Belmont
Health & Wealth

ATLANTIC CANADA
REGIONAL COUNCIL OF CARPENTERS MILLWRIGHTS AND ALLIED WORKERS

Date: January 15, 2017

Issue 2

People Who Care….Benefit Solutions That Work

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RECIPROCAL HOURS:

Note that all hours worked in Provinces, other than those as part of the Atlantic Canada Regional Council, may take more than one month to be reciprocated back to the ACRC plan. As a result, it may put your benefits at risk.

To ensure your coverage remains active during any period you are working in other Provinces, please contact Belmont Health & Wealth directly at 1-800-565-7050 to see if you are covered or to determine if you are eligible for the self-pay option.

When hours are received you will receive credit for the months in which you worked, not for upcoming months, and that in order to receive these credits, you are required to remain a member in good standing with your home local.

SELF-PAY PROVISIONS:

If you have not continued to self-pay when you are not working. You are only able to self-pay one month prior to the current month.
Example: If it is July, you can only go back as far as June to make a self-pay. There are no exceptions to this rule.

When you are making self-payments, you are not allowed to skip a month. Your coverage must remain consecutive. If it does not, in order to re-qualify for benefits you would need to return to work and work the required number of hours to be reinstated on benefit.

Once you have chosen a self-pay class, you cannot switch classes. If you opt out of dental on your self-pay plan you will not qualify for dental benefits again until you return to work.

RULES FOR ELIGIBILITY OF COVERAGE:

An active **member in good standing with the Union** and employed by a participating employer in a job class covered by a labour contract or collective agreement with the Union; or

A permanent full-time salaried employee of the Union; or

A full-time employee of a participating employer; or

A member under the self-payment program but **a member in good standing with the union**;

A retired member in good standing with the Union who:
- is at least 55 years of age;
- has been certified as such by the Union and
- was insured as an active member for the 12 month period immediately preceding retirement **and** has a minimum of 10 years' service to be eligible for retirement benefits. (*)

NOTE:

i. 10 years' service, per ACRC meeting, January 10, 2013. A spouse of employee must also be covered immediately preceding retirement (*)

ii. **Member in good standing** means a member that is a dues paying member and continues to pay dues while covered under the plan.

iii. Should a member elect to transfer out of the Local to another Local, that member will be entitled to transfer the value of his or her hours to another approved Health and Welfare Plan. From the date of that transfer, ACRC will be no further obligated or liable for any benefits to that member after that date.

iv. The maximum number of hours a member can accumulate within their hour bank will be limited to 24 months.

Plan Conditions and term as could change due to market conditions. Trustees have the right and obligation to change and/or terminate benefits at any time.

How to use your Benefit Booklet

This booklet has been prepared to provide you with an overview of your group benefits plan.

Atlantic Canada Regional Council of Carpenters Millwrights and Allied Workers offer you several benefits that provide financial protection for you and your family. These benefits include:

- **Prescription Drug Coverage**
  - **Special Authorization Program**
  - **Specialty Drug program**
- **Extended Healthcare Benefit**
  - **Hospital**
  - **Major Medical**
  - **Vision Care**
- **Dental Care Benefit (Divisions 001, 002, 020, 005, 003, 004 (units 001,002 and 004), 016 & 030 ONLY)**

Note that the coverage effective dates are subject to waiting periods that may apply to your specific plan. For more information, please contact your Group Plan Administrator.

The Benefit Booklet provides the information you need about your Benefits and has been specifically designed with your needs in mind. It includes:

- **Information you need to update your coverage information**
- **A brief Summary of the Highlights of your Benefit Package, allowing quick access to the most frequently asked questions**
- **Explanation of Common Benefit Terms**
- **Simple instructions on how to submit a claim**
- **A concise explanation of your Benefits**

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of **Atlantic Canada Regional Council of Carpenters Millwrights and Allied Workers**. This booklet is not a contract of insurance. While every effort has been made to ensure the

accuracy of this booklet, your rights and benefits are governed by the terms of the Contract.

If there are any discrepancies between this booklet and the Contract, the Contract will be the governing documents in all cases. Any amendment to the governing documents is effective without notice to you, except as required by law.

Possession of this booklet alone does not mean that you or your dependents are covered under this plan. The Group Plan must be in effect and you must satisfy all the eligibility requirements of the Contract.

In this booklet, words implying the masculine gender include the feminine.

How to Contact Us

All claims must be received by Belmont within 1 year of the date the expense was incurred or within 90 days of benefit coverage termination.

On-Line Real-time Claims:

If you have elected to have on-line real-time prescription drug and dental coverage, you will receive a Belmont identification card(s). This card will allow your Pharmacist or Dentist to submit claims electronically for adjudication.

Reimbursement Claims:

To submit manual reimbursement claims, you can obtain a claim form from Belmont at www.gobelmont.ca. You will need to sign all claim forms and attach original receipts prior to submitting to Belmont for reimbursement. All claim forms may be sent to:

Belmont Health and Wealth

133 Prince William Street, Suite 605

Saint John, NB

E2L 2B5

eClaims Submission:

Easy online submission and prompt payment (maximum of 5 business days) of Drug, Dental, and Health Care Claims. Please visit www.gobelmont.ca to view our brief online tutorials showing you how to submit a claim electronically. Alternatively, click on the 'My Claims' section from your eProfile menu and access the first item labeled 'Claim Submission Help Videos'.

Please retain all original receipts after your submission for 12 months.
You must register for direct deposit to submit online claims.
Please contact our Customer Response Centre with any questions or concerns.

TO CONTACT BELMONT DIRECTLY

To speak directly with a bilingual Belmont Health and Wealth Customer Service Agent about your claim, call toll free at 1-855-224-6263.

Prescription Drugs

For Prescription Drug questions you may contact Belmont Health and Wealth between the hours of 7:00 a.m. and 11:00 p.m. EST Monday through Friday and on Saturday between the hours of 11:00 a.m. and 4:00 p.m. EST.

Extended Healthcare and Dental

For Extended Healthcare and Dental questions you may contact Belmont Health and Wealth between the hours of 7:00 a.m. and 11:00 p.m. EST Monday through Friday.

You may obtain claim forms from the Belmont Health and Wealth website at www.gobelmont.ca .

