YOUR WELFARE PLAN

SHEET METAL WORKERS
LOCAL UNION 30

ACTIVE MEMBER BOOKLET

Up To Date As At January 1, 2020

Member website: www.lu30plan.com **Facebook site:** www.facebook.com/smwialocal30benefits

This booklet contains important information and should be kept in a safe place

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General Information

ESTABLISHMENT OF THE PLAN

The Sheet Metal Workers Local Union 30 Welfare Trust Fund (the "Fund") was established October 1, 1956 when the members of Local Union 30 set aside $0.10 of their hourly wage package to start a welfare plan . Since that time, the hourly welfare contribution has increased from time to time and reached $4.11 effective May 1, 2009.

Today, the Sheet Metal Workers Local Union 30 Welfare Plan (the "Plan") is among the finest in the Canadian construction industry. Of the current hourly welfare contribution of $4.11 per hour:

- $3.9098 is deposited into your welfare plan dollar bank until your account reaches the permissible maximum balance which is currently $5,040.00. Any excess is held in the welfare fund's Unappropriated Reserve and used to fund any shortfall that arises under the welfare plan or to support new benefits and subsidies.

- $0.03 is deposited into the WSIB (Workplace Safety and Insurance Board) reserve used to fund the Sheet Metal Workers Local Union 30 Pension Plan's ("pension plan") liability to credit pension contributions and the welfare plan's liability to continue welfare plan benefits, for up to one year, for members who are in receipt of WSIB benefits.

- The balance of $0.1702 is deposited into the Extended Benefit reserve used to fund the cost of welfare plan benefits provided to non-working members covered by the Extended Benefits Program. These are formally active plan members who are not working due to layoff, disability or attendance at apprenticeship school.

Benefits are also provided to persons who were formerly active plan members who have retired. A reserve for Retired members benefits has been established by the Trustees to subsidize a portion of Retired member welfare plan benefit costs (currently approximately 50%) not paid directly by the retirees.

Ultimately, the total or partial cost of the benefits provided to former and current active plan members must be paid out of the contributions earned by active plan members and the investment income earned on the "Fund" reserves. The Trustees of the "Fund" continually monitor the ability of the "Fund" to provide benefits.

It is essential that all plan members have a clear understanding that, whereas the Trustees hope to continue providing welfare plan benefits including for those who are not working and earning contributions, the Trustees necessarily reserve the right to amend, suspend or cancel any or all of this plan, and/or to require that persons covered by the plan make a higher contribution to defray the cost of benefits.

General Information

MEMBER BENEFITS

All benefits listed in this active member welfare plan booklet are subject to the terms of the applicable insurance policy or plan text, including eligibility, exclusions and limitations.

- Supplementary health care, vision care, drugs and dental benefits are funded solely by the assets of the "Fund" and processed by its All-In-One Benefit Card technology services provider by Green Shield Canada or by the Administration Services Provider.
- The weekly indemnity (WI) benefit is funded solely by the assets of the "Fund" and administered by the "Fund". Claims are paid by the Administration Services Provider.
- The accidental death and dismemberment benefit are insured by CHUBB Life Insurance Company of Canada.
- Life insurance and long term disability (LTD) benefits are insured by Manulife.
- Emergency Travel Assistance Program (ETA) is provided by Green Shield Canada.
- The plan's Member Assistance Program (MAP) is provided and administered by Family Services Employee Assistance Programs (FSEAP).
- The Health Care Spending Account is funded by the "Fund". Claims are paid by its All-In-One Benefit Card technology services provider by Green Shield Canada.

The insurers, Green Shield Canada and the Plan Administration Office co-operate to ensure that our plan is paying only for claims that are necessary, and that claims are settled at the lowest cost.

You are required to provide notice and proof of claim within certain time limits. If you do not provide notice and proof of claim within those time limits, the claims adjudicators have the right to decline your claim.

The active member welfare plan booklet is not a legal document and is only a summary guide. It is not an insurance policy or contract; it simply attempts to explain the "Plan". Any changes to the plan will be communicated to the plan members and such changes are deemed to amend/modify this booklet.

ACCESS TO PLAN DOCUMENTS WITH RESPECT TO BENEFITS COVERED BY INSURERS

You or any of your covered dependants have the right to request a copy of any or all of the following items:
The sections of the group policy and/ or plan document that apply to you and your dependants, and
your application for group benefits (Member Information Card).

TIME LIMIT FOR LEGAL ACTION

You may not commence legal action against Manulife with respect to benefits underwritten by Manulife (1) less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife for the recovery of money payable under the plan is absolutely barred unless commenced within the time period set out in the Insurance Act or applicable legislation.

(1) Manulife mentioned here but disclosure applies equally to other insurers.

General Information

ADMINISTRATION SERVICES

The Trustees have appointed an administrative service provider to manage the plan and fund. The Plan Administration Office attends to the day-to-day administration of the plan and fund and operates under the direction of the Trustees. The contact information is:

Sheet Metal Workers Local Union 30 Welfare Plan

Plan Administration Office

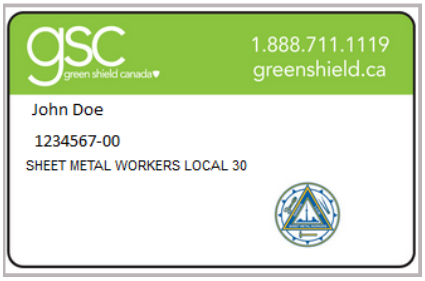
45 McIntosh Drive, Markham, ON, L3R 8C7

Telephone: 1-905-946-9700 Toll-Free: 1-800-263-3564 Fax: 1-905-946-2535

Website: www.lu30plan.ca Facebook Website: www.facebook.com/smwialocal30benefits

HOW DO I SUBMIT CLAIMS?

Drug claims must be submitted directly by your pharmacist using your All-In-One Benefit Card. Dental claims must be submitted directly by your dentist. Most health care providers (chiropractors, massage therapists, psychologist, physiotherapists, etc.) will also be able to submit claims electronically for you and your eligible dependants.



Many tools and services are available online for members. Access to these online services is available at www.greenshield.ca. Click on the Register Login area to begin.

If you are unable to submit claims online, or through your service provider, you may mail your paper claims to the Plan Administration Office.

If you require any assistance, please contact the Plan Administration Office where a staff member will be happy to assist you.

Summary of Benefits

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. New drugs and treatments will 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.

Subject to the limitations and exclusions of the plan's official documents, and as described throughout the booklet, eligible plan members and their eligible dependants qualify for the following benefits:

Active member and dependant benefits

Life Insurance and Accidental Death and Dismemberment Benefits

BENEFIT	DETAILS
Life Insurance	$100,000 (Member), $2,000 (Spouse) & $1,000 (Per Child)
Accidental Death and Dismemberment	$100,000 Principal Sum

Weekly Indemnity (WI) Benefit

The maximum WI benefit payable is $573 per week. The WI benefit amount will be increased to match the Employment Insurance (EI) maximum weekly benefit whenever that benefit changes. Benefit payments are integrated with EI Sickness benefits.

To qualify for WI benefits, a plan member must be disabled to the extent that he/she cannot perform the regular duties of his/her usual occupation.

WI benefits are payable from the 1st day of disability due to an accident or hospitalization, or from the 8th day of illness, for a maximum period of twenty-six (26) consecutive weeks for any one period of disability.

Work-related disabilities covered by WSIB are not covered, nor are disabilities arising from a motor vehicle accident.

Maternity Leave Benefit

Effective January 1, 2019, the plan's disability benefit coverage will include a maternity leave benefit for plan members. The benefit will be available to pregnant women who are laid off work prior to their due date because of their pregnancy. The benefit will help to bridge the gap before regular EI maternity and parental leave benefits begin. The benefit is intended to be a special benefit and not interfere with EI maternity and parental leave benefits. The maximum benefit period provided by the plan is four weeks. The maximum benefit is the EI declared maximum disability benefit.

Long Term Disability (LTD) Benefit

The maximum Long Term Disability benefit is $2,000 per month with respect to disabilities commencing on or after January 1, 2016.

To qualify, a plan member must be under age 65 and be "Totally Disabled" as defined in the Insurance Policy for a continuous period of twenty-six (26) consecutive weeks.

LTD benefits are payable until the earlier of the attainment of age 65, recovery, or death.

LTD benefits will be reduced by any payments received from WSIB. Disabilities arising from a motor vehicle accident are not covered.

Summary of Benefits

ACTIVE MEMBER AND DEPENDANTS BENEFITS (CONTINUED)

Supplementary Health Care

BENEFIT	DETAILS
Deductible	Nil
Reimbursement	100% of Reasonable and Customary charges (R&C) for members and their eligible dependants except where stated below.
Overall Maximum	Unlimited. However, limits apply to some services and supplies.
Prescription Drugs	100% of the lower of the brand name or generic drug ingredient cost even if your physician has prescribed no substitution, including the lower cost of biologic drugs or their biosimilar, where biosimilar drugs are available. The plan will not cover the drug ingredient cost of any drug that qualifies for coverage under the Ontario Drug Benefit (ODB) for Seniors. A Prescription Drug must have a drug identification number and compliance certificate both issued by Health Canada. Medical cannabis including any derivative product is not covered.
Dispensing Fee	Maximum of $8.50 per prescription
Prescription Drugs for Fertility Treatment	Fertility drugs and treatment are covered to a lifetime maximum of $2,500 per family unit.
Prescription Drugs for Smoking Cessations	Lifetime maximum of $250.

Note: Over the counter drugs, vaccines, vitamins and supplements are not covered by the plan.

Paramedical Practitioners

PRACTITIONER	ALLOWED EXPENSE
Podiatrist, Chiropractor and Physiotherapist	Reasonable and Customary (R&C) charges apply.
Registered Massage Therapist and Osteopaths	80% to a combined annual maximum of $1,000.
Acupuncture	80% to an annual maximum of $1,000.
Speech Therapy	100% to an annual maximum of $200.
Registered psychologist, registered psychotherapist, psychiatrist, registered social worker (Master of Social Work)	On/after January 1, 2020, 100% of R&C charges for the listed practitioners up to a maximum of $200 per hour and subject to a combined $2,000 maximum benefit per person per calendar year
All Paramedical Services are subject to R&C charge limits.	

Summary of Benefits

ACTIVE MEMBER AND DEPENDANTS BENEFITS (CONTINUED)

Hearing Aids

$400 maximum in any consecutive four (4) year period. Batteries are not covered.

Custom Made Foot Orthotics

$400 maximum per calendar year for orthotics, or for orthopedic shoes that have been specifically designed and molded for the member or dependant and necessary to correct a diagnosed physical impairment.

Vision Care

Eye Exams	1 Eye examination every 24 months for persons between age 20 – 64 to a maximum of $50.
Lenses, Frames and Contact Lenses	Maximum of $240 in a consecutive 24-month period.

Other Medical Services and Supplies

The plan covers ambulance, rehabilitation hospital, diabetic services and supplies, accidental dental, durable medical equipment (hospital bed, wheelchair, braces, and crutches), prostheses and surgical stockings at a Reasonable and Customary (R&C) charge.

Emergency Travel Assistance Program and Out of Canada Coverage

The plan provides coverage (in excess of your provincial health care plan) with a maximum of $5,000,000 per person per incident for expenses incurred as a result of an unforeseen medical emergency and/or travel assistance services while travelling outside your province of residence. Members should contact the insurer to discuss their coverage, their trip destinations and current health status before travelling. The insurer is Green Shield Canada and their number is 1-800-936-6226.

Dental Benefits

Dental Fee Guide

Reimbursement of dental services is based on the 2019 Ontario Dental Association Suggested Fee Guide for General Practitioners.

