

WELCOME

Dear Plan Member,

Within the pages of this booklet, you will find a description of the benefits to which you and your Family are entitled as Members of the Millwrights' Health and Welfare Trust Fund for Alberta. This booklet has been published to give you an up-to-date description of the benefits provided by The Fund as of July 1, 2010. This booklet deals with most of the issues that may affect your participation in The Plan; however, it does not address every aspect of the rules and regulations. These are contained within The Plan Text.

The Plan Text is maintained and interpreted by the governing Board of Trustees. Should a discrepancy or conflict occur between the material in this booklet and The Plan Text, the provisions of The Plan Text will prevail, under the authority of the Trustees. Therefore, it should be understood that the Trustees disclaim any responsibility, whatsoever, for errors, omissions, claims for damages, or costs arising from the use of, or reliance upon, any part of this booklet.

We urge you to read your booklet carefully to familiarize yourself with the benefits that are available to you and your Dependents. If, at any time, you have questions or need assistance filling out the claim forms, please contact your Plan Administrator, PBAS.

Sincerely,

Board of Trustees

Millwrights' Health and Welfare Trust Fund for Alberta

The Millwrights' Health and Welfare Trust Fund for Alberta

Administrator

Prudent Benefits Administration Services Inc.
Suite 101, 2635 – 37 Avenue N.E.
Calgary Alberta T1Y 5Z6
Toll-free: 1.888.525.1460
Ph: 403.769.9866
Email: MW1460@pbas.ca
Fax: 403.250.9236

Auditors

Al Scherbarth Professional Corporation

Consultants

Benchmark Decisions Ltd.

Insurance Underwriters

Desjardins Financial SecurityLTD, CI & Life Insurance
Expert Travel Financial Security IncTravel Insurance
Industrial Alliance Pacific..... Accidental Death & Dismemberment

Legal

Syveny Scott Lawyers

Trustees - Union

Gord Evers – Chair
Bob Hugh
Ted Remenda

Trustees - Participating Employer

Pat Herson – Co-Chair
Mike Yorke
Ursula Buller

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PLAN SUMMARY / BENEFIT SCHEDULE

EXTENDED HEALTH BENEFITS APPLY TO ALL MEMBERS UNLESS SPECIFIED

Benefit	Amount	Maximum	Information
Ambulance	100%	Unlimited	Transport from injury site to nearest Hospital or between Hospitals
Breast Prosthesis Replacement	100%	two/two calendar years	Required as a result of a mastectomy
Hearing Aids	100%	\$1000/per ear/ four consecutive calendar years	As prescribed by an Otolaryngologist
Hospital	100%	Unlimited	Plan pays difference in cost between ward and private room in Hospital. Room charges for outpatients are not covered.
Medical services/ equipment	100%	Unlimited	For eligible expenses
Nursing care 69 and under	100%	\$10,000/three consecutive calendar years	Registered Nurse, Reg. Nursing Assistant, Registered Practical Nurse & Licensed Practical Nurse
Nursing care 70 and over	100%	\$10,000/lifetime less amount previously paid	Services must be approved prior to cost being incurred
Orthopaedic shoes/ boots	100%	\$350/one pair/ per calendar year	Must be prescribed by a Physician, Podiatrist or Chiropodist
Orthotics 18 and under	100%	\$300/two pairs/ two calendar years	Must be prescribed by a Physician, Podiatrist or Chiropodist
Orthotics 19 and over	100%	\$300/one pair/ two calendar years	Must be prescribed by a Physician, Podiatrist or Chiropodist
Paramedical coverage	100%	\$300/per Practitioner/ calendar year	Includes Acupuncturist, Chiropodist, Chiropractor, Massage Therapist, Speech Therapist, Psychologist, Naturopath, Podiatrist & Osteopath

EXTENDED HEALTH BENEFITS APPLY TO ALL MEMBERS UNLESS SPECIFIED

Benefit	Amount	Maximum	Information
Physiotherapy	100%	Unlimited	Must be prescribed by a Physician
Prescription drugs Active Members	100%	Unlimited	Excludes admin charges. New drugs must be pre-approved
Prescription drugs (Retirees 64 and under)	90%	Unlimited	Excludes admin charges. New drugs must be pre-approved
Prescription drugs (Retirees 65 and over)	20% of total bill to a maximum of \$25/prescription	Unlimited	Claims first submitted to Provincial Senior Citizen Blue Cross
Special drugs	100%	\$300/per category/per calendar year	Contact Administrator for specific details
Surgical bras	2 bras/ calendar year	Unlimited	Required as a result of a mastectomy
Surgical stockings	2 pairs/ calendar year	Unlimited	Must be prescribed by a Physician
Vision care – Diagnosis and treatment	100%	Unlimited	Diagnosis and treatment of accidental injury or disease to eyes
Vision care - Laser eye surgery	50%	\$600/per eye/ lifetime	Disqualifies recipient from glasses/contact coverage for two calendar years
Vision care – eye exam	100%	\$75/two consecutive calendar years	Includes eye refractions
Vision care – glasses/ contacts (17 and under)	100%	\$400/12 consecutive months	Must be approved by Physician, Surgeon, Ophthalmologist, or Optometrist
Vision care – glasses/ contacts (18 and over)	100%	\$400/two consecutive calendar years	Must be approved by Physician, Surgeon, Ophthalmologist, or Optometrist
Visual training and remedial exercises	75%	Unlimited	Must be approved by Physician, Surgeon, Ophthalmologist or Optometrist
Vision care - safety glasses Active Members	100%	\$300/two consecutive calendar years	Must be approved by Physician, Surgeon, Ophthalmologist, or Optometrist

Wigs and hairpieces	100%	\$250/lifetime	Must be medically necessary due to disease or chemotherapy
Out of province/country Active Members 69 and under	100%	\$5,000,000	First 60 days of trip/ Global Excel must be contacted prior to treatment
Out of province/country Active Members 70 and over and Retirees	100%	\$5,000,000	First 45 days of trip / Global Excel must be contacted prior to treatment

DENTAL BENEFITS APPLY TO ACTIVE MEMBERS except as noted

Benefit	Amount	Maximum	Information
Accidental Dental Covers All Members	100%	\$2,500/lifetime	For charges approved within 90 days of accident
Major Restorative Active Members	75%	\$2,500/ calendar year	Bridges, crowns, inlay/onlay restorations, posts/cores
Orthodontia Active Members	50%	\$3,500/ Lifetime	Plan procedure must be submitted for pre-approval
Preventative and Maintenance services Active Members	100% Subject to MW Dental Fee Guide	Unlimited	Anaesthesia, dentures, exams, extractions, fillings, root canals, x-rays

BASIC LIFE INSURANCE

Benefit	Amount	Maximum	Information
Active Members 69 and under	\$100,000		Contact Plan Administrator for applicable form.
Active Members 70 and over	\$10,000		Contact Plan Administrator for applicable form.
Spouse Of Active Member	\$20,000		Contact Plan Administrator for applicable form.
Dependent Child Of Active Member	\$10,000		Contact Plan Administrator for applicable form.

ACCIDENTAL DEATH & DISMEMBERMENT

Benefit	Amount	Maximum	Information
Active Members 69 and under Basic amount	\$100,000		Contact Plan Administrator for applicable form.

CRITICAL ILLNESS

Benefit	Amount	Maximum	Information
Active Members 64 and under	\$25,000		Contact Plan Administrator for applicable form.

LONG TERM DISABILITY

Benefit	Amount	Maximum	Information
Active Members 64 and under	\$1,500/month	Taxable	Contact Plan Administrator for applicable form.

MEMBERSHIP IN THE PLAN

INITIAL ELIGIBILITY

In order to gain initial eligibility for coverage and therefore become a Member of The Plan, a person must satisfy all of the conditions specified by one of the three following provisions:

1. The person must be a Member in Good Standing of the Union and, during a period of not more than the preceding 24 months, have had contributions of at least 1,000 hours made on the Member's behalf by one or more Participating Employers.
2. The person must be a non-Unionized Employee of a Participating Employer, for whom the Board of Trustees has approved his/her participation, and on whose behalf the Participating Employer has made contributions of at least 1,000 hours during a period of not more than the preceding 24 months.
3. The person must be an Employee of the Union or of the Alberta Regional Council of Carpenters, for whom the Board of Trustees has approved his/her participation, and on whose behalf the Participating Employer has made contributions of at least 1,000 hours during a period of not more than the preceding 24 months.

INITIAL EFFECTIVE DATE OF COVERAGE

The initial effective date of coverage for the Member is the first day of the month in which the Member has satisfied the requirements for initial eligibility, provided the Member has filed an accurately completed Registration Card with the Administrator.

If the Member has not filed the Registration Card with the Administrator, or if the Registration Card has been filed in an incomplete fashion, the Member's coverage will be suspended until such time as a completed Registration Card is received by the Administrator. Then, the Member's coverage will be back-dated to the first of the month in which the Registration Card is received.

INITIAL EFFECTIVE DATE OF COVERAGE FOR MEMBER'S DEPENDENTS

The initial effective date of coverage for the Member's Dependents is the same as that of the Member.

If the Member acquires Dependents after his/her initial effective date for coverage, such Dependents will be covered as of the date on which the revised and accurately completed Registration Card is received by the Administrator. However, the newly-acquired Dependents' coverage can be back-dated for up to six months prior to the Registration Card being received if the Member was on benefit and the Dependents met the required qualifiers as of the requested date. Please contact the Administrator for details on the specifics required to back-date coverage.

COVERAGE FOR MEMBERS AND DEPENDENTS

After the Member has acquired coverage, that coverage will continue in force provided the Member remains in Good Standing with the Union and satisfies the conditions of one of the following:

1. contributions continue to be made by a Participating Employer,
2. contributions have been made, by a Participating Employer, in the most recent six consecutive month period and the Member maintains their name on the Union's out-of-work list, or
3. the Member receives a Letter Of Authorization from the Union to remain on The Plan, and provides such letter to the Administrator. Such authorization should not exceed three months.

If the Member fails to satisfy the conditions of one of the three provisions above, the Administrator alerts the Member to the need for a self payment.

SELF PAYMENT

In order to maintain coverage through self-payment, the Member must present the current amount requested to The Plan Administrator prior to the first of the month for which the coverage is to be extended. Members may make up to six consecutive monthly self-payments, after which their coverage ceases, unless they then qualify for coverage based on the provisions previously stated.

Members should contact the Administrator for the current self-pay rates.

COVERAGE FOR DISABLED MEMBERS

Once a Member is receiving disability income from The Plan, Employment Insurance (Medical) or from WCB, the Member may apply to the Administrator for Plan Paid Coverage. Proof of such circumstances, satisfactory to the Administrator, must be provided initially and at subsequent intervals appropriate to the nature of the disability. The Plan Paid Coverage will continue for a period of up to 12 months from the month the Member was last employed by a Participating Employer. After that, the Member may continue his/her coverage by making self payments during an uninterrupted period of disability, until the earlier of the cessation of disability or the date on which the Member reaches 65 years of age.

COVERAGE FOR THE FAMILY OF A DECEASED MEMBER

The Dependents of a deceased Member (who was covered at the time of his/her death) will have their coverage continued for 24 months after the month in which the Member passed away, provided they continue to qualify under the definition for Dependents. The types and amount of coverage will remain the same as those in force at the time of the Member's death.

