Member Information Booklet

For Eligible Active and Retired ICI Plan Members of U.A. Local 787

U.A. LOCAL 787 BENEFIT PLANS

Health Plan

Vacation and Statutory Holiday Pay Plan

Pension Plan

Up to Date at January 1, 2018

U.A. Local 787 Benefit Plans

Board of Trustees

Ian Frost
Tony Panetta
Joe Pellarin
Randy Pye
Andrew Tarr

Administrator

Employee Benefit Plan Services Limited (EBPS)
45 McIntosh Drive
Markham, ON L3R 8C7

Phone: (905) 946-2220 or
1 (866) 946-2220 toll-free
Fax: (905) 946-2535
E-mail: info@787benefits.ca

Insurance Companies

The Manufacturers Life Insurance Company (Manulife Financial)
Policy Number 901437

CHUBB Life Insurance Company of Canada (AD&D Insurance)
Policy Number AB10423401

Green Shield Canada (GSC): Plan Number 4759

Member Assistance Program Provider

Family Services (FSEAP)
Phone: 1-800-668-9920
www.myfseap.com
Group Name: toUA787
Password: myfseap1

Legal Counsel

Koskie Minsky LLP

Consultant

J.J. McAteer & Associates Incorporated

Investment Consultant

Ellement Consulting Group

Auditor

BDO Canada LLP

Website

www.ualocal787.org/Site/Benefits.html

Visit our U.A Local 787 facebook page at:
www.facebook.com/ualocal787benefits

January 1, 2018

Dear ICI Plan Member,

We are pleased to provide you with this Member Information Booklet that describes the benefits of the U.A. Local 787 Benefit Plans as of January 1, 2018, for all Active and Retired Plan Members and their eligible dependants.

A variety of comprehensive Benefits are available to you and your immediate family. We believe that our Benefit Plans (Health, Vacation Pay and Pension), provide an excellent range of valuable benefits for all eligible U.A. Local 787 Plan Members and their immediate families such as:

- Member Life Insurance and Accidental Death & Dismemberment (AD&D) benefits;
- Disability benefits (including LTD insurance) protecting your income during a qualified disability;
- Medical benefits providing reimbursement of eligible expenses for you and your qualified family members including prescription drugs, medical practitioners, vision care with the All-In-One Benefit Card;
- Dental benefits including preventive services, basic & major services and orthodontic procedures;
- Emergency Travel Assistance (ETA) insurance for out-of-province/Canada travel services and emergency medical procedures;
- a Member Assistance Program (MAP) providing confidential counselling, information and referral;
- Vacation and Statutory Holiday Pay payments twice a year; and
- Pension Plan benefits upon retirement, or earlier termination of Plan Membership, or death.

This Booklet describes the benefits provided to qualified Members of U.A. Local 787 and their eligible Dependants. This Booklet also summarizes the rules governing the Benefit Plans including Eligibility, Benefit Duration and Costs, Benefit Amounts and how to submit claims for any of the Benefits of the Plans. Your Benefit Plans are governed by a Board of Trustees appointed pursuant to the Trust Agreement governing the Benefit Plans.

The Trustees reserve the right to amend the Benefit Plans as deemed appropriate or necessary, and as permitted by law. Any changes made to the Benefit Plans will be communicated to all Plan Members as appropriate, and such changes are deemed to amend and/or modify this Member Information Booklet. In the event of any inconsistency between this Booklet and the Benefit Plan Trust Agreements and Plan documents (including insurance policies), the Benefit Plan Trust Agreements and Plan documents (including insurance policies) shall prevail. Members who wish to view the governing plan documents are invited to contact the Board of Trustees or the Plan Administrator.

Please read this Member Information Booklet carefully and keep it in a safe place for future reference. You may contact the Plan Administrator if you have any questions about this Booklet or our Benefit Plans.

Sincerely,

Board of Trustees of the U.A. Local 787 Benefit Plans

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GENERAL INFORMATION ALL BENEFIT PLANS

ABOUT THIS BOOKLET

This Member Information Booklet has been prepared for reference purposes only. It is an informal guide providing general information which summarizes the rules, coverage and benefits of the Benefit Plans. All benefits described in this Booklet and the rights thereto, are governed by the provisions of the Plans' Official Documents, the Insurance Company Contract(s), and applicable law, including the rules for eligibility, benefit exclusions and limitations.

Every effort has been made to ensure that the information provided in this Booklet is accurate and up to date. However, if there is ever any discrepancy between this Booklet and the Plans' Official Documents, including the Benefit Plan Trust Agreement and the Insurance Company Contract(s), the Plans' Official Documents will prevail in all cases. The final decision on the payment of any benefit, the answer to any question, or the resolution to any problem, will be governed by the Plans' Official Documents, which must be deemed to be compliant with prevailing legislation.

The information in this Booklet does not modify or change the terms of the Plans' Official Documents. Members who wish to view the governing plan documents are invited to contact the Board of Trustees or the Plan Administrator.

PLAN CONTINUANCE & GOVERNANCE

The Trustees hope to continue to provide the excellent benefits available to you under our Benefit Plans. However, the benefits of the Plans described in this Booklet cannot be guaranteed. In order to protect the Benefit Plans, the Board of Trustees, in their sole and absolute discretion, reserves the right, subject only to applicable legislation, to modify, reduce, or terminate the benefits of any, or all Plans, as circumstances may warrant.

In the event of reductions in, or the termination of any benefits presently provided by Federal or Provincial Governments, there is no obligation on the part of the Board of Trustees to provide these former government benefits under any of these U.A. Local 787 Benefit Plans.

Some of the benefits provided under the Health Plan are insured by insurance companies. The Health Care, Dental and Weekly Indemnity benefits are paid from the assets of the Trust Fund and are self-funded. The continuation of coverage for any, or all of the benefits provided under the Plans, including any related benefit payments, is subject to the availability of the funds necessary to provide the benefits from the Trust Fund, and the ability to continue to insure the benefits, where appropriate. The Board of Trustees reserves the right to cancel the Health Plan Insurance Company Contract(s).

The Board of Trustees also reserves the right, at any time, to amend the applicable Member cost-sharing arrangements; that is, the portion of the cost of the Health Plan coverage that must be paid for by Members (including Retired Members, and/or their dependants), compared to the portion of the coverage that is paid for by the Trust Fund.

CONTACTING THE ADMINISTRATOR

The Board of Trustees has retained a Plan Administrator, Employee Benefit Plan Services Limited (EBPS), to manage the administration as well as many of the benefit payments from the Plans. You can help the Plan Administrator to serve you efficiently by providing the information they need to assist you. When contacting the Plan Administrator by telephone, in writing, by email, or in person, please always provide them with:

- your full name and identification code (which is your Union number), and if applicable, your dependant's full name;
- your complete address and phone number, including area code, where the Plan Administrator can contact you;
- the name of your Plan "U.A. Local 787".

KEEPING THE ADMINISTRATOR UP TO DATE

Please make sure you advise the Plan Administrator, as soon as possible, if there have been any changes to your personal information such as:

- your mailing address;

- your family status (marriage, separation, divorce, common-law relationships, birth, adoption or death of a Dependant);
- a change in dependant status for children Age 21 to 26 (e.g. begins, or graduates from University or College);
- a change or modification to your designated beneficiary.

The Plan Administrator will advise you if additional information and/or documentation will be required. If the Plan Administrator does not have your current mailing address, you might not receive your Vacation Pay benefit cheque, other Plan benefit payments, or other important Plan notices and/or documents. If you submit a claim for a dependant who was not listed on your enrolment form, the claim will be held until you complete a new enrolment form, showing the dependant's enrolment information. It is therefore important to make sure the Plan Administrator always has your most current personal information.

YOUR PERSONAL INFORMATION IS PROTECTED

The Trustees are committed to protecting the privacy of our Plan Members. You may view the Plan's Privacy Policy on the Plan's Website

The Plans' Privacy Policy protects all personal information, including the personal health information, of all current and former Plan Members, their Dependants and their beneficiaries. The Privacy Policy applies not only to the Trustees, but also to all third-parties that service our Plans (such as the Plan Administrator, Legal Counsel, etc.) and to U.A. Local 787.

The Trustees, Plan Administrator, and others involved with our Benefit Plans collect only the personal information necessary to administer the Benefit Plans, which is permitted or required by law. From time to time, it may be necessary to obtain consent from you for the collection, use and disclosure of personal information, as required to administer the Plans, including the processing of your claims for specific benefits of the Plan. You are entitled to review your personal information on file with the Plan Administrator to ensure its accuracy. Should you wish to do so, please contact the Plans' Chief Privacy Officers.

PRIVACY OFFICERS

The Board of Trustees has appointed two **Chief Privacy Officers** who you may contact about any privacy information or issues relating to the Benefit Plans. The Officers are:

Trustee: **Randy Pye**, who may be contacted at the U.A. Local 787 Office; and

Manager of Corporate Services, EBPS: **Tara Seebaran**, who may be contacted at the Plan Administrator's office.

MEMBER INTERNET SITE – ACCESS YOUR BENEFIT PLAN INFORMATION

Plan Members can obtain general information about the Benefit Plans at any time by accessing the Plans' website at:

http://www.ualocal787.org/Site/Benefits.html

When viewing the web page noted above, Plan Members who have registered for the Plans' online internet access with the Plan Administrator can sign in by clicking on the "**McAteer Pension/Benefits Link"**. When you register for online access with the Plan Administrator, you can review the details of your benefits 24/7, including:

- how long you will be covered for under the Health Plan;
- who you presently have registered as your dependants under the Health Plan;
- who you presently have designated as your beneficiaries;
- the history of your Vacation Pay payments;
- the value in your Pension Plan account.

Your online information is current up to the last employer contribution report the Plan Administrator has received for you.

Many of the Plan's forms can be downloaded from the Plan's website by clicking on the applicable links found on the home page. All of the Health Plan's specific claim forms (and other forms) are also available from the Plan Administrator and from the U.A. Local 787 Office.

By clicking on the "(GSC) Green Shield Canada" logo, Plan Members can register and access various Health Care and Dental Benefit claims information about the Plan's All-In-One Benefit Card. Please follow the instructions provided online.

HOW TO SUBMIT A CLAIM TO ANY OF THE PLANS

When you or an eligible dependant believe you have a Health Plan, Vacation Plan or Pension Plan benefit entitlement, you should contact the Plan Administrator who will supply you with the necessary forms and instructions for submission of a claim to the Plan.

There are many ways to submit a claim to the Plan including:

- using the Plan's All-In-One Benefit Card for most Health Care and Dental claims at the time you incur the expense;
- using the online claim submission process;
- in person, by email, by regular mail or by faxing a paper claim form to the Plan Administrator

ALL-IN-ONE BENEFIT CARD

Provide your All-In-One Benefit Card to your pharmacist, dentist or other GSC registered health service provider so they can submit claims for you electronically at the point of sale. All prescription drug claims must be submitted to the Plan by your pharmacist using your All-In-One Benefit Card. Many other GSC registered health care providers can submit claims electronically for you and your eligible dependants. Dental claims should be submitted directly by your dentist.

If you experience technical difficulty with your All-In-One Benefit Card or if your card is lost, damaged or stolen, please immediately notify the Plan Administrator by calling 1-905-946-2220 or Toll Free at 1-800-946-2220.

ONLINE CLAIM SUBMISSION

By clicking on the "Benefit Packages (GSC) Green Shield Canada" on the Plans' website and registering as noted above, Plan Members are able to submit claims online using the GSC Member Online Services.

Members may be asked to submit their receipts to the GSC for claims filed electronically. These random audits ensure the Plan is protected. You must therefore retain your receipts for 13 months.

From time to time, when processing claims electronically, confirmation of a traceable and identifiable source of payment is required. This means that you will need to submit a copy of your payment transaction with your claim to confirm the claim was paid in full. Accepted forms of confirmation of payment include:

- cancelled cheque
- authorized electronic credit card receipt and/or credit card statement
- direct payment/debit receipt
- bank statement

SUBMITTING A CLAIM TO THE PLAN ADMINISTRATOR

Claims for most of the Plan's benefits (except for prescription drugs and most outside Canada ETA claims) may be submitted to the Plan Administrator either in person, by email, by regular mail or by fax at:

Employee Benefit Plan Services Limited (EBPS)

45 McIntosh Drive

Markham, ON L3R 8C7

Phone: (905) 946-2220 or 1 (866) 946-2220 (toll-free)

Fax: (905) 946-2535

E-mail: info@787benefits.ca

The necessary claim forms and instructions for submission are available online or from the Plan Administrator. In order to quickly process your claim, all claim forms should clearly indicate:

- your full name and residential mailing address;

- your Plan Member Identification Code
- your Provincial Health Insurance ID number (when claiming Emergency Travel Assistance benefits).

Additional Claim Submission Information

The reimbursement of certain eligible Health Plan expenses will require advance approval from the Plan. For example:

- claims for certain high cost prescription drugs require prior authorization. Additional information may be required from your physician before payment is approved.
- claims for any dental treatment that will cost $500 or more require a Dental Treatment Plan. You must submit the Dental Treatment Plan to Green Shield Canada who will assess the amount the Plan will pay.

Dental claim forms must indicate the procedure codes and be authorized or signed and dated by the dentist.

Please always keep a copy of your submitted claim forms, receipts, physician's statements, explanation of benefit statements and/or Plan Applications for your records. The Plan Administrator may request copies or original claim documents from you for a period of up to 24 months after you submit a claim. If you are emailing claim information to the Plan Administrator, please password protect all attached documents to protect your personal information.

Direct Deposit of Your Benefit Payments

You can have some of the Plan's benefit payments for claims deposited directly into your personal bank account. You can register for direct deposit of Health Care and Dental claims by registering for Green Shield Canada (GSC) Online Member Services as noted above. For other direct deposit claims, please contact the Plan Administrator for more information.

Health Care and Dental Expenses

Expenses that are eligible under your provincial health care plan are not eligible expenses under the Health Plan.

The Trustees rely on the experience of the Plan Administrator, insurance companies and benefit providers with respect to the eligibility of the person submitting a claim to the Plan, the eligibility of the submitted claim expense based on the Plan's rules and their advice with respect to whether the claim expense submitted to the Plan represents charges for eligible expenses which are:

- **medically necessary; and**
- **reasonable and customary.**

If an expense submitted to the Plan is not medically necessary the claim will be denied.

The reimbursement of eligible medically necessary claim expenses will be based on the Health Plan's rules and are always subject to what is considered to be the reasonable and customary charges for the type of Health or Dental service or supply. Reasonable and customary charges are established based on criteria such as the typical cost of the expense in the same geographical region, the medical condition reported and the nature of the service and/or supply being claimed for.

Claims for eligible Heath Plan expenses that are considered medically necessary, but are in excess of the Plan's applicable reasonable and customary charges, will be reimbursed up to the level of reasonable and customary charges.

Co-ordination Between Benefit Plans

You (and your spouse, where applicable) may be covered for benefits by more than one health plan. In this case, the reimbursement of certain expenses for you, and for your dependants, may be co-ordinated so that 100% of the expense is reimbursed. The total benefits payable from all available plans will not ever exceed 100% of the eligible claim amount.

The Plan's Administrator, Insurers and benefit providers have the right to receive and release information relating to Health Care, Vision Care, Emergency Travel Assistance and Dental expenses that are claimed for reimbursement, and/or any Disability benefits paid, and/or if necessary, to collect any overpayments that may have been made in error.

HEALTH CARE, VISION CARE, EMERGENCY TRAVEL ASSISTANCE AND DENTAL BENEFITS

You may co-ordinate the reimbursement of these types of expenses for you and your dependants between the Health Plan and your spouse's benefit plan. To do so:

- Send claims for your spouse's expenses to your spouse's plan first before being sent to your Plan;
- Send claims for your children to the plan of the person whose birthday occurs first in the calendar year (for example, if your spouse's birthday is in June, and your birthday is in December, claims for your children should be submitted to your spouse's plan first). Any unpaid claim amount may then be submitted to this Plan by you, the Plan Member.

DISABILITY BENEFITS

You may apply for and receive disability benefits from more than one health plan. You must report all other disability benefits and/or sources of income that you receive while disabled to the Plan Administrator and/or to the insurance company. Disability benefits paid from this Plan may be reduced by any disability benefits paid from other plans, and/or by the amount of any other income you receive, as described in the **HEALTH PLAN BENEFIT DETAILS** section of this Booklet.

THE DATE OF YOUR EXPENSES DETERMINES WHETHER CLAIMS ARE PAID

Some of the Health Plan's eligible expenses (e.g. vision care and dental benefits) are reimbursed by the Plan up to a maximum dollar amount within a defined period of time (usually in each calendar year, or over a 24 month period). The Health Plan's rules determine when that benefit year, or 24 month period, starts and stops based on the dates of the submitted expenses.

The reimbursement of eligible medical and dental expenses by the Health Plan is determined based on when the service or supply is paid for, and/or is provided or dispensed to the claimant. Some examples are provided below.

INCURRED DATE EXAMPLES

Prescription Drugs: On March 12th a prescription was submitted to and paid for at a pharmacy. The pharmacist filled the prescription and the patient picked up the prescription later that same day. For the purposes of the Plan the expense was incurred on March 12th which is the date the expense was paid for.

Vision Care: On October 9th new prescription lenses are ordered and paid for. On October 16th the new glasses are fitted and taken by the patient. October 16th is the date used by the Plan to determine if the glasses are eligible for reimbursement, even though the glasses were paid for on October 9th. If this was the very first Vision Care claim submitted to the Plan, then October 16th is also the start date of any applicable 24 month maximum benefit period (before another claim may be submitted, if the maximum benefit was used).

Dental Crown: On December 21, 2011, treatments for a dental crown began. The patient returned to the dentist four times for related treatments until the dental crown was completed on March 18, 2012. The incurred date of this claim is March 18, 2012 as that is the date when the work was completed. The eligible claim amount will count towards the 2012 Maximum Annual Dental Benefit payable by the Plan (not 2011).

CLAIM SUBMISSION DEADLINES

Details for the requirements when submitting claims for the benefits of the Plans are provided throughout this Booklet.

If you and/or your eligible dependants, and/or your designated beneficiaries have a claim to be considered for payment by any of the Plans, the necessary claim information and/or applications must be submitted to the Plan Administrator within the specific submission deadlines as noted below:

LIFE INSURANCE:

- Completed claim forms, including proof of death, must be provided no later than 12 months from the date of death;

ACCIDENTAL DEATH & DISMEMBERMENT:

- Completed claim forms, including proof of the accident or death, must be provided no later than 12 months from the date of the accidental injury, death or disappearance;

WEEKLY INDEMNITY:

- Completed claim forms, including the attending physicians' statement, must be provided between the second week and six months from the date when you first become disabled;

LONG TERM DISABILITY:

- Completed claim forms, including the attending physician's statement, must be provided no later than nine months from the date you first become disabled;

HEALTH CARE & DENTAL:

- Completed claim forms and all required receipts, must be provided no later than 18 months from the date the expense was incurred;
- If your Health Plan coverage has terminated, completed claim forms and all required receipts but be provided no later than 12 months from the date the expense was incurred.

EMERGENCY TRAVEL ASSISTANCE:

- Travel outside Canada Medical expenses over $200 should be reported to Green Shield Canada Travel Assistance within 48 hours of the start of any medical treatment. Often, these expenses are forwarded directly to Green Shield Canada by the hospital, or other health care service providers.
- You are required to pay for total expenses that are under $200. You then submit these expenses for reimbursement. Completed claim forms and all required receipts must be submitted no later than 18 months after the date the expense was incurred and no later than 12 months after your health Plan coverage terminates.

VACATION PAY BENEFITS:

- You may submit a claim for one optional benefit payment at any time, except from May 1 to the May payment date, and from November 1 to the November payment date;

PENSION PLAN RETIREMENT BENEFITS:

- Please contact the Plan Administrator at least one month prior to your retirement for the necessary forms and instructions. Not allowing enough time for your application may delay your Pension payment;

PENSION PLAN TERMINATION BENEFITS:

- The Plan Administrator will contact you in writing if and when you are eligible for a Pension Plan Termination Benefit; and

PENSION PLAN DEATH BENEFIT:

- Your Designated Beneficiary should contact the Plan Administrator in the event of your death. The necessary forms will be provided to your Beneficiary for completion.

