teibas
TORONTO ELECTRICAL INDUSTRY
BENEFIT ADMINISTRATION SERVICES

IBEW LOCAL 353
PENSION & BENEFIT PLANS

05|24

IBEW Local 353

Benefit Plan

protecting **your** future

Questions? Contact us. We're here to help.

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About This Booklet

This booklet describes the IBEW Local 353 Benefit Plan in plain language. It is not an official plan document. If there is a difference between the information contained here and in the official plan documents, the official documents will apply.

The Trustees expect to maintain this plan indefinitely. However, they reserve the right to change or cancel any or all of the benefits described in these pages at any time.

The benefit coverage explained in this booklet is subject to a number of exceptions, set out in the official plan documents. For example, the official plan documents state that coverage is not provided for claims that arise from criminal acts, self-inflicted injuries, or injuries as a result of war (whether declared or not). For more information about exclusions, call TEIBAS or Canada Life.

About TEIBAS

The Toronto Electrical Industry Benefit Administration Services Limited (TEIBAS Ltd.) was founded in 1990 to administer the group benefit and pension plans and provide services to you, the members of the International Brotherhood of Electrical Workers (IBEW) Local 353.

We are owned by the IBEW Local 353 Trust Funds. We act on behalf of the Board of Trustees to effectively and efficiently administer the IBEW Local 353 Trust Funds and strive to be a trusted source of information and services to our stakeholders.

PRIVACY POLICY

It's impossible to administer your benefits without using personal information. However, the Trustees are committed to protecting your privacy and have strict safeguards in place to protect your information from unauthorized access or use.

Use and disclosure of your information is restricted to the Trustees of the IBEW Local 353 Trust Funds, TEIBAS, their professional advisers, authorized staff of IBEW Local 353, and other authorized service providers. Any professional advisers or other authorized service providers that are in possession of members' personal information must also use the information only for the purposes identified below.

This information is used for the sole purpose of:

- Allowing our staff to identify you properly,
- Determining eligibility for benefits,
- Administering the plans and paying benefits,
- Designing the financial management of the plans, and
- Communicating plan information directly to plan beneficiaries.

Limited personal information may be shared with authorized staff of the IBEW Local 353 to allow you to obtain benefits and privileges provided by the IBEW Local 353, or the IBEW International Union. Any personal information provided to these authorized individuals will be limited to non-identifying information concerning the number of dependents, and/or notification of death and confirmation of beneficiary for IBEW International Union communication purposes.

When required by law, information may also be disclosed to authorized agencies, including law enforcement agencies and the Canada Revenue Agency. Also, personal information may be disclosed to specific individuals as authorized by you. We have security procedures to safeguard and protect personal information against loss, theft, unauthorized disclosure, copying, and unauthorized use or modification. The most sensitive information receives the highest level of protection. We do not sell your information.

We do our best to ensure that the personal information we maintain is accurate and, up to date. It's in your best interest — and your responsibility — to inform TEIBAS promptly of any change in your name, address, family status, or any other relevant information. You may also access the personal information in your file and, if necessary, correct any inaccuracies.

For more information, please contact TEIBAS.

Register for www.myteibas.com today for all your Benefit and Pension details.
See page 11 for more information.

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PENSION & BENEFIT PLANS

protecting **your** future

Benefits At A Glance For Active Members

Benefit*	General Coverage
Life Insurance	Member: $150,000 Spouse: $40,000 Dependent Child: $10,000
Critical Illness	Member: up to $25,000
Accidental Death Benefit	Member: $150,000 Spouse: $40,000 Child: $10,000
Short-Term Disability	Equal to 75% of basic weekly earnings to a maximum of $750 per week, payable for up to 26 weeks Benefits start on the first day if due to accident or hospitalization; on the eighth day if due to illness
Long-Term Disability	75% of basic monthly earnings to a maximum of $3,400 per month Benefits will start after 26 weeks of total disability, coverage ends at retirement or age 62, which ever comes first
Medical	Eligible expenses reimbursed up to 100% based on reasonable and customary charges Certain medical supplies and durable equipment In-home private duty nursing services to a maximum of $10,000 per year Orthopedic shoes or orthotics to a maximum of $500 every 12 months
Prescription Drugs	Drug Card provided Only drugs that legally require a prescription and have a Drug Identification Number (DIN) Reimbursed at 100% based on reasonable and customary charges, name brands covered where there is no generic available, or where doctor has requested no substitution Dispensing fee coverage up to maximum of $8.00, per prescription Some drugs are subject to pre-approval
Hospital	Semi-private coverage for acute care accommodations in a publicly funded hospital in Ontario
Vision Care	Prescription glasses, contact lenses, prescription safety glasses and prescription sunglasses up to $750 per person, every 24 months Eye exams covered up to $150 per person, every 24 months Laser eye surgery of up to $3,000 per eye, lifetime maximum
Paramedical Services	Reimbursements up to 100%, to a maximum of $2,500 per calendar year, per person for all practitioners combined. Based on reasonable and customary charges See page 8 for a list of eligible practitioners
Mental Wellness Benefit	Reimbursed at 100% based on reasonable and customary charges, to a maximum of $3,000 per calendar year, per person for all practitioners combined See page 8 for a list of eligible practitioners
Dental	Fees reimbursed at either 75% or 100% depending on the type of service based on the current year's Ontario Dental Association Fee Guide For General Practitioners Services include cleaning, polishing, minor and major restorative services, dentures, crowns, orthodontics and implants See pages 9 and 10 for complete details $10,000 annual maximum per person, excluding orthodontics and implants
Member Assistance Program 24/7 availability 1-800-387-4765 www.one.telushealth.com	Telus Health (formerly LifeWorks) provides confidential short term counseling for relationship and family issues, legal and financial matters, addictions and health advice, nutritional and personal well-being. **username: canadalife and password: telus1**
Teladoc 24/7 availability 1-877-419-2378 www.teladoc.ca/medical-experts	Provides a comprehensive medical review that addresses three key questions: Is my diagnosis correct? What's the best treatment? What's going to happen to me? The service is available for you, your spouse, your dependents, parents and parents-in-law.
Travel Medical Emergency Insurance & Assistance Toll-free: 1-855-369-5444 International: 514-285-8186 Policy #**1TR55**	Beneva Travel Insurance covers the first 60 days of each trip, up to 100% of emergency medical expenses while travelling outside the province, to a maximum of $5 million per person per trip; coverage ends when you start your pension or age 70, whichever comes first.

* Benefits are subject to reasonable and customary limits as defined by Canada Life and industry practices. Benefits At A Glance provided here are highlights of the benefits available to members of the IBEW Local 353 not in receipt of an IBEW pension. Should there be any difference between the information contained here and the legal plan documents, the plan documents will apply. The Board of Trustees reserve the right to change or cancel any of all benefits described on this page at any time. For more information, see page 25.

How Your Plan Works

There are many advantages to being a member of the International Brotherhood of Electrical Workers (IBEW) Local 353 and one of the first among them is your benefit plan. If you've ever tried to buy medical, dental or disability coverage on your own, you already know that it's expensive. Most of your benefits, including health, dental, short-term disability and the first 10 years of long-term disability payments, are self-insured. **This means eligible claims are paid directly from the plan. So all of us, and not an insurance company, pick up the tab.**

Self-insured benefits and what you can do to protect your plan:

- **Coordinate your coverage:** If you or your spouse are covered by another plan, tell us. That way we can make sure both plans pay their fair share. See page 6 for more on coordinating benefits.
- **Use the plan wisely:** The purpose of your benefit plan is to ensure you and your family have access to good and affordable health care, so use it wisely. The plan belongs to us.
- **Shop and compare:** Spend the plan's money as if it is your own. When possible, take the time to comparison shop before buying health items, services, or prescription drugs covered by the plan. Following these steps will help to control costs, which in turn will allow us to continue offering comprehensive benefits.

The benefits provided by the plan are intended to supplement benefits provided by your provincial health plan.

Accumulating Hours To Pay For Benefits

Generally, for every hour of pay you earn, your employer makes a contribution on your behalf to the IBEW Local 353 Trust Funds, and you receive one hour towards your hour bank. TEIBAS deducts the required hours (currently 135 hours) from your account each month to cover the cost of your benefits.

The maximum number of hours that you can have in your account is enough to pay for 36 months of benefit coverage (or 4,860 hours). If you earn in excess of 4,860 hours, the excess hours are transferred to the general reserve of the IBEW Local 353 Trust Fund.

Eligibility For Coverage

Coverage begins on the first day of the second month after you have earned 450 benefit hours. You must earn these 450 hours within a period of no more than six consecutive months. This six-month period is extended to make up for time you spend in trade school. Once you qualify, TEIBAS will notify you.

To be eligible for benefits you must:
Be a member of IBEW Local 353, and
Have at least 450 hours in your account to begin coverage (the number of hours to be earned within 6 months to reinstate coverage may differ)
Have at least 135 hours in your hour-bank account at the beginning of each month

To be subsidized, you must:
Remain a member of IBEW Local 353, and
Comply with the IBEW Local 353 eligibility criteria, and
Be on an approved leave, or attending trade school, or
Be receiving short or long-term disability payments from the plan, or
Be receiving Full Loss of Earnings from WSIB, or
Be in receipt of statutory accident benefits from an Ontario motor vehicle insurance carrier, or
Be fully retired and meet the eligibility criteria

When Coverage Ends

Benefit coverage for you and your family ends if you don't have at least 135 hours in your account on the first of the month and you are not registered on the out of work list or otherwise eligible to be subsidized. You must submit any outstanding extended health and dental claims within 90 days of your coverage ending in order for them to be reimbursed. Dental prosthetics (such as bridges or crowns) ordered while you were covered will be reimbursed if they are installed within 90 days of your coverage ending.

You may be eligible to convert your group life insurance to one of the individual policies offered by Canada Life without proof of your insurability. You have 31 days from the termination of your benefit coverage to submit your application to Canada Life. Contact TEIBAS for more information.

Getting your coverage back

The following are the hours required to reinstate your benefit coverage if it lapses. Your coverage will be reinstated on the first day of the second month following the month in which you accumulate the required hours. You will be notified in writing when your coverage is reinstated:

Fell out of Benefits	Hours required
Less than 12 months ago	300 hours within 6 consecutive months
More than 12 months ago	450 hours within 6 consecutive months

Covering Your Family Members

As a member of the plan, your family is also covered for health, dental, travel and accident insurance. However, family members are not covered for short and long-term disability or critical illness insurance — these benefits are for you alone. **You must notify TEIBAS immediately in writing about any changes in your family status.**

The following family members qualify for coverage while you are a member of the plan:

- The person you are legally married to and are currently living with in a conjugal relationship; or the person who is publicly presented as your spouse, and who you are currently living with in a conjugal relationship and have been with for at least the past 12 months.
- Any child of yours or your spouse's (including any step-child, adopted child, legal ward or natural child) who are not married and are:
  - Under 21 years of age and dependent on your support (e.g., a minor who is not working more than 30 hours a week unless they are a full time student), are a resident within Canada, and aren't eligible as an Employee under this or any other group policy), or
  - Under 25 years of age and registered as a student in a full-time program at an accredited post-secondary institution, or
  - 21 years of age or over and incapable of self-sustaining employment by reason of mental or physical disability, and covered under this plan prior to age 21 and continuously thereafter.

