COMMERCIAL WORKERS BENEFIT PLAN

CENTURY PRINTING INC.

WELCOME TO ALL FULL-TIME EMPLOYEES

Within the pages of this booklet, you will find a description of the benefits to which you are entitled under the Commercial Workers Benefit Trust Fund-Benefit Plan ("the Plan"), which the Board of Trustees is pleased to sponsor.

This booklet explains the rules regarding eligibility and the procedures to follow when you submit a claim. Life Insurance and Dependant Life Insurance are provided through Industrial Alliance under group contract number 24403. Accidental Death and Dismemberment (AD&D) is provided by Industrial Alliance Pacific under group contract 100005820. Out-of-Country benefits are provided through ETFS Financial Group Inc. ("ETFS"), under group contract number 30726445. All other benefits are reimbursed directly from the assets of the Fund.

In addition, eligible Members will receive an information brochure explaining the details of their Emergency Travel Assistance program, along with an Emergency Travel Assistance card.

The information contained in this booklet does not create or confer any contractual or other rights. The Trustees and the insurance providers, have full authority to resolve all questions related to the provisions of this program and may, from time to time, amend the Plan. If your coverage is modified after the effective date of the details printed here, you will receive written notification of this change.

If you have any questions about the information stated here, or you have claims to submit, please contact the Administrator at the address below.

Office of the Administrator
Commercial Workers Benefit Trust Fund
Suite 110 - 61 International Blvd.
Toronto, Ontario
M9W 6K4

Telephone: (416) 674-3350
Facsimile: (416) 674-1525

www.workersbenefits.ca

PLAN REGISTRATION CARD

All new Members are asked to complete and sign (in ink) a registration card and return it to the Office of the Administrator. Registration cards may be obtained through your employer, local union, or by contacting the Administrator. If the information on the registration card changes, please complete another card fully, and remit to the Office of the Administrator as soon as possible.

BENEFICIARY

As part of the information required on the registration card you are asked to name a beneficiary (ies) as the recipient of your Member Life Insurance and Accidental Death and Dismemberment benefit. Should you need to change your designated beneficiary, you must complete a new registration card and forward it to the Office of the Administrator. The change will take effect as of the date the designation is executed, according to provincial law, and without prejudice to the Plan for any payments made before such request is received.

In the event that the Administrator does not receive a beneficiary designation, the Member Life Insurance benefit must be paid to your estate and will be subject to an otherwise avoidable probate fee.

PRIVACY POLICY

Participation in the Plan depends on the collection, storage, use, and sometimes the destruction of personal information about you the Member, your dependants and beneficiaries. It forms the foundation upon which individual entitlements are built, and from which benefit payments are calculated and made. As well, segments of this personal information may be needed to satisfy government demands for facts, to facilitate audits of the Plan, to estimate future operating costs, to inform Members about their accumulated values, and to transfer data to any replacement program. As well, the information could be called into a court action. In all cases, however, your personal information is stored with the utmost attention to security and deployed sparingly, to fulfill the requirements of the Plan and the law.

Registration to participate in the Plan involves an authorization to allow the Trustees to gather and apply personal information in specific ways. You may revoke this authorization, subject to certain legal constraints. However, doing so precipitates the destruction of your personal information file and may, therefore, render ongoing participation impossible.

Complaints regarding personal information may be directed to the Administrator's Privacy Officer at the address noted on the previous page, by contacting the Office of the Privacy Commissioner of Canada or, if applicable, the Provincial Commissioner.

TABLE OF CONTENTS

SECTION 1 - MEMBERSHIP Page

Eligibility 7

SECTION 2 - COVERAGE

Life Insurance 10
Dependant Life Insurance 12
Accidental Death and Dismemberment 13
Dental 16
Health 20
Out of Province 23

SECTION 3 - CLAIM PROVISIONS

Claim Provisions 25

SECTION 4 - INDEX OF TERMS

Definitions 27

FREQUENTLY ASKED QUESTIONS

Eligibility

Am I eligible for benefits? 7
When do I become elegible for benefits? 7
How do I maintain my eligibility for benefits? 7
Are my dependants eligible for benefits? 7
Do my benefits continue during a temporary absence from work? 8
When does my coverage terminate? 9

Life Insurance

Do I have Life Insurance? 10
What happens to Life Insurance coverage if I become Totally and Permanently Disabled while I am covered? 10

If I am no longer eligible for Life Insurance or my Life Insurance coverage reduces, is there an option to convert it to an individual policy? 11

Dependant Life Insurance

Does my Plan provide Dependant Life Insurance coverage? 12

Can Dependant Life Insurance be converted to an individual policy? 12

Accidental Death and Dismemberment ('AD&D')

Do I have an Accidental Death and Dismemberment benefit? 13

What other related expenses are covered in the event of AD&D? 14

Are there any exclusions or limitations? 16

Dental

Do I have Dental Coverage? 16

Could my dentist's charges be based on a different fee guide? 16

What is considered routine dental work? 17

What is covered with respect to dentures? 17

What is covered with respect to crowns and bridgework? 18

What is covered with respect to orthodontics? 18

Can work be performed by other dental practitioners? 18

What dental procedures are not covered by this Plan? 18

What do I need to know before I go to the dentist? 19

Should I have my dental treatment pre-authorized? 19

Health

Do I have Health Coverage? 20

How are these eligible services reimbursed? 20

If I am traveling outside of Canada, do I have medical coverage? 23

What is covered by the Out-of-Province benefit? 23

Are there any exclusions or limitations? 24

Claim Provisions

How do I make a claim? 25

What if my spouse also has Health and/or Dental coverage? 25

Proof of Loss 25

SECTION 1 - MEMBERSHIP

ELIGIBILITY

AM I ELIGIBLE FOR BENEFITS?

