ACAW Health & Wellness Plan

January 2023

Try scanning this QR Code from your smart device to visit our website – where you can get up-to-date information about the ACAW Trust Funds, download forms, hours of operation and much more.

www.acawtrustfunds.ca

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FOR MORE INFORMATION

For information about your ACAW Health & Wellness Plan, contact the Plan Office:

ACAW TRUST FUNDS

Suite 101, 15315 - 123 Avenue, Edmonton, AB, Canada T5V 1S6

Phone: 780-477-9131
Toll Free: 800-588-1037
Option #1: ACAW Health & Wellness Plan
Option #3: Self Payments, Weekly Disability & Life Insurance

Fax: 780-477-9134
Email: info@acawtrustfunds.ca

www.acawtrustfunds.ca

INTRODUCTION

This booklet provides an overview of the ACAW Health & Wellness Plan. This is an *Hour Bank* Plan and payment of your claims depends on your Hour Bank balance when an expense is incurred. See the section *How the Hour Bank Works* in this booklet for a detailed description of how you qualify for and maintain your eligibility for benefits.

The Plan is funded by participating employer contributions as per the current Collective Agreement.

Where a claimant disagrees with an administrative decision, such decision can be appealed in writing to the Board of Trustees. All appeals are considered.

This booklet will provide the Plan Member with a summary of the Plan Text effective January 1, 2023 to December 31, 2023. Only services and expenses incurred **IN CANADA** are eligible to be covered by ACAW Health & Wellness Plan benefits.

If there are discrepancies between this booklet and the official Plan Text or Life Insurance Contract, the official Plan Text or Life Insurance Contract shall prevail.

For more detailed information about the Plan, information regarding your status, rights and privileges, and how to appeal a decision, please contact the Plan Office.

BENEFIT CHANGES AS OF JANUARY 1, 2023

The following are highlights of benefit changes provided by the ACAW Health & Wellness Plan and only apply to services obtained or commenced **on or after January 1, 2023**.

This is intended for information purposes only. It does not mean you have coverage under the Plan. Please call the Plan Office to confirm your eligibility before you incur expenses that you want to have reimbursed from the Plan.

MENTAL HEALTH SERVICE PROFESSIONALS IN CANADA

Mental Health Service Professionals (Psychologist & Psychiatrist) – $1,500.00 per person per calendar year.

The Plan provides 100% coverage for eligible psychology and psychiatry services incurred in Canada to a maximum of $1,500 per person per calendar year. Eligible services must be provided by a clinical psychologist, or a psychiatrist licensed as a medical doctor specializing in mental health disorders, registered with their respective College, and licensed to practice in Canada.

Note: The Plan does not provide coverage for services incurred in a hospital or for services covered under a provincial healthcare plan or similar government health plan. Respective College registration can be confirmed on your local provincial website.

*** REMINDER: LIFEWORKS MEMBER AND FAMILY ASSISTANCE PROGRAM (MFAP) ***

Since 2022, ACAW Trust Funds offers a **Member and Family Assistance Program,** provided by **Lifeworks.**

- The **MFAP** by **Lifeworks** can be accessed by phone at **1-844-880-9142** (English), **1-811-880-9143** (French), or by visiting their website at **acaw.lifeworks.com** (**username:** acaw / **password:** lifeworks)
- A copy of the MFAP brochure can be found on the ACAW Trust Funds website at **www.acawtrustfunds.ca**

OTHER

All benefits are subject to Reasonable and Customary Charges

The ACAW Health & Wellness Plan limits the maximum eligible amounts for health care services and supplies covered by the Plan. If your provider or supplier charges more than the allowed amount, you will be responsible for paying the difference. This contributes to the sustainability of the benefits provided to you by the Plan.

Additional Information

- The Plan may request additional information and/or documentation necessary to administer the Plan. This may include but is not limited to proof of payment, marriage documents, cohabitation documentation, etc.
- ACAW Health & Wellness Plan has a responsibility regarding your benefits. This includes the right to decide, from time to time, which providers are eligible for coverage or products and services the Plan provides coverage for. If your provider has been designated as ineligible, claims from this provider will be denied.
- Request for Information – An administration fee of not less than $500 must be paid by the Member for researching and providing requested information pertaining to a Member or their Dependents. Such information shall not be provided without a signed release from the Member.
- The definition of Spouse has been expanded; if a Member has a Spouse with respect to his membership in the ACAW Health & Wellness Plan, then this same person will be his Spouse with respect to his membership in the ACAW Pension Plan if it meets the definition of Pension Partner / Spouse as defined in the ACAW Pension Plan.

The ACAW Health & Wellness Plan benefits cover **eligible expenses** and **services** incurred in **Canada only.**

For more information, call **780-477-9131, option #1**, toll free at **1-800-588-1037, option #1**, or visit our website at **www.acawtrustfunds.ca**. *If there are any discrepancies between this information and the official documents, the Plan Text and Insurance Contract will prevail.*

GENERAL INFORMATION

The ACAW Health & Wellness Plan provides benefits to members and their eligible dependents to help maintain their health and to provide financial assistance in the case of a member's disability or death.

The Plan includes:
- Supplementary Health Care
- Dental
- Weekly Disability
- Life Insurance

If you are a Member of Local Unions 1325, 2103, or 2010, or are employed by a Participating Employer, you are automatically enrolled in the Plan upon completion of the eligibility requirements (see **Page 6** – *How the Hour Bank Works).* To enrol your eligible dependents you must complete a form and the dependents must meet the eligibility requirements (see **Page 8** – *Eligible Dependents)* of the Plan. Coverage for dependents will not take effect until both the eligibility requirements and the appropriate forms have been completed and received by the Plan Office. Enrollment forms are mailed to new members and can also be requested from the Plan Office.

