination of your LTD Benefit payments.

TAX STATUS

This benefit is taxable however no tax will be withheld from your monthly payments. You will be mailed a T4A for all paid amounts by the end of February of the following year.

CONTINUOUS PERIOD OF DISABILITY

If you become disabled from the same or related causes within 6 months after return to active work, it will be considered one continuous period of disability and the qualifying period will not be reapplied.

If you have returned to active work for one full month and become disabled from different and unrelated causes, it will be considered a new period of disability, subject to a new qualifying period.

EXCLUSIONS AND LIMITATIONS

No benefits are payable:

- for any day for which you are entitled to benefits under the Weekly Wage Replacement Plan;
- for the portion of a period of disability during which you are not under treatment by a legally qualified physician or specialist;
- for a disability resulting from injury or disease which occurred while the Member is on active duty in the armed forces of any country, or while participating in a riot, insurrection, rebellion or civil commotion;
- for a disability resulting from participation in the commission of a criminal offence;
- for the portion of disability during which you are imprisoned in a penal institution or confined in a Hospital or similar institution as a result of criminal proceedings;
- for a disability resulting from intentionally self-inflicted injuries or illness while sane or insane;
- for a disability resulting from an accident which occurs while you are operating a motor vehicle and your blood contains more than 80 milligrams of alcohol in 100 milliliters of blood (.08%);
- for any portion of a period of disability resulting from an eating disorder, or substance abuse, including alcoholism and drug addiction, unless you are participating in a recognized substance withdrawal program;
- an illness or injury caused or contributed to by a Motor Vehicle Accident that occurs in Ontario or Quebec;
- during any leave of absence (including maternity/paternity leave);
- for a disability which commences on or after the date a strike begins, subject to any provincial Employment or Labour Standards Act. However, you can fulfill your qualifying disability period during a strike.

EXTENDED INSURANCE

If your LTD coverage terminates during a period of total disability, the Trust Fund continues to be liable as though the coverage provision remained in force. The Trust Fund shall not be liable for disabilities occurring after the LTD coverage provision terminates.

TERMINATION OF COVERAGE

Your eligibility for LTD terminates at attainment of age 60.

HOW TO FILE LONG TERM DISABILITY CLAIMS

After approximately 98 weeks of receiving combined Weekly Wage Replacement and Employment Insurance Sickness Benefits, your Case Worker will send you the appropriate forms for completion (with instructions), so that you may apply for benefits under the LTD Benefit portion of the Trust Fund.

When the forms have been fully completed by yourself, and your physician, forward the forms to your Case Worker. Your benefit cheques will be mailed directly to you.

Remember! You must be under the continuous personal care of a physician to qualify for Weekly Disability Income and LTD Benefits.

PROOF OF LOSS

Written proof stating the occurrence, character and extent of loss must be submitted to the Claims Office within 6 months after the end of the qualifying period for LTD Insurance. The qualifying period is 106 weeks, therefore you must apply within 30 months of leaving work due to disability.

Written proof of the continuance of disability must be furnished to the Claims Office at such intervals as it may reasonably require. As part of the proof, the Trust Fund shall have the right to require satisfactory evidence that the Member has made application for all benefits referred to in the reductions provision and that all required proofs for such benefits have been furnished. If you did not make such application, you must provide satisfactory evidence that you were not eligible for such benefits.

The Claim Adjudicator shall have the right to require satisfactory evidence of the amount of such benefits payable.

The Claim Adjudicator shall also have the right and opportunity to independently examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pending and payment period, if any, of such claim.

CRITICAL ILLNESS

The benefits described in this section apply to Eligible Members only. Critical Illness Benefits cease when you reach age 70, retire or in accordance with the Termination of Coverage provision, whichever is earlier.

Critical Illness Benefits provide financial assistance in the event you are diagnosed with one of the covered illnesses. The benefit is designed to alleviate some of the financial stress resulting from a critical illness at a time when the focus should be on recovery. There is no restriction on the use of the benefit: you may use it in any way that will meet your particular needs.