Please visit the "eProfile ™ Account Login" section located at the end of the menu bar of our Home Page and click "Member" to access up to date claims information via the Internet. If you are visiting the site for the first time, you will be required to "Register now" prior to obtaining a Username and Password to access your personal claims.

Life, Disability or Travel

For Life, Disability or Travel you may contact:

Medavie Blue Cross – Policy #10616
644 Main Street, Box 220
Moncton, NB
E1C 8L3
Toll free – 1-(800)-667-4511

Travel Insurance: (SSQ Insurance)
(Not for retired members or members over 70)

- Out-of-Country Emergency Travel Coverage: Insured with SSQ INSURANCE – 100% to a maximum of $1,000,000
- Your SSQ Travel Insurance **Policy Number is: 1PP85**
- In the event of an emergency, while travelling please call 1-866-783-9473 toll Free from USA or Canada, or 514-285-8195 collect from elsewhere in the world. These numbers are available 24 hours per day, 7 days per week.

Your Coverage Information

To apply for Benefits, you must submit a completed eligibility form to your employer. Your employer will then forward the information to Belmont.

Your Identification Number:

After you have enrolled in the Benefit Plan, you will receive an identification card with a group plan number and your certificate number. Please record this information in the space provided to have it handy when completing claim forms.

Your Group Number is 32262

Your Certificate ID is _____

To ensure that coverage is kept up-to-date for yourself and your dependents, it is vital that you report any changes to your employer. These changes could include:

- Addition or deletion of Dependent(s)
- Change of Address
- Change in your Name or change in your Dependents' Name(s)

Summary of your Benefit Plan

Prescription Drug Benefit:

Benefit Effective Date	»	January 1, 2013
Benefit Period	»	Calendar Year
Annual Deductible	»	N/A
Per Prescription Deductible	»	Costco - $2.50/Sobeys, Loblaw's & Walmart - $4.50/All other pharmacies - $7.50
Plan Type	»	Generic Prescription Drug Plan
Special Authorization Program	»	Yes
Preferred Provider Networks (PPN)	»	RxAdvantage Specialty Support
Annual Maximum	»	N/A
Member Maximum Age	»	99 (65 – Division 030 & 031)
Dependent Maximum Age	»	21
Student Maximum Age	»	25

For additional detailed descriptions and limitations please refer to the Prescription Drug Benefit section

Extended Healthcare Benefit:

Benefit Effective Date	»	January 1, 2013
Benefit Period	»	Calendar Year
Annual Deductible	»	N/A
Benefit Reimbursement:		
Hospital	»	100%
Major Medical	»	100%
Vision	»	100%
Annual Maximum	»	N/A
Member Maximum Age	»	99 (65 – Division 030 & 031)
Dependent Maximum Age	»	21
Student Maximum Age	»	25

For additional detailed descriptions and limitations please refer to the Extended Health Benefit section

Accidental Dental »

Maximum benefit of $5,000 per person every 12 consecutive months. Services rendered must be completed within 180 days of the date of the accident. *Pre-approval by ClaimSecure is required.*

Convalescent Care »

Maximum Benefit of $20 per day up to one-hundred twenty (120) days per covered person per disability and immediately follows three (3) or more days of hospital confinement of acute care.

Eye Exams for members age 18 & over »

Maximum Benefit of one (1) eye exam per covered person to a maximum of $350 every twenty-four (24) consecutive months . Combined with vision. Allow for provider direct payment. (30 day grace period)

Eye Exams for dependents under the age of 18 »

Maximum Benefit of one (1) eye exam per covered person to a maximum of $350 every twelve (12) consecutive months. Combine with vision. Allow for provider direct payment. (30 day grace period)

Hearing Aids »

Maximum Benefit of $2,000 per ear every sixty (60) consecutive months per covered person.

Orthotics »

Maximum Benefit of $400 every twelve (12) consecutive months per covered person.

Custom Made Orthopedic Shoes »

Maximum Benefit of $400 every twelve (12) consecutive months per covered person.

Off the shelf orthopedic shoes and Orthopedic Modifications»

Are covered up to a maximum benefit of $400 every twelve (12) consecutive months per covered person. Including Off the Shelf Orthopedic Boots.

Hospital Care »

Semi-Private - Unlimited

Private Duty Nursing »

Maximum Benefit $10,000 every benefit period per covered person.

Vision Care Services for members age 18 & over »

Maximum Benefit is $350 every twenty-four (24) consecutive months per covered person from last date of purchase. Allow for provider direct payment. (30 days grace period)

Vision Care Services for dependents under the age of 18

Maximum Benefit is $300 every twelve (12) consecutive months per covered person from last date of purchase. Allow for provider direct payment. (30 days grace period)

Paramedical Services: maximum based on all practitioners combined Coverage from first dollar except where Provincial Health Insurance plan prohibits by law

Acupuncturist: covered to a maximum of $1,500 *

Chiropodist/Podiatrist: covered to a maximum of $1,500 *

Chiropractor: covered to a maximum of $1,500 *

Naturopath: covered to a maximum of $1,500 *

Osteopath: covered to a maximum of $1,500 *

Physiotherapist: covered to a maximum of $1,500 *

Massage Therapist: covered to a maximum of $1,500 *

Psychologist: covered to a maximum of $1,500 *

Speech Therapist: covered to a maximum of $1,500 *

Social Worker: covered to a maximum of $1,500 *

Note: any practitioner listed above with "*" may be combined with another. Please contact our Customer Response center for further details.

Doctor referrals apply to the following practitioners:

Massage Therapist

For additional detailed descriptions and limitations please refer to the Extended Health Benefit section

Dental Care Benefit:

Benefit Effective Date	»	January 1, 2013
Benefit Period	»	Calendar Year
Annual Deductible	»	N/A
Dental Fee Guide	»	Lagging Fee Guide of 1 yr
Benefit Reimbursement:		
Level 1 (Basic Restorative)		» 100%
Level 2 (Periodontic & Endodontic)		» 100%
Level 3 (Major Restorative)		» 75%
Level 4 (Orthodontics)		» 50%
Lifetime Maximum	»	
Level 4 for children under the age of 18 - $2,000		
Annual Maximum	»	Level 1, 2 and 3 combined $2,000
Member Maximum Age	»	99 (65 – Division 030 & 031)
Dependent Maximum Age	»	21
Student Maximum Age	»	25

For additional detailed descriptions and limitations please refer to the Dental Benefit section

General Provisions of Your Coverage

WHO IS ELIGIBLE FOR COVERAGE

You are eligible for Benefits if you:

- are an active employee,
- are a member of an eligible class/unit,
- are younger than the termination age,
- are residing in Canada, and are insured under a Provincial Health Insurance Plan, and
- have completed the waiting period (if applicable).

