

Sheet Metal Workers

Local Union 30

Retired Members Welfare Plan

Retired



APRIL 2009



SHEET METAL WORKERS LOCAL UNION 30

WELFARE PLAN FOR RETIRED 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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THE WELFARE PLAN AT A GLANCE

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 Retired Members' Welfare 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 the Prescription Drug Plan) increased significantly because of the spiraling increase in the ingredient cost of the prescription drugs. There was also a surge in the number of Members retiring before their 65th birthdays when they would be eligible for almost 100% coverage by the Ontario Drug Benefit Program for Seniors, or a similar publicly sponsored Plan that commonly exists outside Ontario.

By 2001, the cost of the Retired Members' Welfare Plan had escalated to the point where it could no longer be funded entirely by the Active Members. New optional Plans were designed for Retired Members which achieved the goals of providing choice, providing important benefits and ensuring affordability. Eligible Retired Members can continue Welfare Plan Benefits under one of three Optional Plans, according to their choice, by agreeing to pay a Monthly Contribution which will be deducted from their Monthly Pension Benefit. Retired Members can decline enrolment in any Option, in which case coverage would be terminated and there would be no future opportunity to regain coverage.

The three Optional Plans are described below:

OPTION A

Death Benefit

- \$10,000 Group Term Life Insurance. If you are disabled and on Waiver of Premium at retirement, please refer to the note on page 3.

Supplementary Health

- The Prescription Drug Plan pays 100% of the Ingredient Cost of Generic Drugs and 70% of the Ingredient Cost of Brand Name Drugs (100% if there is no Generic Equivalent), along with 100% of the Dispensing Fee to a maximum of \$8.50 per Prescription, for Prescriptions ordered by your attending Physician, provided that the Prescription is for the treatment of illness or injury and the Prescription Order was written for a covered person who is not yet age 65. If the person for whom the Prescription Order was written is age 65 or older, the cost of the prescription is usually covered by Ontario's Drug Benefit Program for Seniors, or a similar Public Plan that may be available to those persons who live outside Ontario. Except in unusual circumstances, no Benefit is payable for Prescription Orders filled for a covered person who is age 65 or older.
- The Vision Care Plan pays up to \$50 for you and each of your eligible Dependants per 24 month period, for the initial purchase or replacement of prescription eye glasses. There is a Lifetime Maximum Benefit of \$200 for contact lenses.
- The Major Medical Plan pays all or a part of the usual and customary charges for a broad range of ancillary medical expenses that are not covered by the Ontario Health Insurance Plan (OHIP), provided that legislation does not prevent the payment thereof 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 Canada in the event of an emergency. Coverage is limited to a Lifetime Maximum of \$50,000 for you and each of your eligible Dependants. There is a deductible of \$100 per calendar year for you and each of your eligible Dependants.

Dental Care

- The Dental Care Plan provides a comprehensive range of Benefits subject to an annual deductible of \$100 for you and each of your eligible Dependants, up to an Annual Maximum Benefit of \$1,000 per person. Claims are paid on the basis of the 2007 Ontario Dental Association Suggested Fee Guide for General Practitioners. There is coinsurance of 50% applicable to some services.

OPTION B

All of the Benefits of Option A, except there is no coverage for Prescription Drugs. If you are disabled and on Waiver of Premium at retirement, please refer to the note below.

OPTION C

The only Benefit of Option C is \$10,000 Group Term Life Insurance. If you are disabled and on Waiver of Premium at retirement, please refer to the note below.

Please note: If you are approved for Life Insurance Waiver of Premium at retirement, the amount waived will be your current Life Insurance benefit provided it is at least \$10,000. If the amount waived is \$5,000, or if it will reduce to \$5,000 when you attain age 65, special rules apply and you should contact the Administration Office for details. If your Waiver of Premium Benefit terminates before age 65 you may elect a Life Insurance option at that time. While on Waiver of Premium, you are not eligible for the \$10,000 Group Term Life Insurance Benefit described in this Booklet.