You are eligible to receive the benefits described in this booklet if:

- You have been employed on a full-time basis (working a minimum of 39 hours a week) for more than 3 months and are actively at work; **and**,
- You are an active, full-time, permanent employee, of an employer that contributes to the Commercial Workers Benefit Trust Fund on your behalf; **and**,
- You are insured under a provincial health plan.

WHEN DO I BECOME ELIGIBLE FOR BENEFITS?

You become eligible for benefits on the first day of the month following 3 months of continuous full-time employment. If you are absent from work due to sickness or disability on the day you would normally become eligible for coverage, or an increased level of coverage, it will become effective the date you return to work for one full day.

HOW DO I MAINTAIN MY ELIGIBILITY FOR BENEFITS?

To remain eligible for benefits you must work a minimum of one four-hour shift each month and continue to be insured under a provincial health plan. If this requirement is not met, you must re-qualify for benefits in accordance with the rules for eligibility described above.

ARE MY DEPENDANTS ELIGIBLE FOR BENEFITS?

If you are eligible for benefits, so are all the eligible dependants in your immediate family as long as they are covered under a provincial health insurance plan. Eligible dependants include your:

Spouse to whom you are legally married or with whom you have cohabited for at least one continuous year and publicly represent as your spouse

Children who are either your natural or legally adopted or stepchildren or other children living with you on a full-time basis; and are,

- over 31 days old and no longer confined to hospital after birth; **or**,

• under the age of 21 and dependent upon you for support while living in a parent - child relationship; **or**,

• children over the age of 21 and under the age of 25 who are in full-time attendance at an accredited educational institution. Proof must be provided to the Administrator each year to verify full-time attendance at an accredited educational institution; **or**,

• unmarried dependent children over the limiting age (described above) who have been identified as disabled and where proof has been submitted to the Administrator and/or the insurance company, within 31 days after the date and annually thereafter, that the child:

  • is incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent on you for support and maintenance; **and**,

  • became so disabled prior to age 21, or 25 if regularly in attendance at a full-time accredited educational institution

Note: Coverage, or any increase in coverage, for any eligible dependant who is confined to hospital because of illness or injury, will not become effective until the date such dependant is no longer confined.

DO MY BENEFITS CONTINUE DURING A TEMPORARY ABSENCE FROM WORK?

You and your eligible dependants may continue to be covered for benefits, at the option of the Board of Trustees, and subject to continued contribution payments (where required), if your absence from active work is not due to termination of employment, retirement, or death. Regardless of the reason or length of your absence, your benefits will not continue beyond age 65.

ILLNESS OR INJURY

• Health and Dental coverage will be continued by the Fund for up to 24 months from the first of the month in which the absence from illness or injury began.

AN APPROVED TEMPORARY LEAVE WITHOUT PAY

• All benefits will be continued up to 12 months from the first of the month during which the absence began, provided you make self-payments directly to the Fund.

AN APPROVED TEMPORARY LEAVE WITHOUT PAY, FOR UNION ACTIVITIES

• All benefits will be continued provided your union pays the required contributions.

MATERNITY OR PARENTAL LEAVE

• All benefits will be continued for the period of the leave, in accordance with provincial legislation, provided you notify your employer of your intent to do so and continue to pay the required employee contributions, to the Fund.

TEMPORARY LAY-OFF WITH THE RIGHT TO RECALL

• All benefits will not be continued.

• If you are recalled to work you will not be required to fulfill another waiting period and will be entitled to coverage immediately, provided you meet the other eligibility requirements described in the ELIGIBILITY SECTION.

PERMANENT LAY-OFF (as defined in the Ontario Employment Standards Act)

• All benefits will be continued by the Fund for up to 3 months, from the end of month in which such lay-off began.

SUSPENSION OR STRIKE ACTION

• Benefits will be discontinued.

WHEN DOES MY COVERAGE TERMINATE?

Coverage for you and your dependants terminates on the earliest of the date:

• you retire; **or**,

• your employment terminates or you cease active employment, except as noted under the Temporary Absence From Work provision; **or**,

• you cease to be a member of an eligible class; **or**,

• you die; **or**,

• contribution payments cease; **or**,

• The Plan is discontinued.

For more information and to download application forms, please visit us at www.workersbenefits.ca

SECTION 2 – COVERAGE

LIFE INSURANCE

DO I HAVE LIFE INSURANCE?