You are eligible for a flat amount which is referred to as the principal sum. A Multiple Event Benefit may be payable equal to the Benefit Amount, subject to certain conditions as described under Multiple Event Benefit.

BENEFIT PAYMENT CONDITIONS

Payment of benefits upon the first diagnosis of a covered critical illness is subject to the following conditions:

- The diagnosis is made within Canada,
- The diagnosis is made while you are eligible for coverage by the Trust Fund,
- Payment is not precluded by any general or specific exclusion or limitation set forth in the insurance contract, and
- Once 100% of the principal sum has been paid, coverage terminates and no further benefits are payable, except as described under Second Event Benefit.

COVERED CRITICAL ILLNESSES

All covered critical illnesses must be diagnosed after the Eligible Member's effective date of coverage by the Trust Fund. To be considered a covered illness, it must be positively diagnosed by a licensed or certified specialist in that field of medicine, and must be supported by medical evidence collected by a physician.

Life-threatening and non-life-threatening cancer must be positively diagnosed by a physician and supported by a pathological report. Clinical diagnoses alone do not meet this standard.

Stroke must be diagnosed by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.

Diagnoses must be for one of the following covered critical illnesses or conditions:

COVERED CRITICAL ILLNESSES*

- Aortic surgery
- Aplastic anemia
- Bacterial Meningitis
- Benign brain tumour
- Blindness
- Coma
- Coronary artery bypass surgery
- Coronary angioplasty (partial payment of 10% of the principal sum
- Deafness
- Dementia, including Alzheimer's Disease
- Heart attack
- Heart valve replacement or repair
- Kidney (renal) failure
- Life-threatening cancer
- Loss of independent existence
- Loss of limbs
- Loss of speech
- Major organ failure on waiting list
- Major organ transplant
- Motor neuron disease
- Multiple sclerosis
- Muscular dystrophy
- Non-life-threatening cancer (partial payment – see below)
- Occupational HIV infection
- Parkinson's disease and specified atypical Parkinson disorders
- Quadriplegia, paraplegia, hemiplegia
- Severe burn
- Stroke

* For each covered illness or condition, the insurance contract specifies what the illness or condition is, what signs and symptoms need to be present to be diagnosed with the illness or condition, who needs to make the diagnosis, and the tests and/or diagnostic procedures that must be performed to arrive at the diagnosis. Contact the Administrative Agent for these details.

PARTIAL PAYMENT FOR NON-LIFE-THREATENING CANCER

The benefit will provide 25% of the principal sum for the following non-life-threatening conditions:

- Stage I malignant melanoma of the skin;

- Basal or Squamous Cell Carcinoma;
- Stage I Colon cancer (T1 or T2);
- Carcinoma in situ;
- T1a or T1b Prostate cancer;
- Papillary thyroid cancer or follicular thyroid cancer;
- Chronic lymphocytic leukemia classified as Rai stage 0, and
- Any tumour in the presence of any Human Immunodeficiency (HIV).

Upon payment of the Partial Payment for Non-Life-Threatening Cancer, your insurance remains in effect with the principal sum reduced by the amount of the partial payment. Only one claim per condition is permitted for partial payment for non-life-threatening cancer.

MULTIPLE EVENT BENEFIT

If you are diagnosed with a critical illness for which the principal sum has been paid and is then diagnosed with a subsequent critical illness, an additional payment equal to the principal sum is payable. The subsequent critical illness must be a different critical illness group than the initial critical illness group for which the principal sum has been paid.

You are eligible for payment of the principal sum one time per critical illness group, as follows:

- **Group 1:** Aortic surgery, coronary artery bypass surgery, heart attack, heart valve replacement or repair, stroke;
- **Group 2:** Aplastic anemia, kidney failure, major organ failure on waiting list, major organ transplant;
- **Group 3:** Bacterial meningitis, benign brain tumor, coma, dementia including Alzheimer's disease, loss of independent existence, loss of speech, motor neuron disease, multiple sclerosis, muscular dystrophy, Parkinson's disease and specified atypical Parkinson disorders, quadriplegia, paraplegia, hemiplegia;
- **Group 4:** Blindness;
- **Group 5:** Deafness;
- **Group 6:** Life-threatening cancer;
- **Group 7:** Loss of limbs;
- **Group 8:** Occupational HIV infection;
- **Group 9:** Severe burn.

