

WELFARE PLAN

For Active Members

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WELFARE PLAN FOR ACTIVE MEMBERS

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SUMMARY OF WELFARE PLAN BENEFITS FOR ELIGIBLE ACTIVE MEMBERS

ELIGIBILITY: You will be covered by the Plan provided:

- a) you are a Member in good standing of a Participating Local Union;
- b) you have met initial eligibility or have reinstated your eligibility or you are self-paying for coverage;
- c) you have completed and submitted a Member Information Card; and
- d) your coverage has not terminated.

BENEFITS FOR ELIGIBLE ACTIVE MEMBERS INSURANCE

Life Insurance	\$100,000
Accidental Death And Dismemberment Benefit	\$100,000
Weekly Income Benefit (Integrated with E.I.)	66 2/3% of weekly earnings subject to a Weekly Maximum of \$468
Long Term Disability Benefit	Flat \$2,000 – Subject to All Source Maximum of 70% Gross Earnings

BENEFITS FOR ELIGIBLE DEPENDENTS

Life Insurance on Spouse	\$15,000
Life Insurance on Eligible Dependent Children After 24 hours old	\$ 7,500

MAJOR MEDICAL BENEFITS FOR ELIGIBLE ACTIVE MEMBERS AND THEIR DEPENDENTS

Major Medical coverage with \$500,000 Lifetime Maximum integrated with provincial health care benefits. All of the following services must be medically necessary and used to treat or correct a diagnosed physical impairment, injury or illness:

- Prescription Drugs
 - Ingredient Cost:
 - 100% for Level 1
 - 90% for Level 2
 - 80% for Level 3

For drugs listed in the Ontario Drug Benefit Formulary and Limited Use drugs the ingredient cost will be limited to the current formulary price plus a 15% mark-up. For all other drugs the ingredient cost will be limited to the pricing followed by the major drug wholesaler in the province of Ontario, plus a 15% mark-up.

- Dispensing Fee:
A maximum eligible expense of \$8.00 per prescription. Maintenance drugs are limited to one dispensing fee for each 90-day supply. Drug compounds, solutions, creams and mixtures will be reimbursed up to \$30 for the professional fee. A drug compound is a special medication made up of a mixture of drugs.

- Other Covered Medical Expenses - refer to Major Medical Benefits under DESCRIPTION OF BENEFITS in this section
- Vision Care and Eye Exam Expenses - refer to Major Medical Benefits under DESCRIPTION OF BENEFITS in this section
- Emergency Out of Province Medical Coverage - 100% for emergency medical fees and charges over and above provincial health care benefits with a \$5,000,000 lifetime maximum for insured individuals up to the age 70 and a \$100,000 lifetime maximum for insured individuals age 70 to 74 inclusive

DENTAL BENEFITS FOR ELIGIBLE ACTIVE MEMBERS AND THEIR DEPENDENTS

- Electronic Filing of Dental Claims is available
- Deductible \$10.00 single/\$20.00 family per calendar year
- 100% of covered Basic Services and 90% of covered Major Services (after deductible satisfied) up to the maximums in the 2010 Ontario Dental Association Fee Guide
- Combined Basic and Major Services Calendar Year Maximum per person:

1st Year.....	\$1,000
2nd Year.....	\$1,500
3rd Year.....	\$2,000
4th Year.....	\$2,500
5th & Subsequent Years.....	\$3,000
- Orthodontic Expenses for dependent children:
 - 70% to a Lifetime Maximum per child of.....\$4,000

HOW TO FILE CLAIMS

Please note: You may choose to use direct deposit for the payment of your claims – refer to page III for more information

ALL CLAIMS should clearly indicate the following:

1. Name of Plan – Millwright Benefit Plan Trust Fund.
2. The Group Policy Number is 918163, the Group Policy Number for AD&D is BSC 9018858 and the Policy Number for Emergency Out of Province Medical Coverage is SRG 9026480.
3. Member's Name, Address, Local, and Certificate Number/Union Number.
4. If the claim is for your dependent(s), provide dependent's first name, date of birth and relationship to insured.
5. If your spouse has coverage under another plan, provide the policy number and name of the insurance company.
1. Review the forms to be sure ALL information has been included and remember to sign and date all claim forms.

Note:

Please ensure that your address is correct on all claim forms before submitting them to the Plan Administrator. Address changes will be made from claim forms in certain circumstances.

7. Claims for Major Medical, Dental or Disability benefits, that are not submitted within the deadlines outlined below, will be denied.

Submit all Claims (other than your Pay Direct Drug Card claims) to the Plan Administrator:

**Manion, Wilkins & Associates Ltd.
Claims Department
626 – 21 Four Seasons Place
Etobicoke, ON M9B 0A6
Contact Centre: 416-234-3511 or Toll Free - 1-866-532-8999**

1. Major Medical Benefits – Policy 918163

Claims (other than your Pay Direct Drug Card claims) under this program should be made as soon as you have incurred “eligible” expenses. To make a claim, complete the Major Medical Claim Report form and submit it with proof of all paid expenses (bills and statements) to the Claims Department (address above). Major Medical Benefits will be paid to you upon receipt of proof of claim. It is necessary to keep separate records of your expenses for each claimant because the Lifetime Maximum applies separately to each insured individual.

To Make A Drug Claim

Your Benefit Card provides your pharmacist with immediate confirmation of covered drug expenses.

To fill a prescription for covered drug expenses:

- (a) present your Benefit Card to the pharmacist at the time of purchase, and
- (b) pay any portion of each prescription that is not covered under this Plan.

You will be required to pay the full cost of the prescription at the time of purchase if:

- (a) the pharmacy cannot access the pay-direct drug adjudication system,
- (b) you do not have your Benefit Card with you at that time, or
- (c) the prescription is not payable through the pay-direct drug adjudication system.

In these cases, send your drug receipts with a completed Major Medical Claim Report form directly to the Claims Department (address above) for consideration within the rules of the policy.

2. **Dental Benefits – Policy 918163**

Option 1 – Electronic Filing

Electronic Filing of Dental Claims allows your Dental Office to submit dental claims for you and your family electronically to the Plan Administrator for payment. This eliminates the need for mailing dental claims and speeds up reimbursement of eligible expenses.

Tell your Dentist that your Plan accepts claims electronically. If your Dentist has access to this service, show your Dentist your Benefit Card which notes the policy number needed to verify that the Plan Administrator does accept electronic filing of dental claims.

Option 2 – Paper Filing

Otherwise, when you know that you or your dependents are going to visit the dentist while insured under this Plan you can obtain a Dental Claim Form from either your Union Office or the Plan Administrator. Otherwise the standard dental claim forms available from your dentist are accepted.

Please have the Dentist's Office complete the Claim Form. The completed form should then be submitted to the Plan Administrator. Benefits for treatment rendered will be paid to you upon receipt of proof of claim or to your dentist, if you completed the assignment portion on the Claim Form.

Note:

Major Medical and Dental Claims must be submitted within 12 months of the date the expenses were incurred.

3. **Coordination With Other Benefit Plans (Applicable To Major Medical And Dental Benefits Only)**

When your spouse has medical or dental insurance for himself/herself, you and/or your dependent children, the details must be provided to your Plan and the Plan Administrator. The Coordination of Benefits provision (COB) ensures that you and your family receive maximum reimbursement of medical and dental expenses you incur. **You must provide the details in the Coordination of Benefits section of the Welfare Plan Member Information Card and file it with the Plan Administrator.** In addition, there is a section on your claim forms that must be completed in full with the details of your spouse's benefit plan. Failure to provide coordination of benefits information will result in claims payment delays for your spouse and/or dependents.

When you and your spouse both have benefit coverage for yourselves and your dependent children, claims for coordinated benefits (health and/or dental) are to be submitted for payment as follows:

Your claims go to your Plan first. Anything not covered by your Plan is then to be submitted to your spouse's plan. Within the rules of your spouse's plan, it will pay up to 100% of the amount not covered by your Plan.

Your spouse's claims go to her/his plan first. Anything not covered by her/his plan is then to be submitted to your Plan. Within rules of your Plan, we will pay up to 100% of the amount not covered by your spouse's plan.

The expenses for dependent children are also to be coordinated. The parent with the earliest month of birth is to submit claims for dependent children to his/her plan first. Therefore, if you were born in March and your spouse was born in September, your Plan would be the first payor of the claims for your dependent children. If your spouse was born in February and you were born in November, then your spouse's plan would be first payor of the claims for your dependent children.