Yes, all eligible, active, full-time Members have Life Insurance coverage as follows:

- 2 times annual earnings to a maximum of $58,000.00

Your Life Insurance benefit will be paid to your beneficiary(ies), subject to provincial laws, upon your death. If you have not assigned a beneficiary or they have predeceased you, the proceeds of your Life Insurance benefit will be paid to your estate.

WHAT HAPPENS TO LIFE INSURANCE COVERAGE IF I BECOME TOTALLY AND PERMANENTLY DISABLED WHILE I AM COVERED?

Waiver of Premium

If you become Totally and Permanently Disabled as defined in section 4, you may be entitled to apply for a Waiver of Premium. This means that premiums do not need to be paid to continue your Life Insurance coverage during your approved disability. The application must be completed and returned to the Administrator. Premiums may still be waived on your behalf provided:

- You are not beyond the age of 65 at the onset of disability
- You became disabled while insured and before termination of your employment
- You have been disabled for at least 6 continuous months
- Proof of your disability has been submitted to the Administrator within 9 months of the onset of your disability.

You will then be eligible for the amount of insurance for which the Waiver of Premium applies on your life, subject to any reductions which would be applicable had you been actively at work.

If your application is approved, Premium Waiver will begin on the day following a continuous period of disability of 6 months.

If you believe you may be eligible and have not been asked to complete a Waiver of Premium application, please contact the Administrator. Satisfactory proof that you are disabled will be requested by the Administrator and the life insurance company within 9 months of the date you cease active work. From then on you will be asked to submit satisfactory proof of disability, periodically, as requested.

A Waiver of Premium will terminate on the earliest of:

• The date on which you cease to be disabled; **or**,

• The date on which you fail to submit to an examination by a medical doctor (M.D.) designated by the Administrator; **or**,

• The date on which you retire or reach age 65; **or**,

• The date on which you fail to provide any proof of disability required by the Administrator; **or**,

• The date on which you are incarcerated after committing a criminal offence for which you are found guilty.

If on the date your Waiver of Premium terminates, you are not eligible for the Life Insurance benefit, you may be eligible to exercise the conversion privilege as outlined below.

IF I AM NO LONGER ELIGIBLE FOR LIFE INSURANCE, OR MY LIFE INSURANCE COVERAGE REDUCES, IS THERE AN OPTION TO CONVERT IT TO AN INDIVIDUAL POLICY?

Yes. If your Life Insurance is cancelled or is reduced on, or prior to, your 65th birthday due to termination of:

• Your employment; **or**,

• Your group membership; **or**,

• Your group policy (if you have been continuously insured for at least 5 years)

then you will be able to convert all or part of your insurance to an individual policy without having to provide evidence of insurability.

You may choose to convert to one of the following types of insurance:

• Permanent

• Term to age 65

• One year term convertible into permanent or term to age 65 at the end of one year.

The amount that you can convert to an individual policy will include the Life Insurance that you are covered for under this benefit, an Optional Life Insurance benefit and any other group insurance policy issued by the insurance company, not exceeding the lesser of:

• The amount selected by you; **or**,

• The amount for which you were insured immediately prior to the termination of your insurance; **or**,

• The difference between the amount for which you were insured immediately prior to the termination of your insurance and the amount for which you are eligible under a new group insurance policy; **or**,

• $200,000.

Your individual insurance policy shall not include a Disability benefit, or an Accidental Death and Dismemberment benefit, and the premium shall be based on the insurance company's rates in effect which apply to the type and amount of such policy, according to your age and sex.

Your policy will be issued only if the insurance company receives a written request to that effect, together with a deposit to cover the monthly premium for a one-year term policy within 31 days of the date of the termination of your Life Insurance. It will take effect only at the expiration of that period. Should you die during the 31 days following the termination of your insurance, the insurance company shall pay an amount equal to that which you could have converted whether or not you made an application for the individual policy.

DEPENDANT LIFE INSURANCE

DOES MY PLAN PROVIDE DEPENDANT LIFE INSURANCE COVERAGE?

Yes, all eligible, active full-time Members, under the age of 70, with dependants, have Life Insurance coverage for each of their eligible dependants as follows:

Spouse	$7,500
Each Child	$2,500

If a dependant dies while covered, Dependant Life Insurance will be paid to you, if living, or otherwise to your estate.

Note: Dependant Life Insurance will terminate when your Member Life Insurance terminates.

Waiver of Premium

The same terms and conditions apply as outlined in the Life Insurance section.

CAN DEPENDANT LIFE INSURANCE BE CONVERTED TO AN INDIVIDUAL POLICY?

If you are no longer eligible for Dependant Life Insurance you may have the option to convert the insurance for your dependants to an individual policy. Refer to the Life Insurance section of this booklet for further details.

Extension of Dependant Life Insurance

If your dependant dies within 31 days of the date the Dependant Life Insurance terminates, the amount that could have been converted will be paid to you as a death benefit under this Plan, even if no application for conversion was made.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

DO I HAVE AN ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT?

Yes, all eligible, active, full-time Members, under the age of 70 have AD&D coverage in an amount equal to the value of the Member Life Insurance benefit (or a percentage of) which is payable if you die or sustain a loss of limb or body function as a direct result of an accident, as described below.