COVERAGE FOR RETIRED MEMBERS

Members who apply for coverage to the Administrator within 90 days of their retirement may continue to make Retiree self payments to maintain their coverage. The Retiree's date of coverage and the date from which Retiree self payments must be made is the later of the date the Member retires and the date a retired Member qualifies to make a self payment.

For the initial year, the prorated amount of the annual self payment must be received by the Administrator 60 days prior to the transition date from regular active benefits to Retiree benefits. After the initial year, the full annual amount must be received by the Administrator prior to the first of the year for which the coverage is to be extended.

The Plan currently subsidizes retired Members and their Spouses with a further subsidy provided for Members who have over 15 years of continuous service. There are two premiums available dependent on the age of the Retiree. The Board of Trustees has the full authority and absolute discretion to set the annual rates for these Retiree self payments. Please contact the Administrator for current applicable rates.

Please Note:

Retirees retain all of the coverages that the active Members have (except as noted in the summary on pages 4 – 6) with the following exceptions:

Out of Province/Country Coverage	only the first 45 days of each trip
Prescription Drugs	90% for age 64 and under
Prescription Drugs	20% for age 65 and over/ maximum \$25 per prescription
Dental	No Coverage except Accidental
Long Term Disability	No Coverage
Critical Illness.....	No Coverage
Life Insurance	No Coverage
Dependent Life Insurance.....	No Coverage

TERMINATION OF COVERAGE FOR MEMBERS/RETIRED MEMBERS

A Member's coverage terminates on the earliest of the following:

- the end of the month in which the Member no longer meets the qualifying conditions and the Member fails to make the self payment required to continue his/her coverage,
- the end of the month for which the Member has made his sixth consecutive self payment and does not immediately re-qualify,
- the date the Member ceases to be a Member in Good Standing with the Union,
- the date premium payments cease, or
- the date The Plan terminates.

REINSTATEMENT OF COVERAGE

Reinstatement of coverage that was terminated requires the satisfaction of the rules governing initial eligibility, except that during a period of not more than 24 months succeeding the Member's coverage termination, only 300 hours worth of contributions made on their behalf from one or more Participating Employers are required in order to re-qualify.

After 24 months without coverage under The Plan, the former Member must re-qualify by satisfying the initial eligibility criteria, including the 1,000 contributed hours requirement.

COVERAGE DESCRIPTIONS

EXTENDED HEALTH CARE

We will pay 100 per cent for most charges (exceptions noted under each category) of the covered medical costs, up to any maximum amounts stated in the description of the benefit. The Plan will pay for the usual cost of covered services and supplies that are medically necessary to treat an illness, injury or pregnancy. Only the following are covered:

- the amount that is usually charged for the service or supplies in the area in which the charge is made,
- services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Employer as effective and appropriate and based on accepted standards of Canadian health care,
- services and supplies that we are legally allowed by the government to cover. We will not cover services or supplies that are covered by the government plan in the Insured Person's home province, and
- charges for services and supplies that are incurred while the person is insured.

Ambulance services

We will cover the cost of a licensed ambulance or other emergency service that transports the Insured Person to and from the nearest Hospital that is able to give the necessary treatment. This also covers required travel between Hospitals. If transportation is not provided by a licensed ambulance, we may also cover the cost of a person accompanying the Insured Person, if it is medically necessary.

Drugs

We will cover the cost of drugs, serums and vaccines prescribed by a Physician, Surgeon or Dentist, with some exclusions including costs of dietary supplements, experimental drugs and any charges for the administration of serums, vaccines and injectable drugs.

Special drugs

We will cover the cost of prescription drugs used to treat smoking cessation, sexual dysfunction and obesity to a maximum of \$300 per category per calendar year. Please contact the Administrator for specific details.

Hospital accommodation

We will cover the difference between the cost of a ward and a private room in a Hospital. Room charges for outpatients will not be covered. The Hospital stay must be because of illness, injury or pregnancy.

Vision care

We will cover the cost of contact lenses or eyeglasses, only to the extent that they are recommended or approved by a Physician, Surgeon, Ophthalmologist or Optometrist.

- For eyeglasses or contact lenses, we will pay up to a maximum of \$400 in any 12 consecutive months for each Member and each Dependent who is 17 years of age and under.
- For eyeglasses or contact lenses, we will pay up to a maximum of \$400 in any two consecutive calendar years for each Member and each Dependent who is 19 years of age and over.
- For Members only, we will pay up to a maximum of \$300 in any two consecutive calendar years for approved safety glasses. This coverage is in addition to the coverage noted above.
- For Physician surgical fees (but not facility or other charges) related to Photorefractive Keratectomy (PKR) and Laser Assisted In-Situ Keratomileusis (LASIK) we will cover 50% of the actual expense to a lifetime maximum of \$600 per eye. Reimbursement under this provision will disqualify a Member or Dependent for coverage for glasses or contact lenses for a period of two calendar years. Reimbursement under this provision will not disqualify a Member for coverage for safety glasses.
- We will cover the cost of one eye examination up to \$75 in any two consecutive calendar years, for each Member and each Dependent (including eye refractions).
- We will cover the costs of diagnosis and treatment of accidental injury or disease to the eyes.
- Please note that The Plan will pay only 75% of the cost for visual training or remedial exercises.

When you make a claim please ensure that the receipt includes the name of the person who was prescribed the eyeglasses or contact lenses, as well as the date on which they were received. Receipts for deposits are not acceptable. If you have a receipt for a deposit, include it with the receipt for the balance when you make a claim.

Medical services and equipment

We will cover the cost of the following services and supplies if they are prescribed by a Physician:

- Services provided by a Registered Nurse, Registered Nursing Assistant, Registered Practical Nurse and Licensed Practical Nurse.
 - We must approve the services before we will cover the cost. These services must be provided in the Insured Person's home by a Registered Nurse, Registered Nursing Assistant, Registered Practical Nurse or Licensed Practical Nurse who does not normally live with, is not related to, nor is a member of the Insured Person's Immediate Family.

- We will pay up to \$10,000 in any period of three consecutive calendar years until the Insured Person reaches age 70. After age 70, we will pay up to a lifetime maximum of \$10,000 minus the amount we paid in the previous three calendar years. This change to a lifetime maximum takes place on the January 1st following the 70th birthday. If the birthday is January 1st, this \$10,000 lifetime maximum begins on the 70th birthday.
- We will not cover the cost of a Registered Nurse, Registered Nursing Assistant or Registered Practical Nurse if the care they provide is not the skilled duties that only they can provide. We will also not cover the cost of care from a Registered Nurse, Registered Nursing Assistant, Registered Practical Nurse or Licensed Practical Nurse that is provided in a nursing home, rest home, home for the aged, Hospital, or any facility that provides similar care.
- Out-patient services and supplies from a Hospital in the Insured Person's home province or from a surgical supply company.
- Braces, crutches, artificial limbs and eyes, and other prosthetic devices that we approve. As the cost of these items varies greatly, we recommend that you contact us before purchasing a device. We will ask you for the written information that we require to determine how much of the cost we will cover based on the least expensive device that is medically adequate and, once it is provided, we will advise you of the amount we will cover.
- Breast prosthesis after a mastectomy, including replacement(s) every two calendar years, and two surgical bras in a calendar year.
- Oxygen and blood serum.
- Orthopaedic shoes or boots prescribed by a Physician, Podiatrist, or Chiropodist. We will cover one pair each calendar year to a maximum cost of \$350.00.
- Foot orthotics prescribed by a Physician, Podiatrist, or Chiropodist. They must be determined as being necessary by a biomechanical examination and be custom-made. They must be required to carry out regular daily living activities, and not just for sports or recreation. We will pay for 2 pairs of foot orthotics per two calendar years for an Insured Person who is 18 years of age or younger and one pair per two calendar years for other Insured Persons. Maximum cost in either circumstance is \$300.00 per calendar year.
- Two pairs of surgical stockings each calendar year.
- Wigs and hairpieces purchased if necessary as a result of chemotherapy or disease up to a lifetime maximum of \$250.00.
- Diagnostic tests, radium treatments and x-ray examinations.
- Services of a qualified physiotherapist upon written recommendation by a Physician.

- Hearing aids prescribed by a legally licensed Otolaryngologist, up to a maximum of \$1000 for one instrument per ear per Insured Person in each period of four consecutive calendar years.
- Rental charges for wheelchairs, hospital beds and other temporary therapeutic equipment that we approve. We may cover the cost of a purchase before it is made. We will pay for the least expensive device that is medically adequate.

Paramedical services

We will cover 100 per cent of the cost of the following services up to a maximum of \$300 per calendar year per practitioner: Acupuncturist, Chiropracist, Chiropractor, Massage Therapist, Naturopath, Osteopath, Podiatrist, Psychologist and Speech Therapist.

What you are not covered for under any Health Care coverage

We will not pay for the cost of:

- health care services or supplies that the Insured Person is eligible to claim under Workers' Compensation legislation in the Insured Person's province of residence;
- health care services or supplies required due to intentionally self-inflicted injury;
- health care services or supplies required as the result of war, rebellion, or hostilities of any kind, whether or not the Insured Person is a participant;
- health care services or supplies required as the result of participation in a riot or civil disturbance;
- health care services or supplies due to committing a criminal offence or provoking an assault;
- services required by a court, the Insured Person's Participating Employer, a school or anyone other than the Insured Person's Physician;
- treatment to correct temporomandibular joint dysfunction (the hinge joint of the jaw is called the temporomandibular joint);
- any service and supplies for which the Insured Person would not normally be charged;
- cosmetic treatments;
- "in vitro" or "in vivo" procedures, or any other infertility procedures, unless otherwise specifically covered in this policy;
- any service for which we are not legally allowed to pay; or
- health care services or supplies required for recreation or sport, but not for regular daily living activities.

Co-ordination of benefits with your Spouse's plan

Co-ordination with your Spouse's plan is one of the advantages of the group policy. It may allow you to receive up to 100% of health care costs. First, you must have family coverage that includes health care coverage and have an eligible Spouse. Second, your Spouse must have the same type of coverage.

Here are the procedures to follow:

- **Claiming your expenses**

If you are claiming your expenses, the claim must be sent to us first. We will pay the portion of the claim that is covered by us and send you an explanation of payment. Your Spouse can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to their group plan.

Claiming your Spouse's expenses

If you are claiming your Spouse's expenses, a claim must be sent to your Spouse's plan first. Your Spouse's plan will pay for the portion of the claim that is covered by them and send your Spouse an explanation of payment. You can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to us.

- **Claiming your Child's expenses**

If you are claiming expenses for your Child, you must first claim from the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 19th and your Spouse's birthday is June 11th, your Child will claim under your plan first. Then, the claim for the unpaid portion should be sent to your Spouse's plan along with a copy of the explanation of payment and a copy of the receipts.

If you are separated or divorced, claims for your Child's benefit must be coordinated based on the standard industry guidelines.

Submitting a claim

Complete the claim form that is available from the Administrator or your Union office.

Make sure that your receipts include:

- the name of the person who received the service or supply,
- the date the service or supply was received,
- the type of service or supply, and
- the cost.

We must receive satisfactory proof of claim by the earlier of the following dates:

- 18 months after the date of service or purchase, or
- 90 days after the date the policy terminates.

If you have any questions, please contact the Administrator at 1-888-525-1460.

