YOUR WELFARE PLAN

SHEET METAL WORKERS
LOCAL UNION 30

RETIRED MEMBERS BOOKLET

Up to Date as At January 1, 2020

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

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

Contents

General Information

ESTABLISHMENT OF THE PLAN

Prior to July 1, 2001 retired members of Sheet Metal Workers Local Union 30 who met certain eligibility requirements were automatically covered by the Sheet Metal Workers Local Union 30 Welfare Plan (the "Plan"). The entire cost of that plan was paid by Local Union 30's active members. As time passed, the number of retired members covered by the plan increased rapidly. The cost of certain benefits (notably prescription drugs) increased significantly because of the spiraling increase in the ingredient cost of the prescription drugs. There was also an increase in the number of members retiring before their 65th birthdays – before they would be eligible for almost 100% coverage by the Ontario Drug Benefit Program (ODB) for Seniors, or a similar publicly sponsored plan that commonly exists outside Ontario.

By 2001, the cost of the retired members' benefits had escalated to the point where it could no longer be funded entirely by active members. New optional benefit options were designed for retired members which achieved the goals of providing choice, providing important benefits and ensuring affordability. Eligible retired members may choose welfare plan benefits under one of three options. The retired member makes the applicable monthly contribution for their selected option. Monthly contributions for benefits are deducted from monthly pension benefits. Retired members can decline enrolment in any health plan option, in which case coverage would be terminated and there would be no future opportunity to regain coverage.

All benefits described in this booklet and the rights thereto, are governed by the provisions of the plan and the applicable contracts of insurance and documents, including eligibility exclusions and limitations.

Supplementary Health Care, Vision and Dental benefits are not insured. They are self-funded and supported by the assets of the Sheet Metal Workers Local Union 30 Welfare Fund only.

Life Insurance is insured by Manulife under policy number 901884.

The Emergency Travel Assistance Program benefit (ETA) is provided by Green Shield Canada (GSC) under group number 4932.

The plan's Member Assistance Program (MAP) is administered by Family Services Employee Assistance Programs (FSEAP). FSEAP provides confidential counseling services for crisis support, advice and information by telephone, face-to-face or online.

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 given the available funding. New 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.

SHEET METAL WORKERS LOCAL UNION 30 RETIRED MEMBERS' WELFARE PLAN

Members covered under any of the Options listed below must be and remain members in good standing of Sheet Metal Workers Local Union 30 (the "Union"). The Union is the sole decision maker of the status of membership in good standing.

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

It is essential that all plan members have a clear understanding that, whereas the Trustees hope to continue providing welfare plan benefits, the Trustees necessarily reserve the right to amend, suspend or cancel any or all benefits, 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 retired members' 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 Welfare Trust Fund (the "Fund") and processed by its All-In-One Benefit Card technology services provider by Green Shield Canada or by the Administration Services Provider.
- Life Insurance 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 plan has the right to decline your claim.

The retired members' 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 plan members and such changes are deemed to amend/modify this booklet and the applicable plan documents.

ACCESS TO OFFICIAL 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 is mentioned here but the time limits apply equally to other insurers.

General Information

ADMINISTRATION SERVICES

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

Sheet Metal Workers Local Union 30 Welfare Plan

Plan Administration Office

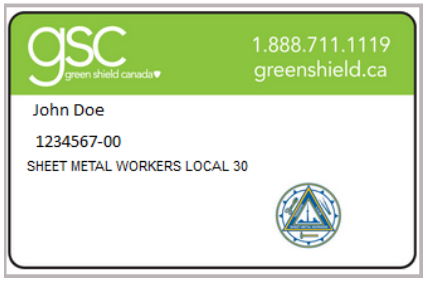
45 McIntosh Drive, Markham, ON, L3R 8C7

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

Website: www.lu30plan.com Facebook: 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 (vision care, 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:

Retired Member and Dependants' benefits

Life Insurance Death Benefit

BENEFIT	DETAILS
Life Insurance (Retired Members only)	$10,000

Summary of Benefits

RETIRED MEMBERS' AND DEPENDANTS' BENEFITS (CONTINUED)

Supplementary Health Care – Plan "A" and Plan "B" unless otherwise indicated

BENEFIT	DETAILS
Deductible	Nil
Reimbursement	100% of reasonable and customary charges (R&C) for Members and their eligible dependants except where stated below.
Overall Lifetime Maximum	$100,000 lifetime maximum (excluding dental, vision care and emergency travel assistance program).
Prescription Drugs – Plan "A" Only	100% of the lower of the brand name or generic drug ingredient cost even if your physician has prescribed no substation, 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 – Plan "A" Only	Maximum of $8.50 per prescription
Prescription Drugs for Smoking Cessations – Plan "A" Only	Lifetime maximum of $250.