Student Coverage

Students aged 21 and over, but under age 25 may qualify for coverage if studying full-time at an accredited post-secondary institution.

To apply for or continue coverage for a student as defined above, you must complete the Declaration of Attendance form or provide TEIBAS with official proof of enrolment from the post-secondary institution. Proof must confirm that your dependant is enrolled on a full-time basis and must be submitted at the beginning of each semester or school year. Be sure to advise TEIBAS when your dependant's student status changes. If you don't notify us and incur ineligible costs to the plan, any benefit overpayments will be recovered from future benefit payments, or from your accumulated bank hours.

(If your dependant attends school outside Canada, please contact TEIBAS for further information.)

Students are ineligible for benefits if they:

- **Attend school outside Canada, please contact TEIBAS for further information.**
- Have their own individual employee health benefits under another plan, or
- Are being paid to attend school, or
- Are studying part-time.

Coordinating your benefits

If your spouse has group coverage through their employer, you must notify TEIBAS of the other insurance. The coordination of benefits provision allows you to submit any unpaid portion of your claims to your spouse's plan for reimbursement. Your spouse can also submit unpaid portions from their plan to your plan as illustrated below.

Coordinating claims with your spouse's plan:

You receive treatment

1. Send your claim to the IBEW Local 353 Benefit Plan first.
2. Submit any unpaid portion to your spouse's plan.

Your spouse receives treatment

1. Spouse sends claim to their own benefit plan first.
2. Submit any unpaid portion to the IBEW Local 353 Benefit Plan.

If your children are also covered under a spouse's group plan, the coordination of benefits provision allows claims for your children to be submitted as illustrated below.

If you are living with your child's other parent

1. Send the claim to the parent's plan whose birthday comes earlier in the calendar year.
2. Submit any unpaid portion to the parent's plan whose birthday comes later in the calendar year.

If you are separated or divorced – Sole Custody
Claims must be submitted in this order:

1. To the plan of the parent with custody.
2. To the plan of the spouse of the parent with custody.
3. To the plan of the parent not having custody.
4. To the plan of the spouse of the parent not having custody.

If you are separated or divorced – Joint Custody
Claims must be submitted in this order:

1. To the plan of the parent with joint custody with the earlier birth date.
2. To the plan of the parent with joint custody with the later birth date.
3. To the plan of the spouse of the parent with the earlier birth date.
4. To the plan of the spouse of the parent with the later birth date.

Health Benefits And Services

If you're not sure whether something is covered, please contact **Canada Life at 1-844-232-4239**, before you spend your money. Please refer to your Canada Life Assure Drug Card for your Plan Number and Personal Identification Number (PIN). All expenses are limited to reasonable and customary costs established by Canada Life. You can find out the maximum amount Canada Life will reimburse for a service by contacting them at the number above or online at https://my.canadalife.com/sign-in.

What's Covered

Expenses must be reasonable and customary amounts that you're legally required to pay and be:

- Medically necessary;
- Made while under the care of a licensed doctor or dentist or licensed health professional and prescribed by that licensed doctor or dentist, or licensed health professional
- Recognized throughout the provider's profession as an appropriate course of action;
- Supported by written proof from the provider;
- Related to a non-occupational injury or illness, and
- Not prohibited by law.

What's not covered

- Expenses eligible to be covered by the Workplace Safety & Insurance Board (WSIB),
- Expenses normally covered by any government plan or agency,
- Expenses related to a motor vehicle accident,
- Cancellation, administrative, or personal protective equipment charges.

Drug Plan

You will be provided with an IBEW Local 353 drug card that is accepted at most pharmacies in Canada. When you provide your pharmacist with your drug card they will put your prescription through Canada Life's system, electronically. If your card is lost or misplaced, notify TEIBAS immediately. You will receive a replacement card in approximately 4 weeks. While you're waiting for your replacement card to arrive, you can confirm your ID number by visiting My Canada Life at Work for Plan Members, or download an electronic card to your phone via the My Canada Life at Work app, or by contacting TEIBAS. When the card is used by your pharmacist, the system electronically identifies:

- Covered family members,
- The plan's dispensing fee maximum of $8.00,
- 100% payment on eligible generic drugs as well as brand name drugs that don't have a generic equivalent, and
- Plan restrictions, including notification of any pre-authorization requirements.

Log into
https://my.canadalife.com/sign-in
or call Canada Life IBEW Local 353 direct line at 1-844-232-4239.

We encourage you to use your drug card as it ensures that pharmacies only mark up drugs to a reasonable and customary amount, and avoids you having to pay out of pocket until you are reimbursed. You can still submit drug claims to Canada Life by completing the medical expense claim form either on-line, or in paper form, however, reimbursement does take a little longer and you will not benefit from the drug mark up controls of your drug card. Effective September 1, 2024, the plan introduced a standard generic drug program. If you or your covered family member are unable to take a generic drug, the prescriber may indicate "no substitutions" on the prescription, and the name brand drug will be dispensed. Unless the prescriber has prescribed a drug by its brand name and has specified in writing that the product is not to be interchanged, the plan will cover only the cost of the lowest priced equivalent generic drug.

What's covered under the IBEW Local 353 drug plan?

Your drug plan covers most prescription drugs as prescribed. Specialized or new drugs may require pre-approval by FACET, an independent specialist that helps the plan manage prescription drugs and the use of medical equipment and appliances.

Erectile dysfunction drugs are limited to $500 per calendar year and fertility drugs are limited to $5,000 lifetime.

What's not covered

- Any drugs or items which do not have a Drug Identification Number (DIN).
- Over-the-counter medications such as cold remedies, laxatives or antacids.
- Weight loss drugs.
- Vaccines and immunization products (some exclusions apply).
- Any drugs or items that do not legally require a prescription.
- Vitamins.

FACET – Drugs that require pre-approval

We're committed to effectively managing our drug plan while ensuring our members and their families receive the care they need. Some medications require a pre-approval or prior authorization review to be submitted before they can be approved and claimed for. These prior authorization reviews are limited to complex specialty medications, most of which are used to treat serious conditions such as Cancer, Multiple Sclerosis, Rheumatoid Arthritis, and rare genetic disorders. These are all areas where drug therapy decisions need to consider different condition-specific factors. Because of their complexity, these claims require clinical experts to review the information.

A Prior Authorization (PA) medication requires you to provide written consent to an independent clinical case evaluator to get relevant personal medical information from your health care professional team (e.g. a physician, pharmacist, nurse practitioner, case manager, etc.) as needed, to make a coverage decision.

A PA medication has a maximum initial approval period of one (1) year. A renewal request form will need to be filled out prior to the end of the initial approval period to continue with coverage beyond the initial period that was approved. **Note:** An initial approval for a given product doesn't guarantee approval at renewal time. Renewals are based on demonstrated safety and clinical effectiveness of the product, and appropriate adherence to therapy.

A specific PA medication may not be covered under the following situations:

- If it has been determined that you have not attempted an adequate trial of appropriate first- and/or second- and/or third line therapies according to updated clinical practice guidelines for a given underlying condition that are not contraindicated in your case.
- If the requested dosing for a requested PA medication is clinically inappropriate.
- If the requested PA medication is being used for an indication that is not approved by Health Canada.
- If the PA medication or a clinically appropriate alternative is covered by a public program.
- If it has been determined that you have not attempted another medication for the same condition which is of comparable efficacy and safety but is more cost-effective.
- If a specific PA medication being requested has not received an unconditional recommendation for listing by the Canadian Agency for Drugs and Technologies in Health (CADTH) or a similar independent Health Technology Assessment agency based on concerns around safety and/or clinical effectiveness and/or cost-effectiveness.

The plan retains the right to require an adequate trial of clinically appropriate alternative(s) before a requested PA Drug is approved and reimbursed under the plan.

The plan currently uses FACET to assess applications for PA drugs. FACET is an independent PA program developed by a team of licensed, clinical pharmacists who are completely independent of the claim. FACET has no financial incentive to approve, modify or decline a given claim. Each FACET PA claim is managed end-to-end by a Doctor of Pharmacy (PharmD) credentialed medication expert. The program uses objective, evidence-based clinical criteria to review claims to ensure the medication and dosage requested are appropriate, and to determine if the claim can be reimbursed under the rules of the plan. All FACET decisions that involve a required modification to a medication request or a decline in coverage include a detailed, transparent clinical reason that is shared with both the member and their Physician.

The FACET Clinical Pharmacy team works directly with a member's Physician to review the underlying medical condition in depth before a decision is rendered on which (if any) medication would be the most appropriate next step in the treatment process.

The FACET team manages Prior Authorization claims for complex medications for over 1 million Canadians across the country and has experience assessing tens of thousands of PA medication requests. The FACET Clinical Team deals with medication requests for more than 200 different complex medical conditions each year.

If your prescription requires pre-approval, or you would like to know if a medication that you and your physician are considering is on the list, please follow these steps:

- Go to www.facetprogram.ca/IBEW353.
- Download the form specific to the medical condition in question.
- Fill out your information, sign the consent form, and have your physician fill in the remaining information.
- Email the completed form to IBEW353@facetprogram.ca or fax to 1-844-446-1575.
- The process of submitting a Prior Authorization form does not guarantee a claim will be approved.

After the review is completed you will be notified of the decision. FACET claims are reviewed within 2 business days once all of the necessary information is received. If a claim is approved, FACET will notify Canada Life of the approval. If you have any questions, you can contact FACET at 1-844-492-9105.

What's Covered

Vision Care

Eye exams are covered up to $150 every 24 months from the date of your last eye exam. You are also covered for the following services and supplies up to a combined limit of $750 every 24 months starting from the date of your first purchase. You must have a written prescription by an ophthalmologist or optometrist in all cases. Eligible expenses include:

- Eye pressure monitor.
- Glasses, contact lenses, prescription sunglasses and prescription safety glasses.
- Visual training and therapy to improve faulty visual skills.
- Contact lenses for special medical conditions (separate limit up to $750 per lifetime).

Please call Canada Life or check My Canada Life at Work for Plan Members for your current vision care balance and next eligibility date before incurring these expenses, https://my.canadalife.com/sign-in.

Laser Eye Surgery

Laser eye surgery and refractive lens exchange required to correct vision when performed by a licenced ophthalmologist will be covered to a lifetime maximum of $3,000 per eye.
Laser eye expenses related to cataract surgery are not eligible under the IBEW Local 353 Health and Welfare Plan (pre-determination required).

Hearing Aids

The plan pays the cost of hearing aids including repairs to a maximum of $750 per ear in any 36-month period. Before you make a purchase, contact the Ontario Assistive Devices Program, which may pay as much as 75% or $500 toward the cost of the hearing aid. To learn more about Ontario Assistive Devices Program, visit www.ontario.ca/page/assistive-devices-program, or call 1-800-268-6021.