DENTAL CARE

We will pay for the covered dental care charges that are incurred while the person is insured and care was provided by a licensed Dentist, Denturist, Dental Hygienist, Anaesthetist or specialist. When we use the term “Dentist” in this provision, we intend it to include all of the above.

Amount we will pay

We will pay a percentage of the covered dental costs, up to any maximum amounts stated in the description of the benefit.

The amount we will pay is based on the current Millwrights’ Dental Fee Guide. We base coverage on the least expensive treatment that could be used to treat or prevent the dental problem. If the cost of the dental work given is more than the cost of the least expensive treatment, we will only cover the cost of the least expensive treatment.

The maximum we will pay for preventive and maintenance covered costs combined is unlimited.

When your dental treatment will cost more than \$500

If the cost of any dental treatment will be more than \$500, we strongly recommend that you send us a “pre-determination” before the treatment is started. A pre-determination is a report describing the proposed treatment and cost. We will determine how much of the treatment is covered and give a written estimate of how much you will be responsible to pay before the treatment begins.

We may also need the following information:

- a fully complete written estimate, and
- pre-operative x-rays, study models, and laboratory reports.

If we ask you for the above information, we cannot process the pre-determination or pay any claim until we receive it.

What you are covered for

Dental coverage is made up of various types of coverage. We have included detailed descriptions of each type below.

Dental accident

We will cover the cost of a legally licensed Dentist for dental treatment of injuries to natural teeth or the replacement of natural teeth, up to a maximum of \$2500 in total for all accidents suffered by any one Insured Person. However, all of the following conditions apply:

- the treatment or replacement must be necessitated by a direct accidental blow to the Insured Person’s mouth and not by an object wittingly or unwittingly placed in the mouth,
- the accidental blow must have occurred while the person was insured under this provision,

- the treatment is the least expensive that will provide a professionally adequate result,
- no payment will be made for any part of the charge which exceeds the amount shown for the treatment in the current Dental Participating Employer Schedule of Fees for General Practitioners in the Insured Person's province or territory of residence, and
- if treatment is to be received more than 90 days after the accidental blow, a treatment plan must be submitted to us within 90 days of the accident.

Preventive coverage – 100%

These are procedures used to treat or help prevent basic dental problems. Some of the procedures are examinations, x-rays, fluoride treatments and fillings.

- **Examinations**

- **Initial or Complete Examinations**

A complete examination includes examination and charting of the teeth, gums and underlying bone, pulp vitality tests, recording the history of the patient's dental work and planning a treatment. One complete examination is covered per Dentist every 36 months.

- **Recall Examinations**

A recall examination includes a complete examination of the teeth, gums and underlying bone, pulp vitality tests, checking occlusion and consulting with the patient. Two recall examinations are covered every calendar year.

- **Specific Examinations**

A specific examination may include an examination of the teeth or a specific tooth, gums and underlying bone, pulp vitality tests and checking occlusion. One specific examination is covered once every six months.

- **Emergency Examinations**

An emergency examination includes checking for pain or infection and pulp vitality tests.

- **Consultation**

This is a visit to the Insured Person's Dentist to discuss a serious dental problem and to agree on a treatment plan and is covered for up to \$50 per consultation.

- **X-rays**

- **Full Mouth Series X-rays**

Full mouth x-rays are a series of at least 16 films including bitewings. One series is covered every 36 months.

➤ **Panorex X-rays**

A panorex is one view of the entire mouth and is covered once every 36 months.

➤ **Periapical X-rays**

Periapical x-rays are x-rays of single teeth. There is no limit to the number of periapical x-rays for which the insured is covered.

➤ **Bitewing X-rays**

A bitewing x-ray is used to detect decay in molar teeth. Two sets of bitewing x-rays are covered in a calendar year.

➤ **Bite X-rays**

Bite x-rays are x-rays of the chewing surface of the teeth. These x-rays show the fit between the upper and lower teeth when they are in contact. There is no limit to the number of bite x-rays for which the Insured Person is covered.

• **Tests**

➤ **Biopsy of Oral Tissue**

A biopsy occurs when a small piece of tissue is removed and sent to a laboratory to be tested for disease. There are no limits.

➤ **Pulp Vitality Test**

The pulp is the soft tissue inside a tooth. This test is performed to see if the pulp is healthy. One pulp vitality test per tooth is covered if the test is done more than 30 days prior to a root canal therapy.

• **Cavity Prevention**

➤ **Polishing or Cleaning Teeth**

One unit (15 minutes) is covered each visit and up to two treatments every calendar year.

➤ **Fluoride**

Fluoride is a substance which is applied to the teeth to strengthen the enamel and prevent decay in primary and permanent teeth.

➤ **Oral Hygiene Instruction**

This is instruction on how to brush and floss. This is one-on-one instruction between the Insured Person and the Dentist or Oral Hygienist and is covered once every six months.

➤ **Pit and Fissure Sealants**

This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. There is no limit to the number of treatments for which the Insured Person is covered.

➤ **Interproximal Disking**

Interproximal disking is the removal of a thin slice of tooth enamel to make more room for the teeth that are slightly crowded.

• **Space Maintainers**

➤ **Space Maintainers**

A space maintainer is an appliance that a Dentist uses to maintain a space where a tooth has been removed. Only children 14 or younger are covered for one space maintainer per space in a calendar year.

➤ **Maintenance of Space Maintainers**

Maintenance of a space maintainer means adjusting, recementing or repairing an appliance used to maintain a space where a tooth has been removed. Only children 14 or younger are covered.

• **Fillings**

Please note: These procedures may include local anaesthesia, removal of decay, pulp protection (a sedative used to protect the nerve) and bite adjustment (work done to make sure that the fit between the top and bottom teeth is correct). The cost of finishing or polishing is not covered.

➤ **Amalgam Fillings**

These are silver fillings that are used to restore teeth. If a bonded silver filling is installed, we will only cover the cost of a non-bonded silver filling.

➤ **Composite Fillings**

These are white fillings that are used to restore teeth.

➤ **Retentive Pins**

These are pins used to make sure that a restoration or filling stays in place.

➤ **Pre-fabricated Posts**

These are pre-made posts used for additional support to the tooth after root canal treatment.

➤ **Stainless Steel, Plastic and Polycarbonate Caps**

This is a cap that is installed to cover the whole tooth or teeth. Only children 14 or younger are covered for this treatment.

➤ **Sedative Fillings for Caries, Trauma and Pain Control**

Caries result from tooth decay. Trauma means a blow to the mouth or teeth resulting in injury. Severe wear may be considered a traumatic injury. Pain control includes temporary fillings and local anaesthesia to reduce pain before a permanent filling is installed.

Sedative fillings that are applied to reduce pain are covered. This procedure includes local anaesthesia, removal of decay and/or removal of existing restoration, bite adjustment (treatment to make sure that the fit between the top and bottom teeth is correct) pulp cap (a sedative placed on an exposed nerve to reduce pain and prevent infection) and placement of a sedative filling (a sedative placed under a filling to reduce pain).

- **Bite Adjustment/Equilibration**

This is a procedure to correct the bite problem between the upper and lower teeth when they are in contact. Bite adjustments are covered for up to eight units every calendar year.

- **Minor Oral Surgery**

Please note: These procedures may include local anaesthesia, appropriate x-rays, surgery and follow-up care.

- **Extractions**

Extraction means removing a tooth, included an impacted tooth. There is no limit to the number of extractions per visit.

- **Residual Root Removal**

Residual root removal means removing tooth roots left behind when a tooth is extracted. One root removal is covered per tooth in a lifetime.

- **Anaesthesia**

All necessary anaesthesia during a surgical dental procedure is covered including:

- general anaesthesia (total loss of consciousness),
- deep sedation (where the Insured Person may be in and out of consciousness during a procedure),
- intravenous sedation (the injection of a sedative into the blood stream), and
- inhalation technique (sedation given using a mask).

Maintenance Coverage – 100%

Some of the procedures that are covered are treatment of gums, root canal therapy, periodontal scaling, denture maintenance, major oral surgery, and appliance and appliance adjustments.

- **Major Oral Surgery**

Please note: These procedures may include local anaesthesia, appropriate x-rays, surgery and follow-up care.

Treatments for these procedures are unlimited as long as they are not for cosmetic purposes and not part of any implant (supports for artificial teeth surgically placed in the jaw bone) or part of any orthognatic surgery, remodeling or repositioning of the lower jaw.

➤ **Surgical Exposure**

This is surgical incision to expose teeth that will not erupt or come on time.

➤ **Alveoloplasty, Gingivoplasty, Stomatoplasty, Vestibuloplasty**

Alveoloplasty means remodeling, removing or reducing bone.

Gingivoplasty means remodeling gums. Stomatoplasty means remodeling the floor of the mouth. Vestibuloplasty involves ridge reconstruction.

➤ **Surgical Excision**

This includes the removal of cysts or a foreign body.

➤ **Surgical Incision**

This is an incision made to an infected area usually to allow drainage.

➤ **Fractures**

This is the treatment of fractures of the upper or lower alveolar bone which holds the teeth in the sockets.

➤ **Frenectomy**

Frenectomy involves surgery on the frenulum (a thin tissue that connects the lips to the gums and the tongue to the floor of the mouth).

➤ **Sialolithotomy**

This is the partial removal of the salivary duct.

➤ **Antral Surgery**

This is the surgical removal of a tooth that has been forced up into a sinus cavity

➤ **Hemorrhage Control**

This is treatment to stop bleeding resulting from an extraction or trauma.

➤ **Post Surgical Care**

This is treatment given by the Dentist after surgery until healing is completed.

• **Treatment of roots**

➤ **Pulpotomy**

Pulpotomy is the removal of dental pulp from the crown portion of the

tooth. This procedure may include a treatment plan, anaesthesia, the treatment, appropriate x-rays, and follow-up care and must occur more than 30 days before a root canal therapy.

➤ **Pulpectomy**

Pulpectomy is the removal of tissue from the pulp chamber. This procedure may include a treatment plan, anaesthesia, the treatment, appropriate x-rays, and follow-up care and must occur more than 30 days before a root canal therapy.

➤ **Root Canal Therapy**

This procedure includes:

- treatment plan,
- pulp vitality test,
- pulpectomy (removing the diseased nerve from inside the tooth to reduce pain),
- opening and drainage,
- tooth isolation, and
- clinical procedure with appropriate x-rays.

One root canal therapy is covered per tooth in a lifetime. Retreatment procedures are not covered. If dental coverage ends during root canal therapy, we will extend coverage for 30 days to complete the root canal service. If the dental coverage is replaced by a policy with another insurer before the procedure is completed, the replacing insurer will be responsible for the cost of the entire procedure.

➤ **Apexification**

Apexification means closing the root of a tooth with hard tissue. This procedure may include a treatment plan, anaesthesia, tooth isolation, the treatment with appropriate x-rays, placement of dentogenic media (material which causes a root tip to form in young teeth so that root canal therapy can be done), and follow-up care. Apexification is covered once per tooth in a lifetime.

➤ **Retrofilling**

This is a filling done through the root end and is covered once per tooth in a lifetime.

➤ **Apicoectomy**

This is the surgical removal of a root end after root canal therapy and is covered once per tooth in a lifetime.

➤ **Root Amputation**

Root(s) from a tooth may have to be removed because of infection. However, the crown and at least one root remain so that the tooth does not have to be removed and is covered once per tooth in a lifetime.

