U.A. LOCAL 787 BENEFIT PLANS

Health Plan

Vacation and Statutory Holiday Pay Plan

Pension Plan

Up to Date at July 1, 2012
U.A. Local 787 Benefit Plans

Administrator
Employee Benefit Plan Services Limited (EBPS)
45 McIntosh Drive
Markham, ON L3R 8C7
Phone: (905) 946-2220 or
1 (866) 946-2220 toll-free
Fax: (905) 946-2535
E-mail: ebps@mcateer.ca

Insurance Companies
The Manufacturers Life Insurance Company (Manulife Financial)
Policy Number 901437
ACE INA Canada (AD&D Insurance)
Policy Number AB10423401

Member Assistance Program Provider
Family Services (FSEAP)
Phone: 1-800-668-9920
www.myfseap.com
Group Name: toua787
Password: MAP

Legal Counsel
Koskie Minsky LLP

Consultant
J.J. McAteer & Associates Incorporated

Investment Consultant
API Asset Performance Inc.

Auditor
BDO Canada LLP

Website
www.ualocal787.org/Site/Welcome.html
www.ualocal787.org/Site/Benefits.html
www.ualocal787.org/Site/Forms.html

Board of Trustees
Tony Finelli
Tony Panetta
Joe Pellarin
Randy Pye
Andrew Tarr

Visit our U.A Local 787 facebook page at:
www.facebook.com/ualocal787benefits
Dear Plan Member,

We are pleased to provide you with this consolidated Plan Member Information Booklet. This Booklet describes the Benefits of our Plans for all Active and Retired Plan Members and includes information on the improvements made to the Health Plan up to July 1, 2012. Some of these improvements include:

- AD&D benefit enhancements for all Members starting June 1, 2012;
- Dental services are paid based on the 2011 ODA Suggested Fee Guide effective January 1, 2012;
- Access to the Retired Member Health Plan for qualifying Disabled Members starting April 1, 2011;
- Life Insurance benefit increases for all Members effective July 1, 2009;
- AD&D benefit increases for Active Members under Age 65 effective July 1, 2009;
- Introduction of a Member Assistance Program for all Members on July 1, 2008;
- Increase to the Major Medical Maximum Lifetime Benefit for all Members effective July 1, 2007;
- Increases to the Vision Care, Hearing Aid, Practitioner & Orthopaedic benefits on July 1, 2007;
- Increase to the Dental Maximum Annual Benefit to $2,500 for all Members effective July 1, 2007;
- Increases to the Weekly Indemnity Maximum Benefits effective July 1, 2007;
- Increases to the Long Term Disability Maximum Benefits effective July 1, 2007;
- Introduction of the Retired Member Health Plan (RMHP) on July 1, 2006; and
- Dental Fee Guide enhancements each year since 2006.

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

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

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

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

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

Sincerely,

Board of Trustees of the U.A. Local 787 Benefit Plans
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GENERAL INFORMATION
ALL BENEFIT PLANS

ABOUT THIS BOOKLET

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

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

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

Your Benefit Plans are governed by a Board of Trustees appointed pursuant to the Trust Agreement governing the Benefit Plans. The Trustees reserve the right to amend the Benefit Plans as deemed appropriate or necessary, and as permitted by law. Any changes made to the Benefit Plans will be communicated to all Plan Members as appropriate, and such changes are deemed to amend and/or modify this Member Information Booklet.

Please read this Booklet carefully and keep it in a safe place for future reference. You may contact the Administrator if you have any questions about the Benefit Plans, benefit entitlement, administration, or other rules of the Plans.

PLAN CONTINUANCE & GOVERNANCE

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

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

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

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

CONTACTING THE ADMINISTRATOR

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

- Your full name and identification code (which is your Union number), and if applicable, your Dependant’s full name;
- Your complete address and phone number, including area code, where the Administrator can contact you;
- The name of your Plan “U.A. Local 787” (if this is not already shown on your claim form).
**KEEPING THE ADMINISTRATOR UP TO DATE**

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

- Your Mailing Address;
- Your Family Status (marriage, separation, divorce, common-law relationships, birth, adoption or death of a Dependant);
- A Change in Dependant Status for children Age 21 to 26 (e.g. begins, or graduates from University or College);
- A change or modification to your Designated Beneficiary.

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

**YOUR PERSONAL INFORMATION IS PROTECTED**

The Trustees are committed to protecting the privacy of our Plan Members and the confidentiality of your personal information. A Privacy Policy was adopted by the Trustees on October 1, 2004, in accordance applicable privacy legislation. The Privacy Policy was confirmed by the Trustees in June 2011. In addition, the Trustees have put in place a number of procedures to protect your personal information, including privacy of personal information agreements with any organizations that service our Plans. You may view the Privacy Policy on the Plan website, as set out below.

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

The Trustees, Administrator, and others involved with our Plans collect only the personal information necessary to administer the Benefit Plans, which is permitted or required by law. From time to time, it may be necessary to obtain consent from you for the collection, use and disclosure of personal information, as required to administer the Plans, including the processing of your claims for specific Benefits of the Plan.

You are entitled to consult the personal information kept on file with the Administrator to ensure its accuracy. Should you wish to do so, please contact the Plans’ Chief Privacy Officers.

**PRIVACY OFFICERS**

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

- **Trustee:** Randy Pye, who may be contacted at the U.A. Local 787 Office; and
- **Manager of Corporate Services, EBPS:** Tara Seebaran, who may be contacted at the Administrator's office.