Loss of, or Loss of Use of:	% of AD&D Benefit payable:
Life	100%
Both hands or feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and the sight of one eye	100%
One foot and the sight of one eye	100%
Speech and hearing in both ears	100%
One arm or one leg	75%
One hand or one foot or sight of one eye	66.6%
Speech	66.6%
Hearing in both ears	66.6%
Thumb and index finger, or at least four fingers of one hand	33.3%
Hearing in one ear	33.3%
All toes of one foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Note: Accidental Death and Dismemberment will reduce by 50% upon attainment of age 65.

'Loss' is defined as:

- to hand or foot, complete severance at or above the wrist or ankle joint but below the elbow or knee joint;
- to arm or leg, complete severance at or above the elbow or knee joint;
- to thumb and fingers, complete severance at or above the metacarpophalangeal joint;
- to toes, complete severance at or above the metatarsophalangeal joint;
- to eyes, the irrecoverable loss of the entire sight thereof;
- to speech, the total and irrecoverable loss thereof;

• to hearing, the total and irrecoverable loss thereof;

• for Quadriplegia, Paraplegia, and Hemiplegia, the permanent and irrecoverable paralysis of such limbs.

Loss of use when referred to in this booklet means a loss that is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

WHAT OTHER RELATED EXPENSES ARE COVERED BY MY AD&D BENEFIT?

Repatriation Benefit

If injury results in loss of life, the insurance company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

Identification Benefit

If injury results in loss of life and requires body identification, the insurance company will pay the expenses actually incurred by a member of the immediate family for lodging, board, and transportation by the most direct route, provided the body is located not less than 150 kilometers from the member of the immediate family's residence and the identification of the body is required by police or similar law enforcement agency having authority over such matters.

Spousal Retraining Benefit

If injury results in the loss of life, the insurance company will reimburse the spouse for the actual expenses incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

Education Benefit

If injury results in loss of life, the insurance company will pay 5% of the principle sum to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, there are no dependent children eligible for the Education benefit, the insurance company shall pay an additional amount of $2,500.00 to the designated beneficiary.

Day Care Benefit

If injury results in the loss of life, the insurance company will pay 5% of the principle sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed four years) for each dependent child who is under 13 years of age and enrolled in a legally licensed day care centre on the date of the accident, or within the 12 months following.

Seat Belt Benefit

If injury results in a loss payable under the Accidental Death & Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10%, if, at the time of the accident, the eligible Member was driving or riding in a vehicle and wearing a properly fastened seat belt.

Family Transportation Benefit

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death & Dismemberment and Specific Loss Indemnity, and the hospital is located at least 150 kilometers from the Member's residence, the insurance company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by most direct route to the confined Member.

Rehabilitation Benefit

If injury requires that the Member undergo specific training in order to be engaged in an occupation in which the Member would not have engaged except for such injury, the insurance company will pay the reasonable and necessary expense incurred for such training, provided the injury results in a loss payable under the Accidental Death & Dismemberment and Specific Loss Indemnity.

Home Alteration and Vehicle Modification Benefit

If an injury requires the use of a wheelchair, the insurance company will pay the cost of alternations to the Member's principal residence and/or the cost of modification to one motor vehicle utilized by the Member, provided such injury results in a loss payable under the Accidental Death & Dismemberment and Specific Loss Indemnity.

Waiver of Premium

In the event of Total Disability and approval of Waiver of Premium by the life insurance company, premium under this benefit will be waived until the earlier of: death, recovery, attainment of age 65, or the date the policy is cancelled.

Termination of Insurance

Coverage will be terminated immediately on the earliest of the date:

- You Retire
- Employment terminates or you cease active work, except as noted under the Absence From Work provisions
- You cease to be a member of an eligible class
- The policy terminates
- The premium's due date if the policy holder fails to pay the eligible Member's premium, except inadvertently
- The premium's due date coinciding with, or immediately following the date a Member attains age 70
- The premium's due date next following the date an eligible Member is ineligible

ARE THERE ANY EXCLUSIONS OR LIMITATIONS?

Yes. No benefits are paid for injury or death resulting from:

- Suicide or any attempt thereat while sane or insane
- Intentionally self-inflicting injury
- Declared or undeclared war or any act thereof
- Full-time active service in the armed forces of any country
- Flying as a pilot or crew member of any aircraft
- Flying in any aircraft owned, operated or leased by the policyholder
- Flying in any vehicle or device for aerial navigation, except as provided in the policy

DENTAL

DO I HAVE DENTAL COVERAGE?

Yes, if you are an eligible Member, you and your eligible dependants have Dental benefits. Once each calendar year a $20 per person dental deductible will be applied, to a maximum of $40 per family. Expenses incurred in excess of this deductible will be reimbursed as follows:

- $2,000 Combined Maximum for routine care, dentures, crowns and bridgework for every 2 Calendar Years from the date your first claim was incurred.
- $2,000 Lifetime Maximum for Orthodontics

Type of Dental Work	Percentage Payable
Routine	100%
Dentures	90%*
Crowns and Bridgework ** 50% if teeth were extracted prior to May 1, 1990.*	90%*
Orthodontics (not an eligible expense for anyone over the age of 25)	50%

Eligible Dental expenses are paid based on a fee guide, published by the Ontario Dental Association (ODA) and chosen periodically by the Trustees. The fee guide currently used by your Plan is the 2001 ODA fee guide.