Medical Supplies And Services

Expenses listed below are covered up to reasonable and customary amounts. ('Reasonable and customary costs' are the general level of charges that will be reimbursed for a specific service or product in a geographic location where the expenses are incurred). An estimate or pre-approval should be sent to Canada Life prior to incurring any costs:

- Ambulance transportation (must provide proof of medical emergency requiring professional ambulance services, does NOT include ambulance from hospital to home).
- Artificial limbs and eyes.
- Blood-letting devices and related supplies.
- Braces prescribed by a chiropractor, physiotherapist or physician (must be made of rigid material).
- Casts and crutches.
- CaverMap disposable parts and supplies related to the use in prostate surgery or similar device.
- Continuous Glucose Monitors (CGM) for type 1 diabetes or Flash Glucose Monitors for type 1 or type 2 diabetes (individual must be hypo/hyperglycemic and on insulin), including parts and related supplies to an annual combined maximum of $3,000 (pre-determination required).
- Compression hose (requires a prescription from doctor that includes specific medical diagnosis), minimum 20mmHg, limited to four pairs per calendar year.
- Dental treatment performed outside a hospital by a dentist or oral surgeon for accidental injury to natural teeth (within 12 months of accident).
- Durable equipment; breathing equipment, electric mobility scooters, traction kits, walkers and wheelchairs (pre-determination required).*
- Fertility treatment to a lifetime maximum of $5,000 per covered individual (pre-determination required).
- Gender affirmation coverage to a lifetime maximum of $25,000 per covered individual over the age of 18 (pre-determination required).
- Hospital bed (rental or purchase, pre-determination required).
- In home nursing services administered by a licensed practical nurse (LPN) or registered nursing assistants (RNA), to a maximum of $10,000 per year for medical purposes only (pre-determination required, contact Canada Life).
- Custom made orthopedic shoes or orthotics to a combined maximum of $500 in any 12-month period, including:
  - Orthopedic shoes or orthotics and special foot appliances, prescribed by a physician or surgeon, custom-made and specifically designed and moulded to protect or restore the function of a limb or limbs to compensate for limitations or to increase physiological performance.
  - Custom-made orthotics, lifts or wedges prescribed by a podiatrist, chiropodist, chiropractor, orthopaedic surgeon or physician (does not include sport orthotics or fashion orthotics).
- Oxygen and its administration.
- Sleep apnea appliances and equipment up to $500 every five years (after Ontario Assistive Devices Program), plus an additional $600 per calendar year for related parts and supplies, after year 1. **Excludes cleaning supplies.** Cannot purchase multiples of the same supply item at the same time.
- Semi-private hospital acute care accommodations. (Plan covers the difference between semi-private hospital charges and standard ward rate accommodations in a publicly funded acute care hospital in Ontario). **Chronic care, long-term care accommodation is NOT eligible under the benefit plan.**
- Prostate-Specific Antigen Tests (limit to one test per year per individual).

There's no big insurance company picking up the tab — and there's a limited pool of money to pay for benefit claims.

*This will require information from your physician as to why the purchase is medically necessary.

Medical Supplies And Services (continued)

- Splints
- Synovial fluid supplementation injections - $2,000 per calendar year
- Trusses
- Wheelchair (rental or purchase, if approved)
- Wig - one every 24 months when required as a result of medical treatment, injury or illness/disease

Assistive Devices Program (ADP)

If you need a medical device, you may qualify for benefits from the Ontario Ministry of Health's Assistive Devices Program (ADP). Devices covered under this program include;

- Artificial eyes and facial prosthetics
- Communication aids
- Custom orthotic braces, compression garments and lymphedema pumps
- Diabetic equipment and supplies
- Enteral-feeding pumps and ostomy supplies
- Hearing aids and other devices
- Home oxygen therapy
- Mobility aids
- Prosthetic breasts or limbs
- Respiratory equipment and supplies
- Visual aids

The ADP keeps a list of eligible devices and their approved prices, and will contribute up to 75% toward their cost up to certain limits. If you or a family member needs the type of equipment mentioned here, you should ask your family doctor first, before submitting a claim for the device through the plan.

For a list of registered vendors, visit the Assistive Devices Program https://www.ontario.ca/page/assistive-devices-program. In most cases, the supplier will automatically reduce the cost of the device by the amount covered by ADP and charge you the difference. You can then submit a claim to Canada Life for your out-of-pocket expense.

Paramedical Services

Listed below are the paramedical services covered under the IBEW Local 353 Benefit Plan. Coverage is to a maximum of $2,500 per calendar year, per person for all practitioners combined. Reimbursement is limited to reasonable and customary charges. Practitioners must be registered with the paramedical profession's regulatory or governing body in the province where services are provided.

- Acupuncture
- Audiologist
- Chiropractor
- Christian Science Practitioner
- Dietician
- Homeopath
- Naturopath
- Osteopath
- Physiotherapist
- Podiatrist/Chiropodist
- Registered Kinesiologist
- Registered Massage Therapist
- Registered Occupational Therapist
- Speech Therapist

Mental Wellness Benefit

The mental wellness paramedical services listed below are covered under the IBEW Local 353 Benefit Plan. Coverage under this benefit is limited to a $3,000 per calendar year, per person, for all mental wellness practitioners combined. Practitioners must be registered with their profession's regulatory or governing body in the province where services are provided. Coverage is subject to reasonable and customary limits.

- Clinical psychologist
- Intensive Behavioural Intervention (IBI)
- Psychotherapist
- Social Worker

What's Not Covered

Expenses incurred outside the plan member's or covered dependent's normal province of residence are not covered.

- Acne therapy, wart therapy, antiseborrheics
- Allergy serums and compounds, (exceptions apply)
- Antacids, antiflatulents, absorbents
- Anthelmintics, antiparasitics
- Antihistamines, decongestants, antipyretics, analgesics, antitussives, antiphlogistics, expectorants
- Antinauseants, antiemetics
- Any cost for administration (as distinct from the $8.00 per prescription dispensing fee)
- Any drug or items which do not have a Drug Identification Number (DIN)
- Blood pressure monitors
- Breast pump
- Contact lens care products, eye lubricants
- Cosmetic services (unless otherwise indicated)
- Dental and oral hygiene products including toothpastes, mouthwashes, prophylaxis treatment
- Departure taxes
- Diagnostic agents or products intended to be used in a hospital or outpatient clinic environment
- Disinfectants or non-prescription requiring anti-infective products, antifungals, antiseptics, detergents, topical anaesthetics, antipruritics, topical antibiotics
- Examinations, checkups or certification
- Food and food products including infant formula, infant foods, salt and sugar substitutes
- Intentionally self-inflicted injuries
- Laboratory tests or fees
- Laser eye services related to cataract surgery
- Laxatives, antidiarrheal, haemorrhoidal
- Lozenges and cough suppressants
- Missed appointments
- Nicotine transdermal systems, nicorette gum or similar products
- Obusform backrest
- Over-the-counter medications such as cold remedies, laxatives or antacids
- Personal hygiene products, contraceptives preparations and devices (other than oral contraceptive)

What's Not Covered (continued)

- Pregnancy tests, examinations, check-ups
- Services incurred outside Canada, unless covered under travel medical emergency insurance and assistance plan
- Services eligible under a government plan
- Services of doctors or surgeons (unless otherwise indicated)
- Services or products that are prescribed or provided by a family member or a person who resides with you or is related by blood or marriage
- Services or supplies that are educational or experimental in nature
- **Services and claims related to motor vehicle accidents**
- Skin and hair care products, including protective, soaps, cleansers, emollients, lubricants, suntan lotions, deodorants
- **Surgeries such as procedures covered by OHIP/or a relevant provincial body and obtained in publicly funded hospitals or in private health clinics aren't covered in any part by the benefit program unless explicitly stated in this document**
- The cost of infusion (intravenous delivery) of medication
- Transportation or travel (unless otherwise indicated)
- Vaccines and immunization products (except for shingles vaccines and hepatitis A & B vaccines)
- Vitamins, vitamin supplements, dietary supplements, diet foods, minerals other than hematinics (not haematinics in combinations), anorexiants
- Weight loss drugs and related products

Dental Benefits

Our dental plan is a key feature of IBEW Local 353's benefit package and accounts for about a third of total plan costs. **It pays up to 100% of the cost of many dental treatments and provides partial payment for others.** There is an annual combined maximum of $10,000 per insured individual for basic and major dental coverage (excluding orthodontics and implants). Dental fees and services will be reimbursed based on the current year's Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners. Extra charges incurred from specialists aren't covered.

Coverage for Diagnostic and Preventative Services*	**Reimbursed at up to 100% in a Calendar Year (January to December)**
Complete oral examination	Once every two calendar years
Standard and/or periodontal recall examination of a previous patient	Limited to once in any calendar year for adults and twice in any calendar year for children under age 25
Intraoral complete series (full mouth x-rays) or panoramic film	Once every two calendar years
Posterior bitewings films	Limited to once in any calendar year for adults and twice in any calendar year for children under age 25
Routine polishing and scaling	Limited to a combined maximum of 4 units of time in any calendar year, per patient
Periodontal scaling (after the routine limit has been satisfied) and root planing	Limited to 12 units of time per calendar year per patient
Preventive recall packages	Limited to once in any calendar year for adults and twice in any calendar year for children under age 25
Topical and supervised fluoride brush-in	Limited to twice in any calendar year for children under age 25 and **excluded for adults**
Pit and fissure sealants to permanent or bicuspid teeth of children under age 25	Limited to one application per tooth every 24 months
Oral hygiene instruction	A maximum of one unit of time per lifetime per patient, and is only eligible when submitted within the preventive recall packaging code series

A unit of time is considered to be a 15 minute interval or any portion of a 15 minute interval.

* Dental benefits are payable at the current year's ODA Fee Guide for General Practitioners. Benefits At A Glance provided here are highlights of the benefits available to members of the IBEW Local 353 not in receipt of an IBEW pension. Should there be any difference between the information contained here and the legal plan documents, the plan documents will apply. The Board of Trustees reserve the right to change or cancel any of all benefits described on this page at any time.

Dental Benefits (Continued)

Coverage for Minor Restorative and Surgical Services	**Reimbursed up to 100%** Subject to a combined maximum of $10,000 per calendar year, per insured, for all dental services excluding implants and orthodontics
Amalgam restorations, retentive pins, prefabricated restorations and tooth coloured restorations	
Tooth coloured veneer application	Only when performed in a non-cosmetic capacity
Anaesthesia, treatment of pain, sedation and visits	
Coverage for Endodontic Services	**Reimbursed up to 100%** Subject to a combined maximum of $10,000 per calendar year, per insured, for all dental services excluding implants and orthodontics
Root canals and periapical services	
Coverage for Prosthodontic Services	**Reimbursed up to 100%** Subject to a combined maximum of $10,000 per calendar year, per insured, for all dental services excluding implants and orthodontics
Initial dentures	
Replacement dentures if:	• Existing denture is more than 3 years old and cannot be repaired • Additional natural tooth is extracted • Transitional denture requires replacement within 12 months
Relining, rebasing or remakes	Limited to one upper and one lower reline, rebase or remake per calendar year
Coverage for Periodontal Services	**Reimbursed up to 75%** Subject to a combined maximum of $10,000 per calendar year, per insured, for all dental services excluding implants and orthodontics
Periodontal surgery Occlusal equilibration	
Coverage for Major Restorative Services	**Reimbursed up to 75%** Subject to a combined maximum of $10,000 per calendar year, per insured, for all dental services excluding implants and orthodontics
Some exclusions apply to the following procedures. Please submit pre-determination to Canada Life prior to commencing treatment: Gold foil restorations, inlays, onlays, posts and retentive pins Crowns, initial and repairs Initial bridges	Replacement bridge if: • Existing bridge is more than 3 years old and cannot be repaired • Additional natural tooth is extracted •Transitional bridge requires replacement within 12 months • Removing and recementing bridge
Coverage for Dental Implants	**Reimbursed up to 75%** Subject to a lifetime maximum of $6,000 per insured individual
Implants and related surgeries	A pre-determination must be submitted prior to commencing treatments
Coverage for Orthodontic Services	**Reimbursed up to 75%** Subject to a lifetime maximum of $3,500 per insured individual
Fixed and removable appliances, including repairs only when treatment begins	Lifetime maximum: $3,500

* Dental benefits are payable at the current year's ODA Fee Guide for General Practitioners. Benefits at a glance provided here are highlights of the benefits available to members of the IBEW Local 353 not in receipt of an IBEW pension. Should there be any difference between the information contained here and the legal plan documents, the plan documents will apply. The Board of Trustees reserve the right to change or cancel any of all benefits described on this page at any time.

