

Sheet Metal Workers

Local Union 30

Active Members Welfare Plan

Active



APRIL 2009



SHEET METAL WORKERS LOCAL UNION 30

WELFARE PLAN FOR ACTIVE MEMBERS

Up to Date at April 1, 2009

**This Booklet contains important information
and should be kept in a safe place.**

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Actively Employed Members

Death Benefits:

- \$50,000 Group Term Life Insurance
- \$25,000 Accidental Death and Dismemberment
- \$900 Spouse, \$600 Child/Children Monthly Survivor Income Benefit
- \$2,000 Spouse, \$1,000 Child Dependant Life Insurance

Disability Income:

- \$445 per week, Weekly Income Benefit, 26 week Maximum Benefit, integrated with Employment Insurance, commencing on the first day of disability due to accident, eighth day due to illness.
- \$1,500 Monthly Income Benefit, Long Term Disability Plan, payable from the 27th week of continuous Total Disability to a maximum of Age 65.

Supplementary Health

- The Prescription Drug Plan pays 100% of the reasonable and customary charges for the ingredient cost of Generic Drugs, 70% of the reasonable and customary charges for the ingredient cost of Brand Name Drugs (100% if no Generic equivalent is available), and up to \$8.50 for the Professional Dispensing Fee with respect to Prescriptions issued by your attending Physician, provided that the prescription is for the treatment of illness or injury.
- The Vision Care Plan pays up to \$240 for you and each Dependant per 24 month period, for the initial purchase or replacement of prescription eye glasses or contact lenses.

- The Major Medical Plan pays 100% of the usual and customary charges for a broad range of ancillary medical expenses that are not covered by OHIP, provided that legislation does not prevent payment by this Plan. Included are charges for the services of a Registered Nurse out-of-hospital, Ambulance, Prosthetic Devices, Hearing Aids, Speech Therapy, and Hospital/Surgical/Medical Services received outside Ontario in the event of an emergency.

Dental Care

The Dental Care Plan provides a comprehensive range of Benefits, to a Total Annual Maximum Benefit of \$2,000 per person. The Plan also includes an Orthodontia Benefit which pays 75% of such expenses to a Maximum Annual Benefit of \$500 per person, within the \$2,000 Total Annual Maximum Benefit. Claims are paid on the basis of the 2007 Ontario Dental Association Suggested Fee Guide for General Practitioners.

EXTENDED BENEFIT PROGRAMME FOR MEMBERS UNEMPLOYED DUE TO DISABILITY OR SHORTAGE OF WORK

The Extended Benefit Programme provides all of the Benefits provided to Actively Employed Members, except the two Disability Income Benefits, described above.

Eligible Dependants' Coverage

Your Spouse and unmarried children under Age 22 are covered by the above-described Prescription Drug, Vision Care, Dental Care and Major Medical Plans, as well as the earlier-described Death Benefit for Dependants.

GENERAL INFORMATION

The Sheet Metal Workers Local Union 30 Welfare Trust Fund was established October 1, 1956 when the Members of Local Union 30 set aside 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 \$3.71 effective May 1, 2008, with a further increase of \$0.40 per hour scheduled for May 1, 2009. Today, the Sheet Metal Workers Local Union 30 Welfare Plan is among the finest in the Canadian Construction Industry. Of the current Contribution of \$3.71 per hour:

- \$3.3898 is deposited into your own Welfare Plan Dollar Bank Account until your Account reaches the permissible maximum balance (currently \$4,392). Any excess is held in the Welfare Fund's Unappropriated Reserve which is used to fund any shortfall that arises under the Welfare Plan.
- \$0.03 is deposited into the W.S.I.B. (Workplace Safety and Insurance Board) Reserve used to fund the Pension Plan's liability to credit Pension Contributions and Welfare Plan's liability to continue Welfare Plan Benefits, for up to one year, for Members who are in receipt of W.S.I.B. benefits.
- the balance of \$0.2902 is deposited into the Extended Benefit Reserve used to fund the cost of Welfare Benefits provided to non-working Members covered by the Extended Benefits Programme. These are formerly Active Plan Members who are not working due to layoff, disability or attendance at Apprenticeship School.

In addition, 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 Welfare Plan Benefit costs (currently 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 Welfare Trust Fund reserves. The Trustees of the Welfare Trust Fund continually monitor the ability of the Welfare Trust Fund to provide Benefits for persons who are not working since a widespread and long term downturn in the Industry results in sharply reduced Contributions (fewer persons are working) and an increase in Expenditure (more persons are on the Extended Benefit Programme or Retired Member Benefits).

It's 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.

All of the Benefits provided by the Welfare Plan are insured by Manulife Financial. With the exception of our Accidental Death and Dismemberment Plan and our Long Term Disability Income plan, the Premiums we pay for the Welfare Plan are based upon the claims submitted by our Members. The Insurer and the Administration Office co-operate to ensure that our Plan is paying only for claims that are necessary, as well as for claims that can be settled for the lowest cost.

Numerous studies have concluded that a Generic Drug is as good as its "Brand Name" equivalent. If you always ask your physician to prescribe the Generic Equivalent, then the cost of Prescription Drug Claims to this Welfare Plan may decrease by as much as 30%. In an effort to control Welfare Plan costs, the Prescription Drug Plan has been designed to encourage Members to avoid using Brand Name drugs when Generic equivalents are available, and to utilize pharmacies that charge lower dispensing fees than do some of the larger chain stores.

The same control is exercised in the Dental Care Plan, to ensure that the Plan pays for the least expensive, professionally-adequate, method of treatment. For example, if a partial denture is adequate in the circumstances, that is what the Plan will pay; if you prefer the more expensive Fixed

Bridge, then you will be required to pay the difference between the two treatment methods.

Finally, and as mentioned above, the Benefits of the Welfare Plan are provided through an Insurance Contract. In that Contract the Insurer is bound to pay the cost of Eligible Claims, provided that the Insurer has received Notice of Claim, and Proof of Claim, within the Time Limits specified in the Insurance Contract.

In this Booklet, these requirements will be spelled out for you. If you do not provide Notice and Proof as required in the Contract and as set out in this Booklet, the Insurer has the right to decline your Claim.

