OPERATING ENGINEERS IN ONTARIO

LIFE & HEALTH BENEFITS PLAN

ACTIVE MEMBERS

JANUARY 2023

CONTENTS

This booklet contains the Rules of your IUOE Life and Health Benefits and the Rules of the IUOE Pre-paid Legal Plan. The governing body responsible for the benefit plan is a Board of Trustees consisting of representatives of both the Union and Management (i.e., Participating Employers). They are appointed pursuant to the trust document that governs the Plan and are charged with the duty to establish, direct, and supervise the Plan. They have selected the OE Benefits Administration Corporation (OEBAC) to manage the day-to-day administration of the Plan. The IUOE Local 793 Board of Trustees reserve the right to change the terms of the plan at any time.

INTRODUCTION

FOR ALL MEMBERS

This booklet sets out the terms of the IUOE Local 793 Life and Health Benefits Plan and the Legal Services Plan as of the date of publication in 2023. Rules and benefits coverage may change from time to time, and you are best advised to consult the OEBAC website for the most current terms and conditions in the event of any changes. The booklet also represents the Trustees' best efforts to set out all the Rules for the Benefit Plan as well as the relevant terms of the applicable Trust Agreements, Insurance Contracts and Policies. The Rules of the Plan themselves are embodied in this Booklet. However, in the event of any omission in this booklet or a conflict with these official documents, the official documents will govern. They are available to members on request.

In the event of any omission in this booklet or a conflict with the governing documents (including the Plan trust document), the governing documents shall prevail. Also note that the rules and benefits may change from time to time after publication of this booklet and you are best advised to check the OEBAC website or consult with OEBAC staff regarding any possible changes.

OEBAC and the trustees will ensure that all information and documentation pertaining to your use of the Plan and its benefits are kept confidential pursuant to the Trustees` privacy policy available on the OEBAC website. Data and information will only be used or disclosed to the extent it is necessary for the purposes of administration of the Plan. Please visit https://www.oebac.org/privacy for further details.

The IUOE Local 793 Life and Health Benefits Plan and Group Legal Plan provide eligible members with a wide range of benefits including Death Benefits, Accidental Dismemberment Coverage, Short- and Long-Term Disability Income, Supplementary Health Care, Vision Care, Platinum Level Healthcare service provided by Members Health, Dental Care, Bereavement and Parental Leave benefits and various legal services (Active Benefits).

The purpose of this booklet is to explain and summarize the benefits available so that each Member will know:

- How the plans operate; and
- The plans' eligibility criteria; and
- What you are entitled to receive; and
- How to submit a claim to your benefit plans.

These plans are financed primarily by participating employers through contributions determined through collective bargaining. Such contributions are deposited in benefit trust funds to secure the future delivery of benefits. Deductions, as authorized by the Trustees (e.g.: Retiree Subsidy and Group Legal), are made before deposits occur in the member's dollarbank. The rights of Members, recipients and all other persons entitled to receive any payments or benefits under the plans are limited by the assets held in such benefit trust fund.

The Trustees wish to assure you that they will continue to carefully administer the plans, in consultation with advisors, so that you will receive the superior benefits that may be provided from the contributions made to the Benefits Plans. The Trustees may also amend the Plan provisions from time to time.

This booklet describes the main features of each plan, in effect as of January 1, 2023, and every effort has been made to ensure that the information is accurate. If any questions of interpretation arise, the Group Insurance Contracts, Plan Master Application and plan documents will be the sole governing documents. This booklet is not a substitute for official plan provisions as established from time to time by the Trustees.

Please note that any mention of Workplace Safety and Insurance Board (WSIB)/Act also includes Workers' Compensation.

We encourage you to read each section of this booklet to understand more fully your benefits and the conditions under which they are payable. If you are unclear about the benefits program or your coverage or circumstances, please contact your Local Union Hall or Operating Engineers Benefits Administration Corporation (OEBAC), your plan's administrator.

To help us ensure you receive the benefits to which you are entitled, please always keep your personal information up to date. Address changes and changes in your status should be reported promptly to IUOE Local 793.

The Active Benefits Plan is financed principally by negotiated contributions. The Trustees have established the terms of the Benefits Plan that can be provided by such contributions and the plan's assets. If there are losses or gains from operations or future increases in contributions, then the Trustees may change the provisions of the Active Benefits Plan accordingly. The Trustees may modify a plan requirement in an individual situation if they consider the requirement unreasonable under the circumstances and a cause of undue hardship to an Active Member or the Active Member's family.

HOW TO CONTACT OEBAC

As the administrator of your plans, OEBAC will answer your questions, process your claims and offer support as needed.

Call Centre

If you wish to talk to a member of the OEBAC team, the OEBAC Member Call Centre is open Monday to Thursday from 8:30 A.M. to 9:00 P.M and Friday from 8:30 A.M. to 8:30 P.M. toll-free at 1-844-793-1919.

Email

Questions about your benefits and electronic claims may be submitted to OEBAC at the following email address: info@oebac.org

OEBAC Online

OEBAC provides Active Members the ability to submit their Health and Dental claims online by logging into the member portal on the iuoelocal793.org website or through the OEBAC Mobile App. To log into iuoelocal793.org, you must have:

- Your Union Registration Number (found on the front of your union card)
- Your password (created when you set up your online member account)

If you have not yet registered for an online member account, you can create one by clicking “REGISTER NOW”

On the right-hand side of the “MEMBER LOGIN” page. For member registration, you will need:

- Your Union Registration Number (located on the front of your union card)
- Your date of birth
- Your email address

OEBAC Mobile

Members are encouraged to use the OEBAC Mobile App to submit Health and Dental claims. To sign into the OEBAC Mobile App, you must have:

- Your Union Registration Number (found on the front of your union card)
- Your password (created when you set up your online member account)

By Mail

Paper claims can be mailed to OEBAC at:

OEBAC Claims Department
2201 Speers Road, Unit 1
Oakville, Ontario, L6L 2X9

NOTE: Only claims for parental leave, bereavement leave, and legal services must be submitted on paper. These paper claims can be submitted by email at info@oebac.org. Please also note that all paper claims must be accompanied by a completed claim form signed by the member.

For all other claims you have the option to go digital! Try it, it is more convenient and should result in faster payment.

With OEBAC Online and the OEBAC Mobile App, you can:

- Submit a claim
- Submit an expense for pre-approval
- Check the status of a claim, see the amount paid and see how the claim was adjudicated
- Reminds you about Health Care Spending Account and gives you the opportunity to direct any remaining claim amounts for payment from toward your Healthcare Spending Account (HCSA). Check how much you have left in your HCSA
- Check how much of your maximums you have spent and how much is left
- When you can claim next?
- View the details of your plans and much more

Direct billing using the OEBAC Benefits Card:

Pharmacies, dental offices, and many health service providers will now be able to submit your claims electronically by providing your OEBAC Benefits Card during your visit. If your medical professional is unable to submit your claim electronically, please arrange payment and obtain a detailed receipt and submit your claim to OEBAC using your OEBAC Mobile App, OEBAC Online, or sending it to us by email or regular mail.

Visit the OEBAC Website

You will find a lot of information https://www.oebac.org/ about your benefits including videos explaining the features of the plan, tutorial videos explaining how to submit claims on your phone, all the forms that you need to submit claims, and much more.

IMPORTANT: Whether you submit claims either online or through the OEBAC Mobile App, you must keep the original paper copies of all your claims for 18 months for audit purposes.

HOW TO SUBMIT A CLAIM FOR BENEFITS

SUPPLEMENTARY HEALTH CARE AND DENTAL CARE

Take your OEBAC Benefits Card with you when you obtain covered services and present it when it's time to pay. If your pharmacy, dental office, or medical professional is unable to submit your claim electronically, arrange payment and obtain a detailed receipt.

Please be sure to complete the appropriate form fully, attach all necessary original paid in full receipts with any other original documentation where applicable making sure they are properly signed and stamped, by the provider of the services or supplies and submit to OEBAC in the following ways:

Online and mobile claims using OEBAC Mobile - You may then submit your claim electronically through the OEBAC Mobile App available on the Apple App Store and Google Play, or by logging in to the member section of iuoelocal793.org with your username and password.

Provider submitted claims – using your OEBAC Benefits card

Paper Claims – The traditional paper form is still an option and claim forms can be obtained by contacting OEBAC at 1-844-793-1919, or from the website (oebac.org under forms tab) or from the Local 793 website. Complete the appropriate claim forms and submit all required documents. These paper claims can be emailed to info@oebac.org or mailed to OEBAC at:

You can also obtain a paper claim form from our website at https://www.oebac.org/forms

These paper claims can be emailed to info@oebac.org or mailed to OEBAC at:

OEBAC Claims Department
2201 Speers Road, Unit 1
Oakville, Ontario, L6L 2X9

NOTE: Be sure to keep your receipts, your completed claim form, and any other documentation provided. Originals will not be returned.

You can deal directly with the OEBAC Team – Toll free call: 1-844-793-1919 or email at info@oebac.org. Our representatives will assist you with the questions you may have.

In all instances, the name of the patient should be clearly indicated on each claim receipt. The following information must accompany certain types of claims in order to obtain a reimbursement from the Active Benefits Plan:

- Drug Claims - If you do not use your benefit card for electronic claim submission, you must complete a medical claim form with your certificate number. You must include the receipt clearly showing the prescription number, Drug Identification Number (DIN), cost, date of purchase, name of the patient, name and quantity of the drug. Some drugs claims may require prior approval by OEBAC or its specialized consultant. More details can be obtained on https://www.oebac.org

- Paramedical Claims - (chiropractor, massage, osteopath, acupuncture etc. requires an official receipt with the provider's proof of registration number. See full Services listing for all pertinent details) - Complete a claim form listing all expenses incurred and attach copies of all receipts.

  NOTE: **Physiotherapy claims, Kinesiology claims and Certified Athletic Therapy claims require a physician's referral that outlines 1) the medical diagnosis; and 2) the duration of treatment recommended; and 3) confirmation that the diagnosis is not related to a motor vehicle accident.** To avoid delays, include the doctor referral with the first claim form or online submission.

- Durable Equipment – Reimbursement is subject to a physician's recommendation stating your diagnosis and confirming your diagnosis is not related to a Motor Vehicle Accident. You must include a letter from your physician along with the receipt for the expense. This letter should describe the nature of your disability or your Dependant's disability, a diagnosis, how the particular service or equipment will improve/stabilize the condition and the length of time the service or equipment will be required.

- Private Duty Nursing - Reimbursement is subject to prior approval. Please fill out the Private Duty Nursing Pre-Approval form and submit to OEBAC.

- Dental Care - If you do not use your benefit card, obtain the standard dental billing form from your dentist at the time of your visit. Payment for dental care claims will be made directly to you unless you assign the benefits payable to your dentist by indicating so on Part 1 of the claim form. Ensure forms are complete with signatures and your certificate number.

- Orthodontic Claims - **Must be under the age of 21 years old to be eligible for this benefit**. Although most orthodontists will quote a single amount for the full course of treatment covering several years, **orthodontic reimbursements are limited to a monthly or quarterly fee and you will only be reimbursed for the services as they are actually rendered. Prepayments are not reimbursable under this plan. Eligibility for this plan is for eligible individuals under the age of 21.** Payment for orthodontic claims will also be made directly to you, unless you assign the benefits payable to your dentist by indicating so on Part 1 of the claim form.

NOTE: **FOR ALL CLAIMS**: If any of the information is missing, payment of your claim may be delayed. Forward all completed forms and receipts to OEBAC for processing.

- Death Benefit for Active Members - Your beneficiary (or the individual handling your estate) should contact OEBAC as soon as possible following your death. The named beneficiary will be given the appropriate claim forms to complete.

- Accidental Dismemberment - The claim forms must be completed by your attending physician clearly indicating the date and details of the accident, the nature of the injury, the date of the loss and the degree of the loss.

- Accidental Death Benefit - Appropriate forms can be obtained through the OEBAC website or by contacting OEBAC.

- Death Benefit for Dependant - You should contact OEBAC as soon as possible following the death of your Spouse or Dependant child. You will be given the appropriate claim forms to complete.

- Bereavement Leave - You and your employer must fill the claim form. Make sure you indicate the date of death of your eligible family member and the relationship to you. The completed claim form should be forwarded to OEBAC for processing. Claim forms can be obtained from any Union Office, OEBAC and are also available on our website at https://www.oebac.org/forms.

  To be eligible for this benefit you must be actively working at the time the bereavement occurs and benefits are payable from the 1st day of lost earnings as a result of making arrangements and/or attending funeral or religious services for a deceased eligible family member. Payment is not made during periods of layoff, only for time missed during periods of employment.

- Parental Leave - You and your employer must fill out a claim form and forward the completed form along with a copy of the birth certificate or a temporary health card from the hospital for the birth of a biological child OR in case of adoption of a child, proof of adoption papers are required along with an updated Personal Information Form (PIF). The PIF and claim form can be obtained from any Union Office, OEBAC and are also available at https://www.oebac.org/forms.

- Short-Term Disability - You must be a Member with Benefit Plan coverage on the date your disability started. Complete and sign the **Plan Member Statement** of the Short-Term Disability application and apply for Employment Insurance (EI) Sickness Benefits immediately upon becoming disabled. If you continue to be disabled after exhaustion of your EI Sickness Benefits, you may be eligible for an additional 10-weeks of benefit payments provided you remain disabled and provide ongoing medical documentation to support your disability by having your physician complete the **Attending Physician's Statement**. Return all portions of the Short-Term Application to OEBAC Disability Department.

- Long-Term Disability - You may be eligible for Long-Term Disability benefits if you remain totally disabled and are under the age of 65. The Long-Term Disability Application will be sent to you by the OEBAC Disability Department prior to you receiving the maximum benefit under Short-Term Disability benefits.

Medical expenses and disability benefit payments relating to a motor vehicle accident are not an eligible expense under the Short-Term Disability, Long-Term Disability or Supplementary Health plans. These expenses are currently insured under automobile insurance policies in Ontario. If you are injured as a result of a motor vehicle accident, your claim should be filed under your auto insurance policy. If you are in receipt Income Replacement Benefit (IRB) from your insurer, please ensure that you complete the Dollarbank Account Freeze Form.

IS THERE A TIME LIMIT FOR SUBMITTING CLAIMS?

Yes. It is important that all claims incurred under the Active Benefits Plan be submitted promptly for payment.

For death benefit claims, notification should be given to OEBAC and the union within 6 months of the date of death. If it is not possible to give proof within such time limit, then the claim should be filed as soon as reasonably possible and in no event later than one year from the time proof is otherwise required.

For all claims other than for death benefits, claims must be submitted to OEBAC no later than 18 months from the date you incurred the expense in order for you to receive reimbursement. Expenses submitted more than 18 months after the date they were incurred will not be covered by the Active Benefits Plan.

If there are special circumstances that prevented you or your beneficiary from submitting the claims within this time frame, an explanation should be submitted to OEBAC, along with your claims and a completed Appeal to Trustees form, for review by the Appeals Committee.

LIFE AND HEALTH BENEFITS PLAN FOR ACTIVE MEMBERS

SUMMARY

The IUOE Local 793 Life and Health Benefits Plan (Active Benefits Plan) provides eligible Members with a wide range of benefits. Details of eligibility requirements, coverage levels and any restrictions are described in this booklet. The following section briefly summarizes the benefits available to you and highlights the main provisions of these benefits.

Members Benefit coverage is based on the negotiated terms of what is covered under their collective agreement. If you are unsure speak to a Union Representative for clarification. Not all collective agreements are the same.

BENEFITS FOR ACTIVE MEMBERS

Death Benefit (Paid to your Beneficiary)	Flat benefit of $150,000 if Member was in benefit on the date of death.
Self-insured Death Benefit (Paid to your Beneficiary)	In addition, if you are an Initiated Member in good standing with IUOE Local 793 and union dues were paid up at the time of death, the Active Benefit Plan will provide a further benefit of $2,000 (less applicable taxes) on a self-insured basis.
Accidental Dismemberment Coverage (Paid to you or in the event of your death, your Beneficiary)	Up to a maximum of $25,000 (less applicable taxes) on a self-insured basis.
Accidental Death Benefit (under age 70) (Paid to your Beneficiary if Member was in good standing at the time of death)	Flat benefit of $5,000 (less applicable taxes) on a self-insured basis.
Bereavement Leave (for Members Only)	$175 per day for up to 5 working days per incident.
Parental Benefit (for Members Only)	$175 per day for up to maximum 3 working days.

Short Term Disability (for Members Only)	**Benefits Payable:** • Maximum benefit of $800 per week less withholding tax from each weekly benefit payment. In addition, be sure to apply for the Local 793 SUB Plan Benefit at the same time as you are filing for Short Term Disability. Details are available at https://www.oebac.org/sub-plan. **Benefit commences on:** • The conclusion of the EI integration period; or • The 8th day of disability if you do not qualify for EI Sickness benefits; or • The 1st day absent from work if the disability results from a nonoccupational accidental injury and you have been treated by a physician; or • The date you are hospitalized for over 18hrs, including day surgery. Day surgery means procedures which require an incision or laser procedures which would otherwise be performed as a qualifying surgical procedure. Outpatient testing procedures, including scopes which do not require an incision, are not covered under hospitalization.
Long Term Disability (For Members Only)	**Benefit commences when:** • Seen by, treated by, and under the continued care of a licensed physician in Canada. • Totally disabled and under the ongoing care of a licensed physician in Canada. • Totally disabled due to a non-occupational illness or injury. • Absent from work for more than the waiting period of 26 or 37 weeks. **Benefits Payable:** Maximum benefit of $1,500 per month less withholding tax for each payment. Benefits end the earliest of: • 10 years of benefits payments; • The end of the month in which you attain age 65; • The date you recover; or • The date you die.