➤ **Hemisection**

Hemisection means removing a portion of the root(s) and the crown of a tooth but leaving the other root(s) in place and is covered once per tooth in a lifetime.

➤ **Bleaching Endodontically Treated Tooth/Teeth**

This is the whitening of a tooth internally through the root canal opening of a tooth.

➤ **Intentional Removal, Apical Filling and Reimplantation**

This is the intentional removal of a healthy tooth and implanting it. For example, a third molar is removed and used to replace a missing first molar. The Insured Person is covered for one procedure per tooth in a lifetime.

• **Treatment of Gums**

Please note: These procedures may include local anaesthesia, surgical dressing, sutures and follow-up care for one month. Post-treatment evaluation is not covered.

➤ **Displacement Dressing**

A displacement dressing means placing a medicated pack on inflamed gums to move gums away from the calculus (deposits on teeth that irritate gums).

➤ **Desensitization**

Desensitization means applying fluoride to reduce sensitivity.

➤ **Gingival Curettage**

Gingival curettage means scraping out damaged tissue inside the gums.

➤ **Gingivectomy**

Gingivectomy means removing damaged gum tissue.

➤ **Flap Surgery**

Flap surgery is the opening made for bone removal.

➤ **Tissue Graft**

Tissue graft is the transfer of healthy gums to an area where the gums have receded.

➤ **Periodontal Scaling and/or Root Planing (Tartar Removal)**

Scaling means removing calcium deposits on teeth. Root planing means the smoothing of rough tooth surfaces and removing any calcium deposits and is covered for up to 12 units of scaling and/or root planing every calendar year.

• **Appliances and Appliance Adjustment**

➤ **Periodontal Appliances**

The cost of making the impression and inserting the appliance is covered.

➤ **Adjustment of Periodontal Appliances**

There is no limit to the number of adjustments for which the Insured Person is covered.

• **Dentures**

Please note: These procedures may include a treatment plan, initial and final impressions, jaw relations records, try-in insertion, bite equilibration (work done to make sure that the fit between the top and bottom teeth is correct), and three month follow-up care.

If coverage ends after preparations have been made for a denture(s) but before the procedure has been finished, we will extend coverage for 90 days to complete the denture(s), even if the dental coverage is replaced by a policy with another insurer.

If the Insured Person is covered by this policy on the date that the denture is installed, we will continue to cover the cost even if this policy is replaced by another insurer.

➤ **Complete Dentures**

Complete dentures means dentures that replace either all of the top teeth or all of the bottom teeth. Charges for replacing an existing denture will only be paid if such replacement is for an equivalent denture and meets one of the conditions shown below:

- It has been more than 36 months since the last complete denture was inserted; or
- It has been less than 36 months since the last complete denture was inserted and the existing denture is no longer wearable. We must approve this.

➤ **Transitional Dentures**

Transitional dentures are temporary dentures used for healing purposes due to the extraction of one or more teeth. Permanent dentures must be inserted within 12 months of the date the temporary dentures were inserted.

➤ **Acrylic Dentures**

Acrylic dentures are dentures with an acrylic denture base. Acrylic dentures are covered only if it has been more than 36 months since the last acrylic dentures were inserted.

➤ **Partial Dentures**

Partial dentures replace one or more top or bottom teeth. They may be an acrylic (plastic), metal or chrome base that can have acrylic, wire or chrome clasps (which hold on to the teeth). Partial dentures are covered only if it has been more than 36 months since the last partial dentures were inserted or additional teeth have been extracted.

• **Denture Maintenance**

➤ **Denture Adjustments**

Adjustments are covered and unlimited as long as the adjustments are made more than three months after the new dentures were first inserted.

➤ **Denture Repairs**

Repairing dentures means fixing broken or damaged dentures and is unlimited.

➤ **Denture Rebasing and Relining**

Rebasing dentures means fitting dentures with a new base. Relining dentures means adding materials so that the dentures fit properly.

➤ **Tissue Conditioning**

Tissue conditioning means applying a conditioner to the alveolar ridge that ensures a proper denture fit.

Major Restorative Coverage – 75%

To a maximum of \$2,500 per Insured Person per calendar year

These are procedures used to treat major dental problems. Some of the procedures are post and core, crowns, bridgework, inlays, onlays and veneers.

• **Caps and Tooth Coverings**

Please note: These procedures may include treatment planning, bite records, local anaesthesia, subgingival preparation of the tooth (work done below the gum line), removal of decay and old restoration, tooth preparation, pulp protection (a sedative used to protect the nerve), impressions, temporary services, insertion, bite adjustments (work done to make sure that the fit between the top and bottom teeth is correct) and cementation.

Crown lengthening (subgingival preparation) before tooth preparation is not an eligible benefit.

If the Insured Person's coverage ends after a tooth has been prepared for a crown, inlay, onlay or veneer but before the procedure has been finished, we will extend coverage for 90 days to complete the procedure even if the dental coverage is replaced by a policy with another insurer.

➤ **Inlay/Onlay Restorations**

Inlay and onlays are metal or porcelain casts placed on the surface of the tooth.

➤ **Crowns**

A crown is a cap that covers the whole tooth.

➤ **Retentive Pins in Inlays, Onlays and Crowns**

These pins are used to make sure that the inlays, onlays or crowns stay in place.

➤ **Build-up/Fillings**

This means restoring a tooth prior to capping for better adaptation of the cap.

➤ **Posts and Cores**

These are laboratory-processed posts and cores used for additional support to the tooth after root canal therapy.

• **Bridges**

Please note: These procedures may include treatment planning, bite records, local anaesthesia, subgingival preparation of the tooth (work done below the gum line), removal of decay and old restoration, tooth preparation, pulp protection (a sedative used to protect the nerve), impressions, temporary services, insertion, bite adjustments (work done to make sure that the fit between the top and bottom teeth is correct) and cementation.

Crown lengthening (subgingival preparation) before tooth preparation is not an eligible benefit.

Charges for replacing an existing bridge will only be paid if such replacement is for an equivalent bridge and meets one of the conditions shown below:

- It has been more than 36 months since the last bridge was inserted; or
- It has been less than 36 months since the last bridge was inserted and the existing bridge is no longer wearable. We must approve this.

➤ **Pontics**

A pontic is an artificial tooth that replaces a missing tooth. Pontic replacement is covered only if it has been more than 36 months since the last pontic was installed in that space. A porcelain pontic installed on a molar is not covered.

➤ **Retainers/Abutments**

A retainer/abutment is the tooth beside the missing tooth that will be used to support the bridge. The preparation of the tooth is covered only if it has been more than 36 months since the last preparations were made to that tooth.

➤ **Bridgework Repairs**

Repairing bridgework means fixing or repairing damaged bridgework.

➤ **Posts in Retainers/Abutments**

These are post and cores used for additional support to the retainer/abutment. Post and cores are covered only if it has been more than 36 months since the last installation to that tooth.

Orthodontic Coverage – 50%

To a maximum of \$3,500 per Insured Person in a lifetime

These are procedures used to correct crooked or misaligned teeth. This includes all necessary dental treatment needed to correct this problem such as examinations, x-rays, models, photographs, reports and surgical exposure of teeth, appliances and adjustments.

We require that a treatment plan prepared by the Dentist be sent to us. We will then pay up to 30% of the cost at the beginning of treatment, minus the diagnostic fee. We will calculate the remaining payments by dividing the rest of the cost by the number of months in the treatment plan. We will pay monthly or quarterly, depending on when the Dentist bills us or when we receive the receipts. We will not make any advance payments.

The cost of dental treatment that is not an orthodontic service but is needed because of the orthodontic treatment will be included and covered as if it were an orthodontic service.

What you are not covered for

- Dental services or supplies that you are eligible to claim under the Workers' Compensation legislation in your province of residence.
- Any dental charges not included in the current Millwrights' Dental Fee Guide.
- Cosmetic procedures.
- Charges for appointments that you do not keep.
- Charges for completing claim forms.

- Treatment to correct temporomandibular joint dysfunction (The hinge joint of the jaw is called temporomandibular joint.).
- Any endodontic treatment which started before you became insured.
- Any replacement of dental appliances that are lost, misplaced or stolen.
- Any treatment related to orthognathic surgery (remodeling or reconstruction of your jaw).
- Any crowns, bridges or dentures for which tooth preparations were started before you became insured.
- Procedures or supplies used in vertical dimension corrections (changing the height of the teeth) or to correct attrition problems (worn down teeth).
- Any orthodontic services received before you became insured.

Co-ordination of benefits with your Spouse's plan

Co-ordination with your Spouse's plan is one of the advantages of your group policy. It may allow you to receive up to 100% of your dental costs. First, you must have family coverage that includes health care coverage and have an eligible Spouse. Second, your Spouse must have the same type of coverage.

Here are the procedures to follow:

- **Claiming your expenses**

If you are claiming your expenses, the claim must be sent to us first. We will pay the portion of the claim that is covered by us and send you an explanation of payment. Your Spouse can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to his/her group plan.

- **Claiming your Spouse's expenses**

If you are claiming your Spouse's expenses, a claim must be sent to your Spouse's plan first. Your Spouse's plan will pay for the portion of the claim that is covered by them and send your Spouse an explanation of payment. You can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to us.

- **Claiming your Child's expenses**

If you are claiming expenses for your Child, you must first claim from the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 19th and your Spouse's birthday is June 11th, your Child will claim under your plan first. Then, the claim for the unpaid portion should be sent to your Spouse's plan along with a copy of the explanation of payment and a copy of the receipts.

If you are separated or divorced, claims for your Child's benefit must be coordinated based on the standard industry guidelines.

- **Submitting a claim**

Complete the claim form that is available from the Administrator or your Union office. Your Dentist has to complete a section of the claim form.

If your Dentist sends claims to us electronically, you will not have to fill out a claim form. We will make the payment to the person designated. Once payment has been made, we will send you an explanation of our payment.

We will pay benefits to you when we receive satisfactory proof of claim.

We must receive all claims by the earlier of the following dates:

- 18 months after receipt of the treatment, service or supply; or
- 90 days after the date the policy terminates.

If you have any questions, please contact the Administrator at 1-888-525-1460.

MEMBER LONG-TERM DISABILITY

Flat monthly benefit amount	\$1,500
Elimination period	119 days
Taxability of benefits	taxable
Pension credit	4.17 hours per day disabled
Benefit termination	age 65 or loss of coverage (whichever occurs first)

Definitions – as used in this benefit

- **Elimination Period** means the period, as specified in the Benefit Schedule, of continuous total disability that must be completed before long term disability benefits commence under this benefit.
- **Maximum Benefit Period** means the maximum period, as specified in the Benefit Schedule, during which monthly benefits are payable.
- **Net Monthly Earnings** means the monthly earnings in effect immediately prior to commencement of total disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon.
- **Total Disability (Totally Disabled)**
 - During the elimination period provided for in the long term disability benefit and the succeeding 24 months, total disability is a state of incapacity, resulting from an illness or accident, which wholly prevents the Member from performing each and every essential duty of his regular occupation;
 - After the elimination period and the succeeding 24 months have elapsed, total disability is a state of incapacity, resulting from an illness or accident, that wholly prevents the Member from working in any occupation:
 - for which he would earn 60% or more of his earning in effect immediately prior to commencement of total disability, and
 - for which he is suited by education, training and experience.
 - Whether or not any such gainful occupation is available in the area where the Member resides does not affect his entitlement to long term disability benefits.
 - A Member who requires a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.
- **Training and Experience** is defined as all of the knowledge and skills the Member acquired while in school, in the performance of his current or former professional activities, or during his non-working hours.

