



# GROUP BENEFITS PLAN

Quinte St. Lawrence  
Electrical Workers

Health & Welfare  
Trust Fund



September 2008



# **GROUP BENEFITS PLAN**

## **QUINTE ST. LAWRENCE ELECTRICAL WORKERS HEALTH & WELFARE TRUST FUND**



SEPTEMBER 2008

# QUINTE ST. LAWRENCE ELECTRICAL WORKERS HEALTH & WELFARE TRUST FUND

We are pleased to provide you with this booklet that briefly outlines the various benefits and conditions of the plan. We suggest you read it carefully to familiarize yourself with the coverage available to you and your dependants.

Our major medical, dental and vision care benefits are self-insured. All administration and claims adjudication takes place at the QSLEW Trust Fund. Drug plan prescriptions are adjudicated through the ASSURE drug card.

Weekly indemnity, long-term disability, life insurance, AD&D and dependant life insurance are underwritten by the Great-West Life Assurance Company. Claims for these benefits are adjudicated in their offices. The member assistance program (MAP) is provided by the Ottawa-Hull Building Trades Council. Our consultant is Coughlin & Associates Ltd.

We hope the plan will continue to contribute to the security and well-being of you and your family.

Your trustees

# IMPORTANT

This document contains important information about your employee benefits coverage and should be kept in a safe place. It supersedes and replaces all previous communications material and is the plan document in respect to the benefits described herein.

The extended health care, dental care and vision care benefits are underwritten on a self-insured basis by the QSLEW Trust Fund, the plan sponsor. All risks in respect to these benefits are borne by the QSLEW Trust Fund.

As sponsor of the plan, the QSLEW Trust Fund or its trustees or designates may establish rules or regulations for the administration or governance of the benefits plan and any transactions associated with it.

The QSLEW Trust Fund, or its trustees or designates, have the right to interpret the plan and decide any and all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the medical, dental or vision coverage described in this booklet.

*Reasonable and customary* means that the treatment provided is accepted by the appropriate Canadian medical profession as being proven scientifically and effective medically and of a form, intensity, frequency and duration essential to the diagnosis and management of the disease or injury.

In respect to these benefits, no payment will be made for expenses that are related to services, treatments or supplies payable by or covered by a government plan.

The interpretations or decision of the administrator made with respect to the benefits plan will be final and binding on all parties.

**IF YOU HAVE A CONCERN ABOUT A CLAIM, PLEASE CONTACT THE ADMINISTRATOR.**

# PROTECTING YOUR PERSONAL INFORMATION

The administrator of your group benefit plans is the QSLEW Trust Fund.

At the QSLEW Trust Fund, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of the QSLEW Trust Fund, or the offices of an organization authorized by the QSLEW Trust Fund. We use the information to administer the group benefits plan. We limit access to information in your file to the QSLEW Trust Fund staff or persons authorized by the QSLEW Trust Fund who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

# QUINTE ST. LAWRENCE ELECTRICAL WORKERS HEALTH & WELFARE TRUST FUND

## ABOARD OF TRUSTEES

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# SCHEDULE OF INSURED BENEFITS: GROUP POLICY #6810

## FOR MEMBERS

### Life insurance

\$100,000

### Accidental death & dismemberment

\$100,000

(Principal sum)

### Weekly income insurance

Gross weekly benefit: \$350  
(Seven days for sickness)

Elimination period: Nil for accident

Maximum benefit period: 26 weeks\*

*\*Where a member is entitled to EI benefits, weekly indemnity may be payable for the first two weeks of disability and will resume once all EI sick benefits have been exhausted, but will not exceed 26 weeks combined payments.*

### Long-term disability insurance

Gross monthly benefit: \$1,500

Elimination period: 180 days or end of weekly indemnity benefit period

Maximum benefit period: To age 65. Benefits may be reduced by other income.

## **FOR DEPENDANTS**

### **Life insurance**

Spouse: \$12,000

Children: \$12,000

## **HEALTH CARE AND DENTAL CARE INSURANCE BENEFITS**

Lifetime maximum: \$25,000 for prescription drugs and \$25,000 for all other health care expenses

Hospital benefit: semi-private room

## **HEALTH CARE**

Deductible: \$25 per individual or family per calendar year

Co-insurance: 100% of eligible expenses

## **VISION CARE**

Deductible: Nil

Co-insurance: 100% of eligible expenses

Maximum: \$300 in any 24-month period of eligible expenses

## **DENTAL CARE**

Deductible: \$25 per individual or family per calendar year

Co-insurance: 100% of eligible expenses

Maximum: \$2,000 per person per calendar year

## **MEMBER ASSISTANCE PROGRAM (MAP)**

The MAP was established to help members and their families face situations such as stress, burn-out, marital, legal, financial problems, alcohol and drug abuse.

The program is completely confidential.

Contact: Mr. Gabriel Chauvin, MAP co-ordinator, pager number 613-787-8075

## LIFE INSURANCE FOR MEMBERS

In the event of your death, your beneficiary will be paid the amount of your group life insurance. (See *Schedule of benefits*).

Should you become totally disabled while insured before reaching age 65, and the disability continues without interruption for at least six months, your life insurance will remain in force without further premium payment. After you have been totally disabled for six months, submit the appropriate claim forms to the insurer. Your premiums will be waived upon satisfactory proof of your disability but only until you reach age 65. At the discretion of the insurer, proof of continued disability may be required.