This Booklet is not a legal document and is only a guide. It is not an insurance policy or contract; it simply attempts to explain the Welfare Plan. All rights and benefits under the Welfare Plan are governed by the Insurance Contract issued by Manulife Financial, the Declaration of Trust, and applicable law. Any changes to the Plan will be communicated to the Plan Members and such changes are deemed to amend/modify this Booklet.

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 Dependents is protected through the implementation of the Plan's Privacy Policies and Practices document, a copy of which is available from the Local Union Office or the Plan's Administration Office. These Policies and Practices will be adhered to by the Plan's 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 Policies and Practices require 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 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 destroyed.

ELIGIBILITY

Active Plan Members

The Welfare Plan covers three categories of Plan Members, namely:

- Active Plan Members
- Extended Benefit Programme Members
- Retired Members

Each category has its own Eligibility Rules, as set out below: An "Active Plan Member" is a Journeyman or Apprentice of Local Union 30, who is employed by an Employer bound to a Collective Agreement requiring Contributions to the Sheet Metal Workers Local Union 30 Welfare Trust Fund. That Collective Agreement specifies the Hourly Contribution Rate, which varies from time to time as approved by the Membership of Local Union 30. At the time this Booklet was written, the Hourly Rate was \$3.71. How this Contribution is allocated is set out in the "General Information" section of this Booklet.

By the 20th of each calendar month, every Contributing Employer is required to send a Contribution Report to the Administration Office, listing thereon the names of every Plan Member employed by that Employer in the previous calendar month, and showing the number of hours worked in that month. When the Administration Office receives that Contribution Report, the Contributions received on behalf of each Plan Member are placed in that Plan Member's Dollar Bank Account. The Plan Member and Eligible Dependants are covered by the Welfare Plan in accordance with the Eligibility Rules then in effect.

As noted earlier in this Booklet, 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; but generally speaking, Initial Eligibility and

Reinstatement will be equal to approximately 220 contributory hours of work, and for each month you are covered by the Welfare Plan your Dollar Bank Account 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 Account, up to a Maximum Dollar Bank Account equal to 12 months' coverage.

The following Eligibility Rules are those in effect at April 1, 2009:

Initial Eligibility - the first day of the calendar month first following the day on which your Earned Contributions were at least \$732.00.

Monthly Deduction - for each month you are covered by the Welfare Plan, \$366.00 will be deducted from your Dollar Bank Account.

Termination - your Insurance is terminated at the end of the calendar month in which your Dollar Bank Account is less than \$366.00.

Reinstatement - If you were covered by the Plan, and then terminated, you can regain Coverage by fulfilling the requirements set out above, for Initial Eligibility. The Dollar Bank Account 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 Account is erased.

Maximum Dollar Bank Account - Your excess Hourly Contributions accumulate in your own Account up to \$4,392.00 which, at the time this Booklet was written, is the equivalent of 12 months' coverage.

Extended Benefit Programme Members

The Extended Benefit Programme is funded by the Active Members. A part of your hourly Contribution provides Benefits to persons who were previously Active Members, and whose

Dollar Bank Accounts 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 Account is insufficient for a further month's coverage, the Administration Office will notify you by registered mail. If you receive such a notice, you may apply to the Office of Sheet Metal Workers Local Union 30 to transfer to the Extended Benefit Programme. In order to qualify, you must be and remain a Member in Good Standing, Local Union 30, and be actively seeking work through the Local Union 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.

At present, there is no maximum period of time during which you can be covered by the Extended Benefit Programme if you are unemployed due to shortage of work; if you are unemployed due to disability, you may remain on the Extended Benefit Programme for a maximum of twelve consecutive months. These rules are subject to change in the future.

Retired Members

Persons who are, and remain, Members 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 60 months (in total, and not necessarily consecutively) by the Welfare Plan (as an Active Member and/or Extended Benefit Programme Member) in the 120 months immediately preceding the effective date of your Pension.

The Retired Members' Welfare Plan is partly funded by Active Members, who have allocated a part of their Hourly Contribution to ensure that Retired Members continue to enjoy Benefits. The balance is paid by subscribing Retired Members.

The Welfare Plan for Retired Members is described in a separate Booklet.

Eligible Dependants

These include your Spouse, and your unmarried children under Age 22 who are dependent on you and/or your Spouse for their support. These 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 the Plan Information Card and filed with the Administration Office. If the Administration Office receives a Claim for an unlisted Dependant, you will be contacted and asked to provide written confirmation that the person is your Dependant. Payment of the Claim will be withheld until that confirmation is received by the Administration Office.

“Spouse”, as used above, means that 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” means your unmarried biological children, stepchildren, and legally adopted children who are under Age 22, and who are unemployed such that they would normally look to you and/or your Spouse for their support. Such children of a person who qualifies as your Spouse under the above three year co-habitation rule will be covered by the Plan on the date your Spouse qualifies.

Information Card

Please obtain an Information Card from the Administration Office or the Office of Local Union 30. The Information Card is to be fully completed **in ink** signed and dated by you, and forwarded to the Administration Office. As noted earlier, Claims for your Dependants will not be paid unless your Information Card, or a subsequent written notification, records these persons as your Dependants.

In addition to identifying you and your Dependants to the Administration Office, completing the 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 an Information Card, or otherwise failed to name a Beneficiary on your Card, then the Life Insurance Benefit will automatically be paid to your Estate. You would be well advised to remember that your Estate may be required to pay Probate Fees on the Benefit, which may not be payable if your Estate is not the Beneficiary.

DEATH BENEFIT PLANS

GROUP TERM LIFE INSURANCE

Active Members Only

If you die while insured under this Plan, \$50,000* will be paid to your Beneficiary regardless of the cause, time or place of your death. Your Beneficiary may be any person, religious or charitable institution you wish to appoint, or you may designate that the money be paid to your Estate.

* 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.

Waiver of Premium Benefit

If, while insured, you become totally disabled for at least 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, 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 reduces to \$10,000 at Age 65. If you were disabled prior to October 1, 2003, your Life Insurance 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 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. Please see the Section "How To Claim Benefits" for further information.