Summary of Benefits

ACTIVE MEMBER AND DEPENDANTS BENEFITS (CONTINUED)

Dental Benefits (Continued)

BENEFIT	DETAILS
Deductible	Nil
Basic Dental Services	100% reimbursement.
Basic Dental Services Include	Diagnostic, preventative, restorative surgery, fillings, anesthesia, 1 complete series of X-rays, 1 Set of bitewing X-rays, polishing, topical fluoride treatment, periodontal scaling.
Recall Examinations	1 recall examination each 6 months.
Complete Examinations	1 complete oral examination each 24 months.
Major Dental Services	75% reimbursement.
Major Dental Services Include	Crowns, bridges, dentures, replacement bridges / dentures are covered under certain circumstances.
Orthodontics	75% reimbursement.
Basic and Major Maximums	$2,000 per person per calendar year combined, of which $1,000 may be applied towards orthodontia.

Pre-Determination of Benefits

Prior to a planned course of treatment exceeding $500, a Pre-Determination of Benefits, including x-rays, should be submitted to Green Shield Canada for approval.

Health Care Spending Account (HCSA)

$650 per family for 2020. This benefit is subject to change.

Summary of Benefits

ACTIVE MEMBER AND DEPENDANTS BENEFITS (CONTINUED)

Member Assistance Program (MAP)

Provided by: Family Services Employee Assistance Program (FSEAP)

Website: www.fseap.ca

Username: tosmwiamap

Password: myfseap1

Toll free number: 1-800-668-9920

FSEAP provides confidential counselling, information, advice and referral services for plan members and their eligible dependents. FSEAP covers counselling, education and self-development services in addition to assessment and referral when required, for a full spectrum of personal issues including, but not limited to:

1. Job Loss
2. Stress Management
3. Personal Issues
4. Marital and Family Issues
5. Financial Planning
6. Legal Counselling
7. Health Management and Retirement
8. Alcohol and Drug Dependency
9. Smoking Cessation
10. Sexual Harassment and Abuse

fseap Now we're talking.

Eligibility

The welfare plan covers three (3) categories of plan membership:

1. Active Plan Members
2. Extended Benefit Program Members
3. Retired Plan Members

Each category of plan membership has its own eligibility rules as set out below.

ACTIVE PLAN MEMBERS

An active plan member is a Journeyman or Apprentice of Sheet Metal Workers Local Union 30, who is, or was, employed by an employer bound to a collective agreement requiring contributions to the "Fund".

By the 20th of each calendar month, every contributing employer is required to send a contribution report to the Plan Administration Office, listing thereon the names of every plan member employed by the particular employer in the previous calendar month, and showing the number of hours worked in that month. When the Plan Administration Office receives the contribution report, the contributions received on behalf of each plan member are placed in that plan member's dollar bank. The plan member and eligible dependants are covered by the welfare plan in accordance with the eligibility rules then in effect.

The hourly contribution rate is subject to change, as are the benefits of the welfare plan and therefore the premiums paid for those benefits. Because of these variables, the eligibility rules are always subject to change and for each month you are covered by the welfare plan your dollar bank will be debited, as set out later, to pay for your benefits. If the amount of contributions you earn in any month is greater than the amount required to pay for your benefits, the excess remains in your dollar bank, up to a maximum dollar bank equal to 12 months' coverage.

Initial Eligibility

You are initially eligible for benefits on the 1st day of the 2nd month following the month in which your dollar bank has a balance of $840.00.

Monthly Dollar Bank Deduction

For each month you are covered by the welfare plan, $420.00 will be deducted from your dollar bank. This amount is subject to change.

Termination

You are considered to be terminated from the welfare plan at the end of the month when the $420.00 monthly dollar bank deduction is taken out and leaves your dollar bank with less than $420.00.

Eligibility

ACTIVE PLAN MEMBERS (CONTINUED)

Reinstatement

If you were covered by the welfare plan, and then terminated, you can regain coverage by fulfilling the initial eligibility requirements set out above.

The dollar bank balance you had upon your termination remains available to you for the 12 calendar months following your termination. If you are not reinstated during that period of time, your dollar bank is erased.

Maximum Dollar Bank

Your net hourly contributions may accumulate in your own dollar bank up to $5,040.00, which is the equivalent of 12 months' coverage.

Apprentices

Indentured Apprentices must periodically take time off work to attend apprenticeship training school. In order to ensure that they do not lose their welfare plan benefits due to lack of contributions, Apprentices can make arrangements with Local Union 30 to have credits granted in the welfare plan at a rate equal to the monthly dollar bank deduction, so that their dollar bank is not depleted while they are attending apprenticeship training school.

EXTENDED BENEFIT PROGRAM MEMBERS

The extended benefit program is funded by the active members. A part of hourly contributions provides benefits to persons who were previously active members, and whose dollar bank were exhausted because they were no longer employed by a contributing employer on account of layoff or disability.

If you are covered as an active member, and your dollar bank is insufficient for a further month's coverage, the Plan Administration Office will notify you by mail. If you receive such a notice, you may apply to the Sheet Metal Workers Local Union 30 to transfer to the extended benefit program. In order to qualify, you must be and remain a member in Good Standing, Local Union 30, and be actively seeking work through Local Union 30 if you are unemployed due to layoff, or be disabled to the extent that you cannot perform all of the duties of your usual occupation if you are unemployed due to disability.

If your unemployment is due to a shortage of work, benefits will continue subject to ongoing authorization by Local Union 30. Extended Benefits are limited to a maximum of 18 months (in aggregate and not necessarily consecutive) in any 36 consecutive month period.

Eligibility

EXTENDED BENEFIT PROGRAM MEMBERS (CONTINUED)

If you refuse work three times while on Extended Benefits you will be removed from Extended Benefits. Once removed, you will not be eligible for Extended Benefits again until you have worked at least 217 contributory hours for a contributing employer.

If you are unemployed due to disability, you may remain on the extended benefit program for a maximum of twelve (12) consecutive months for any one period of disability.

Retirees, including those who return to work, are not eligible for the Extended Benefits Program.

Please note that these rules are subject to change in the future.

RETIRED PLAN MEMBERS

Members who are, and remain, in Good Standing of Sheet Metal Workers Local Union 30, are eligible to enrol in the retired members welfare plan. You must have been covered for at least sixty (60) months (in total, and not necessarily consecutively) by the welfare plan as an active member and/or extended benefits program member in the one hundred and twenty (120) months immediately preceding the effective date of your pension from the Sheet Metal Workers Local Union 30 Pension Plan. On the day prior to your retirement you must be covered by the welfare plan as an active or extended benefits program member.

The retired members welfare plan is partly funded by active members and plan investment income. The balance is paid by subscribing retired members.

THE WELFARE PLAN FOR RETIRED MEMBERS IS DESCRIBED FURTHER IN THE RETIRED MEMBERS WELFARE BOOKLET. YOU MAY REQUEST A COPY FROM THE PLAN ADMINISTRATION OFFICE OR THE PLAN WEBSITE.

ELIGIBLE DEPENDANTS

Eligible dependants include your spouse, your unmarried children from live birth to their 22nd birthday or to age 25 if a full-time student, who are dependent on you and/or your spouse for their support. Your dependants become eligible for benefits at the time you become eligible for benefits, or the date you acquire them as dependants, whichever is the later. Dependants who permanently live outside Canada are ineligible.

In order to receive benefits, your dependants must be listed on your Member Information Card filed with the Plan Administration Office. If the plan receives a claim for an unlisted dependant, your claim will be denied until you provide written confirmation that the person is your dependant.

Eligibility

ELIGIBLE DEPENDANTS (CONTINUED)

Spouse

Your spouse is the person to whom you are legally married. If there is no such person, or if you and your spouse are separated, "Spouse" means that person of the same or opposite sex with whom you are currently living, and have lived for at least three consecutive years, and whom you hold out publicly to be your Spouse.

Children

a) A dependant child includes children of the plan member's marriage, legally adopted children, and step children. To be considered an eligible dependant, the child must not be married, must be dependent on the member, not be employed on a regular full-time basis, and must be under 22 years of age; and

b) An unmarried child under age 25 who has been continuously covered as a dependant under this plan since first becoming eligible, will continue to be considered an eligible dependant if in full-time attendance at an accredited school, college or university. Verification of attendance must be provided to the Plan Administration Office.

An unmarried child whose normal residence is in Canada will also be considered an eligible dependant when attending an accredited school, college or university outside of Canada, subject to the limitations described under the Supplementary Health Care section of this booklet;

c) A functionally impaired child who was covered as a dependant shall remain covered beyond any limiting age for dependants, provided the child is incapable of self-sustaining employment and is wholly dependent upon the plan member for support and maintenance.

MEMBER INFORMATION CARD

Please obtain a Member Information Card from the Plan Administration Office or the Office of Local Union 30. The Member Information Card is to be fully completed in ink, signed and dated by you, and forwarded to the Plan Administration Office.

Claims for your dependants will not be paid unless your Member Information Card, or a subsequent written notification, records these persons as your dependants.

In addition to identifying you and your dependants to the Plan Administration Office, completing the Member Information Card gives you the opportunity to give a direction to the Insurer with respect to the payment of your life insurance benefit in the event of your death while insured. Your beneficiary may be any person, persons, religious or charitable institution, etc. that you wish. It is essential that you make the beneficiary designation as clear as possible to avoid any confusion or dispute following your death. You may name your estate as your beneficiary, in which case the life insurance benefit will be paid to your estate and distributed in accordance with your Will or, in the absence of a Will, in accordance with applicable legislation.

If you have not filed a Member Information Card, or otherwise did not name a beneficiary on your Member Information Card, then your life insurance benefit will automatically be paid to your Estate. You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from the Plan Administration Office.

You should review your beneficiary designation to be sure that it reflects your current intent. Normally the beneficiary named on the Member Information Card received by the Plan Administration Office prior to your death will receive death benefits under the plan.

Life Insurance Benefit

FOR ACTIVE MEMBERS ONLY

If you die while insured under this welfare plan, $100,000* will be paid to your beneficiary/estate regardless of the cause, time or place of your death. *If you were totally disabled prior to October 1, 2003, continue to be totally disabled today, and qualify for the Waiver of Premium Benefit described below, your Life Insurance remains at $25,000 to age 65. If you were totally disabled between October 1, 2003 and August 31, 2014, and qualify for the Waiver of Premium Benefit, your Life Insurance remains at $50,000 to age 65.

Waiver of Premium Benefit

If, while insured, you become Totally Disabled for at least six (6) consecutive months before age 65, your Life Insurance will continue in force, without premium, as long as you remain so disabled. "Totally Disabled" means your inability to work at any occupation for wage or profit. If you are granted this Waiver of Premium Benefit, the Insurer will periodically require that you provide evidence that Total Disability persists.

The amount of your Life Insurance reduces upon your attainment of age 65. If you became disabled on or after October 1, 2003, your Life Insurance benefit reduces to $10,000 at age 65. If you were disabled prior to October 1, 2003, your Life Insurance benefit reduces to $5,000 at age 65. The reduced amounts of Life Insurance payable after your attainment of age 65 will continue for the remainder of your life.

If you are on the Waiver of Premium Benefit and you retire, you will not be eligible for the retired members Life Insurance benefit while the Waiver of Premium Benefit provides at least $10,000 of Life Insurance. If the Waiver of Premium Benefit provides only $5,000 of Life Insurance when you retire, or when you reach age 65, you will then be eligible for $5,000 of retired members Life Insurance – you should contact the Plan Administration Office for details. In any event, should you recover prior to age 65 and lose entitlement to the Waiver of Premium Benefit you will become eligible for the retired members Life Insurance benefit at that time.

It is solely your responsibility to apply for Waiver of Premium by making prompt application to the Insurance Company.

Life Insurance Benefit

FOR ACTIVE MEMBERS ONLY

Conversion Privilege

If your Life Insurance terminates or reduces, you may be eligible to convert your Life Insurance coverage to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife within thirty-one (31) days of the termination or reduction of your member Life Insurance. If you die during this thirty-one (31) day period, the amount of Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please contact Manulife. Provincial differences may exist.

FOR ELIGIBLE DEPENDANTS ONLY

In the event of the death of an eligible dependant, payment will be made in a lump sum to you.

The benefit payable is:

- Upon the death of your insured Spouse: $2,000
- Upon the death of your insured Child: $1,000

Waiver of Premium

If while insured, you become totally disabled for at least six (6) consecutive months before age 65, your Dependant Life Insurance will continue in force without any further premiums as long as you remain so disabled. Proof of such disability must be submitted at least once a year.