Payment of Benefit

Upon receipt of Proof of Claim satisfactory to the insurer that:

- a Member became totally disabled while insured under this benefit and remained totally disabled during the elimination period, and
- the Member is under the continuing medical care of a Physician,

the insurer will pay monthly long term disability benefits for as long as the Member is totally disabled, in accordance with applicable policy provisions up to the maximum benefit period.

The amount of long term disability benefit payable will be the amount specified in the benefit schedule based on the monthly earnings in effect immediately prior to commencement of total disability.

Long term disability benefits are payable at the end of each month following the completion of the elimination period.

Any payments for a period of less than one month will be at the daily rate of 1/30 of the monthly benefit.

Long term disability benefits may be taxable in accordance with the benefit schedule.

If a Member continues to be insured under this benefit while on maternity or Parental Leave, then the elimination period for any total disability that begins during such leave will be deemed to commence on the date the Member is scheduled to return to active full-time employment with the Participating Employer, provided the Member is then still so disabled and insured under this benefit.

Reduction of Long Term Disability Benefits, Limitations and Exclusions

- **Indirect Offset**

The insurer will reduce long term disability benefits by any amount by which the total monthly income of the Member from all sources exceeds:

- 60% of his gross monthly earnings immediately prior to total disability, if the long term disability benefits are included in his income under the Income Tax Act (Canada); or
- 60% of his net monthly earnings immediately prior to total disability, if the long term disability benefits are not included in his income under the Income Tax Act (Canada).

The total monthly income of a Member from all sources, whether he receives or is eligible to receive this income, will include all of the following:

- any long term disability payments under this benefit;
- any monthly earnings or payments from the Participating Employer;

- any disability benefits payable under the Canada Pension Plan or the Quebec Pension Plan, including early retirement benefits and benefits payable on behalf of Dependents, but excluding any increase in benefits after benefit payments commence due solely to the cost-of-living;
- any disability benefits payable under any Workers' Compensation Act or similar legislation or any other government plan, excluding the Employment Insurance Act;
- any disability benefits payable under any other group or association insurance plan; and
- any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

In the event that a lump-sum payment is made under any of the above-mentioned sources in lieu of monthly payments, monthly benefits will be reduced by the equivalent monthly payment over a period of 60 months or by the number of months of disability for which the lump sum is paid, whichever is the lesser.

The insurer may also reduce the monthly long term disability payments even if the Member, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

The insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

- **Limitations**

No benefits are payable for a period of total disability

- during which the Member is not under continuing medical care, for the illness or bodily injury causing the total disability;
- during a formal maternity or Parental Leave taken by a Member, as provided for under provincial or federal legislation;
- during a Maternity Leave commencing on the earlier of
 - the elected date of leave, as mutually agreed to by the Participating Employer and the Member, and
 - the date of birth of the Child;
 and ending on the earlier of:
 - the elected date of return to active full-time employment with the Participating Employer, as mutually agreed to by the Participating Employer and the Member, and
 - the actual date the Member is again actively at work with the Participating Employer;

- during a Parental Leave as mutually agreed to by the Participating Employer and the Member;
- during the imprisonment of the Member due to conviction of an offence; or
- if the Member remains outside Canada for longer than 3 months for any reason whatsoever, unless the insurer gives prior written consent to continue paying benefits during this period.

No benefits are payable for any period of total disability commencing during the first 12 months of coverage of a Member, if such total disability was directly or indirectly the result of a sickness or injury that was treated by a Physician or for which prescribed drugs were taken during the 3 month period immediately prior to the effective date of such coverage.

However, if the policy has been in force for less than 12 months, and the Member has been covered under a comparable benefit under the Participating Employer's previous group insurance policy, for any period of time immediately prior to the effective date of the policy, that period of time will apply in determination of the 12 month coverage period.

- **Exclusions**

No benefits are payable for a total disability resulting directly or indirectly from any one of the following:

- intentionally self-inflicted injuries while sane or insane;
- war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- committing, or attempting to commit a criminal offence;
- cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an accident which occurred while the Member was insured under this benefit;
- alcohol or drug abuse unless, for such abuse, the Member is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving continuing medical care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care; and
- driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

Recurrent Total Disability

Successive periods of Total Disability due to the same cause or related causes are considered to be the same period of Total Disability unless they are separated by at least:

- two consecutive weeks of active full-time employment during the elimination period; or

- six consecutive months of active full-time employment immediately following a period of total disability for which long term disability benefits were paid under this benefit.

Successive periods of total disability due to entirely unrelated causes are considered to be the same period of total disability, unless they are separated by at least one day of active full-time employment.

Whenever successive periods of total disability are considered to be the same period of total disability, the elimination period will not be applied a second time and the same amount as for the initial total disability minus any payments already made will be payable for the remainder of the maximum benefit period.

Disability Management

The insurer may at any time require a totally disabled Member to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the insurer.

The insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

- co-ordination of access to health care services;
- support program for returning to work,
- negotiations for a gradual return to work,
- rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a totally disabled Member, while receiving long term disability benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the insurer:

- the Member will still be considered totally disabled while taking part in this program, subject to a maximum of 24 months;
- the terms and conditions of this benefit will re-apply to the Member, should he become totally disabled again, as if he had been totally disabled during the rehabilitation period;
- the maximum benefit period during any period of total disability will continue to apply even if the Member is taking part in an approved disability management program or rehabilitative employment;
- any income earned by the Member while taking part in this program will reduce the long term disability benefits payable by the insurer to the Member by the amount produced by the following formula:

$$(A \div B) \times C$$

A = Income earned from any rehabilitative activity

B = Monthly earnings of the Member immediately prior to the commencement of total disability

C = Long term disability benefits otherwise payable under this benefit

- while the Member is taking part in a disability management program, the insurer will reduce his long term disability benefits so that his total income from all sources, if any, as listed in the indirect offset provision of the reduction of long term disability benefits, limitations and exclusions section of this benefit, does not exceed 100 per cent of his net earnings immediately prior to the commencement of total disability if this benefit is non-taxable, or 100 per cent of his gross earnings immediately prior to the commencement of total disability if this benefit is taxable.

A Member who refuses to take part in a disability management program, does not participate in such program in good faith or does not take up rehabilitative employment considered appropriate by the insurer will no longer be eligible for monthly benefits payable under this benefit.

Benefit Termination

Long term disability benefits will cease on the earliest of:

- the date on which the Member ceases to be totally disabled;
- the date on which the Member engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;
- the date set by the insurer on which the Member was required to provide satisfactory proof of total disability or to undergo a medical examination requested by the insurer, but neglected or refused to do so;
- the date on which payments have been paid up to the maximum benefit period for any one period of total disability;
- the date on which the Member refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the insurer; or
- the date on which the Member attains the age limit specified in the benefit schedule.

Extension of Benefit after Termination

If a Member is totally disabled on the date his insurance terminates, the insurer will continue insurance for that total disability as if the insurance under this benefit for that Member were still in force, provided such total disability continues uninterrupted, subject to all other provisions of the policy.

If a Member is not totally disabled on the date this benefit terminates but was receiving long term disability benefits under this benefit less than six months prior to such date, such Member will be eligible to a resumption of long term disability benefits if he again becomes totally disabled from the same or related causes prior to:

- 90 days after the termination of this benefit; or
- 180 days after the last day he was totally disabled.

The reinstated long term disability benefits will be equal to those which the Member was previously eligible to receive and will continue for the remainder of the maximum benefit period.

Notice and Proof of Claim

Initial written notice of a claim must be submitted to the insurer within 30 days of the expiry of the elimination period and initial written proof, within 60 days of the expiry of the elimination period.

In the event of the recurrence of total disability, written notice of a claim must be submitted to the insurer within 30 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

Subsequent written proof satisfactory to the insurer of continuing total disability must be submitted to the insurer at its request.

BASIC MEMBER CRITICAL ILLNESS BENEFIT

Amount of Insurance	\$25,000
Non-Evidence Maximum of Insurability	\$25,000
Age Limit	age 65 of the Member or loss of coverage (whichever occurs first)

Definitions – as used in this benefit

- **Alzheimer's disease** means a progressive neurodegenerative disease diagnosed by a duly qualified Neurologist. The Member must exhibit deterioration in intellectual capacities involving impairment of memory and judgment, resulting in such a reduction in his mental faculties and his ability to function in society that he requires constant supervision.
- **Coma** means a state of profound unconsciousness that persists continuously for at least 96 hours and as a result of which the Member no longer reacts to any external stimuli.
- **Coronary bypass (coronary artery bypass surgery)** means surgery recommended by a duly qualified Cardiologist for the correction of stenosis or occlusion of one or more coronary arteries by way of a bypass graft operation.
- **Heart attack (myocardial infarction)** means the failure of a part of the cardiac muscle due to occlusion of one or more coronary arteries. The diagnosis must be based on the following two elements:
 - new electrocardiographic variations that support the diagnosis of a heart attack; and
 - elevated levels of cardiac enzymes.
- **HIV infection (occupationally-acquired infection)** means infection with the human immunodeficiency virus (HIV) that occurs after the effective date of coverage, due to an accident or injury occurring in Canada while the Member is performing the regular duties of his occupation which exposed him to blood or other body fluids contaminated with HIV.
- **Kidney failure** means the permanent and irrecoverable failure of both kidneys requiring regular dialysis or a kidney transplant.
- **Life-threatening cancer** means a malignant tumour diagnosed by a Physician and characterized by the uncontrolled development and spread of malignant cells invading tissue.
- **Loss of hearing in both ears** means the total and irrecoverable loss of hearing in both ears diagnosed by a duly qualified Otolaryngologist and corresponding to an auditory threshold of greater than 90 decibels.

- **Loss of sight of both eyes** means the total and irrecoverable loss of sight of both eyes diagnosed by a duly qualified ophthalmologist, corresponding to a corrected visual acuity of 20/200 or less, or to a field of vision of less than 20 degrees in both eyes.
- **Loss of speech** means the total and irrecoverable loss of speech as confirmed by a Physician.
- **Major burns** means any third-degree burns diagnosed by a duly qualified Plastic Surgeon and covering at least 20% of the surface area of the Member's body.
- **Major organ transplant** means surgery during which one of the following organs or tissues is transplanted into a recipient: heart, liver, lung, kidney or bone marrow.
- **Multiple sclerosis** means at least two episodes of a minimum duration of six consecutive months during which the Member has experienced well-defined neurological abnormalities, clearly diagnosed by a duly qualified Neurologist and supported by modern research techniques, including but not limited to CT scans and magnetic resonance imaging.
- **Muscular dystrophy** means muscular dystrophy clearly diagnosed by a Physician, characterized by well-defined muscular or neurological abnormalities and supported by electromyography and a muscle biopsy.
- **Paralysis** means the total, irrecoverable and permanent loss of use of two or more limbs for a continuous period of complete disablement of such limbs of not less than 12 months.
- **Parkinson's disease** means idiopathic and degenerative Parkinson's disease diagnosed by a duly qualified Neurologist. The diagnosis must be based on two or more of the following symptoms:
 - *Rigidity*
 - *Tremors*
 - *Bradykinesia*
- **Stroke** means any cerebrovascular injury causing an infarction of brain tissue due to hemorrhage, thrombosis or embolism and producing a measurable neurological deficit that persists for at least 30 days after the stroke.