APPEALING BENEFIT ENTITLEMENT DECISIONS

It is your right as a Plan Member to appeal any claim or benefit entitlement decision. If you believe that a claim should have been paid, or if a claim that was paid or a benefit entitlement should have been calculated differently, please contact the Plan Administrator in writing providing the details of the circumstances and your concerns.

The Plan Administrator will provide a claim appeal form to you. Your completed claim appeal form must be returned to the Plan Administrator together with any necessary attachments.

All appeals are reviewed by the Board of Trustees at the next scheduled Board meeting. The Plan Administrator will confirm the Board's final decision to you.

SUBMITTING FRAUDULENT CLAIMS OR PROVIDING INCORRECT INFORMATION

It is a serious offence to submit a claim to the Plan for expenses for which there was no loss or no out of pocket expense incurred, or for expenses that are rightfully the responsibility of another plan or a third party. For example, claims for expenses due to an illness or disability that is work-related must be submitted to the Workers' Safety Insurance Board. Providing false information about a Dependant's eligibility is also considered fraudulent.

Please note that:

- If a Plan Member submits a fraudulent claim, the claim will not be paid;
- If a Plan Member intentionally provides incorrect or misleading information about the eligibility of a dependant, or about the expense or loss being claimed for, the claim will be held until the correct information has been provided;
- If a claim was paid by the Health Plan, before the claim is deemed to be fraudulent or before the incorrect or misleading information is discovered, the Plan Member will be required to repay the benefit payment amount to the Plan. No further claims will be paid by the Plan for that Plan Member, and/or for that Plan Member's dependants, until the original claim amount has been repaid to the Plan in full, and/or until the correct information is provided.

The Board of Trustees will be advised of any alleged fraudulent activity and of any intentionally provided incorrect or misleading information. The Trustees will determine what further action will be taken., Fraudulent activities may result in serious consequences, including suspension, or termination of the benefits provided under the Plan for a period of time, or such other legal recourses that are available to the Trustees.

U.A. LOCAL 787 – ICI HEALTH PLAN BENEFITS AT A GLANCE

Benefit	Benefit Description	Eligible Active Member Under Age 65	Eligible Active Member Age 65 +	Eligible Inactive or Disabled Member Under Age 65	Eligible Inactive Member Age 65 +	Eligible Retired Member Under Age 65	Eligible Retired Member Age 65 +	Eligible Spouse and Children
Life Insurance	Premiums are a taxable benefit	$100,000	$25,000	$100,000	$25,000	$50,000	$25,000	No
Accidental Death &Dismemberment (AD&D)	Premiums are a taxable benefit	$100,000	$25,000	$100,000	$25,000	$50,000	$25,000	No
Weekly Indemnity (WI)	Benefits paid after 7 consecutive days of disability, for up to 16 Weeks, if no EI sick benefits paid: - **Apprentice 1 to 5 and Maintenance Mechanics: $554/week** - **ICI Journeyman: $692/week**	Yes. Benefit depends on classification.	Yes. Benefit depends on classification.	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Long Term Disability (LTD)	Benefits paid after 17 consecutive weeks of disability, up to age 65. Persons with a work related disability must apply if applied for WSIB benefits: - **Apprentice 1 to 5 and Maintenance Mechanics: $2,400/month** - **ICI Journeyman:$3,000/month**	Yes. Benefit depends on classification.	Not Covered.	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Health Care I	-100% Reimbursement of covered items - Prescription drugs (lowest cost alternative) - $800 per 24 month periods for vision care - $2,000/calendar year for all practitioners combined -Medical services and supplies	$200,000 Lifetime Maximum Per Covered Person	$200,000 Lifetime Maximum Per Covered Person	$200,000 Lifetime Maximum Per Covered Person	$200,000 Lifetime Maximum Per Covered Person	$100,000 Lifetime Maximu m Per Covered Person	$100,000 Lifetime Maximum Per Covered Person	$200,000 Lifetime Maximum. $100,000 if Covered Under the RMHP
Emergency Travel Assistance (ETA)	- Emergency Medical Insurance - Travel Assistance Services - Covers 60 days per trip - Medical Referral Coverage	Yes	Not Covered	Yes	Not Covered	Not Covered	Not Covered	Yes under Active Plan if Dependant is under age 65
Dental	- Based on prior year Ontario Dental Association Fee Guide - 100% for Basic Services - 80% for Major Services - $2,500 / person / year for Basic and Major Services combined -60% for Orthodontic Services (available to dependant children under age of 21) - Orthodontic maximum benefit $2,000/ lifetime	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Member Assistance Program (MAP)	Confidential counselling services providing crisis support, advice and information by telephone, face-to-face, or online.	Yes	Yes	Yes	Yes	Yes	Yes	Yes

U.A. LOCAL 787 – VACATION PAY BENEFITS AT A GLANCE

Contributions	• 10% of your wages for Vacation Pay and Statutory Holiday Pay is paid into the Fund

Automatic Benefit Payments	• Two Automatic Benefit Payments will be made to you as follows:
	  • By May 15, a payment is made (usually Vacation Pay earned from October 1 to March 31); and
	  • By November 15, a payment is made (usually Vacation Pay earned from April 1 to September 30).
	• A Payment is made to Retired Members with respect to Benefits earned prior to retirement
	• A Payment is made to a Designated Beneficiary if there is unpaid Vacation Pay Benefits at the time of a Member's death

Optional Benefit Payments	• You may apply in writing for one Optional Benefit Payment each calendar year (for specified reasons only) • Optional Benefit Payments must be applied in writing (for specified reasons only) and will be reviewed by the Board of Trustees at the next regularly scheduled Board meeting following receipt of your application • An administration fee will be deducted from all Optional Benefit Payments
Special Benefit Payments	• If Fund reserves permit, payments may be made to Members for contributions due from bankrupt/ insolvent employers

U.A. LOCAL 787 – PENSION PLAN BENEFITS AT A GLANCE

Eligibility & Vesting	You become a Plan Member and are vested (you have the right to the Pension earned under the Plan) on the first day of the month after you had 700 hours of contributions remitted to the Pension Plan on your behalf provided no two contributions are separated by more than 18 months
Benefit Payments	Pension Plan contributions made on your behalf are deposited into your Pension Plan Account, which also includes a prorated portion of the Pension Fund's interest, dividends, net realized and unrealized capital gains and losses, and a deduction for a prorated share of the Pension Fund's operational costs. Benefit are paid at: • **Retirement –** If you are a Plan Member, and if you retire between the ages of 55 and 71. Pension Plan Accounts are used to purchase a lifetime monthly pension or acceptable registered pension plan; or • **Termination -** If you are a Plan Member, and if no Pension Plan contributions have been made for a consecutive period of 18 months, you will be eligible for a Termination Benefit. Your Termination Benefit may be transferred to an acceptable registered plan; or • **Death –** If you are a Plan Member, your Pension Plan Account balance is paid to your Designated Beneficiary, which will be your Spouse in certain circumstances.

HEALTH PLAN GENERAL INFORMATION

ELIGIBILITY INFORMATION

The following pages in this Section of the Booklet describe general Health Plan rules relating to items such as:

- Who is eligible for coverage;
- What is the duration of coverage;
- What is the cost of coverage;
- How to maintain coverage when not working;
- Coverage under more than one plan.

In this Section of the Booklet, the terms "**The Health Plan**", "**The Plan**" and "**your Plan**" refers to "**the U.A. Local 787 Health Plan**". The term "**Fund**" refers to the "**The U.A. Local 787 Health Trust Fund**".

"**The Administrator**" refers to Employee Benefit Plan Services (EBPS).

WHO MAY BE COVERED FOR THE BENEFITS OF THE HEALTH PLAN?

This Health Plan is provided to eligible Members in good standing of U.A. Local 787 (and eligible Dependants) provided:

a) the covered person is a Canadian Resident properly enrolled in his/her provincial health care plan; and

b) the covered person meets all of the applicable eligibility requirements described in this Booklet; and

c) contributions have been made to The Fund on his/her behalf by a contributing employer.

DEPENDANT HEALTH PLAN COVERAGE

WHO ARE ELIGIBLE DEPENDANTS?

The following individuals are eligible dependants:

- **Spouse**: The person you are living with, of the same or opposite sex to you, who is your spouse. Your spouse includes a legally married spouse (civil or religious ceremony) from whom you are not legally separated or divorced; or a common-law spouse, if you provide proof that you are living together, are publicly represented as spouses, and have lived together continuously for a minimum of 12 months. Your dependant spouse is the person who has most recently met the above noted requirements. You may designate only one individual to be recognized by the Plan as your dependant spouse, at any given time; and
- **Children**: Your unmarried child/children, including adopted children, those you are a legal guardian for and claim under the Income Tax Act, Canada and your eligible dependant spouse's children, with proof provided, who are living with you and are dependent on you and/or your dependant spouse for support. Your dependant child/children must be under Age 21. If a dependant was covered the day before attaining Age 21 and is under Age 26, he/she may continue to qualify as your eligible dependant if you provide proof that he/she is a full-time student at an accredited learning institution.
  - A child is not considered a dependant for coverage if employed full-time (including serving in the military) or if already covered as a Plan Member of this Plan.
  - A child (who was covered as a dependant under the Health Plan the day before attaining Age 21) who is an unmarried, mentally or physically challenged and totally dependent on you for support will continue to be covered after the limiting Age 21, if you provide proof, including dependency on your support and maintenance under the Income Tax Act Canada.
  - The children of your common-law spouse will become eligible dependants (as shown above) when your common-law spouse qualifies as your dependant spouse.

Designating Your Dependants

Your spouse and children are considered your eligible dependants if they meet the eligibility criteria outlined above and if you have designated them as your dependants on your enrolment form. If you have not listed your spouse and children on your enrolment form, you will be asked to do so before any Health Plan claims may be submitted to the Plan on their behalf.

When Dependants' Health Plan Coverage Begins and Terminates

Health Care, Dental, Emergency Travel Assistance and Member Assistance Program benefits will commence for your eligible dependants on the day when you become eligible for coverage under the Health Plan and your eligible dependants are properly enrolled by being designated on your enrolment form.

If your dependant is hospitalized or in a medical institution at the time his/her coverage would normally begin, his/her coverage will begin after the dependant is released from the hospital or medical institution.

Your dependants will cease to be covered when your coverage in the Health Plan terminates, when he/she ceases to qualify as an eligible dependant, or for any other reason indicated in the **When Health Plan Coverage Terminates** Section below.

EMPLOYER CONTRIBUTIONS & YOUR DOLLAR BANK ACCOUNT

Employer Contributions

Employer contributions must be made to the U.A. Local 787 Health Trust Fund when you work in the amounts required under the applicable U.A. Local 787 Collective Agreement. Each month, the required employer contributions are to be remitted to the Plan Administrator.

Dollar Bank Account

The Plan Administrator sets up a Dollar Bank Account for each Health Plan Member, depositing to that Account all of the contributions earned by the Plan Member and received by the Plan Administrator. The Dollar Bank holds the contributions remitted by the employer on behalf of the Plan Member. Employer contributions are credited to the Plan Member's Account when:

- working for a contributing Employer who remits contributions to the Plan Administrator; or
- (for up to one year) receiving qualifying workers' compensation benefits (Workplace Safety and Insurance Act); or
- on a qualified maternity or parental leave for up to 12 months; or
- working on a travel card in another local union's jurisdiction and there is a Reciprocal Agreement between the plans.

Each month, the Plan Administrator records the hours and contributions reported by signatory employers. You are given a statement of your dollar bank account activity every six months. You should compare this statement to your payroll records to ensure accuracy. The Plan Administrator should be contacted if you discover any discrepancies.

If your Employer becomes bankrupt or insolvent, the Board of Trustees and U.A. Local 787 will do everything possible to collect any contributions that are owing.

EMPLOYER CONTRIBUTION EXAMPLE

A Plan Member works 145 hours in August. The Employer is required to remit the contributions for 145 hours to the Plan Administrator by September 15th. The Plan Administrator credits the received contributions to the Member's Dollar Bank Account balance by September 30.

COST OF HEALTH PLAN COVERAGE

Dollar Bank Deductions

For Active Plan Members, deductions are made from your Dollar Bank Account each month to pay for the benefits of the Health Plan for that month. Depending on your member classification and your benefit status in the Plan, the level of benefits you receive and the amount of your monthly Dollar Bank Deductions may vary.

Under certain conditions, you may be permitted to make Pay Direct payments to the Plan to extend coverage. Dollar Bank Deductions, Pay Direct Amounts and the benefits provided within each Plan Member Classification are subject to change. As of July 1, 2017, the monthly Dollar Bank Deductions for each Member Classification and the corresponding benefits provided are listed in the table below:

ICI MEMBER CLASSIFICATION	MONTHLY DOLLAR BANK DEDUCTION	MONTHLY PAY DIRECT AMOUNT	BENEFITS PROVIDED
Active Members (Under Age 65) Actively Employed	$425.00	$425.00	Life, AD&D, WI, LTD, Medical, Dental, ETA, MAP
Active Members (Age 65 +) Actively Employed	$340.00	$340.00	Reduced Life & AD&D, WI, Medical, Dental, MAP
Inactive Members (Under Age 65) Unemployed 2 Consecutive Months	$340.00	$325.00	Life, AD&D, Medical, Dental, ETA, MAP
Inactive Members (Age 65 +) Unemployed 2 Consecutive Months	$310.00	$310.00	Reduced Life & AD&D, Medical, Dental, MAP
Disabled Members (Under Age 65)	$220.00	$220.00	Life, AD&D, WI, LTD, Medical, Dental, ETA, MAP
Eligible Retired Members (Under 65) Pay Direct Limited RMHP Coverage	$300.00	$300.00	Reduced Life & AD&D, Medical, Dental, MAP
Eligible Retired Members (Age 65 +) Pay Direct Limited RMHP Coverage	$300.00	$300.00	Reduced Life & AD&D, Medical, Dental, MAP
Dependants of a Deceased Active Member Until Age 65	$175.00	$175.00	Medical, ETA, Dental, MAP
Dependants of a Deceased Retired Member	$175.00	$175.00	Medical, Dental, MAP

All monthly Pay Direct Amounts above also require applicable provincial taxes (presently 8% Ontario Retail Sales Tax).

Active, Inactive & Retired Member Health Plan Coverage When Age 65 or Over

When an Active Plan Member attains age 65, the applicable Life Insurance and Accidental Death & Dismemberment benefits reduce. As well, the Long Term Disability and Emergency Travel Assistance benefits terminate. This is also the case for Inactive and Retired Plan Members however the Weekly Indemnity benefit also terminates for these classifications.

Inactive Member Coverage

If you have been unemployed from a signatory employer for 2 consecutive calendar months, you are no longer eligible for Disability coverage (i.e., Weekly Indemnity and Long Term Disability benefits). Weekly Indemnity and Long Term Disability coverage will be reinstated when you return to work for a signatory employer provided your Plan coverage has been maintained.

Disabled Member Coverage

Weekly Indemnity and Long Term Disability coverage may be extended if you are approved by the Plan for Disability benefits as described throughout this Booklet.

Retired Member Health Plan Coverage (RMHP)

In order to become eligible under the Retired Member Health Plan, you must first meet the conditions as outlined in the **RETIRED MEMBER HEALTH PLAN (RMHP) GENERAL INFORMATION** section of this Booklet. Pay Direct payments may be required to maintain coverage.

Dollar Bank Account Maximum

Employer contributions will accumulate in your Dollar Bank Account and may provide you with a maximum of up to 36 months of coverage. The first 4 months of coverage include all Plan benefits. The remaining 32 months of coverage exclude all Disability benefits. The appropriate Dollar Bank Deduction applies in each of these periods.

Employer contributions received in excess of the 36 month Dollar Bank Account maximum are considered excess contributions and will be transferred to the Fund. This transfer is made each month and is necessary to fund the benefits of the Plan including the RMHP.

A Members' Dollar Bank Account balance will also be transferred to the Fund:

- immediately after membership in U.A. Local 787 terminates, or upon expulsion from U.A Local 787; or
- if the Member has not accumulated the minimum of 3 months of employer contributions to become initially eligible for Health Plan coverage, and no further contributions have been received on behalf of the Member for 18 months; or
- if a Member's Health Plan coverage terminates, and there has been no further activity for 18 months. "Activity" means an employer contribution being made on behalf of a Plan Member, a deduction from the Member's Dollar Bank Account, Fund-paid coverage, or a Pay Direct payment made by a Plan Member.

TAXABLE BENEFITS YOU MAY RECEIVE FROM THE PLAN

Life Insurance and Accidental Death and Dismemberment premiums paid to the insurance companies on your behalf, as well as Weekly Indemnity and Long Term Disability benefits paid to you are reported to Canada Revenue Agency as taxable income on T4A's issued by the Plan. T4A's for these taxable benefits are issued by the end of February each year and must be reported when you file your income tax return.

WHEN HEALTH PLAN COVERAGE BEGINS

INITIAL ELIGIBILITY & REINSTATEMENT OF COVERAGE

Coverage under the Health Plan takes effect the first day of the month, following the month during which your Dollar Bank Account balance totals at least:

- **3 months of Dollar Bank Deductions – the first time you are to become covered by the Plan; or**
- **2 months of Dollar Bank Deductions – to reinstate coverage if terminated after you first became covered by the Plan.**

Your coverage begins when you are actively at work. You are considered "actively at work" when your employer is remitting contributions for credit to your Dollar Bank Account (including during workers' compensation and maternity and parental leaves). You are also considered "actively at work" when you are available for work and you are on the U.A. Local 787 out of work list, working on a travel card, or attending trade school.

The eligibility rules for dependants are described earlier in the **DEPENDANTS' HEALTH PLAN COVERAGE** section of this Booklet.

NEW MEMBER EXAMPLE

A new Member first works on February 19. From February 19 to May 25 the new Member earns employer contributions equal to three months of Dollar Bank Deductions. They are remitted to the Plan Administrator and deposited to the new Member's Dollar Bank Account. The May contributions are received and credited to the Member's Dollar Bank Account in June. The new Member's coverage takes effect July 1, which is the first day of the month, following the month during which the Member's Dollar Bank Account balance totals 3 months of Dollar Bank Deductions.

WHEN HEALTH PLAN COVERAGE TERMINATES

HEALTH PLAN COVERAGE TERMINATION FOR MEMBERS & DEPENDANTS

You will be notified by mail when your Health Plan coverage is terminated. Termination of Health Plan coverage for you and your eligible dependants occurs:

- you terminate your Membership in U.A. Local 787; or
- you are expelled by U.A. Local 787; or
- you commence active duty in the armed forces of any country, state or international organization; or
- the insurance company contract terminates (unless the Trustees obtain other coverage); or
- for Emergency Travel Assistance, on the earlier of the date the Plan Member attains Age 65 (or eligible Dependant if

earlier) or enrols in the Retired Member Health Plan; or

- for Long Term Disability insurance, on the earlier of the date the Plan Member attains Age 65 or becomes covered under the Retired Member Health Plan (unless a Disabled Member selects the RMHP option, in which case coverage terminates at Age 65 or earlier recovery from disability). If the Plan Member satisfies the Qualifying Disability Period for Long Term Disability insurance while Age 64 and is considered eligible for Disability Benefits, Long Term Disability benefit payments will be payable for a maximum of 12 months; or
- for Weekly Indemnity coverage, on the date the Plan Member becomes an Inactive Member, or becomes covered under the Retired Member Health Plan.

Otherwise, your Health Plan coverage will terminate on the last day of the coverage month in which:

- your Dollar Bank Account balance is less than the required monthly deduction and you have not made the required Pay Direct payment requested by the Plan Administrator by the required date or you have already made the maximum number of Pay Direct payments; or
- when you, or your dependant(s) no longer qualify for Health Plan coverage due to an eligibility requirement not being met, or due to any limitation or restriction within a benefit of the Health Plan as described in this Booklet.

BENEFIT PAYMENTS AFTER HEALTH PLAN COVERAGE HAS TERMINATED

Although your Health Plan coverage may have terminated, you may continue to receive benefit payments. Claims for Weekly Indemnity and/or Long Term Disability benefits which were approved prior to your Health Plan coverage termination will continue to be paid to you as long as you continue to meet the definition of disability as determined by the Plan Administrator and/or insurance company respectively and remain eligible for the benefit in accordance with the provisions of that benefit.