This benefit is terminated when you reach age 65. It is solely your responsibility to apply for Waiver of Premium by making prompt application to Manulife.

Conversion Privilege

If your spouse's Dependant Life Insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your application for the individual policy, along with the first monthly premium, must be received by Manulife, within thirty-one (31) days of the termination date. If your Spouse dies during this thirty-one (31) day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. If you reside in the province of Quebec and if your dependant child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the conversion privilege for spousal coverage. For more information on the conversion privilege, please contact Manulife. Provincial differences may exist.

Accidental Death and Dismemberment

FOR ACTIVE MEMBERS ONLY

Coverage

The welfare plan offers you full twenty-four (24)-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

Eligibility

All active members, extended benefit, full pay direct, and owner members are eligible.

Benefit Amount

Flat $100,000 (the Principal Sum).

The benefit terminates at retirement.

In the event of your death, the benefit amount is payable to the beneficiary you have named, or in the absence of such designation, to your estate.

In the event of an accidental injury or injuries, if such injury or injuries shall result in any one of the following specific losses within one (1) year from the date of the accident, the insurer will pay the percentage of the Principal Sum in the table set out below, however, not more than one (1) (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

Definitions of "Loss"

- **Loss** means with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If you suffer complete severance of a hand, foot, arm or leg as described above, then the Insurer will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

Accidental Death and Dismemberment

Definitions of "Loss" (Continued)

- **Loss** as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for one hundred and eighty (180) consecutive days and such loss of function is thereafter determined on evidence satisfactory to the Insurer to be permanent.

Definition of "Loss of Use"

- **Loss of Use** means the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for twelve (12) consecutive months and such loss of function is thereafter determined on evidence satisfactory to the Insurer to be permanent.

LOSS OF	PERCENTAGE OF PRINCIPAL SUM PAYABLE
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	75%
Loss of Use of One Hand or One Foot	75%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	75%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

Accidental Death and Dismemberment

Definition of "Brain Death"

- **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.

All benefits that are payable at 200% of the Principal Sum are subject to an all policies combined maximum benefit amount of $1,000,000.

Repatriation Benefit

When injuries result in loss of life of an insured member outside one hundred and fifty (150) kilometers from his/her city of permanent residence or outside Canada and the loss of life occurs within three hundred and sixty five (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 result in a payment being made by the Insurer under any benefit excluding the Loss of Life Benefit, the Insurer will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an insured member provided:

- Such training is required because of such injuries and in order for an insured member to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;
- Expenses are to be incurred within two (2) years from the date of the accident;
- No payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

When injuries result in an insured member's confinement 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 an "Immediate Family Member" 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 an insured member, while confined, but not to exceed $15,000.

An "**Immediate Family Member**" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Accidental Death and Dismemberment

Spousal Occupational Training Benefit

When injuries result in a payment being made by the Insurer under the Loss of Life Benefit, the insurer will pay in addition the expenses actually incurred, within three hundred and sixty five (365) days from the date of the accident, by the spouse of an insured member for a formal occupation 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 hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event an insured member sustains an injury which results in a payment being made under the Schedule of Losses, 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 three hundred and sixty five (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:

1. 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
2. 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 shall be 10% of an insured member's principal sum amount.

Day Care Benefit

If a plan member suffers a 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 policy, a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to a maximum of $5,000 per year, on behalf of any dependant child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within three hundred and sixty five (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 a child is enrolled in a legally licensed day care centre.

Accidental Death and Dismemberment

A "Dependant Child" means the member's eligible unmarried natural, legitimate, illegitimate, adopted, step child or common law child who is principally dependant on the member or the member's spouse for financial support

Special Education Benefit

If an insured member suffers a 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 policy, a Special Education Benefit up to a maximum of $5,000 per year, on behalf of any dependant child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within three hundred and sixty five (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 dependant child continues his or her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by the policy result in loss of life of an insured member within three hundred and sixty five (365) days from the date of the accident, the insurer will pay the reasonable and necessary expenses actually incurred by the spouse and dependant children of the insured member for up to six (6) sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $1,000.

A "Professional Counsellor" is 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 Schedule of Losses, 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 or herself, the Insurer will pay $1,000 for each full month, or 1/30th of such monthly benefit for each day of a partial month, retroactive to the 1st full day of such confinement but not to exceed three hundred and sixty five (365) days in the aggregate for each period of hospital confinement.

Accidental Death and Dismemberment

A "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 twenty-four (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, a place for alcoholics or drug addicts.

"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 a plan member suffers a third degree burn due to an accident, the Insurer will pay an amount depending on the area of the body which was burned according to the following table:

BODY PART	PERCENTAGE OF PRINCIPAL SUM PAYABLE
Face, Neck, Head	$25,000
Hand & Forearm	$25,000
Either Upper Arm	$15,000
Torso (Front or Back)	$25,000
Either Thigh	$10,000
Either Lower Leg (Below the Knee)	$25,000

In the event of a 50% surface burn, the amount of benefit is reduced by 50%. This table represents the amount payable for any one accident. If the insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

In the event a plan member sustains an injury which results in a payment being made under the Schedule of Losses, the insured member's principal sum amount will be increased by 10% if, at the time of the accident, the insured member was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

Accidental Death and Dismemberment

Seat Belt Benefit (Continued)

A "Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile.

A "Seat Belt" means those belts that form a restraint system.

Identification Benefit

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

1. Transportation by the most direct route to the city or town where the body is located; and
2. 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 benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an 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, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

An "Immediate Family Member" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Conversion Privilege

On the date of termination of coverage or during the thirty-one (31) day period following termination of coverage, an insured member may convert his or her insurance to an individual Accidental Death and Dismemberment only insurance policy of the insurer. The individual policy will be effective either as of the date that the application is received by the Insurer or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as a person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of the insurer. The amount of insurance benefit converted shall not exceed that amount issued during employment up to an all policies combined maximum of $200,000. The individual policy will cover Accidental Death and Dismemberment only.

Accidental Death and Dismemberment

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements 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 (1) year of disappearance, stranding, sinking or wrecking of the conveyance in which the insured member was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that the insured member suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

Waiver of Premium

If an insured member, under age 65, becomes totally disabled for six (6) consecutive months and the insured member provides evidence of total disability satisfactory to the Insurer, the Insurer will then waive the payment of each premium which falls due with respect to the insured member. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an insured member until age 65 or earlier termination of the policy.

If after one hundred and twenty (120) days, an insured member receives approval of any long term disability claim provided under a policy of group insurance through the welfare plan, the Insurer will then waive the payment of each Accidental Death and Dismemberment insurance premium subject to the terms stated above.

Recurrent Disabilities

When an insured member becomes totally disabled again from the same or related causes within 6 months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and the Insurer will waive the six (6) month qualification period.

If the same disability recurs more than six (6) months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one (1) day.

Accidental Death and Dismemberment

Termination of Waiver of Premium

Waiver of Premiums will cease on the earliest of:

1. The date the insured member ceases to meet the policy's definition of totally disabled;
2. The date the insured member does not supply the Insurer with appropriate medical evidence as deemed necessary by the Insurer;
3. The date an insured member is no longer receiving regular, ongoing care and treatment of a physician appropriate for the disabling condition, as determined by the Insurer;
4. The date the insured member does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by the Insurer;
5. The date the policy terminates;
6. The date an insured member turns age 65; or
7. The date an insured member dies.

Coverage during Waiver of Premium

While premiums are being waived, Basic Accidental Death and Dismemberment Insurance under the policy on an insured member will continue to be in force. The amount of such insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

"Totally Disabled or Total Disability" with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an insured member's regular occupation for 6 consecutive months.

Continuance of Coverage

If you are:

1. Laid off on a temporary basis;
2. Temporarily absent from work due to short-term disability;
3. On leave of absence; or
4. On maternity leave,

and if you assume other occupational duties during the leave or lay-off period while coverage for this Benefit continues, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Accidental Death and Dismemberment

Exclusions

The plan does not cover any loss which is the result of:

1. Intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. Declared or undeclared war or any act thereof;
3. Travel or flying in an aircraft owned or leased by the welfare plan, an insured member or a member of an insured member's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;
4. Losses occurring while an insured member is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by the Insurer pro-rata for any such period of full-time active duty);
5. Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of the Accidental Death & Dismemberment portion of the policy.

Weekly Income (WI) Disability Benefit

FOR ACTIVE MEMBERS

In the event that, while insured, you become Totally Disabled due to an illness or accident that is not covered by Workers' Compensation (WSIB), the welfare plan will pay a WI benefit commencing with the first day of Total Disability due to accident or hospitalization, or the 8th day of Total Disability due to illness.

There are three (3) important rules affecting the Weekly Income Benefit:

1. Benefits begin on the 1st day (accident or hospitalization) or 8th day (illness) of Total Disability, measured from the first day on which you consult a physician for your disability. If you delay in consulting a physician, this will result in a postponement of the day on which benefits begin. For example, if your first day of Total Disability due to illness is a Tuesday, and you do not consult a physician until Friday, the seven (7) day waiting period starts on the Friday.
2. You must be under the treatment of a legally qualified physician or specialist. A physician is a Medical Doctor (MD). A specialist is a medical doctor who has specialized knowledge deemed appropriate for the impairment causing the disability (for example a psychiatrist in the case of a psychiatric illness).
3. "Total Disability" means your inability to perform the regular duties of your usual occupation.

The WI benefit is currently $573 ($81.86 per calendar day). This amount is equal to the current EI weekly maximum benefit. It will be adjusted to match the EI weekly maximum benefit whenever it changes, subject to its affordability, as determined by the Board of Trustees.

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

Employment Insurance (EI) Integration

The plan's WI benefit is coordinated with Human Resources and Social Development Canada (HRSDC) EI Sickness Benefit. If you are unable to work due to disability, you should immediately file a claim for the plan's WI benefit as well as for EI. It is important that you apply for EI Sickness Benefits, not EI Regular Benefits. If you are already in receipt of EI Regular Benefits when you become disabled, you should notify HRSDC of your disability and switch to EI Sickness Benefits. You should not wait until after you have received EI Sickness Benefits to file a claim for the plan's WI benefit – if you do you may miss the filing deadline, in which case WI benefits will not be paid.

Weekly Income (WI) Disability Benefit

Employment Insurance (EI) Integration (Continued)

The plan will pay benefits during the EI waiting period. This is currently one (1) calendar week. EI will then pay benefits for a maximum of fifteen (15) weeks. If you are still disabled after EI benefits are exhausted, the plan will continue payments to you if you provide medical statements that support your total and continuous disability and a statement from HRSDC indicating the period during which EI benefits were paid.

If EI denies your claim because you worked insufficient hours to qualify for EI benefits, the plan's WI benefit will continue after the two (2) week waiting period if you provide medical statements which support your total and continuous disability and a statement from HRSDC confirming denial of EI benefits.

If EI accepts your claim but reduces your benefit due to other insurance or income, or if EI refuses to pay a benefit because you have breached an EI eligibility rule (e.g. you left the country or failed to claim EI benefits on time), the plan will not pay WI benefits during the fifteen (15) week period EI would normally pay full benefits.

If you are still disabled after EI benefits are exhausted the plan will recommence payments if provided with medical statements which support total and continuous disability. The maximum period for the WI benefit is twenty-six (26) weeks including any weeks paid by EI.

Example: If you are eligible, the welfare plan will consider the first week, EI will pay (if you are eligible) the next fifteen (15) weeks and the welfare plan will pay the remaining weeks. You will be required to provide the welfare plan with medical information supporting continuous disability, including for the period during which you were in receipt of EI Sickness Benefits.

Weekly Income Benefits are not payable in the event that:

- You are not under the regular care of a physician;
- The disability is covered by Worker's Compensation (WSIB);
- The disability is due to intentionally self-inflicted injuries, while sane or insane;
- The disability arises from your voluntary participation in a war, riot or insurrection;
- You are imprisoned in a penal institution or confined in a hospital or similar institution as result of criminal proceedings;
- The illness or injury was caused by or contributed to by a motor vehicle accident;
- The illness arises during any leave of absence (including maternity leave).