Reciprocity – Working in Another Jurisdiction

If you work in a jurisdiction other than the Alberta Regional Council of Carpenters and Allied Workers, and are a member in good standing of the United Brotherhood of Carpenters and Joiners of America, your coverage under this Plan can continue if there is a reciprocal agreement with the ACAW.

Taxation and Your Health and Wellness Benefits

You do not have to pay taxes on the contributions made to the Plan by participating employers. Medical expenses not covered by the Plan may be eligible for the Medical Tax Credit under the *Income Tax Act*. Keep your Explanation of Benefits (EOB) statement to use for this purpose as submitted receipts will not be returned.

If you were eligible for Life Insurance benefits during the year, the premiums paid by your employer(s) are a taxable benefit to you. You will get a T4A for the year showing the amount of the life insurance premiums. Any life insurance premiums you self-pay to maintain your coverage are not taxable and will not be included in the T4A.

If you receive weekly disability payments, the payments are taxable income at source and you will receive a T4A.

Request for Information

An administration fee of not less than $500 must be paid by the Member for researching and providing requested information pertaining to a Member or their Dependents. Such information shall not be provided without a signed release from the Member.

General Exclusions from the Plan (see **Page 16** for the complete list of exclusions)
The following services and conditions are not eligible for reimbursement under the Plan:
- charges incurred outside of Canada
- charges that would not have been made if the Plan didn't exist
- claims relating to past or present service in the armed forces
- charges that exceed the amounts outlined in provincial fee schedules
- anything normally covered by a publicly funded program

Additional Information

The Plan may request additional information and/or documentation necessary to administer the Plan.

HOW THE HOUR BANK WORKS

Think of the Hour Bank as a regular bank account with deposits and withdrawals. Each month, the participating employer reports your previous month's Hours of Covered Employment to the Plan Office. It is your responsibility to make sure the employer reports the correct hours so be sure to keep your own record of your hours worked.

You must accumulate at least 300 hours in your Hour Bank (reported and paid for by a participating employer) over a period of no more than six consecutive months to initiate your coverage.

An example of how hours are reported and applied is as follows:

If you work in April, hours are paid for and received from the participating employer in May and would be utilized for coverage commencing in June.

The following chart provides the Eligibility Date for each month of the year:

ELIGIBILITY EFFECTIVE DATES

If you worked in the month of:	Hours are reported and paid in the month of:	If your Hour Bank has reached the eligibility amount*, then your coverage will begin on:
January	February	March 1st
February	March	April 1st
March	April	May 1st
April	May	June 1st
May	June	July 1st
June	July	August 1st
July	August	September 1st
August	September	October 1st
September	October	November 1st
October	November	December 1st
November	December	January 1st of the following year
December	January of the following year	February 1st of the following year

*Currently 300 hours for a new member or if coverage has lapsed for 4 consecutive months or more.

In addition to the requirements indicated in the table from the previous page, you must also be a member in Good Standing with Local Union 1325, 2103 or 2010, or are employed by a Participating Employer.

Hours worked when suspended **cannot** be credited to your Hour Bank.

In the event you receive a lump-sum payment for Shortened Life Expectancy under the ACAW Pension Plan, any hours of covered employment beyond 2 years from the payment date **cannot** be credited to your Hour Bank.

The Plan Office will send you a letter confirming your coverage after you become eligible. Wait until you have received this letter or have your eligibility confirmed by phoning the Plan Office before you incur expenses that you want to have reviewed for reimbursement from the Plan.

After you become eligible for benefits, 130 hours are withdrawn from your Hour Bank each month, including months in which you do not make a claim.

Your Hour Bank can contain up to 780 banked hours – six months' eligibility – that is used to maintain your eligibility for benefits during periods of unemployment, illness or vacation.

You'll be notified by mail if you don't have enough hours to maintain eligibility for at least another month. It is the sole responsibility of the Member to keep the Union updated with a current mailing address.

Self Payments to Maintain Coverage

You can maintain your coverage though the Plan's Self Payment provision. You will be notified by mail if you are eligible to maintain your coverage by Self Payments for up to six consecutive months. Rates are based on the current contribution rates.

There are strict policies on when Self Payments are due. Your first Self Payment is due approximately 30 days after the date you were last eligible. **Each subsequent consecutive Self Payment must be received on or before the first day of the month for which it is required to continue your coverage.** For example, if your coverage ceased April 30th, you have until June 1st to make your Self Payment (coverage will lapse until payment is processed). Please note that at that time two months of Self Payment will be due (May and June). If you miss making any one of the six consecutive Self Payments, you **cannot** make any additional remaining Self Payments.

Maintaining your coverage through Self Payments provides you with no break in benefits, including life insurance. They will also extend how long any hours remaining in your Hour Bank will remain available for use. Within a four month period your coverage can be reinstated if sufficient hours are reported to increase your Hour Bank to the minimum 130 requirement. If your coverage lapses for 4 consecutive months or more, you must complete the requirements for a "new" member (see previous page).

A dedicated phone line (Option #3) is now available for taking Self Payments. If your call was not answered, your voice message will be accepted – as long as you are eligible and it was received by the date your Self Payment was due.

Extended Benefits and How It Works

Extended benefit coverage (excluding weekly disability benefits) may be available for a Member who:

- is age 65 or older on or after January 1, 2015, and
- is a Member of Carpenters Local Union 1325, 2103, or 2010, or a Member of a Participating Employer, and
- is eligible under the ACAW Health & Wellness Plan, and
- has exhausted all Hour Bank hours, and
- has waived **or** exhausted his Self Payments, and
- has never previously received any extended coverage.

If **all** the above requirements are satisfied, a Member **may** be eligible for up to 6 months of ACAW Health & Wellness Plan benefits at no cost.

If you qualify, extended benefits are automatically initiated following termination of Hour Bank or Self Payments.