Conversion Privilege

If your eligibility for any amount of Group Term Life Insurance terminates, your coverage will remain in force for 31 days. During this time you may replace the coverage with an individual policy up to the same amount. Medical evidence of good health is not necessary if you apply and pay the required Premium within this 31 day period. You must apply directly to the Insurance Company. Conversion is not available after you reach Age 66, nor if you are covered for a smaller amount of Life Insurance such as the \$10,000 Benefit for Retired Plan Members.

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 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 cancelled when you reach Age 65.

It is solely your responsibility to apply for Waiver of Premium by making prompt application to the Insurance Company. Please see the Section "How To Claim Benefits" for further information.

Conversion Privilege

When your eligibility through our Plan terminates, your coverage will remain in force for 31 days. During this time you may replace your Spouse's coverage with an individual policy up to the same amount without medical evidence, by applying directly to the Insurance Company and paying the required Premium. Conversion is not available after you or your Spouse reach Age 66.

ACCIDENTAL DEATH AND DISMEMBERMENT (A.D.&D.)

If, because of an accident while insured, any of the following losses are suffered within 365 days of that accident, the Principal Sum of \$25,000 (or a percentage of it) will be paid. In the event of multiple injuries to the same limb, only one benefit (the highest) will be paid. This Benefit is in addition to any other Benefits payable under your Welfare Plan.

For the Loss of:	Percentage of the Principal Sum
Life	100%
Entire Sight of One Eye	66 2/3%
Speech	66 2/3%
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%

For the Loss or Loss of Use of: Percentage of the Principal Sum

One Arm	75%
One Leg	75%
One Hand	66 2/3%
One Foot	66 2/3%
Thumb & Index Finger or at Least Four Fingers of One Hand	33 1/3%

For Total Paralysis of:	Percentage of the Principal Sum
Both Upper and Lower Limbs (Quadriplegia)	200%
Both Lower Limbs (Paraplegia)	200%
Upper and Lower Limbs of One Side of Body (Hemiplegia)	200%

"Loss" as used above with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and finger means the complete severance at or above the metacarpophalangeal joint; as used with reference to toe means the complete severance at or above the metatarsophalangeal joint; and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as used above with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing.

"Loss" as used above with reference to quadriplegia, paraplegia and hemiplegia means the complete and irreversible paralysis of such limbs.

"Loss" as used above with reference to loss of use means the total and irrecoverable loss of use provided the loss is continuous for twelve consecutive months and such loss of use is determined to be permanent at the end of the period.

Aggregate Limit - \$5,000,000 per accident for all individuals insured under this Plan.

Indemnity provided under this section for all losses sustained by any one insured individual as the result of one accident shall not exceed the following:

(a) The Principal Sum for all losses except quadriplegia, paraplegia and hemiplegia.

(b) Two Times the Principal Sum, or the Principal Sum if Loss of Life occurs within 90 days after the date of the accident with respect to quadriplegia, paraplegia and hemiplegia.

Waiver of Premium Benefit

If while insured for this coverage, you become disabled and qualify for the Waiver of Premium Benefit under your Life Insurance coverage, the Insurer will also waive the payment of your Accidental Death and Dismemberment Insurance Premiums.

Your entitlement to Waiver of Premium Benefit ceases on the earlier of (a) the date your Waiver of Premium for Life Insurance ceases, (b) the date you attain age 65 or (c) the date the Policy or this coverage terminates.

Additional Benefits:

Aircraft Coverage

Coverage is provided while riding as a passenger but not as a Pilot or member of the Crew.

Exposure and Disappearance

Loss due to unavoidable exposure to the elements is covered. Loss of life resulting from bodily injury caused by an accident at the time of disappearance, due to sinking or wrecking of a conveyance in which for Member was riding at the time of the accident is covered.

Repatriation Benefit

The Insurer will pay the reasonable and customary expenses incurred for the transportation of your body to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to your normal place of residence, subject to a maximum of \$10,000.

Occupational Training Benefit

In the event of your accidental death, the Insurer will pay to your Spouse the reasonable and customary expenses incurred within three years following the date of the accident if he/she engages in a formal occupation training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, subject to a maximum of \$10,000.

Rehabilitation Benefit

In the event of an accidental injury which results in a Loss payable and such injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, the Insurer will pay the reasonable and customary expenses incurred for such training subject to a maximum of \$10,000 for any one accident.

Family Transportation Benefit

In the event of an accidental injury and confinement, for a period of at least four days, in a hospital located more than 150 kilometres from your normal place of residence, the Insurer will pay the reasonable expenses incurred by all members of your immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to the hospital, subject to a maximum of \$1,000. "Immediate family" means a person at least eighteen years of age who is your spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

Seat Belt Benefit

In the event you sustain an accidental injury payable under this Benefit, the amount of Principal Sum will be increased by 10%, if, at the time of the accident, you were:

1. wearing a properly fastened seat belt; and
2. driving or riding in a vehicle driven by a driver who was neither intoxicated nor under the influence of drugs, unless taken as prescribed by a Physician, at the time of the accident. Intoxication and being under the influence of drugs are as defined by the local jurisdiction where the accident occurred.

Hospital Indemnity

A daily Benefit (1/30th of 1% of your Principal Sum, maximum of \$2,500 per month) will be payable if you are confined in a hospital for at least 5 days and under the care of a physician for an accidental injury payable under this Benefit, subject to a maximum of 365 days per injury.

Education Benefit

In the event of your accidental death, the Insurer will pay the Education Benefit stated below for each of your dependent children who are enrolled as full-time students in an institution for higher learning within 365 days following the date of your death.

The Education Benefit is equal to the reasonable and customary expenses actually incurred subject to the lesser of 5% of your Principal Sum or \$5,000, for each year the dependent child described above continues his/her education on a full-time basis in an institution for higher learning, but not to exceed 4 years, which must run consecutively, with respect to any one dependent child.

"Institution for higher learning" includes any university, college, or trade school.