CANCER RECURRENCE BENEFIT

If you have already been diagnosed with cancer and, while insured, a new diagnosis of life-threatening cancer is made, you will receive a benefit equivalent to the benefit amount applicable to the person diagnosed with life-threatening cancer, if the following conditions have been met:

- More than 60 months have passed since the previous cancer diagnosis; and
- No treatment relating directly or indirectly to cancer has been received within that 60-month period (treatment does not include preventive medications and follow up visits to the doctor).

The diagnosed cancer must meet the definition of a life-threatening cancer and the Diagnostic Requirements in order to be eligible for a payment under this provision.

Life-Threatening Cancer (under Critical Illness) is defined as a malignant tumour that is first manifested while the insured person's insurance is in effect, and which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Life-threatening cancer includes carcinoma, sarcoma, invasive malignant melanoma, lymphoma, and leukemia, as well as cancers for which chemotherapy or radiation treatments have been recommended. Life-threatening cancer does not provide coverage for any form of cancer defined under Partial Payment for Non-Life-Threatening Cancer.

DIAGNOSTIC REQUIREMENTS

The insurer reserves the right to have any critical illness diagnosis reviewed by a physician of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the diagnosis, the insurer shall have the right to request an examination of either you or the evidence used in the arriving at your diagnosis by an independent acknowledged expert selected by the insurer in the applicable field of medicine. The opinion of such expert as to such diagnosis shall be binding on both you and the insurer.

Diagnosis (under Critical Illness) means a definitive and unequivocal diagnosis made by a physician based upon the use of clinical and/or laboratory investigations as supported by your medical records and meeting any diagnostic requirements described in the insurance contract.

EXCLUSIONS

Benefits are not payable if a critical illness or condition is caused in whole or in part by, or resulting in whole or in part from, the following events:

- Any illness not specifically listed as a covered critical illness,
- Commission of or attempt to commit a felony,
- Declared or undeclared war, or any act of declared or undeclared war,
- Voluntary participation in any riot or civil insurrection, and
- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.

HOW TO CLAIM

Upon receipt of due written proof of loss, benefit payments will be made to you (or on behalf of you, if applicable). If you should die before all payments due have been made, the amount still payable will be paid to your beneficiary.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his/her property, a payment not exceeding $1,000 may be made to any relative by blood or connection by marriage of the payee who, in the insurer's opinion, has assumed custody and support of the minor or responsibility for the incompetent person's affairs.

PROOF OF LOSS

Written proof of loss must be furnished within 90 days after the date of the diagnosis. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

LIFE INSURANCE

The Life Insurance benefit is payable in the event of your death from any cause at any time or place while you are insured. Payment will be made to the Beneficiary designated by you. If there is no designated Beneficiary living at the time of your death, the Insurer will pay the benefit to your Estate. The amount of Life Insurance is specified in the Summary of Benefits of this booklet.

Retirees may be eligible for a Retiree Life Benefit Certificate, and should refer to the description below.

BENEFICIARY

For Member Death Benefits, you may name a Beneficiary/Beneficiaries and, from time to time, change such named Beneficiary/Beneficiaries, subject to Provincial Law, by written request filed with the Administrative Agent. The change will take effect as of the date such request was executed, but without prejudice to the Insurance Company for any payments made before such request is received at its Head Office.

WAIVER OF PREMIUM PROVISION

If, while covered under this, you become totally disabled and have not retired or had your 65th birthday and remain so disabled for six consecutive months, the Insurer will waive payment of the Life Insurance Premiums up to age 65 provided you remain so disabled, and provided proofs of disability are furnished as required.