The termination age and waiting period may vary from benefit to benefit. For this information, please refer to each benefit in the Summary of your Benefit Plan.

Your dependent(s) are eligible if you are eligible; and

- the dependent meets the age conditions as specified in the Summary of your Benefit Plan;
- for health benefits, the dependent must reside in Canada, and be covered under a Provincial Plan.

WHEN DOES YOUR COVERAGE BEGIN

If you are an active member, you will be covered:

- on the benefit effective date as shown in the Summary of your Benefit Plan;
- when you have completed the waiting period for each benefit and are eligible for coverage.

WHEN DOES YOUR DEPENDENT(S) COVERAGE BEGIN

Your dependent coverage becomes effective:

- the date you become eligible;
- the date you first acquire a dependent.

WHEN DOES YOUR COVERAGE END

Your Coverage will terminate:

- the date you cease to be an eligible member; or
- the date the Benefit Plan terminates; or
- the date you reach the benefit maximum age.

WHEN DOES YOUR DEPENDENT(S) COVERAGE END

Your dependent coverage terminates:

- the date your coverage terminates; or
- the date that you are no longer eligible for benefits; or
- the date the dependent ceases to be an eligible dependent; or
- the date on which dependent benefits under the plan are terminated; or
- the date the dependent child(ren) reach the dependent or student maximum age, as defined in the plan details.

WHAT WILL HAPPEN TO YOUR BENEFITS IF THERE ARE CHANGES IN LEGISLATION

Any provision of the plan which, on its effective date, is in conflict with the legislation of the locality in which the plan is delivered is hereby amended to conform to the minimum requirements of those legislations.

WHAT IF BOTH YOU AND YOUR SPOUSE EACH HAVE YOUR OWN HEALTH AND DENTAL BENEFIT PLAN
CO-ORDINATION OF BENEFITS

If you or your dependents are covered for similar benefits under another plan, Coordination of Benefits allows for reimbursement of covered medical and dental expenses from all plans, up to a total of 100% of the actual expense incurred. Plan means any plan providing benefits or services under:

- other Benefit programs;

- any other arrangement of coverage for individuals in a group.

The payment of benefits depends on which plan is the primary carrier. The "primary carrier" is responsible for making the initial payment towards the eligible expense. The "secondary carrier" is responsible for paying the balance up to that plan's maximum.

Example:

If John Smith purchases a prescription drug for $30 for himself, and his employer's plan covers 80% of prescription drug expenses and his wife's insurance plan covers 90% of prescription drug expenses, then, John's employee plan would pay 80% of $30, or $24. John would send a second claim to his wife's plan with the explanation of benefits from his plan and his wife's plan would pay 90% of the $30 to a maximum of $6.00.

For claims incurred by your dependent child, priority will be attributed as follows:

- the plan of the parent with the earlier day and month of birth in the calendar year, or
- if both parents are born on the same day, the plan of the parent whose first name begins alphabetically.

Prescription Drug Benefit

If you or your dependent(s) incur charges for any of the covered expenses listed below, your prescription drug benefit can provide financial assistance as specified in the Summary of your Benefit Plan.

All eligible expenses may be subject to a deductible amount, a co-payment and plan maximums. Charges will be payable for up to a 100-day supply per prescription. This plan will cover most drugs, which by law or convention require a physician's or dentist's prescription.

Lifestyle Medications:

Anti Smoking – Included*

Anti Obesity – Included*

Erectile Dysfunction – Included*

Fertility – Included*

Diabetic Supplies:

Needles – Included

Syringes – Included

Diagnostic tests – Included

Lancets – Included

Serums/ Preventative Vaccines:

Preventative Vaccines – Excluded

Allergy Serums – Included

Injectible vitamins – Included

Contraceptives:

Oral contraceptives – Included

Contraceptives Patch – Included

Intra Uterine Devices (I.U.Ds), Nuvaring – Included

Viscosupplementation Injections:

Orthovisc, Synvisc, Neovisc, Durolane, Euflexxa or any other viscosupplementation product as unlimited with a co-pay of $7.50. Eligible if dispensed by a physician. Does not include physician fees or any other fees.

Note: The items with "*" may have their own maximums. Please contact our Customer Response center for further details.

SPECIAL AUTHORIZATION PROGRAM

As part of Belmont Health and Wealth's commitment to continually enhance our product offering to the benefit of our valued customers, a Special Authorization process for Specialty Drugs has been implemented. To obtain a list of the Specialty Drugs and their approval criteria, please visit www.gobelmont.ca.

This process reduces drug benefit cost while ensuring that members receive the most appropriate and cost efficient drug therapy.
If a member goes to the pharmacy with a prescription for a special authorization drug, it will be declined with the message "DIN Not Covered, May Require Special Authorization". The process to obtain special authorization drug approval is as follows:

1. Obtain special authorization form from the Belmont Health and Wealth website at www.gobelmont.ca forms library, or by calling our bilingual national call centre at 1-855-224-6263.
2. Take the form to the doctor for completion if the member meets the clinical criteria.
3. Return the completed form to Belmont Health and Wealth's Clinical Service Department by mail or fax to:

Mailing Address:

Belmont Health and Wealth

133 Prince William Street, Suite 605

Saint John, NB

E2L 2B5

or

Fax Number:

(506) 634-6371

4. Belmont will reply in writing within 10 working days upon receipt.

Note: In the case of a generic plan, the pharmacist will only be reimbursed for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary.

RxAdvantage Specialty Support – Is a specialty drug preferred provider network administered by ClaimSecure as further detailed in the Benefit Plan. This program does not apply to Participants who are residents of Quebec.