Also, coverage for impressions for dentures and root canal or orthodontic treatments started while covered, continues for 30 days after Plan coverage is terminated, subject to Plan limits.

Your Life Insurance coverage continues for 31 days after your Health Plan coverage is terminated. You may be eligible to convert your Life Insurance coverage to an individual policy as shown in LIFE INSURANCE – The Details.

If you or a dependant (spouse or child) is receiving counselling through the Member Assistance Program, the counselling will continue as though your Plan coverage had not terminated.

MAINTAINING YOUR HEALTH PLAN COVERAGE WHEN UNEMPLOYED

PAY DIRECT PAYMENTS

As an unemployed Inactive Plan Member in good standing of U.A. Local 787, you can maintain most of your Health Plan coverage for a period of time after employer contributions cease to be made on your behalf. Initially, monthly deductions will continue to be made from your Dollar Bank Account, where funds available. Once your Account has been depleted, you may pay for your coverage directly on a monthly basis with Pay Direct payments.

The maximum total coverage extension is 36 months which coincides with the Dollar Bank Maximum. The monthly cost of this extended coverage may come first from your Dollar Bank Account (if your Account has sufficient funds) and may continue for up to an additional 12 months by making Pay Direct payments.

If your Dollar Bank Account has a balance of less than one month's worth of deductions remaining, you may make monthly Pay Direct payments to maintain your Health Plan coverage for up to a maximum of 12 consecutive months. However, your total coverage extension while unemployed (Dollar Bank Account monthly deductions plus monthly Pay Direct payments) cannot exceed 36 months. Note that Disability coverage is only extended for a period of no greater than 2 months. Afterward, a Member is considered an Inactive Member subject to the applicable Pay Direct Plan.

EXAMPLES OF PAY DIRECT PAYMENTS

Dollar Bank Deductions Available on Account	Maximum Number of Allowable Pay Direct Payments
3 months	12 months
25 months	11 months
31 months	5 months
36 months	NIL

The Plan Administrator will advise you in writing, by a **Warning Letter**, when you are required to make a Pay Direct payment to maintain your coverage. Your Pay Direct payment must be received by the Plan Administrator by the date shown on the Warning Letter. **If the total required Pay Direct payment (Pay Direct amount, plus applicable taxes, presently 8% Ontario Retail Sales Tax) is not made as required, your coverage is terminated on the date indicated in the Warning Letter.**

Once terminated, your coverage cannot be reinstated in the Health Plan until you return to active work for a contributing employer and accumulate at least two months of deductions in your Dollar Bank Account.

Upon termination of your coverage, you may have the right to convert your Life Insurance benefit to an individual life insurance policy. You must pay strict attention to the procedures for converting this benefit, as there is only a short timeframe after termination of coverage to convert your Life Insurance benefit. More details about the Life Conversion Privilege can be found under the **Life Insurance** section of this Booklet.

MAINTAINING YOUR HEALTH PLAN COVERAGE WHEN RECEIVING WORKERS' COMPENSATION BENEFITS

If you are receiving Workplace Safety and Insurance Act (WSIA) benefits, Health Plan and Pension Plan contributions are made by your employer on your behalf for the first year of WSIA benefits receipt as though you were working.

Please notify the Plan Administrator as soon as possible when you are receiving WSIA benefits to ensure the required employer contributions are made on your behalf for up to the 12 month maximum.

If as a Plan Member of U.A. Local 787, you continue to receive WSIA benefits beyond the 12 month maximum period required by your employer to continue contributions, you can maintain your coverage. Initially, monthly deductions will continue to be made from your Dollar Bank Account, where available. Once your Account has been depleted you may pay for your coverage by making Pay Direct payments.

The maximum total coverage extension period while receiving WSIA benefits is 36 months after the 12 months of required employer contributions are made. The cost of this coverage extension may first come from your Dollar Bank Account deductions if your Account has sufficient funds and up to a further 12 months of Pay Direct payments.

If your Dollar Bank Account has a balance of less than one month's worth of deductions remaining, you may make monthly Pay Direct payments to maintain your coverage. Pay Direct payments may be made for a maximum of 12 consecutive months. Your total coverage extension after your employer stops contributing (Account deductions plus Pay Direct payments) cannot exceed 36 months.

If you are considered by the Plan to be "totally disabled", you may also be eligible to receive the Health Plan Weekly Indemnity and/or Long Term Disability coverage (both may be reduced by any WSIA benefits you receive), and/or continued coverage of your then current Life Insurance benefit. Please contact the Plan Administrator in this situation, as a written application must be made by you for these benefits no later than three months after the start of your disability (12 months for the Life Insurance Benefit).

MAINTAINING YOUR HEALTH PLAN COVERAGE WHEN RECEIVING DISABILITY BENEFITS FROM THE PLAN

Eligibility for Disabled Member Coverage

Disabled Member Health Plan coverage is available to qualifying Plan Members who are receiving Long Term Disability (LTD) benefits from the Plan. Life Insurance, Accidental Death and Dismemberment (AD&D), Weekly Indemnity, Long Term Disability, Health Care, Emergency Travel Assistance, Dental and Member Assistance Program coverage is continued for a disabled Plan Member if he/she:

- is under Age 65 and receiving LTD Benefit payments from the Plan's insurer; and
- remains a Member in good standing of U.A. Local 787, in accordance with the U.A. Constitution and U.A. Local 787 By-Laws; and
- was covered for Health Plan benefits on the date when LTD benefit payments begin; and
- has applied for the Canada Pension Plan disability benefit.

If you have an approved claim for Long Term Disability benefits, your Life, AD&D, WI and LTD coverage is extended for as long as you remain disabled, up to age 65. The amount of Life, AD&D, WI and LTD coverage provided under the Disabled Member Health Plan are the amounts in effect for you on the date you first became disabled.

Duration and Cost of Disabled Member Coverage

Full Health Plan coverage for eligible disabled Plan Members will continue for a minimum of 36 months, as long as the Member remains in good standing of U.A. Local 787 and continues to receive LTD benefit payments. If the disabled Member's Dollar Bank Account balance has less than 36 months of deductions, the remainder of the 36 months will be paid by the Fund. That is, eligible disabled Plan Members do not have to make any Pay Direct payments during the first 36 months of the Disabled Member coverage extension.

After the first 36 months, Disabled Member coverage may be continued under certain circumstances by making Pay Direct payments for the remaining months of available extended coverage. The monthly Pay Direct cost for Disabled Member coverage (which is subject to change) is shown in the **COST OF HEALTH PLAN COVERAGE** section of this Booklet. The length of the available Disabled Member coverage extension period depends on how long the disabled Member was continuously covered under the Plan as an Active Plan Member on the date the Member first became disabled.

Continuous Time Covered as an Active Member	Minimum Duration of Disabled Member Coverage	Maximum Duration of Disabled Member Pay Direct Coverage	Maximum Total Duration of Disabled Member Coverage (Minimum + Pay Direct)
Less Than 48 Months	36 Months	12 Months	48 Months
48 Months Up To 10 Years	36 Months	7 Years	10 Years
10 Years or More	36 Months	7 Years	10 Years

If you have been covered as an **Active Member for less than 48 months**, your Disabled Member coverage is continued for the 36 month minimum. You may then make Pay Direct payments for up to 12 months of additional coverage.

If you have been covered as an **Active Member for 48 months or more, but less than 10 years**, your Disabled Member coverage is continued for the 36 month minimum. You may then make Pay Direct payments for a period equal to the number of years you have been covered as an Active Member, less the initial 36 month minimum duration.

If you have been covered as an **Active Member for 10 years or more**, your Disabled Member coverage is continued for the 36 month minimum. You may then make Pay Direct payments for a period of up to 7 years.

DISABLED MEMBER COVERAGE EXAMPLE

An Active Member has been continuously covered for Health Plan benefits for 9 years.

The Member is approved for Disability benefits and has a Dollar Bank Account balance of 14 months of deductions.

During the first 36 months of Disabled Member coverage, monthly Dollar Bank Account deductions are made for 14 months and Fund-paid Coverage is provided for 22 months (for a total of 36 months).

The Disabled Member may then continue Disabled Member coverage for an additional 6 years (9 years minus 36 months) by making the appropriate monthly Pay Direct Payment.

Disabled Member's Option to Select Retired Member Health Plan (RMHP) Coverage

If you are at least Age 55, at the end of the first 36 months of your Disabled Member minimum coverage continuation period, you may choose to continue your Disabled Member coverage as described above (where applicable), or you may apply for coverage under the Retired Member Health Plan.

Enrolling in the RMHP may be of benefit to Plan Members whose Pay Direct option under the Disabled Member coverage described above would terminate prior to the attainment of Age 65, when LTD benefit payments cease.

A Disabled Member who does not enrol in the RMHP would continue to receive Disability benefit payments and Disability coverage until Age 65. However, all other coverage under the Health Plan would terminate at the end of the **Maximum**

Total Duration of Disabled Member Coverage (Minimum + Pay Direct) as outlined above.

Note that there are differences between the coverage provided under the Plan's Disabled Member coverage classification and the RMHP. The RMHP does not provide Emergency Travel Assistance coverage. Life and AD&D coverage is reduced. The Health Care Maximum Lifetime Benefit is reduced. Long Term Disability benefit payments and coverage would continue under the RMHP until Age 65, unless you recover from your approved disability before a subsequent disability occurs.

Coverage in any Health Plan classification may not be reinstated once Pay Direct payments cease, unless a Disabled Member again becomes an Active Member and satisfies the eligibility requirements described earlier in this Booklet. Once approved for RMHP coverage, Active Member coverage cannot be reinstated even if the Member recovers and works for a contributing employer and works sufficient hours to qualify for Active Member coverage.

If applying under this option, you will be required to submit a **Retired Member Health Plan Application Form** to the Plan Administrator. Your irrevocable option (Disabled Member coverage or RMHP coverage) must be made in writing within 90 days of the date the Application Form was sent to you by the Plan Administrator. Disabled Member coverage and/or RMHP coverage must be maintained continuously from the time a Member first becomes disabled. All coverage will terminate if Pay Direct Payments are not made when due.

A description of the RMHP eligibility, coverage, duration of coverage, and coverage cost is provided in the **RETIRED MEMBER HEALTH PLAN (RMHP) GENERAL INFORMATION** Section of this Booklet.

MAINTAINING COVERAGE FOR DEPENDANTS OF DECEASED PLAN MEMBERS

Eligibility for Surviving Dependant Coverage

Coverage for the eligible dependants of a deceased Active, Inactive, Disabled or Retired Member may be continued in certain circumstances provided that:

- the deceased Plan Member was covered for the Health Plan's benefits at his/her death; and
- the surviving spouse and/or children were eligible dependants designated on the Plan Member's enrolment form (an unborn child on the Member's date of death is thereafter eligible for dependant coverage if the other parent was designated as a dependant spouse).

Duration and Cost of Surviving Dependant Coverage

During the first 24 months following a Plan Member's death, coverage for surviving eligible dependants, who were listed on the Plan Member's enrolment form, is continued first from monthly deductions from the Member's Dollar Bank Account, and then by any Fund-paid coverage. The monthly Pay Direct cost for surviving dependants, which is subject to change, is shown in the **COST OF HEALTH PLAN COVERAGE** section of this Booklet.

After the initial 24 month coverage period, coverage may be continued for the dependants of a deceased Plan Member, based upon the deceased Member's duration of Active Member Coverage. This is the length of time the deceased Member was continuously covered under the Health Plan as an Active Member and/or Inactive Member at the date of death.

Years of Continuous Health Plan Coverage Upon Member's Death	Minimum Duration of Surviving Dependant Coverage	Maximum Duration of Surviving Dependant Pay Direct Coverage	Maximum Total Duration of Surviving Dependant Coverage (Minimum + Pay Direct)
Active Member Coverage With Less Than 10 Years	24 Months	8 years	10 years
Active Member Coverage With 10 Years or More	24 Months	8 years	10 years
Retired Member Coverage With Less Than 10 Years; **Pay Direct Limited Coverage**	24 Months	8 years	10 years
Retired Member Coverage With 10 Years to 30 Years; **Fund Paid Limited Coverage**	Lesser of 10 Years or the RMHP Coverage Balance	Not Applicable	10 years

Retired Member Coverage With More Than 30 Years; **Fund Paid Lifetime Coverage**	10 years	Not Applicable	10 years

Coverage for Surviving Dependants of Active Members

If you were covered as an **Active Member for less than 10 years** upon the date of your death, the surviving dependant coverage is continued for the 24 month minimum period. Pay Direct payments may be made for a period equal to the number of years you had been covered as an Active Member, minus the initial 24 month guaranteed duration.

If you had been covered as an **Active Member for 10 years or more** upon the date of your death, the surviving dependant coverage is continued for the 24 month minimum. , Pay Direct payments may be made for a period of up to 8 years.

Emergency Travel Assistance coverage terminates under this surviving dependant coverage extension when the surviving spouse of an Active Member reaches Age 65.

Coverage for Surviving Dependants of Retired Members

If you were covered as **Retired Member with Fund Paid Lifetime Coverage** upon the date of your death, surviving dependant coverage is continued for 10 years. Pay Direct payments are not required and may not be made after this 10 year period.

If you were covered as **Retired Member with Fund Paid Limited Coverage** upon the date of your death, the surviving dependant coverage is continued for the lesser of the remaining number of years of Fund Paid coverage the Member would have received had he continued to lived, and 10 years. Pay Direct payments are not required and may not be made after the expiration of the coverage extension period.

If you had been covered as **Retired Member with Pay Direct Limited Coverage** upon the date of your death, the surviving dependant coverage may be continued for the remaining period of time for which the Member could have made Pay Direct payments. Pay Direct payments are required to continue and may not be made after the expiration of the coverage extension period.

If a Retired Member in the **Pay Direct Limited Coverage** program had been enrolled in the RMHP for less than 2 years, coverage for the balance of the initial 2 year period will be paid first from the deceased Retired Member's Dollar Bank Account.

If there is a sufficient balance in the deceased Retired Member's Dollar Bank Account after the first 24 month coverage extension period, funding for dependant coverage will continue to be made from Dollar Bank Account deductions, before dependants are required to make Pay Direct payments. This does not change the maximum coverage continuation period described above. Thereafter, payments as required under the RMHP Pay Direct Limited Coverage program must be made to the Fund to maintain coverage.

The maximum duration of surviving dependants' coverage may apply once only. For example, if a Retired Member eligible for 10 or less years of coverage dies, the maximum combined continuous years for the Retired Member plus for the deceased Member's surviving dependants is 10 years (or less, if applicable).

Surviving dependant coverage must be maintained continuously from the time coverage for dependants of a deceased Member begins. Coverage will terminate if Pay Direct payments are not made when due. Coverage may not be reinstated once Pay Direct payments cease.

Benefits For Surviving Dependants Covered Under More Than One Plan

The U.A. Local 787 Health Plan will be the second payer of claims in the following circumstances:

- after the death of a Plan Member, if a spouse is working for, or starts to work for an employer that offers a group health benefit program, the spouse's employer plan will be the first payer of claims for the spouse and any other eligible dependants; and/or
- if the spouse of a deceased Plan Member has coverage as a dependant under any other group health benefit program, then the other plan will become the first payer of claims for the spouse and any eligible dependants.

Any unpaid claim expenses may then be submitted to this Plan.

COVERAGE OUTSIDE ONTARIO / CANADA

The following Health Plan coverage is provided (where applicable) to eligible Active, Inactive, Disabled and Retired Members and/or their eligible dependants when travelling (or residing, if approved) outside of the province of Ontario, or outside of Canada, provided all of the Plan's eligibility rules have been met. All eligible expenses will be reimbursed in Canadian Dollars on the following basis:

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

- Life Insurance and AD&D coverage will be provided as described in this Booklet.

WEEKLY INDEMNITY (WI) AND LONG TERM DISABILITY (LTD)

- Disability coverage is provided to Active Members, provided they are working for a signatory employer.

HEALTH CARE, EMERGENCY TRAVEL ASSISTANCE & DENTAL

- Expenses eligible under any government Medicare program you are covered under or would have been covered under as a resident of the province of Ontario, or other province or territory, are not eligible under the Plan;
- All of the Plan's rules including medical necessity, reasonable and customary charges, dollar maximums and frequency limitations will apply on the same basis as if in Ontario. Expenses will be reimbursed based on the lesser of the reasonable and customary charges of Ontario, and the area in which the expense was incurred. All of the Plan's dollar maximums remain in Canadian dollars;
- Charges that are not eligible under the Plan for a resident of Ontario will not be covered outside of Ontario (e.g., ward room hospital charges covered through OHIP, etc.);
- Any expenses relating to an occupational accident or disease are not covered;
- Medical Practitioners providing services must have comparable licensing requirements to those required in Ontario (e.g., a chiropractor must be licensed in the jurisdiction for the fees to be reimbursed);
- English translation requirements are not covered..

HEALTH CARE

- If you are Age 65 or older, expenses for prescription drugs covered under the Ontario Drug Benefit (ODB) program for Seniors are not be eligible under the Plan;
- A prescription drug will only be covered if it is "available by prescription only" in Ontario;
- If deductibles and/or dispensing fees apply to the government drug benefit program you are covered under, they will only be reimbursed up to the amount of the ODB annual deductibles and dispensing fee;

EMERGENCY TRAVEL ASSISTANCE (ETA)

- ETA coverage will only be available if you are a Canadian Resident, you are properly enrolled under your provincial health care plan and if you meet all of the eligibility requirements (e.g., you are under Age 65 and not retired, etc.).
- Coverage is limited to the first 60 consecutive days of travel or vacation outside of Ontario.

DENTAL

- An expense will be eligible if it is a covered procedure under the Ontario Dental Association Suggested Fee Guide for General Practitioners and covered by the Plan. Experimental procedures are not covered;
- Expenses will be reimbursed up to the lesser of the Ontario Dental Association Fee Suggested Fee Guide for General Practitioners in effect at the time and the reasonable and customary charges for the area in which the expense was incurred;
- Dental Practitioners providing services must have comparable licensing requirements to those required in Ontario;

MEMBER ASSISTANCE PROGRAM

- The toll free number (1-800-668-9920) for FSEAP can be used in Canada and the United Stated to access face-to-

face counselling and assistance. For TTY Service, call 1-888-234-0414.

- For registered users, FSEAP services may also be accessed online at **http://www.myfseap.com** (Group Name: **toUA787**, Password: **myfseap1**)

RETIRED MEMBER HEALTH PLAN (RMHP) GENERAL INFORMATION

This section of the Member Information Booklet describes some of the general rules of the Plan that specifically apply to the Retired Member Health Plan (RMHP). Some of the rules described in this section include:

- Eligibility for RMHP coverage
- Applying for RMHP coverage
- When RMHP coverage starts
- When RMHP coverage ends
- The Cost of RMHP coverage

It is important to note that the rules that apply to all Plan Members, described in the **HEALTH PLAN GENERAL INFORMATION** section of this Booklet, also apply to eligible Retired Members while covered under the RMHP. Please refer to the previous sections of this Booklet for specific further information about:

- **Dependant Health Plan coverage**
- **The cost of Health Plan coverage**
- **When Health Plan coverage terminates**
- **A Disabled Member's option to select the RMHP coverage**
- **Maintaining Health Plan coverage for dependants of deceased Health Plan Members**

ELIGIBILITY FOR RETIRED MEMBER HEALTH PLAN (RMHP) COVERAGE

Under certain conditions, qualified Plan Members and their eligible dependants may be entitled to coverage under the RMHP.. Members who qualify for RMHP coverage must meet all of the following conditions on the date they wish to begin RMHP coverage:

- You are age 55 or over; **and**
- You have been covered for Health Plan coverage as an Active, Inactive and/or as a Disabled Member (including any Pay Direct coverage) on a continuous basis:

  (a) for a minimum of 24 months immediately prior to the date you chose to begin RMHP coverage, and for at least 5 of the last 10 years on a cumulative basis; **or**

  (b) from the date you first became a Member in good standing of U.A. Local 787 (if you have been covered as a Plan Member for less than 5 years);

  and you have either:

  (c) had employer contributions made on your behalf, made Pay Direct contributions or received Long Term Disability benefit payments **within the 6 month period** before your RMHP coverage begins; **or**

  (d) been available for work and on the U.A. Local 787 Out of Work List, or working on a Travel Card **within the 24 month period** before your RMHP coverage begins; **and**
- You cease to work, or be available to work for a contributing employer, you do not have employer contributions being made on your behalf during WSIA (i.e. Workers' Compensation) benefit receipt, you are not receiving Long Term Disability (LTD) benefit payments (or do not have an application in process for such benefits, unless you have elected RMHP coverage under the Disabled Member Plan provisions); **and**
- You are, and remain a Member in good standing of U.A. Local 787 in accordance with the U.A. Constitution & U.A. Local 787 By-Laws.