If you are not approved for waiver of premium, your life insurance will be continued with premium payment until the earlier of the following:

- the date your union membership ends;
- the date your insurance would normally terminate as described in the *Termination of insurance* section.

If any or all of your insurance terminates on or prior to your 65th birthday, you may be able to apply for a conversion policy. See your plan administrator for further details regarding conversion policies. Application for an individual policy must be made within 31 days after your insurance terminates, during which period your life insurance will remain in force free of charge.

### OPTIONAL GROUP TERM LIFE AND CRITICAL ILLNESS INSURANCE

To accommodate your personal insurance needs, additional group term life and critical illness insurance can be purchased at attractive rates. You and your spouse may be eligible upon approval for this additional coverage provided you are under age 65. Coverage is available in units of \$10,000 to a maximum of \$400,000 per person. Contact the trust fund administrator for an application.

# ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT INSURANCE

Should you suffer the loss of life, limb or sight as a result of an accident, the insurer will pay up to the “*principal sum*”, stated in the *Schedule of benefits*. The principal sum will be paid for loss of:

- life;
- both hands or feet;
- sight of both eyes;
- one hand and one foot;
- one hand or one foot and sight of one eye.

Half of the principal sum will be paid for loss of:

- one hand or one foot;
- the sight of one eye.

A sum will be paid for loss of use of:

- both legs or both arms or both hands;
- one leg or one arm;
- one hand.

## POINTS TO NOTE ABOUT AD&D INSURANCE

The *principal sum* is the maximum amount that will be paid for injuries to any one person resulting from an accident. This means that if a member lost both hands and both feet in an automobile accident, he/she would receive the principal sum only, not double the amount of the principal sum.

AD&D insurance will not be paid in the event of injury or death resulting from intentional self-mutilation, suicide, ptomaine

poisoning, bacterial infection, any form of disease or illness, physical or mental infirmity, or medical or surgical treatment, war or any incident thereof.

AD&D insurance will not be paid if loss of life, limb or sight occurs more than 365 days after the accident.

For AD&D insurance, "*loss*" means complete loss by severance except, in the case of loss of sight, it means loss of sight beyond remedy by surgical or other means.

"*Loss of use*" shall mean: with regard to arms, hands and legs, total loss of the ability to perform each and every action and service the arm, hand or leg was able to perform before the accident occurred. Loss of use must be total and irrecoverable and beyond remedy by surgical or other means.

## WEEKLY INCOME INSURANCE

Should you be unable to earn your living due to accident or illness, your **weekly income insurance** will provide you with a weekly income. (See *Schedule of benefits*). These benefits are taxable.

To receive weekly income benefits, you need not be confined at home. However, your disability must be severe enough to prevent you from performing your regular work, and you must be under the continuous care and personal attendance of a qualified doctor.

If you become disabled during a period of leave of absence or temporary lay-off, no benefits will be payable for any portion of a period of disability which pre-dates your scheduled return to work.

Weekly income benefits begin on the first day of disability due to injury or the eighth consecutive day of disability due to sickness, but in no event prior to the date of the first treatment by the doctor. They will be paid for a total of not more than 26 weeks for each period of disability. For a disabled member, weekly indemnity benefits will not be payable from the third to the 17th weeks inclusive, when the disabled employee is eligible for and receives Employment Insurance (EI) sick benefits. A disabled employee must show proof of application to EI as well as proof of response from EI.

Benefits for disability due to pregnancy will also be paid for up to 26 weeks. Pregnancy benefits are not payable during the period the member receives EI maternity benefits or during the period the member is on maternity leave.

The insurer will not pay for disability due to injury sustained while working for pay or profit or illness for which you are covered under the Workers' Insurance Safety Board or a similar program.

In the event that your insurance terminated while you were disabled, you will continue to receive weekly income benefits during that period of disability, up to the maximum noted above.

Successive absences from work are considered to be in the same period of disability unless separated by:

- two complete consecutive weeks of active full-time work; or
- one full day of work and due to wholly different causes.

**Your weekly income insurance claim must be filed within 90 days of your disability date or you will not be eligible for disability benefits.**

**You must apply for weekly income insurance at the same time you file for EI benefits. If you wait until your EI runs out, you will not be eligible for disability benefits.**

# LONG-TERM DISABILITY INSURANCE

Long-term disability insurance provides a regular income to replace salary or wages lost due to a lengthy disability resulting from an accident or sickness. These benefits are taxable.

## COMMENCEMENT AND DURATION OF BENEFITS

Your first benefit is payable after:

- you have been disabled for more than 180 days; or
- your weekly income insurance benefit payments end, and you will continue to receive LTD benefits for as long as your disability continues, but not beyond your 65th birthday.

LTD benefits will be paid for the first two years following commencement of payments if you are unable to perform your **regular** work. After two years, LTD benefits will continue only if your disability prevents you from performing **any** work for which you are or can become reasonably suited by your education, training or experience, but not beyond your 65th birthday.

## AMOUNT OF MONTHLY LTD BENEFIT

The plan will provide you with a monthly benefit as shown in the *Schedule of benefits*.

Your LTD insurance payments will be reduced by any amount payable from the Workers' Safety Insurance Board.

The total income from all sources, including your LTD benefit under this plan and your rehabilitative employment income, cannot exceed your pre-disability income.

LTD will not be reduced by any CPP disability benefits.