BENEFITS FOR ACTIVE MEMBERS AND YOUR DEPENDANTS

Death Benefit for Dependant (Paid to Member)	Flat benefit of $12,000 per eligible dependant.
Group Legal & Pension	Group Legal Plan provisions are at the back of this booklet. The pension benefits are listed in a separate booklet.
Supplementary Health Care	100% of most medical expenses (including Prescription Drugs) to a lifetime maximum of $150,000 (not including dental) per covered dependant for all eligible expenses.
Hospital Room	The hospital's charge for Private hospital room accommodation based on your province of residence.
Psychological Services	Psychological Treatment services performed by a Registered: • Psychologist • Psychotherapist or • Social worker Are subject to a combined maximum of $5,000 per person, per calendar year.
Health Care Spending Account (HSCA)	The HCSA covers out-of-pocket medical and dental expenses that exceed your Active Benefits Plan coverage. The HCSA maximum benefit is $500 per family per calendar year. Amounts remaining in your HCSA at the end of the calendar year can be carried forward for one year only. The maximum amount you can accumulate in any two (2) year period is $1,000. HCSA can only be used for eligible expenses under our plan where a plan maximum has been reached.

Prescription Eyewear	Effective January 1st, 2022, and every January 1st thereafter, the Member and covered dependants will each have a 100% maximum of $800 to purchase prescription glasses (not restricted to one claim). Prescription Eyewear which includes: • Prescription glasses • Prescription contacts • Prescription safety glasses • Prescription sunglasses • Including: Frames & prescription lenses Note: Your receipt must reflect "prescription lens" in all instances for your claim to be eligible under the plan for reimbursement. • Eyewear ordered on-line from a Canadian company that manufacturers eyewear in Canada. (Must be made and manufactured in Canada to be covered under the plan).
Eye Exams	100% to a maximum of $125 once every 24 months for individuals over the age of 21; once every 12 months for individuals under the age of 21. Restricted to one claim per period.
Specific Eye Exams	Coverage will be provided where it is medically necessary to have specific eye exams for certain medical conditions with a medical note from Physician or Eye Doctor attached to receipt.
Corrective Laser Eye Surgery	100% to a lifetime maximum of $2,000, in order to correct eye conditions such as: near sighted and far-sighted vision, astigmatism etc. covered separately from prescription glasses (excludes cataract surgery).

Dental Care	**Fee Guide:** Eligible expenses are reimbursed based on the Ontario Dental Association (ODA) Fee Guide for General Practitioners with a one-year lag, as follows: • January 1, 2022: 2021 ODA Fee Guide • January 1, 2023: 2022 ODA Fee Guide • January 1, 2024: 2023 ODA Fee Guide **Reimbursement %** • Basic coverage 100% • Major Restorative: 100% • Lab fees: 100% • Orthodontic: 75% up to a maximum of $5,000 (for Member or eligible dependants who are under the age of 21) **Benefit Maximum** Basic and Major Restorative services combined to calendar year maximum of $3,000 per insured. Effective January 1, 2022, the amount of $3,000 per person, per calendar year is available (separate from the annual dental maximum) to cover the cost of a dental implant. **Reimbursement will be made only AFTER the procedure is completed.** Effective January 1, 2021, for new claims - Orthodontics services are limited to a lifetime maximum of up to $5,000 and are only available to the Member or eligible dependants who are under the age of 21. Any Orthodontic work started prior to Jan 1, 2021, will be subject to a $3,500 lifetime maximum. Effective January 1st, 2022, and every January 1st thereafter, 10 units of scaling are available that can be utilized as needed (1 unit = 15 minutes of treatment) each per Member and eligible dependants.

ELIGIBILITY AND COVERAGE

WHEN AM I ELIGIBLE FOR BENEFIT COVERAGE?

You become eligible under the Active Benefits Plan when you work for a contributing employer who pays contributions to the IUOE Local 793 Life and Health Benefits Plan for you. The contributions reported by your participating employers are recorded in your dollarbank and accumulate to establish your eligibility for benefits.

You will become eligible for coverage on the first day of the second month after you accumulate the required dollars in your dollarbank. Dollarbank eligibility requirements are adjusted from time to time to reflect the cost of the benefit program.

You must accumulate the equivalent of two months draw in your dollarbank to maintain ongoing eligibility.

Effective October 1, 2022, the monthly draw has been set to $425 for 2022, $475 for October 1, 2023 and $525 for October 1, 2024. The Trustees reserve the right to raise the monthly draw amount from time to time due to cost increases or addition of new benefits.

Regular Active Members - Drawdown Changes					
Effective Date		Monthly Drawdown Rate	Dollarbank Max. Coverage Period		**Dollarbank Maximum $**
Year 1 - Oct 2022	$	425.00	20 Month Max.	**$**	**8,500.00**
Year 2 - Oct 2023	$	475.00	22 Month Max.	**$**	**10,450.00**
Year 3 - Oct 2024	$	525.00	24 Month Max.	**$**	**12,600.00**

FOR EXAMPLE: If a member acquires $400 in their dollarbank in October and $450 in November, the eligibility requirements are met as of November 30th with $850 and benefit coverage will commence on January 1st.

Coverage continues automatically for each month provided you have the required minimum of $425 for 2022, $475 for 2023 and $525 for 2024 in your dollarbank.

If you are an Active Member of the Benefits Plan working under another union local who has signed a reciprocal agreement with IUOE Local 793, contributions received by IUOE Local 793 on your behalf will

be forwarded to your home local, upon your home local's written request. Always contact your Local Union office before working under another local to ensure a reciprocal agreement is in place.

For newly organized members, the Trustees may, in their discretion, waive any eligibility requirements subject to such terms and conditions as they determine. Such conditions shall include the repayment of waived drawdown amounts once the member reaches the dollarbank maximum under the Plan.

WHEN DOES MY COVERAGE START?

Your benefit coverage commences on the 1st day of the second month following the accumulation of two monthly draws (after October 1, 2022) $850 ($425 X 2).

In order to receive reimbursement for your claims, you must first complete a Personal Information Form (PIF) available from OEBAC, your local union office and https://iuoelocal793.org/. Reimbursement for benefit coverage for you and your dependants cannot be implemented until OEBAC has received a completed PIF. If the PIF has not been received, benefits cannot be paid for you or your dependants.

Who pays for my benefits?

While you are actively working, your participating employer is required to make negotiated contributions on your behalf to the Benefits Plan.

How do I get credit for contributions made by my employer?

A participating employer signs an agreement with the Union and reports contributions to OEBAC on a monthly basis. The dollars reported for you are credited to your own dollarbank. Your dollarbank is not a bank account for your use. It is a notional account for purposes of benefit coverage and is not transferable to you or to any other benefit plan or account except as provided under the terms of this Plan.

What happens if my dollarbank is credited with more than the monthly benefit premium required to maintain my benefits?

Under the current Rules, as of October 2022, you may accumulate a maximum in your dollarbank of 20 months OR $8,500; in October 2023 the maximum you can accumulate in your dollarbank is 22 Months OR $10,450; and in October 2024 the maximum in your dollarbank you can accumulate is 24 Months OR $12,600, representing your amount of monthly of coverage.

However, the Trustees reserve the right to increase this amount in the event of an increase in the monthly drawdown amount. If you reach the maximum amount in your dollarbank, any additional contribution will be allocated to your Pension Plan, as required by the applicable collective agreement.

When will my coverage terminate under this plan?

Coverage for you and your eligible Dependants will terminate under this Plan on the earliest of, the following dates:

- On the last day of the month that you have less than the monthly drawdown amount or you do not make the necessary self-payment to maintain your coverage.
- On the last day of the month, you stop making self-payments or are not permitted to make future self-payments.
- Short-Term Disability, Long-Term Disability, Bereavement Leave and Parental Leave benefits will terminate on the day you retire, even if you have an accumulated balance in your dollarbank.

What happens if my dollarbank falls below the minimum monthly requirement?

If your dollarbank falls below the minimum monthly requirement to maintain benefit coverage and remains below this minimum level for two years with no activity under your dollarbank, any balance will be released into the general reserves of the Benefits Plan on December 31st coincident with or immediately following this two-year period. Activity would include any period for which contributions are credited to your dollarbank, any period of disability freezing to your dollarbank or any period during which you make Pay-Direct contributions to the Benefits Plan.

Can I pay for benefit protection personally?

Yes. You may pay for continued benefit coverage under the Benefits Plan Pay-Direct provision if you are:

- An initiated Member in Good Standing of IUOE Local 793; and
- Registered and maintain on the union out-of-work list at the time your dollarbank falls below the minimum dollars required to maintain coverage.

You are **not allowed to make Pay-Direct contributions if you are not an IUOE Local 793 initiated Member in Good Standing, if you are an Owner/Operator, or a suspended member or no longer working with a signatory employer of IUOE Local 793 or have taken a salaried position with your employer where benefit coverage is available through them.

How does the Pay-Direct provision work?

The Pay-Direct provision is available to you if you are an IUOE Local 793 initiated Member in Good Standing, registered on the Union's out of work list and your coverage will otherwise cease because your dollarbank has dropped below the monthly dollarbank deduction. Under this provision, you will be allowed to make monthly payments to keep your coverage in force until you earn/work enough hours to bring your dollarbank back up above the monthly dollarbank deduction for up to 24 consecutive months.

OEBAC will notify you when you first need to make a Pay-Direct contribution. You are responsible for maintaining Pay-Direct contributions thereafter if you are not working for a contributing employer but wish to maintain your benefit coverage. Pay-Direct contributions will be limited to a maximum of 24 consecutive months.

Retroactive Pay-Direct contributions are not allowed.

All Pay-Direct contributions must be received by the 15th of the month prior to the eligibility month. The Pay-Direct contributions may be waived if you are receiving disability benefits from the Benefits Plan or from Workplace Safety and Insurance Board (WSIB) or wage loss supplements from your private insurance provider. Please see the section "What happens to my dollarbank if I become disabled?" for more information.

What are the Pay-Direct options and how much will Pay-Direct cost?

For Active Members, the Pay-Direct option provides full Medical and Dental benefit coverage excluding Maternity and Compassionate Care premium of waiver benefits, Bereavement Leave, Parental Leave, Short Term Disability and Long-Term Disability.

The Pay-Direct contribution rate is adjusted from time to time to reflect the expected cost of coverage. This rate is intended to represent 75% of the monthly draw, with the Active Benefits Plan subsidizing the remaining 25%. The Pay-Direct contribution rate is made up of three components:

1. Benefits coverage
2. 8% Retail Sales Tax (RST) on benefits coverage
3. Group Legal coverage

The monthly Pay-Direct contribution rate is as follows:

Active Monthly Pay Direct				Pay-Direct Contribution Rate Components			
	Monthly Draw	Pay-Direct Portion	Active Pay Direct Rate	Benefits	RST	Group Legal	Active Pay Direct Rate
Year 1 Oct 2022 to Sep 2023	$ 425.00	75%	**$ 318.75**	$ 281.25	$ 22.50	$ 15.00	**$ 318.75**
Year 2 Oct 2023 to Sep 2024	$ 475.00	75%	**$ 356.25**	$ 315.97	$ 25.28	$ 15.00	**$ 356.25**
Year 3 Oct 2024 to Sep 2025	$ 525.00	75%	**$ 393.75**	$ 350.69	$ 28.06	$ 15.00	**$ 393.75**

The monthly pay direct amount will vary in the event of an increase in the monthly drawdown amount.

Can I become covered again after my benefit coverage stops?

If your coverage stops because you have less than the monthly deduction in your dollarbank, you can become covered again on the first day of the second month following the accumulation of two months draw in your dollarbank.

WHO ARE MY ELIGIBLE DEPENDANTS?

Your eligible dependants are your Spouse and Dependant Children.

Members and their eligible dependants must be covered under a provincial health insurance plan in order to be eligible under this plan. An individual cannot be covered until provincial coverage is in place. All eligible dependants must be indicated on your Personal Information Form.

DEFINITION OF AN ELIGIBLE DEPENDANT SPOUSE

Eligible Dependant Spouse is:

- Either married to you through an ecclesiastical or civil ceremony; or
- Living common law with you in a conjugal relationship, continuously for at least one year; or
- If you are both parents of a child as defined in the Family Law Act, 1986.

A separated or divorced spouse, legal or common-law, who once qualified as a spouse under this Active Benefits Plan, may be covered at your option. You may provide benefit coverage for only one "Spouse" under this Active Benefits Plan at any one point in time.

DEFINITION OF AN ELIGIBLE DEPENDANT CHILD

Eligible Dependant Child includes:

- Unmarried children including adopted children, foster children, stepchildren and children of your common-law Spouse under the age of 21 who are dependant on you for support.
  - Benefits for foster children are provided only to the extent that they are not covered by any government agency.

- Unmarried children under age 25 if they are in full-time continuous attendance at an accredited school, university or college and dependant on you for support. *An accredited institution is one that is a publicly funded body or one where tuition receipts qualify for deduction from income tax under the Income Tax Act.* **Proof of full-time attendance will be required annually from the school's registration office. Coverage ends at the end of the month of attaining age 25.**

- Unmarried dependant children who are mentally or physically disabled and totally dependant on you for support will continue to be covered by this Active Benefits Plan past age 20, if they were covered as a dependant immediately prior to reaching the limiting age and proof of disability is reported to OEBAC within 31 days of each dependant child reaching the limiting age. Continued proof of disability may be required from time to time and will be requested by OEBAC when necessary.

Your family members listed above will be considered Eligible Dependants if they qualify and you have listed them on your Personal Information Form (PIF). Retroactive benefits cannot be provided for

dependants under a common-law relationship. Coverage may begin after OEBAC is given written notification of the common-law relationship.

What if my Spouse also has group insurance benefits?

If you or your Eligible Dependants are covered under more than one health care and/or dental plan, the **coordination of benefits** provision allows benefits under all plans to be adjusted so as to limit the combined payment of 100% of the total allowable expense.

If you and your Spouse are both working and have family coverage under your respective plans, claims should be submitted as follows:

- The Active Member's claims should be submitted to the Active Benefits Plan first. Submit any remaining unpaid balance to your Spouse's insurance company along with a copy of your Explanation of Benefits (EOB).
- Your Spouse's claims should be submitted to their insurance company first. Submit any unpaid balance along with the Explanation of Benefits (EOB) statement from your Spouse's plan to your Active Benefits Plan.
- Dependant Children's claims should be submitted first to the insurance company covering the parent whose birthday occurs first in the calendar year. Submit any unpaid balance to the other parent's insurer along with the Explanation of Benefits (EOB) statement. For example, if you were born on July 7th and your Spouse was born on February 23rd, your Spouse's insurance company pays the first portion of your Dependant Children's claims.

What happens to my coverage when I retire?

Qualified Pensioners may participate in the Retiree Benefit Plan after their dollarbank is exhausted. Provisions of the Retiree Benefit Plan are set out in the next section of this booklet. A Pensioner is defined as an individual drawing a pension from:

- The I.U.O.E. Local 793 Pension Plan for Operating Engineers in Ontario; or
- Proof submitted from the Member that they were in receipt of a government sponsored pension plan (such as Canadian Pension Plan (CPP), Canadian Pension Plan Disability (CPPD) or Old Age Security (OAS)) or the pension plan of an employer or association directly affiliated with the IUOE Local 793 Pension Plan, to which the individual contributed and/or had contributions made on his/her behalf in their name.
  NOTE: Survivor pensions from outside plans are excluded from entitlement of this benefit.
- Not performing any work covered by a Local 793 collective agreement, working non-union or as a member or employee of another union or related organization.

In order to qualify for benefits under the Retiree Benefits Plan, a Pensioner must meet ALL of the following criteria on his or her retirement date:

- Be a Member in Good Standing, as defined in the Union's Constitution and by-laws, and remain a member in Good Standing;
- Have been an Initiated Member of IUOE Local 793 for 7 or more consecutive years; and

- Have been covered by the IUOE Local 793 Life and Health Benefit Plan for 12 of the last 24 months immediately prior to retirement and be covered for benefits on the date of retirement.
- If you meet the eligibility criteria to participate in the Retiree Benefit Plan you will be given a one-time opportunity to join the plan. If you decide to decline the Retiree Benefit coverage offer you cannot come back at a later date and request to join the plan.

What happens if I return to work after Retirement?

If you are a Pensioner covered under the IUOE Local 793 Retiree Benefit Trust Fund who is receiving a monthly pension from the IUOE Local 793 Pension Trust Fund and you return to work with a participating employer, your coverage under the IUOE Local 793 Retiree Benefit Plan will pause and you will begin to generate eligibility under IUOE Local 793 Active Benefits. Once you accumulate the required dollars in your dollarbank under the IUOE Local 793 Active Members Benefit Fund, you will be considered an Active Member under the IUOE Local 793 Active Members Benefit Fund and not a Retiree.

What happens to my family coverage in the event of my death?

If you die while covered for Active Benefits under this plan, coverage under the Supplementary Health Care, Dental Care and Group Legal benefits will be extended to your Eligible Dependants to the end of month following the six months after the date of your death. Thereafter, your eligible dependants will continue to have coverage under the benefit plan until your dollarbank account has been exhausted.

Provided you were a member in Good Standing and eligible under the Active Benefits Plan, your Spouse may apply for Retiree Supplementary Health Care, Dental Care and Group Legal benefit coverage at the same rates that apply to retired members. Dependant children will also be covered.

Spouse and Dependant Children are not covered for Life Insurance, Maternity or Compassionate Care Benefits, Bereavement, Parental Leave, Short Term Disability and Long Term Disability benefits.

Coverage is extended to the spouse and dependant children at the time of the Member's death with no new dependants added at a later time.

In the event of the Surviving Spouse's death (who was participating in one of the Retiree Benefit Plans) there is no additional life insurance paid out.

What happens to my dollarbank if I become disabled?

If you become disabled prior to retirement or attainment of age 65 while covered for benefits under the Active Benefits Plan (excluding Pay-Direct) your benefit coverage will be maintained without further payments from you or your employer, under the following circumstances:

Occupational (work-related) accident or illness

If you become disabled due to a work-related injury or illness and are eligible for wage loss benefits from the Workplace Safety and Insurance Board (WSIB), you and your eligible dependants will remain covered for the Plan's benefits and your dollarbank will be frozen for a maximum period of 12 months from the date of disability while in receipt of loss of earnings benefits under the Workplace Safety and Insurance Act.

Thereafter, if you are an Initiated Member in Good Standing of IUOE Local 793, are under age 65, continue to receive loss of earnings benefits from the WSIB, the cost of covering you and your dependants will continue to be paid from the general reserves of the Benefits Plan until the earliest of the following dates:

- The date you are no longer disabled as defined under the Benefits Plan; or
- The end of the month in which you attain age 65; or
- Ten years and nine months following the date you became disabled; or
- The date you are no longer a Member in Good Standing with IUOE Local 793

No cost coverage may also be continued if you are at work under a rehabilitation program approved by the WSIB.