The WI benefit will be reduced, dollar for dollar, by any amount of earnings or payments you receive from any employer, any income replacement payable under any automobile insurance plan, as well as any earnings recovered through a legally enforceable cause of action against a third party for income lost as a result of the disability.

Weekly Income (WI) Disability Benefit

Weekly Income (WI) Benefits are not payable: (Continued)

In the event that you are in receipt of WI, recover and return to the usual duties of your occupation for at least one (1) day and are again disabled due to a wholly different cause, you are entitled to another twenty six (26) weeks of WI, assuming, of course, that you are still covered at the time of the onset of the subsequent disability.

In the event that, while you are receiving WI, you recover and return to the usual duties of your occupation and within two (2) weeks are again disabled due (essentially) to the same or related cause, you are entitled to receive twenty six (26) weeks of WI minus the number of weeks of WI already paid for that disability, again assuming that you are still covered at the time of the relapse.

Third Party Liability

The term "third party" includes your own insurance coverage and any other home or automobile insurance, as well as any individual, business, insurer or government agency insurance against which you may be entitled to claim for loss of income arising from your disability.

The term "subrogation", for the purposes of this provision, means the plan's right to recover WI benefits paid to you if another party is, or may be, legally liable to compensate you for income lost due to your disability. The term "compensation" shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

If you are entitled, as a result of the incident which caused or contributed to your disability, to recover compensation for loss of income from a third party, the plan will be subrogated to all your rights of recovery for loss of income. The subrogation will apply to the extent of the sum of benefits paid or payable by the plan. You will be required to provide full disclosure about the recovery or attempted recovery, for the loss.

In the event that you provide proof to the Plan Administration Office that you have not recovered full compensation for loss of income, the plan will determine the proportion of damages actually recovered and share pro rata in that amount.

Should you elect to settle the matter prior to judicial determination, it must be understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the plan's right of subrogation will apply.

Maternity Leave Benefit

FOR ACTIVE MEMBERS

This benefit is for plan members who are pregnant and who are required to leave employment due to safety concerns.

Maternity Leave Benefit Eligibility

To be eligible for this benefit you must:

- Be the plan member who is pregnant
- Provide the employer's separation certificate showing separation from employment
- Provide the plan's Maternity Leave Benefit Statement of Claim within thirty (30) days of separation from employment

The Maternity Leave Benefit will be available between the sixteenth (16^{th}) week and twelfth (12^{th}) week before the due date.

Maternity Leave Benefit Payment

- The maximum benefit payment provided by the plan is four (4) weeks
- The maximum benefit will be the EI declared maximum
- All other terms of the plan will apply including all source maximum benefits and offsets for other coverage

The disability benefit will not extend beyond the date EI would otherwise provide a benefit including pre-due date benefits.

Maintaining Coverage Under the Plan

- You may be eligible for extended benefits as approved by the Local Union 30
- You may be eligible to pay direct for benefits once extended benefits have expired

Things to Know

- You must provide the information requested to administer the benefit
- The plan is not responsible for any implications of this benefit with respect to your application and coverage period for government or other benefits
- You are responsible for applying for EI maternity and other applicable benefits at such time that you qualify for them including pre-due date benefits.

- Claim forms are available from the Plan Administration Office or on the members website at www.lu30plan.com. Please be sure to complete the claim fully and provide all necessary documentation.

Long Term Disability Benefit

FOR ACTIVE MEMBERS

To qualify for Long Term Disability (LTD) benefits you must be continuously and Totally Disabled during the waiting period. The term "Waiting Period" means twenty-six (26) weeks. After this, the LTD benefit will be paid as long as you are Totally Disabled. Benefits cease on the earlier of death, recovery or the attainment of age 65. Benefits received are taxable income in the year received.

Definition of Total Disability

During the waiting period and the immediately following two (2) years, you must be unable to perform the duties of your own occupation and must not work in any capacity for wage or profit, except as provided for under the Rehabilitation Provision. If your disability lasts longer than two and a half years (2.5 years), it must be to such an extent that you cannot perform any job for which you may be qualified through experience, training or education. You must be under the continuing care of a legally qualified physician to receive benefit payments.

Amount of Benefit

The current monthly LTD benefit payable under the plan is $2,000.00 for disabilities arising on or after January 1, 2016.

This amount will be reduced by any income you may receive from Workers' Compensation (WSIB) or similar legislation. For instance, if Workers' Compensation paid you $1,100.00 per month, you would receive $900.00 from the plan. Your monthly LTD benefit may be further reduced if you receive disability income from any other group plan except the Canada Pension Plan.

If the total benefits from other group plans (including the Sheet Metal Workers Local Union 30 Pension Plan) together with LTD benefits add up to more than 75% of your pre-disability before-tax earnings, the benefit from the plan will be reduced so that you will be receiving a total of 75% of those earnings.

In other words, you may receive income while disabled to a maximum of 75% of your gross earnings before your disability. In determining your "pre-disability before-tax earnings", the insurer will assume that, in each of the fifty two (52) weeks prior to the onset of your disability, your gross earnings are equal to your hourly wage rate at the onset of disability multiplied by the number of hours in a regular work week as defined in the collective agreement in effect at the onset of your disability.

Income from the LTD benefit is not offset by disability benefits from the Canada Pension Plan (CPP).

Long Term Disability Benefit

Rehabilitation Provision

The welfare plan encourages you to return to work after a period of Total Disability even though you are not able to work at your regular occupation. If you do take a job for which you are reasonably qualified, you will receive the benefit you had been receiving from the plan less 80% of the income you get from the job.

For example: Suppose that you were receiving the full monthly LTD benefit while Totally Disabled. We will assume that you take a job which is not your regular occupation and you earn $320 a month. Under the Rehabilitation Provision you would receive:

Regular Monthly Long Term Disability Benefit	$2,000
Less 80% of $320 (Earned Income)	$256
Adjusted Monthly Long Term Disability Benefit	$1,744
When added to your job income of $320, you would be receiving a Total Monthly Income of $2,064	
Note: Your Long Term Disability benefit will be reduced further if the total income you receive from all sources exceeds 75% of your gross earnings.	

The benefits under the Rehabilitation Provision will start with the later of the first day of disability following the waiting period (the time during which you would likely receive benefits under the WI plan) or immediately following a period of Total Disability. The benefits under this provision will not be paid for longer than two (2) years for any one disability.

Recurring Disability

In the event that you have been in receipt of LTD benefits, and you recover only to become disabled again due to the same or a related cause, within six (6) months after you return to active work, you are immediately entitled to receive LTD benefits.

However, if during this period of time you were continuously covered by the full welfare plan, or otherwise you had returned to work with a contributing employer and re-established your eligibility, upon your recurrent disability you would first be entitled to receive WI benefits followed by LTD benefits.

Long Term Disability Benefit

Limitations and Exclusions

LTD benefits will not be paid for any of the following:

- Any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician 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 recommended by said physician;
- Any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;
- Any portion of a period of disability resulting from substance abuse, including alcoholism and drug addiction, unless you are participating in a recognized substance withdrawal program approved by the Insurer;
- Disabilities resulting from intentionally self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;
- Any portion of the disability where you are working in any capacity, expect under the terms of the "Rehabilitation Provision";
- Disabilities resulting from injury or disease which occurred while the member is on active duty in the armed forces of any country, state or international organization or for disability resulting from war or act of war, whether declared or undeclared;
- The portion of a period of disability during which you are imprisoned in a penal institution; or confined in a hospital, or similar institution, as a result of criminal proceedings;
- Any period of disability, or portion thereof, during any leave of absence (including maternity leave);
- Any period of disability, if you refuse to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending physician or on the advice of independent medical opinion;
- Any period of disability, if you refuse to complete and return a Reimbursement Agreement, when requested by the Insurer in connection with Third Party Liability; or
- An Illness or injury caused by or contributed to by a motor vehicle accident.

Canadian Residency Requirement

No benefits are payable if the member is not a resident of Canada unless:

i. **the member has previously notified and received approval in writing from the insurer, and**
ii. **the member remains under the regular care of a licensed physician deemed appropriate by the Insurer, and**
iii. **proof of the ongoing disability can be determined on evidence satisfactory to the insurer in English or French within thirty (30) days of request.**

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability for which benefits are paid or payable, the insurer will be subrogated to all your rights of recovery for loss of income to the extent of the sum of benefits paid or payable by the Insurer. You must execute such documents as are required by the Insurer.

In the event that you provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share pro-rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the Insurer's right of subrogation will apply.

The term “compensation” shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

Supplementary Health Care

FOR ALL MEMBERS & DEPENDANTS

MAJOR MEDICAL PLAN

The plan will pay 100% (or 80% where stated) of Reasonable and Customary (R&C) charges for plan members and their eligible dependants for the following expenses, with no maximum benefit, unless stated below.

Accidental Dental

Necessary dental treatment required as a result of an accidental injury limited to a maximum benefit of $5,000 per accident. Dental treatment must be completed within twelve (12) months of the accident.

Acupuncture

The plan will pay 80% of Reasonable and Customary charges for the services of a qualified registered acupuncturist, to a maximum of $1,000 per annum, provided that these services, including the frequency of treatment, are recommended by your attending physician.

Ambulance

Charges for licensed ambulance service or other emergency service (including fare of a medical attendant where necessary) when used to transport the covered person from the place where bodily injury or disease is suffered to the nearest hospital where adequate treatment can be rendered or from one hospital to another or from a hospital to the covered person's residence.

Chiropractic Services

Reasonable and Customary charges for the services of a qualified chiropractor.

Diabetic Preparations and Supplies

Necessary diabetic preparations, services and supplies.

Hearing Aids

Charges for hearing aids prescribed by a legally licensed otolaryngologist, up to a maximum payment of $400 for one instrument per covered person in any four (4) consecutive years. Please note that batteries are not covered.

Hospital Services and Supplies

Charges for hospital services and supplies obtained from an outpatient department of a licensed hospital or surgical supply company while not confined in a hospital.

Massage Therapist/Osteopath

The plan will pay 80% of Reasonable and Customary charges for the services of a qualified registered massage therapist/osteopath, to a combined maximum of $1,000 per annum, provided that these services, including the frequency of treatment, are recommended by your attending physician.

Mental Health Benefit

The following practitioners will be covered: Registered Psychologist, Registered Psychotherapist, Psychiatrist and Registered Social Worker (Master of Social Work). For expenses incurred on/after January 1, 2020, the Plan will pay 100% of reasonable and customary (R&C) charges for the listed practitioners up to a maximum of $200 per hour and subject to a combined $2,000 maximum benefit per person covered per calendar year.

To make the most of your Plan's mental health benefit, Members are urged to fully utilize the Plan's FSEAP benefit first because that service is free to Members and is not included as part of the annual maximum benefit for mental health services. If additional mental health treatment is required after utilizing the services of FSEAP, then the mental health benefit coverage of the Plan could be utilized.

Podiatrist

Reasonable and Customary charges for the services of a qualified podiatrist.

Physiotherapy

Reasonable and Customary charges for the services of a qualified physiotherapist, who is not normally resident in your home, provided the treatment is recommended and approved by your attending physician.

Registered Nurse

- Charges for the services of a Registered Nurse (RN) or Registered Nursing Assistant (RNA) at the covered individual's residence, provided the RN or RNA is not normally resident in the covered person's home, or in a public general hospital, always provided that such services are necessary in the opinion of the attending physician.
- The maximum benefit is $10,000 within any three (3) consecutive years.

Rehabilitation Hospital

The fee charged by a chronic care hospital/unit or rehabilitation hospital, over and above the allowance made by OHIP or its equivalent, for convalescent, chronic or custodial care.