Specialty Drugs that have not received special authorization from ClaimSecure and have not been dispensed through RxAdvantage Specialty Support program are excluded under the plan.

RAMQ Drug Coverage - Québec Members

In Québec, everyone must be covered by prescription drug insurance. Those under 65 years of age must subscribe to a private drug plan if one is offered to them. When persons who turn 65 years of age remain eligible for a private plan offering basic prescription drug coverage, they have a choice to make. They may decide to be insured:

- Only by the public plan, administered by the Régie de l'assurance maladie du Québec (RAMQ); or
- By the public plan (first payer) and by a private plan offering additional coverage (second payer); or

- Only by a private plan offering drugs covered a listed on the List of Medications maintained by RAMQ.

Drug Coverage

The drugs covered by RAMQ are listed on the List of Medications, which comprises over 5,000 prescriptions drugs—this includes the following therapeutic categories:

- Infertility
- Erectile dysfunction
- Smoking cessation

All private insurers must cover at least the drugs listed on the List of Medications, thereby providing equal coverage for all Québec residents.

Extended Health Benefit

If you or your dependents incur charges for any of the covered expenses listed below, your extended healthcare benefit can provide financial assistance as specified in the Summary of your Benefit Plan.

Belmont shall pay reasonable and customary charges in the geographic area where the claim occurs, for the services, supplies and equipment set out below when the services, supplies and equipment are:

- ordered by a physician or other healthcare provider. A physician means a doctor of medicine who is legally qualified to practice medicine or surgery and is licensed by the appropriate board in the jurisdiction where his or her services are rendered. A healthcare provider is defined as a licensed, certified, registered or chartered practitioner licensed to practice in the jurisdiction where the services are provided.
- medically necessary services defined as services, equipment or supplies consistent with the diagnosis and treatment of the condition and in accordance with the standards of good medical practice. The order, recommendation or approval of a physician does not make the service medically necessary.
- not covered or eligible for coverage by any government program or plan.
- subject to all applicable limitations, exclusions and maximum benefit limits and any deductible or co-insurance specified in the Contract.
- must be incurred while you are eligible under this benefit.

All eligible expenses may be subject to a deductible amount, a co-payment and plan maximums.

WHICH MEDICAL EXPENSES ARE COVERED BY THE PLAN

Coverage is coordinated with coverage provided by your Provincial Health Plan and you must be covered by your Provincial Health Plan to be eligible for this benefit. The expenses specified are covered to the extent that they are reasonable and customary, as determined by Belmont.

In order to be covered, an expense:

- must be incurred while you are covered under the plan,
- must be reasonable and customary and medically necessary in the treatment of sickness or injury,
- must be recommended by a physician,
- legally insurable,
- must be incurred in Canada,
- any claim expense or service provided by an immediate family member.

Paramedical Practitioners:

Services provided by Paramedical Practitioners as specified in the Summary of your Benefit Plan. The only expenses covered are those incurred for consultations or treatments rendered by a health care professional. The health care professional must be a member in good standing of the professional association governing the exercise of the professional's activities and/or use of the title. Failing the existence of such an association, expenses incurred for consultations or treatments rendered by a health care professional member of a professional association recognized by the Insurer are covered.

Only one treatment per day per insured by the same professional is covered.

Services of a physiotherapist will be considered eligible only if the claimant is not confined to a hospital.

Any claim expense or service provided by an immediate family member.

Accidental Dental:

Reasonable and customary charges for the services of a licensed dental provider to repair or replace sound natural teeth damaged as a result of a direct accidental blow to the mouth while covered under this benefit. Payment will be made provided the services are rendered within twelve (12) consecutive months of the date of the accident and while you are covered for this benefit under this plan. Treatment must be completed within 180 days of accident.

Note: Pre-approval by Belmont is required.

Ambulance:

Reasonable and customary charges for emergency transportation to the nearest hospital by a licensed ground ambulance service. In addition, when the circumstances dictate (as pre-approved by Belmont), coverage may be considered for transportation by air, rail or water. Maximum of $1,000 per person per benefit period. Maximum of $500 per person per benefit period for Ambulance Attendant. Allow for provider direct payment.

Convalescent Hospital:

Charges, in excess of the hospital's public ward charge for accommodation and meals while in a convalescent hospital as an in-patient, up to the amount specified in the Summary of your Benefit Plan. Benefits are only payable if:

- The accommodation was specifically elected by the patient;
- The patient is admitted to the convalescent hospital within 3 or more days following hospital confinement of acute care;
- Convalescent hospital was prescribed by a physician.

All confinements in a convalescent hospital will be considered as one period of disability unless separated by at least ninety days. In order to qualify under this covered expense, the convalescent hospital must be approved by the appropriate Provincial Hospital Authority.

Limitations

- Charges for custodial care or long-term care, chronic care in a convalescent hospital, nursing home or similar institution will not be considered eligible expenses;
- Room charges for alcohol and substance abuse, mental health or home for the aged will not be considered eligible expenses;
- Charges for the administrative fees charged by the hospital will not be considered an eligible expense.

Diagnostic Laboratory:

Diagnostic laboratory and x-ray procedures which are defined as diagnostic testing of blood, urine or other bodily fluids and tissues and radiographic examinations performed in the covered person's province of residence are covered when coverage is not available under the Provincial Government Plan. Includes allergy testing and materials associated with the testing.

For the province of Quebec, diagnostic and laboratory tests are covered when performed in a private lab or pharmacy even if there is coverage under the provincial government plan. Include magnetic resonance imaging (MRI) and CT scan.

Eye Exam:

In provinces where routine eye exams are covered under the applicable Provincial Health Plan in any twenty-four (24) month benefit period, no payment will be made for routine eye exams under this plan.

In all other provinces, claim payment will be made for one routine eye exam, performed by an optometrist or ophthalmologist, in any twenty-four (24) month benefit period. Covered expenses are subject to the maximum specified in the Summary of your Benefit Plan.

Hearing Aids:

Purchase and the repairs of hearing aids up to the maximum specified in the Summary of your Benefit Plan. A physician or audiologist referral is required for the purchase of a hearing aid. Provincial assistive device program maximums will be taken into consideration where applicable.