This extended coverage applies on a one-time basis. It will cease prior to the 6 month limit, if the Member returns to work or is no longer a Member of Carpenters Local Union 1325, 2103, or 2010, or a Member of a Participating Employer, or upon the Member's death.

It does not apply on any subsequent re-employment.

ELIGIBLE DEPENDENTS

You must list your eligible dependents on a form available from the Plan Office. Your spouse and dependent children as defined by the Plan are eligible for benefits when you become eligible and only after the Plan Office receives your written notification.

Spouse

"Spouse" means a person who at the relevant time:

(a) is married to the Member and has not been living separate and apart from that Member for a continuous period of longer than 3 years, or,

(b) if there is no person in (a), a person who, preceding the relevant time, had lived with the Member in a marriage-like relationship:

(i) for a continuous period of at least 3 years preceding the relevant time, or

(ii) of some permanence, if there is a child of the relationship by birth or adoption.

It is the Member's responsibility to make or change the declaration of a Spouse by filing the appropriate signed form with the Plan office.

Only one Spouse can qualify for benefits at a time. For clarity, any declaration of a Spouse **cannot** be backdated to a date that is earlier than the latest claim of any prior Spouse.

If a Member has a Spouse with respect to his membership in the ACAW Health & Wellness Plan, then this same person will be his Spouse with respect to his membership in the ACAW Pension Plan if it meets the definition of Pension Partner/Spouse as defined in the ACAW Pension Plan.

Dependent Children

"Child" of a Member means:

- an **unmarried** natural, or legally adopted child, a stepchild or a child where custody is granted by Court Order, who reside in Canada and is:
  (a) less than 19 years of age, or
  (b) at least 19 years of age but less than 25 years of age and is in full-time attendance at a recognized school or university, or
  (c) of any age, if he/she is unable to perform the required functions of independent living due to a permanent physical or mental impairment provided such impairment was in effect at the time he/she otherwise satisfied either (a) or (b) above.
- Child also includes an unmarried child of the Spouse.
- A Child of a common-law Spouse is considered to be a Dependent if the Child meets the above requirements and resides with the Member.
- The Member must provide the Plan with a *Court Order* which confirms the Member has custody and guardianship of a Child. The Member must also sign an agreement with the Plan which requires the Member to inform the Plan of all changes to the *Court Order*. The Plan will reserve the right to obtain this information and any other necessary documentation from the Member on an annual basis, or upon request.

You'll need to provide proof of age and status (e.g. full-time student) to confirm your dependents eligibility after age 19. Benefits will not be paid until the Plan Office receives this information.

Change in the Status of Dependents

Your dependents are not eligible for benefits when they no longer meet the definition of eligible dependents. If you divorce or separate, or if your child's status changes (because of leaving school, marriage, or exceeding the qualifying age), you must fill out a form and send it to the Plan Office. A dependent child who reaches age 19 is automatically removed from your benefits unless proof of school attendance or disability is provided.

Ongoing Benefits for Dependents if You Die

If you die while you are a member of the Plan, coverage continues for your eligible dependents for at least three months following the month you die or until there are less than 130 hours in your Hour Bank, whichever is later. Your spouse and/or dependent children must be listed in order to be covered under your Plan.

Forms to list your dependents and/or name a beneficiary will be sent to you when the Plan first receives hours reported and paid for on your behalf by a participating employer.

It is the sole responsibility of the Member to list eligible dependents and a spouse, if applicable. As well, it is the sole responsibility of the Member to designate their beneficiary(ies) for their life insurance. If you do not designate a beneficiary, benefits will be payable to your estate.

MAKING CLAIMS

A single form is now all that is required to claim for you, your spouse and dependent children. This claim form, with instructions for submitting your claim, is available on our website at **www.acawtrustfunds.ca** or by contacting the Plan Office.

If your health care provider asks you for a contract or ID number, explain that the Plan is self-funded so there is no contract or ID number. If a contract number is required, use your Union Local number. If a personal ID number is required, use your Union ID number.

Medical expenses related to a work injury covered by Workers' Compensation are not covered by the Supplementary Health Care Plan. Submit the claim for these expenses directly to the WCB for reimbursement. Some pharmacies will also bill the WCB directly.

Deadlines for Submitting Claims to the Plan Office

- Supplementary Health Care and Dental claims – Claims must be received by the Plan Office within one year of the date the expense was incurred.
- Weekly Disability claims – Claims must be received by the Plan Office within 15 days of your injury or start of your illness.

Processing and Paying Claims

When you submit your claim, please allow at least four weeks for processing and payment. Periods of high claims volume and holidays can require longer processing time. Your patience and consideration are appreciated.

You can avoid delays and help us to better serve you by:

- ensuring forms contain all of the required information, including the **member's** signature
- submitting fewer receipts at one-time (five receipts can be processed more quickly than 25 receipts)

Direct billing by service providers has been limited to **Dental, Drugs, Ambulance** and **Hospital Room Charges. ALL MEMBERS WILL BE REQUIRED TO FIRST MAKE PAYMENT TO ALL OTHER SERVICE PROVIDERS** and then submit their claims to the ACAW Trust Funds office. Direct billing by service providers that are not listed above will not be paid. There will be no exceptions to this notice.

The Plan will only pay reasonable and customary charges for services and supplies provided.

If a payment is lost or destroyed, you can request a replacement cheque by submitting a *Lost Cheque Statement*. Before a replacement can be issued, the Plan Office must verify that the original cheque has not been cashed, which takes at least 90 days. If found, you must return the uncashed "lost" cheque to the Plan Office.

Proof of Payment

Receipts where payment is showing as "cash" are not always an acceptable form of payment. When processing claims we will request a valid traceable and identifiable confirmation of payment.

This means you will need to submit a copy of your payment transaction with your claim to confirm the claim was paid in full. We recommend you keep a copy of some other

identifiable payment confirmation, such as a cancelled cheque (copy is acceptable if both sides of the cheque are provided), an authorized electronic credit card receipt and/or credit card statement, direct payment/debit receipt or bank statements.