COULD MY DENTIST'S CHARGES BE BASED ON A FEE GUIDE FROM A DIFFERENT YEAR?

Yes. Your dentist may charge on the basis of a different year's fee guide with more costly charges. If so, you are responsible for any excess over and above the payments made by this Plan.

WHAT IS CONSIDERED ROUTINE DENTAL WORK?

- Oral exams and cleaning; once every 6 months
- Scaling and root planning to a combined maximum of 10 units per year
- Occlusal Equilibration to a maximum of 8 units per year
- Topical application of sodium or stannous fluoride; once every 6 months
- Consultations
- Dental x-rays every 18 months
- Fillings
- Extractions
- Oral surgery, including the removal of impacted wisdom teeth
- Antibiotic drug injections
- Anesthesia and its administration
- Prefabricated full coverage restorations for primary teeth
- Periodontic treatment for disease of the bone and gums of the mouth including tissue grafts
- Endodontic treatment, including root canal therapy
- Occlusal guards prescribed for bruxism (grinding of teeth) but not athletic guards

WHAT IS COVERED BY MY PLAN WITH RESPECT TO DENTURES?*

- The first installation, including adjustments of partial permanent or full temporary or permanent removable dentures to replace 1 or more natural teeth extracted while you were covered
- Repair, relining or rebasing of dentures
- Denture adjustments that occur not more than 3 months after installation
- Replacement of an existing partial or full removable denture, if it:
    - was installed at least 5 years before and cannot be made serviceable; and,
    - is a temporary full denture which replaces 1 or more natural teeth extracted while you were covered; and,
    - for which replacement by permanent denture is required; and,
    - takes place within 1 year from the date the temporary denture was installed.
- Addition of teeth to an existing partial denture, if required to replace 1 or more natural teeth extracted while you were covered.

**Pre-approval is required.*
***50% if your teeth were extracted prior to May 1, 1990*

WHAT IS COVERED BY MY PLAN WITH RESPECT TO CROWNS AND BRIDGEWORK?*

- Inlays, onlays, gold fillings and crowns
- Repair, resurfacing or recementing of crowns, inlays, onlays or bridges
- The first installation of fixed bridgework, including crowns to form abutments, to replace 1 or more natural teeth extracted while you were covered
- Replacement of existing bridgework, but only if it was installed at least 5 years before and cannot be made serviceable.

** Pre-approval is required.*
*** 50% if your teeth were extracted prior to May 1, 1990*

WHAT IS COVERED WITH RESPECT TO ORTHODONTICS*?

Note: Members and their dependants over age 25 are not eligible for this benefit.

- Space maintainers
- Diagnostic procedures, including models
- Therapy and appliances
- Correction of malocclusion
- Habit breaking appliances

** Pre-approval is required.*

CAN WORK BE PERFORMED BY OTHER DENTAL PRACTITIONERS?

The following procedures are eligible for reimbursement provided the charges for eligible services and the maximum amount payable is the amount shown in the fee guide for the least expensive service or supply required to produce a professionally adequate result.

- Scaling and cleaning of teeth done by a licensed dental hygienist
- Installation, adjustment, repair, relining or rebasing of full dentures done by a denturist, denture therapist, technician or mechanic who is registered and practicing within the scope of their license.

WHAT DENTAL PROCEDURES ARE NOT COVERED BY THIS PLAN?

No amount will be paid for the following:

- Cosmetic dental care
- Completion of claim forms
- Missed appointments

- Dental care covered under a medical plan provided by an employer or government
- Charges which would not have been made in absence of this Plan
- Prefabricated full coverage restorations for permanent teeth
- Oral hygiene instruction or nutritional counseling
- Protective athletic appliances
- A full mouth reconstruction for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction
- Prosthesis, including crowns and bridgework, and the fitting thereof, ordered while you were not covered, or ordered while covered but finally installed or delivered after the Plan is discontinued or more than 31 days or after termination for any other reason
- Replacement of a lost or stolen prosthesis
- Orthodontic treatment or correction of malocclusion for Members and their dependants over age of age 25.

WHAT DO I NEED TO KNOW BEFORE GOING TO THE DENTIST?

It is good practice to take along this benefit booklet when you visit the dentist, to determine what charges are covered, and to what extent. This Plan is self-funded so there is no policy number. However, the Plan number is 150, and can be provided to the dentist. It is also good practice to check the details of your dental bill to determine accuracy.

SHOULD I HAVE MY DENTAL TREATMENT PRE-AUTHORIZED?

A Predetermination of Benefits should be completed if charges for a planned course of treatment exceeds $400. In some instances you must submit proposed details of treatment and x-rays for approval. Failure to do so may result in payment of a lesser amount under the Alternative Benefit Provision, than you anticipate. All x-rays are returned to the dentist.