## REHABILITATION FEATURE

As an incentive to encourage you to return to gainful employment prior to full recovery after a total disability, you may perform certain work without forfeiting benefits under this program. This allows you to receive increased income in connection with work performed in an approved rehabilitation program.

Great West Life co-ordinates your LTD insurance with 50 per cent of the earnings you receive during the first 24 months of rehabilitative employment, provided your total income during the rehabilitative program does not exceed your pre-disability income.

## BENEFIT PROVISIONS AND LIMITATIONS

Benefits for disability from health condition that exists on the date your coverage commences will be paid **only if** you have not received any treatment, services or supplies because of disability resulting from such a pre-existing condition for an uninterrupted period of three months ending on or after the date you become covered or the total disability begins after you have been insured under this plan for 24 months.

To qualify for LTD benefits, you need not be confined to your home. However, you must be under the continuous care and personal attendance of a physician.

Benefits for disability due to pregnancy will also be paid. However, no long-term disability benefits will be paid during the period you receive EI maternity benefits or during the period you are on maternity leave.

This plan provides coverage for disability resulting from an accident or from sickness (except certain mental disorders). While the plan does cover absence from work due to psychosis (i.e. a serious mental disease or derangement), for which continuous treatment is received from a physician who is certified in psychiatry, it does not cover absence from work due to any other mental illness, such as psychoneurosis, emotional disorders, personality problems, behavioural disorders or anxiety reactions.

This plan does not provide benefits for disability resulting from intentionally self-inflicted injury, war or injury sustained while working for another employer or while committing or attempting to commit an assault or crime.

### **SUCCESSIVE DISABILITIES**

Successive absences from work are considered to be in the same period of disability unless separated by:

- six months of active full-time work while insured; or
- one full month of work while insured and due to wholly different causes. Work performed under a rehabilitation program will not be considered in determining successive periods of disability.

### **CONVERSION PRIVILEGE**

If you change jobs, you may apply for an individual LTD policy (one of the standard conversion policies offered by Great West Life), without taking a medical examination.

You must apply within one month of the date you start your new job. However, you must start your new job within six months of the date you leave your present one.

## HOSPITAL COVERAGE

Should you incur hospital expenses for room and board and other necessary services and supplies above those paid by your provincial government hospital plan, your health insurance plan will pay the reasonable and customary charges incurred, provided the confinement is medically necessary and is not for chronic or custodial care.

For each day of confinement, the plan will pay up to the usual daily charge of the hospital concerned for semi-private care.

If you or one of your dependants require treatment as an out-patient, the administrator will pay the actual charges incurred for services and supplies received for such treatment, up to a maximum of \$50 during any one benefit period.

A new benefit period begins for a **member** if he returns to work for two full weeks between disabilities, or if they are entirely different disabilities. For **dependants**, a new benefit period begins if the dependant has completely recovered from the prior disability or if he/she has an entirely different disability.

Hospital confinement for pregnancy is covered. Benefits are the same as they are for any other disability.

**Please note:** No benefits will be payable for a hospital confinement that began before your insurance became effective.

### OUT-OF-PROVINCE AND OUT-OF-COUNTRY EXPENSES

Our policy will only cover out-of-province or out-of-country hospital expenses:

- for an emergency or unexpected sudden illness, and only up to the amount that would have been paid if incurred in the province of residence;

- if the required medical treatment is not readily available in the province of residence and the person is forced to seek such treatment elsewhere. A treatment plan showing all costs must be submitted to the trustees for approval before any benefits will be paid.

*All members should obtain supplementary coverage when travelling out-of-province or out-of-country.*

### **CONTINUATION OF HOSPITAL BENEFITS**

If you are totally disabled when your hospital insurance terminates and you have expenses for an illness that would have been covered had your coverage continued, your benefit payments will continue until the earliest of the following:

- the date your disability ceases;
- the date which is 90 days after the group policy terminates;
- the date on which you have received maximum benefits;
- the date on which you received benefits for a period equal in length to the period for which you were insured;
- the end of the calendar year following the calendar year your insurance terminates.

## MAJOR MEDICAL INSURANCE

Major medical insurance is designed to assist you with the payment of your larger medical bills. It does not pay the total cost of medical services and supplies. In effect, the plan shares with you the payment of your medical bills. Major medical insurance covers only those expenses that are considered reasonable and customary for the service provided, in the area where the expenses are incurred, and which are in excess of benefits available under other parts of this plan.

Each calendar year you pay the first \$25 (deductible) of covered expenses. The plan pays the rest.

The deductible is paid only once in any one calendar year for any one person or any one family.

Any expenses incurred for covered dental care expenses may be used to satisfy the deductible for the major medical benefit.

### POINTS TO NOTE ABOUT MAJOR MEDICAL INSURANCE

The lifetime maximum major medical benefit for each person is \$25,000 for prescription drugs and \$25,000 for all other major medical expenses. If some or all of this maximum is used, it will be increased by up to \$1,000 each January. If this does not bring your maximum up to the full amount, you may have it adjusted to the full amount by providing *proof of insurability*.

If one of your dependants is treated for an injury or sickness within 30 days before the date insurance coverage becomes effective, no benefits will be payable for services and supplies received in connection with that condition, unless such services and supplies are received after the last day of a 30-day period during which no expenses were incurred in for the condition.