Exclusions/Inclusions:

- Hearing tests. Excluded
- Moulded ear plugs - Included – max $75 per member every twenty-four (24) months
- Batteries. Excluded
- Charges of batteries. Excluded
- Installation & maintenance of hearing aids. Excluded

Medical Equipment:

For all medical equipment and supplies covered under this provision, covered expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs, provided the expense is incurred in your province of residence. Pre-approval is required.

Durable Medical Equipment:

Rental or, when approved by the administrator and prescribed by a physician, purchase of but excludes repairs, maintenance or replacements of:

- mist tents and nebulizers,
- oxygen and the equipment needed for its administration,
- continuous positive airway pressure machine (CPAP, APAP & BiPap) - Maximum benefit $2,500 every sixty (60) consecutive months per covered person. Supplies are excluded, CPAP supplies – one (1) mask per person per calendar year up to a max $300,
- intermittent positive pressure breathing machine (IPPB) - Maximum benefit one (1) per lifetime per covered person. Supplies are excluded,
- apnea monitors for respiratory dysrhythmias,
- tracheostoma tubes.

Orthopedic Equipment:

Purchase, adjustment, replacement or repair of the following types of orthopedic equipment:

- splints, including splints attached to a brace but excluding dental splints – Note**:** intra-oral splints are not covered,
- casts,
- braces – Note**:** braces are wearable, orthopedic appliances and must be made of rigid or semi-rigid material such as metal or hard plastic to hold parts of the body of the correct position.
    - Rigid or semi rigid knee brace over $500.00 requires an estimate and a questionnaire. The questionnaire is located at www.gobelmont.ca.
    - Please ensure the questionnaire is completed clearly and in full. If not, this may delay the assessment of your claim/estimate.
- cervical collars.

Non-Dental Prostheses and Supports:

Purchase of:

- external prosthesis and standard artificial limb(s) (Excludes Myoelectric Limbs) for each limb if the disability causing the loss of the natural limb was suffered while the patient was covered by this benefit,
- artificial eyes including repair and replacement,
- external breast prosthesis maximum benefit one (1) per breast every twelve (12) consecutive months required because of a total or radical mastectomy,
- shoulder harnesses,
- stump socks,
- voice prostheses.

Under no circumstances will maintenance of any durable equipment be an eligible expense.

Mobility Equipment:

Rental for temporary use of:

- crutches, canes, walkers,

- mechanical or hydraulic patient lifters - $2,000 per person per lifter every sixty (60) months,
- outdoor wheelchair ramps - $2,000 per person per lifetime,
- wheelchair, standard, or where medically required electric – Maximum benefit $10,000 every sixty (60) consecutive months. Note**:** Pre-approval is required from ClaimSecure.
    - Wheelchair requires an estimate and a questionnaire. The questionnaire is located at www.gobelmont.ca.
    - Please ensure the questionnaire is completed clearly and in full. If not, this may delay the assessment of your claim/estimate.

Other Medical Equipment:

Rental or, when approved by the administrator, purchase of but not the repair, maintenance or replacement of therapeutic devices to the maximum specified in the Summary of your Benefit Plan. Devices include:

- glucometer to a maximum of one (1) every forty-eight (48) consecutive months,
- insulin pumps/PDM & supplies $6,500 every sixty (60) consecutive months,
- Diabetic tubing,
- Insulin Jet injectors - $1,000 per person per lifetime,
- intra-uterine contraceptive devices, maximum of $200 per person every twenty-four (24) months, Note: Must be inserted by a doctor,
- standard hospital beds excludes electric hospital beds,
    - Hospital bed requires an estimate and a questionnaire. The questionnaire is located at www.gobelmont.ca.
    - Please ensure the questionnaire is completed clearly and in full. If not, this may delay the assessment of your claim/estimate.
- support hose and compression stockings limited to a compression factor greater than 20 mm/Hg to a maximum of $250 every benefit period,
- extremity pump for lymphedema - $1,500 per person per lifetime,

- speech aids - $2,000 per person per lifetime,
- aerochambers (no age limit),
- surgical brassieres to a maximum of two (2) every benefit period,
- bed rails,
- colostomy and ileostomy supplies,
- custom made burn garments,
- custom-made pressure supports for lymphedema,
- head halters,
- traction apparatus,
- surgical shoes, boots, cast covers purchased after foot surgery for temporary use,
- trapeze bars, and
- urethral catheters.

Transcutaneous Nerve Stimulator (TENS machine):

Purchase of a TENS machine for the control of chronic pain to a maximum of $700 per lifetime.

Wigs:

Required as a result of

- chemotherapy treatment; Included
- Alopecia; Excluded
- other medical condition; Excluded
- Hairpieces. Excluded

up to a maximum of $200 per lifetime.

Foot Orthotics:

Foot orthotics must be individually designed and constructed to medical specifications from an officially licensed laboratory specializing in foot orthotics to the maximum listed in the Summary of your Benefit Plan. A written referral from a physician or chiropodist/podiatrist's will be required.

In order to consider your claim, the following information is required:

- Prior authorization with original pre-dated physician/chiropodist or podiatrist referral including your diagnosis prior to purchase; without prior authorization claim may be denied;
- eligible dispensers: registered podiatrist, chiropodist, pedorthist or orthotist;
- prescriber and dispenser must be two different providers unless the orthotic was sent to an offsite laboratory to be fabricated;
- if the orthotic was sent to an offsite laboratory, the laboratory information is required;
- gait analysis or biomechanical exam;
- description of how they were fabricated and;
- name, license number and credentials of practitioners;
- paid in full receipt.

Orthopedic Shoes:

Purchase, adjustment, replacement or repair of shoes custom designed and made to measure for the insured from a cast when such shoes are needed to correct a defect in the foot and are obtained from a specialized orthopedic laboratory holding a license issued by legal authorities.

Orthopedic shoe(s) or the permanent modification of a regular shoe. Modifications may include sole build-ups, lifts, wedges, steel plates, calliper plates, stirrups to accommodate braces and self-adhesive closures.