To request no cost coverage, complete the "Dollarbank Account Freeze Claim Form" available on www.oebac.org and submit the required documents from the WSIB to support acceptance and entitlement to wage loss benefits under your claim.

Non-occupational accident or illness (receiving EI Sickness and/or short term and/or long-term disability benefits)

If you are an Initiated Member in Good Standing of IUOE Local 793, are under age 65, and become disabled because of a non-occupational accident or illness, and are currently in receipt of Employment Insurance (EI) Sickness Benefits, Short-Term and/or Long-Term Disability income from this Benefits Plan, the cost of covering you and your dependants will continue to be paid from the general reserves of the Benefits Plan until the earliest of the following dates:

- The date you are no longer disabled as defined under the Benefits Plan; or
- The end of the month in which you attain age 65; or
- Ten years and nine months following the date you became disabled; or
- The date you are no longer a Member in Good Standing with IUOE Local 793.

To request no cost coverage, complete the "Dollarbank Account Freeze Claim Form" available on www.oebac.org and submit the required documents from Service Canada to support acceptance and entitlement to sickness benefits under your claim.

MOTOR VEHICLE ACCIDENT (MVA) INJURIES

If you are an Initiated Member in Good Standing of IUOE Local 793, are under age 65, and you become disabled from injuries suffered in a motor vehicle accident and have been approved income replacement benefits under your automobile insurance policy, the cost of covering you (claims not related to your MVA) and your dependants will be paid from the general reserves of the Benefits Plan until the earliest of:

- The date you no longer provide proof that you continue to be in receipt of the above benefits;
- The date of your death, return to employment, recovery, or the end of the month in which you attain age 65;
- The date you are no longer a Member in Good Standing with IUOE Local 793.

To request no cost coverage, complete the "Dollarbank Account Freeze Claim Form" available on www.oebac.org and submit the required documents from your private insurance provider to support acceptance and entitlement to these benefits.

SUBROGATION PROVISION

Requires reimbursement back to the Plan in the case of a settlement or a court judgement from a third party as a result of personal injury lawsuit. If you pursue a claim against a third party for any type of personal injury, you are obliged to attempt to recover the amount of any expenses paid by the Plan relating to that injury.

An example would be:

- a case of a slip and fall,
- food poisoning,
- Miscellaneous – Any instance where you received either medication, treatment and other expenses that were claimed and reimbursed from the IUOE Local 793 Benefit Plan and for which you later received a settlement from a third party.

EI MATERNITY/PARENTAL/COMPASSIONATE CARE BENEFITS

If you are an Initiated Member in Good Standing of IUOE Local 793, are under age 65, and are in receipt of Employment Insurance maternity, parental or compassionate care benefits, the cost of covering you and your dependants will be paid from the general reserves of the Benefits Plan until the earliest of the following dates:

- The date you no longer provide proof that you continue to be in receipt of the above benefits;
- The date of your death, return to employment, recovery, or the end of the attainment of age 65;
- The date you are no longer a Member in Good Standing with IUOE Local 793.

To request no cost coverage, complete the "Dollarbank Account Freeze Claim Form" available on www.oebac.org and submit the required documents from Employment Insurance to support acceptance and entitlement to these benefits.

Waiver of Premium (WOP) Benefit Extension

Effective January 1, 2019, if you are under age 65, and continue to be totally disabled after reaching the maximum dollarbank freezing (10 years and 6 months prior to December 18, 2022 and 10 years and 9 months after this date) to remain eligible for no cost coverage under this Benefits Plan for you and your eligible dependants, you are required to:

- Remain under the continued care of a licensed physician in Canada;
- Comply with requests deemed necessary for the ongoing assessment of your claim.

Coverage will terminate on the date of your death, return to employment, recovery, or the end of the month that you attain age 65.

Exclusions and Limitations:

Please note that all no-cost coverage privileges for your current disability will end and be permanently lost at the later of the following:

- At the end of the month coincident with or immediately following the date you are suspended from the IUOE Local 793 or are no longer a Member in Good Standing.

What happens when my dollarbank freezing ends?

When you no longer qualify for this no-cost coverage, your dollarbank will again be reduced by the monthly dollarbank deduction each month to pay for your benefit coverage. When the dollarbank account has been exhausted the following additional benefits may be available:

- Life and Health Benefits Plan for Retired Members (see eligibility criteria)

What should I do if my address or my dependant status changes?

Most status changes can be made online by logging into the Member portal on the https://iuoelocal793.org/ website and updating changes on a Personal Information Form (PIF). Changes include such items as:

- Change in marital status.
- Change of address.
- Establishment of a common-law relationship.
- Birth or adoption of a child.
- Guardianship of a minor. Proof must be in the form of a Court Order or Children's Aid Society appointment of Guardian. Legal documentation must be attached to the completed Personal Information Form (PIF).
- Change of beneficiary for any reason, including your beneficiary's death.
- A Dependant Child becoming disabled.
- A Dependant Child commencing full-time attendance at a post-secondary school.

- Spousal coverage as a result of marital status change would be dependant on the terms outlined in your Separation Agreement, Court Order or Divorce decree. Please contact OEBAC Pension Department for assistance in this matter.

The assistance available from the Active Benefits Plan is described in the health care section of this booklet.

What if my claim for benefits contains fraudulent information?

Any Active Member who obtains, or attempts to obtain, a benefit to which the Active Member is not entitled (including a benefit greater than the entitlement) by submitting false, misleading, or inaccurate information, may, at the discretion of the Trustees:

- Be refused payment of every such benefit.
- Be denied coverage under the Active Benefits Plan.
- Be declared ineligible for future benefits under the Active Benefits Plan unless the Active Member can establish that any discrepancy in the information submitted was due solely to a bona fide error on his/her part.

This provision also applies if an Active Member fails to repay any benefit overpayments received from this Active Benefits Plan as a result of benefits granted by any private insurance provider or government authority, including benefits received under any Workplace Safety and Insurance Act or Canada/Quebec Pension Plan.

Any member who knowingly obtains or attempts to obtain benefits under false pretenses may be subject to both civil action by the Trustees or criminal prosecution.

What income tax is payable?

Under current tax law, Life Insurance and Group Legal Benefits premiums paid to an insurance company by an employer are considered a taxable benefit to the member.

Plan Members who were covered for these benefits in the previous calendar year will receive a T4A every February from OEBAC that indicates the total amount of premium paid in the prior year.

Short-Term and Long-Term Disability, Accidental Death & Dismemberment, Bereavement and Parental Leave, Jury Duty Benefits received from the Plan are taxable and the appropriate amount of taxes will be withheld from these benefits. Plan Members who received these benefits in the previous calendar year will receive a T4A every February from OEBAC reflecting the taxable benefits you received and any income tax deducted.

Any premiums paid for the above referenced benefits on behalf of the Plan Member (shown on the T4A) must be reported by the Plan Member on their annual income tax return.

Does the Active Benefits Plan cover accidents at work?

The Active Benefits Plan provides a lump sum death benefit or dismemberment benefits as a result of an accident at work. The Workplace Safety and Insurance Board (WSIB) provides benefits for loss of income, death, dismemberment, and expenses resulting from occupational accidents or occupational sickness. If your claim has been denied by WSIB you may be eligible for Short and/or Long-Term Disability benefits as outlined in this booklet.

DEATH BENEFIT

ACTIVE MEMBERS

In the event of your death due to any cause, while covered under the Plan, your named beneficiary will receive a lump sum payment in the amount of your coverage. If you are covered under the Active Benefits Plan, $150,000 will be paid to your beneficiary. This benefit is insured by Manulife Financial.

In addition, if you are an Initiated Member in good standing with IUOE Local 793 and union dues were paid up at the time of death, the Active Benefit Plan will provide a further benefit of $2,000 (less applicable taxes) on a self-insured basis to be paid to your named beneficiary.

If you do not have a named beneficiary, or if your named beneficiary is deceased, benefits will be paid to your estate subject to any applicable federal or provincial laws.

You may change your beneficiary, subject to Provincial Law, by completing a new Personal Information Form (PIF) and forwarding it to OEBAC. A PIF can be obtained from OEBAC, the administrator's website https://www.oebac.org/, any local office of the Union and the union website https://iuoelocal793.org/.

Can I convert my Group Life Insurance coverage into my own private plan if I decide to leave the union?

Under most circumstances, during the 31 days after your benefit coverage ends, you may convert up to $150,000 of the group death benefit to an individual life insurance policy. No medical examination is required. The policy will be effective at the end of the 31-day period and the premiums will be based on your age and class of risk at the time of conversion. The application to convert your coverage, and the first premium due, must be received by Manulife Financial within the 31-day period if you are under the age of 65. Please contact OEBAC at 1-844-793-1919 regarding this matter.

If you die during the 31-day period after your benefit coverage stops under the Active plan, a death benefit will be paid to your beneficiary whether or not you had applied to convert your insurance. Contact OEBAC at 1-844-793-1919 to obtain further information regarding death benefits.

Death of a Dependant

In the event of the death of one of your eligible Dependants due to any cause, as the Plan Member you will receive a lump sum payment in the amount of $12,000. This benefit is insured by Manulife Financial. Please see section "WHO ARE MY ELIGIBLE DEPENDANTS?" for more information.

Can I continue my dependant death benefit coverage after I leave the Active Benefits Plan?

This coverage cannot be continued past the date your participation in the Active Benefits Plan ceases.

ACCIDENTAL DEATH BENEFIT FOR MEMBERS ONLY

If you are a member in good standing with IUOE Local 793 and under age 70, you shall be covered for $5,000 less applicable taxes to be paid to your named beneficiary in the case of an accidental death. This benefit is self-insured by the Active Benefits Plan.

ACCIDENTAL DISMEMBERMENT BENEFIT FOR MEMBERS ONLY

What is paid if I am injured in an accident?

As the member, this coverage applies 24 hours per day, on or off the job. If you suffer any of the losses shown below and submit a claim within 365 days from the date of such accident, you may be eligible to receive a benefit as follows:

Loss of one hand or both hands	$25,000
Loss of one foot or both feet	$25,000
Loss of one hand and one foot	$25,000
Loss of sight of both eyes	$25,000
Loss of sight of one eye	$12,500
Loss of speech or hearing	$12,500
Loss of each finger	$1,000
Loss of each toe	$1,000
Quadriplegia, paraplegia, or hemiplegia	$25,000

The Active Benefits Plan will recognize the actual loss of a limb (dismemberment) as described, including the loss of use of that limb determined by medical evidence satisfactory to the Trustees. For purposes of this Active Benefits Plan, loss of a finger or toe means the loss of one or more joints of such finger or toe. “Loss of use” means the total and irrecoverable loss of use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of this 12-month period.

A maximum benefit of $25,000 will be paid for all losses suffered, whether the result of one or more accidents, while you are covered under this Active Benefits Plan.

Are there any limitations to the payment of these benefits?

Yes. Dismemberment benefits will not be paid for losses resulting directly or indirectly from:

- Attempted suicide, while sane or insane.
- Deliberately self-inflicted injuries, while sane or insane.
- War, whether or not war was declared.
- Service in the armed forces of any country.
- Illness or disease.

In order for dismemberment benefits to be paid by the Active Benefits Plan, the dismemberment must be caused by an accident directly, solely and independently of all other causes, matter, physical or mental conditions or means.

SHORT-TERM DISABILITY FOR MEMBERS ONLY

If you become disabled while covered for benefits under this Plan because of either an illness or accidental injury that is non-occupational and you cannot perform your job duties and are under the age of 70, you may be entitled to Short Term Disability benefits as follows:

ELIGIBILITY REQUIREMENTS

To be eligible for this benefit:

- Employer contributions must have provided your Benefit Plan coverage on the day you become disabled. If your benefit coverage is being maintained through self-payment (Pay Directs) at the onset of your disability, you are not eligible for wage loss benefits.
- You must be under age 70 at the onset of your disability and not in receipt of a Pension Benefit from Local 793.
- Your disability must be a result of a non-occupational illness or non-occupational injury.
- If the injury or illness that prevents you from working is work-related, you must file a claim with the Workplace Safety & Insurance Board (WSIB). Please contact the Social Services Department if you require assistance filing a claim. Work-related disability benefits are provided by WSIB.
- If there is any doubt as to the cause of the disability, this Benefits Plan may pay these benefits subject to your written agreement that any benefits received from this Plan will be repaid in full, if your WSIB claim for wage loss benefits is approved.
- You must be diagnosed with a bona-fide medical condition which prevents you from working and performing the important duties of your own occupation.
- You must be seen by, treated by, and under the continued care of a licensed physician in Canada.
- Benefits do not commence until you are seen by and treated by a physician.
- You must be absent from work for more than 7 days (waiting period) unless your disability is a result of a non-occupational accident, then the waiting period does not apply; or you are hospitalized for at least 18 hours due to an illness, then benefits are payable from the first date of hospitalization, including day surgery.
- Disability caused by or contributed by motor vehicle accidents are excluded from the policy. Please contact your automobile insurer.

BENEFIT AMOUNT AND DURATION

If you have met the eligibility requirements, you may be eligible for the following benefits:

- Effective March 15, 2020, maximum benefit of $800 per week less withholding tax from each weekly benefit payment.
- If you are disabled for part of a week, benefit payments will be 1/5th of the weekly benefit for each working day you are disabled, subject to a maximum of 5 working days per week.
- No benefits are payable for days that are not regular working days.

- Under current tax law, Short-Term Disability benefits are subject to income tax. Income tax will be withheld from the payments you receive from the Benefits Plan. You will receive a T4A tax slip from OEBAC, reflecting the total amount of benefits received from the Benefits Plan and taxes withheld for the calendar year.

Integration with EI Sickness Benefits

Benefits under this Plan are integrated with Employment Insurance (EI) Sickness Benefits, and you are required to apply for EI Benefits. The EI pays sickness benefits beginning on day 8 of the disability and continues for a maximum period of 26 weeks, for new claims established December 18, 2022, or later.

Be sure to apply for EI Sickness benefits immediately upon becoming disabled. No Short-Term Disability benefits will be paid under the Plan for any period during which you are eligible to receive EI Sickness Benefits.

If you qualify for sickness benefits under EI but are not eligible to receive the full 26 weeks, or you do not qualify for EI benefits, Short-Term Disability benefits will be payable during this time provided you remain disabled and submit supporting documentation of your ineligibility for EI benefits. If you are not covered by EI benefits because you have breached an EI eligibility rule (e.g., left the country or failed to claim EI benefits on time) or for any other reason, the Plan will not pay benefits for any portion of the 26 weeks that EI sickness benefits would have been payable.

Supplementary Unemployment Benefit (SUB) Plan

You may also be eligible for SUB Plan benefits to top-up your EI Sickness Benefits for up to a maximum of six (6) weeks if your employer remits to the SUB Plan and you have the required contributions.

See https://www.oebac.org/sub-plan for details.

WHAT HAPPENS WHEN EI SICKNESS BENEFITS END?

If you continue to be disabled after exhausting EI benefits, the Plan will resume Short Term Disability benefit payments provided you remain disabled and provide ongoing medical documentation to support your disability, if required.

- Short Term Disability Benefits commence:
  - At the conclusion of the integration period; or
  - The 8th day of disability if you do not qualify for EI Sickness benefits; or
  - The 1st day absent from work if the disability results from a non-occupational accidental injury and you have been treated by a physician; or
  - The date you are hospitalized for over 18 hours, including day surgery. Day surgery means procedures which require an incision or laser procedures which would otherwise be performed as a qualifying surgical procedure. Outpatient testing procedures, including scopes which do not require an incision, are not covered under hospitalization.

How long will benefit payments be made to me?

Short-Term Disability benefits are payable to a maximum of 26 weeks (for EI claims established before December 18, 2022) or 37 weeks (EI claims established on or after December 18, 2022) from the start of your disability, inclusive of any weeks paid by EI.

- Short Term Disability Benefits end once:
  - You are no longer under the continuing care and treatment of a physician.
  - You return to active full-time work; or
  - You return to any work for pay or profit; or
  - You are deemed fit to return to your pre-disability job; or
  - You turn age 70; or
  - You reach the maximum benefit duration (26 or 37 weeks).

What if I recover and then become disabled again?

- Once you have been disabled and received benefit payments under this Benefits Plan, a later disability will be considered a continuation of your first disability if you again become disabled due to the same or a related condition within three months of your recovery. Your claim will be continued based on your remaining entitlement and subject to the provisions of the EI Plan.

- Your disability will not be considered a continuation of a previous disability, if it results from an injury or illness entirely unrelated to the causes of the previous disability, or if it occurs at least 3 months after your date of recovery.

Exclusions and Limitations

- No Short-Term Disability benefits will be paid for:
  - Any day you do any kind of work for pay or profit.
  - The period you are entitled to pregnancy or parental leave of absence by statute, contract, or employment agreement, except where benefits are provided during the post-natal recovery.
  - The period of illness or injury for which benefits are payable under Employment Insurance (EI).

Are any disabilities excluded from coverage?

Yes. Disability Income benefits will not be payable for:

- A disability commencing in the first 12 months you are covered by the Benefits Plan if the disability is caused directly or indirectly by a disease or injury for which you received medical treatment or prescribed medication during the 3-month period immediately prior to becoming covered under this Benefits Plan. If your coverage under this Benefits Plan terminates for any reason and is subsequently reinstated, this pre-existing condition limitation will apply again for the first 12 months of your reinstated coverage.

- Disabilities caused by an intentionally self-inflicted injury, suicide, or attempted suicide, while sane or insane.
- Disabilities caused by the use of narcotics, barbiturates, hallucinogenic substances except for the program for treatment of alcohol and drug addiction outlined below.
- Disabilities resulting from a criminal offence, except that this exclusion shall not serve to limit payment of benefits for any offence under the Criminal Code of Canada related to the operation of a motor vehicle. In case of a criminal charge, no disability payments will be made from the Benefits Plan while such charge is pending and awaiting a decision.
- Disabilities resulting from insurrection, war, (whether declared or not), service in the armed forces of any country, rebellion or participation in a riot or civil commotion.
- Your commission of, or attempt to commit, an assault or criminal offense.
- Disabilities caused by or contributed by a motor vehicle accident.