Evidence of Insurability

Evidence of insurability satisfactory to the insurer will be required of a Member applying for any amount of basic Member critical illness benefit in excess of the amount specified in the benefit schedule as the non-evidence maximum of insurability under the basic Member critical illness benefit.

Payment of Benefit

Upon receipt of Proof of Claim satisfactory to the insurer confirming:

- that a Physician, specialized in the appropriate field and licensed to practise in Canada, has diagnosed a Member as having one of the Illnesses listed in the eligible critical Illness benefit schedule;
- that the Member is covered under this benefit when the Illness from which he suffers is first diagnosed.
- that the Member survived for at least 30 days after the date the diagnosis was made by a licensed Physician;
- in the event that the Member has cancer:
 - that the medical symptoms or problems that gave rise to the diagnosis of that cancer appeared at least 90 days after coverage took effect or was reinstated, or
 - that the cancer was diagnosed by a Physician at least 90 days after coverage took effect or was reinstated, then

the Insurer will pay the amount applicable to any Illness in accordance with the eligible critical Illness benefit schedule and other applicable policy provisions.

The Member may only make one claim for only one Critical Illness under this benefit.

Eligible Critical Illness Benefit Schedule

The amount payable for each type of Illness corresponds to the percentage indicated below multiplied by the insurance amount specified in the benefit schedule.

Extended Coverage

Critical Illness	% Payable
Alzheimer's disease	100%
Muscular dystrophy	100%
Multiple sclerosis	100%
Paralysis	100%
Parkinson's disease	100%
Loss of sight of both eyes	100%
Kidney failure	100%
Major burns	100%
Major organ transplant	100%
Stroke	100%
Coma	100%
Coronary bypass	100%
Heart attack (myocardial infarction)	100%
Life-threatening cancer	100%
Loss of hearing in both ears	100%
Loss of speech	100%

Restrictions, Exclusions and Limitations

No benefit is payable for any critical illness resulting directly or indirectly from any of the following:

- intentionally self-inflicted injury, voluntary exposure to an illness or attempted suicide while sane or insane;
- war, whether war be declared or not, or active service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- committing, or attempting to commit a criminal offence;
- alcohol abuse; or
- the use of any medication, narcotic, intoxicant or any other harmful substance, except when prescribed or recommended by a Physician.

No benefit is payable for the following:

- a loss sustained as a result of an accident causing bodily injury for which the insurer has paid the applicable amount under the member accidental death and dismemberment benefit;
- an illness or pre-existing condition for which the Member has received care, treatment or services, consulted a Physician or taken medication that was prescribed to him, in the 24 months prior to the effective date of coverage, unless the illness in question was diagnosed at least 24 months after the effective date of the insurance of the Member, subject to other applicable provisions of the policy;
- paralysis, paraplegia, hemiplegia or quadriplegia resulting directly or indirectly from the practice of one or more of the following activities: amateur or professional boxing, bungee jumping, cliff diving, mountain climbing, car racing or speed races on land or water, parachuting or underwater activities;
- transient cerebral ischemia;
- all types of parkinsonism other than idiopathic and degenerative Parkinson's disease;
- non-surgical techniques, such as balloon angioplasty or the correction of an occlusion using laser treatment or any other non-bypass technique; or
- organic brain syndromes and psychiatric disorders other than Alzheimer's disease.

Restrictions, Exclusions and Limitations Related to Cancer Diagnosis

This benefit does not apply when cancer is diagnosed within 90 days of the effective date of coverage or reinstatement or when the medical symptoms or problems giving rise to the diagnosis of cancer appeared during this initial 90-day period.

In addition, no benefit is payable for the following forms of cancer:

- early prostate cancer, diagnosed as being type T1NOMO or an equivalent stage;

- non-invasive cancer in situ;
- precancerous lesions, benign tumors or polyps;
- any tumour that develops in a person who is HIV seropositive; or
- any skin cancer, excluding invasive malignant melanoma affecting the dermis or developing at a deeper level.

Restrictions, Exclusions and Limitations Related to Diagnosis of HIV Infection

Benefits are payable provided that the following conditions are met:

- the Insured Person (or the Policyholder) must inform the insurer of any accident or injury that could result in HIV infection within 14 days of the event;
- within 14 days of the accident or injury, the Insured Person must undergo blood tests confirming that he is HIV seronegative; and
- between the third and sixth month following the accident or injury, the Insured Person must undergo blood tests confirming that he has become HIV seropositive.

The insurer may require that all blood samples taken be provided so they can be analyzed by an independent lab, and may request any other blood test that it deems appropriate.

If an HIV vaccine becomes available, no benefits will be paid to an Insured Person who has an accident or is injured on the job and who previously refused to be vaccinated. In addition, no benefits will be payable if a cure for HIV became available prior to the accident or injury giving rise to the claim. HIV infections resulting from any cause not related to the Insured Person's work, such as sexual activity or drug use, are not covered under this benefit.

Geographic Limitations

If an eligible critical illness is diagnosed outside Canada following an accident or illness, the insurer will only assess the claim once the Member, having returned to Canada, has obtained an assessment of the diagnosis made previously and has received medical care.

Benefit Termination

This benefit terminates on the earliest of the following dates:

- the date on which the Member attains the age limit specified in the benefit schedule;
- the earliest of the dates indicated in the termination of Member insurance provision;
- the date on which the insurer pays the amount applicable to one of the eligible critical illnesses under this benefit.

Notice and Proof of Claim

Before settling any claim under this benefit, the insurer will require satisfactory written proof of the existence of the relevant illness and of the Member's eligibility for benefits at the time the diagnosis was made.

A written initial notice of claim must be submitted to the insurer within 30 days of the events.

The insurer reserves the right to verify the diagnosis with the attending Physician(s) and to require any Member who has submitted a claim to be examined at the insurer's expense.

Proof of Claim Related to an Accident or Injury that may Result in HIV Infection

A written notice of claim must be submitted to the insurer within 14 days of the accident or injury.

The Insured Person (or the Policyholder) must notify the insurer of the accident or injury, which will then be investigated and a report produced in accordance with the established procedures for the occupation in question.

BASIC MEMBER LIFE INSURANCE BENEFIT

Basic Member Life Insurance Benefit Amounts

Active Member (69 years of age and under)	\$100,000
Active Member (70 years and older)	\$10,000
Non-Evidence Maximum of Insurability	\$100,000
Age Limit	Terminates at date of death or retirement

Payment of Benefit

Upon receipt of proof of claim satisfactory to the insurer that a Member died while insured under this benefit, the insurer will pay the amount of life insurance applicable to such Member in accordance with the benefit schedule and other applicable provisions.

Living Benefit

Subject to the approval of the insurer, any Member whose life expectancy is less than 24 months may apply for payment of a portion of the amount of life insurance applicable to him, subject to the following conditions:

- a totally disabled Member may be required to be examined by a Physician designated by the insurer;
- a totally disabled Member must qualify for approval for the Waiver of Premium under the basic Member life insurance benefit of the policy;
- prior approval must be obtained from the policyholder before any payment may be made; and
- any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the insurer.

The living benefit is equal to 50% of the amount of life insurance applicable to the Member in accordance with the benefit schedule. In addition, this amount may not be less than \$5,000 or more than \$100,000.

At the death of the Member, the value of the living benefit will be deducted from the amount that would otherwise have been payable under the basic Member life insurance benefit.

Living Benefit Exclusion

The living benefit will not be payable if there has been any material misrepresentation or non disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the living benefit is paid, the value of the living benefit will be repaid to the insurer by the recipient of the living benefit.

Benefit Termination

This benefit terminates on the date the Member attains the age limit specified in the benefit schedule or on the earliest of the dates indicated in the Termination of Member Insurance provision.

Conversion Privilege

If the life insurance of a Member aged 64 or younger terminates or is reduced for any reason other than due to policy termination, the Member will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

Please contact the Administrator for complete details.

Extension of Benefit after Termination

If a Member dies within 31 days of termination of insurance under this benefit, the amount of life insurance he was eligible to convert will be payable.

Notice and Proof of Claim

Before settling any death claim, the insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislations, the insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Member will be paid to the beneficiary designated by the Member within 60 days of receipt of satisfactory proof of claim to the Insurer.

Waiver of Premium

Benefits for which premiums are waived in the event of total disability:

- basic Member life insurance benefit,
- Dependent life insurance benefit,
- Member optional life insurance benefit,
- basic Member critical Illness benefit, and
- Member long term disability benefit.

Beginning of Waiver of Premium

The date on which long term disability benefits are expected to commence.

For the benefits listed in the Waiver of Premium provision in the benefit schedule, as of the beginning of Waiver of Premium mentioned in the Waiver of Premium provision in the benefit schedule, premiums will be waived for a Member who becomes totally disabled while insured under the policy but prior to attaining age 65, if he submits proof of claim satisfactory to the insurer. Premiums will continue to be waived for as long as the total disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:

- the date on which the Member is unable or unwilling to provide satisfactory proof of total disability to the Insurer, if such proof is not provided within three months of the request,
- the date on which the Member ceases to be totally disabled,
- for the life insurance benefit, the date on which the Member converts his insurance under the Conversion Privilege provision,
- the date on which the Member attains age 65 or retires, if earlier, or
- in respect of each of the benefits listed in the Waiver of Premium provision terminates in the benefit schedule, the date on which each benefit or the policy terminates except for the basic Member life insurance benefit, the Dependent life insurance benefit, the Member optional life insurance benefit and the Member long term disability benefit.

Under the policy, any provision for an increase in coverage is suspended during a total disability.

A recurrence of total disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.

In the case of the life insurance benefit, if a totally disabled Member dies more than 31 days after his insurance terminates, prior to attaining age 65, and written notice and proof of total disability has not been received by the insurer, the amount of life insurance applicable to such Member in accordance with the benefit schedule that was in effect at the time his insurance terminated will be payable provided that:

- the Member became totally disabled while insured under this benefit,
- the total disability of the Member was uninterrupted from the onset of his total disability to the date of his death,
- the Member dies within 12 months from the onset of his total disability,

- the Member did not convert any or all of his insurance under the Conversion Privilege provision at the time his insurance terminated, and
- satisfactory proof of the total disability and death of the Member is received by the Insurer within 90 days of his death.

To be eligible for Waiver of Premium, the insurer must receive written notice of total disability within 12 months of the date the Member becomes totally disabled, and proof satisfactory to the insurer of total disability within 90 days following the date the Insurer received written notice.

In the event of recurrent total disability, the insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

ACCIDENTAL DEATH & DISMEMBERMENT

The accidental death and dismemberment benefit provides accident insurance 24 hours a day, anywhere in the world. All eligible Members of The Millwrights' Health and Welfare Trust Fund for Alberta aged 69 and under are automatically covered by this insurance for a benefit amount of \$100,000.