Dental Estimates and Pre-Determinations
Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to Canada Life. It is recommended that a treatment plan be submitted before having dental treatment that will cost $200 or more. Canada Life will calculate the benefits payable for the proposed treatment, so you will know in advance the approximate portion of costs that you will have to pay. Orthodontic treatment must begin within 90 days of the date you submit the treatment plan.

Dental Work as a Result of an Accident
Dental treatment resulting from an accident may not be covered under your dental plan. However, it may be covered under your health plan if treatment is completed within 12 months of the accident (excluding motor vehicle or workplace accidents). It is recommended that a treatment plan be submitted to Canada Life before having any dental treatment completed. Contact Canada Life for more information on submitting a dental treatment plan at 1-844-232-4239.

What's Not Covered
In general, the dental plan will not pay for:

- Cosmetic treatment, such as treatment performed to cover discoloured enamel, close spaces between teeth or reshape malformed teeth (as determined by Canada Life).
- Lab fees and diagnostic services that exceed reasonable and customary charges.
- Fluoride treatments for persons age 25 and over.
- Replacing an existing appliance that was lost or stolen.
- Services and supplies for full mouth reconstruction, correcting vertical dimension or correcting temporomandibular joint dysfunction.
- Specialist fees.
- Charges made by a dental office for missed appointments or for completion of claim forms.
- Orthodontics and related procedures for retired members.

Health or dental claims submitted later than one year from the date of treatment or the purchase of the product will not be paid.

Submitting A Claim

All claims must be submitted to Canada Life as soon as possible, but no later than 12 months after you have incurred the expense. When submitting a claim, you must include the plan number 51189 and your personal identification number located on the front of your drug card.

Health Claims
To make a health claim, follow these steps:

E-Claims
E-claims are the quick and easy way to get reimbursed for your eligible health care costs. Claims can be submitted online by accessing Canada Life My Canada Life at Work for Plan Members. Once registered you can submit eligible claims online, anytime. To register and for more information, visit my.canadalife.com/sign-in. Once registered for My Canada Life at Work you can also submit claims using the My Canada Life at Work Mobile app. Visit your smartphone app store and search for My Canada Life at Work. Claims can be submitted electronically if:

- The service was provided in Canada, and
- Payment is to be made payable to you.

Paper-Claims

- Pay out of pocket for the eligible service or supply.
- Complete, sign and date the Canada Life Health Claim Form available for download at www.teibas.com/forms/, including plan number 51189.
- Make a copy of the claim form and receipts for your records.
- Attach original receipts and send the completed claim form to Canada Life at the address noted on the form.

Prescription Drug Claims
Your IBEW Local 353 drug card provides you with an electronic payment system that gives on-the-spot processing of prescription drug claims at almost any pharmacy in Canada. It's a quick, convenient, easy-to-use alternative to submitting claim forms. To make a prescription drug claim through your pharmacy, simply provide your drug card to your pharmacist. To make a paper prescription drug claim, follow the steps outlined above under Health Claims.

Dental Claims
For your convenience, dental claims can be electronically submitted by your dentist. Provide the plan number 51189 to your dentist and they will do the rest. To prevent unnecessary claims payment delays, please ensure that your mailing address with the dental office is up-to-date.

Canada Life 1-844-232-4239

As a member of IBEW Local 353 you have access to a dedicated and direct line at Canada Life for all your questions related to prescription drugs, medical, dental and vision claims - toll-free at 1-844-232-4239.

Vist my.canadalife.com/sign-in to register for online claims submission with Canada Life.

Member Assistance Program 1-866-289-6749

As a member of IBEW Local 353 you have the added benefit of your Member Assistance Program (MAP), Telus Health (formerly LifeWorks).

It's support when you need it, for all kinds of issues. If you're feeling stressed about work, family, finances, or you need some help finding services for life's complications, contact Telus Health. Your MAP provides 24/7 confidential short-term counselling at your fingertips anytime, anywhere whether online, on the phone, or on their app. Your MAP also offers a range of wellness tools and personalized recommendations such as LIFT fitness sessions, assessments, digital clinical programs, and challenges to help you reach your health and fitness goals and keep you on track. If you're not sure if the MAP service can help you, give them a call or visit www.one.telushealth.com.

Your MAP is available 24/7/365: call the Care Access Centre toll-free at 1-866-289-6749 and indicate that you are a member of the IBEW Local 353. Or visit;
www.one.telushealth.com
Username: canadalife | **Password:** telus1

Teladoc 1-877-419-2378

Teladoc is a confidential service offered to you and your eligible dependents as part of your IBEW Local 353 benefits. Teladoc provides a comprehensive medical review of a medical diagnosis and provides a review of your treatment plan and can make recommendations that are best for you. Whether you need medical questions answered, a diagnosis double-checked, help deciding on a treatment plan, or guidance about a surgery, they provide an expert medical opinion when you need it most.

Teladoc Medical experts provide a range of services that can help you:

- Feel confident about your diagnosis and treatment options,
- Answer your medical questions and concerns
- Find a specialist or treatment facility either within or outside of Canada and,
- Navigate the healthcare system with useful resources.
- If you're in doubt, it's best to call Teladoc — it's a service that's available 24 hours a day, seven days a week and is completely confidential. For more information call 1-877-419-2378 or visit www.teladoc.ca/canadalife.

myTEIBAS.com

Log into www.myteibas.com to access the IBEW Local 353 benefit and pension plans information, view your quarterly contribution statements, use our pension estimator, review beneficiaries on file, access claim forms, and much more.

You only need four things to start using www.myteibas.com:
1) Member PIN number - Your PIN# can be located on your drug card
2) Year of birth
3) Last three digits of your SIN#
4) Valid email address

Step 1: Visit **www.teibas.com**
Click on "myTEIBAS Login" located at the top right hand corner of the page.

Step 2: Click "Create Account"
Step 3: Sign Up (Complete the required information on the Create Account page.)
Step 4: Set up your password (A temporary password will be emailed to you.)
Step 5: Login
You are now ready to view your own personal information by logging into www.myteibas.com using your email address and temporary password.
Step 6: Customize your Password
Once logged in, click your name on the top right hand corner, a drop down menu will appear, select **"CHANGE PASSWORD".**

Need assistance?
Contact TEIBAS directly by calling directly 416-637-6789, or toll-free at 1-800-267-0602 or email at members@teibas.com.

You must notify TEIBAS immediately in writing about any changes in your family status.

Short-and Long-Term Disability

When you can't work because of illness or injury, it's important to know that you'll still have money coming in. You may qualify for short-term disability benefits for up to 26 weeks and long-term disability benefits thereafter.

Eligibility
You qualify for short-term disability benefits if you have worked within 91 days of the disability and have earned at least 100 bank hours in the 180 days just before the day your disability begins (including periods between different disabilities).

You receive benefits if you are totally disabled and can't work at your own job because you are sick, injured or participating in an approved substance abuse program. Medical proof is required to back up your claim. Your benefits are reduced by any amount paid to you by the Workplace Safety and Insurance Board (WSIB) and the disability plan for the same disability.

Your short-term disability benefit is:

- Equal to 75% of basic weekly earnings, up to $750 per week, and
- Payable for up to 26 weeks.

Under income tax law, short-term disability benefits are treated as taxable income. Canada Life will deduct taxes before paying you your benefit.

In all cases of disability, including WSIB, you must notify the union and Canada Life when you return to work.

What's not covered
Short-and long-term disability benefits are not paid for injuries resulting from a motor vehicle accident. They are also not paid for any period in which you receive direct payments from your employer (unless it is received during an approved period of rehabilitative employment), or do not participate or cooperate in a reasonable and approved treatment program. To qualify for benefits you must:

- Not be receiving an IBEW Local 353 pension.
- Not be working, except as part of a rehabilitation program that has been approved under the plan.
- Not be incarcerated in a prison or similar institution.
- Not be on parental or maternity leave, unless disabled as a direct result of the pregnancy.

You have 90 days from the beginning of your injury or illness to submit your application for disability benefits.

Waiting period
When applying for disability, the sooner you notify the union office and submit your completed claim form, the sooner your disability claim can be assessed. The deadline for applying is 90 days from the date of the disabling injury or illness.

You have 90 days from the beginning of your injury or illness to submit your application for disability benefits.

Your benefit is paid:

- From the first day if you are in a hospital as an in-patient or an out-patient requiring day surgery (excluding diagnostic or exploratory procedures that don't require general anaesthesia).
- From the first day after you have been treated by a doctor or chiropractor if you are totally disabled within 30 days due to an accidental injury, or
- From the eighth day after you have been treated by a doctor or chiropractor if you are absent from work because of sickness.

The first or eighth day is counted from the later of your last day at work, or the date of the doctor's visit. If you return to work and become disabled again within two weeks, there is no waiting period unless your new illness or injury is unrelated to your previous condition.

If your coverage ends, or if you are unemployed for any reason and you still meet the requirement for 100 accumulated hours, your short-term disability coverage continues for 91 days after your last day at work.

IMPORTANT REMINDER
Contact the IBEW Local 353 Union Hall at 416-510-3530 to discuss disability eligibility requirements and request a Short-Term Disability Claim Form.

Remember to receive benefits you must follow these steps:

Step 1

See a medical doctor!

Your claim for disability benefits can't be assessed without the physician's statement, copies of their clinical notes, and any test results completed, included with the application form. Make sure to see a doctor right away. Otherwise your benefits could be delayed. If you think your illness/injury is work related apply for both WSIB and disability benefits.

Step 2

Contact the IBEW Local 353 Union Hall

Tell the IBEW Local 353 Union Hall as soon as possible that you're sick or injured. Even if you don't have all the information you need, alerting the union will get things ready if you're eligible and can start any payments as soon as possible.

Step 3

Apply for benefits

To apply for benefits, you must be completely unable to work at your job and must have full benefit coverage at the start of your disability. Ask the IBEW Local 353 Union Hall for a disability claim form. Contact the IBEW Local 353 Union Hall at 416-510-3530 to a request disability claims package.

Physician's care
Short-term disability benefits are paid only while you are under the care of an appropriate medical practitioner and receiving care appropriate for your condition. In some circumstances you may be required to see a specialist. If you stop seeing a medical practitioner, your benefits will stop. If substance abuse contributes to your disability, you must participate in a recognized substance abuse program.