Can I claim benefits under this Active Benefits Plan while receiving Workplace Safety and Insurance Benefits?

No. Occupational disabilities are covered by the Workplace Safety and Insurance Board (WSIB).

If you become disabled due to a work-related injury or illness and are eligible for wage loss benefits from WSIB you and your eligible dependants may be eligible for dollarbank freezing. See section "WHO ARE MY ELIGIBLE DEPENDANTS?" for more information.

If the injury or illness that prevents you from working is work-related you must file a claim with the WSIB and if your claim is denied you may be eligible for disability benefits under this Benefit Plan. See section "SHORT-TERM DISABILITY FOR MEMBERS ONLY" for more information.

Can I claim benefits under this plan for disabilities caused by a Motor Vehicle Accident (MVA)?

No. Medical expenses and disability payments relating to a motor vehicle accident are not an eligible expense under the Active Benefits Plan. Your claim should be filed under your auto insurance policy.

If you become disabled from injuries suffered in a MVA and are in receipt of an Income Replacement Benefit (IRB) wage from your insurer you and your eligible dependants may be eligible for dollarbank freezing. See section on "MOTOR VEHICLE ACCIDENT (MVA) INJURIES" for additional information.

LONG TERM DISABILITY (LTD) INCOME FOR ACTIVE MEMBERS ONLY

If you remain totally disabled while covered for benefits under this Benefit Plan and are under the age of 65, have received the maximum benefit under the Short-Term Disability benefit and are unable to return to active full-time employment, then you may be eligible for Long Term Disability as follows:

ELIGIBILITY REQUIREMENTS

To be eligible for this benefit, you must be:

- Seen by, treated by, and under the **ongoing care** of a licensed physician in Canada.
- Totally disabled and under the **ongoing care** of a licensed physician in Canada
- Totally disabled due to a **non-occupational** illness or injury.
- Absent from work for more than the waiting period of 26 or 37 weeks.

BENEFIT AMOUNT AND DURATION

If you have met the eligibility requirements, you may be eligible for the following benefits:

- Maximum benefits of $1,500.00 per month less withholding tax from each monthly benefit payment.
- Under current tax law, Long Term Disability benefit payments you receive from this Benefits Plan are taxable for the member in the calendar year in which it was received. You will receive a T4A tax slip from OEBAC, reflecting the total amount of benefits received from the Benefits Plan and taxes withheld for the calendar year.
- Benefits are payable to a maximum of 10 years, recovery, death or to the attainment of 65 years of age.
- Benefit payments may be terminated if you are not receiving accepted standard professional treatment for the condition being treated and where appropriate treatment by a relevant and certified specialist.

Your long-term disability benefits will continue until the earliest of the following dates:

- The date you are no longer disabled.
- The date you start working at a reasonable occupation.
- The date you cease to be under the regular care of a physician.
- The date you fail to furnish proof of continuance of total disability.
- The date you fail to furnish required information regarding income received from other sources including EI, Canada/Quebec Pension Plan, Workplace Safety and Insurance Board or earnings from rehabilitative employment.
- The date you die.
- The date you have received Long Term Disability benefit payments for 10 years.
- The date you cease to reside in Canada unless prior approval has been obtained from OEBAC.
- The end of the month in which you turn age 65.

DEFINITION OF TOTAL DISABILITY

- Totally Disabled means you are totally and continuously disabled due to illness or injury provided you are treated by a physician within the first 31 days of your disability and, as a result, are unable to perform the duties of your normal occupation during the first 24 months you are disabled.
- Change of Definition (COD) Date - Thereafter, you will continue to be considered Totally Disabled if you are unable to perform the duties of any occupation that would provide you with at least 80% of your pre-disability earnings as an Operating Engineer, based on your education, training and experience.

RECURRENT DISABILITY

What if I recover and then become disabled again?

- Once you have been disabled and received benefit payments under this Benefits Plan, a later disability will be considered a continuation of your first disability if you again become disabled due to the same or a related condition within three months of your recovery. In this situation, you would not be required to satisfy the 26 or 37 weeks qualifying period and benefits would commence immediately.

- Your disability will not be considered a continuation of a previous disability, if it results from an injury or illness entirely unrelated to the causes of the previous disability, or if it occurs at least 3 months after your date of recovery. A new qualifying period would have to be satisfied prior to Long-Term Disability benefits becoming payable.

Offsetting income

- Your Long-Term Disability Benefits will be reduced by other income to which you may be entitled from any of the following sources:
  - 100% of disability income payable to you under Employment Insurance.
  - One-half of the disability pension benefits payable from the Canada Pension Plan (CPP/QPP) on your behalf, but not including any benefits payable on behalf of your Dependant(s).
  - 100% of loss of earnings benefits payable under any Workplace Safety and Insurance Act.
  - One-half of the earnings you receive from approved rehabilitative employment.

- Disability benefits received from CPP/QPP on behalf of your Dependant(s), and any disability pension benefits payable from the IUOE Local 793 Pension Plan, will be paid in addition to the income you receive from this Benefits Plan and will not reduce your long-term disability benefit.

- Where the degree of your disability is severe and will result in a long-term claim, your initial benefit payments will be reduced by 50% of your estimated disability benefit under CPP/QPP.

Once you receive the actual Notice of Entitlement, adjustments may be required to reflect your actual benefit award and will be made, subject to the Benefits Plan's receipt of that information.

- If you do not wish to have your initial Long Term Disability payments offset by an estimate of your CPP/QPP entitlement, or if your disability may be work-related and your Workplace Safety and Insurance Board claim is under appeal, you must sign a Reimbursement Agreement guaranteeing that any overpayments resulting from disability benefits received from CPP/QPP or Workplace Safety and Insurance Board will be repaid to the Benefits Plan in full, upon your receipt of the respective awards or settlements.

Recovery of benefits

If you receive a benefit under this Plan more than what should have been paid, OEBAC has the right to recover the amount of such excess from you or deduct it from future monthly benefits payable to you.

Exclusions and limitations

No Long-Term Disability benefits will be paid for:

- Any day you do any kind of work for pay or profit.
- The period you are entitled to pregnancy or parental leave of absence by statute, contract, or employment agreement, except where benefits are provided during the post-natal recovery.
- The period of illness or injury for which benefits are payable under Employment Insurance (EI).

Are any disabilities excluded from coverage?

Yes. Disability Income benefits will not be payable for:

- A disability commencing in the first 12 months you are covered by the Benefits Plan if the disability is caused directly or indirectly by a disease or injury for which you received medical treatment or prescribed medication during the 3-month period immediately prior to becoming covered under this Benefits Plan. If your coverage under this Benefits Plan terminates for any reason and is subsequently reinstated, this pre-existing condition limitation will apply again for the first 12 months of your reinstated coverage.
- A disability commencing more than 6 months after your 64th birthday.
- Disabilities caused by an intentionally self-inflicted injury, suicide, or attempted suicide, while sane or insane.
- Disabilities caused by the use of narcotics, barbiturates, hallucinogenic substances, except for the program for treatment of alcohol and drug addiction outlined below.
- Disabilities resulting from a criminal offence, except that this exclusion shall not serve to limit payment of benefits for any offence under the Criminal Code of Canada related to the operation of a motor vehicle. In case of a criminal charge, no disability payments will be made from the Benefits Plan while such charge is pending and awaiting a decision.

- Disabilities resulting from insurrection, war, (whether declared or not), service in the armed forces of any country, rebellion or participation in a riot or civil commotion.
- Your commission of, or attempt to commit, an assault or criminal offense.
- Disabilities caused by or contributed by a motor vehicle accident.

What happens if I am disabled during a maternity leave?

Benefits for disability due to complications of pregnancy will be paid. However, no LTD benefits will be paid during the period you are receiving EI, maternity benefits or during the period you are on an approved maternity leave. If you become disabled during your maternity leave, your Qualifying Period will start on your date of disability. If your Qualifying Period ends when you would still be in your maternity leave period, LTD payments will not commence until your scheduled date of return to work.

Terminally Ill

If you become terminally ill where death is imminent within a 24-month period, you and your Dependants will continue to be covered for up to 12 months. While you are entitled to this no-cost coverage, your dollarbank will be frozen and any applicable Pay-Direct contributions will be waived.

What is rehabilitative employment?

Long Term Disability benefits are designed to be paid during periods when you are disabled and cannot work. However, you may be able to work at some type of job and earn an income, even though you are not yet fully recovered. The Trustees may deem this type of work to be Rehabilitative Employment and approve continuation of LTD benefits for up to a maximum of 2 years.

IMPORTANT: During this time of rehabilitative employment, your LTD benefits will be your normal monthly benefit reduced by 50% of any earnings from your rehabilitative employment.

What happens if my disability results from a Motor Vehicle Accident (MVA)?

No benefits will be paid for any claims arising from a motor vehicle accident. Certain benefits may be available to you through the "no fault" scheme established by the Province of Ontario if you suffer an impairment as a result of a motor vehicle accident. The Active Benefits Plan excludes these benefits to the extent that you are entitled to receive them.

Therefore, you will not be entitled to benefits under the Benefits Plan if you are eligible to receive "no fault" benefits. This is the case if you are not receiving "no fault" benefits if you have failed to diligently make application and pursue the "no fault" benefits.

You will be entitled to receive disability benefits under the Active Benefits Plan to the extent that:

- Disability benefits are not available as "no fault" benefits; or

- There are exclusions in the “no fault” plan which would exclude or exempt coverage that is not exempt by this plan; or
- The “no fault” benefits are of a limited duration and the benefits available under this Active Benefits Plan are of a greater duration; or
- The benefits would otherwise be available to you under the terms of the Active Benefits Plan.

What happens if I accept a settlement as a result of MVA?

An individual will NOT be entitled to benefits under the Active Benefits Plan if he or she:

- Fails to diligently apply for and provide all necessary information to become entitled to “no fault” benefits; or
- Fails to provide further information and to maintain qualification for the “no fault” benefits.

An Active Member shall also be disentitled to benefits under the Active Benefits Plan if the Active Member accepts a settlement respecting the “no fault” benefits to which he or she would otherwise have been entitled. The Active Member shall be disentitled to benefits under the Active Benefits Plan to the extent that the settlement constitutes a compromise of or waiver of entitlement to “no fault” benefits otherwise available to the Active Member.

Where an Active Member makes a claim for benefits under the Active Benefits Plan and has been in receipt of “no fault” benefits, the Active Member may be required to provide an accounting of the benefits as received under the “no fault” plan. In addition, an Active Member who has not indicated receipt of “no fault” benefits may be required to provide evidence that the loss for which a claim is being made does not arise out of a motor vehicle accident.

The benefits under the Active Benefits Plan affected by these provisions will depend on the “no fault” benefits available from time to time. At the date of the writing of this provision, those benefits include but are not necessarily limited to the following:

1. Short- and Long-Term Disability benefits; and
2. Supplementary Health benefits, including:
    - Prescription drugs.
    - Vision care.
    - Ambulance service.
    - Private duty nursing.
    - Dental accidents
    - Orthopaedic supplies.
    - Hearing aids.
    - Physiotherapy and occupational therapy.
    - Artificial and assistive devices.
    - Psychological services.

The exclusions and limitations described in this section which are applicable to an Active Member are also applicable to a Dependant who makes a claim under the Active Benefits Plan.

How can I obtain assistance for alcoholism or drug addiction?

Members of Local 793, their spouses and their Dependants under the age of 25, have access to the DeNovo Treatment Centre, a substance abuse program which is jointly sponsored by participating union and management organizations for workers in the construction industry. The Active Benefits Plan covers only the DeNovo Treatment Centre.

Dependants under the age of 25 will be required to provide proof that they are residing with the Active Member in order to be eligible for the services of the DeNovo Treatment Centre. Documents that would be accepted to provide proof of residency would be Driver's license, Canada Revenue Agency Tax Assessment, Income Tax Receipts, Visa/Master Card Statement or Provincial Health Card.

This coverage is available to Dependants under the age of 25 without the proof of full-time attendance at an accredited school, university or college as long as the above criterion is met.

CANADA PENSION PLAN DISABILITY BENEFITS

In the event that your disability is severe and will continue for a long time, you may be eligible for CPP/QPP disability benefits. Application for CPP/QPP disability benefits should be made when you are applying for Long Term Disability benefits. These benefits are available after you have been totally and permanently disabled for a minimum of 4 months.

For assistance with your CPP Disability Application please contact the Social Services Department at IUOE Local 793 Head Office.

LOCAL 793 DISABILITY PENSION

If you are an Active Initiated Member of the Plan and are totally disabled and likely will never return to any work and have at least 7 consecutive years of union membership in Local 793 or have accumulated at least 10,000 regular hours of contributions under the Local 793 Pension Plan on the date of disability, you may be eligible for a disability pension from the Local 793 Pension Plan. Application for this benefit should be made to OEBAC when applying for Long Term Disability benefits.

The disability pension starts on the first of the month following the date of disability and is equal to the full amount of pension you have earned up to the date of disability. The disability pension amount is not reduced due to early retirement or by any disability benefits received from any other plan.

SUPPLEMENTARY HEALTH CARE FOR MEMBERS AND THEIR ELIGIBLE DEPENDANTS

The Benefits Plan helps pay for certain supplementary health care expenses not covered by the Provincial Medicare program for you and your eligible dependants. Eligible services and supplies must be medically necessary, recommended by a legally qualified physician in Canada, and must be reasonable and customary. Should there be uncertainty in that regard, the Trustees will seek medical advice for a conclusive decision of your entitlement under the Active Benefits Plan.

LIFETIME MAXIMUM

The Active Benefits Plan will pay for covered health care expenses (including Prescription Drugs) to a lifetime maximum of $150,000 per eligible Dependant with an annual reinstatement (on January 1st of each year) of up to $20,000 but not more than required to bring the lifetime maximum back up to $150,000. You may also apply for full restoration of you/your Dependants' maximum by submitting medical evidence of good health if the lifetime maximum for benefit reimbursement is attained.

NOTE: **Dental expenses are not included in lifetime maximum and will continue. Dental expenses follow annual maximums as described under Dental Benefits.**

Once any individual has attained the lifetime maximum for benefit reimbursement, that particular member of your family is no longer covered for medical expenses until such time as she/he submits medical evidence of good health, satisfactory to the Trustees. Upon approval of the medical evidence, the full maximum would be restored for the respective individual.

THE FACET PROGRAM

Effective September 1, 2021 the FACET Program (administered by Cubic Health) is available to all 793 Plan members and their eligible dependants. The FACET Program is a service that administers Prior Authorization for specialty drugs used to treat complex medical conditions that include, but are not limited to: Asthma/COPD, Hypercholesterolemia, Cancer, Multiple Sclerosis, Chronic Migraines, Psoriasis, Crohn's Disease, Rheumatoid Arthritis.

FACET applies a concierge, member-centric clinical review process that provides independent assessment, quicker turnaround and help to ensure the most appropriate medication is being used in every case. The FACET Clinical Team members are experts in the pharmacological management of these complex conditions and manages every FACET case from beginning to end. There is a collaborative approach between the independent Clinical Pharmacist and the prescribing Physician to ensure the best treatment. FACET renders an unbiased assessment based on the clinical information provided, using the most up-to-date clinical evidence available at the time of the request.

How does it work?

To find out whether the medication your Physician is considering or has prescribed requires Prior Authorization, please visit the FACET website at www.facetprogram.ca.

The process for submitting a FACET request is straightforward and very similar to how Prior Authorization requests are submitted today:

- Both the Plan Member/eligible dependant and the Physician have access to FACET disease state forms. FACET Prior Authorization forms can be found online at www.facetprogram.ca.
- The forms can be printed and will need to be completed with your Doctor's assistance and faxed in or can be completed and submitted online to FACET (along with all supporting clinical information) to either claims@facetprogram.ca or via fax to FACET at 1-844-446-1575.
- The Plan Member/eligible dependant is required to provide consent to Cubic and the FACET Program to contact the Physician(s) and any pharmacy/pharmacies the member may be using to obtain additional information relevant to the case.
- Once received, the FACET Clinical Team can review the information and render a decision.
- If the decision is made to approve the therapy/therapies, the information is shared with OEBAC to ensure the member can claim through their benefit plan.

What decisions are possible with a FACET request?

There are three (3) possible decisions that can be rendered in the FACET Program:

1. Request is approved as submitted.
2. Request is conditionally approved – a decision has been made to approve specialty therapy for the member, but the medication and/or dosage regimen prescribed must be optimized in order for the request to be approved and reimbursed by the plan (i.e., there is a more cost-effective, safe and

evidence-based therapy available and/or there is a change needed to requested dose of a medication.) A *conditional approval* happens most commonly in cases where multiple therapies exist, and some may be substantially more expensive than others but are not any more effective or safe.

3. Request does not meet criteria – case when a member does not meet evidence-based clinical criteria for any specialty medication for a given disease state, or where a medication does not meet established cost-effectiveness thresholds. For example, there are medications on the market today that are not covered by some plans because the proven clinical benefit of the therapy is minimal and does not justify the cost of the medication.

What if I am on a specialty drug prior to the move to FACET on September 1, 2021?

No action is needed. Your existing approval will be grand-parented and there is no need to submit under FACET for approval. If you need to change an existing specialty therapy on or after September 1, 2021 (i.e., because the existing specialty medication is no longer effective or there are issues with medication side effects), a Prior Authorization request for a new therapy will need to be sent through FACET.

COVERED SUPPLEMENTARY HEALTH CARE EXPENSES

Covered expenses are those charges for the following services and supplies relating to the treatment of non-occupational injuries and diseases.

Prescription Drugs (Not covered by a Provincial Program).