The following benefits are provided if the loss occurs as a result of an accident within one year from the date of the accident:

For loss of	Benefit Amount
Life	100%
Speech and Hearing in Both Ears	100%
Both Hands, Both Feet or Sight of Both Eyes or a Combination of a Hand, a Foot or Sight of One Eye	100%
One Arm or One Leg	75%
One Hand, One Foot or Sight of One Eye	67%
Speech or Hearing in Both Ears	67%
Thumb or Index Finger of Either Hand	33%
Hearing in One Ear	33%
Four Fingers of Either Hand	33%
All Toes of One Foot	25%

For Loss of Use of

Both Hands or Both Feet or a Combination of a Hand and a Foot	100%
Both Arms or Both Legs or a Combination of an Arm and a Leg	100%
One Arm or One Leg	75%
One Hand or One Foot	67%
Thumb and Index Finger of Either Hand	33%

Paralysis

Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

Definitions

"Loss"

- with reference to speech means the permanent and irrecoverable loss of the capability of speech without the aid of mechanical devices,
- with reference to hearing means the permanent and irrecoverable loss of hearing in both ears,
- with reference to hand or foot means complete severance through or above the knuckle joint of at least four fingers or three fingers and a thumb or ankle joint,
- with reference to arm or leg means complete severance through or above the elbow or knee joint,

- with reference to sight of an eye means the permanent loss of vision in one eye, and
- with reference to thumb and index finger means complete severance through or above the knuckle joints of the thumb and index finger.

“Paralysis”

- means complete and irreversible loss of all motion of all practical use of an arm or leg provided the loss is continuous for 12 consecutive months.

“Loss of Use”

- means the permanent and total inability of the specified body part to function providing the loss is continuous for 12 consecutive months.

Exposure & Disappearance

If the Member has not been found within one year of the disappearance, stranding, sinking, wrecking or breakdown of any conveyance in which the Member was covered as an occupant, it will be assumed, subject to all other terms of this policy, that the Member has suffered loss of life under the policy.

Accident includes unavoidable exposure to elements.

Beneficiary Designation

The loss of life benefit will be paid to the beneficiary designated by the Member. If no beneficiary is designated, the benefit will be paid to the first surviving class in the following order:

1. The Member’s Spouse
2. In equal shares to the Member’s surviving Children
3. In equal shares to the Member’s surviving parents
4. In equal shares to the Member’s surviving siblings
5. To the Member’s estate

All other benefits are paid to the Member.

Day Care Benefit

If the Member suffers accidental loss of life, this benefit helps pay for the Child care of covered Dependents under the age of 13. The day care expense benefit will be paid for actual costs incurred, up to \$5,000 for each eligible Child per year to a maximum total payment of \$20,000 for all Children, and all years. The Child/Children must be enrolled in a legally licensed day care centre or be enrolled within 12 months after the date of death of the Member.

Education Expense

If the Member suffers accidental loss of life, this benefit helps pay for the higher education of covered Dependents who are enrolled or who enroll full time in a private or public college, university or professional trade school (above Grade 12) within two years of the loss of life. Education expense benefits are payable for actual incurred

costs for tuition, fee, room and board billed by the institution of higher learning, and for required books and course supplies to a maximum of \$5,000 annually for each eligible Child for up to four consecutive years.

If on the date of the Member's accidental loss of life no Dependents are eligible for the education expense benefit, a one-time amount of \$2,500 will be paid.

Family Transportation

If an accidental bodily injury causes the Member to suffer a covered loss that results in confinement in a Hospital not less than 150 kilometres away from the Member's permanent residence and the attendance of an Immediate Family Member is recommended by the attending Physician, a benefit amount of up to \$10,000 for transportation costs of that Family Member will be paid.

"Immediate Family" includes Spouse (legal or common-law), parent, grandparent, Child aged 18 and over, and sibling.

If transportation occurs in a vehicle or device other than one operated under a licence for the conveyance of passenger for hire, then the reimbursement of transportation expenses will be limited to a maximum of \$.20 per kilometre traveled.

Home/Vehicle Adaptation

If an accidental bodily injury causes the Member to suffer a covered loss that results in a Physician determining that home/vehicle adaptation is needed to accommodate a physical disability, a benefit of up to \$10,000 will be paid for home alterations or vehicle modifications.

Home/vehicle adaptation also includes expenses incurred for hiring of transportation services necessary to accommodate the physical disability of the Member.

Eye glasses, Contact lenses and Hearing Aids Benefit

If an accidental bodily injury for which the Member is treated by a Physician, results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the accident, The Plan will pay the reasonable and necessary expenses up to \$1,000.

Repatriation

If the Member suffers accidental loss of life, The Plan will pay up to \$10,000 for the preparation and return of the body to the Member's city of residence.

Rehabilitation Benefit

If an injury sustained by the Member requires that the Member undergo special training in order to be qualified to engage in a special occupation in which he would not have engaged except for such injury, The Plan will pay the reasonable and necessary expenses incurred for such training, subject to a maximum of \$10,000.

Seat Belt

If a motor vehicle accident causes the Member's accidental loss of life, or an injury covered by this benefit, while operating or riding in a private passenger automobile and using a seat belt, this benefit pays an additional amount equal to 10 per cent of the amount that would otherwise be paid.

Spouse Employment Training Expense

If the Member suffers accidental loss of life, this benefit helps pay for the covered Spouse's expenses associated with training to obtain or refresh skills needed for employment. To be eligible, the Spouse must enroll in a public or private college, university or professional trade school (above Grade 12) within three years of the Member's loss of life.

The Spouse employment training expense benefit is payable for the actual incurred cost of tuition, fees, room and board billed by an institution of higher learning, and for required books and course supplies up to a maximum benefit of \$10,000.

Waiver of Premium

If a Member aged 64 or under suffers an accidental bodily injury(ies) or sickness which causes a disability that continues for 90 days, the premium is waived for the Member at the end of the 90 days. The waiver of premium ends at the earliest the date the Member attains age 65, the date this policy ends or the day the Member ceases to be disabled.

Exclusions

Certain situations the policy does not cover include the following:

- loss resulting from suicide, attempted suicide or loss that is intentionally self-inflicted,
- loss caused by or resulting from a declared or undeclared war, but war does not include acts of terrorism, or
- loss occurring while the Member is in active full-time service in the armed forces of any country.

DEPENDENT LIFE INSURANCE BENEFIT

Dependent Life Insurance Benefit Amounts

Dependents of eligible Members:

- Eligible Spouse \$20,000
- Child (commences 14 days from birth) \$10,000

Age Limit Terminates at date of death

Payment of Benefit

Upon receipt of Proof of Claim satisfactory to the insurer that a Dependent died while insured under this benefit, the insurer will pay the amount of Dependent life insurance applicable to such individual in accordance with the benefit schedule and other applicable policy provisions.

Commencement of Newborn Children Insurance

Insurance for a newborn Child of a Member with insured Dependents will commence in accordance with the terms specified in the benefit schedule and the policy provisions, including those that pertain to the commencement of Dependent insurance.

Benefit Termination

This benefit terminates on the date the Member attains the age limit specified in the benefit schedule or on the earliest of the dates indicated in the termination of Dependent insurance provision.

Spouse Conversion Privilege

If the Dependent life insurance of a Spouse aged 65 or younger, insured for a minimum amount of \$5,000, terminates for any reason other than policy termination, the Member or the Spouse, in the event of the death of such Member, may convert the Dependent life insurance on the Spouse to an individual policy, without evidence of insurability, subject to the following conditions:

- the written application for conversion must be submitted to the insurer and the first premium paid with 31 days of the date of termination of the insurance of the Spouse under this benefit;
- the individual policy may be any regular permanent plan issued by the insurer at the date of conversion, excluding special permanent plans as may be designated by the insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times;
- the individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the insurer at the date of conversion;

- the individual policy premium will be based on the rate used by the insurer on the effective date of that policy and that is applicable to The Plan and the amount of the policy issued, the Spouse's age at nearest birthday and the class of risk to which the Spouse belongs;
- if the amount of Dependent life insurance that may be converted is less than the minimum amount for which the insurer will normally issue the selected plan, the individual policy must be for the full amount that the Spouse may convert; and
- the individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Spouse under this benefit.

Extension of Benefit after Termination

If a Spouse dies within 31 days of the termination of his insurance under this benefit, the amount of Dependent life insurance payable will be the amount that the Member or the Spouse, in the event of the death of such Member, was eligible to convert.

Notice and Proof of Claim

Before settling any death claim, the insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the insurer may request an autopsy in order to assess its liability in connection with a claim.

MEMBER OPTIONAL LIFE INSURANCE BENEFIT

Amount of Insurance	Any multiple of \$25,000 with a minimum of \$25,000 and a maximum of \$250,000
Age Limit	Age 65 of the Member, or loss of coverage (whichever occurs first)

Eligibility and Evidence of Insurability

As a prior eligibility requirement for this benefit, evidence of insurability satisfactory to the insurer will be required of a Member applying for any amount of Member optional life insurance.

Payment of Benefit

Upon receipt of Proof of Claim satisfactory to the insurer that a Member died while insured under this benefit, the insurer will pay the amount of optional life insurance applicable to such Member in accordance with the benefit schedule and other applicable policy provisions.

Suicide Exclusion

No optional life insurance benefit is payable in respect of a Member who commits suicide, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance.

Benefit Termination

This benefit terminates on the date the Member attains the age limit specified in the benefit schedule or on the earliest of the dates indicated in the termination of Member insurance provision.

Conversion Privilege

If the optional life insurance of a Member aged 65 or younger terminates under any of the conditions specified under the conversion privilege of the basic Member life insurance benefit and not solely the Member's request, the Member will be entitled to convert that insurance to an individual policy, without evidence of insurability.

The terms, conditions and restrictions applicable under the conversion privilege of the basic Member life insurance benefit will apply to any individual policy available under this benefit except that the maximum amount that may be converted under this benefit will be the maximum specified under the conversion privilege of the basic Member life insurance benefit, minus the amount of any basic Member life insurance that may be converted.

Extension of Benefit after Termination

If a Member dies within 31 days of termination of insurance under this benefit, the amount of optional life insurance he was eligible to convert will be payable.

Notice and Proof of Claim

Before settling any death claim, the insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the insurer may request an autopsy in order to assess its liability in connection with a claim.

OUT OF PROVINCE/COUNTRY COVERAGE

Emergency out of province/country treatment

100% of the costs above the Insured Person's provincial health plan coverage are covered with no deductible. Some restrictions may apply.

- If you or a Dependent are confined in a licensed Hospital in Canada as a result of disease, bodily injury or pregnancy, The Plan will cover the charges for the lesser of:
 - the actual amount charged by the Hospital for room and board less any amount which is payable with respect to the charge under any Government Hospitalization plan, or if you or your Dependent are not covered under any plan, less any amount which would be payable with respect to the charge under the Government Hospitalization plan of the province or territory in which you are resident if you were covered under such plan, or
 - the Hospital room rate differential, for each day that you or your Dependent are confined in the Hospital while your insurance under this provision is in force.
- If you or your Dependent are confined in a licensed Hospital outside of Canada as a result of disease, bodily injury or pregnancy, The Plan will cover charges from the Hospital's average private Hospital room rate differential for each day that you or your Dependent are confined in the Hospital and is insurable under government out-of-Canada regulations, while his insurance under this provision is in force.
- We will only cover the first 60 days of a trip for active Members age 69 and under, the first 45 days of a trip for active Members age 70 and over, and the first 45 days for Members on Retiree coverage. Active Members age 70 and over and Members on Retiree coverage must have a 6-month pre-existing stability period prior to the date of travel. This limitation is not applicable to in-Canada emergency health care coverage.