Services and Supplies

Charges for the following services and supplies:

- Purchase of braces, crutches, surgical stockings, artificial limbs and eyes and prosthetic devices approved by the Insurer including surgical brassieres and breast prostheses required following a mastectomy;
- Rental of, or at the plan's option, purchase of a wheelchair, hospital-type bed or other durable equipment for temporary therapeutic use;
- Oxygen and blood serum;
- One (1) pair of custom-made orthotics or orthopedic shoes, to a maximum of $400 per calendar year, if prescribed by a physician, podiatrist or chiropodist. They must be supported by a statement of diagnosis, related symptoms and physical findings, and a description of the abnormal walking pattern associated with the medical condition, and they must be dispensed by a certified podiatrist, chiropodist, pedorthist, orthotist or physician,

Speech Therapy

- Reasonable and Customary charges for the services of a qualified speech therapist are covered to a maximum payment of $200 per calendar year for each covered person.

Expenses Outside of Canada or your Province of Residence

Subject to certain conditions set out in this booklet, including a medical stability clause, the Emergency Travel Assistance Program provides coverage in excess of your provincial health care plan to a maximum of $5,000,000 per eligible person for expenses incurred as a result of an unforeseen medical emergency and/or for travel assistance services while travelling outside of the province of residence.

Please refer to the section "Emergency Travel Assistance Program" for further details.

Supplementary Health Care

PRESCRIPTION DRUG PLAN

The plan covers the cost of drugs prescribed by your physician or dentist for you and your eligible dependants. Eligible drugs must be approved for use by Health Canada and have both a Health Canada compliance certificate and a Drug Identification Number (DIN).

The maximum reimbursement for the pharmacist's professional dispensing fee is $8.50 per prescription. There is full reimbursement for the pharmacist's professional dispensing fee for compounds prepared by the pharmacist.

The plan will pay 100% of the lower of the brand name or generic drug ingredient cost even if your physician has prescribed no substitution, including the lower cost of biologic drugs or their biosimilar, where biosimilar drugs are available. If there is no generic equivalent to the prescribed brand name drug, the plan will pay 100% of the ingredient cost of the brand name drug.

The plan does not cover the cost of proprietary medicines, or vitamins (unless injected), nor products that are not for the treatment of illness or injury, such as prescriptions for weight control, hair loss, etc.

Fertility drugs and treatment are covered to a lifetime maximum of $2,500 per family unit.

Smoking cessation products are covered up to lifetime maximum of $250.

No benefits will be payable for the following specific drug expenses:

- Charges over the maximum or the specific drug expenses not covered by the plan
- Non-Injectable vitamins, vitamin supplements, dietary supplements, or diet foods
- Weight loss drugs
- Medical cannabis including any derivative product
- Food and food products, including infant formula and foods, salt and sugar substitutes
- General products or any other product which can be sold at any retail outlet including, but not limited to, such items as contact lens care, non-medicated shampoo, toothpaste, skin protectors, emollients and soaps
- Any single purchase of drugs which would not reasonably be used within one hundred (100) days from the date of purchase
- Drugs that have not been issued a compliance certificate and a drug identification number by Health Canada whether or not they have been approved under a provincial formulary
- Drugs prescribed or issued to manage an illness or disability arising out of a workplace accident, disability or injury or due to a motor vehicle accident.

Supplementary Health Care

PRESCRIPTION DRUG PLAN (CONTINUED)

Prior Authorization Drugs

Certain drugs require prior authorization. If you receive a prescription for a drug that requires prior authorization, your pharmacy will let you know and you will have to apply for coverage for that drug from the plan. Your physician or authorized prescriber will need to fill out the plan's Prescription Drug Special Authorization Request Form. You can get the form through your pharmacy or by calling the Plan Administration Office. Review of drug coverage normally takes forty-eight (48) hours.

Once you receive approval for this drug, your profile in the Plan Administration Office system is updated so that all future covered claims for the same drug are automatically approved. Be sure to let your physician and pharmacist know that your plan includes a prior authorization program.

High Cost Specialty Drugs

There are approximately one hundred and twenty (120) specialty drugs that require prior authorization. These drugs are very expensive and are for very serious medical conditions. The prior authorization process for receiving speciality drugs has been enhanced to be consistent with general industry practice.

As part of the prior authorization process, a case manager will provide patient support to you or your eligible dependants and will help to navigate the process with one of the designated pharmacies within the network. Prior authorization can help to better manage overall plan costs for these speciality drugs.

Please note: Regular prescription drugs that are not Speciality Drugs can continue to be purchased at your usual pharmacy.

VISION CARE PLAN

You and your eligible dependants between the ages of 20 and 64 are eligible for one (1) eye examination each consecutive twenty-four (24) month period. The plan will pay up to $50 towards the cost of the eye examination.

The plan helps pay for the cost of eyeglasses (frames, lenses and fitting of prescription glasses), as well as contact lenses. Repairs to frames are not covered. Contact lenses must achieve visual acuity of at least 20/40 level. The maximum benefit is $240 per person in any consecutive twenty-four (24) month period.

Supplementary Health Care

Supplementary Health Care Expenses Not Covered

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

- Anything prohibited by legislation. Benefits will be reduced by amounts paid, or that would be paid if covered, by government plans such as OHIP. Expenses related to motor vehicle accidents are not covered
- Charges not medically necessary to the care and treatment of any existing or suspected illness, injury or pregnancy
- Charges for surgical procedures or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedures or treatment
- Charges for services or supplies provided without the recommendation and approval of a physician acting within the scope of his/her license
- Charges for services or supplies resulting from any intentionally self-inflicted injury
- Charges for drugs or supplies that are not approved by Health Canada with a compliance certificate and that do not have a Drug Identification Number (DIN) or are approved but not for the particular condition being treated (off label use) or are experimental in nature. Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society
- Charges made by a physician or other health practitioner for travel, broken appointments, communication costs, completion of forms, or physician's or other practitioner's supplies
- Charges which the plan is not permitted, by any law or regulation including rules established by the Trustees to cover
- Charges which were considered a covered service of any provincial government plan at the time this booklet was issued and subsequently were modified, suspended or discontinued
- Charges for general health examinations, and examinations required for use of a third party
- Charges for medical treatment or surgical procedures by a physician incurred outside Canada or your province of residence other than as specifically provided for under the Emergency Travel Assistance Program
- Charges that result from an occupational injury or disease covered by any Workers' Compensation law or similar legislation including from a motor vehicle accident
- Charges for services or supplies not listed as eligible expenses in this booklet

Supplementary Health Care

Supplementary Health Care Expenses Not Covered (Continued)

- Charges that would not normally have occurred but for the presence of this coverage or for which you or your dependant are not legally obligated to pay;
- Charges for dental work where a third party is responsible for payment of such charges;
- Charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind.

Emergency Travel Assistance Program

FOR ALL MEMBERS & DEPENDANTS

Eligible Members

The plan covers eligible active members of the "Plan", excluding active members paying direct for life insurance only.

If you wish to know whether your plan includes Travel Benefits please call the Plan Administration Office at 1-800-263-3564. If you have any questions about this coverage please call 1-800-936-6226. Green Shield will confirm the coverage that is available under this plan.

Eligible Benefits

The Travel Benefits are intended to supplement your provincial health insurance plan if you experience a medical emergency while travelling outside of your province of residence or Canada, if your provincial health plan includes out of Canada benefits. Hospital and medical services are eligible only if the covered person's provincial health insurance plan provides payment toward the cost of incurred services. The benefits shown below will be eligible if they are medically necessary for the emergency treatment of a sudden and unforeseen illness or injury and reimbursement will be limited to reasonable and customary charges for the area in which they are incurred.

Benefits are limited to a maximum of sixty (60) days per trip commencing with the date of departure from the covered person's province of residence. If the covered person is hospitalized on the 60th day, benefits will be extended until the date of discharge.

Emergency Services

Emergency services will be paid to a maximum of $5,000,000 per covered person per incident. Referral services will be paid to a maximum of $50,000 per covered person per calendar year.

To qualify for benefits, claimants must be covered by their respective provincial government health plan or equivalent at the time the expenses are incurred.

If you have any questions about this coverage please call 1-800-936-6226. Green Shield Canada will confirm the coverage that is available under this plan.

Eligible travel benefits will be reasonable and customary charges in the area where they were received, less the amount payable by the covered person's provincial health insurance plan.

All maximums and limitations stated are in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, 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.

Emergency Services (Continued)

Reimbursement of eligible benefits for emergency services will be made only if the services were required as a result of a medical emergency while you or an eligible dependent are temporarily outside of your regular province of residence for vacation, business, or education. To qualify for benefits, the claimants must be covered by their respective provincial government health plan or equivalent at the time the expenses are incurred. Eligible travel benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial health insurance plan, if your province provides such coverage. This limitation does not apply if you reside in a province that does not offer out of Canada coverage.

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 the covered person is medically able to return to his/her province of residence.

Upon notification of the necessity for treatment of an accidental injury or medical emergency, the patient must contact Green Shield Canada Travel Assistance at the number that appears on your Green Shield Canada Identification Card **within forty-eight (48) hours of commencement of treatment**. Failure to notify Green Shield Canada 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 plan maximum, whichever is the lesser of the two.

Any invasive or investigative procedures must be pre-approved by the Green Shield Canada Assistance Medical Team.

1. Hospital services and accommodation up to a standard ward rate in a public general hospital;
2. Medical/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 covered person's provincial health insurance plan or to the nearest qualified medical facility.
4. Referral services – (a) hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or (b) medical surgical services rendered by a legally qualified physician or surgeon;
   - **Prior to the commencement of any referral treatment, written pre-authorization** from the covered person's provincial health insurance plan and Green Shield Canada **must be obtained**. The provincial health insurance plan may cover this referral benefit entirely. The covered person must provide Green Shield Canada with a letter from their 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**.

Emergency Services (Continued)

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 (RN) registered in the jurisdiction in which treatment is provided. The covered person must contact Green Shield Canada Travel Assistance for pre-approval;
6. Diagnostic laboratory tests and x-rays when prescribed by the attending physician. Except in emergency situations, Green Shield Canada 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 which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded). Submit to Green Shield Canada Travel Assistance the original paid receipt from the pharmacist, physician or hospital outside your province of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.
8. 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 covered person's province of residence;
9. 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 and after return) must be provided within ninety (90) days of the accident. Details of the accident must be provided to Green Shield Canada Travel Assistance along with dental x-rays;
10. Coming Home - when the covered person's emergency illness or injury is such that:
    - Green Shield Canada's Assistance Medical Team specifies in writing that the covered person should immediately return to his/her province of residence for immediate medical attention, 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 their 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.
    - Green Shield Canada's 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 a relative of the covered person 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.
11. Cost of returning the covered person's personal use motor vehicle to his/her residence or nearest appropriate vehicle rental agency when he/she is unable to due to sickness, physical injury or death, up to a maximum of $1,000 per trip. Green Shield Canada requires original receipts for costs incurred, i.e. gasoline, accommodation and airfares;

Emergency Travel Assistance Program

Emergency Services (Continued)

12. Meals and accommodation up to $1,500 (maximum of $150 per day for up to ten (10) days) will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred when the covered person remains with a travelling companion or a person included in the "family" coverage, 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 commercial organization;
13. Transportation to the bedside including round trip economy airfare by the most direct route from the covered person's province of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of five (5) days for meals and accommodation at a commercial establishment will be paid for that family member to:
    - Be with the covered person when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least seven (7) days outside their 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 prior to release of the body.
14. Return airfare if the personal use motor vehicle of the covered person 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 their province of residence. An official report of the loss or accident is required.
15. 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 of the 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 covered person's 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.

GREEN SHIELD CANADA TRAVEL ASSISTANCE SERVICE

The following services are available twenty-four (24) hours per day, seven (7) days per week through Green Shield Canada's international medical service organization.

Services Include

1. 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.
2. Multilingual assistance.