Note: Any information on a credit card or bank statement that does not pertain to the claim awaiting payment may be omitted.

Coordinating Benefits – Making a Claim Under More Than One Plan

If your spouse has health and/or dental benefits, you can coordinate coverage from both plans.

- If the claim is for you, submit the claim to the ACAW Health & Wellness Plan first. If there is an unpaid amount, you can submit it to your spouse's plan.
- If the claim is for your spouse, they should submit it to their plan first. If there is an unpaid amount after your spouse's plan has paid, you can submit it to the ACAW Health & Wellness Plan. You must submit a copy of the receipt and EOB from the other plan with your claim form to the ACAW Plan Office.
- If the claim is for dependent children, submit it first to the plan of the parent whose birthday (month and day) falls earliest in the calendar year. So if your birthday is October 1st and your spouse's birthday is June 5th, claim it under your spouse's plan first. If both parents have the same date of birth, claims should be sent to the plan of the parent whose name begins with the earlier letter of the alphabet. You must submit a copy of the EOB from the other plan with your claim form to the ACAW Plan Office.

Coordination of Benefits – Both Members of the ACAW Health & Wellness Plan

If you and your spouse are both members of the ACAW Health & Wellness Plan, you can coordinate benefits within our Plan and each receive up to 100% reimbursement.

The guidelines for coordinating benefits as outlined above apply also to spouses who are both eligible members of the Plan. The member who incurred the expense must submit and receive payment first. Then the other member can submit a claim for the balance payable. A completed claim form, EOB, and copies of receipts are required. **Receipts will not be returned by the Plan Office.** For more information on coordinating benefits within the Plan, call the Plan Office.

Making a False Claim

If you submit a false or misleading claim to the Plan, the Trustees can reject the claim, cancel your Hour Bank, cancel your eligibility for benefits and recover any benefits that you obtained fraudulently.

If You Recover Costs from a Third Party (Subrogation)

You must tell the Plan Office if you will be making a claim against a third party (for example from an insurance company to cover costs related to an automobile accident injury). To become eligible for weekly disability benefits, you must complete and sign a *Subrogation Reimbursement Agreement* in which you agree to reimburse the Plan for weekly disability payments and other expenses related to the accident, if you receive any compensation from a third party.

You must obtain the written consent of the Trustees before you settle a claim against a third party. If you do not obtain the consent of the Trustees, you will not be eligible for future benefits under the Plan. You are responsible for all legal fees.

Residing Outside of Alberta

If a member or eligible dependent resides outside of Alberta, the member or dependent will be reimbursed to the extent that they would have been had such member or dependent been a resident of Alberta and the services performed or received in Alberta.

SUPPLEMENTARY HEALTH CARE

Supplementary health care helps make a wide range of health care products and services more affordable and accessible for members and their families. The benefit provides assistance to cover part of the costs of services and items not covered by provincial health care.

There is an overall per person lifetime maximum of $10,000 for Ambulance and Hospital services and $20,000 for Medical Benefits.

SUPPLEMENTARY HEALTH CARE AT A GLANCE

Item	Coverage	Maximums
Prescription Drugs	90%	$15,000 per family per year*
Smoking Cessation Products	90%	$400 per person every three-year period
Ambulance and Hospital – ward and semi-private accommodation	100%	**Lifetime maximum $10,000 per person****
Vision	100%	$95 per 24-month period for an eye exam (age limits apply) $500 per 24-month period for adults $250 per 12-month period for children under 19
Hearing Aids	100%	$2,000 per person once every four-year period
Medical Benefits		**Lifetime maximum $20,000 per person**
Paramedical Practitioners (See **Page 14**)	90%	$900 per person (ages 16 and up), per practitioner per year*
Speech Therapist	90%	$1,500 per person per year*
Acupuncturist	90%	$320 per person per year*
Private Nurse	90%	$5,300 per person every three-year period
Other Medical Equipment, Supplies and Services	90%	Some specific maximums apply – see details
Mental Health Service Professionals	100%	$1,500 per person, per calendar year

*Year = calendar year **Coverage subject to Alberta provincial fee schedule

Some specific maximums apply. Phone the Plan Office for more details.

Details of Your Supplementary Health Coverage

Prescription Drugs

Supplementary health provides 90% coverage for prescription drugs and medicines that require a written prescription from a qualified physician or dentist. The Plan covers a 100-day supply at one time. If your official prescription receipt does not provide details of the daily dosage or number of days supply, please obtain this information in writing from your pharmacy, qualified physician or dentist.

Smoking Cessation Products

The Plan provides 90% coverage for medication and some products designed to help you quit smoking. Although these products may not require a prescription, they will only be reimbursed if you provide a written recommendation from a qualified physician along with your claim. Reimbursement is to a maximum of $400 for one course of treatment every three-year period. A course of treatment is three months from the date of purchase of the nicotine patch or eight months from the date of the first purchase of nicotine gum.

Epipen

The Plan covers the cost of an Epipen (an auto-injection device used to treat anaphylactic shock by persons with severe allergies) with a limit of two per eligible person every 12 months to a maximum of four per family (Member and Dependent in total) per year.

Lifestyle Drugs

The Plan covers the cost of drugs for the treatment of erectile dysfunction, limited to a maximum of $140 per month.

The Plan covers feminine contraceptives with the written prescription of a Qualified Physician subject to a maximum of $500 per family (Member and Dependent in total) per year (Subject to 100-day supply limit, per person).

Amounts paid for Lifestyle drugs are part of your Annual maximum for drugs and medicines.