REQUIRED MONTHLY CONTRIBUTIONS

All of the Benefits in the three Optional Plans are fully insured. The Premium is negotiated from time to time by the Trustees with the Insurer. The Premium is determined by the cost of claims paid to, or on account of, covered persons, and is guaranteed by the Insurer for at least one year. At the time this

Booklet was written, the Monthly Contribution required of Retired Members equaled 50% of the Premium (the balance being paid by the Active Members).

The Required Monthly Contribution Rates in effect at present, including the cost of \$10,000 Group Term Life Insurance, are:

Option A - \$99.55

Option B - \$62.24

Option C - \$ 2.52

If you reside in Ontario, the Contribution Rate set out above will be increased by 8%, which is Ontario's Retail Sales Tax and which the Trustees are required to collect from you. The Trustees reserve the right to amend the Options available and the Required Monthly Contribution Rates.

CHANGING YOUR OPTION

When you choose an Option, you are not required to stay covered by that Option permanently. You may change your Option at any time provided that the Option to which you want to transfer provides fewer Benefits than the Option you presently have. For example, you can transfer from Option A to B or C, or from Option B to C, provided that:

- (1) changes will be made effective the first day of a calendar month;
- (2) you provide written notice to the Administration Office of your decision, such that it is received at least 30 days in advance of the first day of the calendar month in which the change is to be made; and
- (3) if you change your Option, you will have no opportunity to re-enrol in the Option from which you transferred.

GENERAL INFORMATION

It is essential that all Plan Members have a clear understanding that, whereas the Trustees hope to continue providing Welfare Plan Benefits including for those who are not working and earning Contributions, the Trustees necessarily reserve the right to amend, suspend or cancel this Plan, or to require that persons covered by the Plan make a higher Contribution to defray the cost.

All of the Benefits provided by the Retired Members' Welfare Plan are insured by Manulife Financial. The Premiums paid for the Welfare Plan are based upon the claims submitted by Retired Members. The Insurer and the Administration Office co-operate to ensure that the Plan is paying only for claims that are necessary on a cost effective basis.

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.

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. These requirements are spelled out for you in the General Provisions section of this Booklet. 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 Dependants is protected through the implementation of the Plan's Privacy Policies and Practice document, a copy of which is available from the Plan Administration Office or the Union 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.

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 Premium charged by the Insurer for the chosen Option. If you choose not to enroll, then your coverage in the Welfare 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 this Option A are all of the Benefits described in this Booklet.
- B. The Benefits in this Option B are all of the Benefits described in this Booklet, not including the Prescription Drug Plan.
- C. The only Benefit in this Option C is the \$10,000 Group Term Life Insurance Benefit, covering the Member only. If you are on Life Waiver of Premium when you retire and the amount being waived is at least \$10,000, you are only eligible for Options A and B. Coverage under these Options will not include the Group Term Life Insurance Benefit. If you are on Life Waiver of Premium when you retire and the amount being waived is \$5,000, or if it will reduce to \$5,000 when you attain age 65, then special rules apply and you should contact the Administration Office for details.

The Trustees reserve the right to amend the Plan's Options. If you choose one of these Options, the Contribution Rate you are required to pay will be deducted each month from your Pension Benefit. The Contribution Rate required is subject to change from time to time - no more frequently than annually. The Contribution is determined by the Premium charged by the Insurer. When the time comes for you to choose an Option, the Administration Office will advise you of the Contribution Rate then in effect.

Option B may be attractive to you if you and your Spouse are at least Age 65, since there will be little Benefit, if any, payable

by Option A's Prescription Drug Plan. This is because you would be eligible for Ontario's Drug Plan for Seniors or, if you do not live in Ontario, that public drug plan for seniors which exists in many jurisdictions throughout Canada and the United States. However, all Members should make this choice very carefully, since the Province of Ontario (for example) has acted in the recent past to delete the payment of 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

When you retire, all of the Benefits that you enjoyed under the Active Members' Welfare Plan, except Disability Income Benefits, will remain in force until your Dollar Bank Balance is less than the then current amount deducted from each Active Member's Dollar Bank. At that time, provided you are and remain a Member in Good Standing of Sheet Metal Workers Local Union 30, you are eligible to enroll in one of three Optional Plans of 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 coverage in the Retired Members' Welfare Plan. You must be in receipt of a Monthly Pension from the Sheet Metal Workers Local Union 30 Pension Plan.