Totally disabled (under Life Insurance) means you are incapacitated by an injury or disease to the extent that you are not able to perform any work for compensation or profit and are not able to engage in any business or occupation.

In order to qualify for the Waiver of Premium provision, you must notify the Insurer within 12 months of the last active day at work and must furnish due proof of disability, satisfactory to the Insurer.

From time to time during the first year that premiums are waived, the Insurer shall have the right to require proof of continuance of your disability. After a year, proof shall only be required no more than once a year.

You may be required to be examined by a medical examiner designated by the Insurer, at the Insurer's expense. No benefits will be provided under this benefit if you fail to submit proof of disability when required.

The Insurer will waive premiums starting with the date the required proof is approved. Premiums shall not be waived beyond the earlier of your age 65 or the date you cease to be totally disabled. The benefit will cease if you fail to submit proof of continuance of disability when required or if you fail to be examined by a qualified physician when required.

If you do not return to work within 31 days after this benefit ceases, you may convert the amount of insurance that was subject to this provision as though the insurance had ceased on that date due to termination of employment. If a benefit is payable under the Conversion Privilege of this policy, the amount of insurance payable under this provision shall be reduced by the amount of that benefit. If an individual policy has been issued in accordance with the Conversion Privilege, no payment shall be made under this provision unless the individual policy is surrendered to the Insurer without payment of the claim. If the policy is surrendered, the Insurer will refund any premiums paid on the individual policy.

If you die while your Life Insurance is being continued under this Waiver of Premium provision, the amount of insurance payable will be the amount of insurance for which premiums are being waived. Subsequent increases in Life Insurance benefits for Active Members do not apply to Members covered by premium waiver.

If you die within one year of becoming totally disabled and unable to work due to such disability, but before due proof of the disability was furnished to the Insurer, the Insurer will pay your Beneficiary the amount of Life Insurance to which you were entitled on the date you became so disabled. The Insurer must receive proof of the death and total disability during this period not later than one year after your death.

The Insurer shall not be liable for Waiver of Premium Benefits after termination of the Contract or Waiver of Premium provision once a replacing insurer is bound contractually or as a matter of law.

However, if this Contract or Waiver of Premium provision terminates, the Insurer remains liable to provide Waiver of Premium benefits for a continuous disability caused by an accident or sickness that occurred prior to termination provided a claim is submitted within 12 months of the Member's last active day at work and due proof of disability, satisfactory to the Insurer, is furnished within 18 months of the last active working day. At the end of any six-month period during which the Member was not disabled the Insurer ceases to be liable for any further waiver of premium benefit, for disability caused by an accident or sickness that occurred prior to termination.

RETIREE LIFE BENEFIT CERTIFICATE (Separate from Basic Life)

You are eligible to receive a Retiree Life Benefit Certificate when you retire, if:

- you have reached age 65,
- your hour bank balance has run out, and
- you were eligible for benefits under this Trust Fund immediately prior to your retirement.

For purposes of the Retiree Life Benefit Certificate, "Retirement" is defined as receiving Pension Benefits under the terms of the Insulators Local 95 Pension Plan. Self-Paying Retirees who have received their Retiree Life Benefit Certificate are not entitled to any other Life Insurance benefits from the Trust Fund.

The Administrative Agent will automatically arrange, on your behalf, for the issuance of a Life Benefit Certificate once you commence receiving pension benefits under the Pension Plan.

However, should you retire before age 65 you must continue your benefits through the Self-Pay provision in order to be eligible for a Life Benefit Certificate to be issued upon your attainment of age 65. If you are disabled and on an approved Life Waiver of premium, a Life Benefit Certificate will be issued upon your attainment of age 65.

Once a Life Benefit Certificate is issued to you, it should be kept with your other important documents. A lump sum payment, in the face amount set out on the Certificate, will be made to your named Beneficiary upon your death.

HOW TO FILE LIFE INSURANCE CLAIMS

You should acquaint your Beneficiary/Beneficiaries with the fact that in the event of your death, they should contact your Employer, the Union, and the Trust Fund's Administrative Agent immediately. A claim form will then be forwarded with specific instructions as to how it is to be completed. Claim forms may be obtained from the Claims Office.