Chiropractor's care
If you are being treated by a chiropractor instead of a doctor, benefits can be paid for a maximum of four weeks.

Rehabilitation
Your disability case manager from Canada Life will assess your need for rehabilitation and put you in touch with the right internal experts to help you get well. In consultation with your doctor, Canada Life may put together a program of treatment or activities to help you get in shape for work. You must participate in order to continue receiving your benefit payments.

Workplace Safety and Insurance Board (WSIB) and Canada Pension Plan (CPP) and Quebec Pension Plan (QPP) benefits
If you are disabled because of an accident at work, you must apply for WSIB benefits. Any long-term or short-term disability benefits you receive from this plan are reduced by any WSIB benefits you receive for the same disability. This ensures that IBEW Local 353 plan covers only what's not already covered by WSIB.

CPP and QPP disability benefits aren't offset against monthly long-term disability, however, they are to be offset from your short-term disability benefits. You should apply for CPP/QPP disability benefits if your disability is expected to be prolonged and it is severe. Be aware there are time limits to apply for this benefit. For more information visit www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-disability-benefit.html or call 1-800-277-9914.

Before any disability benefits begin, you must complete assignment of benefits authorization forms required by Canada Life. This allows the plan to communicate with WSIB or CPP/QPP and recover any overpayments of disability benefits as applicable.

If you're receiving disability benefits and WSIB or CPP/QPP later pays benefits for the same illness or injury, you must repay the IBEW Local 353 plan for the disability benefits you have already received, as applicable.

When you're injured at work, you should always apply for short-term disability benefits within 90 days of the injury in the event your WSIB claim is rejected. This will ensure that you meet the notice and proof deadlines for submission of claims. You must also let the union office know if you are applying for WSIB benefits so that the union office can notify the insurance company and TEIBAS.

Continuing disability benefits
After the 26-week short-term disability coverage ends, you may be assessed for long-term disability benefits if you are still totally disabled. Your long-term disability benefit is 75% of your pre-disability earnings up to a maximum benefit of $3,400 per month. Under income tax law, long-term disability benefits are treated as taxable income. Canada Life must deduct tax before paying your benefit.

What totally disabled means
You're considered totally disabled if you have an illness or injury which prevents you from performing the essential duties of your own job during the qualifying period (26 weeks) and the next twenty-four months. After that, you are totally disabled only if, due to illness or injury, you are unable to perform the duties of any occupation for which you are or may become reasonably qualified by education, training and experience.

Doctor Fees
Fees related to doctor's certification of disability and provision of related information are eligible to a maximum of $300 annually. This is an active member reimbursement benefit only.

Proof of disability
From time to time, you will be asked by Canada Life to provide medical proof of your disability. Canada Life may also need to assess how well you are able to function and whether you require retraining. This may involve seeing a specialist for your condition or taking tests to measure job skills or your ability to perform physical tasks. You must cooperate with Canada Life on these requests in order to continue receiving your benefits.

Duration of long-term disability benefits
Benefits are paid for as long as you remain totally disabled up to age 62, or when you retire, whichever comes first. If you qualified for long-term disability benefits before January 1, 1995, your benefits are paid to age 65.

Reductions in long-term disability (offsets)
Your IBEW Local 353 long-term disability benefit is reduced by:

- Any WSIB benefits you receive for the same period of disability, excluding indexing adjustments,
- Any benefit received for the same disability from government programs, excluding CPP and QPP benefits,
- Any pension from the IBEW Local 353, or
- Any benefit from the IBEW International benefit fund.

  If you are receiving income benefits (other than the direct offsets described above), your IBEW Local 353 long-term disability payment combined with these other benefits must not equal more than 85% of your monthly pre-disability earnings. If it does, your long-term disability payment will be reduced by the excess. Other benefits that are counted under this 85% all sources maximum include:
  - Direct offset amounts (WSIB),
  - Any benefit received for an unrelated disability from government programs, excluding indexing adjustments and dependent benefits, and
  - Benefits from another group insurance plan.

Rehabilitative employment

If you are disabled and receiving long-term disability benefits, you may be able to perform some kind of rehabilitative employment, part-time work or retraining activities. This may help you get back to full-time employment. Any rehabilitative employment or activity, whether paid or unpaid, must be approved by your doctor and Canada Life.

If your total monthly income from the following three sources is more than your basic monthly earnings before you became disabled, your long-term disability benefits will be reduced by the excess amount:

1) Your long-term disability benefits,
2) Your income from rehabilitative employment, and
3) Any amounts that are offsets.

If you continue to earn income from rehabilitative employment more than 24 months after the end of your period of short-term disability, your long-term disability benefits may stop if Canada Life determines you no longer meet the plan's definition of totally disabled.

Reminder: If you are receiving disability payments from Canada Life and later receive payments from WSIB for the same period, you will have to pay back Canada Life for any overpayments. Canada Life will work with you on a repayment plan for any overpayments if you can't make a lump sum payment.

Coverage while on short-term, long-term or WSIB benefits

If you maintain your IBEW Local 353 union membership, your coverage under the IBEW Local 353 Benefit Plan continues at no cost to you as long as you are receiving short-term disability, long-term disability from the plan, or full WSIB benefits. If you're approved for WSIB, the plan will provide benefit coverage during the first 12 months from the date of the disability, regardless of your membership in IBEW Local 353. After the 12 months of WSIB benefits, the plan can terminate coverage if membership in the union is not maintained. If you are receiving workers' compensation benefits from outside Ontario, you may submit a request for coverage to the Trustees.

Coverage while off work due to a Motor Vehicle Accident

If you're injured or off work due to a Motor Vehicle Accident (MVA) your accident-related medical expenses including disability benefits are not covered under the IBEW Local 353 Benefit Plan. However, if you maintain you IBEW Local 353 union membership and are in receipt of monthly income replacement benefits from your automotive insurance carrier, you may be eligible to maintain your benefit coverage under the IBEW Local 353 Benefit Plan.

If you're involved in an MVA, contact the IBEW Local 353 Union Hall as soon as possible at 416-510-3530. Your dispatch record will be updated, and it will also provide you with opportunity to ask how to maintain your health and welfare benefit eligibility.

If you're injured or off work due to a Motor Vehicle Accident (MVA) your accident-related medical expenses including disability benefits aren't covered under the IBEW Local 353 Benefit Plan.

Travel Insurance 1-855-369-5444

If you are sick or injured while away from home, your travel medical insurance program provides important coverage. Always travel with your travel card with the policy and phone number on it when travelling out of province/country.

You're covered under the travel insurance only if:

- You are a member of the IBEW Local 353 in good standing,
- You have benefit coverage under the IBEW Local 353 Health & Welfare Plan,
- You and your family are covered under your provincial health insurance plan,
- You are not going to be away from home for more than 60 days (after 60 days, coverage stops), you must return home for at least 24-hours between trips.

Coverage

Your IBEW Local 353 travel plan provides three types of coverage:

1) Medical emergency benefits including emergency health care expenses while traveling outside the province, such as hospital accommodation, doctor's charges, diagnostic services, paramedical services, prescriptions, etc.
2) Non-medical benefits such as flying a friend or family member to your bedside, meals and accommodation, returning a deceased family member to Canada, etc.
3) Other emergency services such as helping you find a doctor or hospital, translation services, emergency evacuation, direct billing and the transmission of urgent messages to family.

The travel medical emergency insurance and assistance plan covers a wide range of medical emergencies, but it doesn't cover everything. When it comes to medical insurance it's better to be safe than sorry — so know what's covered and what's not. Refer to the Group Travel Insurance Booklet available at www.myteibas.com for coverage information.

Beneva Travel Insurance Card

The Beneva Travel Insurance Card is the key to your travel medical coverage. The card provides telephone numbers for Beneva – available 24 hours a day, seven days a week. Services include finding the nearest doctor, clinic or hospital, as well as benefit and claim information, urgent message relay, direct billing and translation. You can download your Beneva Travel Insurance Card which is available on www.myteibas.com.

Before you go on vacation

Always take your travel information with you when traveling out of province/country. Make sure you have the phone numbers to call, and the policy number to provide in a medical emergency. You, or a member of your travel group, must call before seeking medical treatment whenever possible.

Contact Beneva at 1-855-369-5444 for more information.

Before you receive medical treatment:

- If you have a travel emergency, you must call one of the numbers for Beneva immediately before seeking medical treatment:
  from Canada and the U.S. toll-free at **1-855-369-5444** or
  from anywhere in the world call collect + **514-285-8186**
- Tell the Beneva representative your group policy number: **1TR55**.

If you don't call before receiving medical treatment, your coverage may be denied. The only exception is if you are unconscious or too sick or injured to call. In this case, someone you know must call as soon as possible.

Extensions over the 60-day limit

There are a few situations in which the 60-day period is automatically extended for up to 72 hours.

For example:

- If you are traveling by car and it breaks down, or a late plane, train, etc. makes you miss your scheduled return home.
- If your doctor orders you to delay your departure because of a covered medical emergency.
- If you're in the hospital when your 60-day limit is up (coverage is extended until after your release from the hospital).

Travel Coverage Ends

Your coverage ends automatically when:

- You begin your IBEW Local 353 pension* or,
- You reach age 70 or,
- You are no longer covered under the IBEW Local 353 Health & Welfare Plan.

* If you begin your IBEW Local 353 pension and are eligible for retiree benefits, you will be covered under the retiree travel insurance policy. This policy provides travel insurance coverage for 30 days per trip under policy number: 1TR55.

Refer to the Out of Country Travel Insurance Booklet for additional information, available for download at www.myteibas.com

Don't forget to come home. Your medical insurance covers trips up to 60 days.
You **must** return home for at least one day before starting your next trip.

Leaves

Leave of Absence

If you are on an approved leave as defined by the Ontario *Employment Standards Act*, you may be eligible to continue to receive benefit coverage from the IBEW Local 353 during your leave.

Under the Ontario Employment Standards Act, most eligible leaves are unpaid absences. However, you may be eligible for Employment Insurance benefits and the IBEW Local 353 Supplementary Unemployment Benefits (SUB).

To ensure you maintain health and welfare coverage during an eligible leave, you must notify your employer, the IBEW Local 353 Union Hall and TEIBAS prior to taking a leave of absence.

Pregnancy and Parental Leave

To be eligible for continued benefit coverage while on a pregnancy or parental leave, you must be working and in-benefit before the leave begins.

While on approved pregnancy or parental leave, your bank hours will not be reduced. As well, you will receive full credits toward the pension plan during your pregnancy or parental leave (pro-rated for partial months).

A surrogate may have statutory entitlement to pregnancy leave, whether or not they are entitled to parental leave.

If one woman in a same-sex relationship carries a child and gives birth, the other woman (who may identify as a "Mother") may be entitled to parental leave but not pregnancy leave.

You may be eligible for Employment Insurance benefits and the top-up of Supplementary Unemployment Benefits (SUB), contact the IBEW Local 353 Union Hall for more information.

If you are unable to work due to your pregnancy, it is recommended that you apply for short-term disability benefits. To apply for short-term disability, contact the IBEW Local 353 Union Hall at 416-510-3530.