## COVERED EXPENSES

The following services and supplies are covered by your **major medical health insurance** (where permitted by law and to the extent they are not covered under your provincial plan.) A doctor's recommendation or letter may be required for any of the following:

### HOSPITAL-COVERED EXPENSES

*Hospital-covered expenses* means, where permitted by law, reasonable and customary charges necessarily incurred for expenses that are medically necessary and not primarily for chronic or custodial care.

The plan considers the following as hospital covered expenses when recommended and approved by a physician or surgeon:

- reasonable and customary charges for semi-private room and board as a result of:
  - confinement as a registered bed-patient in a hospital or Convalescent hospital up to but not exceeding \$5 per day for the use of a private hospital room;
  - services and supplies received while confined as a registered bed-patient in a hospital or convalescent hospital;
  - reasonable and customary charges for room and board and other services and supplies received while confined in an intensive care unit; and
  - reasonable and customary charges for services and supplies received during treatment as an out-patient to a maximum of \$50 per benefit period.

**Please note:** Hospital charges are not eligible for payment under major medical until maximum hospital benefits have been paid under the basic hospital benefits described earlier.

While the mother is hospital confined, routine hospital care of a newborn infant will not be considered a covered expense related to the pregnancy.

The above charges shall be decreased by the amount of the benefit to which the insured or dependant is entitled under any government hospital plan.

*Benefit period* means successive periods of confinement not separated by at least two weeks of active and full-time employment.

*Convalescent hospital* means an extended care facility, such as a sanatorium or skilled nursing home or a special wing or ward of a hospital, which has a transfer agreement with the hospital.

*Eligible convalescent hospital confinement* means an in-patient confinement in a convalescent hospital, provided that:

- the insured or dependant was transferred to the convalescent hospital from an active treatment hospital to which such person had been confined as a registered bed-patient for a least three days; and
- the confinement in the convalescent hospital is primarily for rehabilitative or convalescent care.

## **BASIC COVERED EXPENSES**

*Basic covered expenses* means, where permitted by law and to the extent that such services and supplies or portion thereof are medically necessary and are not covered by the medical care insurance plan or the provincial government hospital plan of the insured's home province, reasonable and customary charges necessarily incurred for:

1. Services rendered by a physician or surgeon outside the insured's home province, including outside Canada.
2. Out-of-hospital treatment rendered by a dentist or oral surgeon for accidental injuries to natural teeth completed within six months after the accident.
3. The following services and supplies when prescribed by a physician or surgeon:

- out-of-hospital services of graduate registered nurses, licensed practical nurses and registered nursing assistants, other than members of the insured's family (to a maximum of \$5,000 per calendar year);
- services for the following shall be paid at \$500 per year combined maximum for all items, after OHIP is exhausted and subject to a combined \$200 per year deductible:
  - duly qualified and licensed chiropractors;
  - acupuncturists and massage therapists other than members of the insured's family;
  - physiotherapy services;
  - naturopathy.

A referral from a licensed physician is required for all the above services.

- a total of \$50 per month is payable for supplements provided by a licensed naturopath on condition that a referral from a licensed physician to attend the naturopath is on file with the administrator;
- professional ambulance services, including licensed air ambulance, to the nearest adequate treatment facility;
- oxygen and its administration;
- injectable drugs, when administered by a physician and for which no reasonable non-injectable alternative is available;
- radioactive materials;
- blood, blood products and their transfusion;
- rental or, at the company's discretion, purchase of the following supplies, appliances and prosthetic devices prescribed by a physician or surgeon:

- standard wheelchairs (excluding electric wheelchairs except for quadriplegics);
- standard hospital beds (excluding electric hospital beds), bed rails and trapeze bars;
- splints (excluding dental splints), trusses, canes, walkers, crutches, casts;
- Jobst burn garments, Jobst sleeves for lymphoedema following mastectomy and Jobst support hose;
- braces with rigid supports (excluding lumbar supports);
- all prescribed knee braces limited to \$800 lifetime
- orthopaedic shoes, if an integral part of a brace;
- stump socks, shoulder harness, head halters, traction apparatus and cervical collars;
- colostomy and ileostomy apparatus and catheters (portion not covered by provincial government);
- enuretic devices;
- PUVA therapy for psoriasis, when administered by a dermatologist;
- intermittent positive pressure breathing machine;
- any breathing apparatus required by prescription to enable continued breathing (to a maximum of \$800 per insured person per lifetime);
- aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis, or chronic asthma;
- apnea monitors for respiratory dysrhythmias;
- iron lung;

- insulin and syringes, blood letting devices, lancets and home chemical diabetic supplies;
- prostatic specific antigen blood tests required by a physician;
- artificial eyes, including repairs;
- one pair of eyeglasses or contact lenses following cataract surgery;
- artificial limbs including repairs and replacement (excluding myoelectrical limbs);
- external breast prosthesis, once per calendar year, post-mastectomy;
- transcutaneous nerve stimulator for up to six months (for nerve stimulation but not muscle stimulation);
- bone stimulators;
- pacemakers.
- wigs and/or hairpieces as a result of cancer treatments

### **COVERED PARAMEDICAL EXPENSES**

Services of a licensed podiatrist to a maximum of \$200 in any calendar year.

Speech therapy for dependant children to a maximum of \$500 providing a doctor's referral has been supplied and proof has been provided that no other avenue for reimbursement is available

### **EXTRA CARE COVERED EXPENSES**

A total of 50 per cent of the cost of two pairs of orthopaedic shoes (when not forming an integral part of a brace) to a maximum of \$200 per insured person in any calendar year.