Before submitting the claim form, your Beneficiary or Executor must ensure that all questions have been answered, that the claimant and the insured are clearly identified by full name, return mailing address, and the name of your Employer and Union. Faulty or missing information will only result in a delay in processing the claim.

When the above has been completed, forward the form and all attachments to the Administrative Agent. The claim will be validated by the Administrative Agent and forwarded to the Insurance Carrier for settlement.

PROOF OF LOSS

Written proof stating the occurrence, character and extent of loss must be submitted to the Administrative Agent within 12 months after the date of death for Life Insurance, and within 18 months after the date the Member ceases active work because of total and permanent disability under the disability provision for Life Insurance.

CONVERSION PRIVILEGE

If your entire amount of Life Insurance is discontinued because of a change in your eligibility status or your termination in this Trust Fund, and you are under 65 years of age, you are entitled to purchase an individual Life Insurance policy issued by the Insurer, without evidence of insurability, subject to the following conditions:

- The amount of the individual policy shall not exceed the amount of insurance for which you were covered when your coverage was discontinued, subject to the following maximums:
    - $200,000.00 if your Life Insurance coverage is terminated, or

    - if the entire policy is terminated then the maximum shall be three times the maximum pensionable earnings established under Canada Pension Plan for the calendar year during which the application for conversion is made.
- The individual policy shall be, at the Member's option, any one of the regular policies other than term insurance then customarily being issued by the Insurer; or a non-renewable term insurance policy to age 65; or a one-year non-renewable term insurance policy with premiums payable not more frequently than quarterly. At any time prior to the end of the one-year term period, this one-year non-renewable policy may be converted without evidence of insurability to either of the other two types of policy described above;
- This individual policy shall not be a policy providing a disability or double indemnity benefit;
- This individual policy shall not provide a dividend option other than cash, premium reduction, or dividends left on deposit;
- The premium for the individual policy shall be determined by the Insurer according to the insurer's current rates for your attained age (nearest birthday) on the effective date of the individual policy; the class of risk to which you then belong; and the form and amount of the individual policy;
- The first premium and written application for the individual policy shall be delivered to the Insurer within 31 days after the date on which your insurance is terminated;
- Insurance under the individual policy shall be effective at the end of the 31-day period described above;
- Evidence of insurability shall not be required for such individual policy.

If you die within the 31-day period during which you could have converted, the Insurer shall pay the maximum amount of insurance you could have converted. If an individual policy has already been issued through conversion, no payment shall be made through this provision unless the individual policy is surrendered without payment of the claim. Upon surrender the Insurer shall refund premiums paid on the individual policy. A Beneficiary designated in any conversion application shall be the Beneficiary under this provision.

NOTE: This conversion privilege does not apply to Life Insurance that is terminating or reducing because you retire or attain a certain age specified in the Group Policy.

VOLUNTARY INSURANCE

The benefits described in this section apply to Eligible Members and their Eligible Dependents.

Voluntary insurance is coverage that Members can choose to purchase to complement their existing insurance coverage. Voluntary insurance allows you to select the types and levels of coverage that best fit their individual circumstances and preferences.

Emergency Medical Travel:

- Ability to purchase trip coverage, top-up coverage, and trip cancellation with lost baggage separately;
- Available for a single trip or multiple trips.

Voluntary Critical Illness Insurance:

- Guaranteed issue amount of $10,000;
- Simplified underwriting from $20,000 to $50,000;
- Medically underwritten from $60,000 to $500,000;
- Coverage available for spouses up to $500,000 and children to $10,000.

Voluntary AD&D Insurance:

- Guaranteed up to $500,000.

Voluntary Term Life Insurance:

- Guaranteed issue amount of $10,000;
- Simplified underwriting from $20,000 to $100,000;
- Medically underwritten from $110,000 to $500,000;
- Coverage available for spouses up to $500,000 and children to $20,000.