Designation	Pregnancy Leave	Parental Leave
Pregnant parent	Maximum 17 continuous weeks	Plus, maximum 61 weeks immediately following pregnancy leave
Other parent	Not applicable	Maximum 63 continuous weeks, must start within 78 weeks after the birth
Adoptive parents	Not applicable	Maximum 63 continuous weeks, must start within 78 weeks after the adoption

You must notify TEIBAS of the birth or adoption of your child as soon as possible. In order to add your child to the health and welfare plan, you must provide TEIBAS with:

- A copy of the completed Change/Update of Information Form available at www.myteibas.com.
- A certified copy (long form) of the child's birth certificate, or a certified copy of the adoption order.
- A copy of both sides of the child's original health card.

If you are on one of the following listed eligible leaves as defined under the Ontario Employment Standards Act, you may be eligible for continued benefit coverage and pension credits from the IBEW Local 353 Trust Funds during your leave (pro-rated for partial months). Some leaves may also be eligible or Supplementary Unemployment Benefits (SUB) and Employment Insurance benefits.

To ensure members maintain health and welfare coverage during an eligible leave, you should notify your employer, the IBEW Local 353 Union Hall and TEIBAS prior to taking a leave of absence.

All leaves are subject to the provisions and standards outlined in the Ontario Employment Standards Act.

Family Medical Leave
A member may take up to 28 weeks of leave to provide care or support to certain family members and people who consider the member to be like a family member, if the family member has a serious medical condition with a significant risk of death occurring within a period of 26 weeks.

Family Caregiver Leave
Members may take up to 8 weeks of leave in respect of each qualifying family member that has a serious medical condition over the course of a calendar year. Members are not required to take the leave consecutively.

Critical Illness Leave
Critical illness leave may be taken to provide care or support of up to 37 weeks in relation to a critically ill minor child, or 17 weeks in relation to a critically ill adult within a 52-week period.

Organ Donor Leave
If a member undergoes surgery to donate all or part of certain organs (kidney, liver, lung, pancreas, or small bowel) to another individual, the member may be eligible for up to 13 weeks of leave. In certain cases, organ donor leave can be extended for up to an additional 13 weeks.

Child Death Leave
A member may take up to 104 weeks of leave with respect to the death of a child. “Child” means a child, step-child, child under the legal guardianship of the employee or foster child who is under 18 years of age.

Crime-related Child Disappearance Leave
A member may take up to 104 weeks of leave with respect crime-related child death or disappearance of a child. “Child” means a child, step-child or foster child who is under 18 years of age.

Domestic Or Sexual Violence Leave
A member may take up to 10 individual days and a total of 15 weeks in a calendar year of time off to be taken for specific purposes when a member or a member’s child has experienced or been threatened with domestic or sexual violence. The first five days of leave taken in a calendar year are paid, and the rest are unpaid.

Reservist Leave
Members who are reservists and who are deployed to an international operation or to an operation within Canada that is or will be providing assistance in dealing with an emergency or its aftermath (including search and rescue operations, recovery from national disasters such as flood relief, military aid following ice storms, and aircraft crash recovery) are entitled under the Ontario Employment Standards Act to unpaid leave for the time necessary to engage in that operation. In the case of an operation outside Canada, the leave would include pre-deployment and post-deployment activities that are required by the Canadian Forces in connection with that operation.

Other Leaves
Members may be eligible for wage replacement due to time missed at work as a result of jury duty, subpoena as a witness and bereavement leave. Contact the IBEW Local 353 Union Hall at 416-510-3530 for additional information.

Self-Pay

The IBEW Local 353 Benefit Plan requires that members have at least 135 hours in their hour bank in order to be eligible for a month's benefit coverage. If a member falls below 135 hours and is not eligible for subsidized coverage, the IBEW Local 353 union office may offer self-pay coverage, if eligible. Members self-pay by remitting benefit premiums to TEIBAS directly to maintain benefit coverage in the IBEW Local 353 Benefit Plan.

Why Self-Pay?

- Excellent value — you wouldn't be able to purchase this coverage elsewhere.
- Coverage at cost—which means it's not subsidized by the fund.
- You aren't required to provide proof of good health to be insured.

There is a two-year self-pay maximum for active (non-retired) members. Retiree coverage can be longer if needed to bridge to fully retired benefit coverage, or if you are a surviving spouse. Contact TEIBAS for details.

There are two benefit coverage options for self-pay. They are deluxe and standard coverage. Members can make a one-time change to their deluxe self-pay option to the standard self-pay option after 12 months of self-pay participation. Members who elected the standard self-pay option cannot upgrade to the deluxe option at a later date.

If a member elects not to participate in the self-pay program, benefit coverage will be terminated on the first day of the following month. Once a member declines the self-pay offer, benefit coverage can only be reinstated when they re-qualify for benefits by rebuilding their hour bank.

Members who have been out of regular benefit for less than 12 months need to rebuild their hour bank to 300 hours within 6 consecutive months in order to requalify for reinstatement in the IBEW Local 353 Benefit Plan. If a member has been out of benefit for longer than 12 months, they will need to rebuild their hour bank to 450 hours within 6 consecutive months to requalify for regular coverage.

Active Member Self-Pay Reimbursement Rate (for eligible expenses, subject to current limits on pages 5, 7 & 8)	**Standard**	**Deluxe**
Health: Drugs, medical, vision, hearing, paramedical	Up to 75%	Up to 100%
Member Assistance Program	Covered	Covered
Teladoc	Covered	Covered
Dental: Diagnostic, preventive, minor restorative, endodontics	Up to 75%	Up to 100%
Dentures	Not covered	Up to 100%
Periodontics	Not covered	Up to 75%
Major restorative	Not covered	Up to 75%
Orthodontics	Not covered	Up to 75%
Life / Accidental Death (member only)	$150,000	$150,000
Emergency travel health insurance	Up to 100%	Up to 100%

Life Insurance

You are covered for $150,000 of life insurance. This is paid tax free to your named beneficiary, or to your estate if no beneficiary is named. If a pensioner is participating in one of the retiree plans, there is a $20,000 death benefit payable to their beneficiary upon their death. The first $10,000 of the death benefit for eligible retirees is not taxable, but the remaining $10,000 is taxable.

Spousal And Dependent Life Insurance

Dependent life insurance is payable in the amount of $40,000 in the event of your spouse passing and $10,000 for dependent children. This benefit is payable tax free to the member. This benefit ends once a member is in receipt of IBEW Local 353 pension. To be payable the spouse and/or eligible dependents need to be in benefits at time of death.

Taxes On Life Insurance

Life insurance benefits are received tax free by your beneficiary. Under income tax law, employer contributions for life insurance are taxed as income. This amount is shown on the T4A form that you receive from TEIBAS every year.

Accidental Death & Dismemberment

When accidents happen, it's good to know that you and your family have the extra protection of accident insurance which pays a benefit if you're injured or die because of an accident, on or off the job. Payments are tax-free and are paid in addition to any other insurance you may have. Accidental death insurance coverage for members not in receipt of an IBEW Local 353 pension is $150,000 member, $40,000 spouse, $10,000 for each child, if death or permanent injury occurs within 90 days of an accident. If you die in an accident, your spouse and child continue to receive accident insurance for 12 months at no cost.

If you suffer an accident and, within one year from the accident, you suffer one of the specific losses listed below as a result of the accident, then you may be eligible for an amount equal to a percentage of the accidental death benefit amount. However, if you suffer more than one of the specific losses as a result of the same accident, you will only be eligible for one payment (the larger of the applicable payments). The schedule below is a summary of benefit coverage available under the IBEW Local 353 accident insurance plan. Visit www.myteibas.com for more information. You have one year from the date of an accident to submit a claim to the insurance carrier.

Claim	Percentage of Benefit Amount
Loss of Entire Sight of One Eye	100%
Loss of One Arm or One Leg	100%
Loss of Use of One Arm or One Leg	100%
Loss of One Hand or One Foot	100%
Loss of Use of One Hand or One Foot	100%
Loss of Speech and Hearing	100%
Brain Death	100%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Both Hands or Both Feet	200%
Loss of Entire Sight of Both Eyes	200%
Loss of One Hand and One Foot	200%
Loss of Use of One Hand and One Foot	200%
Loss of One Hand and Entire Sight of One Eye	200%
Loss of Use of One Hand and Entire Sight of One Eye	200%
Loss of One Foot and Entire Sight of One Eye	200%
Loss of Use of One Foot and Entire Sight of One Eye	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of Speech or Hearing	66 2/3%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	25%
Loss of All Toes of Same Foot	12 1/2%

Accident insurance may also help cover other costs. For example, if you die in an accident, accident insurance may help cover the cost of day care for children under age 12. Accident insurance may also help cover the cost of transportation for a family member to visit a member or covered dependent who is hospitalized more than 150 kilometres from home. Accident insurance may also help cover the cost of rehabilitation for special training required as a result of injuries. Contact TEIBAS or the IBEW Local 353 Union Hall to apply for accident insurance benefits. Chubb Life adjudicates and administers accident claims for members of the IBEW Local 353. For inquiries related to an accident claim status, contact Chubb Life at 1-877-772-7797. Accident insurance doesn't cover any form of disease, illness, physical or mental infirmity, or bacterial infections.

Naming a beneficiary for accident and life insurance
When you first join the plan, you must complete an application form where space is provided to name your life insurance and accident insurance beneficiary(ies). You may name anyone you wish as your beneficiary and you may name more than one person. If you name more than one person, your death benefit will be divided equally unless you provide other instructions. Any death benefit will be paid to the most recently named beneficiary on file with TEIBAS unless you have a more recent will that makes specific reference to your IBEW Local 353 life insurance and/or your IBEW Local 353 personal accident insurance. If you don't name a beneficiary, death benefits will be paid to your estate and may be subject to probate fees, estate taxes and creditor claims.

If your beneficiary is a minor, you should consider appointing a trustee to look after your child's benefits. Otherwise, your death benefits may be held in trust until your child reaches age 18.

Shortened Life Expectancy

If you have a terminal illness with less than one year to live, you may request an advance life insurance payment of up to $50,000. This option is not available under retiree death benefits. This will be deducted from the life insurance payment upon your death. Contact TEIBAS for more information on this benefit.

Critical Illness Insurance

Critical illness insurance coverage is available to members under age 65 and not collecting an IBEW Local 353 pension. If a member is diagnosed with an eligible condition listed below, the member may be eligible for up to $25,000 upon approval of their claim. Paid benefits can be used to cover childcare costs, make modifications to your home or however else you choose. Here is the list of diagnoses covered under your critical illness insurance policy:

- Alzheimer's Disease
- Aorta Surgery
- Benign Brain Tumour
- Blindness
- Cancer
- Cancer Recurrence
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dismemberment
- Heart Attack
- Heart Valve Replacement
- Loss of Independence
- Loss of Speech
- Major Organ Failure
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

Critical illness insurance may be partially payable for:

- Ductal Carcinoma in Situ (DCIS-early stage breast cancer)
- Early Prostate Cancer Treatment
- Hip & Total Knee replacement surgery
- Second Event Benefit (for Cancer and Cardiovascular Condition only)

Critical illness claims must be submitted within 30 days of accident or diagnosis and proof must be received within 90 days. If you are eligible for a claim payment but do not survive to receive it, the benefit payment will be made to your named life insurance beneficiary(ies) on file. Should you be diagnosed with multiple illnesses, it is recommended you submit a claim for each illness to determine eligibility.
If a member is diagnosed with, or meets the definition of one of the listed insured conditions, which results in the member incurring any of the following expenses directly related to the diagnosis of an insured condition, Chubb Life will reimburse such expenses, subject to all policy terms and conditions, up to an overall policy maximum of $1,000.00.