Ambulance and Hospital**

After provincial health care has paid its share, the Plan provides 100% coverage (to a lifetime maximum of $10,000 per person) for:

- transportation by ambulance to the nearest hospital where satisfactory treatment can be provided
- response call in event of a death
- ward or semi-private room and board
- up to 120 days of chronic and convalescent hospital care ordered by a qualified physician after at least five days of hospitalization
- other necessary hospital charges (including maternity)

**Coverage subject to Alberta provincial fee schedule

Vision Care

The Plan provides coverage for:

- eye exams, including contact lens exams, for members and dependents between ages 19 and 64 (maximum of $95 once every 24 months). In Alberta, eye exams for residents under age 19 and over age of 65 are covered by provincial health care.
- For adults aged 19 and up the purchase of glasses (lenses and frames), contact lenses or laser surgery prescribed by an ophthalmologist or optometrist to a maximum of $500, during a 24-month period.

- For a child up to and including age 18 for the purchase of glasses (lenses and frames), contact lenses or laser surgery prescribed by an ophthalmologist or optometrist to a maximum of $250, during a 12-month period.

Hearing Aids

The Plan provides coverage for hearing aids, to a maximum of $2,000 per person once every four-year period. There are specific requirements to be met to qualify for this benefit. This must be prescribed by an ear, nose and throat specialist or an audiologist. Please contact the Plan Office for more information.

- The Plan covers a hearing exam up to a maximum of $150 per person once every four years.

Medical Benefits

Supplementary medical benefits are designed to ensure you receive the treatment and assistance you need to stay healthy and mobile and to treat chronic conditions. The Plan provides reimbursement of up to 90% (to a lifetime maximum of $20,000 per eligible family member) for eligible expenses. **Additional maximums and limitations apply to various benefits as described on the following pages.** Where indicated, the qualified physician referral is required *prior* to incurring the expense.

Paramedical Practitioners

The Plan provides 90% coverage for the services of paramedical practitioners licensed in Canada up to the following maximums:

- $900 per person (ages 16 and up) per practitioner, per calendar year for the services of:
  - physiotherapist
  - chiropractor
  - certified athletic therapist
  - naturopath
  - podiatrist
  - licensed massage therapist

  Note: Valid practitioners license number(s) will be required. Such services **cannot** be provided by a Related Person.
- $320 per person per calendar year for the services of an acupuncturist
- $1,500 per person, per calendar year for the services of a licensed speech therapist

Other Medical Equipment, Supplies and Services

The Plan provides some coverage (some specific **maximums apply**) for the following equipment supplies and services:

- anaesthetic, oxygen and their administration (except for oral surgery)
- rental of equipment such as personal mobility aids (wheelchair/scooter), hospital beds, iron lungs, and oxygen or respiratory set ups (other than CPAP machines)
  - in lieu of such rental, in some cases the Plan Office may approve a one-time purchase not to exceed $1,500 per person
  - if a purchase is approved and paid, no benefits shall be payable for rental fees if required in the future
- splints, trusses, braces, crutches, casts and cervical pillows*
- walkers and canes to a maximum of $150 per person per calendar year
- surgical support stockings (minimum thickness 20 mm) for ages 19 and up, when prescribed by a qualified physician (limit of 2 pairs to a maximum of $300 per person per calendar year)*
- artificial limbs and eyes

*Reasonable and customary charge

- custom orthotics for ages 16 and up subject to a limit of $350 per pair with the total not to exceed $700 per calender year per person, when recommended by a Physician or podiatrist in Canada (must include the medical diagnosis for which the custom orthotic is being prescribed)
- orthopedic shoes must be custom made from raw materials using an impression of the foot, or therapeutic footwear that has been permanently modified, (excluding sandals and running shoes), or orthopedic boots when accompanied by a leg brace. A prescription is required from a Physician or podiatrist and must include the medical diagnosis for which the shoe or boot is being prescribed. In the case of shoes, details of the manufacturing process or the permanent modification must be provided. These will be covered at 90% subject to a limit of $500 per person per calendar year.
- breast prosthesis or other prosthetic appliance required to replace the natural parts of the body which are lost
- wigs when required as a result of a medical condition and on the recommendation of a Physician to a lifetime maximum of $1,000
- x-ray, radium and radioactive isotope treatment
- syringes, lancets, one-touch strips, gel singles, chemstrips, and when recommended by a physician, a blood testing monitor (with the blood testing monitor limited to $160 every five-year period)
- syringes for other injectable medications when recommended by a qualified physician
- sensors for Glucose Monitoring Systems when supported by a Physician recommendation – maximum of $125 per month
- purchase of a device for the treatment of Sleep Apnea to a maximum of $1,500 per person on the first purchase and a maximum of $1,000 per person on subsequent purchases, limited to one purchase in any 5-year period (must be accompanied by a recommendation by a Physician)
- the cost of accessories for a device for the treatment of sleep apnea to a maximum of $150 per person per calendar year
- the services of a registered or licensed nurse (**cannot** be a Related Person or a person living with you), when prescribed by a qualified physician, up to a maximum of $5,300 per person every three-year period
- the cost of a blood pressure monitor is limited to a maximum of $100 every two years
- the cost of an asthma nebulizer or aero chamber to a maximum of $50 per person per calendar year
- supplies required to prevent infection for driveline insertion sites associated with LVAD (Left Ventricular Assist Device) subject to a maximum of $125 per month

Mental Health Service Professionals

The Plan provides 100% coverage for eligible psychology and psychiatry services incurred in Canada to a maximum of $1,500 per person per calendar year. Eligible services must be provided by a clinical psychologist, or a psychiatrist licensed as a medical doctor specializing in mental health disorders, registered with their respective College, and licensed to practice in Canada.

Note: The Plan does not provide coverage for services incurred in a hospital or for services covered under a provincial healthcare plan or similar government health plan. Respective College registration can be confirmed on your local provincial website.