Your Welfare Plan has been designed to help meet the cost of treating disease or injury. It is not intended, through the coordination process, that you receive benefits greater than the actual medical/dental expenses incurred. Any coverage you or any member of your family has under other "plans" will be taken into account when determining the amount payable under this Plan.

The Trustees are continually striving to provide the best benefit coverage that is available at the most economical cost. One factor that impacts on this goal is this Coordination of Benefits provision that requires you, as a Plan member, to cover those persons who are considered your dependents. Your failure to comply with these COB rules is a serious matter that could result in loss of coverage for you and your dependents.

Further information regarding the rules of coordinating benefit payments can be obtained from the Plan Administrator.

**4. Emergency Out Of Province Medical Coverage
Prior To Age 75 – Policy SRG 9026480**

Minor Expenses

For expenses associated with minor medical emergencies (less than \$250), keep your receipts and file your claims with your government health plan first and then with

**Chartis Insurance Company of Canada
145 Wellington Street West
Toronto, Ontario M5J 1H8**

Major Expenses

For major emergencies that require hospitalization or day surgery, AIAS Assistance Services Inc. will coordinate services between the provider and the Company to insure direct billing of your expenses.

5. Weekly Income Benefit – Policy 918163

For the first seventeen weeks of disability, Sickness Benefits (or weekly income) are provided by Employment Insurance (E.I.). Claim forms may be obtained from the nearest office of Human Resources Development Canada.

If you are advised by E.I. that you do not qualify for benefits or that your benefits have been discontinued because you do not have a sufficient period of employment, notify the Contact Centre and request the appropriate claim forms to claim the Weekly Income Benefits under this Plan. A copy of the fully completed Weekly Income Benefit Claim forms **and** a copy of the letter of E.I. denial or discontinuance must be sent to the Claims Department.

REMEMBER! You must first apply to E.I. for Sickness Benefits. If they are denied, you may qualify for benefits under this Plan.

6. Long Term Disability Benefit – Policy 918163

If you are disabled for longer than seventeen weeks you may be entitled to a monthly payment under the Long Term Disability Benefit. The necessary claim forms are available from the Claims Department of the Plan Administrator.

In order to avoid delays in payment, please ensure that all required information is provided. Submit the completed forms to the Plan Administrator.

You should apply for LTD after thirteen (13) weeks of disability but in no case later than six (6) months from the date you became disabled. It is important that you apply for LTD whether or not you are claiming for WSIB benefits or any other form of disability income. You must also apply for Canada Pension Plan disability benefits.

7. Group Life Insurance - Policy 918163; And Accidental Death And Dismemberment Benefits - BSC 9018858

a) **Death Claims** - The Plan Administrator should be immediately notified of the death of an insured person. The appropriate death claim forms will then be sent to the beneficiary for completion.

b) **Accidental Death and Dismemberment Claims** - The Plan Administrator should be contacted immediately in the event that the insured Member dies or is dismembered as a result of an accident. The claim form will then be provided for completion.

8. De Novo Substance Abuse Program

The objective of the De Novo program is to help individuals regain responsibility for themselves, their family and their job(s). De Novo is available 24 hours a day and 7 days a week. Just pick up the phone and make the call. All calls are strictly confidential and private.

Phone: 705-384-1466 or 1-800-933-6686

Fax: 705-384-1509

DESCRIPTION OF BENEFITS

LIFE INSURANCE

Life Insurance of \$100,000 is payable in the event of your death while you are insured.

This term Life Insurance coverage automatically ceases when you are no longer insured following the expiry of the Conversion Privilege.

Retiree Life Insurance benefits are outlined in detail in the booklet for Retired Members.

Pre-Existing Conditions

No benefits are payable if your death occurs as a result of any total disability commencing within twelve months of your effective date of insurance, if this disability was caused or contributed to by, or was the consequence of, a sickness or injury for which you received medical treatment or services (including prescribed drugs or medicine) at any time within ninety (90) days before the effective date of your insurance.

The above pre-existing conditions clause will not apply provided you worked a minimum of 1,500 hours and twelve months with Contributing Employer(s).

Conversion Privilege When Your Coverage Terminates

If your Group Benefits terminate, you may be eligible to convert your Member Life Insurance coverage to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by the Insurer within 31 days of the termination or reduction of your Member Life Insurance. If you die during this 31-day period, the amount of Member Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Waiver Of Premium Benefit When Totally Disabled

If while insured under this coverage you become totally disabled for at least 9 consecutive months before the date that Unreduced Early Retirement benefits are available under the Millwright Pension Plan, whether or not you qualify for an unreduced pension, the Insurer will waive the payment of life insurance premiums for you.

Totally disabled shall mean you are incapacitated by an injury or disease to the extent that you are not able to perform any work for compensation or profit and is not able to engage in any business or occupation.

In order to qualify for the waiver of premium benefit, you must notify the Insurer within 12 months of the last active day at work and must furnish due proof of disability, satisfactory to the Insurer, within 18 months of that last active working day.

Premiums will be waived starting with the date the required proof is approved by the Insurer. Premiums shall not be waived beyond the earlier of:

- (1) the date that Unreduced Early Retirement benefits are available under the Millwright Pension Plan whether or not you qualify for an Unreduced Pension;
- (2) the date you retire; or
- (3) the date you cease to be totally disabled.

From time to time during the first 2 years that premiums are waived, the Insurer shall have the right to require proof of continuance of your total disability. After 2 years, proof shall be required no more than once a year. You may be required to be examined by a medical examiner designated by the Insurer, at the Insurer's expense.

No benefit shall be provided for you under this benefit if you fail to submit proof of disability when required.

The amount of life insurance for which premiums shall first be waived shall be the amount in force on your date of disability. If the amount of insurance would have reduced at a later date based on the schedule of insurance in force on your date of disability then the amount of insurance for which premiums are being waived will be reduced in a like manner.

If you die while insurance is being continued in accordance with this provision, the amount of insurance that the Insurer will pay will be the amount of insurance for which premiums are being waived at the time of death.

Note: No further benefit shall be provided for you under this provision if:

- (1) you cease to be totally disabled; or
- (2) you fail to submit proof of continuance of disability when required; or
- (3) you fail to be examined by a qualified physician when required; or
- (4) Unreduced Early Retirement benefits are available under the Millwright Pension Plan whether or not you qualify for an Unreduced Pension; or
- (5) you retire.

If you do not return to active work within 31 days after this benefit ceases, you may convert the amount of insurance that was subject to this provision as though insurance had ceased on that date due to termination of employment.

If a benefit is payable under "Conversion Privilege When Your Coverage Terminates," the amount of insurance payable under this provision shall be reduced by the amount of that benefit.

If an individual policy has been issued in accordance with the Conversion Privilege no payment shall be made under this provision if the individual policy is not surrendered, to the Insurer, without payment of claim. If the policy is surrendered, the Insurer will refund any premium paid on the individual policy.

If this policy or waiver of premium provision terminates, the Insurer remains liable to provide waiver of premium benefits for a continuous disability caused by an accident or sickness that occurred prior to termination provided a claim is submitted within 12 months of your last active day at work and due proof of disability, satisfactory to the Insurer, is furnished within 18 months of the last active working day.

However, the Insurer shall not be liable for waiver of premium benefits after termination of the contract or waiver of premium provision if a replacing insurer is bound contractually or as a matter of law.

At the end of any 6 month period during which you are not disabled, the Insurer ceases to be liable for any future waiver of premium benefit, for any disability caused by an accident or sickness that occurred prior to termination.

Beneficiary

You may designate a beneficiary for life insurance. Such a designation must be in writing and entered in the insurance records. If there is no designated beneficiary living at your death, then the Insurer shall pay the benefit to your estate.

Beneficiary Changes

You may only change the beneficiary designation (subject to Provincial law) by doing so in writing. Only when entered in the insurance records shall it be deemed that the Insurer is notified. When recorded, the designation shall relate back to the date of signature, however the Insurer shall not be prejudiced by payments made or actions taken prior to the date of the Insurer's knowledge of a new designation.