- Drugs, sera and injectables only on the written prescription of a physician or dentist and dispensed by a physician, pharmacist, or dentist.
- Drugs and supplies available without a prescription and required because of a colostomy, ileostomy or diabetes (proof of Government grant must be provided in order to process your claim – ask a Customer Service Representative for a tracking recorder to assist you with this task) and/or for the treatment of cystic fibrosis, Parkinson's or heart disease.
- Vitamins (except those that are injected). Vitamin preparations, food supplements, patent or proprietary medicines and drugs or medications available without a prescription (unless noted above) are **not covered** under this benefit whether purchased on the prescription of a physician.
- Fertility Treatment – Covers the member and spouse for any fertility treatment to a lifetime limit of $1,000 per eligible person (would include drugs/treatment/sperm wash and storage of eggs or sperm).
- Erectile dysfunction drugs for individuals whose medical condition is the cause of erectile dysfunction. **All claims for these drugs require prior approval.**
- Smoking Cessation products up to a lifetime maximum of $400 per eligible person. Only drugs which legally require a prescription are eligible.
- For active members, age 65 and over, reimbursement of the $100 annual deductible as well as the per prescription co-payments (up to $6.11 per prescription) charged by the Ontario Drug Benefit (ODB) program.

Hospital Accommodation

- Private Hospital Room – The hospital's charge for a private hospital room accommodation.
- Convalescent & Chronic Care facility - Charges by a convalescent hospital for private hospital room accommodation limited to a maximum of 120 days during any one period of disability, provided the individual is admitted to the convalescent hospital within 14 days following confinement in a general hospital. All confinements in a convalescent or chronic care hospital will be considered as one period of disability unless the confinements are separated by at least 90 days.

Private Duty Nursing

Services of a registered nurse as ordered by a physician and confirmed as being needed by a physician, provided the nurse does not ordinarily reside in your home, or is not a member of your or your Spouse's family. Services must be such that they require the skills of a registered nurse and are not custodial in nature. Reimbursement is limited to a lifetime maximum of $10,000 per individual while you are covered as an Active Member.

Private Duty Nursing coverage must be pre-approved by OEBAC. The private duty nursing pre-approval form is available on OEBAC's website. Up to $1,000 of this maximum will be restored on January 1st each year but not more than is required to bring the maximum benefit up to $10,000. You may also apply for full restoration of your/your Dependant's maximum by submitting medical evidence of good health. If the lifetime maximum for benefit reimbursement is attained, the individual is no longer covered for Private Duty Nursing under the Active Benefits Plan, until such time as he/she submits medical evidence of good health satisfactory to the Trustees. Upon approval of the medical evidence, the full maximum would be restored for the respective individual.

Ambulance services

Professional ambulance services for transportation to the first hospital where required treatment is given or from a general hospital to a convalescent hospital. Covered ambulance expenses are reimbursed under the plan based on your province of residence and can include those charges over and above the Provincial Medicare payments, where these charges can legally be covered by the Active Benefit Plan. Coverage for transport from home to Doctor's appointments are not covered under the plan.

Vision Care Benefit

You and your eligible dependants are covered for Vision care expenses when prescribed by a qualified physician or optometrist. Effective January 1st, 2022, and every January 1st thereafter, the Active Benefit Plan will reimburse the Member and eligible dependants a 100% maximum of $800 each to purchase prescription glasses (not restricted to one claim).

Eligible Prescription Eyewear:

- Prescription eyeglasses
- Prescription contact lenses
- Prescription safety glasses
- Prescription sunglasses
- Including frames and prescription lenses
- Eye wear ordered on-line from a Canadian company that manufacturers eyewear in Canada. (Must be made and manufactured in Canada in order to be covered under the plan).

Eye Examinations

Limited to $125 once every 12 months for persons under 21 years of age, and up to $125 once every 24 months for persons of age 21 and older. Specific eye examinations will be covered where specific exams are necessary due to a medical condition, to the extent they are not covered by provincial medicare. A Physician's note or Eye Doctor's note stating your medical condition must be attached to the receipt.

Corrective Laser eye surgery

Corrective Laser eye surgery up to a lifetime maximum of $2,000. The surgery must correct an eye condition such as near-sighted and far-sighted vision, or astigmatism. The coverage is separate from prescription eyeglasses coverage. NOTE: Our plan does not cover CATARACT laser eye surgery.

EXTENDED HEALTH CARE BENEFITS FOR ACTIVE PLAN MEMBERS

PARAMEDICAL & MEDICAL PRACTITIONERS BENEFIT SERVICES

The Plan provides reimbursement for the following paramedical and medical practitioner services, subject to the expense limits, exclusions, and professional certification requirements as follows:

PARAMEDICAL PRACTITIONER	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Acupuncturist Chiropodist Osteopath Naturopath Podiatrist Pedorthist Occupational Therapist Speech Therapist	Maximum $800 per calendar year for all paramedical practitioners combined. Note: X-ray examinations are eligible and included in the benefit up to a maximum of $25	Paramedical practitioner must be a licensed, certified, or registered practitioner.		Prior recommendation of a physician is not required. Original paid in full receipt outlining: • Patient's name • Paramedical practitioner's information including name, title, designation, and registration number. • Date of service • Description of service provided
Behavioral Therapist • Dependant diagnosed with Autism	$4,000 per calendar year for therapy for eligible dependant diagnosed with autism	Paramedical practitioner must be a licensed, certified, or registered practitioner.		Original paid in full receipt outlining: • Patient's name • Paramedical practitioner's information including name, title, designation, and registration number. • Date of service • Description of service provided
Chiropractor	$1,000 per calendar year Note: X-ray examinations are eligible and included in the benefit up to a maximum of $25	Paramedical practitioner must be a licensed, certified, or registered practitioner.		Prior recommendation of a physician is not required. Original paid in full receipt outlining: • Patient's name • Paramedical practitioner's information including name, title, designation, and registration number. • Date of service • Description of service provided

PARAMEDICAL PRACTITIONER	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Cosmetic Surgery *Estimate required before surgery	Required within 90 days as a result of a non-occupational injury incurred while covered for benefits under the active plan			Prior recommendation of a physician required with medical diagnosis and confirmation injury is NOT related to Motor Vehicle Accident. Original paid in full receipt outlining: • Patient's name • Diagnosis and confirmation NOT related to Motor Vehicle Accident • Surgeon's name, title, designation, and registration number. • Date and description of service.
Physiotherapy OR Kinesiologist OR Certified Athletic Therapy	Combined total $1,500 per calendar year	For physiotherapy expenses to be eligible for reimbursement, the services/treatments must be performed by a qualified practitioner not participating under the Provincial Medicare plan. The physiotherapist must be an active, licensed member of the provincial regulatory body where they practice.		OEBAC requires a written recommendation from the prescribing physician, that includes: • Medical diagnosis; • Recommended duration of treatment; and • Confirmation the diagnosis is NOT related to a motor vehicle accident. • Original paid in full receipt Include the physician referral with your first claim.

PARAMEDICAL PRACTITIONER	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Psychologist services provided by a Registered: -Psychologist or -Psychotherapist or -Social Worker	Counseling: The Plan covers counseling services for personal, family, or marital, up to a maximum of $5,000 per calendar year for all mental health practitioners combined	Counseling must be provided by a regulated health professional who is a member in good standing with the applicable regulatory College and who is licensed to practice in the province/territory as a psychologist, psychotherapist, or a Social Worker	Cancelled appointments	Prior recommendation of a physician is not required. Original paid in full receipt outlining: • Patient's name • Practitioner's information including name, title, designation, and registration number. • Date of service • Description of service provided
Psychologist	Assessments: Psychological Assessment and/or Psychological Educational Assessment performed by a registered clinical psychologist may be reimbursed to a maximum of $500 per assessment, up to a maximum of $2,500.	Practitioner must be a licensed, registered practitioner.		If possible, an original single paid in full receipt should be submitted to the plan indicating the type of Assessment performed and stating the number of visits to complete the assessment. This will ensure that the claim is adjudicated properly under assessment coverage instead of treatment coverage
Massage Therapist	$1,000 per calendar year	The massage therapist must be an active registered and licensed member of the provincial regulatory body where they practice.		Prior recommendation of a physician is not required. Original paid in full receipt outlining: • Patient's name • Paramedical practitioner's information including name, title, designation, and registration number. • Date of service • Description of service provided. • Regular massages are covered.

DURABLE MEDICAL EQUIPMENT (DME)

Durable Medical Equipment must be:

- Prescribed by a licensed physician;
- Reasonable and necessary for the treatment of an illness or injury;
- Able to withstand repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally, not useful to a person in the absence of illness or injury;
- Appropriate for use in the home

In addition, the Durable Medical Equipment must satisfy the following general conditions:

- The rental price of the DME shall not exceed the purchase price. The decision to purchase or rent shall be based on the physician's estimate of the duration of need as established by the original prescription.
- When the DME is rented and the rental extends beyond the original prescription, the physician must re-certify (via another prescription) that the equipment is reasonable and medically necessary for treatment of the illness or injury. In the event the re-certification is not submitted, benefits will cease as of the original duration of need date or 30 days after the date of death, if earlier.
- When the DME is purchased, benefits shall be payable for repairs except that routine periodic maintenance is excluded.

To be eligible, the expense must be the reasonable and customary charges, which includes either the rental, or purchase if more economical. Not all items are eligible for reimbursement under the Plan, and you should contact OEBAC before purchasing any new durable equipment to confirm whether the item is covered OR you can submit an estimate to the plan to ensure before you make the purchase that is a covered expense under our plan.

DME requires a prescription to rent or purchase, as applicable, before it is eligible for coverage and the prescription must include:

- The medical diagnosis, and
- Anticipated time frame that the equipment will be needed (if rental), and
- Confirmation the diagnosis is NOT related to a motor vehicle accident.

Eligible expenses under the Plan include but are not limited to:

Aids and Appliances

The Plan covers the reimbursement of charges for the following aids and appliances subject to reasonable and customary fees.

The Provincial plan in your province OR the Assistive Devices Program (ADP) of the Ontario Ministry of Health is the first payer for any items approved under their Program. OEBAC will pay the balance provided the item is an otherwise covered expense. To be eligible under ADP, items must be purchased from an ADP registered vendor.

If the item is covered under your Provincial plan OR ADP the Ontario Ministry of Health will contribute 75% of the cost, up to a maximum contribution base. You may claim the remaining expense from OEBAC by submitting a claim, together with a copy of the supplier's itemized statement identifying Provincial payment/ADP payment or a copy of the Provincial/ADP payment.

If provincial funding is not available for your item, please send your quote to OEBACs Claims Department for review and to determine if the item is eligible for reimbursement. This will ensure, prior to purchasing the item, you are aware of your out-of-pocket costs.

AIDS AND APPLIANCES	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Artificial eyes and/or limbs	Reasonable and customary	Temporary artificial limbs. Permanent artificial limbs, to replace temporary artificial limbs, and replacements thereof but not within: • 60 months of the last purchase in the case of a member or dependant over 21 years of age, or • 12 months of the last purchase in the case of a member or dependant 21 years of age of less.		OEBAC requires a written recommendation from the prescribing physician, that must include: • The medical diagnosis, and • Anticipated time frame that the equipment will be needed (if rental), and • Confirmation the diagnosis is NOT related to a motor vehicle accident. • Original paid in full receipt
Braces	Reasonable and customary. Includes custom or off the shelf braces. *Estimate for custom brace must be submitted prior to purchase	Braces, including repair, which contain either metal or hard plastic.	Excludes orthodontic dental braces and braces used primarily for athletic use.	OEBAC requires a written recommendation from the prescribing physician, that must include: • The medical diagnosis, and • Anticipated time frame that the equipment will be needed (if rental), and • Confirmation the diagnosis is NOT related to a motor vehicle accident • Original paid in full receipt

AIDS AND APPLIANCES	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Brassieres	Two mastectomy bras per calendar year following a mastectomy.			Include the physician referral stating diagnosis with your claim and the official paid in full receipt from the service provider.
Breast prostheses	Breast prostheses following mastectomy and a replacement.			Include the physician referral stating diagnosis with your claim and the official paid in full receipt from the service provider.
Continuous Positive Air Pressure unit (CPAP) and eligible supplies	Limited to one every 5 years. Servicing fees, repairs, and replacement parts for CPAP. Travel CPAP is also covered under the Plan by utilizing the HSCA only.	Eligible Supplies Masks – 2 replacement masks are covered per year along with Filter. (including internet purchases)	Does not include expenses for cleaning supplies or warranties, headgear and tubing	A copy of the Sleep Study report must be included with the claim. Your Provincial plan or the Ontario Assistive Devices Program (ADP) may provide reimbursement for certain expenses up to 75% of the cost. You may claim the remaining expense from OEBAC by submitting a claim, together with a copy of the supplier's itemized statement identifying Provincial/ADP payment or a copy of the Provincial/ADP payment. Masks/filters require an original paid in full receipt outlining: • Patient's name • Paramedical practitioner's information including name, title, designation, and registration number. • Original paid in full receipt (included internet purchases) must include the date of service. • Description of product and confirmation product was purchased in Canada.
Contraceptive implants		Intrauterine and arms and intrauterine devices (IUD) including cooper. Cost of device is the only covered expense.	The physician's fee for insertion is not covered.	Include the physician referral with your claim and the original paid in full receipt from the Pharmacy.

AIDS AND APPLIANCES	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Hearing Aids	Up to a maximum of $1,000 every 3 years.	Excluding hearing tests and batteries		Hearing aid claims must include the written recommendation of the otologist, clinical audiologist or otolaryngologist indicating Left or Right or both ears affected accompanied by an original paid in full receipt. NOTE: If you or your health care professional believes your hearing loss is a result of working in the construction industry, please contact the Social Services Department at Local 793 for assistance with filing a Noise Induced Hearing Loss claim through the Workplace Safety and Insurance Board (WSIB).
Hospital beds *Estimate must be submitted prior to the purchase	OEBAC will cover the rental or purchase (pre-approved) of a hospital bed (including mattress) as long as it is medically necessary.	A hospital bed is a bed that has extra features, such as side rails, gel cushioning, or the ability to raise your head or feet.	Adjustable beds or home care beds are not covered.	OEBAC requires a written recommendation from the prescribing physician, that must include: • The medical diagnosis, and • Anticipated time frame that the equipment will be needed (if rental), and • Confirmation the diagnosis is NOT related to a motor vehicle accident. • Original paid in full receipt.

DIABETES TREATMENT SUPPLIES

AIDS AND APPLIANCES	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Blood glucose monitors *Estimate must be submitted prior to the purchase	The reasonable and customary costs of blood glucose monitors for insulin dependant diabetics.	The Plan covers the Dexcom G6 with a reasonable and customary maximum of $4,000		OEBAC requires a written recommendation from the prescribing physician, that must include: • The medical diagnosis, including why it is necessary for monitoring. • Your Provincial plan or the Ontario Assistive Devices Program (ADP) may provide reimbursement for certain expenses up to 75% of the cost. You may claim the remaining expense from OEBAC by submitting a claim, together with a copy of the supplier's itemized statement identifying Provincial/ADP payment or a copy of the Provincial/ADP payment. • Original paid in full receipt.
Insulin Pumps and Insulin Supplies *Estimate must be submitted prior to the purchase	Insulin pumps are covered up to a maximum of $3,000 once every 5 years. Insulin supplies are reimbursed at 80% up to a maximum of $2,500.		Excludes repairs or replacement during the 60-month period following the purchase date of such equipment.	OEBAC requires a written recommendation from the prescribing physician, that must include: • The medical diagnosis, and necessity for the insulin pump. • Your Provincial plan or ADP may provide reimbursement for certain expenses up to 75% of the cost. You may claim the remaining expense from OEBAC by submitting a claim, together with a copy of the supplier's itemized statement identifying Provincial/ADP payment or a copy of the Provincial/ADP payment. • Original paid in full receipt.

Needles & syringes	Charges in a quantity prescribed by a physician deemed reasonable by OEBAC		Needles and syringes are not eligible covered expenses for the 36-month period following the date of purchase of an insulin jet injector device.	• Original paid in full receipt from the pharmacy

MEDICAL SUPPLIES

AIDS AND APPLIANCES	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Air cast boot Canes Crutches Trusses	Reasonable and customary			OEBAC requires a written recommendation from the prescribing physician, that includes: • Medical diagnosis. • Recommended duration of treatment; and • Confirmation the diagnosis is NOT related to a motor vehicle accident. • Physician referral with your claim and the original paid in full receipt from the Pharmacy.
Compression/ Elasticized support stockings	$200 maximum for 4 pairs per calendar year with a minimum compression level of 20 mmHG.			Include the physician referral that includes: • Medical diagnosis including compression level. • Original paid in full receipt from the Pharmacy

Ostomy supplies as a result of: colostomy, cecostomy ileostomy or urostomy, requiring an external pouch. *Must apply for the Provincial/ADP grant. Contact OEBAC For a medical supply recorder that would assistance you this process	Ostomy supplies are limited to the following: tape, spray, adhesive remover, appliance cleaner, drainage bags, pouches, clamps, filters, tubes, flanges, wafers, inserts, catheters, plugs, irrigation bags, sleeves, drain, valves, adaptors, belt, ring, barrier pastes and wipes, prep pads, powder pads, stoma caps and cones, dressings, deodorizers, gloves, pouch covers.		Benefits are not available for filters, gloves, lubricants, appliance, scissors, paper products and garments, soaps, and creams.	Include the physician referral with your claim and the: • Original paid in full receipt from the Pharmacy. • Completed recorder. • Proof of grant information from your Provincial/ADP plan.

MOBILITY AIDS

AIDS AND APPLIANCES	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Mobility aids such as: • Scooters • Walkers, • Wheelchairs *Estimate must be submitted prior to the purchase See also Repairs to Durable Equipment	Reasonable and customary and limited to one every 5 years.			OEBAC requires a written recommendation from the prescribing physician, that includes: • Medical diagnosis; and • Recommended duration of treatment; and • Confirmation the diagnosis is NOT related to a motor vehicle accident. • Include original paid in full receipt. Include the physician referral with your claim. Your provincial plan/ ADP may provide reimbursement for certain expenses up to 75% of the cost. You may claim the remaining expense from OEBAC by submitting a claim, together with a copy of the supplier's itemized statement identifying Provincial/ADP payment or a copy of the Provincial/ADP payment.