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

Paramedical Practitioners – Plan "A" and Plan "B" unless otherwise indicated

PRACTITIONER	ALLOWED EXPENSE
Podiatrist, Registered Massage Therapist and Physiotherapist	$225 maximum per paramedical practitioner per calendar year. For podiatrists - $100 for the surgical removal of toenails or the excision of plantar warts.
Chiropractor and Osteopath	$225 maximum per paramedical practitioner per calendar year. $15 per calendar year for 1 x-ray by a chiropractor and/or osteopath
Naturopath	$225 maximum per paramedical practitioner per calendar year
Speech Therapist	$225 maximum per paramedical practitioner per calendar year
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 plan services are subject to Reasonable and Customary charge limits.	

Summary of Benefits

RETIRED MEMBERS' AND DEPENDANTS' BENEFITS (CONTINUED)

Hearing Aids

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

Custom Made Foot Orthotics

The plan covers 50% of the customary cost to a maximum of $400 per calendar year for orthotics or orthopedic shoes that have been specifically designed and molded for the covered person and necessary to correct a diagnosed physical impairment. The foot orthotics or orthopedic shoes must be prescribed by a physician, podiatrist or chiropodist.

Vision Care

Eye Exams	1 eye examination every 24 months for persons between age 20 – 64 to a maximum cost of $50.
Corrective Lenses and Frames	Maximum of $50 in a consecutive 24-month period.
Contact Lenses	Lifetime maximum of $200, if prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia and if visual acuity can be improved to at least 20/70 level by contact lenses only.

Other Medical Services and Supplies

The plan covers the reasonable and customary (R&C) charges for ambulance, rehabilitation hospital, diabetic services and supplies, accidental dental, durable medical equipment (hospital bed, wheelchair, braces, and crutches), prostheses and surgical stockings.

Emergency Travel Assistance Program and Out of Canada Coverage – Plan "A" and Plan "B" unless otherwise indicated

The plan provides coverage (in excess of your provincial medicare plan) for 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. You should ensure that you meet the medical-stability requirements for this coverage.

Dental Benefits – Plan "A" and Plan "B" unless otherwise indicated

Dental Fee Guide

Reimbursement of dental services is based on the current Ontario Dental Association Suggested Fee Guide for General Practitioners less one year (i.e. expenses for 2020 will be paid on the basis of the 2019 fee guide).

Summary of Benefits

RETIRED MEMBERS" 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 Examination	1 complete oral examination each 24 months
Major Dental Services	50% reimbursement.
Major Dental Services Include	Initial dentures, replacement dentures are covered under certain circumstances.
Basic and Major Maximums	$1,000 per person per calendar year combined

Pre-Determination of Benefits

Prior to a planned course of treatment exceeding $500, your dental practitioner must submit a Pre-Determination of Benefits, including x-rays, to Green Shield Canada for approval.

Health Care Spending Account (HCSA) – Plan "A" and Plan "B" unless otherwise indicated

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

Summary of Benefits

RETIRED MEMBERS" AND DEPENDAN'TS BENEFITS (CONTINUED)

Member Assistance Program (MAP)

Provided by: Family Services Employee Assistance Program (FSEAP)

Website: www.fseap.ca

Username: tosmwiamap

Password: myfseap1

FSEAP provides confidential counselling, information, advice and referral services for plan members and their eligible dependants. 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.

Benefits Coverage For Retired Members' Surviving Spouses

Spouses of retired members are eligible for up to an additional six months of benefits coverage upon the death of the retired member. To be eligible for this additional coverage, the spouse must be receiving a survivor pension from the Sheet Metal Workers Local Union 30 Pension Plan and the retired member must have been covered under Option A or Option B prior to his/her death. The spouse is eligible for the same benefits coverage at the time of the retired member's death. The cost for this additional coverage is 50% of the cost of benefits at the time of the retired member's death.