**MEMBER INTERNET SITE – ACCESS YOUR BENEFIT PLAN INFORMATION**

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

[http://www.ualocal787.org/Site/Benefits.html](http://www.ualocal787.org/Site/Benefits.html)

When viewing the web page noted above, Plan Members who have registered for the Plans’ online internet access with the Administrator can sign in by clicking on the “Benefit Online Access Link” at the top of the web page. When you register for online access with the Administrator, you can review the details of your Benefits 24/7, including:

- How long you will be covered for under the Health Plan;
- Who you presently have registered as your Dependents under the Health Plan;
- Who you have designated as your Beneficiaries;
- The history of your Vacation Pay payments;
- The value in your Pension Plan Account.
Your online information is current up to the last Employer/Contractor contribution report the Administrator has received for you. Plan Members may also download many of the Plan’s forms from the Plan’s website at the following address: http://www.ualocal787.org/Site/Forms.html

HOW TO SUBMIT A CLAIM TO ANY OF THE PLANS

When you or an eligible Dependant believe you have a Health Plan, Vacation Plan or Pension Plan Benefit entitlement, you should contact the Administrator who will supply you with the necessary forms and instructions for submission of a claim to the Plan. In order to quickly process your claim, all claim forms should clearly indicate the following:

- Your full name and residential mailing address;
- Your Plan Identification Code, which is your Union Number;
- You may be required to provide your Provincial Medical Insurance plan ID Number when claiming for Emergency Travel Assistance Benefits.

All of the Health Plans’ specific claim forms (and other forms), as well as applications for Vacation Pay and Pension Plan Benefits are available from the Administrator, or online from the Plans’ website, and from the U.A. Local 787 Union office.

Please remember to always keep a copy of your submitted claim forms, applicable receipts, physician’s statements, explanation of benefit statements and/or Plan Applications for your records.

You can choose to have some of the Plans’ claim payments for Health Plan and Vacation Pay Benefits deposited directly into your personal bank account. Please contact the Administrator for more information.

HEALTH PLAN CLAIM SUBMISSIONS

The Trustees rely on the experience of the Administrator and insurance companies with respect to the eligibility of the person submitting a claim, the eligibility of the submitted claim expense, and their advice with respect to whether claim expenses submitted to the Plan represent charges for expenses which are:

- Medically Necessary; and
- Reasonable and Customary.

All Medical and Dental claim expenses must be Medically Necessary. In the event that the Administrator determines that any claim expense submitted to the Plan for reimbursement is not Medically Necessary, the claim will be denied.

The reimbursement of eligible Medically Necessary claim expenses will be based on the Health Plan’s rules and are always subject to what is considered to be the Reasonable and Customary charges for the type of Medical or Dental procedure, or expense. Reasonable and Customary charges are determined on an ongoing basis by insurance companies and are based on criteria such as the condition reported and the nature of the service and/or supply provided.

Medically Necessary claims for Health Plan expenses which are in excess of the applicable Reasonable and Customary charges for that type of expense, will only be reimbursed up to the Reasonable and Customary level set for that type of expense. Claim amounts in excess of the Reasonable and Customary charges will be denied.

The reimbursement of certain eligible Health Plan expenses will require advance approval from the Plan. The expenses which require the prior approval of the Plan are described in this Booklet. Any expenses which are covered under your provincial health care plan are not covered expenses under the Health Plan.

HEALTH PLAN CLAIM SUBMISSION PROCEDURES

Claims for certain prescription drugs require the prior authorization of the insurance company. Additional information may be required from your physician before any such prescription drug is approved for payment.

Claims for dental treatments costing more than $500 require pre-approval by the Administrator by submission of a Treatment Plan. The Administrator will assess the amount the Plan will pay. Dentists may submit claims to the Administrator electronically.

Your Dentist may submit claims to the Plan via CDA Net, which is an approved, electronic claim submission network for dental practitioners.

All claim forms may be mailed, emailed, faxed or submitted in person to the Administrator at the Benefits Administration Office. If claims are submitted by a method other than mailing, all original documents should be kept in a safe place as the Administrator may request the original documents from you for a period of up to 24 months after you submit the claim. If emailing claims information to the Administrator, please consider encrypting all attached documents to protect your personal information.
COVERAGE UNDER MORE THAN ONE HEALTH PLAN

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

COORDINATION BETWEEN BENEFIT PLANS

The Administrator and insurance companies have the right to receive and release information relating to Major Medical, Vision Care, Emergency Travel Assistance and Dental expenses that are claimed for reimbursement, and/or any Disability Benefits paid, and/or if necessary, to collect any overpayments that may have been made in error.

MAJOR MEDICAL, VISION CARE, EMERGENCY TRAVEL ASSISTANCE AND DENTAL BENEFITS

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

- Send claims for your Spouse’s expenses to your Spouse’s plan first before being sent to your Plan;

- Send claims for your Children to the plan of the person whose birthday occurs first in the calendar year (for example, if your Spouse’s birthday is in June, and your birthday is in December, claims for your Children should be submitted to your Spouse’s plan first). Any unpaid claim amount may then be submitted to this Plan by you, the Plan Member.

DISABILITY BENEFITS

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

THE DATE OF YOUR EXPENSES DETERMINES WHETHER CLAIMS ARE PAID

Some of the Health Plan’s eligible expenses (for example, Vision Care and Dental Benefits) are reimbursed by the Plan up to a maximum dollar amount within a defined period of time (usually in each calendar year, or over a 24 month period). The Health Plan’s rules determine when that benefit year, or 24 month period, starts and stops based on the dates of the submitted expenses.