Arch supports (orthotics) that are specifically designed and constructed for the insured to a maximum of \$200 in any calendar year.

Hearing aids, excluding replacement batteries and repairs, obtained by a written prescription of a physician or qualified audiologist (maximum of \$500 every five years per ear).

Nicotine cessation aids to a maximum of \$200 lifetime.

## **PREGNANCY**

Major medical insurance pays for medical expenses related to pregnancy as it would for any disability.

## **THE PAY DIRECT DRUG CARD**

QSLEW members can have their drug claims processed immediately at any pharmacy in Canada, using the pay direct drug card, provided by ASSURE Canada.

With the pay direct drug card, your drug claims will be processed in seconds while you wait at the retail pharmacy of your choice. Simply present the card to your pharmacist when you purchase a prescription medication. There are no forms to complete. No deduction from your pay is required.

If you have *single* coverage in the QSLEW benefits plan, you will receive one pay direct drug card. If you have *family* coverage, you will receive two cards; one for you and one for your spouse.

An additional card will be issued for eligible dependants over age 21 and in full-time attendance at college or university.

You can also request, in writing, additional cards for dependants under 21 and attending college or university.

If you need an additional card, or if your card is lost or stolen, contact the QSLEW administrator at 613-547-4115.

## **OUT-OF-PROVINCE EXPENSES**

If an expense would have been covered if incurred inside the person's province of residence, such expense will also be covered if incurred outside the province of residence provided:

- the insured is temporarily out-of-province for business or vacation; or
- the required medical treatment is not readily available in the province of residence and the person is forced to seek treatment elsewhere.

## **SERVICES NOT PAID BY MAJOR MEDICAL INSURANCE**

1. Eyeglasses (see *Vision care*).
2. Injury or illness due to war.
3. Dental services, except those listed as covered expenses.
4. Cosmetic surgery or hospital confinement for cosmetic surgery, except to correct deformities resulting from illness or injury, or such congenital defects as interfere with function.
5. Eye and hearing tests.
6. Pregnancy tests.
7. Routine medical examinations.
8. Laser treatment/surgery.
9. Fees for completion of medical forms.
10. Circumcisions.
11. Any and all items pertaining to erectile dysfunction.
12. Vaccines.
13. Physician fees for treatment of varicose veins.
14. Physician fees for treatment of spider veins.

## **CONTINUATION OF MAJOR MEDICAL BENEFITS**

If you are totally disabled when your major medical health insurance terminates and you have expenses for that illness that would have been paid had your coverage continued, your benefit payments will continue until the earliest of the following:

- the date your disability ceases;
- the date which is 90 days after the group policy terminates;
- the date on which you have received maximum benefits;
- the date on which you have received benefits for a period equal in length to the period for which you were insured;
- the end of the calendar year next following the calendar year in which your insurance terminates.

If your major medical insurance terminates due to termination of the major medical benefits, any benefits payable under this plan for accidental injuries to natural teeth will continue after termination as long as the accident occurred while the major medical benefit was still in force.

## DENTAL CARE

Dental care has been designed to help pay for your family's dental expenses, both for routine care and for expensive and unforeseen treatment.

To be considered as a *covered expense*, the charge for a particular service must be reasonable and customary for the service provided in the area where the expense is incurred, and will be limited to the maximum fee level of the *Ontario Dental Association Suggested Fee Guide for General Practitioners* for the year determined by the Board of Trustees.

Each calendar year you pay the first \$25 deductible of covered dental expenses. The plan pays the rest.

**Please note:** The deductible will not be applied to expenses incurred solely as the result of accidental injury to natural teeth.

The deductible for routine and major treatment is paid only once in any one calendar year for any one person or family.

Any expenses incurred in respect of major medical covered expenses may be used to satisfy the deductible for dental care.

The maximum amount the administrator will pay in any one year is \$2,000 for any one person.

### TREATMENT PLAN

Before your dentist starts a course of treatment he will, upon request, prepare a *treatment plan*, a written report describing his recommendations on the necessary treatment and cost.

It is suggested you submit a treatment plan to the plan administrator at least one week before treatment is scheduled to begin, for any routine or major treatment expected to cost more than \$200. A pre-determination of the benefits payable will be calculated so that you know in advance the portion of the cost you will have to pay.

Any pre-determination of benefits is only valid for 180 days from its date of issue.

Confirmation of coverage cannot be obtained over the telephone.

## **COVERED EXPENSES**

The following items are considered covered expenses under the dental care benefit:

### **ROUTINE TREATMENT**

- oral examinations, cleaning teeth, topical application of fluoride solutions and bite-wing X-rays not more than once every six months;
- scaling and root planing to a combined calendar year maximum of eight units;
- polishing to a maximum of one unit every six months;
- full mouth series of X-rays, once every 24 months;
- extractions and alveolectomy at tooth extraction;
- surgical removal of impacted teeth and surgical preparation of dental ridges for prosthetic appliances;
- surgical removal of tumours, cysts, neoplasms; incision and drainage of abscesses;
- general anaesthesia, diagnostic X-ray and laboratory procedures required in relation to dental surgery;
- amalgam, silicate, acrylic and composite fillings;
- necessary treatment for relief of dental pain;
- antibiotic medication and its administration;
- space maintainers for missing primary teeth and habit-breaking appliances, excluding TMJ appliances;
- consultations required by the attending dentist;

- endodontics (root canal therapy);
- periodontics;
- stainless steel crowns (temporary crowns);
- pit and fissure adhesive sealants;
- orthodontics for dependant children only.