Exclusions

This Benefit is not payable for any Loss caused or contributed to by:

1. suicide, or any attempt thereat, while sane or insane;
2. declared or undeclared war, or any act thereof;
3. service in the armed forces of any country;
4. acting as an aircraft pilot or crew member; riding in an aircraft that does not have a current airworthiness certificate; or piloted by a person without a valid pilot's licence, or riding in, boarding or leaving or descending from any aircraft owned or leased by the Board of Trustees;
5. intentionally self-inflicted injuries;
6. committing, attempting or provoking an assault or criminal offence;
7. an accident which occurs while the insured individual is operating a motor vehicle or any other form of motorized transportation and the blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%).

SURVIVOR INCOME BENEFIT (S.I.B.)

This Benefit applies to Members in the following classes:

CLASS I - All Members with a Spouse, including those who are separated, regardless of whether there are dependent children.

CLASS II - All other Members, including those who are single, divorced or widowed, who have dependent children.

Dependent children are those who are your own biological children, step-children and legally adopted children, who are unmarried and under the age of 22.

If you are without Dependents and your status changes to one of the above classes you are automatically covered by this Plan unless you are disabled on the date your status changes. In this case, coverage is postponed until your disability ceases.

The Benefit payable under the Survivor Income Benefit Plan will depend upon whether you are covered under Class I or Class II above. The Benefits are as follows:

Class I Benefit

Spouse's Benefit

Provided you named your Spouse as the "beneficiary of the Spouse's Benefit" on your Information Card, a monthly Benefit of \$900 is paid to her/him until Age 65. The monthly Benefit ceases, however, if she/he should die or remarry before Age 65. This Benefit is not commutable - that is, the method of payment cannot be changed by your Spouse.

You may not wish to name your Spouse for this Benefit. You may name another person or your Estate to receive this Benefit, but it must be understood that in such circumstances, an equivalent Benefit, as calculated by the Insurance Company, will be paid in a lump sum to the named Beneficiary. If you require more information please contact the Administration Office.

Children's Benefit

This Benefit is payable in addition to the Spouse's Benefit above, if you have a Spouse. Upon your death if you have a dependent child or children, the Policy provides that a total Benefit of \$600 a month will be paid. The Benefit ceases when there are no surviving unmarried children under the age of 22.

Class II Benefit

Orphan's Benefit

Upon your death, if you have a dependent child or children, the Policy provides that a total Benefit of \$600 a month will be

paid. The Benefit ceases when there are no surviving unmarried children under the age of 22.

Waiver of Premium

If you become totally disabled for at least 6 consecutive months before Age 65, your Survivor Income Benefit will continue in force without further Premiums as long as you remain so disabled. This Benefit is cancelled when you reach Age 65. Evidence of such disability must be provided at least once each year.

Conversion Privilege

When your eligibility through this Plan terminates, you have the privilege of converting to an individual policy without medical evidence. The maximum amount that may be converted is the lump sum actuarial equivalent value of your Survivor Income Benefit. You must apply for this conversion, and pay the required Premium, within 31 days of the date on which you cease to be eligible.

Please note that no conversion privilege is available when you cease to be insured for the Spouse's or Children's Benefits by reason of reverting to single status, if the Plan terminates the Survivor Income Benefit, if you cease to be an eligible Member of the Plan, if you cease to have eligible dependent children, or after you reach Age 66.

WEEKLY INCOME BENEFIT / Active Plan Members Only

In the event that, while insured, you become Totally Disabled due to an illness or accident that is not covered by Workers' Compensation, this Plan will pay a Weekly Income Benefit commencing with the first day of Total Disability due to accident, or the eighth day of Total Disability due to illness. There are three important Rules affecting this Benefit:

1. As noted, Benefits begin on the first day or eighth day of Total Disability (accident or illness, respectively), 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 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 (M.D.). 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.

At the time this Booklet was written, the amount of gross Weekly Income Benefit was \$445, or \$63.57 per calendar day. The Board of Trustees may adjust the amount of Weekly Income Benefit from time to time, as circumstances permit or require. In the event of an increase or decrease in the Weekly Income Benefit, the change will apply only to disabilities that commence on or after the effective date of the change. Benefits received are considered to be taxable income in the year received.

Employment Insurance Integration

Your Plan's Weekly Income Benefit is coordinated with Human Resources and Social Development Canada (HRSDC) Employment Insurance Sickness Benefit. If you are unable to work due to disability, you should immediately file a claim for the Plan's Weekly Income Benefit as well as for Employment Insurance (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 your Plan's Weekly Income Benefit - if you do you may miss the filing deadline, in which case Weekly Income Benefits will not be paid.

Your Plan will pay Benefits during the EI waiting period. This is currently two calendar weeks. EI will pay benefits for a maximum of 15 weeks. If you are still disabled after EI benefits are exhausted, your Plan will continue payments to you if you provide your Plan medical statements which 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 have worked insufficient hours to qualify for EI benefits, your Plan's Weekly Income Benefit will continue after the two week waiting period if you provide your Plan 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), your Plan will not pay Weekly Income Benefits during the 15 week period EI would normally have paid full benefits.

EI's current maximum weekly benefit is \$447.00.

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 Weekly Income Benefit is 26 weeks including any weeks paid by EI. Example - The Welfare Plan will pay the first 2 weeks, EI will pay (if you are eligible) the next 15 weeks and the Welfare Plan will pay (if you are eligible) the remaining 9 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:

- a) you are not under the regular care of a Physician;
- b) the disability is covered by Worker's Compensation (W.S.I.B.);
- c) the disability is due to intentionally self-inflicted injuries, while sane or insane;
- d) the disability arises from your voluntary participation in a war, riot or insurrection;
- e) that portion of a disability period during which you are imprisoned in a penal institution or confined in a hospital or similar institution as result of criminal proceedings;
- f) the illness or injury was caused or contributed to by a motor vehicle accident;
- g) any period of disability, or portion thereof, during any leave of absence (including maternity leave).

The Weekly Income 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 that are recovered through a legally enforceable cause of action against a third party for income lost as a result of the disability.