- You satisfy the U.A. Local 787 that you have retired from the "HVACR industry" as defined below, both union and non-union; **and**

For the purpose of this Plan, the "HVACR industry" shall mean:

(a) paid work covered by any collective agreement of the U.A. Local 787 or any similar local of the U.A.;

(b) paid work either as an employee or on a self-employed basis of any kind for any participating employer in the Health Fund or an affiliated company or entity, or any work for a competitor of such participating employer or affiliated company;

(c) paid work for any entity that competes with Local 787 or any related entity of U.A. Local 787 including the Joint Training and Apprenticeship Committee (JTAC);

Notwithstanding the foregoing:

(a) where a Plan Member is otherwise eligible for RMHP coverage but is employed by any U.A. union entity, any entity affiliated with the U.A. or any entity affiliated with the AFL-CIO or the CLC that does not compete with Local 787, such person's right to obtain RMHP benefits shall be postponed and his account in the Health Fund suspended until such time as such person has ceased all employment with such union entity or entities and otherwise remains eligible for RMHP benefits;

(b) where any Plan Member returns to covered employment for a participating employer who is making contributions to the Health Plan after receiving RMHP benefits, such person shall continue to receive RMHP benefits but shall receive no other benefits from the Health Plan as a result of such employer contributions.

Disabled Members, who are at least Age 55 after receiving Long Term Disability benefit payments for at least 36 months, may be eligible for coverage under the RMHP. Please refer to the **MAINTAINING YOUR HEALTH PLAN COVERAGE WHEN RECEIVING DISABILITY BENEFITS FROM THE PLAN** in the previous Section of this Booklet for further information about a **Disabled Member's Option to Select RMHP Coverage**.

If you are not eligible for RMHP coverage, you may be eligible to make Pay Direct payments as an Inactive Member. Please refer to the **MAINTAINING YOUR HEALTH PLAN COVERAGE WHEN UNEMPLOYED** section of this Booklet for further information.

APPLICATION FOR RETIRED MEMBER HEALTH PLAN COVERAGE

To become covered under the RMHP, you must apply to the Plan Administrator in writing, on the appropriate RMHP Application Form. The Plan Administrator will notify you and provide you with the necessary Application Form if and when you are eligible to apply for RMHP coverage as described in this Booklet. All RMHP Applications are certified by the U.A. Local 787.

You must submit your completed Application by the deadline given to you by the Plan Administrator so that your coverage under the RMHP begins within either:

- 6 months from the date you last worked for a signatory employer or from the date your Long Term Disability benefit payments cease, if you are a Disabled Member; **or**
- the first 24 months you are available for work and on the U.A. Local 787 Out of Work List or working on a Travel Card; **or**
- 90 days of your receipt of the RMHP Application Form sent to you by the Plan Administrator, if you are applying under the **Disabled Member's Option to Select Retired Member Health Plan Coverage** provision described in the previous section of this Booklet.

Once approved for RMHP coverage, Active Member coverage cannot be reinstated.

DURATION AND COST OF RETIRED MEMBER HEALTH PLAN COVERAGE

The cost (if any) and the duration of your RMHP coverage are based on your specific "Plan Membership" at the time your

RMHP coverage begins.

DEFINITION OF "PLAN MEMBERSHIP"

"Plan Membership" is determined as the average of:

- **your eligible continuous U.A. Local 787 Membership in Good Standing; and**
- **your eligible accumulated Health Plan coverage duration (excluding periods of Disabled Member coverage).**

RETIRED MEMBER HEALTH PLAN COVERAGE CLASSIFICATIONS

There are 3 coverage classifications for RMHP Members as follows:

Retried Member Health Plan Coverage Classification	Required Years of "Plan Membership"	Duration of Retired Member Health Plan Coverage	Required Pay Direct Contribution*	Maximum Duration of Pay Direct Contributions
Fund Paid Lifetime Coverage	More Than 30 Years of Plan Membership	For Your Lifetime	Not Applicable	Not Applicable
Fund Paid Limited Coverage	10 Years to 30 Years of Plan Membership	The Number of Years of Plan Membership	Not Applicable	Not Applicable
Pay Direct Limited Coverage	Less Than 10 Years of Plan Membership	The Number of Years of Plan Membership	Pay Direct Contributions Are Required*	10 years

*Please refer to the **COST OF HEALTH PLAN COVERAGE** in the previous section of this Booklet for more information about the required Pay Direct Amounts in effect at the time this Booklet was prepared.

The RMHP Coverage Classifications are further described below.

1. **Fund Paid Lifetime RMHP Coverage** is provided to Members who have completed a minimum of 30 years of Plan Membership upon the date RMHP coverage begins. RMHP coverage will not terminate and no Pay Direct payments are required.
2. **Fund Paid Limited RMHP Coverage** is provided to Members who have completed 10 or more years of Health Plan Membership, but less than 30 years of Membership. RMHP coverage will continue for a period equal to the Member's years of Plan Membership as determined on the date RMHP coverage begins. No Pay Direct payments are required. Pay Direct payments may not be made when this Limited RMHP coverage terminates.
3. **Pay Direct Limited RMHP Coverage** is available to Members who have completed less than 10 years of Plan Membership upon the date RMHP coverage begins. RMHP coverage will continue for a period equal to the Member's years of Plan Membership as determined on the date RMHP coverage begins. Pay Direct payments are required. Pay Direct payments may not be made when this Limited RMHP coverage terminates.

The **Pay Direct Limited RMHP Coverage** is provided initially by monthly deductions from your Dollar Bank Account. Once your Account has been depleted, monthly Pay Direct payments must be made. The applicable Pay Direct Amounts are shown in the **COST OF HEALTH PLAN COVERAGE** section of this Booklet.

EXAMPLES OF A HOW "PLAN MEMBERSHIP" IS CALCULATED

Fund Paid Lifetime RMHP Coverage - A Member has 33 years of **accumulated** Health Plan participation and has been a Member of U.A. Local 787 in Good Standing for 35 **continuous** years. The Member's Plan Membership is calculated as the average, as follows: (33 + 35) / 2 = 34

This Member has Plan Membership of 34 years, and since this is greater than 30 years, this Member qualifies for Fund Paid Lifetime Coverage. For as long as this Member remains eligible for RMHP coverage, RMHP coverage will not terminate. Pay Direct payments are not required.

Fund Paid Limited RMHP Coverage - A Member has 18 years of **accumulated** Health Plan participation and has been a Member of U.A. Local 787 in Good Standing for 18 years. However, the Member has only been a Member in Good Standing for a **continuous** period during the past 14 years. This Member's Plan Membership is calculated as the average, as follows: (18 + 14) / 2 = 16

This Member has Plan Membership of 16 years, and since this is greater than 10 years, but less than 30 years, this Member qualifies for Fund Paid Limited Coverage. For as long as this Member remains eligible for RMHP coverage, coverage will continue for 16 years. Pay Direct payments are not required.

Pay Direct Limited RMHP Coverage - A Member has 9 years of **accumulated** Health Plan participation and has been a Member of U.A. Local 787 in Good Standing for 9 **continuous** years. This Member's Plan Membership is calculated as the average, as follows: (9 + 9) / 2 = 9

This Member has Plan Membership of 9 years, and since this is less than 10 years, this Member qualifies for Pay Direct Limited Coverage. For as long as this Member remains eligible for RMHP coverage, coverage will continue for 9 years. Pay Direct payments are required and must be made on time so that RMHP coverage is not terminated.

RETIRED MEMBER HEALTH PLAN COVERAGE

When an Active Member retires and qualifies for coverage under the RMHP, the Member's Life Insurance and AD&D Benefits will reduce. The amount of the reduction depends on the Member's age at retirement. The Member's Health Care Maximum Lifetime Benefit will reduce. The Member's Emergency Travel Assistance coverage will terminate. Long Term Disability (LTD) coverage and benefit payments will also terminate, unless a Disabled Member selects the RMHP option while under the Age of 65, in which case LTD coverage and benefit payments will not continue beyond Age 65.

Please see the description of each benefit for further information about coverage amounts, reduction in coverage and the termination of coverage.

WHEN RMHP COVERAGE BEGINS & HOW IT CONTINUES

Retired Member Health Plan coverage for you and your eligible dependants will begin after the date you apply, provided your Application is approved. Coverage will take effect on the first day of the month in which you become a Retired Member.

RMHP coverage will continue for a duration based on your determined Plan Membership as described above and will continue as long as:

- you remain a Member in good standing of U.A. Local 787 on a continuous basis from the date your RMHP coverage begins and you do not work for a non-union employer in the "HVACR industry", in accordance with the U.A. Constitution & U.A. Local 787 By-Laws; and
- you make the necessary RMHP Pay Direct payments when due (where applicable), on a continuous basis after your RMHP coverage begins.

Once approved for RMHP coverage, Active Member coverage cannot be reinstated.

WHEN RETIRED MEMBER HEALTH PLAN COVERAGE TERMINATES

You will be notified by registered mail when your RMHP coverage is terminated. RMHP coverage will terminate for Retired Members and their eligible dependants:

- in accordance with your determined Plan Membership duration as described above (where applicable); or
- in accordance with the coverage and benefit termination rules described in the **WHEN HEALTH PLAN COVERAGE TERMINATES** section of this Booklet; or
- if you work in the "HVACR industry" for a non-union employer in accordance with the U.A. Constitution; or
- if you work as a non-union employer (Owner Operator) after your RMHP coverage begins; or
- if any required Pay Direct Amount is not made to the Plan when due.

Pay Direct Limited RMHP coverage must be maintained continuously from the time a Member's RMHP coverage begins.

RMHP coverage for dependants will also terminate when the Member's coverage terminates as noted above, or on the date when they cease to qualify as an eligible dependant.

Once coverage in the RMHP terminates, for any reason, it cannot be reinstated. In most cases, coverage termination will take effect immediately, however under the following circumstances, coverage termination will take effect at the end of the month in which:

- you, or your dependants no longer qualify for RMHP coverage because the duration of coverage on "Plan

Membership" is exhausted; or

- you have not made the required RMHP Pay Direct payment to the Plan Administrator when due.

HEALTH PLAN BENEFIT DETAILS

You may find that the Plan does not cover every expense you may wish the Plan to pay for. The Plan is established to provide the broadest range of coverage that is suitable for the membership of the Plan. For example, new drugs and treatments may come into the health care environment over time and the Trustees always reserve the right to cover, or not cover any of these and to add limitations to coverage.

LIFE INSURANCE

All Active, Inactive, Disabled & Retired ICI Members

AMOUNT OF COVERAGE

You are covered for the Life Insurance benefit if you are a covered Member of the Plan. The amount of your Life Insurance benefit is based on your Member Classification and your Age, as follows:

Active, Inactive and Disabled Members Under Age 65:	**$100,000**
Active and Inactive Members Over Age 65:	**$25,000**
Retired Members Under Age 65:	**$50,000**
Retired Members Over Age 65:	**$25,000**

Once satisfactory proof of death is provided to the insurance company (claim form and an Attending Physician's Statement), your designated beneficiary (or if there is no beneficiary your estate) will receive the applicable tax free, lump sum Life Insurance benefit.

DESIGNATING A BENEFICIARY

You may choose one or more designated beneficiaries. You may change your designated beneficiary at any time, subject to applicable legislation or court order, by completing a new enrolment form available through the Plan Administrator. Note that termination of a marriage or a change in family relationship does not automatically void a previously designated beneficiary.

If you have not designated a beneficiary at the time of your death, the Life Insurance benefit is paid to your estate. The insurance company reserves the right to pay the benefit into Court in the event of a dispute about the rightful beneficiary. Court and legal costs will be the responsibility of those disputing the right to the benefit. It is therefore important for you to name a beneficiary on your enrolment form and make sure it is kept up to date.

COVERAGE WHILE DISABLED

If you become a Disabled Member, the amount of your Life Insurance benefit will not change. If you are still covered under the Health Plan when you attain Age 65 when Disability benefit payments end, the amount of your Life Insurance benefit will reduce accordingly. If you are under Age 65, not retired, and receiving Long Term Disability benefits, you will continue to receive your Life Insurance coverage until Age 65 or recovery, if earlier. You must provide continuing proof of disability too the insurer as may be requested.

If you become covered under the RMHP while disabled, the amount of your Life Insurance will be $50,000, reducing to $25,000 when you become Age 65.

DEFINITION OF "DISABLED"

You are considered to be disabled when you are receiving Long Term Disability Benefit payments from the Plan.

CONVERTED LIFE INSURANCE COVERAGE – INDIVIDUAL POLICY

When any portion of your Life Insurance coverage terminates for any reason (e.g. your Life Insurance coverage is reduced, you are no longer a Member of the Plan, or the insurance policy is terminated), you may apply to convert the amount of terminated or reduced Life Insurance coverage into an individual policy without providing evidence of good health, however;

- You must apply in writing within 31 days of the termination or reduction of your coverage
- Your Plan's Life Insurance coverage continues for the first 31 days after the date of the termination of your coverage

You can apply for non-convertible term life insurance, a permanent plan that the insurance company offers to the public at the

time of conversion; or one-year non-renewable term life insurance which may be converted while it is in force to one of the other plans the insurer offers.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

All Active, Inactive, Disabled & Retired ICI Members

You are covered for the Accidental Death & Dismemberment benefit if you are a covered Member of the Plan.

PRINCIPLE SUM

The Principle Sum of your AD&D benefit is based on your Member Classification and your age, as follows:

Active, Inactive and Disabled Members Under Age 65:	**$100,000**
Active and Inactive Members Over Age 65:	**$25,000**
Retired Members Under Age 65:	**$50,000**
Retired Members Over Age 65:	**$25,000**

COVERAGE WHILE DISABLED

You can receive the no cost AD&D coverage in the same manner as described earlier in the **Life Insurance** section of this Booklet. If you become covered under the RMHP while disabled, the amount of your AD&D coverage will be $50,000, reducing to $25,000 when you become Age 65.

ACCIDENTAL DEATH BENEFIT

Accidental death is defined as death resulting from accidental bodily injury. Within 365 days of an accidental death, and upon receipt of due proof of loss satisfactory to the Insurer, your **Designated Beneficiary** will receive the applicable Principal Sum. See the **Life Insurance** section above for more information about designating a beneficiary. This AD&D benefit is paid in addition to the Member Life Insurance benefit.

ACCIDENTAL DISMEMBERMENT BENEFIT

The Insurer will pay 100% of the Principal Sum in the event that you should suffer any of the losses listed below:

- Loss of Life
- Loss of Entire Sight of Both Eyes
- Loss of One Hand and One Foot
- Loss of Use of One Hand and One Foot
- Loss of One Hand and Entire Sight of One Eye
- Loss of One Foot and Entire Sight of One Eye
- Loss of Speech and Hearing in Both Ears
- Brain Death

The Insurer will pay 200% of the Principal Sum of $50,000 in the event that you should suffer any of the losses listed below:

- Loss of Both Arms, Both Hands, Both Legs or Both Feet
- Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet
- Quadriplegia
- Paraplegia
- Hemiplegia

The Insurer will pay 75% of the Principal Sum of $50,000 in the event that you should suffer any of the losses listed below:

- Loss of One Arm or One Leg
- Loss of Use of One Arm or One Leg
- Loss of One Hand or One Foot
- Loss of Use of One Hand or One Foot
- Loss of Entire Sight of One Eye
- Loss of Speech or Hearing in Both Ears

The Insurer will pay 33 1/3% of the Principal Sum of $50,000 in the event that you should suffer any of the losses listed below:

- Loss of Thumb and Index Finger of the Same Hand

- Loss of Use of Thumb and Index Finger of the Same Hand
- Loss of Four Fingers of the Same Hand
- Loss of Use of One Arm or One Leg
- Loss of One Hand or One Foot
- Loss of Hearing in One Ear

The Insurer will pay 25% of the Principal Sum of $50,000 in the event that you should suffer any of the losses listed below:

- Loss of All Toes of the Same Foot

"LOSS" IN RELATION TO THE SCHEDULE OF LOSS ABOVE MEANS:

- Loss of Hand and/or Foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
- Loss of Arm or Leg means complete severance through or above the elbow or knee joint;
- Loss of Thumb and Index Finger or loss of Four Fingers of the Same Hand means complete severance at or above the metacarpophalangeal joint (the joint between the fingers and the hand);
- Loss of Toe means complete severance at or above the metatarsalphalangeal (the joints between the toes and the foot);
- Loss of an Eye means the total and irrecoverable loss of entire sight of an eye;
- Loss of Speech means complete and irrecoverable loss of speech which does not allow communication in any degree; and
- Loss of Hearing means complete and irrecoverable loss of hearing, which cannot be corrected by any hearing aid or device.
- With reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs for one hundred and eighty consecutive days and deemed to be permanent by the Insurer.
- "Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.
- **"**Loss of Use" means total and irrecoverable for at least 12 continuous months and deemed to be permanent by the Insurer.

The total AD&D benefit payable cannot exceed $100,000 for one accident (with or without loss of life), except for total paralysis (without loss of life within 90 days) as noted above.

An additional benefit amount of 10% is paid with proof that a covered loss took place when a fastened seat belt was worn in a motor vehicle accident and the driver was not under the influence of alcohol or drugs (see **SEAT BELT BENEFIT** later in this section). A loss because of unavoidable exposure to the elements is also covered.

ADDITIONAL AD&D BENEFITS:

EXPOSURE AND DISAPPEARANCE BENEFIT

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the benefits afforded an insured Member. If the body of an insured Member has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which they were riding at the time of the accident, it shall be presumed, subject to all other conditions of the benefit, that they suffered loss of life resulting from bodily injuries sustained in the accident.

REPATRIATION BENEFIT

When an injury covered results in loss of life of an insured Member outside one hundred and fifty (150) kilometres from their city of permanent residence or outside Canada and within 365 days from the date of the accident, the Insurer will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

REHABILITATION BENEFIT

When injuries shall result in a payment being made by the Insurer under any benefit excluding the loss of life benefit, in addition the Insurer will pay the reasonable and necessary expenses actually incurred up to the maximum amount of $15,000, for special training of the insured Member, provided:

a) such training is required because of such injuries and in order for the insured Member to be qualified to engage in an occupation in which he/she would not have been engaged except for such injuries;

b) expenses are incurred within two (2) years from the date of the accident;

c) no payment will be made for ordinary living, traveling or clothing expenses.

Family Transportation Benefit

When injuries result in an insured Member being confined as an in-patient in a hospital outside one hundred and fifty (150) kilometers from the insured Member's city of permanent residence or outside Canada and requires personal attendance of a member of the immediate family as recommended by the attending physician, in writing, the Insurer will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to the confined insured Member, but not to exceed the maximum amount of $15,000.

Spousal Occupational Training Benefit

When injuries to the insured Member shall result in a payment being made by the Insurer under the loss of life benefit, in addition the Insurer will pay the expense actually incurred, within 365 days from the date of the accident, by the Spouse of the insured Member for a formal occupational training program for the purpose of specifically qualifying such Spouse to gain active employment in an occupation for which the Spouse would otherwise not have sufficient qualifications. The maximum payable shall not exceed the maximum amount of $15,000.

Home Alteration & Vehicle Modification Benefit

This benefit is only payable in the event an insured Member sustains an injury which results in one of the dismemberment losses payable excluding the loss of life benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1) the one-time cost of alterations to the insured Member's principal residence to make it wheelchair accessible and habitable; and

2) the one-time cost of modifications necessary to a motor vehicle utilized by the insured Member to make the vehicle accessible or operable for the insured Member.

Benefit payments herein will not be paid unless:

a) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

b) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 combined will not exceed 10% of the Principal Sum to a maximum of $50,000.