### **MAJOR TREATMENT**

- crowns;
- fixed bridgework;
- partial or complete dentures including replacement;
- re-lines and re-bases to existing dentures and adjustments to dentures after the three-month post-insertion care period;
- inlays/onlays.

### **EXCLUSIONS**

Covered dental expenses do not include and no payment is made for:

- appliances, splints and all expenses relating to TMJ;
- charges made by the dentist for dietary planning for the control of dental surgery, oral hygiene instruction, plaque control;
- hypnosis as a method of pain control;
- expenses for accidental injury to natural teeth incurred more than 12 months after the accident;
- installation of an initial appliance (bridgework, dentures etc) replacing natural teeth extracted prior to the effective date of coverage for the individual, unless necessitated by the extraction of additional natural teeth after the individual's effective date of coverage;
- replacement of existing dentures or bridgework unless the replacement is:

- required due to the extraction of one or more natural teeth after the effective date of coverage of the individual;
- replacing an existing denture which is at least five years old and is unserviceable;
- replacing a temporary appliance within 12 months of installation of the temporary appliance.
- expense of dentures which have been lost, mislaid or stolen;
- expense of dental treatment required as a result of any self-inflicted injury, war or from engaging in a riot;
- charges by a dentist for broken appointments or form completion;
- expenses of dental treatment for which coverage is provided under the major medical benefit (i.e. accidental dental benefits);
- treatment furnished without charge or paid directly or indirectly by any government plan for which a government prohibits payment of benefits;
- treatment rendered mainly for cosmetic purposes;
- treatment received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar group;
- expenses not recommended or prescribed by a dentist or physician.

### **CONTINUATION OF DENTAL CARE BENEFITS**

If your dental care insurance terminates due to termination of this dental care benefit, any benefits payable under this plan for accidental injuries to natural teeth will continue after termination provided the accident occurred while the dental care benefit was still in force.

## VISION CARE

Vision care insurance covers 100 per cent of the covered expenses listed below when prescribed by an ophthalmologist or an optometrist up to the maximums specified below, provided such expenses are considered reasonable and customary for the service provided in the area where the expenses are incurred.

### COVERED EXPENSES

The plan will pay for **one** of the following covered expenses:

- eyeglass frames and lenses; or
- prescription safety glasses; or
- contact lenses; or
- prescription sunglasses;
- eye exams;

required for:

- an initial lens prescription;
- a change in a lens prescription; or
- replacement frames or lenses which have been broken, lost or stolen up to but not exceeding \$300 in any 24-month period:
  - a) an additional benefit of \$200 every four years (less any payments for glasses and contact lenses during that period) for contact lenses when the following conditions are met:
    - i. they are prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus, or aphakia; and
    - ii. vision in the better eye cannot be corrected to the 24/40 level by glasses; and

- b) for a portion of the cost of laser eye surgery in lieu of lenses, frames or contact lenses, up to the plan maximum per two year period. At two-year intervals, the claims administrator may consider the remaining balance in the same fashion upon receipt of a claim submission.

**Please note:** Coverage for eyeglasses also includes the cost of tinting, photo greying and hardening of lenses.

### **SERVICES NOT COVERED BY THE VISION CARE BENEFIT**

1. Treatment furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits.
2. Injury or illness that is a direct result of war, insurrection or engaging in a riot.
3. Services and supplies received principally for cosmetic purposes.
4. Eye test or examinations required by an employer, school, or any government agency.
5. Treatment received from a medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar group.
6. Artificial eyes, sunglasses.
7. Eyeglass cases.

## CO-ORDINATION OF BENEFITS

In addition to the benefits payable under this plan, sometimes an employee or dependant is entitled to benefits for the same expense under an automobile insurance plan or another group insurance plan.

Should this type of duplication occur, the benefits under this plan will be co-ordinated so that the total benefits from all plans will not exceed the expenses actually incurred. Priority will be given to the plan that does not include a co-ordination of benefits provision. If it does include this provision, the plan that covers you or your spouse as an employee will pay first. In the event of dependant coverage, priority will be given to the plan covering the person whose date of birth excluding year of birth, is earlier in the calendar year.

# GENERAL INFORMATION

## Plan effective date

The plan described in this booklet is up-to-date as of October 1, 2008.

## YOUR PLAN SUPPLEMENTS PROVINCIAL PLANS

Your group benefit plan is designed to supplement protection, not duplicate or take the place of, the benefits available under provincial hospital and medical care plans.

Therefore, the benefit plan excludes care and services that can be provided under a provincial plan. The group plan cannot provide any benefits where care or treatment by private insurance is prohibited.

## ELIGIBLE MEMBERS

**Member** means either of the following:

1. a member in good standing of the union, who is employed and directly compensated for services by an employer who, pursuant to collective agreement with the union, is obligated to make contributions to the QSLEW Trust Fund on behalf of that member; or
2. a salaried employee of the union or QSLEW Trust Fund who is employed on a full-time basis.

## WAITING PERIOD

You will become eligible for benefits the first day of the month following the accumulation of 390 hours in your hour bank account.