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

INCEIVED DATE EXAMPLES

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

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

**Dental Crown:** On December 21, 2011, treatments for a dental crown began. The patient returned to the dentist four times for related treatments until the dental crown was completed on March 18, 2012. The incurred date of this claim is March 18, 2012 as that is the date when the work was completed. The eligible claim amount will count towards the 2012 Maximum Annual Dental Benefit payable by the Plan (not 2011).
CLAIM SUBMISSION DEADLINES
Details for the requirements when submitting claims for the Benefits of the Plans are provided throughout this Booklet.

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

LIFE INSURANCE:
- completed claim forms, including proof of death, must be provided within 12 months from the date of death;

ACCIDENTAL DEATH & DISMEMBERMENT:
- completed claim forms, including proof of the accident, must be provided within 12 months from the date of the accidental injury or death (or disappearance);

WEEKLY INDEMNITY:
- completed claim forms, including the attending physicians’ statement, must be provided between the second week and six months from the date when you first become disabled;

LONG TERM DISABILITY:
- completed claim forms, including the attending physician's statement, must be provided within nine months from the date when you first become disabled;

MAJOR MEDICAL & DENTAL:
- completed claim forms and all required receipts, must be provided within 18 months from the date the expense was incurred (12 months after your Plan coverage terminates, if earlier). Dental claim forms must indicate the procedure codes and must be authorized or signed and dated by the dentist. Claim forms may be faxed, mailed, sent electronically or delivered in person to the Administration Office. Dental claims may also be sent directly to the Administrator electronically by your dentist;

EMERGENCY TRAVEL ASSISTANCE:
- Travel and Medical expenses over $200 should be reported to Allianz Global Assistance as soon as possible while travelling. Often, these expenses are forwarded directly to the insurance company from the hospital, or other health care service provider. Completed claim forms and all required receipts, must be provided within 18 months after the date the expense was incurred (12 months after your Plan coverage terminates, if earlier) for eligible expenses which you must pay for out of pocket;

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

PENSION PLAN RETIREMENT BENEFITS:
- please contact the Administrator at least one month prior to your retirement for the necessary forms and instructions. Not allowing enough time for your application may delay your Pension payment;

PENSION PLAN TERMINATION BENEFITS:
- the Administrator will contact you in writing if and when you are eligible for a Pension Plan Termination Benefit; and

PENSION PLAN DEATH BENEFIT:
- your Designated Beneficiary should contact the Administrator in the event of your death. The necessary forms will be provided to your Beneficiary for completion.
APPEALING BENEFIT ENTITLEMENT DECISIONS

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

The Administrator will review the initial decision and the appeal (together with the insurance company, if necessary or applicable) and advise you of the final decision and whether changes to the initial decision have been made.

If you wish to appeal the Administrator's final decision, please advise the Administrator. For claim decisions, the Administrator will provide a Claim Appeal Form to you. Your completed Claim Appeal Form must be returned to the Administrator (together with any necessary attachments). All claim and Benefit entitlement appeals are reviewed by the Board of Trustees at the next scheduled Board meeting. The Administrator will confirm the Board's final decision to you.

All claim and Benefit entitlement appeals must commence within a reasonable period of time, after the initial decision was provided to you by the Administrator (and/or the insurance company, where applicable), or as soon as practicable in your circumstances.

SUBMITTING FRAUDULENT CLAIMS OR PROVIDING INCORRECT INFORMATION

The Trustees are very concerned about the submission of fraudulent claims (any claim for which there was no actual loss or expense incurred) and whether incorrect or misleading information is intentionally provided to the Administrator (or insurance company) in support of a submitted claim or benefit application.

The Trustees take all of these activities very seriously. They are all considered to be fraudulent activities and may result in serious consequences, including legal action. It is also a serious offence to submit a claim to the Plan for expenses which are rightfully the responsibility of another plan or a third party. For example, claims for expenses due to an illness or disability which is work-related are to be submitted to the Workers' Safety Insurance Board.

Please note that:

- If a Member submits a fraudulent claim for an expense that was not ever paid for, or for a service that was not ever provided, or a disability that did not occur, the claim will not be paid;
- If a Member intentionally provides incorrect or misleading information about the eligibility of a Dependant, or about the expense or loss being claimed for, the claim will be held until the correct information has been provided;
- If a claim was paid by the Plan for any reason, before the claim is deemed to be fraudulent or before the incorrect or misleading information is discovered, the Member will be required to repay the claim amount to the Plan. No further claims will be paid from the applicable Benefit Plan for that Plan Member, and/or for the Plan Member’s Dependents, until such time as the original claim amount has been repaid to the Plan in full, and/or until the correct information is provided.

The Board of Trustees will be advised of any alleged fraudulent claims that have been submitted to the Plan, or of any intentionally provided incorrect or misleading claim or eligibility information. The Trustees will then determine what further action will be taken, based upon the extent and seriousness of the fraudulent activity. Further action may include the suspension, or termination of the benefits provided under any of the Benefit Plans, or the suspension, or termination of any benefit payments from the Health Plan for a period of time, or such other legal recourses that are available to the Trustees.