Day Care Benefit

If an insured Member suffers loss of life in a covered accident while the policy is in force, the Insurer will pay, in addition to all other benefits payable under the Benefit, a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to:

a) the lesser of 5% of the insured Member's Principal Sum amount; or

b) a maximum of $5,000 per year:

for any Dependent Child who is 12 years of Age and under. The Dependent Child must be enrolled in a legally licensed day care centre on the date of the accident or must be enrolled in a legally licensed day care centre within 365 days following the date of the accident. The day care benefit will be paid each year for four (4) consecutive years, but only upon receipt of satisfactory proof that the child is enrolled in a legally licensed day care centre.

Special Education Benefit

If an insured Member suffers loss of life in a covered accident while the policy is in force, the Insurer will pay, in addition to all other benefits payable under the coverage, a "Special Education Benefit", of 5% of the insured person's Principal Sum up to a maximum of $5,000 per year, on behalf of any Dependent Child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning and subsequently enrols as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident. The "special education benefit" is payable annually for a maximum of four (4) consecutive annual payments but only if the Dependent Child continues his education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by this policy result in loss of life of an insured Member within 365 days from the date of the accident, the Insurer will pay the reasonable and necessary expenses actually incurred by the eligible Dependants of the insured Member (Spouse and Children) for up to six (6) sessions of grief counselling, by a Professional Counsellor, subject to a maximum amount of $1,000.

“Professional Counsellor” means the treatment or counselling by a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income Benefit

In the event an insured Member sustains an injury which results in a payment being made under the Accidental Dismemberment benefit, excluding the loss of life benefit and the insured Member is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself, the Insurer will pay for each full month, one percent (1%) of the Principal Sum, subject to a maximum benefit of $2,500, or one-thirtieth (1/30) of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements:

1. operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
2. provides 24 hour a day nursing service by registered or graduate nurses;
3. has a staff of one or more licensed physicians available at all times;
4. provides organized facilities for diagnosis and surgical facilities; and
5. is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, an establishment offering treatment for persons suffering from alcohol or drug dependency.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement Benefit

If, an insured Member suffers a third degree burn in a non-occupational accident, the Insurer will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table:

Body Part	(C) Maximum % of Principal Sum Payable
Face, Neck, Head	100%
Hand & Forearm	25%
Either Upper Arm	15%
Torso (Front or Back)	35%
Either Thigh	10%
Either Lower Leg (below knee)	25%

Seat Belt Benefit

This benefit is only payable in the event an insured Member sustains an injury which results in one of the losses payable under the Accidental Death or Dismemberment coverage. In the event of a 50% surface burn, the percentage of benefit is reduced by 50%. The table only represents the maximum percent of the Prinicpal Sum payable for any one accident. If the insured Member suffers burns in more than one area as a result of any one accident, the benefits will not exceed $25,000.

Identification Benefit

In the event accidental loss of life is sustained by the insured person not less than one hundred and fifty (150) kilometers from the insured Person's normal place of residence and identification of the body by a member of the immediate family has been requested by the police or a similar governmental authority, the Insurer will reimburse the reasonable expenses actually incurred by such family member for:

a) transportation by the most direct route to the city or town where the body is located; and

b) hotel accommodation in such city or town, subject to a maximum duration of three (3) days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable in accordance with the terms of this benefit following the identification of the body as the insured Member. The maximum amount payable will not exceed $15,000 for all such expenses. Payment will not be made for board or other ordinary living, traveling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

AD&D Coverage Exclusions

This benefit does not cover loss caused by or resulting from any one or more of the following:

a) Intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;

b) Declared or undeclared war or any act thereof;

c) Travel or flying in an aircraft owned or leased by the policyholder, an insured Member or a member of an insured Member's household, or aircraft being used for any test or experimental purpose, firefighting, powerline inspection, pipeline inspection, aerial photography or exploration;

d) Losses occurring while the insured Member is serving on full-time active duty in the Armed Forces of any country or international authority;

e) Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the description of this benefit.

With respect to air travel, the insurance afforded shall apply to loss caused by or resulting from travel or flight in any aircraft or any other device for aerial navigation, including boarding or alighting there from, except:

a) while being used for any test or experimental purpose; or

b) while the insured Member is operating, learning to operate or serving as a member of the crew thereof; or

c) while being operated by or for or under the direction of any military authority, other than transport type aircraft operated by the Canadian Armed Forces Air Transport Command or the similar air transport service of any other country; or

d) any such aircraft or device which is owned or leased by or on behalf of the Union or Employer/Contractor or any subsidiary or affiliate thereof, or by an insured Member or any member of his/her household; or

e) while being used for fire fighting, pipeline inspection, power line inspection, aerial photography or exploration.

Benefits other than Death and Dismemberment benefits will be limited to only one (1) insurance policy in the event the benefits are contained in two (2) or more policies covering the same Member issued by the Insurer.

DISABILITY BENEFITS

WEEKLY INDEMNITY BENEFITS (WI)

All Active ICI Members (Regardless of Age) & Disabled ICI Members Under Age 65

You are covered for the Weekly Indemnity Benefit if you are covered by the Plan and you have worked in the last 2 consecutive months immediately prior to the date you first became disabled.

You will also continue to be covered if you have been approved for any of the Disability benefits of the Plan. Your coverage will end when you become an Inactive Member, or retire, whichever occurs first.

If the disability is, or could be work-related, you must apply for workers' compensation benefits. You must notify the Plan Administrator as soon as possible after starting to receive workers' compensation disability benefits.

AMOUNT OF WI BENEFIT

If you become Totally Disabled while covered under the Plan, the Plan will provide a Weekly Indemnity benefit as follows:

- **$554 Per Week for an Apprentice Level 1 to 5 and Maintenance Mechanics**
- **$692 Per Week for an ICI Journeyman**

Weekly Indemnity benefits are reduced dollar for dollar by any workers' compensation benefits you receive. Disability benefits paid to you from an Individual or association plan do not reduce the WI benefit payable.

Disability benefit payments are taxable income and are therefore subject to income tax withholding. You will receive a T4A from the Plan Administrator indicating the WI benefit payments you received in the prior year and the amount of tax withheld.

DIRECT DEPOSIT OF WI BENEFIT PAYMENTS

You can choose to receive your WI benefit payments by way of direct deposit into your bank account at your selected financial institution. You will need to complete the necessary Direct Deposit forms.

Please contact the Plan Administrator for the applicable form or for more information. Forms are also available from the U.A. Local 787 Office, or online from the Plan's website.

WHEN WI BENEFIT PAYMENTS BEGIN & END

The Plan will provide a WI benefit for each calendar week, or portion thereof of total disability:

- **Starting on the 8th day, after 7 consecutive days of an absence from work due to a qualifying accidental injury or illness; and**
- **Payable up to and including the 17th week of a disability.**

You are considered to be Totally Disabled when you are totally incapacitated by a medically determined physical or mental impairment and you are unable to perform any and every duty of your regular job.

WI benefits are paid provided at the time of your disability you are under a Physician's care from the first day you became disabled or confined to a hospital. Disability payments will begin no earlier than the first day you see a Physician.

The required claim forms and proof of total disability must be provided to the Plan Administrator, including an Attending Physician's Statement and any additional doctors' examinations if required (at your, or the Fund's expense, depending on the requirement).

Do not delay in submitting your disability claim to the Plan Administrator and adhere to the claim submission deadlines outlined in this Booklet.

Psychological Disorders and Substance Abuse

WI benefits will be paid for these types of disabling conditions, provided you qualify for benefits and:

1) the treatment program for a psychological disorder is supervised by a psychiatrist or a registered psychologist; and
2) the treatment for substance abuse, including alcoholism and drug addiction, includes participation in a recognized substance abuse treatment program.

Recurring Disabilities

If you return to work for a period of less than 4 weeks, during which there is a recurring disability due to the same or related disabling condition, the recurring disability will be treated as a continuation of the initial disability claim. A recurring disability will be treated as a new period of disability (a new claim) if you return to work for a period of 4 weeks or more.

Excluded Disabilities

No WI benefit is payable during the following periods or for disabilities relating to:

- Intentionally self-inflicted injuries;
- Civil disorder, participation in a criminal offence or declared/undeclared acts of war, while on active military duty;
- Disabilities from substance abuse if not in a recognized substance treatment program, or for which you received medical attention, consultation, diagnosis or treatment before you become covered by this Plan;
- Any time imprisoned in a penal institution or confined to a hospital as a result of criminal proceedings; and
- Any period of time a leave of absence is taken, including any parental or maternity leave, subject to applicable legislation.

Subrogation of Recovered Benefits

If any benefit payment is made under this coverage, the Plan shall be subrogated to all of the Member's claims to rights of recovery for similarly paid benefits, made against any other person or organization. The Member must do whatever is necessary to secure such rights.

LONG TERM DISABILITY BENEFITS (LTD)

All Active & Disabled ICI Members Who Are Under Age 65

You are covered for the LTD benefit if you are a covered Plan Member and you have worked for a signatory employer during the last 2 consecutive months immediately prior to the date you first become disabled.

You will also continue to be covered if you have been approved for any of the Disability benefits of the Plan. Your coverage will end when you become an Inactive Member, reach Age 65 or retire, whichever occurs first.

If the disability is, or could be, work-related, you must apply for workers' compensation benefits. You must notify the Plan Administrator as soon as possible after starting to receive workers' compensation disability benefits.

Amount of LTD Benefit

If you become Totally Disabled while covered under the Plan, the insurance company will provide a Long Term Disability benefit as follows:

- **$2,400 Per Month for an Apprentice Level 1 to 5 and Maintenance Mechanics**
- **$3,000 Per Month for an ICI Journeyman**

LTD Benefit Reductions

LTD Benefits are directly reduced for workers' compensation benefits paid to you for the same disability.

If your monthly LTD benefit amount, plus any or all of the following other sources of income, exceeds 85% of your pre-disability earnings, your monthly LTD benefit amount will be reduced by the excess:

- Canada (Quebec) Pension Plan benefits paid to you (primary and family benefits as of the date of commencement of disability payments); plus
- Monthly pension benefits or benefits from an annuity, locked in retirement account, life income fund or other registered plan where the payment was funded by the U.A. Local 787 Pension Plan; plus
- Any work-related earnings received while "disabled", including those from an authorized rehabilitation program; plus
- Workers' compensation benefits paid to you for the same disability; plus
- Disability benefits paid to you from any plan or program of any government, or of any subdivision or agency thereof, other than any benefits payable under the Employment Insurance Act.

Benefits paid to you from an Individual or association disability plan do not reduce the LTD benefit payable.

Because the Trustees wish to encourage you to work part-time or participate in a rehabilitation program, if possible, your LTD benefit may be only partly reduced by your wages if you are employed under a Rehabilitation Program approved by the insurance company.

Your pre-disability earnings are defined as your basic hourly wage rate (based on the collective agreement that you worked under) multiplied by the number of hours in the regular workweek when your disability began.

Disability benefits are taxable income and are therefore subject to income tax withholding. You will receive a T4A from the Plan Administrator indicating the Long Term Disability benefits you received in the prior year and the amount of tax withheld.

WHEN LTD BENEFITS BEGIN & END

If your disability continues beyond the 17 week WI maximum duration and your LTD claim has been approved by the insurance company, the insurer will provide a LTD benefit payment for each month, or portion thereof, of total disability **starting in the 18th week of your disability**.

LTD benefit payments will be made to you for as long as you provide proof of total disability as required and will continue:

- **for an illness due to drug and/or alcohol addiction, until the earlier of 2 years, the attainment of Age 65, or your recovery; and**
- **for any other disability, until the earlier of the attainment of Age 65 or your recovery.**

You are considered to be totally disabled when you are totally incapacitated by a medically determined physical or mental impairment and you are unable to work for wage or profit or engage in any business or occupation and cannot perform:

(a) any and every duty of your regular job for the first 2 years and 17 weeks of a disability; and

(b) any job you are reasonably suited for by education, training or experience for the remainder of your disability (after 2 years and 17 weeks).

LTD benefit payments are paid by the insurance company provided at the time of your disability you are under a physician's care from the first day you became disabled or confined to a hospital. Disability payments will begin no earlier than the first day you see a physician.

The required claim forms and proof of total disability must be provided to the Plan Administrator, including an Attending Physician's Statement and any additional doctors' examinations if required (at your, or the Fund's expense, depending on the requirement).

Do not delay in submitting your disability claim to the Plan Administrator and adhere to the claim submission deadlines outlined in this Booklet.

If you were covered under the Disabled Member Health Plan and selected the RMHP option, your LTD coverage and benefit payments (where applicable) will terminate on the earlier of your attainment of Age 65, or your recovery from disability.

PSYCHOLOGICAL DISORDERS AND SUBSTANCE ABUSE

LTD benefits will be paid for these types of disabling conditions, provided you qualify for coverage and:

1) the treatment program for a psychological disorder is supervised by a psychiatrist or a registered psychologist; and
2) the treatment for substance abuse, including alcoholism and drug addictions, includes participation in a recognized substance abuse treatment program.

Recurring Disabilities

If, after you have started to receive LTD benefit payments, you return to work for a period of less than 6 months, you suffer a recurring disability due to the same or related disabling condition the recurring disability will be treated as a continuation of the initial disability claim. A recurring disability will be treated as a new period of disability (a new claim) if you return to work for a period of 6 months or more.

Excluded Disabilities

No LTD benefits are payable for disabilities occurring during, or as a result of:

- Any portion of a period of disability unless you are receiving ongoing supervision/treatment by a Physician or therapist deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program, which must be recommended by a physician;
- Intentionally self-inflicted injuries;
- Participation in a civil disorder, criminal offence or a declared/undeclared act of war while on active military duty;
- Imprisonment in a penal institution or being confined to a hospital as a result of criminal proceedings;
- Any period of time a leave of absence is taken, including any parental or maternity leave;
- Substance abuse (alcohol and/or drug addiction):

  a) for any disability that began before you were covered under the Health Plan for Disability benefits, unless you were covered under the Health Plan for Disability benefits for at least 12 months, or in some instances for at least 3 months, without receiving treatment or consulting a physician; and

  b) if not in a recognized substance treatment program or for which you received medical attention, consultation, diagnosis or treatment before you become covered by this Plan; and

  c) after 2 years and 17 weeks from the date you first became disabled.

Subrogation of Recovered Benefits

If any benefit payment is made under this coverage, the insurance company shall be subrogated to all of the Member's claims to rights of recovery for similarly paid benefits, made against any other person or organization. The Member shall do whatever is necessary to secure such rights.

HEALTH CARE BENEFITS

All Active, Inactive, Disabled & Retired ICI Members & Their Eligible Dependants

Plan Members and their eligible dependents will receive the Plan's All in One Benefit Card that may be used to submit claims for many of the Plan's eligible Health Care expenses. Using the Benefit Card eliminates the need to complete a claim form and provides immediate payment for eligible expenses.

Summary Of Benefits

Health Care expenses such as prescription drugs, medical practitioners, vision care and medical services & supplies are eligible for reimbursement as described in the following pages. Tabled below is a summary of the Health Care reimbursement levels, annual maximums and reinstatement provisions which are described further below:

Member/Dependant Classification	Level of Reimbursement	Maximum Lifetime Benefit (per person)	Maximum Annual Reinstatement Amount
Active, Inactive, Disabled Member	100%	$200,000 per person	$20,000 per person
Retired Member (RMHP)	100%	$100,000 per person	$10,000 per person

Reimbursement Of Covered Eligible Expenses

The Health Care benefit is designed to complement the coverage you are eligible to receive under your government sponsored Provincial Health insurance plan that you are required to be enrolled in.

Eligible Health Care expenses for you and your dependants which are medically necessary, will be reimbursed 100% by the Plan, subject to any dollar or frequency limitations described below. Eligible expenses must be recommended and approved by a licensed physician and for non-occupational injury or disease.

The Plan will provide reimbursement for the charges of all eligible Health Care expenses provided they are:

- **medically necessary** for the treatment of an illness or injury and recommended by a dentist, or physician, as applicable;
- **reasonable and customary** and not experimental or investigational in nature; and
- **not covered under your provincial health care plan such** as OHIP or another government-sponsored or legally mandated program, or that would have been covered if the covered person was a resident of Ontario and had properly applied for OHIP coverage.

Reasonable And Customary Fees

Certain covered expenses, such as medical practitioner fees, will be reimbursed based on a reasonable and customary fee assessment. Reasonable and customary charges are determined by the Plan, based on the general level of charges in the area, for similar services or supplies. For example, the charges may be based upon the published fee schedules of associations, typical fees for associations without published schedules, or by surveys of practitioners. If you, or a practitioner, have any questions on what charges are considered to be reasonable and customary, please contact the Plan Administrator.

Maximum Lifetime Benefit

The Plan has a Maximum Lifetime Benefit per each covered person (including dependants) as follows:

- **Active, Inactive or Disabled Members (regardless of age) - $200,000**

  reducing to:

- **Retired Members (RMHP) - $100,000**

Annual Reinstatement Of Maximum Lifetime Benefit

A person's Maximum Lifetime benefit can be restored each calendar year in part (or in many cases in full). If a portion of the Maximum Lifetime benefit available to each person is used in a given calendar year, up to 10% of the applicable Maximum Lifetime benefit is automatically restored in the following calendar year.

The Maximum Annual Lifetime benefit reinstatement per each covered person (including dependants) as follows:

- **Active, Inactive or Disabled Members (regardless of age) - $20,000**
- **Retired Members (RMHP) - $10,000**

In the case where a person covered under the Active Member classification has total Health Care claims paid in a calendar year which are less than $20,000 (which is 10% of the applicable $200,000 Maximum Lifetime benefit), that person's Maximum Lifetime benefit is not affected and remains at $200,000 for the next calendar year.

Annual Reinstatement amounts cannot exceed the applicable Maximum Lifetime benefit amount for your Member Classification as outlined above.

LIFETIME MAXIMUM REINSTATEMENT EXAMPLES

As an Active Member, you receive medical benefit payments of $7,500 in a calendar year. Your Maximum Lifetime benefit would reduce from $200,000 to $192,500 (by $7,500). On January 1st of the following year, your Maximum Lifetime benefit is automatically restored by $7,500 to $200,000.

As an Active Member, you receive medical benefit payments of $35,000 in a calendar year. Your Maximum Lifetime benefit would reduce from $200,000 to $165,000 (by $35,000). On January 1st of the following year, your Maximum Lifetime benefit is automatically restored by $20,000 to $185,000. If you apply and provide proof of good health, the additional amount of $15,000 may be restored providing you again with the full Maximum Lifetime benefit of $200,000.

PRESCRIPTION DRUG AND RELATED EXPENSES

The Plan reimburses eligible expenses up to the reasonable and customary charges of medically necessary prescription drugs (up to a 100 day supply) which by law must be prescribed by a physician for the treatment of a diagnosed illness or injury and which must be dispensed by a legally authorized pharmacist or Physician. Eligible drugs must be approved for use by Health Canada and have both Health Canada compliance certificate and a Drug Identification Number (DIN).

The Plan's Benefit Card may be used at participating pharmacies to purchase most prescription drugs. The Plan will reimburse 100% of the cost of the lowest cost alternative between a Brand Name drug and a Generic drug (if available).

The Plan will reimburse the cost of certain "over-the-counter" drugs or supplies (those available without prescription). Only those that are specifically noted below are eligible and only if they are prescribed by a licensed Physician:

- Injectable preparations, diabetic supplies (including insulin preparations and supplies), and allergy serums;
- Nicotine replacement products limited to a maximum of two treatments in a lifetime;
- Fertility treatment including drugs, laboratory tests, x-rays and ultrasounds (but excluding invitro fertilization, and general supplies and professional and administrative staff services) limited to a $5,000 lifetime maximum;
- Life sustaining over-the-counter drugs such as potassium, nitrates and enzymes; and
- Ontario Drug Benefit (ODB) program annual deductible and dispensing fee (in excess of ODB maximums). The Plan does not otherwise reimburse expenses for drugs that are covered by the ODB program.