Optional Benefit Plans

If you become eligible for coverage you will be offered enrolment in your choice of three optional plans. You will be required to make a monthly contribution representing a part of the actual cost of benefits for the chosen option. If you choose not to enroll your coverage in the plan will be terminated permanently and you will not have an opportunity to be covered in the future. The three available options are:

A. The benefits in Option A are all of the benefits described in this booklet.

B. The benefits in Option B are all of the benefits described in this booklet, excluding the prescription drug benefit.

C. The benefits in Option C are the Member Assistance Program and the $10,000 Group Term Life Insurance benefit, covering the member only. For members approved for Life Insurance Waiver of Premium at retirement, the total Life Insurance benefit provided by the Plan will be the greater of the amount approved by the insurer and $10,000.

The Trustees reserve the right to amend the plan's options. If you choose one of these options, the contribution you are required to pay will be deducted each month from your monthly pension benefit. The contribution required is subject to change from time to time – no more frequently than annually. When the time comes for you to choose an Option, the Plan Administration Office will advise you of the contribution then in effect.

Option B may be attractive to you if you and your spouse are at least age 65. This is because you should be eligible for Ontario's Drug Plan for seniors or, if you do not live in Ontario, the applicable public drug plan for seniors in your jurisdiction. However, all members should make this choice very carefully, since the Province of Ontario (for example) has deleted certain pharmaceutical products from the Ontario Drug Plan for Seniors and, as previously noted, if you choose Option B or Option C, you will not be permitted to enroll in Option A at a future date.

Eligibility

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 Plan as an active member and/or Extended Benefit 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 plan as an Active or Extended Benefit Program member.

You must be covered by a Canadian provincial medicare plan (i.e. OHIP) as the plan will not cover any expense that would have been paid by OHIP if you were properly enrolled.

The retired members' welfare plan is partly funded by active members and the "Fund's" investment income. The balance is paid by subscribing retired members.

ELIGIBLE DEPENDANTS

Eligible dependants who can be covered by the plan include your spouse, and 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 (3) consecutive years, and whom you hold out publicly to be your spouse.

Children

a) A dependant child shall include 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 failed to 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

If you die while insured under the plan, $10,000* will be paid to your beneficiary regardless of the cause, time or place of your death.

*For members approved for Life Insurance Waiver of Premium at retirement, the total Life Insurance provided by the plan will be the greater of the amount approved by the insurer and $10,000.

Supplementary Health Care

FOR ALL RETIRED MEMBERS & DEPENDANTS

MAJOR MEDICAL PLAN

The plan will pay reasonable and customary (R&C) charges for plan members and their eligible dependants for the following expenses, unless stated below. The plan has an overall per person lifetime maximum benefit of $100,000 (excluding drugs, dental, vision care, and Emergency Travel Assistance Program).

Limits and maximums stated below are for each covered person.

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 and Osteopath Services

Reasonable and customary charges for the services of a qualified chiropractor or osteopath to a maximum of $225 per practitioner per calendar year; $15 per calendar year for 1 x-ray by a chiropractor and/or an osteopath. The services of an osteopath must be recommended by your attending physician including the frequency of treatment.

Hearing Aids

Charges for hearing aids prescribed by a legally licensed otolaryngologist, up to a maximum payment of $400 for one instrument 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

Reasonable and customary charges for the services of a qualified registered massage therapist to a maximum of $225 per calendar year, 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.

Naturopath

Reasonable and customary charges for the services of a qualified registered naturopath, to a maximum of $225 per calendar year, provided that these services, including the frequency of treatment, are recommended by your attending physician.

Podiatrist

Reasonable and customary charges for the services of a qualified podiatrist to a maximum of $225 per calendar year plus $100 for the surgical removal of toe nails or the excision of plantar warts.

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 to a maximum of $225 per calendar year.

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 plan including surgical brassieres and breast prostheses required following a mastectomy;
- Rental of, or at the plan's option, the purchase of a wheelchair, hospital-type bed or other durable equipment for temporary therapeutic use;
- Oxygen and blood serum;

- 50% of the cost of one pair of custom-made orthotics or orthopedic shoes, to a maximum of $400 per calendar year, if prescribed by a physician, podiatrist or chiropodist. The purchase 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 the item 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 $225 per calendar year.

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 - PLAN "A" ONLY

The plan covers the cost of drugs prescribed by your physician, dentist or appropriately licensed person. 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 plan does not cover any drug that qualifies for coverage under the Ontario Drug Benefit (ODB) for Seniors.