If a Member was overpaid for a claim in error (such as the overpayment of a Disability Benefit after the Member had recovered), the Member will be required to repay the overpaid amount to the Plan. Failure to repay the overpaid amount to the Plan may result in no further benefits being paid from the Plan (to the Plan Member, and/or to the Plan Member’s Dependents, until the amount has been repaid in full) and potential legal action in the event of a refusal to pay.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Description</th>
<th>Eligible Active Member Under Age 65</th>
<th>Eligible Active Member Age 65+</th>
<th>Eligible Inactive or Disabled Member Under Age 65</th>
<th>Eligible Inactive Member Age 65+</th>
<th>Eligible Retired Member Under Age 65</th>
<th>Eligible Retired Member Age 65+</th>
<th>Eligible Spouse and Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>Premiums are a Taxable Benefit</td>
<td>$100,000</td>
<td>$25,000</td>
<td>$100,000</td>
<td>$25,000</td>
<td>$50,000</td>
<td>$25,000</td>
<td>No</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment (AD&amp;D)</td>
<td>Up to $100,000 for Accidental Death or Accidental Injury</td>
<td>$100,000</td>
<td>$25,000</td>
<td>$100,000</td>
<td>$25,000</td>
<td>$50,000</td>
<td>$25,000</td>
<td>No</td>
</tr>
</tbody>
</table>
| Weekly Indemnity (WI)                        | Benefits paid after 7 Consecutive Days of disability, for up to 16 Weeks, if no EI sick benefits paid:  
- Apprentice 1 to 4 and Maintenance Mechanics: $554/week  
- Apprentice 5, Journeyman and above: $692/week | $554 or $692 Weekly                 | $554 or $692 Weekly               | No (Approved Disabled Members May Have Extension) | No                               | No                                | No                             | No                            |
| Long Term Disability (LTD)                   | Benefits paid after 17 Consecutive Weeks of disability, up to Age 65, if applied for WSIB benefits when disability is work related:  
- Apprentice 1 to 4 and Maintenance Mechanics: $2,400/month  
- Apprentice 5, Journeyman and above: $3,000/month | $2,400 or $3,000 Monthly           | No                               | No (Approved Disabled Members May Have Extension) | No                               | No (Yes if RMHP Selected While Disabled) | No                             | No                            |
| Major Medical                                | - 100% Reimbursement  
- Prescription Drugs  
- Vision Care  
- $2,000/Year for all Practitioners  
Medical services and supplies | $200,000 Lifetime Maximum Per Covered Person | $200,000 Lifetime Maximum Per Covered Person | $200,000 Lifetime Maximum Per Covered Person | $200,000 Lifetime Maximum Per Covered Person | $100,000 Lifetime Maximum Per Covered Person | $100,000 Lifetime Maximum Per Covered Person | $200,000 Lifetime Maximum. $100,000 if Covered Under the RMHP | Yes Under Active Plan if Dependant is Under Age 65 |
| Emergency Travel Assistance (ETA)            | - Covers First 60 Days of Travel  
- Emergency Medical Insurance  
- Travel Assistance Services | Yes                               | No                               | Yes                                           | No                               | No                                | No                             | No                            |
| Dental                                       | - Based on 2011 Ontario Dental Association Fee Guide  
- 100% for Basic Services  
- 80% for Major Services  
- 60% for Orthodontic Services  
- $2,500 / person / year for Basic and Major Services combined  
- $2,000 / lifetime for each Dependant child under age 21 | Yes                               | Yes                              | Yes                                           | Yes                              | Yes                               | Yes                            | Yes                            |
| Member Assistance Program (MAP)              | Confidential counselling services providing crisis support, advice and information by telephone, face-to-face, or online. | Yes                               | Yes                              | Yes                                           | Yes                              | Yes                               | Yes                            | Yes                            |
### U.A. LOCAL 787 – VACATION PAY BENEFITS AT A GLANCE

<table>
<thead>
<tr>
<th>Contributions</th>
<th>10% of your wages for Vacation Pay and Statutory Holiday Pay is paid into the Fund</th>
</tr>
</thead>
</table>
| Automatic Benefit Payments | Two Automatic Benefit Payments will be made to you as follows:  
• By May 15, a payment is made (usually Vacation Pay earned from October 1 to March 31); and  
• By November 15, a payment is made (usually Vacation Pay earned from April 1 to September 30).  
• A Benefit Payment is made to Retired Members with respect to Benefits earned prior to retirement  
• A Benefit Payment is made to a Member’s Designated Beneficiary in the event of the death of a Member who has an unpaid Benefit upon death |
| Optional Benefit Payments | You may apply in writing for one Optional Payment each calendar year (for specified reasons only)  
• An additional Optional Payment may be applied for in writing (for specified reasons only) and will be reviewed by the Board of Trustees at the next regularly scheduled Board meeting following receipt of your Application  
• An administration fee will be deducted from all Optional Benefit Payments |
| Special Benefit Payments | If Fund reserves permit, payments may be made to Members for contributions due from bankrupt or insolvent Employers/Contractors |

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

<table>
<thead>
<tr>
<th>Eligibility &amp; Vesting</th>
<th>Plan Membership, and vesting (entitlement to Pension Benefits) begins after the accumulation of 700 hours of Pension Plan contributions within a consecutive 18 month period.</th>
</tr>
</thead>
</table>
| Benefit Payments      | Pension Plan contributions made on your behalf are deposited into your Pension Plan Account, which also includes a prorated portion of the Pension Fund’s interest, dividends, net realized and unrealized capital gains and losses, and after a deduction for a prorated share of the Pension Fund’s operational costs, are paid upon your:  
• Retirement - when you retire between the Ages of 55 and 71 (you must be a Plan Member for at least 2 years if you retire between ages 55-64). Your Pension Plan Account is used to purchase a lifetime monthly Pension or Life Income Fund; or  
• Termination - If no Pension Plan contributions have been made for a consecutive period of 18 months, you will be eligible for a Pension Termination Benefit. Your Termination Benefit may be transferred to an acceptable registered plan; or  
• Death - Your Pension Plan Account balance is paid to your Designated Beneficiary, which will be your Spouse in certain circumstances. |
HEALTH PLAN GENERAL INFORMATION

ELIGIBILITY INFORMATION

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

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

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

“The Administrator” refers to Employee Benefit Plan Services (EBPS).