Surgical Procedures, Viscosupplements and Medical Devices – Member Only

The Plan could provide coverage for surgery at a private clinic if you can show that the wait for surgery through public facilities is more than six months and that the private surgery will let you return to work sooner. The private facility must be licensed, the physician must be legally qualified and the procedure must be for whatever is preventing you from returning to work. **Approval is required before you incur the expense.** If approved, coverage is at 80%. Contact the Plan Office for full details on how to apply and receive approval.

Viscosupplement injections provided by a Physician covered at 80% to a maximum of $500 per course of treatment every 8 months. Physician fees are not covered.

The Plan will cover at 80% a Cold Therapy Unit, including pads, to a maximum of $500 every 5 years. Physician fees are not covered. The Cold Therapy Unit must be prescribed by a Physician. This benefit is not provided for Dependents.

Surgical Procedures and Viscosupplement Injections are not covered for Dependents. Amounts paid are included in the Lifetime Maximum of $20,000 per person for Supplementary Medical.

What's Not Covered (including but not limited to)

The Plan only covers expenses that you and/or your dependents incur while you are eligible for benefits. If an expense is eligible for payment under a government hospital plan, a government health plan, or any other government, public or tax-sponsored plan, you must use the coverage available through the publicly funded plan first.

Medical expenses such as prescription drugs and supplies (casts, dressings, etc.) associated with an injury covered by Workers' Compensation are not covered by Supplementary Health Care. Submit the claim for these expenses directly to the WCB for reimbursement.

Supplementary Health Care does not cover:

- charges resulting from your failure to make a claim under any plan
- fees that a qualified physician charges for a service that are over and above the amounts paid to the qualified physician by the provincial health care for that service
- specialist fees that are refused by the provincial medical insurance plan
- custodial care
- plastic or other surgery (including circumcision) and the resulting hospital confinement or other services if the surgery is not necessary to correct deformities from illness, injury or congenital defects that interfere with normal function
- a single purchase of medication that exceeds a 100-day supply
- charges by a professional ambulance service for responding to a call that does not require transportation to hospital except in the event of death
- sunglasses, tinted glasses or anti-reflective coatings
- charges incurred outside of Canada
- any purchase of medical marijuana products after December 31, 2014
- any methadone products or related drugs in excess of 1 year from original purchase
- services and supplies which are not necessary for treatment of the injury or disease or are not recommended and approved by the attending Physician or which are unreasonable.

- services provided without cost or at a nominal cost by public authorities
- any charge which is in excess of the normal charge for services provided
- charges incurred more than one year prior to the date that the claim is received
- deterrent fees required under any provincial medical insurance or hospital plan
- confinement in a Hospital or institution for drug addicts or alcoholics, a tuberculosis Hospital or sanatorium, a Hospital or institution for mentally ill, or a nursing home, home for the aged, infirmary or other institution, the purpose of which is to provide custodial care
- orthopedic sandals or running shoes

Reimbursement from Another Source

If you receive a payment from the Plan for an expense that you didn't pay for or for which you are reimbursed by another source, you must refund the payment to the Plan. Such fraudulent or illegal behaviour will jeopardize your coverage for benefits.

DENTAL

The Dental benefit helps you and your eligible family members maintain healthy gums and teeth by reimbursing all or part of the cost of basic, major and orthodontic dental treatments. Payment is made according to the ACAW Dental Fee Guide.

DENTAL BENEFITS AT A GLANCE

Treatment	Payment under the ACAW Fee Guide
Basic Oral exams, x-rays, cleanings, fillings	
Major Services Crowns, bridges, new dentures, root canals, periodontics (treatment of gum disease)	Subject to Basic/Major Maximums
Basic and Major Maximum	$4,250 per person per calendar year
Orthodontic Services Only for eligible dependent children age 6 to age 18 when treatment starts	Lifetime maximum $3,500 per child

Understanding the ACAW Dental Fee Guide

The ACAW Dental Fee Guide is a guideline, approved by the Trustees and amended from time to time, of the maximum amounts the Plan will cover for the dental procedures approved. The ACAW Dental Fee Guide is based on reasonable and necessary charges for a wide range of dental treatments and services. *Reasonable and necessary* refers to the number and type of procedures that are consistent with the requirements of good dental health.

The Plan reimburses the least expensive procedure consistent with good dental care. If you choose to have a more expensive treatment, you are responsible for the difference in cost.

Dentists set their own fees which may be different from the fees in the ACAW Dental Fee Guide. It is important to discuss the cost with your dentist before you have a treatment as you are responsible for paying any amount above the Fee Guide payment. The *Frequently Used Dental Procedure Codes* information sheet is available from our website at **www.acawtrustfunds.ca** or from the Plan Office.

Treatment Plans

A treatment plan (pre-authorization) is a written estimate outlining the cost of a course of treatment. Although a treatment plan is not required for benefits to be paid, it does show you how much the Plan will pay for a specific dental procedure before you start a course of treatment and is strongly recommended for any major dental work.

DETAILS OF YOUR DENTAL COVERAGE

Basic and Major Eligible Expenses

The Dental benefit covers the following expenses, paid according to the ACAW Dental Fee Guide, to a maximum of $4,250 per person per calendar year:

- a routine dental exam, cleaning, polishing, fluoride treatments and up to four bite wing x-rays every nine months
- a complete oral exam every two-year period
- a full mouth x-ray every three-year period
- as you need them:
  - extractions including surgical extraction of impacted teeth and preparation of dental bridges for prosthetics
  - fillings and stainless steel crowns
  - space maintainers and habit breaking appliances
  - surgical removal of growths and incision and drainage of abscesses
  - pain relief medication
  - antibiotics
  - repair or re-cementing of crowns, inlays, bridgework, or dentures
  - general anaesthetic for oral surgery
  - crowns, inlays, onlays and gold fillings
  - dental implants
  - fixed bridgework including posts and cores
  - prefabricated veneers, only if the tooth **cannot** be reconstructed in any other way
  - periodontic scaling, including root planing (up to a combined maximum of 16 units per calendar year)
  - root canals and other endodontic treatments

- full dentures or partial removable dentures are provided per person per calendar year, subject to ACAW Dental Fee Guide and the Basic/Major maximum amount per calendar year
- appliances, intraoral, to treat medically diagnosed obstructive sleep apnea, limited to once every two years (a physician recommendation is required)

Orthodontic Eligible Expenses

The Dental benefit provides some coverage for braces and treatments to realign teeth for your eligible dependent children who are age six up to and including age 18 when treatment begins. Expenses are paid according to the ACAW Dental Fee Guide to a lifetime maximum of $3,500 per child. Monthly fees for orthodontic adjustments will continue to be covered past age 18 if the child(ren) continue to qualify as a dependent.