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.

You and your Dependants are referred to as "covered persons" in this Booklet.

In order to receive Benefits, your Dependants must be listed by you 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, indeed, 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 have lived for at least

three consecutive years, and whom you have held 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 the 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 from the Administration Office, or the Office of Local Union 30, an Information Card for Retired Members. The 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.

This card is a special Card for Retired Members, on which you choose to enroll in Option A, B, or C, or choose outright, permanent cancellation of your coverage.

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; but it would be essential for you to 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 Information 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. Probate Fees are not payable if your Estate is not the Beneficiary.

TERMINATION

Provided you remain a Member in Good Standing of Local Union 30, and make the Contributions required from time to time for your chosen Option, your Benefit Plan will continue until the end of the calendar month of your death. Earlier termination will occur if the Retired Members' Welfare Plan is terminated. Coverage for your Dependants is terminated when your coverage is terminated, except that your surviving Spouse may apply for an extension of benefits of up to six months as follows: for the first three months your Spouse will make a Required Monthly Contribution identical to the one in force at the time of your death, and for the next three months your Spouse will make a Required monthly Contribution equal to the full cost of the benefits in force. Please note that continuation of this extension of Benefits option is not guaranteed - the Trustees reserve the right to cancel it at any time.

GROUP TERM LIFE INSURANCE

RETIRED MEMBERS ONLY

If you die while insured under this Plan, a Death Benefit will be paid to your Beneficiary regardless of the cause, time or place of your death.

The Death Benefit is \$10,000. If you are disabled and on Waiver of Premium at retirement, please refer to the note on page 3.

DENTAL CARE PLAN

This Plan will help pay the cost of dental care for you and your family. The amount that will be paid for these 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. The "Covered Expenses 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 made 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 50% co-insurance factor for certain services. This means that the Plan pays half of the fee in the Fee Guide for those services and you pay the balance of your Dentist's bill.

Deductible

Eligible expenses incurred by you and each of your eligible Dependents are paid after the annual Deductible of \$100 has been met by you and each of your eligible Dependents.

Maximum Benefit

There is a calendar year maximum Benefit for each covered person of \$1,000.

Covered Expenses

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

1. Oral examinations, including scaling and cleaning of teeth, but not more than one examination in any period of 6 consecutive months.
2. Complete oral exam and diagnosis once every 24 months.
3. Topical fluoride treatment, once every 6 months.
4. Bitewing films, once every 6 months.
5. Full mouth series of films, once every 24 months.
6. Preventive recall packages, once every 6 months.
7. Amalgam, silicate, acrylic and composite restorations.
8. Consultation required by the attending dentist.
9. Relining, rebasing and repairing an existing denture.
10. Repair of an existing bridge.
11. Extractions, including impacted teeth, simple alveolectomy at the time of tooth extraction, and removal of cysts, neoplasms, plus the incision and drainage of an abscess.
12. Diagnostic radiographs, laboratory procedures and general anaesthetic required in connection with oral surgery.
13. Study casts once per year.
14. Passive space maintainers for dependent Children.

The following expenses will be paid at 50% of the Fee Schedule:

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 insured 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 insured 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 became insured.

Expenses Not Covered

1. Charges for any dental procedure which is included as a covered expense under any type of medical plan provided by your employer or the government, whether benefits are payable for all or any part of such charges;
2. The initial installation of dentures when such charges are incurred for replacement of teeth, all of which were extracted while the individual was not insured under the Plan;
3. The replacement of lost or stolen dentures;
4. Personalization, duplication, or characterization of dentures;
5. Services and supplies that are partially or wholly cosmetic in nature;

6. Prosthetic devices 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;
7. Dental procedures required due to injury or 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 claim forms or broken appointments;
10. Charges for oral hygiene instruction, nutritional counselling or protective athletic appliances;
11. Implants, implantology, installation of fixed bridgework and crowns;
12. Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his or her licence;
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 in whole or in part, directly or indirectly as a result of committing, attempting or provoking an assault or criminal offence, or by 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 are considered an insured service of any provincial government plan at the time this Policy/Benefit was issued and subsequently was modified, suspended or discontinued;
18. Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease;
19. Any charges that would not normally be made but for the presence of this insurance or for which you or your Dependant are not obligated to pay;
20. Any services which are covered by any government plan or program; or for which no charge is made; or for which the Insurer is not permitted by law to cover.