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.

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.

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 assess your claim and if eligible, fill out the 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 claims for the same drug are automatically approved. Be sure to let your physician and pharmacist know that your drug plan includes a prior authorization program.

Supplementary Health Care

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 current 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. Arrangements of this nature 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 BENEFIT

You and your eligible dependants (between the ages of 20 and 64) are eligible for one (1) eye examination every 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 $50 per person in any consecutive twenty-four (24) month period.

There is a lifetime maximum of $200 per person for contact lenses if they are prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia and if visual acuity can be improved to at least 20/70 level by contact lenses only.

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:

- An expense prohibited by legislation.
- Expenses payable, or that would be paid if you were properly enrolled, by government plans such as OHIP.
- Expenses related to motor vehicle accidents.
- Charges not medically necessary for 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 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 and subsequently were modified, suspended or discontinued.
- Charges for general health examinations, and examinations required for use of a third.
- 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 benefit.

Supplementary Health Care

Supplementary Health Care Expenses Not Covered (Continued)

- 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 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.
- Charges for services or supplies not listed as eligible expenses in this booklet.

Emergency Travel Assistance Program

FOR ALL RETIRED MEMBERS & DEPENDANTS

Eligible Members

The Plan covers eligible retired members and their dependants of the Sheet Metal Workers Local Union 30 Welfare Plan.

To confirm that you have 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 Canada will confirm the coverage that is available under the 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.

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.

All dollar maximums and limitations stated are in Canadian dollars. 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.

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 dependant 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.

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

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.

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**.
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;

Emergency Travel Assistance Program

Emergency Services (Continued)

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;

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);

Emergency Travel Assistance Program

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 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 some hospital accommodation and services, nursing homes, 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

OHIP's medical coverage includes some 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 of 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;
- Radiotherapy facilities for treatment of cancer;
- Occupational physiotherapy and speech therapy facilities;
- 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. 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 – Plan "A" and Plan "B" Only

FOR ALL MEMBERS & DEPENDANTS

The plan will help pay the cost of dental care for you and your eligible dependants.

The maximum eligible expense for any service or supply covered by the dental benefit will be the amount set out in the current Ontario Dental Association Suggested Fee Guide for General Practitioners less one year for that service or supply (i.e. expenses for 2020 will be paid on the basis of the 2019 Fee Guide). If your dentist charges more than the fee covered by the plan, the excess is your responsibility. In order that you will know, in advance, the amount that you might have to pay, a special procedure applies to dental services where the charge will exceed $500. Expenses must always be medically necessary, reasonable and customary.

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

There is a total calendar year maximum benefit of $1,000 for basic and major services combined for each member and eligible dependant.

Expenses Covered at 100%

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 calendar year),
   one examination in any period of six consecutive months; complete oral exam and diagnosis once every twenty-four (24) months
2. Topical applications of sodium or stannous fluoride every 6 months, but only if the covered dependant has not yet attained the age of fifteen (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;
7. Anesthetics administered in connection with oral surgery or other covered dental services;
8. Treatment of periodontal and other diseases of the gums and tissues of the mouth;

Dental Care

Expenses Covered at 100% (Continued)

9. Passive space maintainers for dependant children;
10. Repair or re-cementing of existing bridgework or relining, rebasing and repairing an existing denture;
11. One study cast per year;
12. Consultations;
13. Replacing of the facing or veneer of bridgework.

Expenses Covered at 50%

Eligible expenses for the following Major Dental services will be paid at 50%:

1. Installation of an initial full or partial denture, provided the denture replaces at least one natural tooth which was extracted while the patient was covered by the plan.
2. Replacement of an existing denture in one of the following circumstances:
   a. The replacement is necessitated by the extraction of additional natural teeth while covered under the plan; or
   b. The existing denture is at least three years old and cannot be made serviceable; or
   c. The existing denture is a temporary denture and is replaced by a permanent denture within 12 months from the date of installation of the temporary denture.
   d. The replacement of an existing denture is more than 12 months after the individual becomes covered.