Emergency Travel Assistance Program

Services Include (Continued)

3. Assistance in locating the nearest, most appropriate medical care.
4. International preferred provider networks.
5. Green Shield Canada's Assistance Medical Team's consultative and advisory services, including second opinion and review of appropriateness and analysis of the quality of medical care.
6. Assistance in establishing contact with family, personal physician and employer as appropriate.
7. Monitoring of progress during treatment and recovery.
8. Emergency message transmittal service.
9. Translation services and referrals to local interpreters as necessary.
10. Verification of coverage facilitating entry and admissions into hospitals and other medical care providers.
11. Special assistance regarding the co-ordination of direct claims payment.
12. Co-ordination of embassy and consular services.
13. Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary.
14. Management, arrangement and co-ordination of repatriation of remains.
15. Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
    a. The return of unaccompanied travel companions.
    b. Travel to the bedside of a stranded person.
    c. Rearrangement of ticketing due to accident or illness and other travel related emergencies.
    d. The return of a stranded personal use motor vehicle and related personal items.
16. Knowledgeable legal referral assistance.
17. Co-ordination of securing bail bonds and other legal instruments.
18. Special assistance in replacing lost or stolen travel documents including passports.
19. Courtesy assistance in securing incidental aid and other travel related services.

Travel 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 travelling 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;

Emergency Travel Assistance Program

Travel Limitations (Continued)

2. Upon notification of the necessity for treatment of an accidental injury or medical emergency, Green Shield Canada'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 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 his/her 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 his/her province of residence, the expense of such continuing treatment will not be an eligible benefit;

   The patient must contact Green Shield Canada Travel Assistance within forty-eight (48) hours of commencement of treatment. Failure to notify Green Shield within forty-eight (48) hours may result in benefits being limited to only those expenses incurred within the first forty-eight (48) hours of any and each treatment/incident or the plan maximum, whichever is the lesser of the two;

3. Air ambulance services will only be eligible if:
   a. They are pre-approved by Green Shield Canada Travel Assistance
   b. There is a medical need for the covered person to be confined to a stretcher or to be accompanied by a medical attendant during the journey, and
   c. The covered person is admitted directly to a hospital in his/her province of residence, and
   d. Medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to Green Shield Canada Travel Assistance, and
   e. Proof of payment (including air ticket vouchers or air carrier invoices) is submitted to Green Shield Canada Travel Assistance;
4. If planning to travel in areas of political or civil unrest, or in areas where Global Affairs Canada (GAC) has issued a formal travel warning regarding non-essential travel, contact Green Shield Canada Travel Assistance for pre-travel advice, as Green Shield Canada may be unable to guarantee assistance services;

Emergency Travel Assistance Program

Travel Limitations (Continued)

5. Green Shield Canada 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 Green Shield Canada to provide service. This includes travel in any area if at the time of booking the trip (including delay of travel), or before the covered person's departure date, Global Affairs Canada (GAC) 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);

Travel Exclusions

In addition to the Travel Limitations, eligible benefits do not include and reimbursement will not be made for:

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 your departure from your province of residence, was not completely stable (in the professional 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 your medical information at the time of claim.

   Stable means that during the ninety (90) days immediately preceding your departure:
   a) your pre-existing/pre-diagnosed medical condition:
      i) has been controlled by the consistent use of the same medications and dosages (excluding changes in medication that regularly occur as part of your ongoing treatment, or decreases in dosage resulting from an improvement in your pre-existing or pre-diagnosed medical condition) prescribed by a legally qualified medical professional;
      ii) has not, in the reasonable opinion of a legally qualified medical professional, required additional treatment for a recurrence, complications or any other reason related either directly or indirectly to your pre-existing or pre-diagnosed medical condition;
   b) you have not consulted a legally qualified medical professional for, or had investigated or diagnosed, a new medical condition for which you have not received medical treatment;
   c) you have not scheduled/are not awaiting any future appointments for non-routine examinations, consultations, tests or investigations (including results) for an undiagnosed medical condition;
   d) you have not scheduled/are not awaiting any exploratory surgical procedures for an undiagnosed medical condition or surgical procedures for a diagnosed medical condition

2. Any expenses incurred for any services received that were not required due to an Emergency. Eligible benefits will not be reimbursed for treatment or surgery that could reasonably be delayed until you return to your province of residence;
3. Any expenses incurred for treatment or surgery not covered under your provincial health insurance plan had the services been received in your province of residence;

4. Any expenses incurred for services normally covered under your provincial health insurance plan's out of Canada coverage (where applicable), when the province has declined payment;
5. 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 provinces of residence;
6. Any claims arising directly or indirectly from any medical condition the covered person suffers or contracts 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 covered person's departure date, Global Affairs Canada (GAC) 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;
7. 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 recommendation of a physician;
8. Treatment or service that a covered person elects to have performed outside Canada when the medical condition would not prevent their return to Canada for such treatment;
9. Any expenses for injuries caused by, arising from, or directly or indirectly contributed to by the abuse or excessive consumption or use of medications, drugs, alcohol or other toxic substances or for injuries caused by, arising from, or directly or indirectly contributed to as a result of the consequences of such abuse or excessive consumption. Use of alcohol which gives rise to a blood alcohol level of more than 80 milligrams in 100 millilitres of blood will be deemed to be excessive consumption or use and this exclusion will apply;
10. Any expenses relating directly or indirectly to an injury sustained as a result of the covered person's operation of a motorized vehicle while legally impaired or intoxicated as a result of the excessive use of a medication, drugs, alcohol or other toxic substances. Use of alcohol which gives rise to a blood alcohol level of more than 80 milligrams in 100 millilitres of blood will be deemed to be intoxication as a result of excessive use and this exclusion will apply. 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;
11. Amounts paid or payable under any Workplace Safety and Insurance Board or similar plan;
12. Hospital and medical care for childbirth occurring within eight (8) weeks of the expected delivery date from the date of departure, or deliberate termination of pregnancy
13. 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;
14. Services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation;
15. Cataract surgery or the purchase of eyeglasses or hearing aids;
16. Any expenses incurred for during any trip taken for the purpose of seeking medical treatment or advice that has not been previously authorized as outlined in referral services.

Green Shield Canada 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 Green Shield Canada Travel Assistance.

How Travel Assistance Service Works

For assistance dial 1-800-936-6226 within Canada and the United States or call collect 0-519-742-3556 when traveling outside Canada and the United States. These numbers appear on your Green Shield Canada Identification Card.

Quote the Green Shield Canada Travel Assistance Group Number and your Green Shield Canada Identification Number, found on your Green Shield Canada Identification Card, and explain your medical emergency. You must always be able to provide your Green Shield Canada Identification Number and your provincial health insurance plan number.

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, we will guarantee the provider (hospital, clinic or physician), that you have both required provincial health insurance plan coverage and Green Shield Canada travel benefits as detailed above.

Green Shield Canada Assistance Medical Team will follow your progress to ensure that you are receiving the best available medical treatment. These physicians also keep in constant communication with your family physician and your family, depending on the severity of your condition.

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 Green Shield Canada Travel Assistance and submit them for reimbursement upon your return to Canada.

Ontario Health Insurance Plan

The Ontario Health Insurance Plan (OHIP) is a combined medical and hospital insurance plan that will help pay for practically all physicians' services that are required by you and your eligible dependants.

OHIP also covers approved hospital accommodation and services, nursing homes and home care services, etc.

OHIP services are partially funded through the Ontario Health Premium Tax, which is paid by Ontario residents through payroll deduction or as part of their income tax returns. The tax is income based.

Medical Services

These include doctors' services in the home, office or the hospital for medical care, surgery, anesthetics, and obstetrical care. Coverage includes specified dental surgical procedures in hospital.

Services by some health care practitioners such as podiatrists are also covered under OHIP although there are limits on the amount of benefit that will be paid for these services, and in some cases not everyone is covered. For example, children under age 20 and seniors age 65 or older are eligible for physiotherapy services; however, OHIP pays only a small amount per treatment.

Examination of the eyes to determine the need for corrective lenses is also covered, when performed by a physician or a duly qualified optometrist for Ontario residents who are either under age 20 or age 65 and over, or who have a medical condition affecting the eyes such as glaucoma, cataract, retinal disease, etc. as well as diabetes mellitus.

Hospital Services

Ontario residents and their dependants are covered by OHIP for standard ward accommodation, in-hospital meals and hospital services. There is no limit to the number of days for which benefits may be provided.

OHIP also covers certain out-patient services:

- Services and supplies for emergency diagnosis and treatment within twenty-four (24) hours of an accident;
- Follow-up treatment for fractures initially treated in hospital within twenty-four (24) hours of an accident;
- Use of radiotherapy facilities for treatment of cancer;
- Use of occupational physiotherapy and speech therapy facilities;
- All necessary ambulance services, subject to part payment by you.

Ontario Health Insurance Plan

Nursing Home Services

If you make use of nursing and home care services there is a daily charge which you may be required to pay. OHIP will then pay the balance of the cost.

Administration of OHIP

OHIP is administered by the Ontario Ministry of Health and Long Term Care and changes are made in the regulations from time to time. It is suggested that you obtain current government brochures which describe OHIP details more completely or visit:

http://www.health.gov.on.ca/en/public/programs/ohip/ohipfaq_mn.aspx

Ontario Drug Benefit (ODB) Program

You and your eligible dependants age 65 and older must enroll in the ODB Program. The ODB Program covers most of the cost of more than 4,400 prescription drug products, some nutrition products and some diabetic testing agents.

You/your eligible dependants are entitled to ODB if:

1. 65 years of age or older.
2. you/they live in a long-term care home or home for special care.
3. you/they are enrolled in the Home Care program.
4. you/they have high costs relative to your income and are registered in the Trillium Drug Program.
5. you/they receive social assistance through Ontario Works or the Ontario Disability Support Program.

Dental Care

FOR ALL MEMBERS & DEPENDANTS

The plan will help pay the cost of dental care for you and your eligible dependants. The amount that will be paid for services is based on a fee schedule selected by the Board of Trustees that may be changed from time to time as circumstances permit. Expenses must always be medically necessary, reasonable and customary.

The maximum eligible expense for any service or supply covered by the dental benefit will be the amount set out in the 2019 Ontario Dental Association Suggested Fee Guide for General Practitioners. If your dentist charges more than the fee in this schedule, the excess is your responsibility. In order that you will know, in advance, the amount that you will have to pay, a special procedure applies to dental services where the dentist's fee will exceed $500.

All treatment must be given by a legally qualified dentist, except for cleaning or scaling of teeth which may be performed by a registered dental hygienist. Full upper and/or lower dentures, or repairs to full or partial dentures, may be provided by a denture therapist.

Maximum Benefit

The total calendar year maximum benefit is $2,000 for basic and major services combined for each member and eligible dependant. Of this amount, $1,000 may be applied towards orthodontia.

Expenses Covered at 100%

Eligible expenses for the following basic dental services will be paid at 100%:

1. Oral examinations, including scaling and cleaning of teeth (maximum of eight (8) units per plan year), but not more than one (1) examination in any period of six (6) consecutive months; complete oral exam and diagnosis once every twenty-four (24) months
2. Topical applications of sodium or stannous fluoride, but only if the covered dependant has not yet attained the age of 15 years.
3. Dental x-rays; complete series or equivalent once every twenty-four (24) months.
4. Bitewing films, once every six (6) months.
5. Oral surgery, including excision of impacted teeth.
6. Fillings and extractions; Anesthetics administered in connection with oral surgery or other covered dental services.
7. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
8. Endodontic treatment including root canal therapy.

Dental Care

Expenses Covered at 100% (Continued)

9. Initial installation (including adjustments during the six (6) month period following installation) of partial or full removable dentures to replace one (1) or more natural teeth extracted while covered under the plan;
10. Replacement of an existing partial or full removable denture or fixed bridge work, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if evidence satisfactory to the plan is presented that:
    a. The replacement or addition of teeth is required to replace at least one (1) natural tooth extracted while covered under the plan; or
    b. The existing denture or bridgework was installed at least five (5) years prior to its replacement and that the existing denture or bridgework cannot be made serviceable; or
    c. The existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within twelve (12) months from the date of installation of the immediate temporary denture;
    d. The replacement of the existing denture is more than twelve (12) months after the individual became covered.
11. Space maintainers for dependant children only;
12. Repair or re-cementing of crowns, inlays, bridgework or dentures or relining of dentures;
13. Injections of antibiotic drugs by the attending dentist;
14. Study casts one (1) per year;
15. Consultations;
16. Replacing the facing or veneer of bridgework.