Alternate Benefit Provision

If alternative services may be performed for the treatment of a dental condition, the maximum amount payable will be the amount shown in the fee guide for the least expensive service or supply required to produce a professionally adequate result.

HEALTH

DO I HAVE HEALTH COVERAGE?

Yes, if you are an eligible Member, you and your eligible dependants have Health Care benefits. The following services are covered by your Plan:

- Hospital Care
- Prescription Drugs
- Ambulance
- Diagnostic Procedures
- Out-of-Hospital Nursing care
- Health Practitioners
- Dental Care for Accidental Injury
- Durable Medical Equipment and Supplies
- Vision Care
- Hearing Care
- Foot Care
- Out-of-Province Care

HOW ARE THESE ELIGIBLE SERVICES REIMBURSED?

Once each calendar year's $25 deductible is applied, (the deductible does not apply to hospital care) the following services are eligible for payment:

HOSPITAL CARE

- A semi-private room in a hospital in your home province is reimbursed at 100%. This includes charges in excess of the Ward Rate* up to the Room and Board Limit*.
- A semi-private room in a convalescent/rehabilitation hospital in your home province is reimbursed at 100%. This includes charges in excess of the Ward Rate up to the Room and Board Limit to a maximum of 180 days, per disability. Confinement must begin within 14 days of hospital discharge. A new maximum stay limit will apply if the patient has not been confined in a convalescent/rehabilitation hospital for at least 90 days.

**See Section 4 for definitions of these terms.*

PRESCRIPTION DRUGS

Prescription drugs that have been prescribed by an M.D. or dentist and dispensed by a licensed pharmacist are eligible for reimbursement as follows:

- 100% of the eligible cost

If you are prescribed a maintenance drug, you are permitted to acquire up to six months of medication at one time.

Note: The maximum drug benefit, per lifetime, for fertility drugs is $6,000. The maximum drug benefit, per calendar year, for erectile dysfunction is $1,000.

AMBULANCE SERVICE

A licensed ambulance service (including air or rail) is covered at 100% of the cost, in excess of the amount payable under the provincial health plan, subject to prior approval from the Administrator. Such service will transport the covered patient from the place of debilitation to the nearest hospital or from the first hospital to another for specialized treatment, or to a convalescent/rehabilitation hospital.

DIAGNOSTIC LABORATORY PROCEDURES

Diagnostic laboratory procedures and x-rays that are ordered by an M.D. are covered for you and your eligible dependants.

OUT-OF-HOSPITAL NURSING CARE

Out-of-hospital nursing services are reimbursed at 100% to a maximum of $5000 per calendar year for care administered by a Registered Nurse (R.N.), a Registered Nursing Assistant (R.N.A) or Licensed Practical Nurse (L.P.N.). Such care must be required by medical necessity and requested by an M.D., and the practitioner cannot be a family member or a person who normally lives in your home.

HEALTH PRACTITIONERS

Services provided by the following practitioners, if services are considered medically necessary, will be paid as follows

Physiotherapy..... $58 per visit

Chiropractor*, Osteopath, Naturopath,
or Podiatrist*: ..... $25 per visit

12 visits per calendar year per type of practitioner

** X-rays up to a maximum of $75 per calendar year.*

Speech Therapist..... $20 per visit
12 visits per calendar year

Psychologist..... $25 per visit
20 visits per calendar year

**No amount will be paid for any visit for which any amount is payable under the covered person's provincial health plan, unless permitted by law.*

DENTAL CARE FOR ACCIDENTAL INJURY

Dental care by a licensed dentist or dental surgeon is covered up to the Benefit Maximum for the prompt repair of sound natural teeth, required as the result of a non-occupational accidental injury caused by external trauma to the mouth. Contact the Plan Administrator for further details regarding this coverage.

DURABLE MEDICAL EQUIPMENT & SUPPLIES

The rental and/or purchase of durable medical equipment and supplies is reimbursed at 100% of the actual cost for Reasonable and Customary Charges*. All equipment must be the model and type specifically suited to the nature and severity of the disability. This benefit does not cover items for personal comfort, exercise, safety, self-help or environmental control. Before you incur any major expense, details must be submitted to the Administrator to determine to what extent benefits are payable. A letter is required from an M.D. describing the nature of the disability, medical needs, and the type and estimated duration for the use of such equipment or supplies.

**See Section 4 for a definition of this term.*

VISION CARE

Glasses or contact lenses, when prescribed by an ophthalmologist or optometrist, are reimbursed as follows:

Vision Care **Maximum Allowed every 24 months**	**% Payable**
Frames $35	100%
Lenses Reasonable and Customary Charges	100%
OR	
Contact Lenses* $75	100%

**When vision can be improved to at least the 20/70 level by contact lenses but cannot be improved to the level by glasses, the total cost of such contact lenses will be reimbursed by the Plan.*

Note: No amount will be paid for safety or sunglasses, anti-reflective coatings, or tints other than No. 1 or No. 2

HEARING CARE

Hearing aids, excluding batteries, when recommended by an otolaryngologist, will be covered to a maximum of $350 in any 24-month period.