Optional Methods Of Settlement

Any amount of insurance proceeds payable for life insurance shall normally be payable in a lump sum. However, you or your personal beneficiary may elect a settlement option which must be agreed to and acknowledged by the Insurer. No settlement options are available to an executor, administrator, trustee, corporation, partnership, or association. The Insurer shall determine the interest rate applicable for settlement options in the year you die.

DEPENDENT LIFE INSURANCE

The Insurer will pay you the amount of life insurance in force on your spouse and dependent children (shown in the Summary of Welfare Plan Benefits) at the date of death provided that the Insurer receives due proof that the dependent died while insured under this coverage. If you are not living, the insurance shall be paid to your estate.

Conversion Privilege For Your Spouse When Coverage Terminates

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your application for the individual policy, along with the first monthly premium, must be received by the Insurer, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for spousal coverage.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Waiver Of Premium

If while insured for this coverage, you become disabled and qualify for the Waiver of Premium Benefit under your insurance coverage, the Insurer will also waive the payment of Dependent Life Insurance premiums for you.

The amount of Dependent Life Insurance for which premiums shall first be waived shall be the amount in force on your date of disability.

Your entitlement to this Waiver of Premium Benefit ceases on the earlier of:

- (1) the date the Waiver of Premium for your Life Insurance ceases; and
- (2) the date the policy or coverage terminates.

TAXATION OF LIFE INSURANCE PREMIUMS

The Income Tax Act (Canada) requires that 100 percent of the premiums paid by the Trust Fund for life insurance and dependent life insurance during a calendar year be included in your annual taxable income. The required tax receipt (T4A) will be issued to you annually by the Plan Administrator.

Note:

Life Insurance premiums are not taxable for months in which you self pay.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

This benefit provides payment for the loss of life, limb or sight, where you sustain, while insured, a bodily injury caused by external, violent and accidental means, provided the loss occurs within 365 days of the date of the accident.

Amount Of Benefit

Such payments are made in addition to any payment under the Life Insurance Benefit. This benefit provides 24 hour coverage. Notice of a claim must be submitted within thirty days of the date the loss occurred. The maximum amount payable is shown in the Summary of Welfare Plan Benefits. The following outlines the amount payable under different circumstances:

Table Of Circumstances	Amount Payable
Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand & One Foot	The Principal Sum
Loss of One Hand & the Entire Sight of One Eye	The Principal Sum
Loss of One Foot & the Entire Sight of One Eye	The Principal Sum
Loss of One Arm	3/4 of The Principal Sum
Loss of One Leg	3/4 of The Principal Sum

Loss of One Hand	2/3 of The Principal Sum
Loss of One Foot	2/3 of The Principal Sum
Loss of Entire Sight of One Eye	2/3 of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	1/3 of The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Speech or Hearing	2/3 of The Principal Sum
Loss of Hearing in One Ear	1/6 of The Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	The Principal Sum
Paraplegia (total paralysis of both lower limbs)	The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	The Principal Sum
Loss of Use of Both Arms or Both Hands	The Principal Sum
Loss of Use of One Hand or One Foot	2/3 of The Principal Sum
Loss of Use of One Arm or One Leg	3/4 of The Principal Sum
Loss of Four Fingers of One Hand	1/3 of the Principal Sum
Loss of All Toes of One Foot	1/8 of the Principal Sum

Definitions Of "Loss"

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means, complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing in both ears.

"Loss" as used with reference to "Loss of Use" means the total and irrevocable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

All claims submitted under this policy for Loss of Use must be verified by agreement between a licensed practising physician appointed by the Policyholder and a licensed practising physician appointed by the Insurer, or in the event that the two physicians so appointed cannot arrive at an agreement, a third licensed practising physician shall be selected by the first two physicians and the majority decision of the three physicians shall be binding on the Policyholder and the Insurer. This procedure may be waived by the Insurer at its sole discretion.

Indemnity provided under this program will not be paid under any circumstances, for more than one of the losses, the greatest, sustained by any one Insured Person as the result of any one accident.

Disappearance

If your body has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that you have suffered loss of life within the meaning of the policy.

Repatriation (Return Home) Benefit

When injuries covered by this policy result in your loss of life outside 200 km. from your permanent city of residence and within 365 days of the date of the accident, the Insurer shall pay the actual expenses incurred for preparing your body for burial and shipment of your body to your city of residence. The amount payable will not exceed \$10,000.

Rehabilitation Benefit

When injuries shall result in a payment being made by the Insurer under this policy, the Insurer shall pay you for the reasonable and necessary expenses you actually incur up to a limit of \$10,000 provided:

- a) such training is required because of such injuries and in order for you to be qualified to engage in an occupation in which you would not have been engaged except for such injuries,
- b) such expenses be incurred within two years from the date of the accident, and
- c) eligible expenses do not include ordinary living, travelling or clothing expenses.

Family Transportation

When injuries covered by the Plan result in you being confined to a hospital, outside 200 km. from your permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Insurer shall pay the actual expenses incurred by your immediate family member for transportation by the most direct route by a licensed common carrier to the hospital in which you are confined. The amount payable will not exceed the amount of \$10,000.

The term “member of the immediate family” means your spouse (or common law spouse), parents, grandparents, children age 18 and over, or your brother or sister.

Seat Belt Rider

Benefits under the Plan shall be increased by 10% if your injury or death results while you are a passenger or driver of a private passenger type automobile and your seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Waiver Of Premium

In the event you become totally and permanently disabled and your waiver of premium claim is accepted and approved under the Millwright’s group life policy, then the premiums payable under the AD & D policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier:

- a) the date Unreduced Early Retirement benefits are available under the Millwright Pension Plan, or earlier if you retire,
- b) the date of your death or recovery, and
- c) the date the Master Policy is terminated.

Conversion Privilege

On the date of termination of coverage or during the 60 day period following termination of your insurance, you may change your A.D.& D. insurance to Chartis Insurance Company of Canada’s individual insurance policy. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the policy ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of the Chartis Insurance Company of Canada. The amount of insurance benefit converted to shall not exceed that amount of A.D.& D. insurance for which you were eligible for prior to termination of benefit coverage.

Exclusions

No benefits are payable for any loss, fatal or non-fatal, caused by or resulting from:

1. suicide or any attempt thereof by you while sane, or self destruction or any attempt thereof by you while insane;
2. injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation;
3. declared or undeclared war or any act thereof; or
4. active full time service in the armed forces of any country.

Note:

The Accidental Death and Dismemberment Benefit is underwritten by Chartis Insurance Company of Canada, Policy Number BSC 9018858.

WEEKLY INCOME BENEFIT

Eligibility

This benefit provides you with a weekly income when you are totally disabled due to a non-occupational injury or disease and do not qualify for disability benefits from Employment Insurance (E.I.).

To qualify for the Weekly Income Benefit (WI), you must satisfy the following:

1. You have not reached the date that Unreduced Early Retirement benefits are available from the Millwright Pension Plan (whether or not you are entitled to an Unreduced Early Retirement pension).
2. Your date of disability occurred within a period of six (6) months from the date you last worked for a Contributing Employer.
3. You, as a totally disabled member, must apply to E.I. for benefits. If you meet the E.I. eligibility requirements, you will receive up to a maximum of fifteen (15) weekly benefit payments from E.I.
4. If you, as a totally disabled member, qualify for disability benefits from E.I. but are not eligible to receive the maximum of fifteen (15) weeks from the E.I. program, you may be eligible for the remaining weekly benefits from this Plan provided you continue to be totally disabled and satisfy all of the eligibility requirements.
5. If you are totally disabled but do not satisfy the E.I. eligibility requirements, you may be eligible for disability benefits from this Plan for a maximum of fifteen (15) weeks.

Note:

You must be under treatment by a duly qualified physician to be eligible. (Refer to Exceptions and Limitations section.)

Waiting Period

- 14 days with benefits payable on the 15th day of disability.

Amount Of Weekly Benefit

- 66 2/3% of your normal weekly earnings to the maximum payable.
- Maximum equal to maximum payable by E. I. (\$468.00).

Benefit Duration

A maximum of 15 weeks of WI benefits are payable. However, this benefit is coordinated with your Pension Plan. Therefore:

- WI benefits are not payable beyond the end of the month that Unreduced Early Retirement benefits are available from the Millwright Pension Plan (whether or not you are entitled to an Unreduced Early Retirement pension);

OR

- Earlier, if you do retire and receive a benefit from the Millwright Pension Plan.