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

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

a) they are Canadian Residents who are properly enrolled in their provincial health care plan; and

b) they meet all of the applicable eligibility requirements described in this Booklet; and

c) contributions have been made to The Fund on their behalf by a contributing Employer/Contractor.

DEPENDANT HEALTH PLAN COVERAGE

WHO ARE ELIGIBLE DEPENDANTS?

The following individuals are considered your eligible Dependents for applicable Dependant coverage under the Plan:

- **Spouse**: A person you are living with, of the same or opposite sex to you, who is your spouse. Your spouse includes a legally married spouse (civil or religious ceremony) from whom you are not legally separated or divorced; or a common-law spouse, if you provide proof that you are living together, are publicly represented as spouses, and have lived together continuously for a minimum of 12 months. Your Dependant Spouse is the person who has most recently met the above noted requirements. You may designate only one individual to be recognized by the Plan as your Dependant Spouse, at any given time; and

- **Children**: Your unmarried child/children, including adopted children, those you are a legal guardian for (and can claim under the Income Tax Act) and your eligible Dependant common-law Spouse's children, with proof provided, who are living with you and are dependent on you and/or your Dependant Spouse for support. Your Dependant child/children must be under Age 21. If a Dependant was covered the day before attaining Age 21 and is under Age 26, he/she may continue to qualify as your eligible Dependant if you provide proof that he/she is a full-time student at an accredited learning institution.

- A child is not considered a Dependant for coverage if employed full-time (including serving in the military) or if already covered as a Member of this Plan.

- A child (who was covered as a Dependant under the Health Plan the day before attaining Age 21) who is an unmarried, mentally or physically challenged and totally dependent on you for support will continue to be covered after the limiting Age 21, if you provide proof, including dependency on your support and maintenance under the Income Tax Act.

- The children of your common-law Spouse will become eligible Dependents (as shown above) when your common-law Spouse qualifies as your Dependant.
DESIGNATING YOUR DEPENDANTS

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

WHEN DEPENDANTS’ HEALTH PLAN COVERAGE BEGINS AND TERMINATES

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

If a Dependant is hospitalized or in a medical institution at the time their coverage would normally begin, their coverage will begin after the Dependant is released from the hospital or medical institution.

Your Dependents will cease to be covered when your coverage in the Health Plan terminates, when they cease to qualify as eligible Dependents, or for any other reason indicated in the When Health Plan Coverage Terminates Section below.

EMPLOYER/CONTRACTOR CONTRIBUTIONS & YOUR DOLLAR BANK ACCOUNT

EMPLOYER/CONTRACTOR CONTRIBUTIONS

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

DOLLAR BANK ACCOUNT

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

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

Each month, the Administrator records the hours and contributions reported by Signatory Employers/Contractors. You are given a statement of your Dollar Bank Account activity every six months. You should compare this statement to your payroll records to ensure accuracy. The Administrator should be contacted if you discover any discrepancies.

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

EMPLOYER/CONTRACTOR CONTRIBUTION EXAMPLE

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

COST OF HEALTH PLAN COVERAGE

DOLLAR BANK DEDUCTIONS

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

Under certain conditions, you may be permitted to make Pay Direct payments to the Plan to extend coverage. Dollar Bank Deductions, Pay Direct Amounts and the Benefits provided within each Member Classification are subject to change. Changes are typically made each July 1, but may also occur at other times. As of January 1, 2012, the monthly Dollar Bank Deductions for each Member Classification and the corresponding Benefits provided are listed in the table below:
MEMBER CLASSIFICATION | MONTHLY DOLLAR BANK DEDUCTION | MONTHLY PAY DIRECT AMOUNT | BENEFITS PROVIDED
--- | --- | --- | ---
Active Members (Under Age 65) Actively Employed | $399.00 | $399.00 | Life, AD&D, WI, LTD, Medical, Dental, ETA, MAP
Active Members (Age 65 +) Actively Employed | $175.00 | $175.00 | Reduced Life & AD&D, WI, Medical, Dental, MAP
Inactive Members (Under Age 65) Unemployed 2 Consecutive Months | $295.00 | $220.00 | Life, AD&D, Medical, Dental, ETA, MAP
Inactive Members (Age 65 +) Unemployed 2 Consecutive Months | $175.00 | $175.00 | Reduced Life & AD&D, Medical, Dental, MAP
Disabled Members (Under Age 65) | $220.00 | $220.00 | Life, AD&D, WI, LTD, Medical, Dental, ETA, MAP
Eligible Retired Members (Under 65) Pay Direct Limited RMHP Coverage | $220.00 | $220.00 | Reduced Life & AD&D, Medical, Dental, MAP
Eligible Retired Members (Age 65 +) Pay Direct Limited RMHP Coverage | $175.00 | $175.00 | Reduced Life & AD&D, Medical, Dental, MAP
Dependants of a Deceased Active Member Until Age 65 | $175.00 | $175.00 | Medical, ETA, Dental, MAP

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

**ACTIVE, INACTIVE & RETIRED MEMBER HEALTH PLAN COVERAGE WHEN AGE 65 OR OVER**

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

**INACTIVE MEMBER COVERAGE**

If you become disabled after you have been unemployed from a Signatory Employer/Contractor for 2 consecutive calendar months, you are no longer eligible for Disability Coverage (i.e., Weekly Indemnity and Long Term Disability Benefits). Weekly Indemnity and Long Term Disability Coverage will be reinstated when you return to work for a Signatory Employer/Contractor provided your Plan coverage has been maintained.