The Plan does not consider the following drugs and/or products as eligible for reimbursement:

- Charges over the maximum or specific drug expenses not covered by the Plan
- Erectile dysfunction drugs;
- Medical Marijuana including any derivative product;
- Drugs that are not medically necessary and/or Life Sustaining;
- Atomizers, aero chambers, spacer devices, food supplements, contact lenses care products, cosmetic products, non-medicated products, hair restoration products, contraceptives (except oral contraceptives which are covered), non-injectable vitamins; etc.
- Drugs that have not been issued a compliance certificate and/or a drug identification number by Health Canada whether or not they have been approved under a provincial formulary
- Drugs purchased or issued to manage an illness or disability arising out of a workplace accident, disability or injury or due to an automobile accident

Ontario residents and other covered individuals Age 65 and over will not be covered for drugs that would be covered for an Ontario resident under the Ontario Drug Benefit Formulary. However, if the ODB Formulary plan covers the cost of a generic drug only and the physician prescribes an alternate drug and verifies in writing "no substitution allowed", the Plan will pay the cost difference if it meets the qualifications and provided the ODB plan denies the physician's request to have the applicable drug covered by the ODB plan..

PRESCRIPTION DRUG PRIOR AUTHORIZATION

The reimbursement of certain eligible high cost prescription drugs require prior approval. The approval process is

administered by Green Shield Canada under the guidance of the Plan Administrator. Green Shield periodically issues a prior authorization drug listing and continually reviews criteria such as efficacy and whether a drug is medically necessary under the medial circumstances, to determine which drugs should be added to or removed from the list. The current listing may be obtained from the Plan Administrator or Green Shield Canada.

If a drug listed on the prior authorization drug Listing has not approved, the Plan Administrator and Green Shield will review the drug claim for possible approval. Additional information may be required from the attending physician before any such prior authorization drugs will be approved for reimbursement. It is therefore strongly recommended that you discuss the proposed drug therapy with your attending physician and check with the Plan Administrator to ensure the prescriptions your attending physician prescribes will be reimbursed by the Plan.

MEDICAL PRACTITIONERS

The Plan provides 100% reimbursement of expenses for the services of the following qualified medical practitioners (licensed, certified or registered, as applicable), up to a Maximum Annual benefit of $2,000 in total (combined for all practitioners), each calendar year per covered person:

- **Acupuncturist**
- **Chiropractor**
- **Clinical Psychologist**
- **Massage Therapist**
- **Naturopath**
- **Osteopath**
- **Physiotherapist**
- **Podiatrist/Chiropodist**
- **Speech Therapist**

A clinical psychologist must be a registered member of the College of Psychologists of Ontario and fully licensed. A physician's referral (i.e., prescription) is required for massage therapist expenses. The Plan does not reimburse for expenses of social workers or other similar counsellors. All expenses for the practitioners above will be payable only for the portion which is in excess of OHIP reimbursements.

Please consider contacting the Plan's Member Assistance Program (MAP) for confidential counselling services at 1-800-668-9920. Using the Plan's MAP will leave your $2,000 annual medical practitioner maximum available to you.

More information about our MAP is provided in the **MEMBER ASSISTANCE PROGRAM (MAP) BENEFIT** section of this Booklet.

MEDICAL SUPPLIES

The Plan reimburses 100% of expenses incurred for medically necessary eligible medical equipment and supplies as follows:

- **Orthopaedic Shoes and Foot Orthotic Appliances** - custom made or altered to fit the person's specific medical needs and prescribed by a physician, up to $500 per person, every 12 months;
- **Hearing Aids** - and adjustments/repairs, up to $1,500 per person, every 3 years;
- **Hearing Aids -** if required due to an accidental injury to the ear are subject to reasonable and customary charges;
- **Medical Equipment** – such as artificial Limbs, eyes, braces, crutches, splints, trusses, wigs, surgical braziers and surgical stockings (2 pairs per person, per calendar year); and
- **Durable Medical Equipment** – including wheelchairs, hospital beds and oxygen tents, etc. outside of a hospital (rental or purchase at the decision of the Plan).

MEDICAL SERVICES

The Plan reimburses 100% of expenses incurred for medically necessary eligible medical services, not covered by OHIP, such as:

- **Private Duty Nursing** - if recommended by a physician and medically necessary, subject to an overall maximum of $7,500 per person, every 12 months. A Private Duty Nurse can be a Registered Nurse, a licensed practical nurse, a Certified Nursing Assistant, or a Member of the Victorian Order of Nurses. Services must be provided in the covered person's home and cannot be performed by a family member or resident in your home;

- **Licensed Ambulance Service** - to provide transportation to or from the nearest hospital for necessary medical treatment;
- **Emergency Transportation** - within your province of residence by airline (or rail) to or from the nearest hospital for needed treatment. The Maximum Annual Benefit is $200 per person, per year;
- **Accidental Dental** - treatment of accidental injuries occurring to natural teeth while covered by the Plan, up to a Maximum Benefit of $5,000 per person, per accident. Treatment must begin within 12 months from the date of the accident;
- **Laboratory Tests and X-Rays**
- **Blood Transfusions and Oxygen Administration**.

VISION CARE

The Plan reimburses 100% of eligible expenses **either** for prescription lenses (glasses lenses and frames), or contacts in any consecutive 24 month period or for eye surgery expenses as follows:

(a) Prescription Glasses or Contact Lenses (in a consecutive 24 Month Period)

- up to $800 combined maximum for frames and lenses every consecutive 24-month period; or
- up to $250 for prescription contact lenses every consecutive 24-month period; and

(b) Eye Surgery subject to a $1,500 Maximum Lifetime Benefit

- eligible laser eye surgery; or
- refractive lens exchange surgery, if an individual is not deemed to be a good laser eye surgery candidate, and elects refractive lens exchange surgery in a private clinic, or
- if a Member elects to have cataract surgery in a private clinic (before OHIP-paid surgery could be scheduled), the cost difference between OHIP paid costs and clinic costs are an eligible expense.

The Plan also reimburses 100% of expenses for:

(a) The following medically necessary cataract surgery tools or lenses not covered by OHIP:

- Diagnostic measurement tools
- Foldable, or soft lenses, in lieu of hard lenses;

(b) eye examinations by an optometrist or ophthalmologist up to $80 every 24 consecutive months for each person aged 20 to 64, if not covered by OHIP

REHABILITATION CARE

The Plan reimburses expenses for rehabilitation care, in a licensed facility, excluding a chronic care facility, up to $35 a day for 120 days if the person is transferred from a hospital, following a hospital stay of 3 or more days.

The Plan does not cover expenses for semi-private or private hospital room charges.

TIPS TO BEING BETTER HEALTH CARE CONSUMER

To provide you with a comprehensive Plan, benefit costs must be managed. All Plan Members need you to share this responsibility. This is why the Plan requires that you be a smart health care consumer. With the help of all Plan Members, benefit costs can be controlled so that the valuable benefits of our Plan may be maintained.

The following can help you to be a better health care consumer:

- when you get a prescription filled, there's a dispensing fee. If you regularly buy a prescribed drug, e.g. insulin or birth control, you help lower the cost by buying a 100-day supply rather than filling the prescription on a more frequent basis. This Plan limits single purchase of drugs to a 100 day supply.
- dispensing fees for prescription drugs can vary from approximately $2.00 to over $12.00 – so it pays to shop around for the best deal.
- many prescribed drugs end up being thrown away because the drug caused side effects. was ineffective, or the

amount dispensed was too large. Ask your doctor or pharmacist if you have any concerns.

- request generic drugs, when possible and when less expensive than brand name drugs.

HEALTH CARE EXPENSES NOT COVERED

The Health Care eligible expenses listed above are considered eligible subject to the following coverage limitations and/or exclusions. Reference should also be made to the exclusions under the Plan's drug coverage. The Plan will not pay for:

- services or expenses covered by a provincial government program, e.g. OHIP or workers' compensation or another government sponsored or legally mandated program, or that would have been covered if the patient was a resident of Ontario and had properly applied for OHIP coverage;
- charges for drugs, sera, injectable drugs or supplies that are not approved by Health Canada with a compliance certificate and/or that do not have a Drug Identification Number (DIN) and/or that are experimental or limited in use whether or not so approved;
- any illness or injury covered by workers' compensation or similar legislation including from an automobile accident;
- prescription drugs that are also available over the counter unless otherwise noted;
- charges for safety glasses, special lenses, or tinting of eyeglass lenses;
- hospital room charges, such as semi-private, in excess of ward (ward is covered by OHIP);
- general health examinations;
- unnecessary medical treatment, or services you or your dependants would not normally be billed for or pay for, or for which you are not legally required to pay;
- surgical procedures, hospitalization or treatment performed for cosmetic reasons;
- charges that the Plan is not permitted, by any law or regulation including rules established by the Trustees, to cover;
- services or supplies you or your dependants receive when not covered by the Plan;
- services or expenses covered by OHIP; and
- transportation and travel charges for medical treatment or surgical procedures or other charges not specifically listed in this Booklet.
- Any service not listed above

CO-ORDINATION BETWEEN BENEFIT PLANS

If a covered person has health care coverage under another group benefit plan, your claims can be submitted under both plans so that you may receive up to 100% reimbursement on all eligible expenses.

Please refer to the **COORDINATION OF HEALTH CARE, EMERGENCY TRAVEL ASSISTANCE AND DENTAL BENEFITS** information found in the **GENERAL INFORMATION** section of this Booklet for detailed information on the order of claim submissions when coordinating your claims.,

MEDICAL CLAIM SUBMISSION

There are many ways to submit a claim to the Plan. Please refer to the **HOW TO SUBMIT A CLAIM TO THE PLAN** information found in the **GENERAL INFORMATION** section of this Booklet for detailed information on the various methods of submitting a claim to the Plan.

EMERGENCY TRAVEL ASSISTANCE (ETA) BENEFITS

All Active, Inactive & Disabled ICI Members & Their Eligible Dependants Who Are Under Age 65

You and your eligible dependants are covered for Emergency Travel Assistance (ETA) benefits if you are an Active, Inactive, or Disabled Member and are under Age 65. For your spouse to be covered, he/she must also be under age 65. Retired Members and Disabled Members selecting the RMHP coverage option are not eligible for ETA Benefits.

INTRODUCTION

The Plan's ETA benefit provides emergency medical coverage and travel assistance services while travelling or vacationing (for non-medical reasons) outside your home province. The ETA benefit is insured by Green Shield Canada (GSC). The medical emergency and travel assistance services described below are available 24 hours per day, 7 days per week and administered from the international medical service organization Allianz Global Assistance.

The Plan's All-In-One Benefit Card includes all of the necessary Plan and contact information to access the ETA benefit at any time. The Plan Administration Office can provide a separate ETA card for dependants travelling without a Plan Member or his/her spouse.

It is important that the covered person must be properly enrolled under his/her provincial health care program and must contact GSC Emergency Travel Assistance within 48 hours of commencement of treatment.

It is recommended that you carry your personal ETA card and your provincial health care insurance plan card with you at all times when travelling or on vacation. In case of an emergency, or when assistance is required, call one of the telephone numbers listed on your ETA card.

PRE-TRIP ASSISTANCE SERVICES

The ETA benefit may not cover expenses related to an emergency medical or travel assistance situation if the Covered Person is travelling to certain countries that are under duress. GSC Travel Assistance should be contacted before travelling to ensure that the destination is a country where the ETA coverage will be provided. GSC Travel Assistance may also be contacted prior to departure to obtain up-to-date information on passport and visa, vaccination and inoculation requirements for the intended destination country.

Although not a substitute for contacting GSC Travel Assistance, the Canadian Department of Foreign Affairs and International Trade Canada (DFAIT) web site provides extensive travel information about various destinations and where travel for Canadians is currently not recommended by the Canadian Federal Government. It is recommended that this information be reviewed prior to departure.

http://travel.gc.ca/travelling/advisories

CONTACTING GSC TRAVEL ASSISTANCE

The GSC Travel Assistance Telephone numbers that also appear on the back of the Plan's All-In-One Benefit Card are:

ALLIANZ GLOBAL ASSISTANCE

Use the following information to contact Allianz for ETA services:

In Canada and U.S. call toll-free:	**1-800-936-6226**
Elsewhere call collect:	**1-519-742-3556**
Allianz Global Assistance ID#:	**4932**

When calling for assistance or to explain your medical emergency, quote the Plan's **GSC travel assist group number 4932**. The GSC Travel Assistance Team will also require the covered person's unique Plan Member GSC Identification Number. All of this information appears on the Plan's All-In-One Benefit Card. In addition, the covered person's provincial

health insurance plan number may be required and should be handy at the time of calling.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GSC Travel Assistance and submit them for reimbursement upon your return to Canada.

PAYMENT AND COORDINATION OF CLAIMS

In most cases Allianz Global Assistance will coordinate the payment of claims with the medical provider. However, for charges incurred under $200 the covered person must make payment to the medical provider directly and then submit the receipts to the Plan for reimbursement. The Plan will assess the amount payable under the covered person's provincial health care plan and this Plan and provide reimbursement for the balance of any eligible expenses.

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed $200 (Canadian), payment of such expenses will be arranged by Allianz Global Assistance and claims will be coordinated on behalf of the covered person.

Payment and co-ordination of expenses will take into account the coverage that the covered person is eligible for under their provincial health care plan and this Plan. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered person is entitled, Green Shield Canada shall have the right to recover the excess amount by assignment of provincial health care plan benefits and/or refund from the covered person.

EMERGENCY MEDICAL COVERAGE PROCESS

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, GSC Travel Assistance will guarantee the provider (hospital, clinic or physician), that the covered person has both provincial health insurance plan coverage and GSC travel benefits. The provider may then bill GSC Travel Assistance directly for these approved services for amounts in excess of $200.

The GSC Assistance Medical Team will follow the medical progress to ensure that the Covered Person is receiving the best available medical treatment. These physicians also keep in constant communication with the family physician and family members, depending on the severity of your condition.

For charges incurred under $200, the covered person must make payment to the medical provider directly and then submit the receipts for reimbursement. GSC Travel Assistance will assess the amount payable under the covered person's provincial health care plan and provide reimbursement for the balance of any eligible expenses.

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceeds $200 (Canadian), payment of such expenses will be arranged by GSC Travel Assistance and claims will be coordinated on behalf of the Covered Person.

Payment and co-ordination of expenses will take into account the coverage that the covered person is eligible for under their provincial health care plan and this Plan. If such payments are subsequently determined to be in excess of the amount of

benefits to which the covered person is entitled, Green Shield Canada shall have the right to recover the excess amount by assignment of provincial health care plan benefits and/or refund from the covered person.

EMERGENCY TRAVEL ASSISTANCE BENEFIT MAXIMUMS

EMERGENCY MEDICAL COVERAGE

Coverage is provided with a **$5,000,000 maximum per covered person, per incident** for expenses incurred as a result of a sudden and an unforeseen medical emergency and/or for emergency travel assistance services while travelling outside of your province of residence.

There is no limitation on the number of trips but coverage is provided for a maximum period of 60 consecutive days per trip.

EMERGENCY TRAVEL ASSISTANCE SERVICES COVERAGE

Coverage is provided for variety of specific travel assistance services to assist with any travel emergency.

MEDICAL REFERRAL COVERAGE

Coverage is provided for medical services that have been referred outside of the province of residence when they are not readily available within the province of residence. Coverage is subject to **a $50,000 maximum per covered person, per calendar year.**

EMERGENCY TRAVEL MEDICAL & REFERRAL COVERAGE DETAILS

Coverage is provided for eligible expenses arising as a result of a **medical emergency** while Plan Members and/or their eligible Dependants are travelling temporarily outside of the regular province of residence for vacation, business, or education.

To qualify for benefits, the covered person must be properly enrolled in their respective provincial government health plan or equivalent at the time the expenses are incurred.

Eligible ETA benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by the applicable provincial government health insurance plan.

All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds to both medical providers and the covered person, based on the country of the payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.

When a covered person is notified of their necessity to receive treatment for an accidental injury or a medical emergency, **the covered person must contact GSC Travel Assistance within 48 hours of commencement of treatment**.

Emergency means a sudden, unexpected injury, illness or acute episode of disease that requires immediate medical attention and could not have been reasonably anticipated based upon the patient's prior medical condition. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence. Any invasive or investigative procedures must be pre-approved by GSC Assistance Medical Team.

ELIGIBLE BENEFITS

Eligible benefits are limited to the maximum days per trip noted above, commencing with the date of departure from the province of residence. If a covered person hospitalized on the 60th (last) day of coverage, benefits will be extended until the date of discharge.

1. Hospital Services and Accommodation up to a standard ward rate in a public general hospital;

2. Medical and/or Surgical Services rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;

3. Emergency Transportation

   - Land Ambulance to the nearest qualified medical facility

   - Air Ambulance - the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by the provincial health insurance plan or to the nearest qualified medical facility

4. Referral Services for Medical Procedures

   a) Hospital Services and Accommodation, up to a standard ward rate in a public general hospital, and/or

   b) Medical and/or Surgical Services rendered by a legally qualified physician or surgeon;

   - Prior to the commencement of any Referral treatment, written pre-authorization from your provincial health insurance plan and GSC must be obtained. The provincial health insurance plan may cover this Referral Benefit entirely. The GSC Assistance Medical Team must be provided with a letter from the attending physician stating the reason for the referral, and a letter from the provincial health insurance plan outlining their liability. Failure to comply in obtaining pre-authorization will result in non-payment

5. Services of a Registered Private Nurse up to a maximum of $5,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse (R.N.) registered in the jurisdiction in which treatment is provided. GSC Travel Assistance must be contacted for pre-approval;

6. Diagnostic Laboratory Tests and X-rays when prescribed by the attending physician. Except in emergency situations, GSC Travel Assistance must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery);

7. Reimbursement of prescriptions for drugs, serums and injectables that require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded).

8. Submit to GSC Travel Assistance the original paid receipt from the pharmacist, physician or hospital outside the province of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

9. Medical appliances including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside the province of residence;

10. Treatment by a dentist only when required due to a direct accidental blow to the mouth up to a maximum of $2,000. Treatments (prior to commencement and after return to the province of residence) must be provided within 90 days of the accident. Details of the accident must be provided to GSC Travel Assistance along with dental X- rays;

11. Returning home to the province of residence when the emergency illness or injury is such that:

- GSC Travel Assistance Medical Team specifies in writing that an immediate return to the province of residence for immediate medical attention is necessary, reimbursement will be made for the extra cost incurred for the purchase of a one way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return the covered person by the most direct route to the major air terminal nearest the departure point in the province of residence

  This benefit assumes that the covered person is not holding a valid open-return air ticket. Charges for upgrading, departure taxes, cancellation penalties or airfares for accompanying family members or friends are not included;

- GSC Travel Assistance Medical Team or commercial airline stipulates in writing that the covered person must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not related by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant

12. Cost of returning the covered person's personal use motor vehicle to their residence or nearest appropriate vehicle rental agency when they are unable to due to sickness, physical injury or death, up to a maximum of $1,000 per trip. Original receipts are required for costs incurred, i.e. gasoline, accommodation and airfares;

13. Meals and accommodation up to $1,500 (maximum of $150 per day for up to 10 days) will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by the covered person when they remain with a travelling companion or an eligible Dependant, when the trip is delayed or interrupted due to an illness, accidental injury to or death of a travelling companion. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from a commercial organization;

14. Transportation to the bedside including round trip economy airfare by the most direct route from the province of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of 5 days for meals and accommodation at a commercial establishment will be paid for that family member to:

    - be with the covered person or any covered Dependant when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least 7 days outside of the province of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit

    - identify a deceased person prior to release of the body

15. Return airfare if the personal use motor vehicle of the Plan Member or eligible Dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return the covered person by the most direct route to the major airport nearest the departure point in the province of residence. An official report of the loss or accident is required;

16. Return of deceased up to a maximum of $5,000 toward the cost of embalming or cremation in preparation for homeward transportation in an appropriate container for a covered person when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in the province of residence. The benefit excludes the cost of a burial coffin or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc.