FOOT CARE

Orthopedic shoes when recommended by an M.D. will be reimbursed at 50% to a maximum of $250 each calendar year.

Arch supports, molds or orthotic devices (not for sports) when recommended by an M.D. or podiatrist will be reimbursed at 50% to a maximum of $200 each calendar year.

OUT OF PROVINCE

This benefit is provided by Expert Travel Financial Security (ETFS)

IF I AM TRAVELING OUTSIDE OF CANADA, DO I HAVE MEDICAL COVERAGE?

Yes, if you are an eligible Member, you and your eligible dependants are covered for medical emergencies while traveling or vacationing outside your home province for periods of not more than 60 days, provided you are covered under a provincial health insurance plan. This coverage has an overall maximum of $5,000,000 per lifetime.

It is important that you understand your Plan before you travel. In the event of any discrepancy between the provisions of this booklet or another document, and the provisions of the contract, the provisions of the contract shall govern.

Please contact the Office of the Administrator to obtain your medical assistance card and booklet. In the event of an emergency you must call ETFS immediately. The emergency telephone numbers are listed on the back of the medical assistance card.

WHAT IS COVERED BY THE OUT-OF-PROVINCE BENEFIT?

Emergency Services - $5,000,000 lifetime

Benefit	Benefit Limit
Hospital Accommodations	Semi-private Room
Physician Charges	Reasonable & Customary Charges
Diagnostic Services	Reasonable & Customary Charges
Paramedical Services	$250 per Practitioner
Prescription Drugs	30-day supply per Prescription
Ambulance Services	Reasonable & Customary Charges
Medical Appliances	Reasonable & Customary Charges
Private Duty Nurse	Up to $5,000
Emergency Air Transportation	Reasonable & Customary Charges
Transportation to Bedside	Economy Round-trip Airfare plus up to $150 per day to $3,000 for meals and accommodation
Return of Traveling Companion	One-way Economy Airfare
Treatment of Dental Accidents	Up to $2,000
Vehicle Return	Up to $5,000
Return of Deceased	Up to $5,000
Incidental Expenses	Up to $250

This Travel Insurance does not cover losses or expenses resulting from any medical condition for which, prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization could be required while traveling (except under the terms of the Medical Referral benefits). Additional exclusions, general provisions, and limitations apply.

Non - Emergency, Medical Referral Services - $25,000 Lifetime Benefit Maximum

Reasonable and Customary medical and transportation expenses for you and an approved escort, to a lifetime maximum of $25,000 for a pre-approved Medical Referral Service subject the following conditions.

- Treatment must be unavailable, locally, within 500 kilometers from where you live
- Your attending Canadian physician and a medical specialist from a related medical field must recommend the treatment.
- Eligible expenses in excess of your provincial health insurance plan are covered.
- Medical services and travel must take place within 30 days of receiving approval from your provincial health insurance plan, unless the earliest possible treatment date exceeds 30 days from the date of approval.
- All Medical Referral Services must be submitted in writing along with supporting documentation, and be pre-approved by Global Excel Management Inc.

ARE THERE EXCLUSIONS OR LIMITATIONS?

Certain exclusions and limitations apply. For full details please contact the Administrator.

Benefits will not be paid for the following:

- Expenses that private insurance companies are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage
- Services or supplies that do not represent reasonable treatment
- Services or supplies associated with:
  - treatment performed for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - diagnosis or treatment of infertility
  - contraception
- Extra medical supplies that are spares or alternatives
- Services or supplies received outside Canada except as listed under Out-Of-Province care
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and the insurance company would have paid benefits for the same services or supplies if they had been received in your home province
- Expenses arising from war, insurrection, or voluntary participation in a riot.

SECTION 3 - CLAIM PROVISIONS

HOW DO I MAKE A CLAIM?

Claim forms are available from the Administrator, your employer, or online at www.workersbenefits.ca. Be sure to complete them fully, attach original bills and diagnosis where applicable to substantiate the claim, and submit to the Office of the Administrator. For Health Care and Dental Care benefits, do not submit a claim until the amount of Covered Charges exceeds the amount of any Calendar Year Deductible. It is recommended that you keep copies of your receipts for your records.

In a written request to the Administrator, you may direct that all or part of the payment for Health Care and Dental Care expenses be made directly to the hospital or person rendering such care.

WHAT IF MY SPOUSE ALSO HAS HEALTH AND/OR DENTAL COVERAGE?

If you and your family are covered under this Plan as well as your spouse's plan, benefits payable under this Plan will be coordinated so that the total amount you receive from both will not exceed 100% of the expense incurred. When submitting a claim for yourself, send it to your Plan first and your spouse's to their plan. Any portion of the claim that is not reimbursed by your own Plan should then be forwarded to your spouse's plan. The plan that does not have a Coordination of Benefits provision pays before the plan that does. Children's claims will be reimbursed under the plan of the parent whose date of birth is first in the year. If priority cannot be established in this way, benefits shall be pro-rated between the plans in proportion to the amounts that would have been paid under each had there just been coverage under one plan.