AIDS AND APPLIANCES	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Orthopaedic shoes and custom-made foot orthotics	$300 per calendar year for all services combined	Custom-made orthopedic shoes – footwear prescribed by a doctor, chiropodist or podiatrist and made specifically for one patient, from raw materials, using a variety of measurements and a three-dimensional cast of the patient's feet. Custom-made foot orthotics – prescribed by a doctor, chiropodist, or podiatrist a device made from a cast of the foot that can be inserted into the shoe to support, align, prevent, or accommodate foot abnormalities and improve how the foot functions.	Off-the-shelf, non-orthopedic footwear (e.g., comfort shoes and sandals) Shoes purchased specifically for participation in sports or recreational activities (e.g., cleats) Off-the-shelf, non-custom or prefabricated orthotics (e.g., Dr. Scholl's insoles) A chiropractor is not considered a foot specialist and claims prescribed or dispensed by a chiropractor will be denied.	Must be dispensed by: • Chiropodist • Podiatrist; or • Pedorthist Claims for custom-made orthopedic shoes will also be required to include a lab bill that includes: • Details of the casting technique used: and • A description of the process and material used to fabricate the shoes. Claims for custom-made foot orthotic will also be required to include: • A copy of the detailed biomechanical examination or gait analysis • Details of the casting technique used. • A detailed description of the type of orthotic provided. • A breakdown of the charges for the orthotic • An original paid in full receipt
Oxygen and equipment necessary for its administration	Reasonable and customary			Prescriptions for oxygen must indicate how it is to be administered and what apparatus is to be used. The Provincial plan/Ontario Assistive Devices Program (ADP) may provide reimbursement for certain expenses up to 75% of the cost. You may claim the remaining expense from OEBAC by submitting a claim, together with a copy of the supplier's itemized statement identifying Provincial/ADP payment or a copy of the Provincial/ADP payment.
Nebulizer and Aero chamber for asthma	Reasonable and customary			Provide original paid in full receipt from the Pharmacy.

AIDS AND APPLIANCES	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Bath Chairs Commode Chairs	Reasonable and customary when ordered by a physician for use in your home if you cannot use a regular toilet.		Equipment whose primary purpose is to help you outside of the home. Items designed to improve your comfort or add convenience, like grab bars, air conditioners, or toilet seats Single-use items like incontinence pads or surgical face masks. Home modifications such as widened doors or ramps. Blood Pressure Machines are not covered under the Plan.	OEBAC requires a written recommendation from the prescribing physician, that must include: • The medical diagnosis, and • Anticipated time frame that the equipment will be needed (if rental), and • Confirmation the diagnosis is NOT related to a motor vehicle accident. • Original paid in full receipt
Repairs to Durable Medical Equipment (DME)	Effective January 1, 2023 increased from, $1,000 to $1,500 per calendar year	Repairs, including replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are covered when necessary, to make the item/device serviceable.		• Original paid in full receipt if you previously had DME paid by OEBAC. IF original DME was not previously paid by OEBAC a required a written recommendation from the prescribing physician, that includes: • Medical diagnosis. • Recommended duration of treatment; and • Confirmation the diagnosis is NOT related to a motor vehicle accident. • Original paid in full receipt

AIDS AND APPLIANCES	COVERAGE PER DEPENDANT	CRITERION REQUIRED	WHAT IS NOT COVERED	CLAIM SUBMISSION REQUIREMENTS
Transcutaneous electric stimulators (TENS)	Reimbursement is subject to a reasonable and customary cost up to a maximum of $200.00. Reimbursement one per lifetime.		Dr. Ho's Pain Therapy TENS device is not covered under this Plan. Plan does not cover replacement pads.	OEBAC requires a written recommendation from the prescribing physician, that includes: • Medical diagnosis. • Recommended duration of treatment; and • Confirmation the diagnosis is NOT related to a motor vehicle accident. • Original paid in full receipt
Wig or hairpiece	Limited to a lifetime maximum eligible expense of $500	Covered expense when hair loss is caused by chemotherapy or radiation treatment.	Conditions not related to cancer treatment are not covered.	• Original paid in full receipt

The Trustees reserve the right to exclude the services of any individual practitioner or providers on notice to you if they reasonably believe that such provider is charging or providing excessive services or engaging in fraudulent or dishonest activities.

AM I COVERED FOR OUT OF COUNTRY MEDICAL EXPENSES WHEN I TRAVEL OUTSIDE OF CANADA?

No. Our plan does not extend coverage outside of Canada.

IMPORTANT: Medical and Dental expenses are reimbursed for you or your eligible dependants only when the expense was incurred in Canada and reimbursement is based on the province of your residence.

When you travel you should always purchase Emergency Travel Insurance to cover medical expenses resulting from emergency illness or injuries occurring outside Canada. You are responsible for purchasing your own coverage before you leave on your trip.

If you are travelling outside the country while covered under the Active Benefit Plan, and you purchase a medical protection travel plan through a provider who specializes in this coverage, the Active Benefit Plan will reimburse you for the premiums you pay towards Emergency Travel Insurance, up to a maximum of $500 per family, per year.

Reimbursement of premiums (whether for single/family coverage) will be reimbursed for only those days you are covered under this Active Benefit Plan.

In order to receive reimbursement of your premiums, proof of payment and details of the period covered should be submitted to OEBAC.

IMPORTANT: With the variances of medical coverage between provinces within Canada it would be advisable for you or your dependants to purchase travel insurance while travelling within Canada. If you or your dependants have an illness or injury outside of province you reside in, you will be responsible for covering the rest. OEBAC adjudicates claims based on your province of residence and will only cover eligible expenses up to their provincial maximums, you will be responsible for covering the unpaid balance.

APPEALS

Members may appeal a decision of OEBAC with respect to any benefit application (other than one pertaining to a disability claim) to the Board of Trustees. Appeals are dealt with only in writing and you must complete and submit the Appeal to Trustees form available from OEBAC and on the OEBAC website together with any other pertinent information and documents.

All decisions made by the Appeals Committee are final, conclusive, and binding to all persons.
There are no appeals to the Trustees with decisions and assessments with respect to disability and life insurance claims by OEBAC, as these are considered by qualified Adjudicators. In addition, there are no appeals for travel insurance claims as there is no benefit coverage under the plan. The plan only covers an amount towards the premium to purchase this coverage from an outside vendor.

All decisions are final and binding and only subject to review by the Courts.

MEMBERS HEALTH PROGRAM

Members Health is a platinum level health service that is available to all plan members and their eligible dependants. This coverage will enable you to have access to convenient and personalized healthcare by a team of Ontario licensed Doctors at Members Health.

Doctors are available to help members 24 hours a day 7 days a week. This is especially helpful if your family Physician is not available to assist you with your medical concerns.

Their medical experts can help you with:

- Prescriptions.
- Labs and diagnostics ordered while you are on a video call with them.
- Referrals to/and timely access into Specialists and Surgeons arranged with continuity of care protected by keeping your Family Doctor informed.

Have a medical question or concern and want a leading expert's advice pertaining to preventative health screening, mental health, wellness, and nutrition information.

Go to their website at www.members-health.com OR by calling them at 1-800-484-0152.

To be eligible for this service you must be an initiated union Member in good standing with Local 793.

MEMBER ASSISTANCE PROGRAM (MAP)

This confidential program is available under the Active Benefits Plan offers a Member Assistance Program through Members Health. This program offers the following coverage for Active Members and their Eligible Dependants.

- Assessment counseling, case management and referral services.
- Work-life support and resources.
- Online services.
- Trauma response service.
- Employer / manager support services.

Members Health provides the services to the Active Members on a strictly CONFIDENTIAL basis. The toll-free contact number for assistance is: 1-800-484-0152 and online at https://www.members-health.com/

HEALTH CARE EXPENSES EXCLUDED FROM COVERAGE

The Active Benefits Plan will not pay for any of the following expenses:

- Charges for services and supplies covered by a government hospital or health plan such as the Provincial Medicare plan, and any charges in excess of the maximum amount payable under such plans if precluded by law.
- Any claim eligible for compensation under any Workplace Safety and Insurance or comparable legislation.
- Charges for services and supplies rendered or ordered while a person is not covered by this Active Benefits Plan.
- Charges for experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society.
- Examinations required for use by a third party.
- Charges for completion of claim forms other than those required for Short-Term and Long-Term Disability.
- Travel for health reasons.
- Travel insurance for flight cancellation or lost luggage.
- Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot.
- Expenses incurred by a person while not a resident of Canada.
- Expenses incurred to combat a smoking habit, with the exception of drugs which legally require a prescription. Non-prescription items such as Nicorette gum and NicoDerm patches are not covered.
- Cosmetic surgery or treatment (when classified as such by the Administrator) unless such surgery or treatment is for accidental injuries incurred while you are covered under the Active Benefits Plan and commences within 90 days of the accident. Cosmetic surgery and treatments not covered include removal of skin tags, cysts and moles (unless medically necessary) and varicose veins removal.
- Service, treatment or supplies for which there would be no charge except for the existence of this coverage.
- Expenses resulting from motor vehicle accidents.
- Non-medical expenses relating to hospital and medical appointments, including parking, travel costs, and meals.
- Expenses relating to erectile dysfunction drugs for Active Members (other than those with prior approval due to a medical condition being the cause of the erectile dysfunction).
- Expenses incurred outside of Canada.
- Charges for care other than as specifically described in this booklet.
- Charges for growth hormone medication.
- Expenses incurred for a weight loss program, including gastric by-pass surgery (lap bands).
- Reflexology expenses.
- Gym memberships.

- CPAP cleaning and sanitization equipment.
- Breast pumps and blood pressure monitors.
- Colonoscopy preparation drink.
- Non-medical devices including weighted blankets, OBUS form supports and cushions.
- Dr. Ho's products including Pain therapy system, circulation promoter, and tens machine System.
- Baby formula
- Nutritional drinks like Boost.
- Incontinence products such as adult diapers, Depends or Poise pads.
- Pillows of any sort for things like sleep apnea, neck support etc.

The Active Benefits Plan does not reimburse you for any services covered by your Provincial Medicare Plan including extra charges, except, where noted under Covered Expenses.

DENTAL BENEFITS FOR MEMBERS AND YOUR DEPENDANTS

The Active Benefits Plan is designed to help pay for dental expenses incurred by you and your Dependants. This Active Benefits Plan is a comprehensive plan covering most available dental services. Coverage includes preventive, endodontic (root canal), periodontic (treatment of gums and teeth below the gum line), dentures, crowns and bridgework.

Coverage also includes orthodontic services (straightening of the teeth) for eligible persons (Members and Dependants) under age 21.

Covered expenses are subject to co-payments and maximums set out below. They must be reasonable and necessary according to generally accepted dental practices.

HOW MUCH DOES THE ACTIVE BENEFITS PLAN PAY FOR DENTAL EXPENSES?

The Active Benefits Plan reimbursement is based on the Ontario Dental Fee Guide (ODA) for General Practitioners (including Denturist Fee Guide where applicable) with a 1-year lag as follows:

- January 1, 2022: 2021 ODA Fee Guide
- January 1, 2023: 2022 ODA Fee Guide
- January 1, 2024: 2023 ODA Fee Guide

Reimbursement levels:

- Basic Services – 100%
- Major Restorative Services – 100%
- Orthodontic Services – 75%
- Lab Fees – 100%

Benefit Maximum:

- Basic and Major Restorative Services (including lab work) are limited to a combined maximum of $3,000 per individual, per calendar year.
- Effective January 1, 2021, for new Orthodontic claims - reimbursements are limited to a **lifetime maximum for new claims up to $5,000 per eligible person under the age of 21.** Orthodontic expenses will be reimbursed based on a monthly or quarterly basis as treatment is rendered. Should you choose to pay your Orthodontist the entire treatment fee up front, you will only be reimbursed for the services as they are rendered, no lump sums will be reimbursed. Pre-payments are not reimbursable under this plan.

COVERED EXPENSES

Basic Services – 100% Reimbursement

Covered basic services include x-rays, examinations, cleaning and scaling, fluoride treatment, space maintainers, fillings, endodontic (root canals), periodontal (treatment of gums and teeth below the gum line) and dentures.

The following provides the more technical details of covered services if needed by your dentist:

- Routine oral examinations, bitewing x-rays and prophylaxis (scaling and cleaning of teeth) not more than once in any period of 12 consecutive months (once every 6 months for Dependant Children under age 21).
- Complete oral examinations ("new patient" examination) not more than once in any 36 consecutive months.
- Topical application of fluoride.
- Space maintainers that replace prematurely lost teeth for children under age 21.
- Protective athletic appliances.
- Emergency palliative treatment (to alleviate pain and discomfort).
- Dental x-rays, including full mouth x-rays once in any period of 36 consecutive months, and other dental x-rays as required in connection with the diagnosis of a specific condition requiring treatment.
- Extractions, other than those required for orthodontic treatment.
- Oral surgery, other than as required in connection with orthodontic treatment.
- Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations, including white fillings on back molar teeth, to restore diseased or accidentally broken teeth.
- General anaesthetic when medically necessary and administered in connection with oral or dental surgery and when administered by a separate qualified dentist or physician other than the attending dental surgeon.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth. (Effective January 1st, 2022 scaling is limited to 10 units of time yearly that can be utilized as needed and re-news every January 1st (1 unit = 15 minutes of treatment)).
- Endodontic treatment including root canal therapy, re-treatment of previously completed root canal therapy is reimbursed if more than 36 months has elapsed since the previous root canal therapy.
- Injection of antibiotic drugs by the attending dentist.
- Initial installation of partial or full removable dentures required as a result of one or more natural teeth being extracted while the Active Member is covered by this plan, or if the Active Member has been continuously covered for 24 months when treatment commences, including precision attachments and any adjustments during the 6 months following installation.

- Replacement of an existing partial or full removable denture by a new denture, or the addition of teeth to an existing partial removable denture on presentation of satisfactory evidence that:
  - The replacement or addition of teeth is required to replace one or more natural teeth extracted.
  - The Active Member has been covered under the Active Benefit Plan:
    - after the existing denture was installed; or
    - has been continuously covered for 24 months when treatment commences; or
    - The existing denture was installed at least 5 years prior to its replacement and the existing denture cannot be made serviceable; or
    - The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.
  - Laboratory fees are reimbursed at 100% of the dentist's fee eligible under the Active Benefits Plan.
- Repair, relining or rebasing of dentures more than 6 months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of 3 consecutive years.

Major Restorative Services – 100% Reimbursement

This benefit covers Major Restorative services as follows:

- The initial installation of fixed bridgework (including inlays and crowns as abutments) required as a result of one or more natural teeth being extracted while the Active Member is covered by this plan, or if the Active Member has been continuously covered for 24 months when treatment commences.
- Replacement of existing fixed bridgework by new bridgework, or the addition of teeth to an existing bridge, on presentation of satisfactory evidence that:
  - The replacement or addition of teeth is required to replace one or more teeth extracted after the existing bridgework was installed; or
  - The Active Member has been continuously covered for 24 months when treatment commences; or
  - The existing bridgework was installed at least 5 years prior to its replacement and the existing bridgework cannot be made serviceable.
  - Effective January 1, 2022 the amount of $3,000 per person, per calendar year is available (separate from the annual dental maximum) to cover the cost of a dental implant. Reimbursement will be made only AFTER the procedure is completed.
- Repair or recementing of crowns, inlays, onlays or bridgework.
- Inlays, onlays, gold fillings or crown restorations to restore diseased or accidentally broken teeth when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling.

Orthodontic Services – 75% Reimbursement

Effective January 1, 2021 - For Active Members, Spouses and Dependant Children.

All individuals must be under 21 years of age to be eligible for this benefit. The Active Benefits Plan covers orthodontic diagnostic procedures and treatment consisting of surgical therapy, appliance therapy (including habit breaking appliances) and functional/ myofunctional therapy, including related oral examinations, surgery, and extractions.

Orthodontic treatments are reimbursed under the plan at 75% of $6,666.67 of eligible charges to an overall lifetime maximum of $5,000. For example:

Eligible Charges	Dental Plan Pays
$1,500	$1,125
$2,000	$1,500
$3,000	$2,250
$4,666.67	$3,500 maximum for existing prior to January 1, 2021
$5,000	$3,759
$6,6666.67	$5,000 maximum for new claims on or after January 1, 2021

- The plan allows 1/3 of the total treatment fee to be used for reimbursement for the initial payment (35%).
- The plan allows a monthly reimbursement fee of between $250-$350 (or $1,050 quarterly basis) for reimbursement as treatment is rendered.
- Members can utilize their Health Care Spending Account for any unpaid portion of eligible orthodontic expenses.

COVERAGE OF EXPENSES DUE TO A NON-OCCUPATIONAL INJURY

The Active Benefits Plan pays 100% of eligible dental expenses incurred for services required as a result of a non-occupational injury incurred while you are covered for dental benefits. Treatment must be provided within 365 days of the accident and you must be covered for benefits at the time treatment is rendered.

Expenses required as a result of a non-occupational injury are not included in the $3,000 annual dental maximum. This coverage is separate.

PRE-DETERMINATION

A pre-determination of benefits should be filed with OEBAC whenever the total cost of proposed dental work is expected to exceed $300. This pre-determination, completed by your dentist, outlines details of the proposed work, identifies coverage and limitations for specific services, and clarifies benefits payable BEFORE treatment commences. The pre-determination is not intended to tell you or your dentist what treatments should be performed or what fees should be charged. It is simply intended to indicate, in advance, how much your plan will pay and how much must be paid by you.

Where the proposed work will exceed $300, have the dentist complete the dental claim form clearly indicating the services proposed and not completed, and submit it online to OEBAC. This information, endorsed by both you and your dentist, should be submitted to OEBAC along with the relevant x-rays. You will subsequently be advised what portion of the proposed treatment will be paid by the Active Benefits Plan.

Benefits will be paid only if you are covered by the Active Benefits Plan on the date treatment is rendered, whether or not you have obtained a pre-determination of benefits.

Dental Care Limitations and Exclusions

The Active Benefits Plan will not pay for any of the following expenses:

- Charges for dental treatment for cosmetic purposes, including teeth whitening and dental laser treatments, unless required as a result of a non-occupational injury.
- Charges for services of other than dentists, physicians or licensed denturists unless performed by legally qualified auxiliary personnel under their supervision.
- Treatment by a person ordinarily residing in the patient's home.
- Charges for dental services following an accident and reimbursed under another program or arrangement.
- Charges for dental services eligible for reimbursement under the Workplace Safety and Insurance Act, or comparable legislation.
- Charges for dental treatment started before the Active Member became covered under this Active Benefits Plan.
- Lost, mislaid or stolen appliances including dentures.
- Charges for oral hygiene instruction or nutritional counselling.