1. Services from a registered graduate nurse who is not a family member of the Insured.
2. Transportation costs including; ambulatory fees, taxi, and public transportation to any medical treatments, physician appointments, and post diagnostic testing appointment.
3. Rental costs of a wheel chair or other approved durable equipment for temporary therapeutic treatment.
4. Drugs or medicines dispensed by a licensed pharmacist, which requires the prescription from the attending physician, including deductible amounts under other benefit plans.
5. Meals, in hospital, for the insured, plus one attending caregiver on days where the hospital visit duration is three hours or more.
6. Parking costs at medical facilities such as hospitals, physician's offices, diagnosis testing facilities.
7. Daycare costs for children at a licensed and registered daycare facility.
8. Pet care costs including day boarding, in home care or dog walking, provided by a registered pet care operator.

Critical Illness Insurance **(continued)**

Chubb Life may require proof of payment (original receipts) up to one year from the date of submission. Where a portion of reimbursement may be covered under another group health benefits plan an Explanation of Benefits (EOB) must be submitted with the claim.

Similar to life insurance, the premiums for critical illness insurance paid for by employers will be reported on your T4A. Benefits are payable tax free.

If an insured is diagnosed with either cancer, heart attack, stroke, coronary artery bypass or undergoes aorta surgery or heart valve replacement and a claim is paid by Chubb and the person recovers from their diagnoses and returns to work for more than 90 consecutive days. That insured is eligible for a second Critical Illness claim at the full principal sum for any of the other covered conditions other than the originally paid condition. This does not apply to the cancer diagnosis as this policy has a cancer recurrence benefit which provides for a second cancer payment if the originally paid cancer has been in remission and no treatment or consultation has been received by the claimant for a period of 60 months (5 years).

If an insured's first claim with Chubb for any of the other covered conditions, MS, Parkinson's, Alzheimer's, Benign Brain Tumor, blindness, coma, deafness, dismemberment, loss of speech, loss of independence, organ failure, organ transplant, motor neuron disease, Occupational HIV, paralysis or severe burns, then they are not eligible for the second event provision and they are removed from the policy as of the date of payment of claim.

This provision also does not apply to the partial payments of DCIS, early prostate cancer treatment or hip/knee replacement. These benefits are partial payments and therefore, not subject to the second event benefit. If you make a claim for one of these conditions and are paid an amount, you remain on the policy and the amount paid is not deducted from your $25,000 total benefit.

Contact TEIBAS or the IBEW Local 353 Union Hall to apply for critical illness benefits. Chubb Life adjudicates and administers critical illness claims for members of the IBEW Local 353. For inquiries related to critical illness claim status, contact Chubb Life at 1-877-772-7797.

Your Benefits at Retirement

How Your Plan Works

Full Retiree Coverage

When you become fully retired, you are eligible for full retiree benefits at no cost to you+. Fully retired means that all of the following apply:

- You're 62 or older, or you are totally disabled and receiving a Canada Pension Plan or Quebec Pension Plan (CPP/QPP) disability pension, and
- You receive a benefit from the IBEW International benefit fund, and
- You receive your IBEW Local 353 pension or upon retirement received a small lump sum payment, and
- You were covered under the IBEW Local 353 Benefit Plan at the time you retired, and
- You were covered under this plan for at least 36 of the 60 months immediately before you retired or have 39,000 hours of contributory service in the benefit plan.

Retiree-bridge benefits — coverage until you're fully retired. When you fully retire with the IBEW Local 353, you continue to receive valuable health benefits which as a retiree would be either very expensive or unavailable if you were to purchase them directly from an insurance company.

If you retire on your IBEW Local 353 pension, but are not fully retired (for instance you are not collecting your IBEW International pension or you retire before age 62) you must not allow your coverage to lapse. To remain eligible for full retiree benefits you can purchase retiree bridge benefits on a self-pay basis or use your accumulated hour-bank account. You qualify to self-pay retiree-bridge benefits until you're eligible for full retiree benefits. Self-pay premiums are reviewed annually.

+ The Trustees reserve the right to change or cancel any or all of the benefits described in these pages at any time.

Retiree-Bridge Self-Pay Benefits At A Glance*

	Reimbursement Rate (for eligible expenses, subject to current limits)	
	Standard	**Deluxe**
Health: Drugs, medical, vision, hearing, paramedical	Up to 75%	Up to 100%
Member Assistance Program	Covered	Covered
Teladoc	Covered	Covered
Dental: Diagnostic, preventive, minor restorative, endodontics	Up to 75%	Up to 100%
Dentures	Not covered	Up to 100%
Periodontics	Not covered	Up to 75%
Major restorative	Not covered	Up to 75%
Death Benefit (member only)	$20,000	$20,000
Accident Insurance	Member $10,000 Spouse $4,000 Each Child $1,000	Member $10,000 Spouse $4,000 Each Child $1,000
Travel Medical Emergency Insurance & Assistance Policy #1TR55 Beneva travel insurance covers the first 30 days of each trip up to 100% of emergency medical expenses while traveling outside the province to a maximum of $5 million per person per trip. Pre-existing condition stability clause of six months applies. Call Beneva travel insurance if you have any questions about coverage before you travel at 1-855-369-5444.	Covered	Covered

* Hardship provision provides retiree bridge coverage at no cost for members with family income of less than $35,000 per year. Proof is required. Contact TEIBAS for details.

If you return to work after you start your IBEW Local 353 pension

Once you take your IBEW Local 353 pension you no longer qualify for disability benefits, critical illness benefits, spouse or dependent life insurance and Supplementary Unemployment Benefits (SUB). Your life insurance changes to $20,000 and accident benefits change to $10,000 each, whether you continue to work or not. Also, if you're 65 or older and have taken an IBEW Local 353 pension, you cannot submit Ontario Drug Benefit co-pay or dispensing fees to the IBEW Local 353 plan.

When you're 65 or older

When you turn 65 you qualify for the Ontario Drug Benefit (ODB) program, which covers most of the cost of prescription drug products listed in the Ontario Drug Benefit Formulary. When you're 65 and a resident of Ontario and have valid Ontario Health Insurance (OHIP), you are eligible for drug coverage under the ODB program. The IBEW Local 353 Benefit Plan does not cover the drugs covered in the ODB program.

The ODB program currently covers:

- Over 4,300 quality-assured prescription drug products.
- A number of limited-use drug products.
- Some nutritional products.
- Some diabetic testing products.

At age 65 drug coverage under the IBEW Local 353 the plan changes depending on whether you're collecting an IBEW Local 353 pension or not.

Receiving An IBEW Local 353 Pension	Not Receiving An IBEW Local 353 Pension
ODB dispensing fees and co-payments are not covered by the IBEW Local 353 Benefit Plan. However the annual ODB deductible is covered by the IBEW Local 353 Benefit Plan. Your coverage for other drugs not covered by the ODB remain covered as when you were an active member.	ODB dispensing fees, co-payments and deductibles are covered by the IBEW Local 353 Benefit Plan, provided the drug is covered.

Costs to you under the ODB program

You may be asked to pay some portion of your prescription drug product costs. Based on your combined annual income (or family income), you may be required to pay a $100 deductible per senior before being eligible for drug coverage under the ODB program. After you pay the deductible, you then pay a $6.11 co-payment toward the prescription for a covered drug product in Ontario in the benefit year. The co-payment may be lowered to $2 per perscription, and the deductible waved for low income seniors. Please visit the Ontario Drug Benefit website at https://www.ontario.ca/page/get-coverage-prescription-drugs for further information.

The annual $100 ODB deductible is an eligible expense under the IBEW Local 353 Benefit Plan. The incurred expense should be submitted to Canada Life for review.

Full Retiree Benefits At A Glance - Effective May 1, 2024

Benefit	Coverage
Health: No deductible Reimbursed at 100% (unless otherwise noted) Limits and exclusions apply	**Includes:** Ambulance services Medical supplies (e.g. oxygen, crutches, casts, etc.) Durable medical equipment (e.g. wheelchairs)
Orthopedic shoes or orthotics	Combined maximum of $500 every 12 months
Prescription drugs (Drug card provided)	100% reimbursed for medically necessary prescription drugs Fertility drugs ($5,000 lifetime maximum) and erectile dysfunction drugs $500 per calendar year maximum (e.g. Viagra) Dispensing fee covered to $8.00 per prescription Special rules apply when you are 65 and older Some drugs are subject to pre-approval
Hospital	Semi-private coverage for acute care accommodations
In-home private duty nursing	$10,000 per calendar year
Vision care	Glasses or contact lenses to $750 per person every 24 months
Hearing aids	$750 per ear every 36 months
Paramedical services	Expenses reimbursed up to 100%, based on reasonable customary charges to a maximum of $2,500 per calendar year, per person, for all practitioners combined. See page 8 for a list of eligible practitioners.
Member Assistance Program Telus Health, (formerly LifeWorks) 1-866-289-6749 or www.one.telushealth.com	Provides confidential, short-term counselling for relationship and family issues, legal and financial matters, addictions and health advice, nutritional and personal well-being.
Mental Wellness Benefit	Reimbursed at 100% based on reasonable and customary charges, to a maximum of $3,000 per calendar year, per person for all practitioners combined. See page 8 for a list of eligible practitioners.
Teladoc www.teladoc.ca/medical-experts or 1-877-419-2378	Provides a comprehensive medical review that addresses three key questions: Is my diagnosis correct? What's the best treatment? What's going to happen to me? The service is available for you, your spouse, your dependents, parents and parents-in-law.
Dental	Service includes cleaning, polishing, minor and major restorative services, dentures, crowns and orthodontics (for child dependents only). See pages 9 and 10 for complete details. Fees based on the current year's Ontario Dental Association Fee Guide for General Practitioners. $10,000 annual maximum per person, excluding orthodontics and implants.
Death Benefit (member only)	$20,000
Accident Insurance	Member $10,000; Spouse $4,000; Each Child $1,000
Travel Medical Emergency Insurance & Assistance **Plan ID # 1TR55** Log into www. myteibas.com to access the travel booklet and travel card.	Beneva Retiree Travel Insurance covers the first 30 days of each trip up to 100% of emergency medical expenses while traveling outside the province to a maximum of $5 million per person per trip. Pre-existing condition stability clause of six months applies.

* Benefits are subject to reasonable and customary limits as defined by Canada Life and industry practices. Benefits At A Glance provided here are highlights of the benefits available to eligible retired members of the IBEW Local 353 in receipt of an IBEW Local 353 pension. Should there be any difference between the information contained here and the legal plan documents, the plan documents will apply. The Board of Trustees reserve the right to change or cancel any of all benefits described on this page at any time.

Retiree benefit coverage - Know before you spend

Before incurring any expenses, or beginning any treatment, ask your medical or dental service provider to complete a cost estimate or treatment plan and submit it to Canada Life. It is recommended that an estimate or treatment plan be submitted before purchasing any products or having any treatment that will cost $300 or more. Canada Life will calculate the benefits payable for the proposed expense, so you will know in advance the approximate portion of costs that you will have to pay.