PRESCRIPTION DRUG AND VISION CARE PLAN

Prescription Drug Plan

The Province of Ontario, along with every other jurisdiction in Canada, provides a prescription drug plan for its senior citizens. In Ontario, the plan is known as the Ontario Drug Benefit for Seniors (ODB). The ODB covers almost every drug and medicine prescribed by a Physician for an Ontario resident provided the prescription is filled in Ontario, and the patient is 65 years of age or older. ODB maintains a list of drugs and medicines covered by the plan, known as a Formulary. The Formulary provides the generic equivalent of "brand name" drugs and medicines. In addition to those medications, ODB will pay for a "brand name" prescription if there is no generic equivalent, or if the prescribing Physician specifies "no substitution".

The Prescription Drug Plan covering Retired Members of Sheet Metal Workers Local Union 30 covers you and your eligible Dependents as follows:

1. If the patient is younger than Age 65, the 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.
2. If the patient is younger than Age 65, the Plan will pay a maximum Pharmacist's Professional Dispensing Fee of \$8.50 per script. There is full reimbursement for the Pharmacist's Professional Dispensing Fee for compounds prepared by the Pharmacist.
3. If the patient is 65 years or older, the Plan will not pay any portion of the Ingredient Cost, Pharmacist's Professional Dispensing Fee or deductible with respect to drugs covered by the Ontario Drug Benefit for Seniors, or which would be covered if the patient lived in Ontario. This exclusion applies to all covered persons who are 65 or older, regardless of where they live.

4. Regardless of the age of the covered person, the Plan covers only those prescriptions for the treatment of illness or injury, and in no event will pay a benefit if the prescription is for weight management, hair loss, sexual dysfunction, or any other purpose that is not related to the active treatment of illness or injury.
5. Fertility Drugs and treatment are covered to a lifetime maximum of \$2,500. Smoking cessation products (in drug form only) are covered to a lifetime maximum of \$250.
6. No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days of the date of purchase.

Vision Care Plan

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

The eye glass benefit is limited to \$50 per person in any 24 consecutive month period. The Plan also covers contact lenses up to a lifetime maximum of \$200 per person, 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.

This Plan does not pay for eye glasses that are cosmetic in nature, nor for prescription sunglasses.

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.

MAJOR MEDICAL PLAN

This Plan requires that you pay a Deductible of \$100 each calendar year on account of Claims incurred by you, and on account of claims incurred by each of your eligible Dependants. Expenses covered by OHIP or the equivalent provincial Medicare plan are not covered by this Plan. Subject to a Lifetime Maximum Benefit of \$50,000 for you and each of your eligible Dependants, this Plan will pay for the following expenses:

Covered Expenses

1. Health Care Facilities

- Hospital charges for medical and surgical treatment incurred by a person on an out-patient basis (excluding Physicians' and special nurses' fees).
- Room, board and normal nursing care provided in a licensed nursing home, convalescent hospital, or chronic care hospital/unit, (for convalescent or chronic care, excluding custodial care) up to a maximum expense of \$20 per day.

2. Medical Transportation Services

- Licensed ground ambulance services to and from the nearest medical facility for immediate treatment.
- If medically necessary, emergency transportation by any form of licensed ambulance (including air ambulance) or by any vehicle normally used for public transportation, for:
 - a. transfer to the nearest appropriate medical hospital for necessary treatment, and/or
 - b. medical evacuation for admission to a hospital in the province where the patient normally resides.
- Ground transportation to and from the hospital and airport, at the point of departure and arrival, is also eligible.