- Charges for services or supplies rendered or ordered while a person is not covered by this Active Benefits Plan.
- Charges for prosthetic devices including bridges and crowns ordered while a person is covered by the Active Benefits Plan but installed or delivered more than 30 days after termination of a patient's coverage.
- Charges levied by a dentist or physician for time spent travelling, cancelled appointments, completion of claim forms, transportation costs or advice given by telephone or other means of telecommunication.
- Charges for services and supplies rendered for full mouth re-construction, for a vertical dimension correction, or for a correction due to temporomandibular joint dysfunction.
- Charges for dental treatment rendered outside of Canada.

MEMBER LEAVES

BEREAVEMENT LEAVE FOR MEMBERS ONLY

If you suffer the loss of an eligible family member, while covered for benefits while covered by the Active Benefit Plan, you may be eligible to receive Bereavement Pay from the plan, for attending a funeral or religious service upon proof of loss of time from work and regular earnings.

To be eligible for this benefit, you must be eligible for the following benefits:

- Be actively working at the time the bereavement occurs.

If you have met the eligibility requirements, you may be eligible for the following benefits:

- A maximum of $175 per day
- Benefit payable up to a maximum of 5 days (does not have to be consecutive)

Under current tax law, Bereavement benefit payments are taxable to the member in the calendar year in which it was received. Members who are in receipt of Bereavement benefit payments in the previous calendar year will receive a T4A issued each February from OEBAC that indicates the total amount received in the prior tax year.

Any Bereavement benefit payments received on behalf of the member (shown on the T4A) must be reported by the member as income in the member's annual income tax return.

An eligible Family Member is:

- Your Spouse.
- Your or your Spouse's natural grandparent or great grandparent.
- Your or your Spouse's parent including stepmother or stepfather.
- Your or your Spouse's child including biological/adopted child, stepchild, foster child, child to whom you are the legal guardian.
- Your or your Spouse's son-in-law or daughter-in-law.
- Your brother or sister including a step-brother, step-sister, brother-in-law or sister-in-law.
- Your or your Spouse's grandchild or great-grandchild.

Spouse includes legal or common-law Spouse as defined under "Who are my Eligible Dependants?" section of this booklet. **Ex-spouses are not covered under this plan**.

A loss of wages on a Saturday and/or Sunday will be recognized by the Active Benefits Plan only if such a day of work was an integral part of your regular shift work.

To be eligible for this benefit, you must be covered by your dollarbank at the date of death. Members who are making Pay-Direct contributions are not eligible for this benefit.

Payment is only made for time missed during periods of active employment and not for bereavement leave during periods of layoff, unemployment sickness, disability, or other times when the member is not actively employed.

PARENTAL LEAVE FOR MEMBERS ONLY

The parental Leave Benefit applies to you only, the Plan Member, if you were covered by the plan at the time of the birth/adoption of your child. There is an entitlement of up to three (3) days off if you wanted to spend some time with your family during this time. In order to be covered for this wage loss you had to be actively working with a signatory employer of IUOE Local 793 (and were not Paying Direct for your benefits) at the time of the birth or the adoption.

- The benefit shall be $175 per day up to the maximum of three (3) days as a result of single and multiple births or newly adopted child(ren).

To make this application valid, you will need to attach the following documentation and MAIL in the information to OEBAC.:

- For Biological Births:
    - You must provide a copy of either the original birth certificate or temporary health card from the hospital
    - Personal Information Form including the new dependant(s)
- For Newly Adopted Child(ren)
    - Proof of adoption showing full name and address of the adoption agency
    - Personal Information Form including new dependant(s)

****The newly completed Personal Information Form must have your original signature on the document before your record can be updated into the system. Anytime you make a change you must re-state everything on the form – your existing dependants' plus your new baby/adopted child, beneficiary information, banking, authorized inquires, coordination of benefits etc.**

Please note that this claim **cannot** be submitted on the OEBAC Mobile App, Member Web, Fax or via Email. **To process this claim, we must receive the original Personal Information form with the requested copy of proof of birth/adoption information mentioned above**.

HEALTH CARE SPENDING ACCOUNT

Your Health Care Spending Account (HCSA) is currently $500 per family, per calendar year. The HCSA covers out-of-pocket medical and dental expenses that exceed your Active Benefits Plan coverage. Amounts remaining in your HCSA at the end of the calendar year can be carried forward for one year only. The maximum amount you can accumulate in any two (2) year period is $1,000.

The HCSA provides supplemental coverage for:

- eligible medical and dental expenses under the Active Benefits Plan where maximum coverage has already been reached; and
- unpaid co-insurance reimbursements from a Spouses' plan that would be eligible for coverage under your Active Benefits Plan.

The HCSA cannot be used to pay for:

- medical and dental expenses that are not covered by the Active Benefits Plan;
- medical and dental expenses that are covered by provincial health care plans; or
- expenses covered under the Group Legal Plan.

The HCSA has a 12-Month claim submission period from the date of service.

The HCSA is now accessible online through OEBAC Online or the OEBAC Mobile App available for download in your mobile app store.

GROUP LEGAL PLAN SECTION

GROUP LEGAL BENEFIT

SUMMARY OF BENEFITS

The Board of Trustees is pleased to present you with the Rules of the Plan and Schedule of Benefits provided by the International Union of Operating Engineers Local 793 Group Legal Benefit Trust Fund ("the Legal Plan"). It applies to legal services incurred on or after March 1, 2021, however, claims for services incurred prior to this date will be adjudicated in accordance with the text in the previous benefit booklet.

The Legal Plan provides all eligible Plan Members and their eligible Dependants with the opportunity to be reimbursed for fees incurred for legal representation. Plan Members and their eligible Dependants are entitled to use the licenced legal services provider of their own choice and be reimbursed at the levels set out in this plan. All legal services providers must be lawyers or paralegals who are in good standing as licensees of the Law Society of Ontario. Alternatively, the Law Society of Ontario provides a referral service that may be of assistance. To access the Law Society referral service, please visit: https://lso.ca/public-resources/finding-a-lawyer-or-paralegal/law-society-referral-service

It is important that you understand the provisions of the Legal Plan, the rules governing the eligibility for the benefits, the procedures to follow when making a claim and the conditions under which they are payable. The final determination of any claim, question or problem that may arise will be governed by the trust agreement and the current Schedule of Benefits. Copies of the Trust Agreement and relevant Plan documents are available to members on request to OEBAC.

The Legal Plan provides coverage for legal expenses up to the maximum amounts, which have been approved by your Board of Trustees and specifically, for those services described in this benefits booklet. The Legal Plan will not cover all your legal expenses and non-legal fees are the responsibility of the Plan Member. All claims are subject to the rules and exclusions as described in this booklet. All legal services must be provided by a lawyer, supported by an invoice on legal letterhead, except as noted for proceedings under the Highway Traffic Act. A Plan Member cannot perform legal services for coverage by the Legal Plan.

As rules and benefits may change from time to time after publication of this booklet, you are best advised to check the OEBAC website or consult with OEBAC staff regarding any possible changes. The Trustees hope to continue to provide the best benefits affordable, however, due to the evolving economic climate, benefits provided in this booklet may be subject to change. As circumstances may warrant and in order to protect the Legal Plan, the Trustees have the right to amend, delete, add, modify or suspend the Legal Plan's benefits, monetary or otherwise, as they apply to all current and future members.

The Trustees encourage you to read this booklet so as to familiarize yourself with the legal benefits available to you and your family. Should you have any questions or require assistance with your claim, please do not hesitate to contact the Administrator, OEBAC at 1-844-793-1919 or email at info@oebac.org prior to incurring any expense. The Plan Members union registration number or employee number is required when making inquiries.

Please note that only paper claims can be submitted under the Legal Plan. A properly completed legal claim form must accompany all legal claims.

Legal Benefits are a taxable benefit and Plan Members will receive a T4A for contributions made on their behalf to the Legal Plan.

APPEALS

Members may appeal a decision of OEBAC with respect to any application for reimbursement for benefits to the Board of Trustees. Appeals are only in writing, and you must complete and submit the "Appeal to Trustees" form available on the OEBAC website. Appeals rules are also found on the OEBAC website.

The Appeals Committee will make their best efforts to consider the appeal at their quarterly meeting and a decision will be communicated in writing by OEBAC to the member. All Appeals Committee decisions are final, conclusive and binding on all parties.

PRIVACY AND CONFIDENTIALITY

Any legal advice you receive is privileged and confidential. Information and data need only be provided to the Trustees and OEBAC that is necessary for purposes of administration of the Plan. Your claims and information will be kept confidential pursuant to the Trustees' privacy policy. Data and information will only be used or disclosed to the extent that is necessary or the purposes of administration of the Plan. Please visit https://www.oebac.org/privacy for further details.

ELIGIBILITY

Plan Members of the International Union of Operating Engineers Local 793 (Local 793) are entitled to benefit coverage under the Legal Plan if they are:

- employed by contributing employers participating in the Legal Plan, who are also eligible for benefits in the Local 793 Life and Health Benefits Plan;
- currently eligible for benefit coverage under the International Union of Operating Engineers Local 793 Life and Health Benefit Plan who are paying direct for benefit coverage and who continue to meet the criteria of being an initiated member in good standing and who are listed on the Dispatch Out of Work List;
- effective January 1, 2019, the Legal Plan is available to those Members whose life and health benefits are extended by freezing.

Termination of coverage under the Legal Plan takes place on the same date that the Plan Member ceases to be eligible for coverage in the Life and Health Benefit Plans. Legal services commencing following the date of coverage termination will be ineligible for reimbursement.

CLAIMS PROCEDURES

Plan Members and their eligible Dependants may use the legal services provider of their choice provided that such person is licensed and in good standing with the Law Society of Ontario. Alternatively, the Law Society of Ontario provides a referral service that may be of assistance. To access the Law Society referral service, please visit: https://lso.ca/public-resources/finding-a-lawyer-or-paralegal/law-society-referral-service

Legal Benefits are a taxable benefit and Active Members will receive a T4A for contributions made on their behalf to the Legal Plan.

To submit a claim, the Plan Member must be eligible for benefit coverage on the date of service or the date of offence for Highway Traffic Act matters and claims must be submitted within 24 months of that date.

A Legal claim form may be obtained from OEBAC, from the OEBAC website https://www.oebac.org/, from the Local 793 website https://iuoelocal793.org/ or from any local union office.

Legal claim forms must be completed in its entirety by the Plan Member and submitted to OEBAC along with an Itemized Statement of Account obtained from the service provider. The statement of account must be on the Law Firm's legal letterhead, and include detail the dates of service, a description of the services rendered and provide a breakdown of the legal fees payable separate from the disbursements and taxes.

A copy of the traffic ticket summons or a notice of trial must accompany claims for Highway Traffic Act matters where the date of offence will determine the eligibility for reimbursement.

Please submit all legal claims (in paper) to:

OEBAC Legal Claims Department

2201 Speers Road, Unit 1

Oakville, Ontario, L6L 2X9

Or you can email your legal claims to info@oebac.org

SCHEDULE OF BENEFITS FOR LEGAL SERVICES

The following is the Schedule of Benefits covered by the Legal Plan for legal services incurred on or after September 1, 2019. Claims for services incurred prior to this date will be adjudicated in accordance with the text in the previous benefit booklet.

Unless otherwise specified all Legal Plan maximums are based on a calendar year. The amounts set out in the schedule are the maximum amounts reimbursable for each service even though certain proceedings may take in excess of one calendar year to complete.

Charges beyond the maximum payable by the Legal Plan or for non-legal services such as disbursements, taxes, registration fees, property appraisals, fines, title insurance, administration fees or court costs are the responsibility of the Active Member. All claims are subject to the rules and exclusions applicable to the Legal Benefit Plan. **Please see the listing, at the end of this booklet, of all matters that are excluded from coverage by the Legal Plan.**

Code A - Real Estate

The Plan Member and their dependant Spouse shall be entitled to legal services in connection with the Plan Member's principal family residence. Legal services include a purchase or sale of a family dwelling, purchase of a lot on which to build a family dwelling (building permit must be issued within 1 year) and the purchase or sale of one vacation property. Also covered under the Legal Plan insofar as they relate to the Plan Member's principal family residence is the transfer of title, arrangement of new or renewal of mortgage, mortgage incidental to purchase and discharge of mortgage. The required transfer of title on a property is included in the maximum amount of $550 payable for purchase and sale claims. Code "A6 Mortgage New or Renewal" is only payable for mortgages unrelated to a purchase.

The Schedule below lists codes, description of covered services and coverage maximums provide by the Legal Plan.

NOTE: Legal services provided in connection with commercial or income producing properties are not covered under the Legal Plan.

NOTE: Please ensure the completion of the real estate section on the reverse of the claim form when claiming for a purchase or sale of the Retired Member's principal family residence.

CODES	DESCRIPTION	MAXIMUM AMOUNT
A1	Purchase Family Dwelling	$550
A2	Sale Family Dwelling	$550
A3	Purchase Lot for Family Dwelling	$550
A4	Purchase/Sale Vacation Property	$550
A5	Transfer of Title	$300
A6	Mortgage New or Renewal	$400
A7	Mortgage Incidental to Purchase	$200

A8	Discharge of Mortgage	$150

NOTE: Legal Plan maximums include 1 purchase, 1 sale, 1 transfer of title, 1 mortgage new or renewal or mortgage incidental to purchase and 2 discharges of mortgages in any 12-month period. Benefits relating to a vacation or recreational property are limited to a lifetime Legal Plan maximum of 1 per member.

Mortgage services provided by a financial institution must clearly identify the amount of the legal fee included in the administration fee. If the required information is not provided, a formula will be used to determine the legal portion of the fees charged in order to reimburse the Retired Member.

Survivorship applications will be paid under code "A5 Transfer of Title". Title insurance, title examining counsel fees, property appraisals, mortgage and land registration fees are not covered under the Legal Plan.

Code B - Divorce and Domestic Proceedings

The Plan Member and the Dependant Spouse shall be entitled to representation in connection with any matrimonial or divorce proceedings. Representation includes the preparation of a separation agreement, filing a petition of divorce or separation, establishing the custody and access of children, support payments, the equitable distribution of property and all other proceedings relating to the relationship. However, the Plan will not fund disputes pertaining to a members' pension under the Local 793 Pension Plan.

Reimbursement of the legal expense associated with an initial consultation for a family matter is covered under the Legal Plan. (See Code C – Preventative Law)".

Always ensure that the statement of account from the law firm you are dealing with clearly indicates the date and fees charged for the consultation.

If proceedings are non-contested, it is recommended that independent counsel be sought.

Cheques for legal services provided to a Plan Member's Dependant Spouse will be mailed directly to the Spouse or the lawyer as elected on the claim form for Divorce Spouse, Property and Custody Support Spouse and Separation Agreement Spouse claims.

Please also ensure that the Spouse's mailing address and phone number are provided, in the allocated space on the claim form.

The schedule below lists codes, description of services and coverage maximums for Code B.

CODES	DESCRIPTION	MAXIMUM AMOUNT
B1	Divorce Member	$700
B2	Divorce Spouse	$700
B3	Property and Custody Support Member	$700
B4	Property and Custody Support Spouse	$700

B5	Separation Agreement Member	$700
B6	Separation Agreement Spouse	$700
B7	Modification of Separation Agreement	$300
B8	Adoption (Private)	$500
B9	Guardianship	$400
B10	Change of Name	$250
B11	Birth Certificate Assistance	$200
B12	Post of Pre-Nuptial Agreement	$500

NOTE: The statement of account from the service provider must clearly specify the matter and provide a description of services. The block fees set out herein are payable only for services provided and are not accumulative. When a lawyer prepares a Separation Agreement, you would be entitled to a reimbursement up to $700. You would not be entitled to claim for "Property and Custody Support" when issues of property, custody, access or support are outlined in the Separation Agreement. Mediation is not a covered service under the Legal Plan.

Outlined in this section are the maximum amounts payable for each service despite the fact that certain proceedings may take in excess of one calendar year to complete.

Code C - Preventive Law

Plan Members and their eligible Dependants shall be entitled to receive legal advice by telephone or direct office consultation on any problem that the Plan Member believes to be of a legal nature. It is essential that the statement of account from the service provider clearly indicates the date and fee charged for the initial consultation.

CODES	DESCRIPTION	MAXIMUM AMOUNT
C1	Preventative Law	$300

Code D - Non-Complex Legal Documents

Legal documents (listed below) prepared for Plan Members and their eligible Dependants, which are deemed to be not excessively complex, are covered by the Legal Plan.

CODES	DESCRIPTION	MAXIMUM AMOUNT
D1	Power of Attorney - Personal Care	$ 50
D10	Power of Attorney - Property	$ 50
D2	Deeds	$100
D3	Simple Contracts	$200

D4	Tenant Leases (Residential)	$150
D5	Notarized Affidavits or Documents	$ 25
D6	Other Legal Documents	$200

Code E - Wills

The Plan Member and the Dependant Spouse shall be entitled to have prepared what is commonly regarded as a Simple Will which does not include the creation of any trust or other estate. The Plan Member and the Dependant Spouse shall also be entitled to the periodic review and amendment of all testamentary instruments. Preparation of a simple will, revision of a will or preparation of a codicil is limited to one service in any 12-month period. Generally, powers of attorney are prepared in conjunction with wills. Please note that probation of a will is not a covered service under the Plan.

CODES	DESCRIPTION	MAXIMUM AMOUNT
E1	Simple Will for Member	$300
E2	Simple Will for Spouse	$300
E3	Revised Will or Codicil for Member	$150
E4	Revised Will or Codicil for Spouse	$150

Code F - Landlord and Tenant Matters

The Plan Members and their eligible Dependants as tenants shall be represented in connection with any claims, disputes or controversies arising out of a lessor-lessee relationship in respect to their dwelling. Legal services related to representation for matters before the Landlord and Tenant Board will be paid under this section of the Legal Plan. Proceedings in which the Active Member or an eligible Dependant is the landlord will not be a covered benefit under the Legal Plan.

CODES	DESCRIPTION	MAXIMUM AMOUNT
F1	Leases/Tenancy	$500

Code G - Consumer and Personal Property Law

Plan Members and their eligible Dependants shall be entitled to legal representation in connection with any claim against a manufacturer, distributor, or retailer for defects in any merchandise, article or service or in a recovery on any warranty given in connection with the sale of merchandise, article or service, where such claim is in excess of $100. The Legal Plan shall not be obliged to litigate under code G2 on any claim unless the dollar value exceeds $300, and proceedings brought before the small claims court will be paid under Code G7.