Application

If you are not eligible for disability benefits from E.I. or your disability benefits are terminated by E.I. prior to receiving 15 weeks payments, you must submit proof to the Plan Administrator. E.I. will issue a benefit statement to you which indicates that it is your last payment or that you are not eligible for disability benefits. To apply for WI benefits, you will be required to submit a fully completed WI claim form in addition to your E.I. benefit statement to the Plan Administrator.

Continuous Period Of Disability

If you become disabled from the same or related causes within 2 weeks after you return to active work, it will be considered one continuous period of disability. If you have returned to active work for one full day and become disabled from different and unrelated causes, it will be considered a new period of disability.

Exceptions And Limitations

No benefits are payable for:

1. any portion of a period of your disability when you are not under treatment by a qualified physician;
2. a disability that occurs more than six (6) months from the date you last worked for a Contributing Employer;
3. any disability resulting from intentionally self-inflicted injuries, whether you are sane or insane;
4. any disability resulting from voluntary participation in war, riot or insurrection;
5. any portion of your period of disability during which you are imprisoned in a penal institution, or confined in a hospital, or similar institution, as a result of criminal proceedings;
6. leave of absence;
7. any disability which commences on or after the date a strike begins, subject to any provincial Employment or Labour Standards Act, however, you can fulfill the qualifying period during a strike;
8. any period in which you are in receipt of or eligible for benefits under Employment Insurance or similar program.

Benefit Reductions

The amount of any benefit payable under the WI Program (for any week or portion thereof of total disability) shall be reduced by the amount of any income or benefit payable under any of the following:

1. another plan or program provided to you by or through your Employer or administered by your Employer under which you could have elected not to apply for such benefits. This includes any income benefits paid under Group Life Insurance by reason of permanent and total disability, and
2. any plan or program established of any government, or of any subdivision or agency thereof.

The amount of any lump sum settlement payable to you in lieu of, or as an accumulation of, periodic benefits, shall be apportioned equally from the effective date of such settlement to the date your WI benefits ceased.

Reimbursement (Recovery Of Benefits)

If you received WI benefits under this Plan and you recover monies from a third party (by way of judgement or settlement) for the same disability or as a result of the incident which caused or contributed to your disability, then such recovered monies must be paid to the Insurer up to the total WI benefits received by you. At the Insurer's request, you will be required to execute documents which acknowledge that you understand your obligation to reimburse and to assign monies you recover to the Insurer up to the total amount of WI benefits received for the same period of disability.

LONG TERM DISABILITY BENEFIT

Eligibility

If you are totally disabled for longer than 17 consecutive weeks (119 days) prior to the date that Unreduced Early Retirement pension is available under the Millwright Pension Plan (whether or not you qualify for an unreduced pension), you may be eligible to receive a Long Term Disability benefit, provided:

1. you were at work or available for work on the date your disability commenced;
2. you became disabled within a period of six (6) months from the date you last worked for a Contributing Employer;
3. a premium was paid on your behalf during the month you became totally disabled; and
4. the Insurer received written proof of your disability within the six months following the qualifying period.

Maximum Benefit Period

Benefits cease when you recover or no longer satisfy the definition of "Total Disability."

No benefits are payable for any period of disability unless you are under the continual care of a duly qualified physician.

LTD benefit payments will be paid to you in two monthly installments (15th and 30th of each month) for as long as you remain "Totally Disabled." This benefit is coordinated with your Pension Plan, therefore, in no event will payments be made for any period of disability after the end of the month in which Unreduced Early Retirement pension benefits are available under the Millwright Pension Plan. This rule is applicable whether or not you are eligible for an unreduced pension at that time.

Total Disability – Definition

First 24 months - own occupation

The monthly benefit is payable for up to two years for total disability which prevents you from performing any and every duty of your occupation and provided you are not engaged in any gainful employment.

After first 24 months - any occupation

Thereafter, total and continuous disability must prevent you from engaging in any and every gainful occupation for which you are reasonably fitted by education, training or experience, subject to the restrictions noted previously.

Recurring Disability

If you become disabled from the same or related causes within six (6) months after returning to active work, you will be considered disabled for one continuous period. If you have returned to active work for one full day and become disabled from different and unrelated causes, you will begin a new period of disability.

Reductions (Offsets)

The amount of LTD payable shall be directly reduced by any (periodic or lump sum) income or benefit payable to you under any workers' compensation law or similar law, for the same injury or disease. Also, your monthly LTD benefit is subject to the "All Source Maximum" described later.

The amount of any lump sum settlement payable to you in lieu of, or as an accumulation of, periodic benefits, shall be apportioned equally from the effective date of such settlement to the date your LTD benefits cease.

During a period of rehabilitation, your LTD benefit shall be reduced by 50% of any earnings received from employment under the rehabilitation program so that your total income does not exceed 85% of your gross earnings at the date disability.

Reimbursement (Recovery Of Benefits)

If you received LTD benefits under this Plan and you recover monies from a third party (by way of judgement or settlement) for the same disability or as a result of the incident which caused or contributed to the disability, then such recovered monies must be paid to the Insurer up to the total LTD benefits received by you. You will be required to execute documents which acknowledge that you understand your obligation to reimburse and to assign monies you recover to the Insurer up to the total amount of the LTD benefits you received for the same period of disability.

All Source Maximum

As outlined above, your LTD monthly benefit (gross amount) shall be reduced by any income or benefit payable under any workers' compensation law (WSIB) or similar benefit, if applicable. This reduced monthly benefit may then be further reduced subject to the following:

If your gross monthly LTD benefit plus any income listed below exceeds 70% of your gross pre-disability earnings your LTD benefit will be reduced. The reduction is such that the total income from all sources including those listed below does not exceed 70% of your gross pre-disability earnings.

1. Primary disability benefits from the Canada Pension Plan or Quebec Pension Plan.
2. Reduced early retirement benefits received from the Millwright Pension Plan.
3. Any other plan or program provided to you by or through your Employer or administered by your Employer including any income benefits paid under Group Life Insurance, by reason of permanent and total disability, under which you could have elected not to apply for such benefits.

4. Benefits under any plan or program of any government, or of any subdivision or agency thereof.
5. Benefits under any WSIB or similar law.

Rehabilitation Program

If you, the disabled member, participate in employment under a program of rehabilitation approved by the Insurer, the monthly benefits under this coverage shall be adjusted on the basis of your earnings from that employment, as provided under "Reductions" shown above. Rehabilitation programs include retraining services/programs such as those offered by Human Resources Development Canada. Participation in employment through the Rehabilitation Program will not affect your benefit coverage through the Millwright Trust Fund as long as you are part of the rehabilitation program and meet all the other eligibility rules.

Pre-Existing Conditions

No benefits are payable for a total disability commencing within twelve months of your effective date of insurance if the disability was caused or contributed to by, or is a consequence of, a sickness or injury for which you received medical treatment or services (including prescribed drugs or medicine) at any time within ninety (90) days before your effective date of insurance.

The pre-existing conditions clause will not apply provided you worked a minimum of 1,500 hours and twelve months with contributing employer(s).

Exclusions

Benefits will not be paid for:

1. any portion of your period of disability unless you are under/receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program recommended by your physician;
2. any portion of your period of disability during which you are receiving treatment by a therapist unless the treatment is recommended by a physician deemed appropriate by the Insurer;
3. a disability that occurs more than six (6) months from the date you last worked for a Contributing Employer;
4. any portion of your period of disability resulting from substance abuse, including alcoholism and drug addiction, unless you are participating in a recognized substance withdrawal program;
5. a disability resulting from injury or disease which occurred while you are on active duty in the armed forces of any country, state or international organization or for disability resulting from war or act of war, whether declared or undeclared;
6. a disability resulting from participation in the commission of a criminal offence;
7. any portion of your period of disability during which you are (a) imprisoned in a penal institution, or (b) confined in a hospital, or similar institution, as a result of criminal proceedings;

8. any disability resulting from an accident which occurs while you are operating a motor vehicle and your blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%);
9. any disability resulting from intentionally self-inflicted injury or disease or attempted self-destruction, whether you are sane or insane;
10. leave of absence; or
11. any disability which commences on or after the date a strike begins, subject to any provincial Employment or Labour Standards Act, however, you can fulfill the qualifying disability period during a strike.