**DISABLED MEMBER COVERAGE**

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

**RETIRED MEMBER HEALTH PLAN COVERAGE (RMHP)**

In order to make Pay Direct Payments under the Retired Member Health Plan, you must first meet the conditions as outlined in the RETIRED MEMBER HEALTH PLAN (RMHP) GENERAL INFORMATION Section of this Booklet.

**DOLLAR BANK ACCOUNT MAXIMUM**

Contributions will accumulate in your Dollar Bank Account, which may provide you with up to a maximum of 36 months of coverage (comprised of up to 4 months of “full” coverage, plus 32 months of coverage without Disability Benefits). Contributions over this 36 month Dollar Bank Account maximum are considered as excess contributions and will be transferred from your Dollar Bank Account to the Fund. This transfer is made each month based upon the monthly deductions at that time.
A Members’ Dollar Bank Account balance will also be transferred to the Fund:

- Immediately after membership in U.A. Local 787 terminates, or upon expulsion from U.A Local 787; or
- If a Member has not accumulated the minimum of 3 months of Dollar Bank Contributions to become initially eligible for Plan coverage, and no further contributions have been received on behalf of the Member for 18 months; or
- If a Member’s Health Plan coverage terminates, and there has been no further activity for 18 months. “Activity” means an Employer/Contractor contribution being made on behalf of a Member, a deduction from the Member’s Dollar Bank Account, Fund-paid coverage, or a Pay Direct Payment made by a Member.

**TAXABLE BENEFITS YOU MAY RECEIVE FROM THE PLAN**

Life Insurance premiums paid to the insurance company (from Employer/Contractor contributions) on your behalf, as well as Disability Benefits paid to you (i.e., Weekly Indemnity and Long Term Disability Benefits) are reported to Canada Revenue Agency as taxable income on T4A’s issued by the Plan. T4A’s for these taxable Benefits are issued by the end of February each year.

**WHEN HEALTH PLAN COVERAGE BEGINS**

**INITIAL ELIGIBILITY & REINSTATEMENT OF COVERAGE**

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

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

If you are not actively at work when your coverage would normally begin, your coverage begins when you are actively at work. You are considered “actively at work” when your Employer/Contractor is remitting contributions for credit to your Dollar Bank Account (including during workers’ compensation and maternity and parental leaves). You are also considered “actively at work” when you are available for work and you are on the U.A. Local 787 out of work list, working on a travel card, or attending trade school.

If you do not have sufficient contributions in your Dollar Bank Account to become eligible, and then you do not work for a contributing Employer/Contractor for 18 months, the balance in your Dollar Bank Account will be transferred to the Fund and not used to determine when your coverage begins.

The eligibility rules for Dependents are described earlier in the **DEPENDANTS’ HEALTH PLAN COVERAGE** Section of this Booklet.

**NEW MEMBER EXAMPLE**

A new Member first works on February 19. From February 19 to May 25 the new Member earns contributions equal to three months of Dollar Bank Deductions, and they are remitted to the Administrator and deposited to the new Member’s Dollar Bank Account. The May contributions are received and credited to the Member’s Dollar Bank Account in June. The new Member’s coverage takes effect July 1.

**WHEN HEALTH PLAN COVERAGE TERMINATES**

**HEALTH PLAN COVERAGE TERMINATION FOR MEMBERS & DEPENDANTS**

You will be notified by mail when your Health Plan coverage is terminated. Termination of Health Plan coverage is immediate when:

- You terminate your Membership in U.A. Local 787; or
- You are expelled by U.A. Local 787; or
- You commence active duty in the armed forces of any country, state or international organization; or
- The insurance company Contract terminates (unless the Trustees obtain other coverage); or
- For Emergency Travel Assistance, on the earlier of the date the Member attains Age 65 or enrolls in the Retired Member Health Plan; or
For Long Term Disability insurance, on the earlier of the date the Member attains Age 65 or becomes covered under the Retired Member Health Plan (unless a Disabled Member selects the RMHP option, in which case coverage terminates at Age 65 or earlier recovery from disability). If the Member satisfies the Qualifying Disability Period for Long Term Disability insurance while Age 64 and is considered eligible for Disability Benefits, Long Term Disability benefit payments will be payable for a maximum of 12 months; or

For Weekly Indemnity coverage, on the date the Member becomes an Inactive Member, or becomes covered under the Retired Member Health Plan.

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

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

**BENEFIT PAYMENTS AFTER HEALTH PLAN COVERAGE HAS TERMINATED**

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

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

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

If you or your Dependant (Spouse or Child) is receiving counselling through the Member Assistance Program, the counselling will continue as though your Plan coverage had not terminated.

**MAINTAINING YOUR HEALTH PLAN COVERAGE WHEN UNEMPLOYED**

**PAY DIRECT PAYMENTS**

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

The maximum total coverage extension while unemployed is 36 months. The cost of this coverage may come from your Dollar Bank Account deductions (if your Account has sufficient funds) and up to a further 12 months of Pay Direct Payments.