What's Not Covered Under Dental Care

The Dental benefit does not cover treatments that started before you or your dependents were eligible for benefits. A treatment is considered to have started when an impression is taken for full or partial dentures, when a tooth is prepared for fixed bridgework, crowns and other gold restorations or when a tooth is opened for a root canal.

The Dental benefit does not cover:

- general anaesthetic for anything other than oral surgery, periodontics, fractures or dislocations
- cosmetic procedures
- a procedure performed by any individual who is not a qualified physician, dentist, or dental auxiliary
- crowns and bonded fillings other than those covered by basic or major treatments
- training in and supplies for personal care hygiene, or dietary or nutritional counselling
- anything covered by a government hospital plan, health plan or any other publicly funded or tax supported plan
- expenses you wouldn't be required to pay without a plan
- charges for broken appointments
- charges for completion of claim forms
- charges for orthodontic retention appliances
- expenses incurred more than one year before the Plan Office receives the claim

If you become ineligible for benefits, coverage for some services may continue for up to 60 additional days for treatments started while you were eligible. These treatments include fixed bridgework or crowns where the tooth was already prepared (120 days for fixed bridgework or crown on implant provided a post has been inserted); complete and partial dentures where the impression was already taken; root canal therapy where the tooth was opened and for orthodontic treatment when the braces have been placed or the teeth prepared for placement.

WEEKLY DISABILITY

The Weekly Disability benefit helps protect you and your family by providing a weekly payment of $550 (less applicable Income Tax) for up to 26 weeks if you are unable to work as a result of illness or a non-work related injury.

Eligibility

To be eligible for Weekly Disability, you must be under the continuing, full-time care of a qualified physician and you **cannot** be receiving a retirement pension. You are not eligible if you are receiving disability benefits from Workers' Compensation, even if your illness or injury is not related to those benefits. If you have already received the maximum 26 weeks of disability payments within a 24-month period for an illness claim, you are not eligible to receive weekly disability payments again during the same 24-month period. You must be eligible and maintain eligibility under the ACAW Health & Wellness Plan to be eligible for Weekly Disability.

Applying for Weekly Disability Benefits

Visit our website at **www.acawtrustfunds.ca** or contact the Plan Office to obtain the Weekly Disability benefit claim submission package. All forms must be fully completed. The subrogation information states that you will repay any amounts you receive from the Plan that you subsequently recover from a third party. You and your qualified physician must complete these forms and submit them to the Plan Office before your disability claim can be processed.

You must submit your claim promptly. If the Plan Office does not receive your claim within **15 days** of the illness or injury, you will not be eligible for benefits until after you have received the maximum benefits payable from Employment Insurance (EI) Sickness Benefits.

When Payments Begin and End

Payments are payable from the first day of a disability resulting from a non-work-related injury which requires immediate medical attention, and the 8th day of disability resulting from illness. Payments are assessed initially for two weeks.

If you are still unable to work after two weeks, you must apply for EI Sickness Benefits and exhaust those benefits before you can apply for Weekly Disability benefits or reactivate your claim.

If you do not qualify for EI Sickness Benefits, or if you have received the maximum EI Sickness Benefits, you can receive the remainder of the 26 week maximum of Weekly Disability payments. You must provide the Plan Office with a letter from EI stating that you do not qualify for EI Sickness Benefits. If you have received the maximum EI Sickness Benefit, the letter must identify when those benefits started and ended.

Weekly Disability benefits end when you:

- are no longer disabled,
- start to receive a retirement pension, including any lump-sum payment for Shortened Life Expectancy, or
- have received the maximum 26 weeks of payments.

Required Medical Reports

Your initial medical examination must be done in Canada, and you will be asked to provide periodic progress reports. You may be assessed by the Plan's Medical Consultant.

You are responsible for any costs involved in having your qualified physician or specialist fill out the forms. To save money and reduce the need for frequent visits, make sure your physician completes all the sections of the form and provides as much detail as possible, including a date for your expected return to work.

Maintaining Plan Health & Wellness Benefits During Disability

Freezing of Hours

Whenever an eligible Member is disabled and is receiving benefit payments for at least two consecutive weeks in any calendar month from the ACAW Weekly Disability, or ACAW Pension Plan Disability Pension, no deductions will be made from his/her Hour Bank for that month. In other words, his/her Hour Bank will be "frozen". You must be a member in "Goodstanding" with the Union to have your Hour Bank frozen.

Your Hour Bank may also be frozen if you are receiving benefit payments for at least two consecutive weeks in any calendar month from any of the following:

- Sickness benefits from the *Employment Insurance Act*
- Disability benefits from *Workers Compensation Act*
- Privately retained disability insurance
- Canada Pension Plan (CPP) Disability

If you received disability benefit payments from any of the above organizations, you must notify the ACAW Health & Wellness Plan.

In order for your Hour Bank to be frozen you must provide the following documentation you have received from the above organization(s):

- Start date of the benefit
- Period of time (start and end date) you were in receipt of such benefit.