60 Day Money Back Guarantee

If not completely satisfied, you can receive a full refund if cancellation is made within 60 days of coverage effective date.

Convenient Premium Payment

Premiums administered on an Individually billed basis to be paid annually by cheque or credit card, or monthly by credit card or pre-authorized debit.

Guaranteed Renewable
Once enrolled, no medical evidence is required to renew coverage, even if your health changes.

Please note that the "Voluntary Insurance" available from BPA is not offered as part of the Insulators Local 95 Benefit Fund or paid for by the Trustees of the Insulators Local 95 Benefit Fund (the "Trustees"). As a result, the Trustees are not liable by the Members or their Eligible Dependents if they choose to purchase these benefits

HOW TO USE VOLUNTARY INSURANCE
For more information:

- ✓ **please visit https://specialmarkets.ia.ca/bpa/home, or**
- ✓ **scan the QR Code below**

M.H. (MIKE) NICOLS SCHOLARSHIP

The objective of this program is to encourage and assist students through the medium of a financial award, to further their education at the post-secondary level, thereby improving their potential for personal fulfilment, for a meaningful contribution to society and hopefully to the Insulation Industry. A scholarship is an award made in recognition of academic achievement, general proficiency and financial need.

OUTLINE

This Scholarship is available to qualifying students who are proceeding directly to a full-time post-secondary educational program to obtain a diploma, certificate or degree, at an accredited Canadian Community College/University. Each student applying must be an Eligible Dependent of a Qualifying Member. All applications will be referred to an independent Awards Officer who will make a recommendation, as to the recipient of the Scholarship, to the Board of Trustees of the Benefit Fund. The selection will be based on the written applications and supporting data submitted by and on behalf of the applicants.

Determining factors will be considered in this order of precedence:

- Need for financial assistance, recognizing family circumstances, personal work effort, other scholarships, bursaries, awards, etc (including OSAP);
- Academic history and background with emphasis on proficiency in the year of application;
- Volunteer work and contribution to the community.

The Scholarship Program can be terminated by the Trustees at any time; however, outstanding commitments for the current year will be met.

AWARD

The amount of this Scholarship or Bursary will be determined by the Board of Trustees and may vary from year to year at the discretion of the Trustees. The Scholarship may be renewed annually for four years or until graduation, whichever is to occur earlier, provided the initial qualifying standards are upheld.

In any year, in order to better serve the program objectives, bursaries may be awarded in lieu of a scholarship. Bursaries may be renewed annually for four years, or until graduation, whichever is to occur earlier, provided the initial qualifying standards are upheld.

In order to maximize the amount of financial aid available, the applicants for this Scholarship or Bursary must disclose the extent of all other scholarships, bursaries or awards (including OSAP) to be applied for or received. The Scholarship or Bursary payments will be made directly to the applicable Community College/University on behalf of the applicant.

DEFINITIONS FOR THE PURPOSE OF THIS SCHOLARSHIP FUND:

Eligible Dependent is a Child of a Qualifying Member who has been accepted as a student for a diploma, certificate or degree at an accredited Canadian Community College/University. Legal guardianship will also qualify the Child as an Eligible Dependent.

Qualifying Member is:

- An Active Member, in good standing, of the Insulators Local 95 Union, who has been in benefit in the Insulators Local 95 Benefit Fund at some time in the 12 months immediately preceding the start of the school term for which application is made for the Scholarship;
- A Deceased Member of the Insulators Local 95 Union on whose behalf Life Insurance or pension payments are or have been made by the Insulators Local 95 Benefit Fund;
- A Disabled Member of the Insulators Local 95 Union who is collecting disability benefits from either the Weekly Disability Income or Long Term Disability Income Plans, provided by the Insulators Local 95 Benefit Fund, or Workplace Safety and Insurance (WSIB), or EI;
- A Retired Member of the Insulators Local 95 Union who is receiving pension benefits from the Insulators Local 95 Pension Fund.