PROOF OF LOSS

Written proof stating the occurrence, character, and extent of loss, must be submitted to the Administrator, for each benefit, within:

- 12 months after the date of death under the Death Provision for Life Insurance benefits
- 12 months after the date you cease active work because of Total and Permanent Disability under the Disability Provision for Life Insurance benefits
- 12 months after the date of the loss for Accidental Death and Dismemberment benefits
- 18 months after the date of the loss, but not more than 6 months after the date coverage terminates, for Health Care and Dental Care benefits.

Legal action to recover benefits paid under this Plan must begin within 2 years of the date of loss. An authorized representative of the Plan or insurance company shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as may be reasonably required during the pendency and payment period of such claim.

SECTION 4 - INDEX OF TERMS

DEFINITIONS

The following terms used throughout this booklet are to be defined as follows.

Administrator is the organization chosen by the Trustees to carry on the day-to-day business of the Fund and the Plan. Among its duties the Administrator answers questions from Members and processes their claims for benefits.

Benefit(s) means the amount of money that may be reimbursed to a Member toward the costs for loss of life, a loss related to a disability or an Accidental Death & Dismemberment, or for covered Health and Dental expenses.

Benefit Maximum is the total amount of benefit allotted for reimbursement in the specified period.

Calendar Year Deductible is the amount that the Member must pay every calendar year, before they receive reimbursement for Covered Charges.

Convalescent/Rehabilitation Hospital is a place that has a transfer arrangement with hospitals and provides in-patient nursing care (that meets minimum provincial regulations) for the convalescent/rehabilitation stage of an injury or illness. It must also be approved as a convalescent/rehabilitation hospital for payment of the Ward Rate under the provincial health plan.

Course of Treatment means one or more services rendered by a dentist(s) for the correction of a dental condition, diagnosed in an oral exam. This treatment starts on the date the first corrective service is rendered.

Covered Charges are reasonable and customary charges for Medical and Dental care, services or supplies, received while a Member and dependants are covered.

Dependant(s) means a spouse and unmarried, dependent children of a Member as defined below:

Spouse is a person to whom you are legally married or with whom you have cohabited for at least one continuous year and publicly represent as your spouse

Child Dependants are children who are either natural or legally adopted or stepchildren or children living with you on a full-time basis; and are,

- over 31 days old and no longer confined to hospital after birth; **or**,
- under the age of 21 and dependent upon you for support while living in a parent - child relationship; **or**,

- children over the age of 21 and under the age of 25 who are in full-time attendance at an accredited educational institution (proof must be provided to the Administrator each year to verify full-time attendance at an accredited educational institution; **or**,

- unmarried dependent children over the limiting age (described above) who have been identified as disabled and where proof has been submitted to the Administrator and/or the insurance company, within 31 days after the date and annually thereafter, that the child:

    - is incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent on you for support and maintenance; **and**,

    - became so disabled prior to age 21 or 25 if regularly in attendance at a full-time accredited educational institution

Durable Medical Equipment and Supplies means, but is not limited to, hospital beds, wheelchairs, canes, crutches, walkers and trusses, rigid or semi-rigid braces for the back, neck, arm or leg. This also includes non-dental prosthesis such as artificial limbs and eyes, including replacement, if required, by a change in physical condition. Respiratory equipment required for oxygen and kidney dialysis is considered eligible. Also, contact lenses or glasses following cataract surgery, limited to one pair per lifetime. The purchase of splints, casts, catheters, and hypodermic needles, are eligible expenses.

Hospital is a place that provides in-patient medical care of the injured, sick, or chronically ill, and has a staff of licensed doctors (M.D.) and 24-hour nursing care by registered nurses (R.N.). It must be approved as a hospital for payment of the Ward Rate under the provincial health plan.

Licensed Doctor is a medical doctor, (M.D.) legally practicing within the scope of their license.

Member is a person who is entitled to benefit reimbursement, by virtue of having satisfied the requirements for eligibility.

Percentage Payable is the portion of Covered Charges that the Plan pays after the Calendar Year Deductible is satisfied.

Predetermination of Benefits is the proposed details and x-rays from a course of dental treatment that should be submitted to the Administrator for approval, especially for charges exceeding $400.00.

Reasonable and Customary Charges means any necessary charge connected to health or dental care that is deemed appropriate in relation to a loss and is financially acceptable.

Room and Board Limit is the usual rate set by the provincial government for the cost of room and board in a hospital.

Totally and Permanently Disabled means a state of total and continuous incapacity, resulting from illness or injury which prevents you from performing any work for which you are reasonably qualified by education, training, or experience.

Trustee(s) means the people chosen to govern all aspects of the Plan and Fund.

Union means the participating chartered locals of the United Food and Commercial Workers Union and its affiliates.

Ward Rate is the cost of a hospital stay in a ward which provincial health insurance covers. The difference between this amount and the charge for a semi-private room is covered by this Plan.

For more information and to download application forms, please visit us at www.workersbenefits.ca

cwbp

workersbenefits.ca

Commercial Workers Benefit Trust Fund
Suite 110 - 61 International Blvd.
Toronto, Ontario M9W 6K4
Telephone: (416) 674-3350
Facsimile: (416) 674-1525