Weekly Income Benefits on account of any one period of Total Disability are payable for a maximum of 26 weeks. In the event that you are in receipt of a Benefit, recover for at least one day and are again disabled due to a wholly different cause, you are entitled to another 26 weeks of Weekly Income Benefit assuming, of course, that you are still insured at the time of the onset of the subsequent disability. In the event that, while you are receiving a Weekly Income Benefit, you recover and within two weeks are again disabled due (essentially) to the same cause, you are entitled to receive 26 weeks' Benefit minus the number of weeks of Weekly Income Benefit already paid for that disability, again assuming that you are still insured at the time of the relapse.

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 Plan 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 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.

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.

LONG TERM DISABILITY BENEFIT / Active Plan Members Only

To qualify for Long Term Disability Benefits you must be continuously and totally disabled during the Waiting Period. The term "Waiting Period" means 26 weeks. After this, the Long Term Disability Benefit will be paid as long as you are Totally Disabled. Benefits cease at age 65. Benefits received are considered to be taxable income in the year received.

Definition of Total Disability

During the Waiting Period and the immediately following two 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, 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 Monthly Income Benefit payable under this Plan is \$1,500. This amount will be reduced by any income you may receive from Workers' Compensation or similar legislation. For instance, if Workers' Compensation paid you \$600 a month, you would get \$900 from this Plan. Your Monthly Income Benefit may be further reduced if you receive disability income from any other group plan (except the Canada Pension Plan and our Sheet Metal Workers Local Union 30 Pension Plan). If the total benefits from other group plans together with Benefits from the Long Term Disability Plan, add up to more than 75% of your predisability before-tax earnings, the Benefit from this 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 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.

Note: Income from this Long Term Disability Plan is not offset by disability benefits from the Canada Pension Plan and our Sheet Metal Workers Local Union 30 Pension Plan.

Rehabilitation Provisions

This part of the 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 this Plan less 80% of the income you get from the job.

For example, let us suppose that you were receiving the full \$1,500 Monthly Long Term Disability 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 Provisions of the Plan you would receive:

Regular Monthly Long Term Disability Benefit	\$1,500
Less 80% of \$320 (earned income)	\$256
Adjusted Monthly Long Term Disability Benefit	\$1,244

When added to your job income of \$320, you would be receiving a total monthly income of \$1,564.

The Benefits under this 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 Weekly Income Plan) or immediately following a period of Total Disability. The Benefits under this provision will not be paid for longer than two years for any one disability.

Recurring Disability

In the event that you have been in receipt of a Benefit from the Long Term Disability Plan, and you recover only to become disabled again due to the same or related cause, within 6 months after you return to active work, you are immediately entitled to receive Long Term Disability 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 reestablished your Eligibility, upon your recurrent disability you would first be entitled to receive Weekly Income Benefits followed by Long Term Disability Benefits.

Limitations and Exclusions

Benefits under the Long Term Disability Plan will not be paid for any of the following:

1. 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;
2. 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;
3. 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;
4. disabilities resulting from intentionally self-inflicted injuries or attempted suicide;
5. any portion of the disability where you are working in any capacity, except under the terms of the "Rehabilitation Provisions" set out on page 27;

6. disabilities resulting from participation in a war, riot, insurrection or criminal act;
7. 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;
8. any period of disability, or portion thereof, during any leave of absence (including maternity leave);
9. 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;
10. if you refuse to complete and return a Reimbursement Agreement, when requested by the Insurer in connection with Third Party Liability;
11. an illness or injury caused, or contributed to, by a motor vehicle accident.

Subrogation

The Insurer's rights of subrogation, described in the Weekly Income Benefit section, apply equally to the Long Term Disability Benefit.

Dental Care Plan

This Plan will help pay the cost of dental care for you and your covered Dependants. The amount that will be paid for services is based on a Fee Schedule selected by the Board of Trustees and which may be changed from time to time as circumstances permit. At the time this Booklet was written, the Dental Plan paid Claims on the basis of the 2007 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 (if any) that you will have to pay, a special procedure applies to dental services where the dentist's fee will exceed \$500. The Dental Care Claim Form (see section on "How to Claim Benefits") gives complete details.

The Plan covers most of the usual dental procedures which may be required. The "Dental Care Schedule" included in this section lists the forms of treatment which are eligible expenses under this Plan and those which are not.

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.

There is a 75% co-insurance factor for certain services. This means that the Plan pays three-quarters of the fee in the Fee Guide for those services and you pay the balance of your dentist's bill.

Maximum Benefit

There is a Total Annual Maximum Benefit for each covered person of \$2,000. Of this amount \$500 may be applied towards Orthodontia.

Expenses Covered at 100%

The following Expenses will be paid at 100% of the Fee Guide:

1. Oral examinations, including scaling and cleaning of teeth, but not more than one examination in any period of six consecutive months; complete oral exam and diagnosis once every 24 months;
2. Topical applications of sodium or stannous fluoride, but only if the insured Dependant has not yet attained the age of 15 years;
3. Dental x-rays; complete series or equivalent once every 24 months;
4. Bitewing films, once every 6 months;
5. Oral surgery, including excision of impacted teeth;
6. Fillings and extractions;
7. Anaesthetics 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;
9. Endodontic treatment including root canal therapy;
10. Initial installation (including adjustments during the six month period following installation) of partial or full removable dentures to replace one or more natural teeth extracted while insured under the Plan;

11. 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 Insurer is presented that:

- (i) the replacement or addition of teeth is required to replace at least one natural tooth extracted while insured under the Plan; or
- (ii) the existing denture or bridgework was installed at least five years prior to its replacement and that the existing denture or bridgework cannot be made serviceable; or
- (iii) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within 12 months from the date of installation of the immediate temporary denture;
- (iv) the replacement of the existing denture is more than 12 months after the individual became insured.

12. Space maintainers for dependent children only;

13. Repair or re-cementing of crowns, inlays, bridgework or dentures or relining of dentures;

14. Injections of antibiotic drugs by the attending dentist;

15. Study Casts one per year;

16. Consultations;

17. Replacing of the facing or veneer of bridgework.

Expenses Covered at 75%

Seventy-five percent of the Fee, in the approved Fee Guide, for the following covered expenses will be paid:

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 or more natural teeth extracted while insured under the Plan;

NOTE: When you submit a Predetermination or Claim for this Benefit, you must submit x-rays taken before the treatment was started.