Canadian Residency Requirement

No benefits are payable if you reside outside Canada for any period exceeding 90 consecutive days or a total of 180 days in any 365 day period, unless:

1. you have previously notified and received approval in writing from the Insurer; and
2. you remain under the regular care of a licensed physician deemed appropriate by the Insurer; and
3. proof of ongoing disability can be determined on evidence satisfactory to the Insurer in English or French within 30 days of request.

DE NOVO SUBSTANCE ABUSE PROGRAM

De Novo is a joint Union/Management program that offers help to people in the Unionized Construction Industry. De Novo helps workers and their immediate families who have problems that are affecting their work performance and emotional stability. Alcohol and/or drug dependencies are common problems. Physical or mental illness may be involved.

De Novo can help the family system regain strength. Substance abuse almost always plays a major role in the downturn of personal health and welfare. It affects all who are involved with it, either directly or indirectly.

De Novo Philosophy:

A promise of Trust and Confidentiality. A person's privacy will never be at risk. The care of the affected individual or family member is (De Novo's) primary purpose.

How Does De Novo Operate?

De Novo tailors the treatment and recovery process to the needs of each individual. De Novo offers pre-treatment, post-treatment and counselling programs (on a one-to-one basis or on a couple and family therapy basis). De Novo also provides education and awareness programs. De Novo will help direct members and their families to self-help support groups that can help with a solution to a problem that at one point seemed hopeless.

De Novo is available 24 hours a day and 7 days a week. Just pick up the phone and make the call. They will help to put members on the road to recovery and a happier and healthier lifestyle.

How Does De Novo Work?

De Novo is a substance abuse program. They will assist members through interview/assessment, treatment and after-care.

What About A Member's Job If He/She Agrees To The De Novo Process?

Substance abuse is a recognized illness. Most employers with the assistance of the union will cooperate with you in your recovery and return to work.

Does De Novo Charge For Their Services?

There are NO charges for the De Novo services to the individual.

What About Disability Benefits?

For eligibility, please call your Benefit Administrator at the numbers below.

All questions can be answered, please call:

705-384-1466 or 1-800-933-6686 ● Fax Number: 705-384-1509

MAJOR MEDICAL BENEFITS

Active Members And Eligible Dependents

You are eligible for the following major medical coverage (within the policy provisions) during the months that you are in benefit. If you are eligible for the benefits when your dependents incur expenses their expenses will also be paid by the Plan subject to the policy provisions.

Maximum Benefit

The Maximum Aggregate Benefit for all Eligible Expenses combined is \$500,000 in the lifetime of each insured family member.

Reinstatement Of Maximum Benefit Allowance

On January 1st of each year each insured family member, who has received benefits during prior years, will have up to \$1,000 of his or her Maximum Benefit Allowance restored. No evidence of good health is required for this automatic restoration, but it is not available after your insurance has terminated. For example, if you receive \$1,700 in benefit payments in a calendar year, your Maximum Benefit Allowance will automatically be restored by \$1,000 on the following January 1st and by the remaining \$700 one year later, at which time your maximum would be fully restored. This example assumes that no further benefits have become payable in the meantime.

Eligible Expenses

Eligible Expenses included under the Plan are the charges which the Plan will honour for the following services and supplies received, while you are insured, for the treatment of a diagnosed non-occupational physical impairment, injury or illness.

Note:

Any Member or his/her eligible dependents who are living outside Canada because the Member is employed with a Contributing Employer will qualify for the same benefit coverage as he or she would while the Member is employed in Canada.

1. Prescription Drug Expenses

- Reasonable and customary charges incurred for medically necessary drugs and medicines specified below.
- Such drugs must be obtainable only by prescription from a person entitled by law to prescribe them and dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines, and prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of an illness or injury.

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

Eligible Drug Expenses:

a) Level 1 - Payable at 100% of the Ingredient Cost

Includes:

- All generic drugs and life sustaining medications
- Diabetic supplies such as needles, syringes, test strips, lancets and solutions
- Recognized life supportive pharmaceuticals including epipens and nitroglycerine
- Co-insurance charges by the provincial health plan for insured individuals age 65 and older

b) Level 2 - Payable at 90% of the Ingredient Cost

Includes:

- All brand name drugs which are covered by Ontario Drug Benefit Plan (ODB) under the ODB Formulary or Limited Use Drugs
- Inoculations/immunizations which are medically necessary or required for work

c) Level 3 - Payable at 80% of the Ingredient Cost

Includes:

- All other brand name prescription drugs that are not covered by the Ontario Drug Benefit Plan (ODB)
- Erectile dysfunction drugs are covered to a maximum benefit of \$500 per calendar year per person

Prescription Drug Exclusions

- Over the counter medications or drugs for which a prescription is not required by law (federal or provincial)
- Fertility drugs
- Smoking cessation products
- Vitamins (injectable or oral) unless they legally require a prescription
- Alcohol swabs
- Medications which are provided and administered by a physician or other health care practitioner entitled by law to prescribe them (unless they legally require a prescription)

- Drugs which are not considered medically necessary, e.g. cosmetic or weight loss/lifestyle, unless they are approved under the Prescription Drug Plan – Prior Authorization Procedure (see below)
- Sustained Release (SR) medications
- Drugs, biologicals and related preparations which are intended to be administered in Hospital on an in-patient or out-patient basis and are not intended for an insured's use at home
- Antihistamines
- Varicose vein injections

Prescription Drug Plan – Prior Authorization Procedure

Your drug plan covers prescription drugs which are medically necessary and required in the treatment of an illness or an injury. There are also other new or expensive drugs that may have the potential for misuse. Some of these drugs may have already been covered by the Plan and some may have been previously denied. Under the Prior Authorization Procedure, these drugs will be approved for payment only if your health care practitioner completes the required documentation and it meets the clinical criteria established by ESI Canada Inc.

How Prior Authorization (PA) Works

When you go to the pharmacist to get a prescription filled for one of the drugs under the PA program, your pharmacist will advise you that the drug is on the PA list and will supply you with a PA form for that drug. (You can pay for your medication at this time if you wish, or wait until the PA process is complete.) There is a section that you must complete. You must then take the form to your health care practitioner to complete. Your health care practitioner will send the completed form to ESI Canada Inc. for evaluation. You are responsible for any fee your health care practitioner may charge for the completion of this form. **Note: You will need to complete and submit another authorization request form if you continue to use the PA drug beyond 12 months.**

- If your PA drug is approved, ESI Canada Inc. will notify you and your pharmacist that it is approved. You can then have your prescription filled and your claim will be processed electronically.
- If your PA drug is denied, ESI Canada Inc. will notify you and your pharmacist that the drug has been denied. You can then have your prescription filled at your own expense.

Maintenance Drugs

Your Plan covers one dispensing fee every 90 days for maintenance medications.

Many medications prescribed by a person entitled by law to prescribe them are maintenance medications. These are drugs which you or your eligible dependent have been taking for at least six months and which you or your dependent are required to take for a long period of time for a particular condition. Some examples of maintenance medications include blood pressure medication, birth control pills, heart medication, and thyroid pills.

Maintenance drugs can be identified by the Plan Administrator at the time your claim is processed. The first time a claim is received for a maintenance

medication that is not dispensed in a 90 day supply, you will be paid. You will be advised at that time that the Plan will only pay one dispensing fee of \$8.00 for each 90-day supply of your maintenance medication. You should request a 90-day supply of your maintenance medication(s).

Generic Substitution

Many brand name drugs on the market have a generic equivalent. In Canada, a generic drug has the same active ingredients as the brand name version.

It is recommended that you ask your health care practitioner to prescribe a less expensive generic equivalent drug if there is one. It does not mean your health care will be negatively impacted because in Canada the generic drug has the same active chemical ingredients as a brand name drug. Generic substitution is the substitution of a less expensive drug for the originally prescribed brand name drug. This can be done by the pharmacist without the consent of your health care practitioner and is the normal practice of many pharmacists for a limited number of drugs.

Note: If, for medical reason(s), your health practitioner insists you receive a certain brand name medication, the words “no substitution” should be included on the prescription. You will be reimbursed based on the cost of the brand name drug only after you submit proof to the Plan Administrator and Insurer that your health care practitioner has specified “no substitution.”