QUALIFICATIONS FOR NEW APPLICANTS

- The applicant must be an Eligible Dependent of a Qualifying Member;

- The applicant must have completed applicable secondary education requirements and be accepted by an accredited Canadian Community College/University in a diploma, certificate or degree course;
- The Applicant must submit:
  - His/her official Ontario Student Transcript. In the event final grade 12 marks are not available at the time of the scholarship application deadline, an interim Provincial Report Card for grade 12 will be accepted until final grades are made available. At that time, they must be forwarded to the Scholarship Administrator immediately;
  - A letter of appraisal from the Principal, Vice Principal or Guidance Counsellor from the high school.
- The Applicant must submit a typed short essay, approximately five to six paragraphs in length, detailing:
  - Their need for financial assistance (i.e. details regarding living arrangements while attending school, related costs and family circumstances);
  - Personal work effort;
  - Any achievement awards obtained;
  - Their academic history and background (emphasizing proficiency in the year of application);
  - Their community involvement, extra-curricular activities and interests;
  - Any positions of leadership they may have held;
  - Their educational and vocational goals.
- The applicant must submit a copy of his/her College/University acceptance letter, when available;
- The applicant must disclose to the Trustees the extent of any and all other scholarships, bursaries or awards (including OSAP) and the awarded amounts which have been applied for or received;
- Signature of a Union Official is required on the application form, where indicated, to verify the relationship between the applicant and the Qualifying Member;
- The applicant must enclose a copy of the tuition fee statement from the College/University he/she will be attending (online tuition fee statements are acceptable);

- The applicant must enclose proof of community involvement/volunteer work that they reference in their original short essay in the form of a letter of appraisal from the organization, OR the organization's contact information so that the Scholarship Administrator may confirm the applicant's community involvement/volunteer work.

The Fund Administrator will verify the benefit status of the Qualifying Member.

Application forms are available at:

- ✓ Insulators Local 95 Union Office
  Unit 5 - 166 Newkirk Road
  Richmond Hill, Ontario L4C 3G7
  Telephone: (289) 459-0122|Toll Free: 1-800-268-3396
  Email: admin@insulators95.com|officers@insulators95.com
  Website: www.insulators95.com

- ✓ Benefit Plan Administrators Limited
  Suite 300 - 90 Burnhamthorpe Road West
  Mississauga, Ontario L5B 3C3
  Telephone: 905-275-6466|Toll Free: 1-800-867-5615
  Email: mhnscholarship@bpagroup.com
  Website: www.insulators95benefits.com

Application forms should be returned to:

- ✓ Attention: Insulators Local 95 Scholarship Trust Fund
  M. H. (Mike) Nicols Scholarship Award
  BPA Consulting Group
  Suite 300 - 90 Burnhamthorpe Road West
  Mississauga, Ontario L5B 3C3

In order to meet the June 1st deadline each year, initial electronic applications will be accepted at mhnscholarship@bpagroup.com, however, we will require paper applications to be sent to the BPA Consulting Group mailing address above. Initial applications must be submitted by the deadline to allow time for the determination of the successful applicant. Subsequent supporting documentation such as tuition fee statements and final Ontario School Transcripts must be forwarded when available.

INSURERS

Canada Life Assurance Company (Policy #5916)

- Extended Health Care
- Weekly Wage Replacement
- Life Insurance

Provided directly by the Trust Fund

- Vision Care
- Dental Care
- Long Term Disability
- Retiree Life Benefit Certificate

AIG Insurance Company of Canada

- Accidental Death & Dismemberment (Policy #BSC 9020977)
- Hospital Cash (Policy #SRG 9428312)
- Emergency Travel Medical (Policy #CMG 9428310)
- Critical Illness (Policy #CI 9136485A)

Telus Health

- Member & Family Assistance Program / LifeJourney
- On-Demand Medical Virtual Care / vCare

TeksMed Services Incorporated

- Virtual Mental Healtcare / mHealth
- QuikCare Confidential Mental Health Program
- QuikCare Expedited Access to Healthcare Program