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

**EXAMPLES OF PAY DIRECT PAYMENTS**

<table>
<thead>
<tr>
<th>Dollar Bank Deductions Available on Account</th>
<th>Maximum Number of Allowable Pay Direct Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>12 months</td>
</tr>
<tr>
<td>25 months</td>
<td>11 months</td>
</tr>
<tr>
<td>31 months</td>
<td>5 months</td>
</tr>
<tr>
<td>36 months</td>
<td>NIL</td>
</tr>
</tbody>
</table>

The Administrator will advise you in writing, by a Warning Letter, when you are required to make a Pay Direct Payment to maintain your coverage. Your Pay Direct Payment must be received by the Administrator by the date shown on the Warning Letter. If the total required Pay Direct Payment (Pay Direct amount, plus applicable taxes, presently 8% Ontario Retail Sales Tax) is not made as required, your coverage is terminated on the date indicated in the Warning Letter.
Once terminated, your coverage cannot be reinstated in the Health Plan until you return to active work for a Contributing Employer/Contractor and accumulate at least two months of deductions in your Dollar Bank Account.

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

**MAINTAINING YOUR HEALTH PLAN COVERAGE WHEN RECEIVING WORKERS’ COMPENSATION BENEFITS**

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

**Please notify the Administrator as soon as possible when you are receiving WSIA benefits** to ensure the required Employer/Contractor contributions are made on your behalf (for up to the 12 month maximum).

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

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

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

The Administrator will advise you in writing, by a **Warning Letter**, when you are required to make a Pay Direct Payment to maintain your coverage. Your Pay Direct Payments must be received by the Administrator by the date shown on the Warning Letter. **If the total required Pay Direct Payment** (Pay Direct amount, plus applicable taxes which are presently 8% Ontario Retail Sales Tax) **is not made as required, your coverage is terminated upon the date indicated in the Warning Letter.** Once terminated, your coverage cannot be reinstated in the Health Plan until you return to active work for a Contributing Employer/Contractor and accumulate at least two months of deductions in your Dollar Bank Account.

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

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

**Eligibility for Disabled Member Coverage**

Disabled Member Health Plan coverage is available to qualifying Members who are receiving Long Term Disability (LTD) Benefits from the Plan. Life Insurance, Accidental Death and Dismemberment (AD&D), Weekly Indemnity, Long Term Disability, Major Medical, Emergency Travel Assistance, Dental and Member Assistance Program coverage is provided to disabled Plan Members if:

- You are under Age 65 and receiving LTD Benefit payments from the Plan; and

- You remain a Member in good standing of U.A. Local 787, in accordance with the U.A. Constitution and U.A. Local 787 By-Laws; and

- You were covered for Health Plan Benefits when your LTD benefit payments begin; and

- You have applied for the Canada Pension Plan disability benefit;
If you have an approved ongoing claim for Disability Benefits, your Life, AD&D, WI and LTD coverage is extended for as long as you remain disabled, up to age 65. The amounts of Life, AD&D, WI and LTD insurance provided under the Disabled Member Health Plan will be the amounts that were in effect for the Member on the date the Member first became disabled.

**Duration and Cost of Disabled Member Coverage**

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

After the first 36 months, Disabled Member coverage may be continued under certain circumstances by making Pay Direct Payments for the remaining months of available continued coverage beyond the initial 36 months. The monthly Pay Direct cost for Disabled Member coverage, which is subject to change, is shown in the COST OF HEALTH PLAN COVERAGE Section of this Booklet. The length of your available Disabled Member coverage continuation period beyond the first 36 months depends on how long you were continuously covered under the Plan as an Active Member on the date of disability.

<table>
<thead>
<tr>
<th>Continuous Time Covered as an Active Member</th>
<th>Minimum Duration of Disabled Member Coverage</th>
<th>Maximum Duration of Disabled Member Pay Direct Coverage</th>
<th>Maximum Total Duration of Disabled Member Coverage (Minimum + Pay Direct)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than 48 Months</td>
<td>36 Months</td>
<td>12 Months</td>
<td>48 Months</td>
</tr>
<tr>
<td>48 Months Up To 10 Years</td>
<td>36 Months</td>
<td>7 Years</td>
<td>10 Years</td>
</tr>
<tr>
<td>10 Years Or More</td>
<td>36 Months</td>
<td>7 Years</td>
<td>10 Years</td>
</tr>
</tbody>
</table>

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

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

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

**Disabled Member Coverage Example**

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

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

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

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

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

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

The Retired Member Health Plan option may be of benefit to Members whose Pay Direct option under the Disabled Member Coverage described above would terminate prior to the attainment of Age 65, when LTD benefit payments cease.

A Disabled Member who does not enrol in the Retired Member Health Plan would continue to receive Disability benefit payments and Disability coverage until Age 65. However, all other coverage under the Health Plan would terminate at the end of the **Maximum Total Duration of Disabled Member Coverage (Minimum + Pay Direct)** as outlined above.
Please note there are coverage differences between the Disabled Member’s coverage and coverage under the RMHP. The RMHP does not provide Emergency Travel Assistance coverage. Life and AD&D coverage is reduced. The Major Medical Maximum Lifetime Benefit is reduced. Long Term Disability benefit payments and coverage would continue under the RMHP until Age 65, unless you recover from your approved disability before a subsequent disability occurs.

Coverage in any Health Plan classification may not be reinstated once Pay Direct Payments cease, unless a Disabled Member again becomes an Active Member and satisfies the eligibility requirements described earlier in this Booklet. Once approved for Retired Member Health Plan coverage, Active Member coverage cannot be reinstated even if you recover and work for a contributing Employer/Contractor and you work sufficient hours to qualify for Active Member coverage.