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

Dental Care

Expenses Not Covered

1. Charges for any dental procedure included as a covered medical expense under any type of medical plan provided by your employer or government health insurance plan, 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, ordered while the individual was covered but that were finally installed or delivered to such individual more than thirty days after termination of coverage;
4. The replacement of a lost or stolen prosthetic device;
5. Personalization, duplication or characterization of dentures;
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 hereunder 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 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 considered a covered service of any provincial government plan at the time and subsequently were modified, suspended or discontinued;
18. Services or supplies 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 insurance or for which the member or dependant is not legally obligated to pay;

20. Any services 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. 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 which may not be covered by, or exceed the maximums under, the "Plan".

When you submit a claim either online or by mail, 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 personal HCSA on December 31, 2020 will revert back to the "Fund". Any balance remaining in your 2020 personal HCSA account on December 31, 2020 will be carried forward until December 31, 2021. If there is any money left in your 2020 personal 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 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

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

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.

FSEAP provides 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

At 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. Contact FSEAP and you will be assisted 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 these services and everything is confidential. Counsellors are required by law to maintain the strictest confidentiality. No one 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**

fseap Now we're talking.

General Plan Provisions

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 members' 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.

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 Sheet Metal Workers Local Union 30 Pension Plan; and
- You choose one of the options and pay the required monthly contributions 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.

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 official plan documents such as insurance contracts, and governing legislation such as 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, a copy of which is available from the Local Union Office, the Plan Administration Office or the plan website. 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 will 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.

General Plan Provisions

FRAUDULENT CLAIMS

The cost of 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, 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. Most health care providers can 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.

General Plan Provisions

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

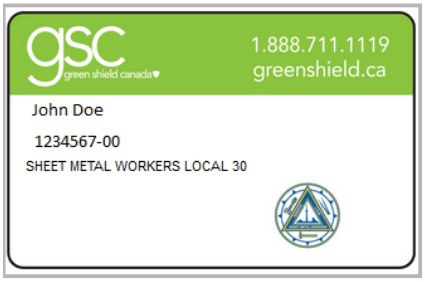
You may not commence legal action against Manulife (with respect to benefits underwritten by Manulife) less than sixty (60) days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against Manulife for the recovery of money payable under the plan is absolutely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

DENTAL CARE

Dental claims must be submitted electronically by your dentist for you and your eligible dependants.

PRESCRIBED DRUGS AND MEDICINES

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



MAJOR MEDICAL EXPENSES

Most health care providers (chiropractors, massage therapists, psychologist, physiotherapists, etc.) will also 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.

General Plan Provisions

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 be able to submit your Major Medical expenses yourself. 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 to the Pan 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 children may have duplicate coverage. You are covered by this plan as a member and your spouse and children are covered as your dependants.

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) has 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, file the unpaid amount with this plan. You will receive the 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.

General Plan Provisions

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.

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 our plan follow accepted industry standards that specify time limits for the filing of claims. If a claim is not filed on time, the insurer 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
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.

TAXABLE BENEFITS

At the time this booklet was written, the Income Tax Act, Canada ("ITA") provided that the premium and applicable retail sales tax paid by the "Fund" for Life Insurance are taxable income to you. If you have chosen Option A or Option B, there is no taxable benefit to you for the Life Insurance benefit, since the Trustees have directed that the contribution you make for either of these options will first be directed to the payment of your Life Insurance premium plus applicable retail sales tax. If you choose Option C, which provides Life Insurance only, you will be in receipt of a taxable benefit calculated as the amount the "Fund" paid for your

General Plan Provisions

Life Insurance premium plus applicable retail sales tax, minus the contribution you made for Option C. Those who subscribe to Option C will receive a T4A from the Plan Administration Office in about February of each year, representing the amount of your taxable benefit for the prior calendar year.

Life Insurance benefits are not taxable. Please note that all other benefits are not taxable. You will receive a statement annually for tax purposes, detailing total contribution paid less the premium paid for Life Insurance. You may be able to claim a deduction or tax credit on your income tax return.

The plan will conform to any future changes to the ITA that affect the tax status of benefits.

FUTURE CHANGES

This retired members' welfare plan 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.

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

Green Shield Travel Assistance Program
Group Number: 4932

Manulife
Group Policy Number: 901884

MEMBER ASSISTANCE PROGRAM

Family Services Employee Assistance Program (FSEAP) fseap Now we're talking.
Website: www.myfseap.ca
Group Name: tosmwiamap
Password: myfseap1

AUDITOR

HS & Partners LLP

WELFARE FUND INVESTMENT MANAGER

RBC Dominion Securities