Expenses Covered at 75%

Eligible expenses for the following major dental services will be paid at 75%:

1. Gold inlays, onlays and crowns (including precision attachments for dentures), and initial installation of fixed bridgework (including inlays and crowns to form abutments) to replace one (1) or more natural teeth extracted while covered under the plan.

   When you submit a Pre-Determination of Benefits or claim for this benefit, you must submit x-rays taken before the treatment was started. Pre-Determination of Benefits must be submitted to Green Shield Canada.

Dental Care

Expenses Covered at 75% (Continued)

2. Charges for orthodontic treatment (including correction of malocclusion). Before orthodontia is started, your orthodontist will tell you the expected total cost of the treatment, and how long it will last. For example, you may be advised that the expected cost is $2,000, and the visits will stretch over twenty-four (24) months. Commonly, the orthodontist will require that you make regular monthly payments, even during those months in which there is no service. In this example, we are assuming that the quoted fee conforms to the fee guide used by the plan. Your claim would be paid at the rate of $62.50 each month, which is 75% of $2,000 divided by twenty-four (24), up to a maximum of $1,000 each calendar year. You must remain covered by the plan throughout the treatment.

Implants and/or Related Services

Should implants and/or related services be obtained, reimbursement will be considered but only up to the maximum that would have been paid for the least costly professionally adequate treatment to restore the entire arch, such as prosthetic devices (crowns, denture and /or bridgework), subject to the coinsurance applicable to the treatment determined to be eligible. Any time limits for replacement or other limitations that may apply to the alternate treatment paid for by the plan will apply.

Orthodontics

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of the teeth". These include active space retainers, or orthodontic appliances for the purpose of repositioning or moving of the teeth. The pre-existing condition clause in the dental expense section does not apply to orthodontic procedures.

Expenses Not Covered

1. Charges for any dental procedure that is included as a covered medical expense under any type of medical plan provided by your employer or the government, whether benefits are payable for all or only part of such charges.
2. The initial installation of dentures and bridgework (including crowns and inlays forming the abutments), when such charges are incurred for replacement of teeth, all of which were extracted while the individual was not covered under the plan.
3. Prosthetic devices (including bridges and crowns) and the fitting thereof, which were ordered while the individual was covered but which were finally installed or delivered to such individual more than thirty (30) days after termination of coverage.
4. The replacement of a lost or stolen prosthetic device.
5. Personalization, duplication or characterization of dentures.

Dental Care

Expenses Not Covered (Continued)

6. Services and supplies that are partially or wholly cosmetic in nature, except cosmetic surgery for prompt repair of a non-occupational injury.
7. Dental procedures required due to any injury or dental disease and supplies which were first prescribed or recommended prior to the date on which the individual would otherwise become covered here for reimbursement in respect of such supplies.
8. Any hospital charges for board and room and other necessary services and supplies, in connection with injuries or diseases of a dental nature.
9. Charges for completion of claims forms, or broken appointments.
10. Charges for oral hygiene instruction, nutritional counselling or protective athletic appliances.
11. Services or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants, except as outlined under the Implants and/or Related Services section;
12. Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his or her license.
13. Any dental examination required by a third party.
14. Services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for a correction of temporomandibular joint dysfunction.
15. Services or supplies which were necessitated either wholly or partly, directly or indirectly as the result of committing, attempting, or provoking an assault or criminal offence, or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind.
16. Services or supplies resulting from any intentionally self-inflicted wound.
17. Charges which were considered a covered service of any provincial government plan at the time this booklet was issued and subsequently were modified, suspended or discontinued.
18. Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease.
19. Any charges that would not normally have been made but for the presence of this coverage or for which the member or dependant is not legally obligated to pay.
20. Any services which are covered by any government plan or program; or for which no charge is made; or which the plan is not permitted by law to cover.
21. No benefit will be paid for any claims arising as a result of or related to a motor vehicle accident, unless prohibited by law.
22. Charges for services and supplies not listed as eligible expenses in this booklet.

Health Care Spending Account (HCSA)

FOR ALL MEMBERS

For the year commencing on January 1, 2020, $650.00 was allocated to HCSA of eligible members. Your HCSA is intended for the reimbursement of eligible expenses that may not be covered or exceed the maximums under the "Plan".

You will be reimbursed for your eligible expenses up to the balance which is left first in your 2019 HCSA and then in your 2020 HCSA. Any balance remaining in your 2019 HCSA on December 31, 2020 will revert back to the fund. Any balance remaining in your 2020 HCSA on December 31, 2020 will be carried forward until December 31, 2021. If there is any money left in your 2020 HCSA at December 31, 2021 it will revert back to the fund.

Members will be notified if the Trustees agree to allocate more money to your HCSA. Allocations are only made if the Trustees consider them affordable.

ELIGIBLE EXPENSES

Eligible expenses are those that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) Income Tax Guidelines. Eligible expenses also include any unpaid portion of an expenses covered by the "Plan".

SUBMITTING HCSA CLAIMS

Online

1. Register for Green Shield Canada Plan Member Online Services.
2. Once you have registered and are logged in, select "Claims Submission "from the left menu.
3. Select "Health Care Spending Account" from the list.
4. Click on the "To Submit a Claim" link.
5. Enter your claims details as instructed.
6. Confirm your claim is correct and click "Submit".

Member Assistance Program

FOR ALL MEMBERS & DEPENDANTS

From time to time your personal issues can become significant enough that they begin to interfere with your effectiveness, happiness or safety, both at work and at home.

The Member Assistance Program (MAP) provided through Family Services Employee Assistance Program (FSEAP) provides confidential personal assistance services twenty-four (24) hours a day, seven (7) days a week for you and your eligible dependants.

FSEAP provides short-term counselling, education and self-development services in addition to assessment and referral when required, for a full spectrum of personal issues including, but not limited to:

- Separation, Divorce, Custody
- Financial and legal difficulties
- Alcohol and drug dependency
- Gambling and other additions
- Smoking cessation
- Eating disorders
- Difficulties with children
- Anger management
- Sexual harassment and abuse
- Bereavement
- Child and elder care resources
- Retirement planning
- Dietician services
- Physical fitness assessment
- Single parenting
- Sleep difficulties

FSEAP, health professionals are registered psychologists or registered counsellors chosen specifically for their extensive experience in dealing with a variety of psychological and health issues. They provide a non-judgmental and unbiased source of expertise and support, ready to listen to your concerns to help guide you towards positive outcomes.

FSEAP offers you and your eligible dependants counselling in person, by phone, or through the internet. FSEAP will assist you in setting up an appointment at a time and office location convenient to you.

There is no cost to members or eligible dependants to use FSEAP services and everything is confidential. Counsellors are required by law to maintain the strictest confidentiality. Anyone who inquiries about or receives services under this plan will be identified to anyone without your written approval. The only exception to this is where the law would require disclosure.

Website: www.myfseap.ca

Group Name: **tosmwiamap**

Password: **myfseap1**

Toll free number: 1-800-668-9920

fseap Now we're talking.

Unemployed Members and Apprentice Members

BENEFITS FOR UNEMPLOYED MEMBERS

As outlined earlier in this booklet, you are covered by the benefits of the plan provided you work sufficient hours with a contributing employer to remain covered. The Trustees recognize that some members may not work sufficient hours to maintain coverage, due to illness or a shortage of work, and in the circumstances special arrangements can be made to maintain coverage on either the extended benefit program, or on a pay direct basis.

Maintenance of benefits, either on the Extended Benefit Program or pay direct, is not available to retired members or to persons who are no longer associated with Local Union 30 as a member in good standing or apprentice.

As noted earlier in this booklet, you remain covered by all of the benefits of the plan until your dollar bank is less than the amount required to pay the next month's benefit cost. If that point is reached, the Plan Administration Office will send a notice by mail to your home address as shown on the plan's records, advising you of the termination date of your benefits unless you take one of the following steps:

EXTENDED BENEFIT PROGRAM

You may continue all of the benefits of the welfare plan, except the Weekly Indemnity benefit and Long Term Disability benefit, provided that you immediately contact the Local Union 30 Office to confirm that you are unable to work due to disability, or are unemployed due to a shortage of work and actively seeking employment through Local Union 30.

If you qualify, Local Union 30 will place your name on a special report to the Plan Administration Office, and you will remain covered by the plan until such time as Local Union 30 no longer considers you eligible, in accordance with the rules set out in the Eligibility section of this booklet.

Please note that, if your unemployment is due to illness, there is no maximum to the number of times that you can be covered by the Extended Benefits Program, but there is a maximum of twelve consecutive months for any one period of continuous disability.

Since the cost of the extended benefit program is paid by the fund – that is, the contributions made by contributing employers on account of actively employed members/apprentices – the continuation of this program is contingent upon the ability of the fund to pay the cost. The Trustees have the cost of this program under continual review, and it may be amended or terminated, or you may have to pay all or a part of the cost at some time in the future if circumstances warrant.

Unemployed Members and Apprentice Members

PAY DIRECT PRIVILEGES

You may continue all of the benefits of the plan, except the Weekly Indemnity benefit and Long Term Disability benefit, for up to three months on a pay direct basis.

The notice that you receive from the Plan Administration Office will extend this option to you, andthe cost as described in the notice.

The notice is clear with respect to your options, including that you must make the required payment by the due date contained in the notice or your benefits will be cancelled.

BENEFITS FOR APPRENTICE MEMBERS

While you are working for a contributing employer, you are covered by all of the benefits set out in this booklet assuming, of course, that you have worked sufficient contributory hours to become and remain covered by the plan.

As an Apprentice, you are required to cease work occasionally in order to attend Apprenticeship School in which case your dollar bank would normally decrease because you are not working. In the event that you are attending Apprenticeship School, you can make arrangements with the Office of Local Union 30 to have your benefits continued at no cost to you. This arrangement is described in the Eligibility section of this booklet. It is your sole responsibility to contact the Office of Local Union 30 to make this arrangement.

At the end of the period for which benefits have been extended as described above, if you have not worked sufficient hours to meet the monthly dollar bank deduction for active member benefits, you should immediately apply to Sheet Metal Workers Local Union 30 to transfer to the extended benefit program.

As mentioned previously in this booklet, the cost of maintaining your benefits while you are not working is paid out of the assets of the “Fund”, and the Trustees necessarily reserve the right to amend, terminate or suspend this feature or otherwise require that you pay all or part of the cost of your benefits.

WORK RELATED DISABILITIES

The Workplace Safety and Insurance Act, Ontario requires that the fund keep all of your benefits in force while you are disabled for a maximum period of twelve (12) months following the date of a work-related disability for which you are in receipt of Workers' Compensation (WSIB).

Unemployed Members and Apprentice Members

The Trustees have asked each contributing employer to notify the Plan Administration Office of such disabilities, and an arrangement is in place with Local Union 30 to provide the same information, so as to make sure that you do not lose your entitlement.

However, in order to be absolutely certain that the Plan Administration Office is aware of your work-related disability, you should contact the Plan Administration Office directly.

BENEFITS FOR RETIRED MEMBERS

On the date of your retirement, if you are covered under the active member welfare plan and you meet the conditions set out below, you will be eligible for coverage under the retired member welfare plan. If you still have money in your dollar bank, those funds will go towards paying for your retired member benefits until your dollar bank is less than the amount required to pay the next month's benefits cost. Please note that the benefits of the welfare plan for retired members are described in a separate booklet.

Upon retirement, you will be covered for the benefits for retired members provided that:

- You are, and remain, a member in good standing of Sheet Metal Workers Local Union 30; and
- During the one hundred and twenty (120) months immediately prior to your retirement, you were covered by the “Plan” as an active member, or on the extended benefit program for at least sixty (60) months; and
- You are receiving a monthly pension from the “Plan”; and
- You choose one of the options and pay the required monthly contribution applicable to that option. If you still have money in your dollar bank upon retirement, those funds will go towards paying for retired members benefits until your dollar bank is less than the amount required to pay the next month’s benefit cost.

General Plan Provisions

All of the information in this booklet is current at January 1, 2020, and reflects the eligibility rules established by the Trustees, the provisions of the Insurance Contracts, and governing legislation such as The Workplace Safety Insurance Board Act, Ontario and the Income Tax Act, Canada. The Trustees will amend, suspend or terminate rules and/or benefits, in the event that future circumstances or legislation require changes.