3. Medical Supplies and Services

- Diagnostic procedures, radiology, blood transfusions and oxygen, including the equipment necessary for administering oxygen.
- Purchase of trusses, braces, crutches, artificial limbs or eyes, and up to a total expense of \$25 per calendar year for elastic support stockings.
- Purchase of external breast prostheses required as the result of a mastectomy.
- Purchase of 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.
- Rental, or at the Insurer's option, purchase of a wheelchair, hospital bed or respirator/ventilator.

4. Dental Services

- Necessary dental treatment required as a direct result of accidental injury to natural teeth, limited to a maximum benefit of \$5,000 per accident. Treatment must be completed within 12 months of the accident.

5. Professional Services

- Physicians' services, where permitted by law, for expenses incurred in Canada, whether inside or outside the claimant's province of residence.

- Medically necessary services of a registered nurse only while the patient is not confined to a hospital, subject to a maximum payment of \$10,000 in any three consecutive calendar years. If a registered nurse is not available when required, expenses incurred for the services of a registered nursing assistant or a licensed practical nurse are eligible. Services of a nurse who is either a resident in the patient's home or is a close relative of the patient - that is, you, your spouse, or child, brother, sister or your parent or your spouse's parent - will not be covered.
- Services for the following licensed certified or registered paramedical practitioners when operating within their recognized field of expertise, up to the levels specified for each such practitioner. Where applicable, no payment can be made until the provincial plans have paid their yearly maximum.
 - **Psychologist:** Expenses of up to \$20 per 1/2 hour for the initial assessment, and up to \$20 per visit for treatment or therapy, to an aggregate maximum payment per person of \$225 per calendar year.
 - **Speech Therapist:** Expenses of up to \$25 for the initial assessment, and up to \$15 per visit for treatment or therapy, to an aggregate maximum payment per person of \$225 per calendar year.
 - **Podiatrist:** Payments up to a total of \$225 per person, per calendar year, limited to \$15 per visit. In addition, up to \$100 for the surgical removal of toe nails or the excision of plantar warts.
 - **Chiropractor/Physiotherapist:** For each such practitioner, up to a total of \$225 per person, per calendar year, limited to \$20 per visit. In addition, up to \$15 for one x-ray per calendar year by a chiropractor.
 - **Osteopath/Naturopath/Masseur:** For each such practitioner, up to a total of \$225 per person, per

calendar year, limited to \$10 per visit. In addition, up to \$15 for one x-ray per calendar year by an osteopath.

6. Hearing Aids

Purchase of hearing aids up to a total payment of \$400 per person in any four consecutive calendar years.

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:

- 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 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.

In addition, expenses incurred outside Canada (for both emergency and non-emergency treatment) will be considered for reimbursement in the same manner as those incurred in Canada for the following items:

- Health Care Facilities
- Medical Transportation
- Medical Supplies and Services
- Dental Services
- Professional Services (Physicians' services are limited to emergencies and referrals as noted on the previous page)
- Hearing Aids

It would be essential to remember that these Benefits are not payable if you leave Canada for the purpose of obtaining treatment for an illness or injury, except as noted above concerning treatment unavailable in Ontario.

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 non-elective reasons, reasonable and customary charges for the services of a Physician, in excess of any government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by a provincial medical plan.

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

Planning a trip? If you are outside Canada 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, and the balance remaining of each such person's Lifetime Maximum Benefit based on Claims already paid by the Plan at the date of the letter.

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 a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure 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;
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 are 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 for which the covered person is 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;
18. Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society.

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 Dependents. 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. Persons with incomes under \$20,000 per annum are exempt.

Medical Services

These include Doctors' services in the home, 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 by 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 Dependents are covered 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:

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

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 and Insurance Act, Ontario and the Income Tax Act, Canada. The Trustees will amend, suspend or terminate Plan 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, Physician, 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 that 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 (in no event later than 15 months from the date the expense was incurred, or 90 days from the date your Benefits terminate):

The Administration Office is:

Employee Benefit Plan Services Limited
45 McIntosh Drive
Markham, Ontario L3R 8C7

*(McIntosh Drive is two traffic lights north of Highway #7,
East off Woodbine Avenue)*

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.

