INSULATORS LOCAL 95 BENEFIT FUND

RETIRED 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

CONTENTS

INTRODUCTION

A MESSAGE FROM THE BOARD

This booklet describes the conditions of eligibility, coverage and claims procedures for the Retirees 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.

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 Spouse.

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. 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. 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. Retirees should list Spouses 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.

If you elect to participate in the Retiree Plan, you must do so within 31 days of becoming eligible. In the event you choose not to participate, you will not be able to enroll at a later date or opt-out of the Plan.

After your insurance becomes effective, you must 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 Retirees & Spouses	
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	$250,000 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 Retirees & Spouses

MAJOR MEDICAL continued

Durable medical equipment & supplies such as:

Breast prosthesis	1 per lifetime
Surgical brassieres	Covered
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	$500 every 24 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 Retirees & Spouses

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 Retirees & Spouses

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 Retirees & Spouses

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 Retirees & Spouses

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 Retirees & Spouses

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

DENTAL CARE
For Eligible Retirees & Spouses

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%
Deductible	NIL
Calendar year maximum	$2,000 per individual
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
Bridge and crown replacement	Once every 5 years
Denture relines/rebases/repairs	Once every 24 months

HOSPITAL CASH For Eligible Retirees Under Age 70 & Spouses	
First 20 days of hospitalization	$225 per day
Next 100 days thereafter	$150 per day
Benefit maximum	$19,500
EMERGENCY TRAVEL MEDICAL For Eligible Retirees Under Age 80 & Spouses	
Lifetime Maximum under age 75	$5,000,000
Lifetime Maximum ages 75 to 80	$1,000,000
Limited to trips of 90 consecutive days.	
CRITICAL ILLNESS For Eligible Retirees Under Age 70	
Principal Sum	$10,000
Covers only specific conditions.	
LIFE INSURANCE For Eligible Retirees	
Basic Life Amount	$10,000
Paid-Up Life Amount	$10,000
VOLUNTARY INSURANCE For Eligible Retirees & Spouses	
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

For the purpose of this Retiree Booklet, **Member or Retired Member** means a Member over the age of 55 who has retired from the Insulators Local 95 and meets the Eligibility Requirements as set out below.

MEMBER ELIGIBILITY

To qualify for coverage:

- You and your Eligible Dependent must be insured under a provincial health insurance plan;
- You must have participated in the Insulators Local 95 Benefit Fund in each of the preceding 5 years;
- You must have been covered under the plan as an Active Member immediately prior to electing Retiree coverage;
- You must apply for coverage within 31 days from the end of Self-Paying or Fund Assistance, exhausting your Hour Bank, stopping work, or electing your pension;
- You must elect your pension;
- You must elect the full benefit package;
- **You may not be actively employed elsewhere**; and
- You must be in good standing with the Union.

Upon your retirement under the Trust Fund, your coverage continues for so long as your account contains the required monthly Member contributions but not beyond any limiting age as set out in the Description of Benefits of this booklet or the date the Group Master Policy is cancelled or terminated.

Upon your death, some benefits may be extended to your Spouse. Please refer to the specific benefit description sections under the Description of Benefits in this booklet.

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, etc.) to ensure that proper coverage for you and your Eligible Dependent is maintained, including a change in beneficiary if applicable.

DEPENDENT SPOUSE ELIGIBILITY

Your Dependent becomes eligible for coverage when you become eligible or, if acquired later, upon becoming your Dependent. To qualify for coverage your Eligible Spouse must be insured under a Provincial Health Plan. Your Spouse 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 Dependent to be covered.

Coverage or any increase in coverage, for your Eligible Spouse 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.

Dependent means a Spouse.

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.

MAINTAINING COVERAGE

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

TERMINATION OF COVERAGE

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

- The first day of any month in which you have less than one monthly contribution in your account, 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 die, some benefits may be extended to you or your Spouse. Please refer to the specific benefit description sections under the Description of Benefits in this booklet.

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

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.

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.

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 Retirees and their Eligible Spouse.

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 Retirees 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 Retirees 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 Retirees over age 65, the first $100 of eligible prescription drug expenses in the program year will be covered by the plan, satisfying the Retiree'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 Retiree'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-o 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, 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;
- 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 Retirees of a group (whether on an insured basis or not), or prepaid health care coverage.

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.

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 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,
- the date which is two years from the date of your death,
- the date your Spouse remarries, or
- the date your Spouse becomes 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 Spouse's 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 or spouse), 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 Retired 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 Retirees) 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 Retirees and their Eligible Spouse.

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, and
- Visual training by an ophthalmologist or optometrist, and
- Laser eye surgery. Retirees 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

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 Spouse's 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 or spouse), 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 Retirees and their Eligible Spouse.

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 Retirees and their Eligible Spouse.

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 Retirees and their Eligible Spouse.

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, Eligible Retirees and 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 Retirees and their Eligible Spouse.

One of the biggest issues today facing Retirees 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 Retirees 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 Retirees 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 Retirees' own home for up to 12 weeks. Retirees 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 Retirees 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 Retirees 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 Retirees and their Eligible Spouse.

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 Retirees 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**

DENTAL CARE

The Dental Benefits described in this section apply to Eligible Retired Members and their Eligible Spouses. 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;
- 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.

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:

- orthodontic treatment;
- 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), or prepaid dental care coverage.

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.

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 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,
- the date which is two years from the date of your death,
- the date your Spouse remarries, or

- the date your Spouse becomes 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

Every time you have a dental service performed, present your Benefit Card to the dentist who will electronically submit a claim on your or your eligible Spouse's behalf. Immediately, your claim will be processed and you will be notified of which expenses are reimbursable.

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 or spouse), 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.

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.

HOSPITAL CASH

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

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 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 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 Retired Members under age 80 and their Eligible Spouses.

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 is insured for the same coverage as the Eligible Retired 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 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, 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.

CRITICAL ILLNESS

The benefits described in this section apply to Eligible Retired 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.

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.

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.

VOLUNTARY INSURANCE

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

Voluntary insurance is coverage that Retirees 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 Retirees 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
- Life Insurance

Provided directly by the Trust Fund

- Vision Care
- Dental Care
- Retiree Life Benefit Certificate

AIG Insurance Company of Canada

- 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