CODES	DESCRIPTION	MAXIMUM AMOUNT
G1	Contracts/Warranty	$400
G2	Consumer Protection Act	$400
G3	Bankruptcy (Personal)	$500
G4	Garnishment of Wages	$300
G5	Tax Advice	$250
G6	Liens (Personal)	$250
G7	Small Claims Court	$500

The fees of a Trustee in Bankruptcy are covered up to the maximum allowed by the Legal Plan for personal bankruptcy (i.e. voluntary petition, not involving a business). The bankrupt must be discharged prior to submitting the claim. A Trustee's Final Statement of Receipts and Disbursements (Form 13) must be submitted with your claim for reimbursement from the Legal Plan. Consumer proposals are not a covered service under the Legal Plan.

While tax advice is covered, preparation of tax returns is excluded from coverage under the Legal Plan.

Code H - Civil Litigation Defendant

Plan Members and their eligible Dependants, represented in connection with any civil action or civil administrative proceeding in which the Active Member or Dependant is named as a defendant or respondent, have coverage from the Legal Plan. The Legal Plan shall be under no duty to provide legal representation to an Active Member or eligible Dependants where representation is provided for under statutory programs.

Plan Members shall be required to pay any disbursements in connection with such defensive litigation including the costs of discovery, witness fees, etc.

Code H - Civil Litigation Plaintiff (Member Only)

Only the Plan Member shall be represented in connection with the filing of a civil or administrative action for and on behalf of the Plan Member in connection with any material injury to person or property for the deprivation or injury of any constitutionally or statutorily guaranteed right, any right conferred at common law or for the adjustment of any grievance both recognizable and actionable in either law or equity.

No representation shall be available under this item for any action that is deemed to be either non-meritorious, calculated to be vexatious only, of a non-material or of a non-consequential nature or would be contrary to public policy. No representation is available in respect of class actions or cases that are brought on a contingent fee basis where your lawyer only gets paid if there is success. No claim may be paid in respect of an adverse costs award against you whether you are a plaintiff or defendant.

In the event that any damages are recovered, or some form of monetary claim effected, the first $4,000 excluding damages for property replacement and/or medical expenses of any such recovery shall be free of any assessment by the Legal Plan for legal costs expended on the Plan Member's behalf. If the monetary settlement is in excess of the $4,000, the Plan Member will have to reimburse the Legal Plan as follows. The Legal Plan shall be entitled to recover any legal costs awarded by the court and from any monetary settlement in excess of $4,000.

CODES	DESCRIPTION	MAXIMUM AMOUNT
H1	Defendant Representation	$3,000
H2	Plaintiff Representation	$3,000

Outlined in this section are the maximum amounts payable for each service despite the fact that certain proceedings may take in excess of one calendar year to complete.

Proceedings within the Small Claims Court maximum limit are not reimbursable under this section. Legal Plan benefits cannot be used to sue OEBAC, the Trustees of any Plan sponsored by Local 793, IUOE Local 793 or any related entity or any officer, director, trustee, employee, or agent of these organizations. The benefits also cannot be used to sue a participating employer or employer association.

Code J - Government Programs and Assistance

The Plan Member and the Dependant Spouse shall be entitled to legal representation on behalf of themselves or their eligible Dependants in any matter requiring legal assistance arising out of disputes or appeals with Social Assistance or Employment Insurance.

The Plan Member and the Dependant Spouse shall be entitled to legal representation in matters of immigration into or out of Canada on behalf of themselves or their Dependants, or on behalf of a relative who the Active Member or Spouse directly sponsored into Canada.

CODES	DESCRIPTION	MAXIMUM AMOUNT
J1	Social Assistance	$150
J2	Employment Insurance Commission	$150
J3	Immigration Retired Member	$600
J4	Immigration Spouse	$600

NOTE: Outlined in this section are the maximum amounts payable for each service despite the fact that certain proceedings may take in excess of one calendar year to complete.

NOTE: Services provided by Immigration Consultants are not covered under the Legal Plan.

Code K - Insurance Related Matters

The Plan Members and their eligible Dependants shall be represented in connection with any claim against the insurer ((except for benefits provided by the International Union of Operating Engineering Local 793 Members Life and Health Benefit Trust or benefits provided by a contributing employer to this Legal Plan)) by reason of failure to provide or pay the benefits as contracted for or to render advice in the interpretation of any policy provision.

In the event it is necessary to litigate any claim against an insurance carrier, the conditions set forth in Code “H” hereinbefore shall apply.

CODES	DESCRIPTION	MAXIMUM AMOUNT
K1	Accident and Health	$300
K2	Life and Annuity	$300
K3	Fire and Homeowners	$300
K4	Casualty	$300
K5	Automobile Liability	$300
K6	Marine	$300
K7	Other	$300

Code L - Automobile Related Matters

Plan Members and their eligible Dependants shall be entitled to legal representation in connection with automobile related incidents. Litigation under this item is subject to the limitations set forth in Code H.

CODES	DESCRIPTION	MAXIMUM AMOUNT
L1	Civil Actions (Re: Auto Accident)	$500
L2	Damage and Personal Injury	$500
L3	Uninsured Motorist	$400

Code M - Criminal Matters

Plan Members and their eligible Dependants shall be entitled to limited legal representation when charged under Provincial or Federal Statutes for summary conviction offences and indictable and hybrid offences. The Legal Plan will only allow reimbursement up to the maximum amount indicated for representation on all charges arising out of a single incident. In the event that multiple charges are laid under the Criminal Code of Canada on a single occasion but arising out of separate incidents, the Legal Plan will only allow reimbursement up to the maximum amount indicated.

Reimbursement of the legal expense associated with an initial consultation for charges under the Criminal Code of Canada is also covered under the Legal Plan (see Code C for details). Ensure that the statement of account from the lawyer providing legal advice clearly indicates the date and fee charged for the consultation.

A copy of the traffic ticket summons or a notice of trial must accompany claims for Highway Traffic Act matters. The Plan Member must be eligible for benefit coverage on the date of offence for Highway Traffic Act claims.

CODES	DESCRIPTION	MAXIMUM AMOUNT
M1	Highway Traffic Act	$400
M2	Provincial Offences Act or Damage and Personal Injury	$500
M3	Criminal Code of Canada	$850
M4	Record Suspension (Pardon)	$600

NOTE: The Legal Plan covers the legal cost for services provided for the processing of an application for a record suspension (formerly known as a pardon). Representation for driving while impaired or driving over 0.8 mg is limited to a single charge in a calendar year and a lifetime maximum of two charges. Paralegal services (i.e., X-Coppers and similar firms) related to traffic tickets and charges under the Highway Traffic Act are covered expenses under Code M1.

Coverage exclusions from the Legal Plan include parking violations and fines. In addition, Federal government processing fees, electronic fingerprinting, local police records check, and U.S. entry waivers are also excluded from coverage under the Legal Plan.

Outlined in this section are the maximum amounts payable for each service despite the fact that certain proceedings may take in excess of one calendar year to complete.

Code N - Appeals

The Plan will cover legal representation on an appeal by a licenced lawyer where the initial proceeding was covered or would have been covered by the Plan. The Legal Plan shall pay a maximum of 50% of the legal fees up to $1,000 on an appeal. Appeals are limited to one appeal per court decision or any conviction arising out of the same incident or charge.

If you are successful on an appeal and recover a monetary award in excess of $4,000, the same rules as are applicable to Civil Litigation under Code H above will apply in terms of reimbursement to the Legal Fund for costs and money recovered up to the cost paid to you by the Fund for both the trial and the appeal.

CODES	DESCRIPTION	MAXIMUM AMOUNT
N1	Appeals	50% up to $1,000

Code O - Jury Duty

If while covered under the Legal Plan, the Plan Member loses wages as a result of reporting for services as an Active Member of a jury or a subpoenaed witness, a benefit may be paid under this Legal Plan for days where wages are lost.

CODES	DESCRIPTION	MAXIMUM AMOUNT
O1	Jury Duty	$165 /full day (first 10 working days) $135/full day (subsequent working days)
O2	Subpoenaed Witness	$165 /full day (first 5 working days)

The benefit for part of the working day will be prorated assuming eight straight hours per working day excluding weekends and periods of unemployment. This benefit is paid in addition to the per diem allowance paid by the court.

A Jury duty or subpoenaed witness claim form may be obtained from OEBAC and is also available at oebac.org. These forms must be completed by the Plan Member and the employer. Completed claim forms must be accompanied by proof of attendance outlining the days attended or the Sheriff's letter and then submitted to the OEBAC.

In order to be eligible for this benefit, the Plan Member must be working and covered under the dollarbank at the time of commencement of jury duty or subpoena to witness.

You will receive a T4A at tax time as this is taxable income.

MAXIMUM REPRESENTATION ANNUAL MAXIMUM LEGAL COVERAGE

The maximum amount of expenses paid from the Legal Plan to representation that Plan Member shall receive under the Legal Plan, inclusive of and their eligible Dependants, shall not exceed $4,500 of legal service in a calendar year.

LEGAL SERVICES EXCLUSIONS EXPENSES NOT COVERED

The following services are excluded from coverage under the Legal Plan:

- Disbursements, taxes, court costs, filing fees, land transfer taxes, administration fees, process server fees, registration fees and property appraisals.
- Title searches, survey fees, title insurance and title examining counsel fees.
- Fines and penalties, whether civil or criminal and parking violations.
- Any judgement for damages, including judicially awarded costs.
- Any proceedings or dispute involving an Employer or their officers, agents, representatives, or employees.
- Any proceedings or dispute involving, as a party, the Union or any related entity or Council of trade unions, a corporation, trust, or other entity established by the Union, and any of such organizations' officers, agents, representatives, or employees.
- Legal Plan benefits cannot be used to sue OEBAC, IUOE Local 793 or any officer, director, trustee, or employee of these organizations.
- Any proceedings arising under the Ontario Labour Relations Act or any other statute that relates to labour relations or terms and conditions of employment, including but not limited to WSIB, Employment Insurance, the Occupational Health and Safety Act or the Ontario Human Rights Code in matters involving an Employer.
- Any dispute involving the Legal Plan, the, Active or Retired Benefits Plan, the Plan of Benefits or any other Plan or Trust Fund provided by a Contributing Employer to the Plan of Benefits or International Union of Operating Engineers Local 793 Members Life and Health Benefit Trusts of Ontario.
- Any dispute involving the Legal Plan or its Trustees or any other trust fund, corporation or benefits plan established to provide any type of benefit to members of Local 793 that are funded by contributions made by Participating Employers or a dispute involving any of the employees, directors, agents, trustees, or officers of such entities.
- Non-personal legal services (e.g., any business-related matters).

- Any controversy between a Plan Member and any Dependants apart from divorce, separation, or annulment. Mediation is excluded from coverage.
- No service shall be provided that will violate Public or Statutory Law.
- Any case in which defense or other legal representation is provided through insurance or other indemnification.
- Action instituted prior to becoming a Plan Member or civil actions requested to file arising out of pre-existing conditions. Exceptions may be waived by the Board of Trustees.
- Class actions or other legal proceedings where the lawyer is paid on a contingent-fee basis, as well as Amicus Curiae filings or interventions in any lawsuit or controversy among parties not involving the immediate and direct interest of a Plan Member.
- Any case in which defense or other legal representation is provided through any government agency, which will represent a Plan Member without charge.
- Any representation required by reason of any acts committed or acts which a Plan Member omitted to perform giving rise to tort, negligence, or criminal claims, or charges, which acts of omission occurred prior to a Plan Member joining the Legal Plan.
- Court appearance in connection with small claims involving an amount less than $100 and civil litigation involving an amount less than $300. Costs of discovery and witness fees are excluded from coverage.
- Services rendered by immigration consultants or other non-lawyers, except paralegal services (i.e., X-Coppers and similar firms) related to traffic tickets and charges under the Highway Traffic Act.
- Fees related to the preparation of documentation to obtain a reverse mortgage.
- Probation of a will and estate matters.
- Preparation of tax returns and consumer proposals.
- Federal government processing fees for a record suspension, local police records check, electronic fingerprinting, and U.S. entry waivers.
- Stale dated claims that were incurred over 24 months prior to their submission.
- Claims instituted outside of Canada.

INTERPRETATION - The Trustees shall be exclusively responsible for the interpretation and application of the Legal Plan, the determination of all questions pertaining to eligibility and entitlement to benefit.

LEGAL PLAN DEFINITIONS

"Benefits" means payment of a monetary sum to or on behalf of a Plan Member for legal fees incurred by the Active Member, Retired Member or eligible Dependants in obtaining legal services for matters covered by the Legal Plan.

"Covered Individual" means a Plan Member, his or her spouse and eligible Dependants.

"Dependants" means any person with the following relationship to the Plan Member:

- Plan Member's spouse in respect of whom the contributions are being made for coverage under the Legal Plan; see "Spouse".
- Plan Member's unmarried children (including adopted and stepchildren) under 21 years of age who are wholly Dependant on the Active Member or Retired Member for support;
- Plan Member's unmarried children (including adopted and stepchildren) up to age 25, who are full time students at a university or similar educational institution and depend wholly on the Active Member or Retired Member for support.

"Employer" means participating employer who makes contributions to the Legal Plan under a Collective Agreement or any other Agreement.

"Legal Plan" means the International Union of Operating Engineers Local 793 Group Legal Benefit Plan.

"Legal Services" means representation or advice from a qualified legal practitioner with respect to those matters listed in the schedule of benefits.

"Plan Member" means a Member of the International Union of Operating Engineers Local 793 who is employed by a Contributing Employer and who is eligible to receive benefits under the Legal Plan.

"Plan" means the International Union of Operating Engineers Local 793 Group Legal Benefit Plan.

"Spouse" means an individual who:

- is married to the Plan Member; or
- or although not legally married to the Plan Member, cohabits with the Plan Member for at least one year in a spousal relationship.
- the contributions are being made for coverage under the Legal Plan.

"Trust Agreement" means the Agreement between the Employers and the Union pursuant to which the Trust Fund was established.

"Trust Fund" means the International Union of Operating Engineers Local 793 Group Legal Trust Fund established pursuant to the Trust Agreement.

Capitalized terms used in this Legal Plan but not defined above shall have the meanings given to those terms in the Trust Agreement.

THE LAW SOCIETY REFERRAL SERVICE

Plan Members and their Dependants are entitled to the use of a service provider of their own choice. Alternatively, the Law Society Referral Service connects residents of Ontario looking for legal assistance with a lawyer or paralegal who practices in the area of law required. The service will help to find a legal professional who will provide up to a 30-minute free consultation to help you determine your rights, options and to meet a specific requirement, such as communicating in a certain language. To access the service please visit: https://lso.ca/public-resources/finding-a-lawyer-or-paralegal/law-society-referral-service

Licensed Paralegal Coverage

Legal Services provided by a licensed paralegal are covered for the following:

- Litigation in Small Claims Court
- Offences under the Provincial Offences Act and Highway Traffic Act
- Minor criminal charges in Ontario Court of Justice
- Hearings before the Immigration and Refugee Board
- Matters before Tribunals

Important Information for Service Providers

In order to assist in the efficient processing of a Legal Plan claim, it is crucial that the supporting documentation be submitted. For your benefit we reiterate the importance of the **Itemized Statement of Account prepared on legal letterhead** detailing the services rendered and the legal fees separate from the disbursements and taxes. Please indicate the name of the client(s) and the amount charged for each service. Non legal fees in excess of the Legal Plan maximum and fees of members who are ineligible are the responsibility of the Plan Member.

Attention must be paid to provide us with a clear description of the services rendered. For instance, **Real Estate Matters** often include the preparation of a mortgage and discharge, but rarely is it itemized on the statement of account and while the closing date further facilitates processing, it is on rare occasion provided. Survivorship applications will be paid under Code A5 “Transfer of Title”. Title Insurance, title examining counsel fees, property appraisals, mortgage and land registration fees are not covered under the Legal Plan.

Statements of accounts relating to **Divorce and Domestic proceedings** must clearly specify the family matter and provide a description of services. The block fees set out herein are payable only for services provided and are not accumulative. When a lawyer prepares a separation agreement, the claim may be reimbursed up to $700. The Plan Member would not be Entitled to claim for Code B3 “Property and Custody Support Retired Member” when issues of property, custody, access or support are outlined in the separation agreement.

Plan Members and their eligible Dependants shall be entitled to receive legal advice by telephone or direct office consultation on any problem that the Plan Member believes to be of a legal nature. When a **Consultation** takes place regarding family or criminal matters, it is important that the consultation be identified on the statement of account so as to allow for the Member to receive an additional benefit. Failure to provide the information could result in a delay in the processing of the claim.

Reimbursement for claims related to **Bankruptcy** requires the submission of a Trustee's Final Statement of Receipts and Disbursements (Form 13).

Highway Traffic Act claims must be accompanied by a copy of the traffic ticket, summons or notice of trial, where the date of offence will determine the eligibility for reimbursement.

The Plan Member must be eligible for benefit coverage on the date of service or the date of offence for Highway Traffic Act matters and claims must be submitted within 24 months of that date.

NOTE: **Maximum representation shall not exceed $4,500 of legal service in a calendar year. For a listing of Exclusions, please see section entitled "Legal Services Exclusions"**. The maximums set out under the Schedule of Benefits Codes are the maximum amounts payable for each service despite the fact that certain proceedings may take in excess of one calendar year to complete. Charges beyond the maximum payable by the Legal Plan or for non-legal services such as disbursements, taxes, registration fees, property appraisals, fines, title insurance, administration fees or court costs are the responsibility of the Member.

The final determination of any claims, question or problem that may arise will be governed by the Trust Agreement and the current Schedule of Benefits. The Legal Plan provides coverage for legal expenses up to the maximum which has been approved by the Board of Trustees and specifically, for those services described in this benefit booklet. All claims are subject to the rules and exclusions applicable to the Plan of Benefits outlined in the booklet.

LOCAL 793
international union of operating engineers

OPERATING ENGINEERS BENEFITS ADMINISTRATION CORP