All expenses are limited to reasonable and customary costs established by Canada Life.

All claims must be submitted to Canada Life as soon as possible, but no later than 12 months after you have incurred the expense or within 90 days of your coverage ending (see page 5). When submitting a claim, you must include the plan number 51189 and your personal identification number located on the front of your drug card.

Prior to travelling review the travel benefits booklet available on www.myteibas.com. It is also recommended that retired members contact Beneva at **1-855-369-5444 (Plan ID # 1TR55)** to confirm coverage details. You must disclose to Beneva if you have had any changes to your prescription and/or changes in medical condition within a six month period prior to travelling. Beneva will advise whether they will cover you should you decide to travel and had any of these changes within the last six months.

For more information visit www.myteibas.com or contact TEIBAS directly at 416-637-6789 or toll-free at 1-800-267-0602.

Surviving Spouse Coverage

In the event a member or retired member passes away, the IBEW Local 353 Benefit Plan provides extended coverage for the member's eligible surviving spouse. Surviving spouses should contact TEIBAS if a member or retired member passes away.

Eligible surviving spouses of IBEW Local 353 members who are in benefit at the time of death are provided with the same level of coverage the deceased member had at the time of death for five years at no cost.

TEIBAS will provide required documentation to the surviving spouse, along with benefit coverage details.

Coverage doesn't include:

- Long-term disability
- Short-term disability
- Critical Illness
- Life Insurance
- Accident Insurance

Remember: when filling out your income tax return, you can't claim medical expenses paid under the plan as a deductible. However, certain self-pay premiums are eligible to be claimed. TEIBAS will issue a T4A for those eligible premiums.

Once the five year coverage expires, surviving spouses may be provided the option to continue their coverage through the self-pay program. The self-pay program provides surviving spouses with the option to continue their benefit coverage by self-paying the premiums. Surviving spouses will have the option to select either a standard or deluxe option.

The standard option pays most benefits up to 75% while the deluxe option pays most benefits up to 100%. Premiums associated with the self-pay program are based on the surviving spouse's age (under/over age 65) and are subject to change annually. For more information contact TEIBAS.

Should a surviving spouse elect not to continue their benefit coverage by participating in the self-pay program, benefit coverage will cease. Once benefit coverage has been terminated, benefit coverage cannot be reinstated.

* The Trustees reserve the right to change or cancel any or all of the benefits described in these pages at any time.

Key Terms

The following Key Terms are used used to explain your group benefit plan:

Administrator
The administrator of the plans is Toronto Electrical Industry Benefit Administration Services Ltd. (TEIBAS). TEIBAS looks after the day-to-day administration of the plans, including receiving contributions, maintaining records, preparing statements, and answering member questions. TEIBAS is owned by the trusts and reports directly to the Board of Trustees.

Beneficiary
The person(s) you name to receive life, accident insurance, or pension death benefits are beneficiaries. You can name anyone you choose to be your beneficiary. However, by law, your spouse is the beneficiary of any pension you have earned since 1987, unless he or she signs a waiver before your death.

Board of Trustees
The plans are governed by a joint Board of Trustees. Four of the Trustees are appointed by the Union and four are appointed by the employers' association (Greater Toronto Electrical Contractors Association).

Co-ordination of benefits
Rules that determine how benefit claims will be paid when a member has coverage under more than one plan to ensure that each plan pays its share of the claim.

Deductible
The portion of an eligible expense that must be paid by you, before any amount can be claimed from the plan.

Dental fee guide
Every year the Ontario Dental Association publishes a Suggested Fee Guide for General Practitioners for dental services in this province.

Dispensing fee
The fee charged by a pharmacist to fill a prescription. It is intended to cover the pharmacist's time and administrative costs.

Eligibility requirements
The conditions you must satisfy to qualify for coverage.

Employer
Any company that has agreed to abide by the provisions of the collective agreement with the union and is obligated to contribute a set amount to the trust funds for every hour a member works or an employer that is otherwise obligated to contribute to the plan through a participation agreement.

Employment Insurance (EI)
A federal government program that provides temporary financial assistance for unemployed Canadians while they look for work or upgrade their skills. EI also provides pregnancy/parental leave benefits and benefits for people who are unable to work because they must care for a family member who is seriously ill with a significant risk of death.

Hour bank
Hours for which a participating employer makes contributions to the trust fund. In general, for every hour worked you receive one hour toward your hour bank balance. Each month 135 hours are deducted to cover the cost of health and welfare benefits. Monthly hours greater than 135 accumulate in your hour bank account to a maximum of 4,860 hours or 36 months.

Jointly-administered plan
A plan that is governed by a committee made up of union and employer representatives. The IBEW Local 353 plans are jointly administered.

Physician/surgeon
A doctor who is legally licensed to practice medicine in the jurisdiction where services are provided and is practicing within the scope of his/her license.

Plan document
A formal written statement outlining the terms of the benefit plans.

Pre-approval process
Certain medical procedures/appliances/drugs must be evaluated and approved by the plan's medical reviewers before being covered under the plan.

Reasonable and customary
The general level of charges that will be reimbursed by the carrier for a specific service or product in the geographic location where the expenses are incurred.

Rehabilitation or rehabilitation plan
A program designed to assist a disabled member who is on disability benefits to return to health and full-time employment. This may involve parttime work at member's own occupation or another occupation, an approved work re-conditioning program, retraining or education.

Self-insurance
An arrangement in which the plan assumes the financial risk and is fully responsible for the cost of certain benefits, rather than having them insured by an insurance company. IBEW Local 353's plan self-insures all health costs, all dental costs, short-term disability payments, long-term disability payments for up to 10 years, and retiree death benefits.

Key Terms (Continued)

Spouse (for Benefit Plan purposes)
For purposes of the IBEW Local 353 Benefit Plan, your "spouse" is the person you are living with and to whom you are legally married or have been in a common-law relationship for at least 12 months (proof required). A different definition of "spouse" applies under pension law.

Totally disabled or total disability
Initially, this term means that you have an illness or injury which prevents you from performing the essential duties of your own job. This meaning applies during the short term disability period (first 26 weeks) and the next twenty four (24) months. After that time passes, the term means that you are unable to perform the duties of any occupation for which you are qualified, or may reasonably be able to become qualified (through education, training, and experience) due to illness or injury.

Trust fund
A "trust" is a legal entity that is created when a person or organization transfers assets to a trustee for the benefit of others. A "trust fund" is a fund with assets managed by a trustee or board of trustees for the benefit of others. The trustee's duties and restrictions are usually laid out in a trust agreement and may also be governed by federal and provincial law.

Trustee
The person or persons entrusted with managing a trust, such as a group benefit plan.

Waiting period
The period of continuous active employment with an employer following which the member and his or her dependents become eligible for insurance.

Other key things to keep in mind

Remember there's no big insurance company picking up the tab — and there's a limited pool of money to pay for benefit claims. Benefit costs continue to increase and it's not unusual for benefit costs to increase at a faster rate than the consumer price index. Three things that are driving costs higher:

Increased demand for paramedical practitioners. We have seen an increase in the use of paramedical practitioners, such as psychologists, message therapists, physiotherapists, and chiropractors.

New drugs. The pace of medical advancement keeps evolving. There are new prescription drugs available to help us beat or cope with illness and disability. However these new drugs are much more expensive than drugs of the past. That means higher costs for the benefit plans.

Cost shifting. In the past, we relied on government to trim costs, but now a bigger slice of our health care expenses is being picked up by plans like ours. Our plan doesn't cover MVA expenses.

Changing the Plan
The Plan provides comprehensive and excellent benefits and our goal is to continue to provide the best possible benefits to our members. However, with today's changing economic environment, there is no guarantee that the same level of benefits can be maintained. To protect, the plan, the Trustees have the right to change, remove, reduce or increase any or all benefits at any time – including benefits for active and retired members and their survivors.

Special Requests
If there is a plan change that you would like to recommend, or a specific medication or piece of medical equipment you think should be covered, you can send in a request to the Board of Trustees. Requests for changes or additions to the plan are reviewed and costed once per year, in January. You can send in your suggestions by visiting the IBEW Local 353 website and completing a members inquiry form at https://form.jotform.com/82495937388275 or you can email them to scmquestions@teibas.com.

Notify Us

Contact us when one or more of these notable events occur:

- **Starting a family:**
  Be sure to provide TEIBAS with your updated forms (available on www.teibas.com and www.myteibas.com) and the proof required along with the name of and date of birth of your new spouse and/or the names and dates of birth of dependent children. It's important to provide TEIBAS with a full list of your eligible dependents so they'll be covered. Also make sure you provide TEIBAS with the name of your life insurance beneficiary (ies); otherwise, the insurance payment will be made to your estate and may be subject to probate fees.
- **Moving:**
  When you change your address, including your email and/or phone number, let TEIBAS know so that your claims, contribution statements, and other important information arrive promptly.
- **Separation or divorce:**
  To be eligible for benefits, your married, or common-law spouse must be living with you. **If you separate or divorce, coverage for your spouse ends.** Your children remain covered. You can cover only one spouse or partner at any one time. If you have been ordered by the court to continue coverage for your ex-spouse, it's your responsibility to buy individual coverage outside the plan. Your IBEW Local 353 Benefit Plan won't continue coverage for your ex-spouse.
- **Preparing for retirement:**
  At retirement you may need to self-pay benefits for a period, before becoming eligible for full retirement benefits. See "Your benefit options at retirement" on page 23 for details.

Contact Information For Service Providers

Health and Dental Claims
Canada Life Assurance Company
Health and Dental Claims Office
P.O. Box 3050
Winnipeg, Manitoba R3C 0E6
Toll-free: 1-844-232-4239
www.canadalife.com

Short- and Long-Term Disability Claims
Canada Life Assurance Company
Disability Claims Office
55 Town Centre Court, Suite 400
Scarborough, Ontario M1P 5B5
Phone: 416-290-3770

Critical Illness and Accident Insurance Claims
Chubb Life Insurance Company of Canada
199 Bay Street - Suite 2500
P.O. Box 139, Commerce Court Postal Station
Toronto, Ontario M5L 1E2
1-877-772-7797

Beneva Group Travel Insurance
Travel Medical Emergency Insurance and Assistance
110 Sheppard Avenue East, Suite 500
Toronto ON
M2N 6Y8

In case of medical emergency:

From Canada and the United States, call toll-free 1-855-369-5444

From anywhere else in the world, call collect + 519-735-9448

Member Assistance Program
TELUS Health (formerly LifeWorks)
1-866-289-6749
www.one.telushealth.com

Teladoc
1-877-419-2378
www.teladoc.ca/medical-experts

protecting **your** future

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Bill Acorn
IBEW Local 353

Dan Camilleri
GTECA

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Dave Graham
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Jeff Irons
IBEW Local 353

Michael Mulgrew
GTECA

Ilona Talab
GTECA

teibas
TORONTO ELECTRICAL INDUSTRY BENEFIT ADMINISTRATION SERVICES
IBEW LOCAL 353 PENSION & BENEFIT PLANS

TEIBAS
110 Sheppard Avenue East, Suite 705,
Toronto, Ontario M2N 6Y8
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MP: www.myteibas.com

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