EMERGENCY TRAVEL ASSISTANCE SERVICES

The following services are available 24 hours per day, 7 days per week through GSC's international medical service organization. These services include:

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination

- Multilingual assistance

- Assistance in locating the nearest, most appropriate medical care

- International preferred provider networks
- GSC Travel Assistance Medical Team consultative and advisory services, including second opinion and review of appropriateness and analysis of the quality of medical care
- Assistance in establishing contact with family, physician and employer as appropriate
- Monitoring of progress during treatment and recovery
- Emergency message transmittal services
- Translation services and referrals to local interpreters as necessary
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers
- Special assistance regarding the co-ordination of direct claims payment
- Co-ordination of embassy and consular services
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary
- Management, arrangement and co-ordination of repatriation of remains
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
- the return of unaccompanied travel companions
- travel to the bedside of a stranded person
- rearrangement of ticketing due to accident or illness and other travel related emergencies
- the return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance
- Co-ordination of securing bail bonds and other legal instruments
- Special assistance in replacing lost or stolen travel documents including passports
- Courtesy assistance in securing incidental aid and other travel related services
- Emergency and payment assistance for major health expenses, which would result in payments in excess of $200

EMERGENCY TRAVEL ASSISTANCE SERVICES COVERAGE LIMITATIONS

1. Coverage becomes effective at the time the covered person crosses the provincial border departing from their province of residence and terminates upon crossing the border returning to their province of residence on the return home. If traveling by air, coverage becomes effective at the time the aircraft takes off in the province of residence and terminates when the aircraft lands in the province of residence on the return home;

2. Upon notification of the necessity for treatment of an accidental injury or medical emergency, GSC's Assistance Medical Team reserves the right to determine whether repatriation is appropriate if the patient's medical condition will require immediate or scheduled care. Such repatriation is mandatory, where the GSC Assistance Medical Team determines that the patient is medically fit to travel and appropriate arrangements have been made to admit the

patient into the provincial government health care system of their province of residence. Repatriation will ensure continued coverage under the plan. Should the patient opt not to be repatriated or elects to have such treatment or surgery outside their province of residence, the expense of such continuing treatment will not be an eligible benefit;

The patient must contact GSC Travel Assistance within 48 hours of commencement of treatment. Failure to notify GSC Travel Assistance within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident or the benefit maximum, whichever is the lesser of the two;

3. Air ambulance services will only be eligible if:

   - they are pre-approved by GSC Travel Assistance
   - there is a medical need for the covered person to be confined to a stretcher or for a medical attendant to accompany you during the journey
   - the covered person is admitted directly to a hospital in the province of residence
   - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GSC Travel Assistance
   - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC Travel Assistance

4. If planning to travel in areas of political or civil unrest, or in areas where Foreign Affairs and International Trade Canada (DFAIT) has issued a formal travel warning regarding non-essential travel, contact GSC Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services;

5. GSC reserves the right, without notice, to suspend, curtail or limit its services in any area in the event of political or civil unrest, including rebellion, riot, military uprising, labour disturbance or strike, act of god, or refusal of authorities in a foreign country to permit GSC to provide service. This includes travel in any area if at the time of booking the trip (including delay of travel), or before the departure date, Foreign Affairs and International Trade Canada (DFAIT) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city due to a likely or actual epidemic or pandemic, (non-essential travel will be deemed as anything other than a significant medical or family emergency, such as the death of a family member).

EMERGENCY TRAVEL ASSISTANCE SERVICES COVERAGE EXCLUSIONS

1. Any expenses incurred for the treatment related directly or indirectly to a pre-existing or pre- diagnosed medical condition that, at the time of departure from the province of residence, was not completely stable (in the opinion of GSC Assistance Medical Team) and where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling. GSC reserves the right to review the medical information at the time of claim.

2. Any expenses incurred for treatment or surgery that is not required for the immediate relief of acute pain or suffering as recommended by a legally qualified physician or surgeon. Eligible benefits will not be reimbursed for treatment or surgery that could reasonably be delayed until the return to the province of residence;

3. Any expenses incurred for treatment or surgery not covered under the provincial health insurance plan or for expenses incurred for treatment or surgery towards which the provincial health insurance plan has not provided payment;

4. Any expenses incurred for services, treatment or surgery received once the patient has opted to not be repatriated or elects to have such treatment or surgery outside their province of residence;

5. Any claims arising directly or indirectly from any medical condition suffered or contracted in a specific country, region or city due to an epidemic or pandemic, if at the time of booking the trip (including delay of travel), or before the departure date, Foreign Affairs and International Trade Canada (DFAIT) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city. In this exclusion a medical condition is limited to the reason for which the formal travel warning was issued and includes complications arising from such medical condition;

6. Treatment or services required for ongoing care, rest cures, health spas, elective surgery, check-ups or travel for health purposes, even if the trip is on the referral of a physician;

7. Treatment or service that the Covered Person elects to have performed outside Canada when the medical condition would not prevent return to Canada for such treatment;

8. Treatment or service required as a result of suicide, attempted suicide, intentionally self-inflicted injury of the covered person, a traveling companion, or immediate family member while sane or insane;

9. Abusive or excessive consumption of medication, drugs or alcohol and the ensuing consequences, including, and as a result of, in connection with or in any way associated with driving a motorized vehicle while impaired by drugs, alcohol or toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood. (A motorized vehicle means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to an automobile, truck, motorcycle, moped, snowmobile, or boat);

10. Amounts paid or payable under any Workplace Safety and Insurance Board or similar plan;

11. Hospital and medical care for childbirth occurring within 8 weeks of the expected delivery date from the date of departure, or deliberate termination of pregnancy;

12. Treatment or service provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, Long-Term Care (LTC) Facility, health spa, or nursing home;

13. Services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation;

14. Cataract surgery or the purchase of eyeglasses or hearing aids;

15. Any expenses incurred for during any trip taken for the purpose of seeking medical treatment or advice that have not been previously authorized as outlined in referral services.

GSC does not assume responsibility for nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other healthcare provider or facility recommended by GSC Travel Assistance.

DUPLICATE HEALTH CARE COVERAGE

The eligible expenses covered under the Plan's Health Care benefit, which are incurred outside the covered person's province of residence, in the event of a medical emergency while travelling, shall be covered under the Emergency Travel Assistance Benefit and not under the Plan's Health Care benefit.

DENTAL BENEFITS

All Active, Inactive, Disabled & Retired ICI Members & Their Eligible Dependants

You and your eligible dependants are covered for Dental benefits if you are a covered Member of the Plan.

SUMMARY OF BENEFITS

The following is an overview of the Plan's Dental coverage.

Dental Service	Level of Reimbursement	Maximum Benefit (per person)	Fee Guide
Preventative/Maintenance Services	100%	$2,500 per calendar year combined	2016 ODA
Basic Services	100%	$2,500 per calendar year combined	2016 ODA
Major Services	80%	$2,500 per calendar year combined	2016 ODA
Orthodontic Services (children under Age 21)	60%	$2,000 per lifetime	2016 ODA

COVERED ELIGIBLE EXPENSES

The Plan will provide reimbursement for the reasonable and customary charges of all eligible medically necessary expenses for Preventive Basic and Major Dental services combined, up to a $2,500 Maximum Annual Benefit per covered person, each calendar year.

The Plan also provides reimbursement up to a $2,000 Maximum Lifetime Benefit for Orthodontic expenses for each eligible Child who is under Age 21.

Effective with Dental claim expenses incurred on or after January 1, 2017, the Plan will reimburse the incurred cost of these expenses based on the 2016 Ontario Dental Association (ODA) Suggested Fee Guide amounts for General Practitioners.

Eligible Dental expenses are covered provided they are:

- **medically necessary** for the treatment of an illness or injury and recommended by a dentist, or physician, as applicable;
- **reasonable and customary** and not experimental or investigational in nature; and
- **not covered under OHIP** or another government-sponsored or legally mandated program, or that would have been covered if the patient was a resident of Ontario and had properly applied for OHIP coverage.

PREVENTIVE / MAINTENANCE SERVICES – 100% REIMBURSEMENT

These are the routine procedures for services such as dental check-ups and preventive:

- **Oral Examinations** – 2 examinations each calendar year;
- **2 Bite-Wing X-Rays** - each calendar year;
- **A Complete X-Ray Series** - or equivalent is covered once every 24 months;
- **Periodontal Scaling** - up to 8 units each calendar year, including periodontal treatment;
- **Teeth Polishing** - once every 6 months;
- **Topical Fluoride Treatments**; and
- **Fluoride Trays** - when an individual is undergoing radiation treatment for cancer.

BASIC SERVICES – 100% REIMBURSEMENT

These are procedures to eliminate or reduce dental treatment:

- **Consultations** – not related to orthodontics;
- **Study casts** – once each calendar year;
- **Amalgam, Silicate, Acrylic and Composite Fillings and Sedative Dressings**;
- **Extractions and Oral Surgery** – including removal of impacted teeth and general anaesthesia;
- **Endodontic Treatment** – therapy dealing with root canal therapy;
- **Periodontic Treatment** – prevention and treatment of diseases of the bone and gums around the teeth is provided up to 8 units each calendar year, and includes periodontal scaling as noted above;
- **Medication and its Administration** - if provided by injection in a dentist's office;
- **Relining, Rebasing and Repairs to Existing Dentures** - including the addition of new teeth and new stainless steel crowns, but excluding the cost of initial dentures, their replacement or duplication; and
- **Passive Space Maintainers** - for primary teeth and habit breaking appliances (Children under Age 21 only).

MAJOR SERVICES – 80% REIMBURSEMENT

These are procedures for expenses relating to crowns, bridges and dentures:

- **Initial Installation of Partial/Full Dentures** - to replace one or more natural teeth that were extracted or fractured while the person is covered by this Plan; and
- **Replacement of Existing Dentures** – if the existing denture is no longer serviceable or replacement is required because an extraction, loss or fracture of a natural tooth occurred while covered by this Plan, or if the existing denture is at least 5 years old and no longer serviceable and the person has been covered by the Plan for at least 12 months; and
- **Crowns** (other than stainless steel), Inlays and Onlays - if a tooth cannot be restored with a filling; and
- **New Bridges** – if a new bridge is required because an extraction, loss or fracture of natural teeth which occurred while the person is covered by this Plan (if there are three or more teeth missing in the arch, the Plan will provide reimbursement for a denture); and
- **Replacement of an Existing Bridge** – if bridge replacement is required because an extraction, loss or fracture of natural teeth occurred while the person is covered by this Plan, or if the existing bridge is at least 5 years old and no longer serviceable and the person has been covered by the Plan for at least 12 months; and
- **Dental Implants** – may be paid as an alternative procedure, up to the cost of the procedure covered by the Plan (i.e., bridge or denture expenses).

ORTHODONTICS – 60% REIMBURSEMENT

These are procedures for the straightening of teeth, including active space retainers, orthodontic appliances, wire appliances, braces and/or other mechanical aids to reposition or move the teeth.

Coverage is available only to eligible children who are under Age 21 and is subject to a Maximum Lifetime Benefit of $2,000 for each child. If you pre-pay orthodontic expenses, you will be reimbursed on an ongoing basis when the treatments are provided.

BASIS OF DENTAL BENEFIT PAYMENTS

Although the Plan uses the ODA Fee Guide Schedule in effect at the time a dental expense is incurred as the basis for reimbursement, certain dental expense will be reimbursed based on a "reasonable and customary" charges assessment.

Reasonable and customary charges are determined by the Plan, based on the general level of charges in the area, for similar treatment, services or supplies, and for similar circumstances, disease or injury.

Expenses may be based upon the published fee guides or schedules of associations (such as the ODA Fee Guide) in effect at the time the expense was incurred, however, laboratory fees, for example, will be reimbursed up to a limit of 60% of the total amount eligible for the full dental treatment. The applicable reimbursement level (coinsurance) would then be applied to the 60% amount.

If you, your dentist, or other dental practitioner, have any questions about what is considered to be a "reasonable and customary," amount by the Plan for a particular dental expense, please contact the Plan Administrator.

DENTAL PRE-APPROVAL AND ALTERNATE TREATMENT

Pre-Approval:

Before treatment begins for dental work anticipated to cost more than $500, or for a crown, bridge, denture or orthodontic work, you must send a Dental Treatment Plan to Green Shield Canada..

Green Shield will tell you the amount of the dental expenses the Plan will reimburse. The Plan may pay for the expenses of an alternate treatment only. Dental Treatment Plans can be sent electronically to GSC by your dentist.

Your dentist must send the necessary information, such as x-rays, to allow GSC to assess the amount of the expenses to be reimbursed by the Plan before the dental work begins.

If the Dental Treatment Plan was approved 90 days or more before the dental work actually starts, you should contact GSC again to confirm that the expenses will continue to be covered. The covered person must be covered for benefits on the date the service is provided, even if an earlier Dental Treatment Plan confirmed coverage was available at that time.

Alternate Treatment

When there is more than one treatment for a given dental condition, which all produce similar professionally adequate results, the Plan will pay for the covered expense as if the least expensive course of treatment. GSC will determine the adequacy of various available treatments through a professional dental consultant.

DENTAL EXPENSES NOT COVERED BY THE PLAN

Benefits are not paid for any dental expenses relating to the following:

- Dental examinations for third party use; and
- Treatment performed for cosmetic reasons; and
- Treatment for injuries, loss or extractions (missing teeth) that occurred while not covered by this Plan; and
- Implants, and services related to implants, unless paid as an alternative treatment; and
- Bodily injuries resulting directly or indirectly from declared or undeclared war or an act of war, insurrection, riot or hostilities of any kind; and
- Injuries resulting from any intentionally self-inflicted wound; and
- Services or expenses covered by a provincial government program, e.g. OHIP or workers' compensation or another government sponsored or legally mandated program, or which would have been covered if the patient was a resident of Ontario and had properly applied for OHIP coverage; and
- Unnecessary medical treatment or services that are usually non-chargeable, or for which you, or your dependants are not legally required to pay; and
- Miscellaneous charges, such as counselling, travel, fraud, broken appointments, communication costs or filling-in forms.

- Dental services and/or supplies not listed as eligible

TIPS TO BEING BETTER DENTAL CONSUMERS

To provide you with a comprehensive Plan, benefit costs must be managed. All Plan Members need to share this responsibility. This is why the Plan requires that you be a smart health care consumer. With the help of the Plan Members, benefit cost can be controlled so that the valuable benefits of the Plan may be maintained.

Here are some suggestions that might help you contain benefit costs:

- Not all dentists use the current fee guide. Ask your dentist what fee guide their invoice is based on. It may be a less expensive fee guide;
- Ask about less expensive, but equally effective alternative treatments; and
- Due to scientific advances and improved oral health, a visit to your dentist every six months for cleaning, scaling and x-rays may not be necessary (once every nine months is often adequate).

CO-ORDINATION BETWEEN BENEFIT PLANS

If a covered person has dental coverage under another group benefit plan, your claims can be submitted under both plans so that you may receive up to 100% reimbursement on all eligible expenses.

Please refer to the **COORDINATION OF HEALTH CARE, EMERGENCY TRAVEL ASSISTANCE AND DENTAL BENEFITS** information found in the **GENERAL INFORMATION** section of this Booklet for detailed information on the order of claim submissions when coordinating your claims.

DENTAL CLAIM SUBMISSION

There are several ways to submit a claim to the Plan. Please refer to the **HOW TO SUBMIT A CLAIM TO THE PLAN** information found in the **GENERAL INFORMATION** section of this Booklet for detailed information on the various methods of submitting a claim to the Plan.

MEMBER ASSITANCE PROGRAM (MAP) BENEFIT

All Active, Inactive, Disabled & Retired ICI Members & Their Eligible Dependants

You and your eligible dependants are covered for the MAP Benefit if you are a covered Plan Member.

CONFIDENTIAL COUNSELLING SERVICES

From time to time, many of us become overwhelmed with personal concerns. If you are in a crisis or emergency situation and require immediate help, Family Services Employee Assistance Programs (FSEAP) professional counsellors are only a phone call away.

Not all of the stresses of everyday life involve an emergency. You, or your eligible spouse or children may want to talk to a counsellor about personal issues such as anxiety, depression, relationship issues, addiction (including gambling), or receive support or information regarding care giving needs, wanting to quit smoking, or even a legal or financial concern.

Our Member Assistance Program (MAP) provides confidential counselling, information, advice and referral service to you and your Dependants. The confidential counselling services are provided by FSEAP. You can contact FSEAP 24 hours a day, every day of the year at 1-800-668-9920. For TTY Service call 1-888-234-0414.

You will be connected immediately with a qualified counsellor who can provide assistance, or arrange a face-to-face counselling appointment. FSEAP provides confidential counselling across Canada and the United States. FSEAP staff includes experienced social workers and psychologists. If long term or specialized counselling is required, the counsellor will assist you with a referral to another resource within your community. This referral may involve a fee. More information is available to you online at:

- www.myfseap.com
- Log-in using Group Name: toUA787
- Password: myfseap1

For added convenience, you can also arrange telephone or web-based (e-counselling) sessions. Anything you or a family member discusses with the counsellor is kept absolutely confidential. Counsellors will not release any information to anyone without your prior written consent except where legally required.

SUMMARY OF MAP SERVICES

Confidential assistance is available for a broad range of personal and work-related issues such as:

- personal or job stress
- relationship issues
- depression/anxiety
- eldercare and childcare
- addictions (including gambling)
- separation and divorce
- parenting
- balancing work and family life
- financial and legal difficulties
- nutritional consultation
- smoking cessation

CONTACTING THE MEMBER ASSISTANCE PROGRAM 24/7

In Canada and U.S. call toll-free:	**1-800-668-9920**
For TTY Service call toll free:	**1-888-234-0414**
Online:	**www.myfseap.com** Group Name: **toUA787** Password: **myfseap1**

Below are details of some of the services available to Members and their eligible dependants.

FAMILY CONNEXIONS

Family Connexions is designed to resolve and address a full range of family care issues. Family care consultants can provide you with phone consultations and quality resource materials to help you balance work and family life, find childcare or eldercare services, or learn to be an effective parent or caregiver.

LEGAL SERVICES

These services offer telephone access to a variety of experienced lawyers practising across Canada and the United States.

- Receive help with issues like consumer law and protection, wills and estate planning, civil and criminal law, family law, motor vehicle law, real estate law, immigration law and other general legal services;
- The legal service also provides referrals to lawyers for in-person consultation. Legal fees for in-person consultation are offered to you at a discounted rate.

FINANCIAL CONSULTATION SERVICES

Financial Consultants are available by phone or in-person to help bring order to your financial life and to help you plan for the future. Consultants can:

- advise on budgeting for significant purchases like a home;
- assist you to budget for major life changes such as birth of a new child, disability or job loss;
- help you with debt consolidation, advocacy with creditors, debt management, tax planning and retirement planning.

TEEN/PARENT HELPLINE

This confidential helpline provides teens and their parents with access to Counsellors who specialize in adolescent issues.

TAKE 10 HELPLINE

This 24-hour telephone helpline can help you control overwhelming feelings of anger, fear or anxiety. If you are feeling angry, a counsellor can help you manage your anger and respond in a non-violent way. If you are feeling threatened or unsafe, a counsellor can help you create an action plan for your personal safety.

CAREER CONNEXIONS

Career consultation specialists offer personalized consultations to address your specific career needs including:

- vocational assessments;
- resume and interview preparation skills;
- career transition.

LIFE COACHING

This service is an effective resource for someone who is looking to make a positive change in almost any area of his or her life. Life Coaching is an energizing process that helps you to plan your life goals.

VACATION & STATUTORY HOLIDAY PAY PLAN

AN OVERVIEW

Vacation Pay and Statutory Holiday Pay equal to 10% of your wages is paid by employers into the U.A. Local 787 Vacation and Statutory Holiday Pay Trust Fund pursuant to applicable collective agreements.

Vacation Pay can only be paid to you if vacation pay contributions are received by the Fund from your employer on your behalf.

The Trustees and U.A. Local 787 will make every effort to collect delinquent vacation pay contributions from employers; however, the Fund cannot guarantee that you will receive vacation pay if your employer is delinquent in making contributions.

Please note: The Vacation and Statutory Holiday Pay Plan does not apply to Owner Operator Members, Staff of U.A. Local 787 and Joint Training and Apprenticeship Committee (J.T.A.C.) and Site Specific Maintenance Members (where applicable).

In this section of the Booklet, the term "**Vacation Pay**" refers to "**the Vacation and Statutory Holiday Pay Benefit**". The terms "**The Plan**", and "**your Plan**" refers to "**the U.A. Local 787 Vacation and Statutory Holiday Pay Plan**".

The term "**Fund**" refers to the "**The U.A. Local 787 Vacation and Statutory Holiday Pay Trust Fund**".

"**The Plan Administrator**" refers to Employee Benefit Plan Services (EBPS).