PRIVACY STATEMENT

The plan is subject to the provisions of federal privacy legislation set out in the Personal Information and Electronic Documents Act (PIPEDA). The plan may be subject to other legislation regarding the protection of personal information. The Board of Trustees has taken steps to ensure that Personal Information of plan members and their dependants is protected through the implementation of the plan's Privacy Policy document, a copy of which is available from the Local Union 30 Office or the Plan Administration Office. These Policies will be adhered to by the Plan Administration Office, the Board of Trustees, the plan's claims payers and insurers, and anyone else who has any responsibilities to the plan.

Briefly, the plan's Privacy Policy requires that the plan collect, maintain, share and retain only the personal information that is necessary for the effective administration of the plan, subject to obtaining consent from the member and/or his/her dependants to do so. Access to Personal information will be restricted to those who are required to use it. Personal information will only be shared if the other party has its own privacy policy. Personal information that is no longer needed will be properly and safely destroyed.

FRAUDULENT CLAIMS

The cost to our plan is determined by the claims that are paid. Every claim is adjudicated before it is paid. Sometimes, the plan may request more supportive evidence to ensure that only legitimate claims are paid.

The Trustees follow a ZERO TOLERANCE POLICY for fraudulent claims from any source (such as a plan member, dependant, dentist, pharmacist or other health practitioner, or clinic) and will report suspected criminal behaviour to the police.

The Trustees also have the right to cancel benefits in the event that they reasonably believe a fraud has been committed.

HOW TO SUBMIT A CLAIM

Please show your All-In-One Benefit Card to your pharmacist, dentist and to other health service providers.

Drug claims must be submitted directly by your pharmacist. Dental claims must be submitted directly by your dentist. Many health care providers should be able to submit your claims electronically for you and your eligible dependants (chiropractors, massage therapists, physiotherapists etc.).

You may also submit your health claims online through Green Shield Canada (GSC) Member Online Services as described in greater detail below under each benefit heading.

If you have any questions regarding registering for GSC's Member Online Services or need any help with submitting claims using your All-In-One Benefit Card, please contact the Plan Administration Office:

Employee Benefit Plan Services Limited

45 McIntosh Drive

Markham, ON

L3R 8C7

Telephone: 1-905-946-9700 or Toll-Free: 1-800-263-3564

Fax: 1-905-946-2535

E-mail: ebps@mcateer.ca

If you require a paper claim form, you may obtain one from the Plan Administration Office, the Union office, or the plan website at www.lu30plan.com. Please avoid sending personal information (health information, income, date of birth, etc.) by email unless it is encrypted.

The Plan Administration Office will provide professional assistance in the settlement of all claims under the plan.

ACCESS TO PLAN DOCUMENTS WITH RESPECT TO BENEFITS COVERED BY MANULIFE

You or any of your covered dependants have the right to request a copy of the sections of the group policy and/ or plan document that applies to you and your dependants. Manulife reserves the right to charge you for such documentation after your first request.

TIME LIMIT FOR LEGAL ACTION WITH RESPECT TO BENEFITS COVERED BY MANULIFE

You may not commence legal action against Manulife (with respect to benefits underwritten by Manulife) less than sixty (60) days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife for the recovery of money payable under the plan is absolutely barred unless commenced within the time period set out in the Insurance Act or applicable legislation.

General Plan Provisions

TIMELINES

If you become Totally Disabled prior to your age 65, you may be entitled to remain covered for your Life Insurance benefit until you reach age 65 and at a reduced level thereafter and to Accidental Death and Dismemberment and Dependant Life Insurance benefits until you reach age 65, at no cost to you, provided that you remain Totally Disabled.

The Contract of Insurance providing this Waiver requires that you notify the Insurer within twelve (12) months of the onset of your disability. The Insurer will notify you whether your disability qualifies for Waiver of Premium. It is absolutely essential that you contact the Plan Administration Office to apply for Waiver of Premium within the prescribed time; otherwise, the Insurer has the right to decline your Claim for Waiver of Premium.

WEEKLY INCOME (WI)

As noted earlier in this booklet, it is essential that you consult a physician on the first day that you are Totally Disabled. Then, apply for EI Sickness benefits and obtain a claim form from the Plan Administration Office, Local Union 30 Office, or the plan website at www.lu30plan.com**.**

Then, please have the appropriate claim form completed by your attending physician and promptly send it to the Plan Administration Office.

If you are claiming Weekly Indemnity benefits, you are required to have your attending physician complete a part of the claim form before any benefits will be paid.

On occasion, continuation of benefits will require additional reports from your physician to confirm that you are and remain disabled. If your physician charges for the completion of these forms, the charge is your responsibility.

LONG TERM DISABILITY (LTD)

If your disability is of such duration that you may qualify for benefits under this plan – that is, your disability is expected to last longer than six (6) months, be sure to contact the Plan Administration Office without delay. Since the Insurer must be promptly notified of any liability under the LTD benefit, please contact the Plan Administration Office, in writing, within six (6) months of the onset of disability, so that proper notice can be filed with the Insurer by the Plan Administration Office in the event that you are entitled to receive a benefit.

If you are claiming LTD benefits, charges (if any) levied by your physician for the supply of medical evidence of disability is at your expense. The only exception is if the Insurer requires additional information and contacts your physician directly.

Do not fail to file a claim for LTD benefits, even if you may not be eligible to receive a benefit because you are receiving Workplace Safety and Insurance Board benefits.

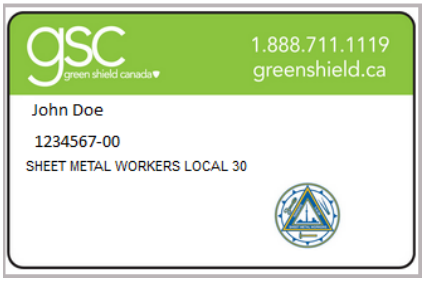
General Plan Provisions

DENTAL CARE

Dental claims must be submitted electronically by your dentist for you and your eligible dependants using your All-In-One Benefit Card.

PRESCRIBED DRUGS AND MEDICINES

Drug claims must be submitted directly by your pharmacist using your All-In-One Benefit Card.



MAJOR MEDICAL EXPENSES

Many health care providers (chiropractors, massage therapists, psychologist, physiotherapists, etc.) will be able to submit claims electronically for you and your eligible dependants. Please show them your All-In-One Benefit card at the point of purchase and request electronic filing.

PLAN MEMBER ONLINE SERVICES

Access to Plan Member Online Services is available at www.greenshield.ca. Click on the Register Login area to begin. Many tools and services are available online for you to submit your Major Medical expenses. Reimbursement for these claims will be directly deposited to the member's bank account.

If you are unable to submit claims online, or through your service provider, you may mail your paper claims into the Plan Administration Office.

If you require any assistance, please contact the Plan Administration Office where a staff member will be happy to assist you.

COORDINATION OF BENEFITS

The prevalence of group health plans may mean that you, your spouse and your children may have duplicate coverage. You are covered by this plan as a member and your spouse and children are covered as your dependants.

General Plan Provisions

COORDINATION OF BENEFITS (CONTINUED)

At the same time, your spouse may be covered as an employee by her/his employer's group health plan, and you and your children are covered as her/his dependants. In order to prevent a payment by both plans for the same expense, such that benefits paid by both plans exceed the amount charged, this plan and many others contains a special "no profit" Coordination of Benefits (COB) provision.

If duplicate coverage exists, all claims, including yours, are first presented to the other plan if it does not have COB. If the other plan does not pay the claim in full, you would then file it with this plan and you will receive the same amount you would have received if there was no duplicate coverage, up to the balance unpaid by the other plan.

If the other plan also has COB, the claim is filed as follows:

1. If you received the service or supply, file the claim first with this plan, and if there is an unpaid balance then file the claim with your Spouse's plan.
2. If your Spouse received the service or supply, file the claim first with her/his plan, and then with this plan if there is an unpaid balance.

If the service or supply is received by one or your children, first submit the claim to the plan that covers the spouse who has the earlier birthday in the calendar year and, if there is an unpaid balance, to the other plan. For example, if your birthday is June 1st, and your spouse's birthday is December 13th, submit the child's claim first to this plan and then to the other plan if this plan did not pay the claim in full.

The above order-of-payment procedure has been agreed upon by Canadian health insurers and applies to all group health plans including those provided by governmental legislation, group insurance plans, and student accident insurance plans above the high school level.

MEDICAL INFORMATION BUREAU (MIB)

MIB Group, Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Manulife or its re-insurers may periodically report information to the MIB. If you apply to receive life or disability coverage from another MIB member company or submit a claim for benefits to such a company, the MIB upon request will supply the other insurer with the information on file.

Manulife or its re-insurers may also release information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. All information obtained will be treated as confidential.

General Plan Provisions

MEDICAL INFORMATION BUREAU (MIB) (CONTINUED)

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek correction.

MEDICAL INFORMATION BUREAU (MIB)

330 University Ave., Suite 501

Toronto, Ontario M5G 1R7

Tel: (416) 597-0590

NOTICE AND PROOF OF CLAIM

The benefits provided through the plan are in accordance with insurance and administration services only contracts, which specify time limits for the filing of claims. If the claim is not filed on time, the service provider or plan may deny liability. It is your responsibility to promptly file claims, in accordance with the information below:

Life Insurance	Within 15 months of the date of death.
Waiver of Premium	Within 12 months of the onset of disability.
AD&D	Notice must be filed within 30 days, and proof within 90 days of the date of loss.
Weekly Income	Within 90 days of the onset of disability.
Long Term Disability	Within 6 months of the onset of disability.
Health and Dental	Within 15 months of the date the expense was incurred, except that the claim must be filed within 90 days of the date your coverage terminates.
WSIB Credits	Within 90 days of the date the WSIB commences disability payments.

TAXABLE BENEFITS

The Income Tax Act (ITA), Canada provides that the benefit paid to you for WI and/or long term disability is a taxable benefit to you, as are life insurance and accidental death and dismemberment premiums paid to an insurer out of employer contributions. In or about February of each year, a T4A will be mailed to you, showing the taxable benefits paid to you or on your behalf in the prior calendar year. You are required to report this income when filing your tax return. The plan will conform to any future changes to the ITA that affect the tax status of benefits.

General Plan Provisions

FUTURE CHANGES

This active member welfare booklet was written to provide you all of the essential eligibility and termination rules, benefits, limitations and exclusions that were in effect at January 1, 2020.

Whereas there will doubtless be changes in the future, these changes will be communicated to you, and you should keep these notices with this booklet.

Subject to the Trustees absolute right to amend or terminate the plan at their sole discretion, in the event that the amounts of Life Insurance, Accidental Death and Dismemberment, Weekly Income or Long Term Disability benefits are increased, or decreased, the change will not apply to you if you are disabled on the effective date of the change. You will be covered by the new benefit upon your recovery and return to work, or availability for work, assuming your dollar bank holds sufficient money.

Service Providers

PLAN ADMINISTRATION OFFICE

45 McIntosh Drive
Markham, ON
L3R 8C7

Telephone: 1-905-946-9700, Toll-Free: 1-800-263-3564, Fax: 1-905-946-2535
Website: www.lu30plan.ca
Facebook website: www.facebook.com/smwialocal30benefits

ADMINISTRATION SERVICES

Employee Benefit Plan Services Limited

CONSULTANTS

Eckler Ltd.

J.J. McAteer & Associates Incorporated

LEGAL COUNSEL

Koskie Minsky LLP

ALL-IN-ONE BENEFIT CARD TECHNOLOGY

Green Shield Canada

INSURERS

Chubb Insurance
Group Policy Number: AB10447201

Green Shield Travel Assistance Program
Group Number: 4932

Manulife
Group Policy Number: 901884

MEMBER ASSISTANCE PROGRAM

Family Services Employee Assistance Program (FSEAP)
Website: www.myfseap.ca
Group Name: tosmwiamap
Password: myfseap1
Toll free number: 1-800-668-9920

AUDITOR

HS & Partners LLP

INVESTMENT MANAGER

RBC Dominion Securities