Travel assistance

The Travel Assistance coverage includes services that are required due to an emergency which occurs while temporarily outside the home province, including outside of Canada, on business or vacation.

Please note:

- We will not cover services required while traveling for health reasons.
- We will only cover the first 60 days of a trip/ the first 45 days for Retirees or active Members aged 70 years and older. This limitation is not applicable to in-Canada emergency health care coverage.

- If traveling outside Canada while pregnant, we will not cover any pregnancy related costs which are incurred within nine weeks of the expected delivery date. Costs associated with a Child born outside of Canada within nine weeks of the expected delivery date, or after the expected delivery date, are not covered.
- The travel assistance benefit does not cover medical emergencies in the home province.

The services under the travel assistance coverage include:

- Multilingual assistance by telephone, 24 hours a day, 365 days a year, for the Insured Person or medical providers to obtain aid, assistance, and exchange information, in matters relating to the covered services.
- Referrals to Physicians or medical facilities, if necessary.
- Arrangements for direct payment, wherever possible, for Physicians' services, Hospitalization and other insured services.
- Communication with the Physician who is treating the Insured Person to get an understanding of the situation and monitor the condition.
- Telephone interpretation services in most major languages.
- The sending and receiving of urgent messages.
- Medical evacuation home or transportation to another medical facility. For transportation home, we will pay for an economy fare ticket.
- Arrangements for (including all necessary documents) and the cost of transporting the Insured Person's remains to their home. We will pay up to a maximum of \$3000.
- Help to locate embassy or consulate services.
- Help to locate lost documents or luggage.

The travel assistance benefit includes the following services but we must approve the charges first:

- The cost of additional commercial accommodation required beyond the original return date, for a companion traveling with the Insured Person. This includes charges for accommodation, meals, telephone and taxi or rental cars. We will pay a maximum of \$150 per day up to a total of \$3,000.
- The cost of an economy fare ticket home, for a companion who is traveling with the Insured Person, and who has forfeited their ticket because of a delay caused by the Insured Person's Illness, injury, or death.
- The cost of an economy fare ticket home for each Child left alone because of the Insured Person's Illness, injury, or death. The travel assistance provider will also arrange for a qualified attendant to accompany the Child(ren), if necessary.

- The cost of a round-trip economy fare ticket for a Family Member to visit an Insured Person who is traveling alone and must be hospitalized for more than 10 days.
- The cost of returning a vehicle to the Insured Person's home or the nearest rental agency. We will pay up to a maximum of \$5,000.

When you or your Dependents travel, please take the travel assistance card given to you by The Plan Administrator or your Union office. It contains the name of your travel assistance provider and the telephone numbers to call in case of an emergency. Please contact the Travel Assistance Centre using the telephone number on the travel assistance card.

We are not legally responsible for the actions or advice of any Physician or attorney to whom we refer the Insured Person.

Extended coverage

Extended coverage may be available for an additional premium – please contact the Administrator for details.

How to make an out-of-province/country claim

In the event of an emergency, you must call Global Excel immediately. The emergency telephone numbers are listed on the back of the medical assistance card provided.

What is not covered for emergency-out-of-province/country treatment and travel assistance

We will not pay for any costs resulting directly or indirectly:

- from an accident occurring while you or your Dependent were operating a vehicle, vessel or aircraft, if you or your Dependent:
 - were impaired by drugs or alcohol, or
 - had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood.
- from the abuse of illegal substances.

SUBMISSION OF CLAIMS

Claim forms for each part of The Plan are available from the Administrator. Each form contains the necessary instructions for its completion and submission. If those instructions cause questions, please speak with the administrative staff, but remember the forms must be fully completed if your claim is to be processed.

The Plan does not accept electronic claims submissions. Please submit all drug, dental and EHC claims manually to the Administrator.

Manual claims and questions about The Plan should be directed to:

The Administrator

The Millwrights' Health & Welfare Trust Fund For Alberta

Suite 101, 2635 – 37 Avenue NE

Calgary AB T1Y 5Z6

Toll-free 1.888.525.1460

Phone: 403.769.9866

E-mail: MW1460@pbas.ca

Fax: 403.250.9236

Notice and Proof of Claim

Notice and proof of any claim must be received by the Administrator within the time limit, if any, specified for each benefit. However, if The Plan terminates, no payment will be made unless the notice and proof of a claim is submitted to the Administrator within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 18 months after the expenses were incurred.

Beneficiary

Subject to legal provisions, a Member may designate or revoke, at any time, one or several beneficiaries of any insurance on written notice to the Administrator. The rights of a beneficiary who dies before the Member revert to the latter.

The death benefit payable when a Dependent dies is paid to the Member, if alive. If the Member is deceased, the death benefit is paid as follows:

- In the event of the Spouse's death:
 - To the Spouse's legal heirs;
- In the event of the death of the Member's Dependent Child:
 - To the Spouse, if alive, or
 - If the Spouse is deceased, to the legal heirs of the Dependent Child.

Claims

Claims under the policy must be submitted to the Administrator on the appropriate form.

Any living benefits will be paid to the Member unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Member must submit to the Administrator proof of death, including a death certificate, proof of age, as well as any other information deemed useful by the insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Member, or is not competent to give valid release, the insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Member life insurance benefit in an amount not exceeding \$5,000 to any person the insurer deems equitably entitled to such amount to cover the Member's burial expenses. Such payment will fully discharge the insurer, and the other insurers, provided this payment is made in good faith.

Medical Examinations

From time to time, the Fund and/or the insurers they employ will be entitled to have a claimant examined by a Physician or Physicians of its choice.

Upon providing payment for incurred expenses or assuming liability for incurred expenses, the insurer is subrogated to all the rights of recovery of the Member against any individual and may bring action in the name of the Member to enforce such rights.

If a Member is entitled to recover damages for loss of income from another party and he is entitled to receive benefits under the long term disability benefit of the policy, the insurer will be subrogated to all the rights of recovery of the Member for loss of income to the extent of the total benefits paid or payable to him.

Misstatement of Age

If the age of any individual has been misstated, the benefits payable under the policy will be based upon the actual age of the individual concerned, at the relevant time. If the age has been misstated, premium adjustments will be made for the full time such insurance has been in force.

Assignment

The rights or interests of a Member under The Plan cannot be assigned.

Claim Forms

Claim forms can also be downloaded from the Millwrights website at

albertamillwrights.com

DEFINITIONS

The following are definitions for some of the terms in your Member booklet. You will find additional definitions included in each section.

- **Actively at Work**

“Actively at Work” means that you are performing normal duties for a Participating Employer or that you are available for work as signified by your name appearing on the Out-Of-Work listing of the Union.

- **Administrator**

The “Administrator” is Prudent Benefits Administration Services Inc. (PBAS).

- **Age**

“Age” refers to the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

- **Child**

A “Child” is an unmarried son or daughter including a stepchild or common-law Child. Common-law Child means a Child of your common-law Spouse and another person. This Child must be Dependent on you and your common-law Spouse for support and maintenance.

A Child must be under age 22 and depend on you for support and maintenance. Coverage is provided for a Child under age 25 and attending an accredited college or university on a full-time basis. Confirmation that the Child is a full-time student and remains Dependent on you for support and maintenance is required.

Coverage will continue beyond the maximum ages indicated above for a Child who is mentally or physically challenged as long as:

- The Child became handicapped before reaching the applicable maximum age stated above, and
- Satisfactory proof is provided to us that the Child is not capable of self-support due to the handicap.

- **Dependent**

A “Dependent” is your Spouse or Child. Anyone who is in the armed forces full-time is not eligible to be a Dependent.

- **Emergency**

An “Emergency” means any sudden, unexpected illness or injury for which the Insured Person needs immediate treatment.

- **Employee**

An “Employee” is a person who lives in Canada and who is employed by a Participating Employer in accordance with the rules, regulations and procedures established by the Trustees of The Millwrights’ Health & Welfare Trust Fund for Alberta.

- **Family**

A “Family” is the Member and his/her Dependents.

- **Good Standing**

A Member in “Good Standing” is a dues-paying Member of Millwrights Local #1460 who appears in the Ultra system and who adheres to the provisions set out in the Out of Work Rules **or** a dues-paying Member of Millwrights Local #1460 who appears in the Ultra system as “Retired” or “Early Retired”.

- **Hospital**

A “Hospital” is an institution that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

- **Illness**

An “Illness” is any health deterioration or bodily disorder certified by a Physician. For the purposes of this policy, organ donations and related complications are also considered Illnesses.

- **Immediate Family**

An “Immediate Family” Member is the person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Member.

- **Insured Person**

“Insured Person” is the Member and/or his Dependent who is covered under The Plan.

- **Leave of Absence**

A “Leave of Absence” is a period of time that you are permitted to be absent from work. The Trustees must have agreed to the Leave of Absence.

- **Maternity Leave or Parental Leave**

“Maternity Leave” or “Parental Leave” is any official period of Maternity or Parental Leave taken by a Member in accordance with provincial or federal legislation or an agreement between the Member and the Participating

Employer, or any other period during which a Member receives maternity benefits under the Employment Insurance program.

- **Member**

“Member” means a Member in Good Standing with the Millwrights Health & Welfare Trust Fund for Alberta, who meets the eligibility requirements as set forth in the rules, regulations and procedures established by the Trustees of the Millwrights’ Health & Welfare Trust Fund for Alberta.

- **Participating Employer**

“Participating Employer” means an entity that:

- is party to or bound by a Collective Agreement with the Union, and
- makes contributions on behalf of its Members to the Millwrights’ Health & Welfare Trust Fund for Alberta.

- **Physician**

A “Physician” is a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

- **The Plan**

“The Plan” is the Millwrights’ Health and Welfare Trust Fund for Alberta.

- **Pregnancy Leave of Absence**

“Pregnancy Leave of Absence” means a period of time you are permitted to be absent from work because of pregnancy. It can either be a pregnancy leave allowed by provincial or federal law or a leave to which you and your Participating Employer agree. It can also mean a pregnancy leave that your Participating Employer asks you to take, if allowed by law.

We consider that a Pregnancy Leave of Absence begins on the earlier of the following dates:

- the date that you or your Participating Employer choose as the beginning of the leave, or
- the date your Child is born.

We consider that a Pregnancy Leave of Absence ends on the earlier of the following dates:

- the day before the date that you are scheduled to return to work, or
- the day before the date that you return to work.

- **Registration Card**

A “Registration Card” is the form titled MILLWRIGHTS’ HEALTH AND WELFARE TRUST FUND FOR ALBERTA REGISTRATION CARD which is supplied by the Administrator. It contains all the information that is required for any insurance to be provided and for any claims to be paid. This form

must be completed on both sides and filed with the Administrator prior to coverage being provided.

- **Retiree**

A “Retiree” is a Member who remains in Good Standing with the Union, and who appears in the Ultra system as either “Retired” or “Early Retired”.

- **Spouse**

A “Spouse” is a person to whom you are legally married or with whom you have a common-law relationship. Common-law Spouse means the person with whom you have been cohabiting for the following amount of time:

- The past 36 months if you are prevented from being married, or
- The past 12 months and with whom you represent as your legally married Spouse if you are not prevented from being married.

Only one Spouse can be covered at a time.

- **Trustees**

“Trustees” means the Trustees of the Millwrights’ Health and Welfare Trust Fund for Alberta.

- **Union**

“Union” means the Millwrights, Machinery Erectors and Maintenance Union Local 1460.