AUTOMATIC BENEFIT PAYMENT

You will receive automatic Vacation Pay payments twice a year as follows:

- **By May 15, a payment is made (usually vacation pay earned from October 1 to March 31), and**
- **By November 15, a payment is made (usually vacation pay earned from April 1 to September 30).**

All benefit cheques are sent to your address on file with the Plan Administrator. You may also apply to have your benefit payments made by direct deposit to your selected financial institution. Please contact the Plan Administrator to provide the necessary information.

OPTIONAL BENEFIT PAYMENT

You may request one optional payment each calendar year by completing the application form and returning it to the Plan Administrator.

Optional payments may be made by the Plan for the following reasons:

- You are taking a vacation,
- You have left the jurisdiction of U.A. Local 787,
- You are no longer a Member of U.A. Local 787,
- You registered as unemployed with E.I.C.,
- You are an apprentice attending trade school,
- You have retired under the U.A. Local 787 Pension Plan, or
- You are disabled and receiving Health Plan, E.I.C. or workers' compensation disability benefits.

One additional optional payment may be requested each calendar year by completing the application form and returning it to the Administrator.

The Plan Member must demonstrate that there are extraordinary personal or financial circumstances necessitating the

additional payment. Such additional payments are subject to the Board of Trustees' procedures.

An administrative fee will be deducted from all optional payments. The fee is subject to adjustment. Optional payments are not made from May 1 for the May payment date or from November 1 for the November payment date. An optional payment cannot be made because you change your employer.

VACATION PAY PLAN DETAILS

Fund Administration

The vacation pay contributions received from employers each month under the terms of the U.A. Local 787 collective agreements are paid into the Fund. The Fund is invested in short-term guaranteed interest investments.

The investment earnings of the Fund are first used to pay the cost of Plan administration and, to the extent of the available net Fund earnings, the earnings may be used to pay vacation pay for Members whose employers have become bankrupt or insolvent and defaulted on payment to the Fund.

Replacement Cheques

If your vacation pay cheque is not received when it is due or you do not cash the cheque within six months of receiving it, you must contact the Plan Administrator to receive a replacement cheque.

A replacement cheque will be issued up to 36 months following the date of the initial uncashed cheque.

Death Benefit

If a Plan Member dies while vacation pay is owed, the vacation pay will be paid to the Plan Member's designated beneficiary (designated on the Member's enrolment form), or to the Member's estate if no beneficiary has been designated.

Assigning Your Vacation Pay

You cannot assign, transfer or pledge your vacation pay to anyone. However, your vacation pay can be placed under garnishee in some circumstances, for example through a Court Order.

BANKRUPT OR INSOLVENT EMPLOYERS

Contacting U.A. Local 787

If your employer becomes bankrupt or insolvent and vacation pay is owed to you, contact U.A. Local 787. U.A. Local 787 will do everything possible to collect your earned vacation pay from the employer or the Trustee in Bankruptcy; however, they cannot guarantee the collection of the vacation pay. This process may take some time to resolve.

How to Claim Vacation Pay Due from Bankrupt or Insolvent Employers

After you sign the proper forms and provide proof of the amount owed to you (e.g. pay slips), subject to available net Fund earnings, your vacation pay may be paid by the Fund on the next automatic payout period (in May or November).

DIRECT DEPOSIT OF VACATION PAY BENEFITS

You can choose to receive your vacation pay benefit payments by direct deposit to your personal bank account at your selected financial institution. You will need to complete the necessary Direct Deposit forms.

Please contact the Plan Administrator for the applicable form or for more information. Forms are also available from the U.A. Local 787 Office, or online on the Plan's website.

PENSION PLAN

INTRODUCTION

This summary has been prepared to increase your understanding of the Pension Plan. It covers relevant Pension Plan information and can be used as a resource when planning for your financial future.

You will receive a personal Pension Statement by June 30th of each year showing the contributions made on your behalf during the previous year and your Pension Plan Account Value at December 31st of the prior year.

In this Section of the Booklet, the terms "**Pension Plan**", "**the Plan**" and "**your Plan**" refers to "**the U.A. Local 787 Pension Plan**". The term "**Fund**" refers to the "**The U.A. Local 787 Pension Trust Fund**".

"**The Plan Administrator**" refers to Employee Benefit Plan Services (EBPS).

"**Pension Plan Account Value**" and **"Pension Plan Account"** means the Pension Plan Member's accumulated contributions submitted by employers under a U.A. Local 787 collective agreement and under reciprocal agreements, plus a prorated portion of the Fund's interest, dividends, net realized and unrealized capital gains and losses less a prorated share of the Fund's operational costs.

"**Locked-in Account**" means you cannot take your Pension Plan Account Value in cash. It can only be transferred to a Locked-in Retirement Account and/or used to provide you with a lifetime pension (annuity) or a Life Income Fund during your retirement years. In some circumstances a portion of your Pension Plan Account Value may be available in cash.

BECOMING A PENSION PLAN MEMBER

If you are working under a U.A. Local 787 collective agreement, you will become a Plan Member and are vested on the first day of the month after you had 700 hours of contributions remitted to the Pension Plan on your behalf provided no two contributions are separated by more than 18 months.,

Benefits are paid from this Plan only for Plan Members, or their designated beneficiaries or spouses. You are not a Pension Plan Member unless you work the necessary number of hours.

RECEIVING PENSION BENEFITS FROM THE PLAN

IF YOU ARE RETIRING

In order to receive a benefit from the Pension Plan, you must be a Pension Plan Member (which means you have had 700 hours of contributions remitted to the Pension Plan within a consecutive 18-month period before November 30th of the year you turn age 71). You must contact the Plan Administrator if you are retiring. Please contact the Plan Administrator at least one month before your retirement to ensure your Pension benefits are available to be paid to you upon your retirement.

IF YOU HAVE TERMINATED

The Plan Administrator will advise you if you are a Pension Plan Member who is eligible for a Termination Benefit. You can elect your termination payment option any time before your Age 55.

IF YOU HAVE DIED - BENEFICIARY OR SPOUSE PENSION BENEFIT APPLICATION

Your designated beneficiary (or spouse) or other representative should contact the Plan Administrator in the event of your death.

If You Are Separating, Divorcing, or if You Are Subject to a Domestic Contract, Court Order or Separation Agreement

Pension legislation provides for a method for you and your spouse to determine the value of your Pension Plan Account. There are prescribed forms that must be filed with the Pension Plan.

You should review these forms with your legal and financial advisors. The Pension Plan will determine the necessary steps to be taken when the prescribed forms are filed with the Pension Plan. The Plan will charge $200.00 per valuation request to offset the costs the Plan incurs in providing this information.

You are required to file a certified copy of any Domestic Contract or Court Order with the Pension Plan as soon as it is signed by all parties.

CONTRIBUTIONS TO THE PENSION PLAN

Employer contributions are payable to the Pension Plan on a monthly basis when you are working under a U.A. Local 787 collective agreement. Your Pension Plan Account is credited with the employer contributions received on your behalf. Your Pension Plan Account is also credited with contributions when you are:

- receiving qualifying workers' compensation benefits (maximum one year);
- on a qualified maternity/parental leave; and
- on a travel card from another local union or transferring to U.A. Local 787 from another local union, if that union's pension plan is covered under a Reciprocal Agreement.

Contributions made on your behalf are credited to your Pension Plan Account until November 30 of the calendar year in which you reach Age 71.

If you are a travel card member from another local union, then any employer contributions are transferred to your home local union Canadian pension plan, if that union's pension plan is covered under a Reciprocal Agreement.

You cannot make personal contributions to the Pension Plan or transfer amounts from other registered plans (except under Reciprocal Agreements).

If your employer becomes bankrupt or insolvent, the Board and U.A. Local 787 will do everything possible to collect the contributions which should have been remitted to the Pension Plan on your behalf. Subject to available fund forfeitures, the owed contributions will be credited to your Pension Plan Account if they cannot be collected.

Reciprocal Agreements

The Board of Trustees has entered into Reciprocal Agreements with other pension plans for Members who work outside of U.A. Local 787's jurisdiction, or transfer in from other locals.

If you work in another jurisdiction in Canada covered by a Reciprocal Agreement:

- The contributions made on your behalf to the other plan while on a travel card will be transferred to this Pension Plan.
- Your Pension Plan Account can be transferred to the new plan if you transfer from U.A. Local 787 to the other local.

YOUR PENSION PLAN ACCOUNT

The assets of the Pension Fund are professionally invested by asset managers appointed and monitored by the Board of Trustees.

Your Pension Plan Account includes employer contributions, plus a prorated portion of the Fund's interest, dividends, and net realized or unrealized capital gains and losses, after the operation expenses of the Fund are deducted.

Other Notes Of Interest

Investments in your Pension Plan Account, such as stocks or bonds, can increase or decrease in value.

Employer contributions are credited to your Pension Plan Account until the earliest of the month you retire, terminate, die, or until November 30th of the calendar year in which you reach Age 71.

ASSIGNING YOUR BENEFITS

Your Pension Plan Account cannot be used as collateral against a loan, mortgage, etc. You cannot assign your right to your Pension Plan Account to anyone else except through a Family Law Act Domestic Contract or Court Order. You are required to file a certified copy of any Domestic Contract or Court Order with the Pension Plan as soon as it is signed by all parties.

Any Pension Benefits or Pension Plan Account paid to you, your Spouse, Beneficiary or estate will be subject to any payment due to a former Spouse as determined by a Court Order or Domestic Contract (as defined in the Family Law Act).

TAXES

The contributions credited to your Pension Plan Account are not included in your taxable income when paid to your Pension Plan Account. However, benefit payments, such as monthly pension (annuity) payments, L.I.F. payments and cash payments, are taxable. You should obtain professional financial and legal advice before commencing payments from your Pension Plan Account.

ACHIEVING YOUR RETIREMENT GOALS

Virtually everyone's personal goal includes a financially secure future, and the Pension Plan can help you achieve this goal.

Your Pension Plan provides an excellent foundation to build your retirement income. The Pension Plan, the voluntary U.A. Local 787 Group RRSP, government plans such as CPP and OAS, and your personal savings, including RRSPs and TFSAs, combine to carry you through the retirement years.

Pre-retirement education sessions are provided periodically by the Fund to groups of Pension Plan Members. We hope that these information sessions will assist you in planning for your retirement.

You can make tax deductible contributions to an RRSP, up to the contribution limits under the Income Tax Act, to increase your retirement income.

You may wish to discuss how you can maintain your current standard of living during your retirement years with your personal financial advisor.

WHEN CAN YOU RETIRE

As a Pension Plan Member, you can retire any time once you reach Age 55 and you stop working for contributing employers. You become entitled to a benefit from the contributions credited to your Pension Plan Account once you become a Pension Plan Member.

Under income tax legislation, you must retire and start to draw a pension by December 1st of the calendar year in which you reach Age 71. If you are considering retirement, contact the Plan Administrator at least one month before you intend to retire. The Plan Administrator will provide you with:

1) estimates of the amount you could receive as a monthly pension (annuity), and

2) information about various pension options, locked-in Life Income Fund (L.I.F.) or L.I.R.A.

You will be asked to complete a Retirement Application including government-required forms and provide certain documents, such as your birth certificate. Your pension (annuity) or L.I.F. can only be paid for the months after you apply. Depending upon the pension option you choose, if you have a spouse when you retire, you may be asked to file a Waiver of Joint and Survivor Pension with the Pension Plan.

APPLYING FOR YOUR RETIREMENT BENEFITS

You should apply for your benefits at least one month before you want to retire. Otherwise your pension may not begin when you retire. Please contact the Plan Administrator who will send the required forms to you.

YOUR PENSION PLAN BENEFITS

When you retire, you can use your Pension Plan Account as follows:

1. MONTHLY LIFETIME PENSION (ANNUITY)

A monthly lifetime pension (annuity) can be purchased for you through an insurance company prior to the end of the calendar year in which you reach Age 71. The amount of the monthly pension will depend on several factors:

a) the amount of your Pension Plan Account;

b) your marital status;

c) your Age at retirement;

d) interest rates at the time you retire;

e) the form of monthly pension (annuity) purchased.

LIFETIME PENSION OPTIONS

Joint & Survivor – if you have a spouse when you retire, pension legislation requires that at least 60% of your pension continue to a surviving spouse when you die. You must purchase a 60% Joint and Survivor pension, unless you and your spouse sign a Waiver of Joint and Survivor Pension (available from the Plan Administrator). You can choose other Joint & Survivor options, such as 50% (if a Waiver is signed), 75% or 100%.

Life Only Pension – provides a monthly pension for your lifetime only and no death benefits are paid to a beneficiary. If you have a spouse on the date of your retirement a Waiver of Joint and Survivor Pension will be required.

Life Pension, Guaranteed 5, 10 or 15 years – provides a monthly pension for your lifetime, and if you die before the guarantee period is complete, the monthly pension continues to your beneficiary until the guarantee period ends. If you have a spouse on the date of your retirement a Waiver of Joint and Survivor Pension will be required.

Integrated with Government Benefits - If you retire before your full government benefits begin (at Age 65), you can opt to receive an increased monthly pension from the U.A. Local 787 Pension Plan in the months before your CPP/QPP and Old Age Security benefits begin. In this way, your monthly pension amount remains about the same before and after Age 65.

If you have a spouse on the date of your retirement a Waiver of Joint and Survivor Pension will be required. As with all options available to you, careful planning is necessary for this option. The Pension Plan's calculation will assume you will be eligible for full CPP/OAS benefits at age 65. No provision will be made for reduced or delayed CPP or OAS benefits. No matter which option you choose, a monthly pension (annuity) is always paid to the Pension Plan Member for their lifetime.

2. LIFE INCOME FUND (L.I.F.)

Your Pension Plan Account can be transferred to a locked-in Life Income Fund. When it is transferred, you may have the option to take a portion of the transfer value in cash (which can be transferred to a not-locked in RRSP). If you have a spouse on the date of your retirement a Waiver of Joint and Survivor Pension will be required.

A L.I.F. is more flexible than a lifetime pension annuity purchased at retirement because you can decide how much you want to withdraw each year (subject to legislated minimum and maximum amounts). The amount paid from a L.I.F. each year depends on your Age and the value of your L.I.F.

A L.I.F. allows you the opportunity to invest in your Locked-in Account. You do not have to purchase a lifetime pension (annuity) at any time with the remaining value of your L.I.F.

3. LOCKED-IN RETIREMENT ACCOUNT (L.I.R.A.)

Your Pension Plan Account can be transferred to a L.I.R.A. (a locked-in RRSP) and used at a later date to purchase a monthly lifetime pension (annuity) or transfer to a L.I.F. The L.I.R.A. administrator may require that you file prescribed forms.

4. CASH PAYMENT

Your Pension Plan Account is paid to you in a lump sum, if the pension (annuity) that can be purchased from your Pension Plan Account, would be less than the legislated minimum ($167.00 per month effective July 1, 2012). If you have a spouse on the date of your retirement a Waiver of Joint and Survivor Pension will be required.

Your Pension Plan Account can be paid to you in a lump sum at retirement or termination if you provide evidence that your life expectancy is considerably shortened due to disability. The Plan will follow the pension regulator's protocol for payment of a benefit on account of reduced life expectancy.

RETURNING TO WORK AFTER RETIREMENT

If you return to work within the U.A. Local 787 jurisdiction and renew your Plan Membership after you receive a benefit paid from this Plan, your future employer contributions will be credited to a **new** Pension Plan Account and you will have to re-establish Pension Plan Membership to be entitled to the value of your Pension Plan Account.

You will become a new Pension Plan Member if you meet the eligibility rules based on the new Pension Plan Account.

GOVERNMENT PENSION BENEFITS

In addition to the Pension Plan and any RRSP or personal savings you may have, you may be eligible for payments from two government programs: the Canada Pension Plan/Quebec Plan (CPP/QPP) and Old Age Security. You should apply for these benefits at least six months before you expect to receive them.

Under current legislation, you become eligible to receive full CPP/QPP benefits at Age 65, but you may choose to receive a reduced benefit as early as Age 60. Under current legislation the Old Age Security benefit can begin at Age 65.

PENSION DEATH BENEFITS BEFORE RETIREMENT

If you are a Plan Member and you die before retirement, 100% of your Pension Plan Account is paid to your spouse or designated beneficiary. If your spouse is your beneficiary, the Pension Plan Account can be transferred to your spouse's personal RRSP on a non-taxed basis or used to purchase a lifetime pension (annuity), with either immediate or deferred payments. The Death benefit is also paid if you have applied for a Pension but the first payment had not yet been made before your death.

DESIGNATING A BENEFICIARY

You may choose one or more beneficiaries, or change your designated beneficiary, at any time in writing, subject to the right of your spouse to receive a Joint and Survivor pension.

Your spouse is deemed to be your designated beneficiary, unless your spouse signs a Waiver of Pre-Retirement Death benefit. A Waiver is not required for contributions made before 1987 payable on death before retirement.

To designate a beneficiary other than your spouse, contact the Plan Administrator for the enrolment form and proper Waiver form, and return them, after completion, to the Plan Administrator.

If you do not have a spouse or do not designate another beneficiary, any Pension Plan Death benefits will be paid to your estate. Termination of a marriage by separation or divorce, or a change in family relationships, does not automatically void a previous designated beneficiary so you should monitor the appointment of beneficiaries carefully.

YOUR SPOUSE

Your "Spouse" is either:

a) A person of the opposite sex, or same sex to whom you are married; or

b) A person of the opposite or same sex to you (to whom you are not married) and with whom you are living in a continuous conjugal relationship of not less than three years, or in a relationship of some permanence, if you are the natural or adoptive parents of a child (both as defined in the Family Law Act).

A person is no longer your spouse if you are living separate and apart at the date of your retirement or death.

If you have an ex-spouse you may be obligated under a separation, Court Order, Domestic Contract or other agreement, to provide a pension to your ex-spouse. You are required to provide a certified copy of any agreement impacting the Plan immediately once the agreement is signed by all parties.

The Plan will determine if the agreement you signed is compliant with pension legislation.

ELIGIBILITY FOR A TERMINATION BENEFIT

You are eligible for a Termination benefit if, after 18 months as a Pension Plan Member no employer contributions have been made, or are required to be made on your behalf. The Plan Administrator will advise you of your options, if they have your current address. You are not eligible to receive a Termination benefit, if you:

- are not a Pension Plan Member; or
- transfer your Pension Plan Account to a new plan according to the terms of a Reciprocal Agreement, or
- continue to be a Member of U.A. Local 787 and apply in writing to the Plan Administrator to continue as an active Pension Plan Member.

If you return to work within the U.A. Local 787 jurisdiction and renew your Plan Membership after you receive, or are eligible to receive, a Termination benefit, your future employer contributions will be credited to a new Pension Plan Account and you must establish Pension Plan Membership again.

YOUR TERMINATION BENEFIT OPTIONS

You may choose from the following Termination benefit options:

PENSION PLAN ACCOUNT OPTION

Your Pension Plan Account can be left in the Pension Plan until you retire.

LOCKED-IN PENSION PLAN ACCOUNT OPTIONS

Your Pension Plan Account can be used to purchase a lifetime pension (annuity), or L.I.F., or you can transfer the locked-in portion or all of your Pension Plan Account on a non-taxed basis as follows:

- to your personal Locked-in Retirement Account (or L.I.R.A., or a locked-in RRSP) and you can later purchase a pension (annuity) or transfer it to a L.I.F. at retirement,
- to a new employer's pension plan, if transfer is permitted by that plan, or
- to an insurance company to purchase a lifetime pension (annuity).

NOT LOCKED-IN PENSION PLAN ACCOUNT OPTIONS

a) Portion not Locked-in

A portion of your Pension Plan Account may not be Locked-in. The not Locked-in portion of your Pension Plan Account is with respect to contributions made for hours worked before 1987.

You can choose to have 25% of your Pension Plan Account paid in cash or transferred to a regular RRSP.

b) 100% not Locked-in

100% of your Pension Plan Account is not Locked-in if your pension annuity at your normal retirement date would not be more than the legislated minimum ($167.00 per month effective July 1, 2012). You may be required to file a Waiver of Joint and Survivor Pension with the Pension Plan before this payment can be made.

This means that you can choose to have your Pension Plan Account paid in cash or transferred to a regular RRSP.