Note: Orthotics / Orthopedic Shoes - Prior authorization along with a doctor's referral and medical diagnosis from doctor prior to purchase. Orthotics / Orthopedic Shoes must be dispensed by a licensed provider other than prescriber. If you do not have approval prior to purchase, your claim may be denied. (Maximum payable: $400 for Orthotics / $400 Orthopedic Shoes per 12 months).

The Orthopedic shoe benefit does not include shoes purchased only to accommodate orthotics or comfortable walking shoes such as Berkenstock, Nike, Brooks, Rockport, etc.

Hospital:

Charges, in excess of the hospital's public ward charge for accommodation and meals while in a hospital in Canada as an in-patient, up to the amount specified in the Summary of your Benefit Plan. Benefits are only payable if:

- the accommodation was specifically elected by the patient;
- hospital was recommended by the attending physician;
- the patient effectively receives curative treatment for illness, injury or for pregnancy; and

Limitations

- Charges for custodial or long-term care in a convalescent hospital, nursing home or similar institution will not be considered an eligible expense.
- Room charges for outpatient care, day surgery, private room, nursing home, chronic care facilities, home for the aged, and rest home will not be considered an eligible expense.
- Charges for the administrative fees charged by the hospital will not be considered an eligible expense.
- Private hospital (Homewood, Rosewood and Bellwood) will not be considered an eligible expense.

Nursing Care:

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by a:

- registered graduate nurse (R.N.); or
- licensed practical nurse (L.P.N.); or
- registered nursing assistant;

who is duly qualified and registered with the appropriate provincial registry or the out of province equivalent.

The services must be made on the recommendation of a physician and must require the specific skills of a trained nurse and be commensurate with the nature and gravity of the sickness or injury being treated. The services must be approved by ClaimSecure with such approval being subject to periodic reassessment. Covered expenses are subject to the maximum specified in the Summary of your Benefit Plan. Among others, nursing care includes:

- instructions for care following surgery,
- checking blood pressure and vital signs,
- change bandages and dressing wounds,
- administration of medication and monitoring solutions,
- sutures and clips,
- taking samples (blood and other).

Charges for the following services are not covered:

- services performed by a nursing practitioner who is related to or lives with either you or any of your dependents,
- homemaking or companion duties, and
- services which can be performed by a person of lesser qualification, a friend.

Pre-determination of Benefits

Services must be pre-approved by Belmont with such approval being subject to periodic reassessment.

Private duty nursing requires an estimate and a questionnaire. The questionnaire is located at www.gobelmont.ca.

Please ensure the questionnaire is completed clearly and in full. If not, this may delay the assessment of your claim/estimate.

Vision Care:

Frames and prescription lenses, prescription sunglasses or prescription contact lenses when dispensed by a licensed Optometrist, Optician or

Ophthalmologist, as specified in the Summary of your Benefit Plan. Allow for provider direct payment.

Exclusions / Inclusions

- Safety glasses - included
- Safety goggles - excluded
- Maximum benefit of $300 every 24 consecutive months for members only;

Note: Member should see the requirements from their employer prior to purchase;

- Replacement of lost, stolen or broken lenses or frames. Excluded
- Duplicate or spare eye glasses. Excluded
- Intra-ocular lens implants. Excluded
- Non-prescription sunglasses. Excluded
- Laser Eye Surgery Included . Maximum benefit of $800 per person per lifetime;
- Refractions required by a client, government body or other third party. Excluded
- Visual training – Maximum benefit of $150 per person per lifetime.

WHICH HEALTH EXPENSES ARE NOT COVERED UNDER THE PLAN

No reimbursement will be made under this benefit for the following charges:

- control devices such as reflectometers, dextrometers, stethoscopes, sphygmomano-meters or other similar devices,
- homeopathic services and homeopathic supplements and remedies,
- home accessories such as a whirlpool, air purifiers, humidifiers, air conditioners or other similar devices. "Home accessories" include: toilet seats, support rails, humidifiers, air conditioners, "air filters", Doctor Gibaud articles (articles supplying heat),

electric cushions, heating pads for cars, solar lamps, thermometers, sitbaths, pressure devices, sphygmomanometers or similar devices, ("water pik") electric toothbrushes, hydrotherapeutic apparatus, sheep skins (for bed sores), alarms for children suffering enuresis (nighttime incontinence), etc,

- any portion of the charge for services in excess of the reasonable and customary charge normally incurred for an illness of the same nature and severity in the locality where the service is provided,
- any covered expense incurred during a period of hospital confinement which began before the covered person became covered under the plan. This limitation will not apply to a child who became covered at birth,
- for dental services except covered expenses under the accidental dental benefit,
- expenses resulting from any attempted suicide or self-inflicted injuries or illness while sane or insane,
- medical care for which benefits are payable under any other benefit provision of this plan,
- medical care resulting from riot, insurrection, war or hostilities of any kind, or any act incident thereto whether war be declared or not and whether or not the claimant was participating therein,
- medical care for which the claimant is entitled to indemnity or compensation under any Workplace Safety and Insurance Board (WSIB) or similar legislation,
- medical care payable in whole or in part by a government under any Government Health Insurance Plan or which would have been payable had the claimant been covered there under or had proper application been made,
- medical care to the extent that the applicable government jurisdiction prohibits the payment of any benefits,
- expenses resulting from the committing of, attempt to commit a criminal offence including, without restriction, an assault,
- medical screening or examinations required for the use of a third party,
- medical care provided by a medical or dental department maintained by an employer, an association, labour union, trustee or similar type of group,

- broken appointments, transportation costs (including travelling time) of the practitioner, advice received by telephone or other means of telecommunication, or the completion of claim forms required by this provision,
- medical care, the charge for which the claimant is not legally required to pay, or for which there is no charge, or for which there would have been no charge but for the existence of a group health benefit plan,
- medical care which is experimental or not necessary according to generally accepted standards of medical practice in Canada,
- medical care rendered principally for cosmetic purposes (as determined by the administrator), except when such medical care is necessitated by accidental injury,
- medical care for the replacement of an appliance which has been lost, mislaid or stolen or to provide any duplicate appliance,
- supplies ordered or services rendered prior to the date the claimant became eligible for this benefit,
- infant formulas, caloric supplements with or without vitamins or minerals,
- services or supplies associated with recreation or sports rather than with other daily living activities,
- services or supplies not listed as covered expenses,
- services or supplies received outside Canada except as provided under the out-of-country emergency care,
- shipping and handling charges,
- expenses that private insurers are not permitted to cover by law,
- services and supplies not shown in the included list of benefits,
- the diagnosis of infertility,
- healthcare services or supplies due to intentional self-inflicted injury, and
- expenses paid under any Welfare Act, any Act respecting Workmen's Compensation, care and services provided in municipal, provincial or federal clinics as well as charges incurred for cosmetic purposes or for treatment of mental illnesses which would normally be paid by public organizations.