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 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, and your Claim will be paid at the rate of \$62.50 each month, which is 75% of \$2,000 divided by 24, up to a maximum of \$500 each year, provided you 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 which 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 insured under the Plan;
3. Prosthetic devices (including bridges and crowns) and the fitting thereof, which were ordered while the individual was insured but which 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 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 an insured service of any provincial government plan at the time this Policy/Benefit 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 which 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 which are covered by any government plan or program; or for which no charge is made; or which the Insurer is not permitted by law to cover.

SUPPLEMENTARY HEALTH PLANS

Major Medical Plan

This plan will pay 100% of reasonable and customary charges for you and your covered Dependents for the following expenses, with no maximum benefit, unless stated below.

1. Charges for the **services of a Registered Nurse (R.N.)** or Registered Nursing Assistant (R.N.A.) at the insured individual's residence, provided the R.N. or R.N.A. is not normally resident in the insured person's home, or in a public general hospital, always provided that such services are necessary in the opinion of the attending Physician. Maximum - \$10,000 within any three consecutive years;
2. 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;
3. **Ambulance:** charges for licensed ambulance service or other emergency service (including fare of a medical attendant where necessary) when used to transport the insured 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 hospital to the insured person's residence;
4. **Services & Supplies:** charges for the following services and supplies:
 - a) 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;
 - b) rental of, or at the Insurer's option, the purchase of a **wheelchair, hospital-type bed** or other durable equipment for temporary therapeutic use;
 - c) Oxygen and blood serum;

- d) One pair of custom made **orthotics or orthopaedic 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.
5. **Diagnostic X-Ray and Laboratory Expenses:** charges for diagnostic tests and radiological treatments including xrays and laboratory tests and radium treatments;
 6. **Physiotherapy:** charges for the services of a qualified Physiotherapist, who is not normally resident in the insured person's home, provided the treatment is recommended and approved by your attending Physician;
 7. **Speech Therapy:** charges for the services of a qualified Speech Therapist, up to a maximum payment of \$200 per calendar year for each insured person;
 8. **Hearing Aids:** charges for hearing aids prescribed by a legally licensed Otolaryngologist, up to a maximum payment of \$400 for one instrument per insured person in any four consecutive years;
 9. **Convalescent Hospital:** The fee charged by a chronic care hospital/unit or convalescent hospital, over and above the allowance made by OHIP, for convalescent, chronic or custodial care;
 10. **Chiropractic Services:** charges for the services of a qualified Chiropractor, but no amount is payable by this Plan for any service for which OHIP makes any payment;
 11. **Massage Therapist:** charges for the services of a qualified Registered Massage Therapist, provided that these services, including the frequency of treatment, are recommended by your attending Physician;
 12. **Podiatrist:** charges for the services of a qualified Podiatrist;
 13. **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 12 months of the accident.
 14. **Diabetic Preparations and Supplies;**
 15. **Outside Canada Expenses:** If, while traveling, vacationing or temporarily residing outside Canada, hospitalization or medical treatment is required due to emergency and nonelective reasons, the following expenses in excess of any provincial government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by a provincial medical plan:
 - a) reasonable and customary charges for ward accommodation
 - b) reasonable and customary charges for the services of a Physician;
 - c) reasonable and customary charges for hospital services and supplies furnished during hospitalization;
 - d) reasonable and customary charges for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

If you are referred by a Physician to a hospital outside Canada for medically necessary treatment which is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada, and which is eligible for reimbursement in whole or in part by any provincial medical plan, the expenses listed above in excess of any provincial government plan allowance are covered.

Out of Province Expenses - Inside Canada: If, while travelling outside your province of residence but inside Canada, hospitalization or medical treatment is required due to emergency and nonelective reasons, the following expenses in excess of any government plan allowance are covered, provided they are eligible for reimbursement in part by a provincial medical plan:

- 1) reasonable and customary charges for ward accommodation;
- 2) reasonable and customary charges for the services of a Physician;
- 3) reasonable and customary charges for hospital services and supplies furnished during hospitalization;
- 4) reasonable and customary charges for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

If you are referred by a Physician to a hospital outside the insured's province of residence but inside Canada for medically necessary treatment which is unavailable in the insured's province of residence and for which there is no medically sufficient alternate treatment available in the insured's province of residence, and which is eligible for reimbursement in whole or in part by a provincial medical plan, the charges listed above in excess of any government plan allowance are covered.

Planning a trip? If you are outside Ontario and a sudden illness or accident occurs, often the hospital or medical doctor will want to be assured that their bill is going to be paid either by you "on the spot" or by your Insurance. You would be well advised to contact the Administration Office, at least two weeks before your departure, and request a letter confirming that you, and your Dependents listed with the Administration Office, are insured by this particular Benefit.

If you are actively employed with a Contributing Employer, the Administration Office will confirm in that letter the date to which your Insurance is in effect, based upon your own Welfare

Plan Dollar Bank Account. If you are on the Extended Benefit Programme, the Administration Office can only confirm that Insurance is in effect for the current month, since remaining on the Extended Benefit Programme is month-to-month.

Prescription Drug Plan/Vision Care Plan

Limitations and Exclusions

No Benefit will be paid if legislation prevents such payment. Benefits will be reduced by amounts paid, or which would be paid if you were covered, by government plans such as OHIP. Expenses related to motor vehicle accidents are not covered by the Plan.

Prescription Drug Plan

This Plan covers the cost of drugs or medicines prescribed by your Physician or Dentist for you and your eligible Dependents. The maximum reimbursement for the Pharmacist's Professional Dispensing Fee is \$8.50. There is full reimbursement for the Pharmacist's Professional Dispensing Fee for compounds prepared by the Pharmacist.

This Plan will pay 100% of the Ingredient Cost of a Generic Drug and 70% of the Ingredient Cost of a Brand Name Drug. 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 treatments are covered to a lifetime maximum of \$2,500. Smoking cessation products are covered up to lifetime maximum of \$250 (in Drug form only).