Important Note: If You (Or Your Spouse) Are Age 65 And Older

In many provinces, residents age 65 and older are automatically covered under the provincial drug benefit plan. The provincial drug plan is “first-payor” for such individuals. If you (or your spouse) are age 65 and older, please make sure your pharmacist processes your claim through the provincial plan.

The Ontario Drug Benefit Plan (ODB) requires all participants, including seniors age 65 and older, to share in the cost of the ODB Plan. The amount to be paid by seniors is dependent on their annual income. Within the terms of this Plan, eligible members/dependents will be reimbursed for expenses incurred as a result of these changes to the ODB plan provisions.

Note: Any medications which are not covered by the ODB plan may be submitted to this Plan for consideration.

Pharmacy Listing

You have the choice of purchasing your drugs anywhere you like. However, in order to assist you in choosing a lower cost pharmacy a list of pharmacies and their current dispensing fees is available. Simply click on www.manionwilkins.com, then click on Claims and then click on Managed Health Care, choose your province, then your city and you will find the names and addresses of the pharmacies in your city indicating the maximum, minimum and average level of their dispensing fees charged. This list is updated on a quarterly basis. This information is also available by contacting the Plan Administrator's Contact Centre at 416-234-3511 or 1-866-532-8999.

What Do I Need To Do? (New Members)

- File Required Enrolment Forms**
You must have completed and filed the required enrolment and Coordination of Benefits forms with the Plan Administrator for you and/or your family to be eligible for prescription drug coverage.
- Advise your Health Care Practitioner**
Tell your health care practitioner you have a Managed Prescription Drug Plan. Show him/her the medical section of this booklet so he/she will see what is covered under the plan.
- Advise your Pharmacist**
Tell your pharmacist that you have a Managed Prescription Drug Plan. Show him/her the medical section of this booklet so he/she will see what is covered under the plan.
- Benefit Cards**
You will also be given a Benefit Card. An extra card is provided for your spouse if applicable. This card should be presented to your pharmacist at the time of purchase.

Note:

It is important that you discuss the type of medication prescribed with your health care practitioner and your pharmacist before you purchase it to make sure you are receiving your medication at the best possible price.

2. Other Covered Medical Expenses:

- Charges for the medical services (excluding custodial care, psychological or personal counselling) provided by a Registered Nurse (R.N.), 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.) which are rendered while the insured is not confined to a hospital subject to an overall maximum benefit of \$10,000 in any calendar year provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and if medically necessary. For the purpose of this policy, custodial care is defined as assistance with daily living or tasks which a layperson could perform.
- Anaesthetics provided they are used in connection with a medically necessary situation.
- Oxygen and its administration.
- Rental (or at the Insurer's option, purchase) of an oxygen tent, hospital bed, wheel chair and similar durable medical equipment designed primarily for use in a hospital for therapeutic purposes.
- Blood or blood plasma and the administration thereof.
- Charges for an infusion pump for insulin and glucometers.
- Charges for Apnea monitors.
- Blood pressure or blood sugar monitors up to a maximum of \$200 each every 3 calendar years.

- Braces, crutches and prostheses when necessitated by accidental bodily injury or disease and charges for replacement when required due to pathological changes, but not including charges for repair or maintenance.
- X-ray examinations and laboratory tests including PSA tests.
- Local ambulance service other than by airline or railroad.
- Emergency transportation by airline or railroad to the nearest hospital qualified to provide the necessary treatment, subject to a maximum expense of \$200 in any period of 12 consecutive months.
- Hospital services and supplies furnished by a licensed hospital during confinement which are not covered by any Government hospital plan. **This does not include semi-private or private hospital accommodation.**
- Charges made for treatment by a licensed and registered paramedical including chiropractor, osteopath, naturopath, acupuncturist, registered massage therapist, speech therapist, clinical psychologist, occupational therapist, podiatrist, or physiotherapist subject to an overall maximum of \$2,500 per calendar year, per person.
- Charges for anti-embolism stockings subject to a maximum of \$400 in any period of 12 months. To be eligible elastic support stockings must be recommended by a licensed doctor (M.D.) or podiatrist, provided they have a compression value of at least 20 to 30 mmHg pressure and are required to treat a diagnosed medical condition as determined by the Insurer's guidelines.
- Chronic or Convalescent Care Facility services or supplies in excess of the expenses covered under the OHIP subject to a maximum of \$30 per day for not more than a total of 100 days. Such confinement must commence by means of a direct transfer from a hospital in which you or your dependent were confined for at least three consecutive days and be for the continued care of the same condition which resulted in that hospital confinement.
- Orthopaedic shoes, orthopaedic work boots, and orthotics **recommended** by a physician, podiatrist or chiropodist which have been specially designed and molded for the insured individual and dispensed by a certified podiatrist, chiropodist, pedorthist or orthotist and are required to correct a diagnosed physical impairment to a maximum of \$200 per shoe to a total of \$400 in any calendar year. The claim must include the written **recommendation** from a physician, podiatrist or chiropodist including the diagnosis, symptoms and chief complaints.

Note:

No orthopaedic or orthotic benefits will be paid if they are prescribed or dispensed by a practitioner other than those listed above.

- Hearing aids subject to a maximum of \$500 per person, per ear, in any period of 36 consecutive months, however, this limitation shall not apply in the event of an accidental injury to the ear. Also, \$75 per year is available for the purchase of batteries. Repairs to hearing aids will also qualify as an eligible expense to a maximum of \$200 per year.

- Charges for dental procedures required for medical reasons or procedures not normally covered as an eligible expense under the Dental benefit.
- Charges for dental procedures when necessitated by damage to sound natural teeth or surrounding tissues as a result of an injury which occurs while the Member or eligible dependent is insured under this Plan, subject to a maximum of \$5,000 per calendar year per person.

Note:

To avoid misinterpretation of what is eligible and what may or may not qualify as a covered expense, it is recommended that you submit an estimate to the Plan Administrator for authorization prior to the purchase of any medical equipment, orthopaedic shoes, orthotics, or other medical services.

Assistive Devices Program

Many of the Major Medical expenses covered under this Plan are also covered by the "Assistive Devices Program" (ADP).

In some cases ADP pays 75% of the cost of items like orthopaedic braces, wheelchairs, and breathing aids. In other cases, such as artificial limbs and breast prostheses, ADP contributes a fixed amount up to a maximum contribution. For some kinds of supplies, such as ostomy and needles and syringes for insulin-dependent seniors, ADP pays an annual grant directly to the person. If you are receiving social assistance benefits under Ontario Works (OW), Ontario Disability Support Program (ODSP) or Assistance to Children with Severe Disabilities (ACSD), you may be eligible to receive more money.

For more information call ADP at (416) 327-8804 or 1-800-268-6021 or visit health.gov.on.ca.

Any claims incurred for these types of expenses must be sent to ADP by your physician and the supplier for consideration prior to purchase. The balance of ADP claims is then sent to the Plan Administrator for consideration.

3. Vision Care Expenses

Vision Care Expenses as specified below; however, the limitations shall not apply in the event of an accidental injury to the natural eye.

- a) Regular prescription lenses and frames for eyeglasses, contact lenses or the cost of laser eye surgery are payable to a maximum of \$400 in any period of two (2) calendar years.
- b) A separate vision care benefit is in effect for eligible dependents under 18 years of age. The benefit is \$200 every calendar year for lenses and frames for eyeglasses, contact lenses or laser eye surgery.

Note:

The time limitations shall be waived for vision care benefits when a new prescription is required as a result of eye surgery, or a medical condition directly affecting vision.

- c) Eye examinations by an ophthalmologist or optometrist up to a maximum of \$80 in any period of two (2) calendar years for covered individuals who are at least age 20, but under the age of 65.
- d) Prescription safety glasses including the hardex treatment will be eligible for payment only for active Members in addition to a) above, up to a maximum of \$300 per calendar year.
- e) Up to \$400 in any period of two (2) calendar years, for contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, providing visual acuity can be improved to at least the 20/40 level by contact lenses, but cannot be improved to that level by spectacle lenses.
- f) Up to a lifetime maximum of \$300 per eye for foldable lens implants and up to a lifetime maximum of \$150 per eye for Intra-Ocular Lens (IOL) eye measurement, for covered individuals who provide medical certification and proof of cataract surgery.