Dental Benefit

WHICH DENTAL EXPENSES ARE COVERED BY THE PLAN

The following expenses are covered under the Group Plan if they are:

- Necessary dental services defined as dental services that are consistent with the diagnosis and treatment of the condition and in accordance with standards of good dental practice.
- Not covered or eligible for coverage by a government program or plan.
- Subject to all applicable limitations, exclusions and maximum benefit limits and any deductible or co-insurance specified in the Contract.
- Incurred while you are eligible under this benefit.
- Provided by a dental provider licensed to practice in the province where the services are performed. A dental provider may be a licensed dentist, dental specialist or denturist.
- any claim expense or service provided by an immediate family member.

LEVEL 1 - DIAGNOSTIC, PREVENTIVE AND MINOR RESTORATIVE, CROWN/BRIDGE/DENTURE MAINTENANCE, MINOR ORAL SURGICAL AND ADJUNCTIVE SERVICES

Clinical Oral Examination:

- Complete oral examination: 1 exam every thirty-six (36) consecutive months;
- Recall oral examination: 1 exam every six (6) consecutive months;
- Specific oral examination: 2 exams every twelve (12) consecutive months;
- Emergency examination: 2 exams every twelve (12) consecutive months.

Radiographs:

- Intra oral films:
  - Bitewing films; 1 every twelve (12) consecutive months;
  - Occlusal films;
  - Periapical films;
- Extra oral films:
  - 1 Complete Series or Panoramic film every thirty-six (36) consecutive months (complete series & panoramics are combined).

Laboratory Tests:

- Bacteriological tests/analyses;
- Histopathological tests/analyses;
- Microbiological tests/analyses.

Preventative Services:

- Topical application of fluoride: 2 every twelve (12) consecutive months;
- Oral hygiene instruction: 1 per lifetime;
- Polishing: 2 units every twelve (12) consecutive months;
- Scaling/Root Planing: 10 units every twelve (12) consecutive months;
- Interproximal disking;
- Pit and fissure sealants.

Space Maintainers:

- Space maintainers & maintenance of space maintainers

Minor Restorative Services:

- Amalgam restorations non-bonded. Bonded amalgam restorations are paid up to the cost of non-bonded amalgam restorations;
- Prefabricated restorations (prefabricated crowns) for primary teeth only;

- Tooth coloured restorations limited to anterior and bi-cuspid teeth only. Tooth colored restorations performed on molar teeth are fully covered for white fillings on molar teeth;
- Caries/trauma/pain control;
- Prefabricated posts;
- Retentive pins.

Repairs or Fixed Bridges and Crowns:

- Repairs of crowns/bridgework;
- Recementation of crowns/bridgework.

Rebase, Reline and Removable Denture Repairs:

- Denture repairs;
- Denture rebase 1 per arch every thirty-six (36) consecutive months;
- Denture reline 1 per arch every thirty-six (36) consecutive months.

Oral Surgical Services:

- Alveoloplasty – simple;
- Antral surgery;
- Extractions & residual root removal;
- Fractures;
- Frenectomy;
- Hemorrhage control;
- Surgical excision;
- Surgical exposure;
- Surgical incision;
- Treatment of salivary glands;
- Vestibuloplasty.

Adjunctive General Services:

- Deep sedation;
- General anaesthesia;
- Nitrous oxide;

- Nitrous oxide with oral sedation;
- Parenteral conscious sedation;
- Therapeutic injections,
- Resilient liner in relined or rebased dentures – one (1) every thirty-six (36) months.

LEVEL 2 – ENDODONTIC AND PERIODONTIC SERVICES

Endodontic Services:

- Root canal therapy. Routine initial root canal therapy. Complicated root canal therapy reduced to cost of routine root canal therapy. Continuation of root canal therapy aborted by referring/previous dentist covered to the cost of a routine root canal therapy. Retreatment of root canal is covered only if at least eighteen (18) consecutive months have elapsed from the date of the initial root canal therapy. No coverage for primary teeth.
- Apexification;
- Apicoectomy;
- Bleaching of endodontically treated teeth;
- Hemisection;
- Intentional removal and implantation;
- Isolation of endodontic tooth;
- Open & drain;
- Pulpectomy;
- Pulpotomy;
- Retrofilling;
- Root amputation.

Periodontic Services:

- Periodontal appliances and maintenance: one (1) appliance per arch every thirty-six (36) consecutive months;
- Management of oral disease;
- Occlusal equilibration; four (4) units, every twelve (12) months;
- Periodontal abscess or periocoronitis;
- Periodontal surgery – flap approach – osteoplasty;

- Periodontal surgery – flap approach – osseous defect;
- Periodontal surgery – gingival curettage;
- Periodontal surgery – gingivoplasty;
- Periodontal surgery – gingivectomy;
- Periodontal surgery – grafts – soft tissue;
- Proximal wedge.

LEVEL 3 – MAJOR RESTORATIVE AND MAJOR ORAL SURGICAL SERVICES

Some restrictions may apply. Prior approval is recommended.

- Prosthodontic examinations

Inlays/Onlays/Crowns:

Crown replacement frequency is every sixty (60) consecutive months.

- Inlays and Onlays - Metal, Composite & Porcelain;
- Acrylic crowns;
- Porcelain/ceramic crowns;
- ¾ Porcelain/ceramic crowns;
- Cast metal crowns;
- ¾ Cast metal crowns;
- Gold foil restorations;
- Cores – amalgam and tooth coloured;
- Equilibration casts;
- Lab processed posts, cores and posts & cores;
- Retentive pins for inlays, onlays & crowns.

Dentures:

Denture replacement frequency is every sixty (60) consecutive months.