No Benefit will be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

Vision Care Plan

Expenses for eye examinations are limited to a maximum Benefit of \$50 per person between 20 to 64 years of age inclusive in any period of 24 consecutive months.

Your Plan provides a Benefit to help pay for the cost of eyeglasses (frames, lenses and fitting of prescription glasses), as well as contact lenses. Repairs to frames are not covered.

The Benefit is limited to \$240 per person in any 24 consecutive month period for eyeglasses or contact lenses. The contact lenses must achieve visual acuity of at least 20/40 level.

Expenses Not Covered

1. Charges which are considered an insured service or supply of any Provincial Government Plan;
2. Charges which are not medically necessary to the care and treatment of any existing or suspected illness, injury or pregnancy;
3. Charges for surgical procedures or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedures or treatment;
4. Charges for services or supplies which are provided without the recommendation and approval of a Physician acting within the scope of his license;
5. Charges for services or supplies resulting from any intentionally self-inflicted injury;
6. Charges for drugs or supplies which are not approved by Health and Welfare Canada or are experimental in nature or limited in use whether or not so approved. Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
7. 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;
8. Charges not listed as an eligible expense in this Booklet;
9. Charges which the Insurer is not permitted, by any law or regulation, to cover;
10. Expenses related to motor vehicle accidents;
11. Charges which were considered an insured service of any provincial government plan at the time this Policy/Benefit was issued and subsequently were modified, suspended or discontinued;
12. Charges for general health examinations, and examinations required for use of a third party;
13. Charges for medical treatment or surgical procedures by a Physician other than as specifically provided under outside Canada or out of Province expenses;
14. Charges that result from an occupational injury or disease covered by any Workers' Compensation law or similar legislation;
15. Charges which would not normally have occurred but for the presence of this Insurance or similar legislation for which you or your Dependant are not legally obligated to pay;
16. Charges for Dental work where a third party is responsible for payment of such charges;
17. 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.

Ontario Health Insurance Plan (OHIP)

OHIP is a combined medical and hospital insurance plan which will help pay for practically all Physicians' services that are required by you and your eligible dependants. OHIP also covers 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, however, persons with incomes under \$20,000 per annum are exempt.

Medical Services

These include Doctors' services in the home, his office or the hospital for medical care, surgery, anaesthetics, 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 the first \$12.20 charged 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, 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 24 hours of an accident.
- follow-up treatment for fractures initially treated in hospital within 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.

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

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

http://www.health.gov.on.ca/english/public/program/ohip/ohip_mn.html

UNEMPLOYED AND APPRENTICE MEMBERS

Benefits for Unemployed Members

As outlined earlier in this Booklet, you are covered by the Benefits of the Welfare Plan provided that 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 Programme, or on a Pay Direct Basis.

It would be important to note that maintenance of Benefits, either on the Extended Benefit Programme or Pay Direct, is not available to Retired Members nor 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 Welfare 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 Administration Office will send a Notice by registered mail to your home address as shown on the Trust Fund's records, advising you of the Termination Date of your Benefits unless you take one of the following steps:

Extended Benefit Programme

You may continue all of the Benefits of the Welfare Plan, except the Weekly Income and Long Term Disability Plans, provided that you immediately contact the Local Union 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, the Local Union Office will place your name on a special Report to the Administration Office, and you will remain covered by the Welfare Plan until such time as the Local Union no longer considers you eligible, which would include a return to work, retirement or termination of your association with Local Union 30.

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 Programme, but there is a maximum of twelve consecutive months for any one period of continuous disability.

Since the cost of this Programme is paid by the Trust Fund - that is, the contributions made by Contributing Employers on account of actively employed Members/Apprentices - the continuation of this Programme is contingent upon the ability of the Trust Fund to pay the cost. The Trustees have the cost of this Programme under continual review, and it may be terminated, or you may have to pay all or a part of the cost at some time in the future, if circumstances warrant such action.

Pay Direct Privileges

You may continue all of the Benefits of the Welfare Plan, except the Weekly Income and Long Term Disability Plans, for up to three months on a Pay Direct Basis.

The registered mail Notice that you receive from the Administration Office will extend this option to you, on the basis of you paying the cost as described in the Notice.

The Notice is clear with respect to your options - but it must be emphasized that time is of the essence, and you must make the required payment by the Due Date contained in the Notice, or your Insurance will be cancelled.

Benefits for Apprentice Members

While you are working with a Contributing Employer, you are covered by all of the Benefits set out in this Booklet for Active Plan Members 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 Account 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 put your name on a Special List that Local Union 30 gives to the Administration Office. Under this arrangement, full Active Member Benefits will continue while you are in Apprenticeship School and your Dollar Bank Account balance will be frozen during that period, so that it will remain to your credit when you return to active work. **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 Extend Benefit Programme.

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 Welfare Trust Fund, and the Trustees necessarily reserve the right to terminate or suspend this feature or otherwise to 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 this Trust Fund keep all of your Benefits in force while you are disabled for a maximum period of 12 months following the date of a work related disability for which you are in receipt of Workers' Compensation.

The Trustees have asked each Contributing Employer to notify the 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 Administration Office is aware of your work-related Disability, you should contact the Administration Office directly.

Benefits for Retired Members

Upon your retirement, you will continue to be covered by all of the Benefits of the Welfare Plan, except the Weekly Income and Long Term Disability Income Plans, until your Dollar Bank is less than the amount required to pay the next month's Benefits Cost. At that point, you will be covered by 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 120 months immediately prior to your retirement, you were covered by the Sheet Metal Workers Local Union 30 Welfare Plan as an Active Member or on the Extended Benefit Programme for at least 60 months; and
- You are receiving a Pension each month 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.

The Retired Members' Benefits are described in a separate Booklet.

General Provisions

All of the information in this Booklet is current at April 1, 2009, 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.

The following information is an important part of the Welfare Plan:

Fraudulent Claims

The cost to our Welfare Plan is determined by the claims that are paid. The Administration Office reviews every claim before it is paid, and will frequently ask for 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 Claim Benefits

All claims, except those covered by OHIP, must be reported to the Administration Office as soon as possible. Do not wait until you return to work to file your claim.