In the event you qualify and receive monies for a **permanent disability** your hour bank may be frozen for an extended period of time. Please contact the Plan Office for additional details if you are applying for or receiving monies for a **permanent disability**.

Freezing of Hours will stop earlier if:

- You cease to be a member of the Plan
- You cease to be disabled
- You return to work
- You pass away

Notwithstanding the above, the Plan also has age restrictions on how long a member can receive freezing of hours. Please contact the Plan Office for more details.

A New or Continuing Disability

If you receive Weekly Disability payments and then return to work, and you become disabled again for the same or related reasons, your disability payments will start immediately as long as you have a balance remaining from your previous benefit period, and they will continue until you've used up your 26-week maximum.

A disability is considered new and is eligible for a new 26-week period of weekly disability benefits only if:

- you return to work for a participating employer or are available for active full-time employment at your regular work for at least three working days, and your disability is not connected to your previous disability, and
- you return to work for a participating employer and have had at least 130 hours of confirmed employment within six months of your last disability payment, and
- you recovered from the disability and the subsequent disability is not connected to any previous disability for which a claim has been made within a 24-month period.

You must provide the Plan with written certification from your qualified physician indicating the date you are able to return to your regular work following a period of disability. If you return to work and the Plan has not received your qualified physician's written approval, and you experience another disability that prevents you from working, this disability may not be considered a new one for the purpose of the Weekly Disability benefit.

If a subsequent disability is considered to be a new disability, a new claim form signed by the Physician must be submitted.

If you receive Weekly Disability benefits for a condition that is subsequently deemed to permanently prevent you from ever working in your pre-disability occupation and you choose to return to work, you will not be eligible for further benefits for a disability that is related to that condition. The Plan has the right to deny any claim which is deemed to be connected to a prior disability and coverage has been provided for 26 weeks.

If You Receive Canada Pension Plan Disability Income

If your disability continues for longer than three months, you must apply for the Canada Pension Plan (CPP) disability pension. The CPP disability pension may be retroactive to the date you became disabled. If you are approved for a CPP disability pension, you must reimburse the Plan for any weekly disability payments you received up to the amount of CPP benefits paid for the same period. You must provide information to the Plan Office on the status of your CPP application until a decision is reached, and then provide a copy of your CPP *Notice of Entitlement*.

When Weekly Disability Benefits are Not Paid

Weekly disability payments are not paid when:

- benefits are available through the *Worker's Compensation Act* or an equivalent law; and/or
- the disability is self inflicted.

You are not eligible for benefits if:

- you are receiving a retirement pension;
- you are receiving disability benefits from Workers' Compensation, even if your illness or injury is not related to those benefits; and/or
- you are not eligible at time disability occurs.

If you have already received the maximum 26 weeks of disability payments within a 24-month period, you **cannot** receive further benefits during that period.

Taxation

Weekly Disability benefits are taxable. Taxes will be deducted from your weekly payments and a T4A will be issued at the end of the year.

LIFE INSURANCE

The ACAW Plan provides basic life insurance for you and your spouse and children. You also have the option to purchase additional life insurance.

Basic Life Insurance

Basic life insurance consists of:

- $150,000 of member life insurance
- $30,000 of spouse life insurance
- $5,000 of dependent child life insurance (covers each dependent child)

You must list your spouse and dependent children on your benefits with a form (available from the Plan Office) to have them covered under basic life insurance. If they are not listed, a benefit will not be paid to you if they die.

Optional Life Insurance

If you are under the age of 65, you can purchase additional group life insurance for yourself or your spouse, up to a maximum of $500,000. The cost for group life insurance is generally lower than the cost for life insurance that is not provided under a group plan. Contact the Plan Office for more information about purchasing additional life insurance.

Naming a Beneficiary

You name a beneficiary for basic and any optional life insurance using a form that is available from the Plan Office. It is the sole responsibility of the Member to designate their beneficiary(ies) for their life insurance. If you fail to name a beneficiary, benefits will be payable to your estate.

Continuing Life Insurance Coverage When You Leave the Plan

If you are no longer eligible for benefits under the ACAW Health & Wellness Plan, you can apply for an individual life insurance policy for yourself and your spouse up to the amount of your coverage under the Plan without providing evidence of good health to the insurance company. You must submit an application to the insurer for this insurance within 31 days after your eligibility for benefits ends. The cost of the life insurance is based on your age and the type of policy you purchase, and is solely managed by the life insurance carrier.

Funeral or Burial Benefit

If you die while you are a Plan member in good standing of Local Union 1325, 2103 or 2010, and you do not have life insurance coverage under the ACAW Health & Wellness Plan, your survivors are eligible for a funeral or burial benefit equal to the cost of the funeral/burial to a maximum of $5,000. Your eligibility for this benefit ends when you turn 65 or 12 months after you start receiving a retirement pension. The person who pays the funeral or burial expenses is entitled to file a claim for this benefit by completing an application, which is available from the Plan Office. The application outlines all information needed to receive this benefit, including which costs are covered.

Making a Life Insurance Claim

If an individual covered by the life insurance benefit dies, you or your beneficiary must complete the life insurance provider's claim form that is available from the Plan Office. The claim form outlines the necessary information and requirements and the Plan Office can help with the completion of the form.

When a death occurs, notify the Plan Office as soon as possible.

NOTES

It is the sole responsibility of the Member to list eligible dependents and a spouse, if applicable. As well, it is the sole responsibility of the Member to designate their beneficiary(ies) for their life insurance.

Life is full of changes. Upon the birth of a child or if your marital status changes, you should notify the Plan Office and we will provide you with a form to complete. It is your responsibility to ensure that your records are up to date.

Keeping your beneficiary information up to date will ensure that life insurance benefits will be payable to the person of your choice, should you die unexpectedly.

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Health & Wellness Plan Office

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