- Standard complete dentures;
- Cast partial dentures including partial dentures with clasps and/or rests;
- Overdentures and complicated dentures are reduced to the cost of standard dentures;
- Partial acrylic dentures including partial dentures with clasps and/or rests.

Bridgework:

Bridge replacement frequency is every sixty (60) consecutive months.

- Cast metal pontics;
- Porcelain/ceramic pontics;
- Acrylic retainers;
- Porcelain/ceramic retainers;
- Cast metal retainers;
- ¾ Cast metal retainers;
- Metal, composite and porcelain, inlay retainers;
- Metal, composite and porcelain, onlay retainers;
- Retentive pins for inlay/onlay retainers.

Note: The initial placement of dentures and bridgework may not be covered if at least one tooth to be replaced is not extracted while the member is covered by the employer's dental plan.

Major Oral Surgery:

- Alveoloplasty – (not performed in conjunction with extractions);
- Crown lengthening;
- Mandibulectomy;
- Maxillectomy;
- Reconstruction;
- Remodeling floor of mouth;
- Sequestrectomy;
- Surgical movement of teeth;
- Dental Implants and Related Services.

LEVEL 4 - ORTHODONTIC SERVICES

NOTE: Requires a prior authorization, x-rays and payment plan. Orthodontic is payable over the course of the treatment plan, (typically 18 months to 24 months).

- Cephalometric radiographs;
- Diagnostic photographs;
- Enucleation;
- Full orthodontic treatment;
- Hand and wrist radiographs (as diagnostic aid for dental treatment);
- Interpretation from other source;
- Monthly payments;
- Oral surgery in conjunction with orthodontics;(These services will be evaluated on a case by case basis)
- Orthodontic examinations;
- Orthodontic casts;
- Surgical exposure;
- Tracing and interpretation.

Explanation of Common Terms

The following is an explanation of the terms used in this Benefit Booklet.

Accident: An accident is any event due to unintentional, sudden and unforeseeable external causes that inflicts bodily injuries which are certified by a physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound that was accidentally sustained.

Administrator: Belmont

Annual Deductible Amount: The annual deductible (if any) as shown in the Summary of your Benefit Plan, is the amount that you are responsible for, in each benefit period, before you are reimbursed under this plan.

Claimant: The member and/or eligible dependents.

Co-payment: The co-payment (if any) as shown in the Summary of your Benefit Plan is the amount for which you are responsible to pay.

Convalescent Hospital: A facility which provides recuperative care, including a rehabilitation hospital which is qualified to participate and is eligible to receive payments under and in accordance with the provisions of the Provincial Hospital Act and which:

- Is located in Canada,
- Is operated in accordance with the applicable laws of the jurisdiction in which it is located,
- Has a licensed physician and registered nurses (R.N.) in attendance 24 hours a day,
- Is regularly engaged in providing room and board and skilled nursing care of sick and injured persons during the convalescent stage of sickness or injury,
- Maintains a daily record of each patient under the care of a physician,
- Is authorized to administer medication to patients on the order of a physician, and
- Is not, other than incidentally, a home for the aged, blind, or deaf, a domiciliary care home, a maternity home, or a home for alcoholics, drug addicts, or the mentally ill.

Dentist: A person who is licensed to practice dentistry by the appropriate authority of the jurisdiction where the services are provided.

Dental Hygienist: A person who is licensed to practice oral hygiene, by the appropriate authority of the jurisdiction, where the services are provided.

Dependents:

Spouse will mean**:**

- is a person of the same or opposite sex to whom you are legally married, or whom you have lived continually in a common-law relationship for more than 12 months and publicly represent as your spouse.

Dependent Child will mean:

- a natural child, adopted child, or stepchild of you or your spouse, or a child for whom you or your spouse are the legal guardian,
- under age 21, or under age 25 if a full-time student,
- unmarried,
- not employed on a full-time basis, and
- unable to financially support oneself due to a functional mental or physical disability occurring prior to age 21, or before age 25 if the child is a full-time student, while he or she was insured under your benefit plan.

Proof of student status or functional impairment may be required.

Dispensing Fee: The fee charged by a pharmacist for the preparation and dispensing of prescription drugs.

Employee: A person who is a resident of Canada, who is actively employed by the employer and who is a member of an eligible classification.

Employer: Atlantic Canada Regional Council of Carpenters Millwrights and Allied Workers

Generic Drugs and Medicine: The lowest cost drugs and medicines that contain the same amount of the same active ingredients in the same dosage form as that indicated in a physician's prescription.

Hospital, Institution: A hospital means a facility, legally constituted as a hospital, which

- is licensed as a hospital where such licensing laws exist and, in Canada, is approved by the Province in which it is situated to provide insured hospital services in accordance with the Government Health Insurance Plan of such Province, and
- is operated primarily to provide medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an in-patient basis, and
- has a staff of one or more physicians available at all times and provides twenty-four hour nursing service by graduate registered nurses, and
- is not principally a sanatorium, a rest home, a convalescent hospital, a nursing home, a home for the aged, an institution solely for the provision of custodial care or other than incidentally, is not principally a medical facility which provides for the treatment of mental illness, alcoholism or drug addiction.

In-patient: A person admitted to and assigned a bed in a hospital in-patient area by the order of a physician.

Lifetime Maximum: The lifetime maximum (if any) as shown in the Summary of your Benefit Plan.

Medical Emergency: Any acute, unexpected condition, illness, disease or injury that requires immediate medical treatment.

Participant: An employee whom the employer identifies as being entitled to coverage under this plan and who has submitted all eligibility requirements.

Physician: A person who is operating within the scope of his license and either licensed to practice medicine and prescribe and administer drugs

or to perform surgery or legally qualified as a medical practitioner and required to be recognized, under the plan for insurance purposes, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

Provincial Health Plan: Any plan which provides hospital, medical, or dental benefits established by the government in the province where the participant lives and which is governed by the Canada Health Act.

Reasonable and Customary Costs: The costs incurred for eligible, covered medical services or supplies that do not exceed the standard costs of other providers of similar standing in the same geographic area, for the same treatment of a similar illness or injury.

Waiting Periods: The continuous length of time you must be actively employed with your employer in an eligible class to become eligible for benefits.

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