Ineligible Expenses

The following items are not considered as Eligible Expenses:

1. Charges which are considered an insured services under any provincial government plan.
2. Charges which are considered an insured service of any provincial government plan at the time this policy/benefit was issued and subsequently were modified, suspended or discontinued.
3. Charges for general health examinations, and examinations required for use of a third party.
4. Charges for eye examinations, except where included as an eligible expense.
5. Charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment.
6. Charges for medical treatment or surgical procedure by a physician, or other health care practitioner entitled to perform medical treatments or procedures by law.
7. Charges for transport or travel, other than as specifically provided under this benefit.
8. Charges not specified in the foregoing list of Eligible Expenses.
9. Charges for services or supplies which are furnished without the recommendation and approval of a physician, or legally recognized health care practitioner, acting within the scope of his or her license.
10. Charges which are not medically necessary to the care and treatment of an existing or suspected injury, illness, disease or pregnancy.
11. Charges which are from an occupational injury, illness or disease covered by any Workplace Safety and Insurance Board or similar legislation.
12. Charges which would not normally have been incurred but for the presence of this insurance or for which the member or dependent is not legally obligated to pay.
13. Charges which the Insurer is not permitted, by any law or regulation, to cover.

14. Charges for dental work where a third party is responsible for payment of such charges.
15. Charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind.
16. Charges for services or supplies resulting from any intentionally self-inflicted wound.
17. Charges for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare – Canada or are experimental or limited in use whether or not so approved.
18. Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society.
19. Charges made by a physician or legally recognized health care practitioner for travel, broken appointments, communication costs, filling in of forms, or physician's or legally recognized health care practitioner's supplies.
20. Drugs where any portion of the cost is incurred under a provincial plan, with the exception of coverage of the coinsurance charges by the provincial health plan for individuals age 65 or older.
21. Charges not listed as an eligible expense in the Summary of Welfare Plan Benefits.

EMERGENCY OUT OF PROVINCE MEDICAL COVERAGE – Prior To Age 75

Emergency Out of Province Medical Coverage is provided by the Chartis Insurance Company of Canada under policy number SRG 9026480 **for Members under age 75**. A brief description of the benefits follows. **Make sure you have a separate benefit pamphlet and identification card which will explain the coverage in further detail.**

HOW IT WORKS

You and your eligible dependents are automatically covered under this Plan, whether you are on vacation or travelling on business.

HERE'S WHAT YOU GET

Broad Emergency Out of Province Medical Coverage - Your Plan provides extensive coverage for medical emergencies outside the province in which you and your eligible dependents reside, anywhere in the world.

Guaranteed Acceptance – As long as an Insured Person's health is stable, coverage is provided regardless of his or her health history.

PERIOD OF COVERAGE

Every Insured Person is covered under this Plan while travelling outside of his or her province of residence, for a period not to exceed 45 days.

EMERGENCY COVERAGE FOR HOSPITAL, MEDICAL AND THERAPEUTIC SERVICES

If an Insured Person suffers a Sickness or Injury that results in an Emergency stay in a Hospital or Emergency medical or therapeutic services as specifically listed herein, the Company will pay benefits, for the period this

contract is in force, not to exceed the lifetime maximums shown in the Summary of Welfare Plan Benefits for the actual expenses an Insured Person incurs outside of his or her province of residence that exceeds the amount which is payable with respect to such expenses under any Health Plan or medical plan in Canada, or if the Insured Person is not covered under any such plan, to the extent that the actual expenses exceed any amount which would be payable with respect to such expenses under the Health Plan or medical care plan if the Insured Person was covered under any such plan.

EMERGENCY HOSPITAL CONFINEMENT

If an Insured Person suffers a Sickness or Injury which results in an Emergency confinement as a resident in-patient in a Hospital, including semi-private accommodation, for reasonable and customary charges made by the Hospital for services and supplies to the extent that such are medically necessary, the Company will pay benefits hereunder, subject to all limitations and conditions of the Plan.

In the event that an Insured Person is confined to a Hospital at the end of a trip outside of his or her province of residence and thus prevented from returning to his or her 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.

EXCLUSIONS AND LIMITATIONS

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- (a) 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;
- (b) pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of an unexpected pregnancy complication occurring before the end of the seventh month;
- (c) Sickness or Injury where the trip is undertaken for the purpose of securing medical treatment or advice for such Sickness or Injury;
- (d) dental surgery or cosmetic surgery unless such surgery is a result of a covered Injury;
- (e) any Sickness or Injury if at the time of the Sickness or Injury, the Insured Person is under the influence of drugs, alcohol (blood level in excess of 80 mg of alcohol per 100 ml of blood) or other intoxicant (unless administered on, and in strict accordance with the advice of a legally qualified Physician);
- (f) emotional or mental disorders unless the Insured Person is confined to a Hospital;
- (g) Sickness or Injury due to participation in professional sports;
- (h) treatment or services that contravene any GHIP plan in Canada;
- (i) expenses incurred on an elective (non-emergency) basis;
- (j) suicide or any attempt at suicide while sane or insane;
- (k) intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury, while sane or insane;

- (l) 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;
- (m) any services or supplies provided by an Insured Person or one of the Insured Person's immediate family members;
- (n) 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;
- (o) 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;
- (p) any treatment or surgery which reasonably could be delayed until the Insured Person returns to his or her province of residence;
- (q) anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to the Insured Person prior to departure;
- (r) that portion, if any, of any expenses for treatment, advice or hospitalization which are not reasonable and customary.

EMERGENCY TRAVEL ASSISTANCE

Travel Assistance is provided by AIAS Assistance Services Inc. With centres worldwide that will:

- help you locate the most appropriate medical facility for the Insured Person
- confirm coverage with Chartis Insurance Company of Canada and assure the Hospital that the Insured Person is covered
- guarantee payment for hospitalization, if necessary
- arrange for admission to a Hospital
- provide translation services
- contact the Insured Person's own doctor for recommendations, when required
- contact the Insured Person's family and employer, when required
- arrange for/co-ordinate emergency medical evacuation
- co-ordinate the Insured Person's return home

TERMINATION

Coverage for a Member terminates when the Member turns age 75.

The coverage for a Member's spouse terminates when the Member's coverage terminates, or when the spouse turns age 75, if earlier.

Coverage for Dependent Children terminates when eligibility based on the applicable criteria is no longer valid.

The information in this booklet is only a brief description of this coverage and, as such, does not create or confer any contractual or other rights. The terms and conditions governing the insurance are set out in the group Master Policy issued by Chartis Insurance Company of Canada. In the event of any variation between the information in this booklet and the provisions of the policy, the latter will prevail.

DENTAL BENEFITS

Active Members And Their Dependents

Should you or your dependents, while insured under this coverage and as a result of a non-occupational injury or a non-occupational dental disease, incur any of the eligible expenses listed in the "List of Covered Items," you will be reimbursed as described in the following sections:

Dental Definitions

For the purposes of this coverage the following terms will have the meaning set forth below:

1. **"Legally qualified dentist"** means a duly licensed practitioner of dentistry acting within the scope of his or her license. If any of the services or supplies which are included in the List of Covered Items are furnished by a physician while practising within the scope of his or her license, the charge for such services or supplies will be considered covered dental expenses unless otherwise excluded.
2. **"Denturist"** means an individual licensed by the respective province under the Denture Therapist Act or similar legislation to provide only service for dentures.
3. **"Orthodontics"** means the prevention or correction of teeth irregularities and malocclusion of the jaws, by wire appliances, braces or other mechanical aids.
4. **"Sound natural teeth"** means natural teeth whether or not restored, but does not mean removable or fixed prosthetics.
5. **"Calendar year"** means the insured Member's calendar year commences January 1 of each year. If a Member is eligible for Welfare benefits June 1st, his/her maximum will be pro-rated for the first year.

Annual Deductible

The first \$10 of the covered expenses for you and each of your dependents is deducted each calendar year before any expenses are paid by the Plan. This is called the "deductible." However, once you and/or each of your dependents have met two "deductibles" or you have \$20 of expenses together, the "deductible" is satisfied and all other covered expenses will be paid that calendar year for you and your dependents.