**Note:** New and reinstated members are covered on the first day of the month following the month in which 390 hours are accumulated and received by the administrator. For example, if a member works 144 hours in August 2008 and 144 hours in September 2008 and at least 102 hours in October 2008, he/she will be insured effective November 1, 2008.

## **ELIGIBLE DEPENDANTS**

You are eligible for dependant coverage while you have a qualified dependant and remain eligible for member coverage. No person may be covered as a dependant while being covered as a member.

## **QUALIFIED DEPENDANT**

A qualified dependant means your spouse and dependant children as defined below.

Spouse means either:

1. an individual to whom you are legally married; or
2. your common-law partner, including a same-sex partner, with whom you have been co-habiting for a period of at least 12 months and whom you publicly represent as your spouse.

You must state the name of the person to be considered your spouse for the purposes of the policy. Only one spouse will be covered under the policy at any time.

Dependant child means either:

1. an unmarried person who is your natural or adopted child; or
2. a child of a common-law spouse, who resides with you and is dependant on you for support;

and who is:

- A. younger than 21 years of age; or
- B. 21 years but under 25 years and in full-time attendance at an accredited institute of learning, and dependent on you for support; or
- C. 21 years or older and incapable of self-sustaining employment due to a mental or physical handicap. His/her child's coverage will be continued under the policy, provided the child's handicap has existed continuously from a time when he/she was otherwise insured as a dependant under this policy.

Requests for changes to covered dependants are subject to review and approval by the QSLEW Trust Fund.

### **HOURLY BANK ACCOUNT**

The plan administrator maintains an hourly bank account for each member showing the hours worked for a contributing employer for whom contributions have been made to purchase the group insurance.

For each hour you work, a contribution, as defined in your collective or participation agreement, will be made to your account.

Each month, a number of hours will be deducted from your hourly bank account to cover the cost of your benefits. The number of required hours can fluctuate depending on the cost of the benefits. Any hours over and above those required to maintain your monthly coverage will accumulate in your hourly bank.

It is important to understand how the cycle of reporting hours works. The hours you work in a month are reported to the plan administrator the following month. They are then used to provide coverage in the month following the month worked.

Note: New and reinstated members are covered on the first day of the month following the month in which 390 hours are accumulated. For example, if a member works 144 hours in August 2008 and 144 hours in September 2008 and at least 102 hours in October 2008, he/she will be insured effective November 1, 2008.

### **PAY DIRECT PROGRAM**

If you are unemployed and do not have sufficient hours in your hourly bank account to continue coverage, you may elect to continue your benefits coverage by making direct payments to the plan for a maximum of 12 months of lay-off. You must remain a member in good standing of the union to participate.

## **SUSPENSION OF UNION MEMBERSHIP AND COVERAGE**

If you do not pay union dues and your membership lapses, your benefits under this plan will terminate as of the effective date of your suspension as reported by the IBEW Local 115 Union. Any balance in your hour bank account will be used to keep your benefits active until they exhaust. You will not be eligible to pay direct unless your membership is reinstated.

## **REINSTATEMENT OF COVERAGE**

If your benefits were terminated because you did not have enough hours of credit in your hour bank account and did not participate in the pay direct program, your coverage may be reinstated when you accumulate 390 hours of credit in any 12-month period. Coverage will become effective on the first day of the month following the date your hour bank account credit totals 390 hours, provided you are at work or eligible to resume work, and are a member in good standing of the union.

If your coverage was suspended with your union membership, benefits will be reinstated as of the reinstatement date of your union membership.

## **DEFINITIONS**

*Active work or actively at work* means you are working at your usual place of employment and performing all of the usual customary duties of your occupation.

*Collective agreement* means the agreement in accordance with which contributions are made to the fund by the employer on behalf of a member.

*Employer* means any of the following:

1. the contractholder;

2. an electrical contractor who is employing a member on a fulltime basis and who, pursuant to the collective agreement with the union, is obligated to make contributions to the fund on behalf of any such member;
3. an electrical contractor who is employing a salaried employee on a full-time basis and who, pursuant to a participation agreement with the union, has agreed to make contributions to the fund on behalf of the employee; or
4. the IBEW Local Union 115 who is employing a salaried employee on a full-time basis.

*Full-time basis* means salaried employees that regularly work at least 20 hours per week.

*Union* means The International Brotherhood of Electrical Workers, Local 115.

## **EFFECTIVE DATE OF COVERAGE**

### **MEMBER COVERAGE**

Your coverage will commence on your date of eligibility.

If you are not actively at work on the date your coverage is to be effective or increase, it will become effective when you return to active work. An absence due solely to a paid vacation or general holiday will not delay your coverage.

### **DEPENDANT COVERAGE**

The effective date of a dependant's coverage will be the latest of the following dates:

1. the date the member coverage is effective, however, if you applied later than 31 days after the effective date of your own coverage, evidence of insurability must also be submitted for each of your dependants and their coverage will be effective on the date the plan administrator approves the evidence;

2. the date you become eligible for dependant coverage, if you had previously selected dependant coverage;
3. the date you apply for dependant coverage, provided application is made within 31 days of the date you are first eligible for dependant coverage otherwise, on the date the plan administrator approves the evidence of insurability submitted for the dependants.

Evidence of a dependant's insurability may be required to be submitted at your expense.