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:

Group Term Life Insurance: 15 months after the date of loss.

Supplementary Health: (Drugs, Major Medical, Vision Care) 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.

Dental Care: 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.

Please follow these guidelines:

Prescribed Drugs and Medicines

If you have eligible expenses you must fill in a 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 (not the name of the purchaser or Member)

The drug claim form with the original receipts 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 or the Plan website: www.lu30plan.com. The completed form and applicable original receipts should be sent to the Administration Office for payment.

Claims will be paid on the basis of charges that are for medically necessary services and which are considered to be reasonable and customary for the service or supply that the patient received in the locality in which the expense was incurred. If the service or supply is a benefit of the Ontario Health Insurance Plan (OHIP) please keep in mind that this Plan's liability is only with respect to the amount (if any) left unpaid by OHIP, or which would be left unpaid by OHIP were you covered by OHIP. The Administration Office cannot settle your claim unless and until OHIP has processed your claim and the unpaid balance can be determined.

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/optometrist is also required, verifying that the contact lenses have been prescribed for severe cornea astigmatism, severe corneal scarring or keratoconus or aphakia, and visual acuity has been improved to at least a 20/70 level.

Dental Care Plan

Special claim forms for services under this Plan are available from the Union Office, the Administration Office or 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. This form is clearly marked PREDETERMINATION OF BENEFIT. You 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. You must be covered for Benefits on the date services are provided.

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.

Coordination of Benefits

You are covered by this Plan as a Retired Member, and your Spouse and children may be covered as your Dependants. At the same time, your Spouse may be covered as an employee or retired employee by her/his employer's group health plan, and you and your children may be 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 may 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 (the Member) 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 the 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.

Taxability of Benefits

At the time this Booklet was written, the Income Tax Act, Canada provided that the Premiums and Retail Sales Tax thereon paid by the Trust 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 Retail Sales Tax thereon. If you choose Option C, which provides Life Insurance only, you will be in receipt of a Taxable Benefit representing the amount paid for your Life Insurance Premium plus Retail Sales Tax thereon, minus the amount of Contribution you made for Option C. Those who subscribe to Option C will receive a T4A from the Administration Office in or about February of each year, representing the amount of the Taxable Benefit in the prior calendar year.

Benefits paid by the Life Insurance Plan are free of tax. Please note that all other Benefits are also free of tax, and the

amounts paid by the Plan may not be used as a deduction on your individual tax return. You will receive a statement annually for tax purposes, detailing total Premium paid less that for Life Insurance. You may be able to claim a deduction or tax credit on your income tax return.

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 by written notice, and you should keep these notices with this Booklet.

THE ADMINISTRATION OFFICE

The Administration Office receives all contributions from Contributing Employers, maintains all Member Records to determine Eligibility, pays the Insurance Premiums, calculates and pays (or validates for the Insurer) all claims. If you wish to contact the Administration Office, please do so as follows:

**Employee Benefit Plan Services Limited
45 McIntosh Drive
Markham, Ontario L3R 8C7**

*(McIntosh Drive is two traffic lights north of Highway #7,
East off Woodbine Avenue)*

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

Plan Website: www.lu30plan.com

INSURER

All of the Benefits provided by the Sheet Metal Workers Local Union 30 Welfare Plan are provided through Insurance Contracts issued to the Board of Trustees by:

**Manulife Financial,
2 Queen Street East, P.O. Box 4606, Station "A",
Toronto, Ontario, M5W 4Z2,
Telephone 416-687-4300**

Manulife Financial's Head Office address is:

**200 Bloor Street East,
Toronto, Ontario M4W 1E5,
Telephone 416-926-3000**

Should you have cause to contact the Insurer, please be sure to identify yourself as a Plan Member, Sheet Metal Workers Local 30 Welfare Plan, and make reference to the **Group Policy Number, which is 901884.**

NOTICE

This Booklet is a non-technical Summary of the Welfare Plan, and does not confer any contractual rights on you. In cases of dispute, the Insurance Contract will determine the status of any person or claim.

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