Claims are to be sent to the Administration Office:

**Employee Benefit Plan Services Limited
45 McIntosh Drive
Markham, Ontario L3R 8C7
Telephone: (905) 946-9700
Toll Free: 1-800-263-3564
Fax: (905) 946-2535**

Claim forms may be obtained from the Administration Office, the Union office, or the Plan website: www.lu30plan.com

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

Please follow these timelines:

Waiver of Premium for Life Insurance, Dependent Life Insurance, Accidental Death and Dismemberment and Survivor Income Benefit (SIB) Plans

As set out earlier in this Booklet, if you become Totally Disabled prior to your Age 65, you may be entitled to remain covered by your Life Insurance until you reach age 65 and at a reduced level thereafter and to Accidental Death and Dismemberment, Dependent Life Insurance and SIB 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 12 months of the onset of your disability. The Insurer will notify you whether your disability qualifies for Waiver.

It is absolutely essential that you contact the Administration Office to apply for Waiver within the prescribed time; otherwise, the Insurer has the right to decline your Claim for Waiver.

Weekly Income

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 Employment Insurance Sickness Benefit and obtain a Claim Form from the Administration Office, Local Union 30 Office, or the Plan website: www.lu30plan.com. Finally, have the Claim Form completed by your attending Physician and promptly mail it to the Administration Office.

If you are claiming Weekly Income Benefits, you are required to have your attending Physician complete a part of the Claim Form before 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) Plan

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 6 months - be sure to contact the Administration Office without delay. Usually, the Administration Office will be aware of your disability (since you have been receiving Weekly Income Benefits), but it may be that the Administration Office is unaware of your disability if, for example, you have been receiving W.S.I.B. benefits. Since the Insurer must be promptly notified of any liability under the LTD Plan, please contact the Administration Office, in writing, **within six months of the onset of disability**, so that proper Notice can be filed with the Insurer by the Administration Office in the event that you are entitled to receive a Benefit.

If you are claiming Long Term Disability Benefits, the 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 Long Term Disability Benefits, even if you may not be eligible to receive a Benefit because you are receiving W.S.I.B.

Dental Care Plan

Special Claim Forms for services under this Plan are available from the Union Office, the Administration Office and the Plan website: www.lu30plan.com. A special feature permits you to find out, in advance, how much the Plan will pay in cases of planned expensive dental service.

Briefly, it works like this: When your dentist proposes a series of treatment and a fee exceeding \$500, you ask him to complete the claim form on which he records the proposed

services and his fees. You or the dentist send the form to the Administration Office, and it will be returned showing the Plan's allowances. If you follow these steps, you'll know exactly what help you can expect before proceeding with expensive dental services. Please note that you must be covered for Benefits on the date the services are provided.

Prescribed Drugs and Medicines

If you have eligible expenses you must fill in a brief Claim Form which may be obtained from the Administration Office, the Union office or the Plan website: www.lu30plan.com. Attach the original receipts which clearly show:

- the prescription number
- the cost of the prescription
- the date of purchase
- the name of the patient

The drug Claim Form with the receipted bills attached should then be sent to the Administration Office so that payment of the allowable expenses may be sent directly to you.

Major Medical Expenses

If you have eligible Major Medical expenses, you must complete a Claim Form which may be obtained from the Administration Office, the Union office and the Plan website: www.lu30plan.com. The completed Form and applicable original receipts should be sent to the Administration Office for payment.

Vision Care Benefit

The statement from your Optometrist or Optician must indicate the name of each patient, the date and type of service provided, and the specific fee for each Patient/Service. In the case of contact lenses, a letter from the prescribing

Physician/Optometrlist is also required, verifying that visual acuity has been improved to at least a 20/40 level.

Coordination of Benefits

The many instances of both spouses working outside the home, and the prevalence of group health plans, may mean that you, your Spouse and your children have duplicate coverage. You are covered by this Plan as a Member, and your Spouse and children are covered as your Dependants.

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, our 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.
3. 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 Financial or its re-insurers may periodically report information to the MIB. If you apply to receive life, disability or health insurance 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 Financial 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.

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. Their address is: MIB, 330 University Ave., Suite 501, Toronto, Ontario M5G 1R7. Tel: (416) 597-0590.

If you have any questions, contact the Administration Office.

Notice and Proof of Claim

The Benefits provided through our Welfare Plan are in accordance with Insurance Contracts, all of which specify time limits for the filing of Claims. If the Claim is not filed on time, the Insurer may deny liability. That being the case, we repeat that **it is your responsibility to promptly file Claims with the Administration Office, in accordance with the information below:**

Life and S.I.B. Plans:	Within 15 months after the date of loss.
Waiver of Premium:	Within 12 months of the onset of disability.
A.D. & D. Plan:	Within 15 months 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 Plans:	Within 15 months of the date the expense was incurred, except that the Claim must be filed within 90 days of the date your Insurance terminates.
W.S.I.B. Credits:	Within 90 days of the date the W.S.I.B. commences disability payments.

Taxable Benefits

At the time this Booklet was written, the Income Tax Act, Canada provides that the Benefit paid to you by the Weekly Income and Long Term Disability Income Plans is a Taxable Benefit to you. The S.I.B. Plan is funded through an annuity which is, in part, comprised of interest which is taxable. In or about February of each year, a T-4 Supplementary will be

mailed to you, covering Benefits paid to you in the prior calendar year, which you are required to attach to your Personal Income Tax Return, and include those Benefits when calculating your Income.

The Welfare Plan will conform to any future changes to the Act that affect the Tax status of Benefits.

Future Changes

This Booklet was written to provide you all of the essential Eligibility and Termination Rules, Benefits, Limitations and Exclusions that were in effect at April 1, 2009. 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.

In the event that the amounts of Life Insurance, Accidental Death and Dismemberment, Survivor Income Benefit, Weekly Income or Long Term Disability Plans 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 Account holds sufficient money.

SHEET METAL WORKERS: LOCAL UNION 30

Benefit Plans' Administration Office:

45 McIntosh Drive, Markham, ON L3R 8C7

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

E-mail: ebps@mcateer.ca · Website: www.lu30plan.com