For example, assume that you have covered expenses of \$350, and your Spouse has covered expenses of \$350, and your two dependent children have some covered expenses. The expenses are being submitted at the tariff allowed under the 2010 ODA. In this case, the Plan will pay the following:

Who Has The Total Expenses?	The Listed Expenses	The Deductible	The Amount This Plan Will Pay
Member	\$350.00	\$10.00	\$340.00
Spouse	\$350.00	\$10.00	\$340.00
1 st Child	\$210.00	--	\$210.00
2 nd Child	\$210.00	--	\$210.00
	\$1,120.00	\$20.00	\$1,100.00

REMEMBER, this “deductible” is subtracted from the covered expenses every calendar year before any of the covered expenses are paid.

Reimbursement

Once the deductible has been satisfied, reimbursement will be made as follows for eligible dental for services rendered on or after January 1, 2011:

- 100% of all covered Basic Services
- 90% of all covered Major Services
- 70% of all covered Orthodontic expenses
- Up to the maximums specified in the 2010 Ontario Dental Association Fee Guide

Combined Basic And Major Services Calendar Year Maximum (per person)

First Calendar Year of Continuous Plan Membership	\$1,000
Second Calendar Year of Continuous Plan Membership	\$1,500
Third Calendar Year of Continuous Plan Membership	\$2,000
Fourth Calendar Year of Continuous Plan Membership	\$2,500
Fifth and all subsequent Calendar Years of Continuous Plan Membership	\$3,000

Note:
If your welfare coverage terminates and you subsequently reinstate your coverage, you will be considered a “New Member,” i.e. you and your dependents will only be entitled to the coverage to the First Calendar Year Maximum.

Orthodontic Lifetime Maximum – Dependent Children Only

Per dependent child for covered orthodontic expenses	\$4,000
	(70% of 5,714)

Limitations On Benefits For Dental Care

Amounts of reimbursement will be based on the **2010 Ontario Dental Association Fee Guide** for General Practitioners. If treatment is rendered outside Canada, payments will be made to the extent that the charges are reasonable and customary but will not, in any case, exceed the maximums specified in the 2010 Ontario Dental Association Fee Guide for General Practitioners.

Pre-Existing Conditions

During the first continuous period of four months that the Member or dependent has been insured under the Plan, payments will be made only in respect of any injury or dental disease for which treatment first began after the Member or dependent became insured. Any treatment for any injury or dental disease will be considered the first treatment provided that the Member or dependent has not received or been advised to receive treatment in respect of the same or related injury or dental disease.

In regards to this four-month period, the Insurer shall have the right to request, at no expense to the Insurer, necessary information concerning the existence of a Pre-existing condition from the attending legally qualified dentist.

Dental Statement Limitations

No payment will be made unless a dental statement, satisfactory to the Insurer and without expense to the Insurer, is submitted.

Alternate Benefits And Submission Of Treatment Plan

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, the Insurer reserves the right to determine eligible expenses on the basis of an alternate benefit.

Pre-Statement Of Liability (What Is Payable?)

Where a proposed course of dental treatment will exceed \$300, a treatment plan should be submitted in advance. The Insurer will advise you of the amount that is payable under this Plan in a "Pre-Statement of Liability" which will remain valid for a period of 90 days.

Covered Dental Expenses

Charges made for any of the services or supplies included in the accompanying "List of Covered Items" shall be considered Covered Dental Expenses:

1. subject to the foregoing paragraph "Limitations on Benefits for Dental Care," and "Combined Basic and Major Services Calendar Year Maximum," and
2. only if such expenses are not included as covered expenses under any other coverage under this or any other group, private or government plan.

List Of Covered Items

The following Covered Items are subject to any "Exclusions" listed on a later page.

BASIC SERVICES

1. **Diagnostics:** Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:
 - a) Oral examinations limited to one in any period of nine (9) consecutive calendar months (equivalent to three (3) examinations within a 27 month period). Note: limited to one in any period of seven (7) consecutive calendar months for individuals under age 18.
 - b) Bitewing X-rays limited to once every nine (9) months. Note: limited to once every seven (7) months for individuals under age 18.

- c) A complete set of X-rays is limited to once during a calendar year. (X-rays which are required to diagnose a specific dental disease or injury, or to determine progress of a specific dental disease or injury shall not be subject to the calendar year limitation.)
 - d) Study casts.
 - e) Consultations.
2. **Preventive Therapy:** Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:
 - a) Scaling/root planing up to eight (8) units (2 hours) per calendar year.
 - b) Polishing (prophylaxis) limited to one treatment per calendar year.
 - c) Topical fluoride applications limited to one such treatment in any period of nine (9) consecutive months. Note: limited to one treatment in any period of seven (7) consecutive months for individuals under age 18.
 - d) Passive space maintainers and mouth guards (those that do not move the teeth) for dependent children only.
 3. **Basic Restorative Dentistry:** The basic procedures used to restore the natural teeth to their normal functions by use of restorations, including prefabricated full coverage for primary teeth and white fillings on molars. In addition, sedative dressings are covered.
 4. **Extractions:** Removal of teeth.
 5. **Anaesthesia:** Anaesthesia where reasonably and customarily required in connection with other covered procedures.
 6. **Endodontics:** Endodontic procedures and root canal therapy.
 7. **Emergency Palliative Treatment:** The lessening of pain without curing or resolving the problem.
 8. **Laboratory Services and Supplies:** Services and supplies furnished in the actual manufacturing of crowns, inlays, onlays or prosthetic devices.
 9. **Periodontics:**
 - a) Adjunctive Services as follows: Acute infections, Occlusal Adjustment, Provisional splinting
 - b) Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery
 - c) Special Periodontal Appliances
 10. **Oral Surgery:** Routine oral surgical procedures such as: surgical removal of impacted teeth, residual roots and associated post operative care.
 11. **Repairs, Relining and Rebasing of Removable Prosthetic Devices:** Repair or relining and rebasing of dentures, including addition of new teeth.

MAJOR SERVICES

1. Removable Prosthetic Devices

- a) The initial installation of partial or full dentures, subject to the pre-existing condition limitations on teeth missing, extracted or fractured prior to the effective date.
- b) Replacement of existing dentures is not covered except if:
 - (i) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan, or
 - (ii) The replacement is more than 12 months after the individual became insured under this coverage, and the existing denture is at least 5 years old and no longer serviceable.

Note: This 5 year replacement rule may be waived if the Insurer is provided with sufficient evidence from the dentist to support an earlier replacement.

- c) Replacement of lost or stolen dentures, the duplication and personalization or characterization of dentures is not covered.

2. Extensive Restorative Dentistry: Those procedures, including inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with amalgam or composite restorations, benefits will be determined based on the usual costs of such a restoration.

3. Fixed Prosthetic Devices:

- a) The initial installation of fixed prosthetic devices subject to the pre-existing condition limitations on teeth missing, extracted or fractured prior to the effective date.
- b) Recementing and replacement of the facing or veneer of the fixed prosthetic device.
- c) The replacement of existing fixed prosthetic devices is not covered except if:
 - (i) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this Plan; or
 - (ii) The replacement is more than 12 months after the individual became insured under this coverage, and the existing fixed prosthetic device is at least 5 years old and no longer serviceable.

ORTHODONTICS – Dependent Children Only

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as “straightening of the teeth.” These include active space retainers, or orthodontic appliances, those for the purpose of repositioning or moving of the teeth. The pre-existing condition clause in this Dental Benefit does not apply to Orthodontic procedures.

Exclusions

The term Covered Dental Expense shall not include any charge:

1. For services or supplies that are primarily for cosmetic dentistry.
2. For services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his or her license.
3. Caused wholly or partly, directly or indirectly by committing, attempting, or provoking an assault or criminal offence or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind.
4. For miscellaneous charges such as counseling, travel, broken appointments, communication costs or filling in of forms.
5. Resulting from any intentionally self-inflicted wound.
6. For services which are covered by any government plan or program, or for which no charge is made, or which the Insurer is not permitted by law to cover.
7. For any hospital charges for room and board and related services and supplies.
8. For dental examinations required by a third party.
9. For services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury or disease.
10. For charges which would not normally have been made but for the presence of this insurance or for which the Member or dependent is not legally obligated to pay.
11. For services or supplies in connection with any procedures excluded as eligible expenses.
12. For implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.
13. For drugs, medicines, radiation therapy and supplies normally intended for consumption in the home.
14. For charges which are from an occupational injury or disease covered by WSIB or similar legislation.
15. For services or supplies for or in connection with a procedure which is not listed as an eligible expense.