**Note:** Any individual residing outside Canada or the continental United States will not be eligible to be covered, unless an exception is requested by the member and approved in writing by the plan administrator and the insurer, where applicable.

You must complete a new enrolment card and a *Change in dependant* form if you wish to add or change a legally married or common-law spouse, or add or remove a child. Requests for changes to covered dependants are subject to review and approval by the QSLEW Trust Fund.

## **BENEFICIARY RULES**

Beneficiary means the person you designate in writing to receive the benefits. Upon enrolment in the plan, an employee must designate the beneficiary to whom the death benefits will be payable.

Benefits becoming payable under the policy on account of your death will be paid to your beneficiary. Any benefit amount for which there is no beneficiary at your death will be paid to your estate.

Subject to any statutory rights of any beneficiaries, you may change the beneficiary at any time by filing a new designation form with the plan administrator. The change will be effective on the date the form is signed, but it will not apply to any payment made by the insurer prior to the date the form is received by the insurer.

If there is more than one beneficiary and the form does not specify their share of the insurance proceeds, the beneficiaries will share the benefit equally.

If a beneficiary dies before you, that beneficiary's interest will end. It will be shared equally by any remaining beneficiaries or, in the absence of a designated beneficiary or beneficiaries, the estate, unless the designation form states otherwise.

### **CHANGE IN COVERAGE**

If your coverage changes due to a change in age, class, earnings, dependant status etc. or as a result of a plan change, it will not be adjusted until the first day, on or after the date of the change, on which you are actively at work and the appropriate contribution is being made.

If a dependant is confined to a hospital on the day increased benefits are scheduled to become effective, they will not go into effect until he/she is released. In any case, payment for services and supplies received before the date of an increase in benefits will always be based on plan benefits in effect before the change.

### **CHANGE IN INFORMATION**

To ensure that you receive all correspondence and that the proper information is stored in your file, contact the plan administrator as soon as a change (i.e. new dependant, beneficiary or address) occurs.

### **TAXATION**

All employer-paid group term life insurance premiums are taxable to the employee. At the end of February each year, you will receive the appropriate tax form to be included in your tax calculation for the prior fiscal year.

## GENERAL LIMITATIONS

Your health insurance does not cover services and supplies in the following situations:

- any expense incurred while your union membership is not in good standing (i.e. dues are not paid up to date );
- injury sustained while working for pay or profit;
- illness for which you or your dependants are covered under Workers' Compensation or a similar program;
- services received in a government hospital;
- services to which the patient is entitled without charge, or for which there would be no charge if there was no insurance;
- services or a portion thereof provided under any government sponsored hospital or medical care program.

### TERMINATION OF INSURANCE

Unless otherwise specified in this booklet, insurance coverage for yourself and your dependants ceases at the earliest of the following events occurs:

- when your employment ends or you retire;
- when your hour bank credits are less than that required to fund benefits, if premiums are not remitted on the self-pay basis; or
- when the group policy terminates; or
- when you are retired or disabled and reach age 65;
- when you are no longer in an eligible class.

If your employment ends because of injury, sickness, leave of absence or temporary lay-off, you may be entitled to continued benefits under this plan. Your plan administrator will provide you with the details on the types of insurance, if any, that may be continued and the length of the extensions available.

## **CONTINUATION OF BENEFITS FOLLOWING RETIREMENT**

Upon retirement, all benefits (other than life, dependant life, AD&D and disability) can be continued on the self-pay basis until age 65.

Retired members over 65 with a spouse under 65 may apply for extended health and dental benefits coverage for the spouse and their dependants until the spouse's attains age 65.

## **CONTINUATION OF HEALTH BENEFITS FOR DEPENDANTS**

In the event of your death, the health benefits for your dependants will be continued for a period of one year.

If your surviving children cease to qualify as eligible dependants the health benefits being continued for your children under this provision will terminate automatically on the date they no longer qualify.

If a dependant is disabled on the date his insurance under this continuation provision would otherwise terminate, his/her insurance payments will be continued until the earliest of the following:

- the date on which his disability ends;
- the date on which he has received maximum benefits;
- the date that is 90 days from the date his insurance terminated.

**Please note:** If your dependant is in the hospital on the last day of this 90 day period, his/her insurance payments will be continued until he/she is discharged from hospital, or until maximum benefits have been paid.

## **CLAIMS PROCEDURES**

In the event of a claim, you or a member of your family should obtain the proper claim form from the claims adjudicator:

Michelle Cotman  
Benefits Administrator  
QSLEW Trust Fund  
40 Binnington Court  
Kingston, ON K7M 8S3

Phone: 613-547-4115

Fax: 613-547-1678

Email: [mcotman@kos.net](mailto:mcotman@kos.net)

All completed claim forms and inquiries must be directed to the administrator at the above address.

All claim forms must be submitted to the administrator within 90 days. No benefits will be payable for expenses incurred more than 12 months prior to the date the claim is submitted.

All claim forms must be fully completed and signed by the member before any payments will be made.

## **OUT-OF-PROVINCE CLAIMS**

Out-of-province claims must be submitted to your provincial Medicare plan first. After you receive the Medicare payment, submit the claims to the administrator along with proof of the payment made by the Medicare plan.

**THIS BOOKLET CONTAINS IMPORTANT INSURANCE INFORMATION AND SHOULD BE KEPT IN A SAFE PLACE KNOWN TO YOU AND YOUR FAMILY.**