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

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

MAINTAINING COVERAGE FOR DEPENDANTS OF DECEASED PLAN MEMBERS

ELIGIBILITY FOR SURVIVING DEPENDANT COVERAGE

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

- The deceased Member was covered for the Health Plan’s Benefits at his date of death; and
- The surviving Spouse and/or Children were eligible Dependents designated on the Member’s enrolment form (an unborn child on the Member’s date of death is thereafter eligible for Dependant coverage if the mother was designated as a Dependant).

DURATION AND COST OF SURVIVING DEPENDANT COVERAGE

During the first 24 months following a Member’s death, coverage for surviving eligible Dependents, who were listed on the Member’s enrolment form, is continued and funded first from monthly deductions from the Member’s Dollar Bank Account, and then by any Fund-paid coverage (if the deceased Member’s Dollar Bank Account has less than 24 months’ worth of deductions at the time of death). The monthly Pay Direct cost for Surviving Dependents, which is subject to change, is shown in the COST OF HEALTH PLAN COVERAGE Section of this Booklet.

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

<table>
<thead>
<tr>
<th>Years of Continuous Health Plan Coverage Upon Member’s Death</th>
<th>Minimum Duration of Surviving Dependant Coverage</th>
<th>Maximum Duration of Surviving Dependant Pay Direct Coverage</th>
<th>Maximum Total Duration of Surviving Dependant Coverage (Minimum + Pay Direct)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Member Coverage With Less Than 10 Years</td>
<td>24 Months</td>
<td>8 years</td>
<td>10 years</td>
</tr>
<tr>
<td>Active Member Coverage With 10 Years or More</td>
<td>24 Months</td>
<td>8 years</td>
<td>10 years</td>
</tr>
<tr>
<td>Retired Member Coverage With Less Than 10 Years; Pay Direct Limited Coverage</td>
<td>24 Months</td>
<td>8 years</td>
<td>10 years</td>
</tr>
<tr>
<td>Retired Member Coverage With 10 Years to 30 Years; Fund Paid Limited Coverage</td>
<td>Lesser of 10 Years or the RHPM Coverage Balance</td>
<td>Not Applicable</td>
<td>10 years</td>
</tr>
<tr>
<td>Retired Member Coverage With More Than 30 Years; Fund Paid Lifetime Coverage</td>
<td>10 years</td>
<td>Not Applicable</td>
<td>10 years</td>
</tr>
</tbody>
</table>
**Coverage for Surviving Dependents of Active Members**

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

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

Emergency Travel Assistance coverage terminates under this Surviving Dependant coverage extension when the Surviving Spouse of an Active Member reaches Age 65.

**Coverage for Surviving Dependents of Retired Members**

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

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

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

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

If there are deductions remaining in the deceased Retired Member’s Dollar Bank Account after the first 24 month coverage extension period, funding for Dependant coverage will continue to be made from Dollar Bank Account deductions, before Dependents are required to make Pay Direct Payments. This does not change the maximum coverage continuation period described above. Thereafter, payments, as required under the Retired Member Health Plan Pay Direct Limited Coverage program, must be made to the Fund.

The **Maximum Duration** of Surviving Dependant coverage may apply once only. For example, if a Retired Member who is eligible for 10 years or less of coverage dies, the maximum combined continuous years for the Retired Member plus for the deceased Member’s Surviving Dependents is 10 years (or less, if applicable).

Surviving Dependant coverage must be maintained continuously from the time coverage for Dependents of a Deceased Member begins. Coverage will terminate if Pay Direct Payments are not made when due. Coverage may not be reinstated once Pay Direct Payments cease.

**Benefits for Surviving Dependents Covered Under More Than One Plan**

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

- After the death of a Member, if a Spouse is working for, or starts to work for an employer that offers a group health benefit program, the Spouse’s employer plan will be the first payer of claims for the Spouse and any other eligible Dependents.

- If the Spouse of a deceased Member has coverage as a Dependant under any other group health benefit program, then the other plan will become the first payer of claims for the Spouse and any eligible Dependents.

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

**Coverage Outside Ontario / Canada**

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

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

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

- Disability coverage is provided to Active Members, provided they are working for a Signatory Employer/Contractor.

MAJOR MEDICAL, EMERGENCY TRAVEL ASSISTANCE & DENTAL

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

MAJOR MEDICAL

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

EMERGENCY TRAVEL ASSISTANCE (ETA)

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

DENTAL

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

MEMBER ASSISTANCE PROGRAM

- The toll free number (1-800-668-9920) for FSEAP can be used in Canada and the United Stated to access face-to-face counselling and assistance.
- For registered users, FSEAP services may also be accessed online at http://www.myfseap.com (Group Name: toua787, Password: MAP)
RETIRED MEMBER HEALTH PLAN (RMHP)
GENERAL INFORMATION

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

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

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

- DEPENDANT HEALTH PLAN COVERAGE
- COST OF HEALTH PLAN COVERAGE
- WHEN HEALTH PLAN COVERAGE TERMINATES
- DISABLED MEMBER’S OPTION TO SELECT RETIRED MEMBER HEALTH PLAN COVERAGE
- MAINTAINING COVERAGE FOR DEPENDANTS OF DECEASED PLAN MEMBERS

ELIGIBILITY FOR RETIRED MEMBER HEALTH PLAN (RMHP) COVERAGE

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

- You are age 55 or over; and
- You have been covered for Health Plan coverage as an Active, Inactive and/or as a Disabled Member (including any Pay Direct coverage) on a continuous basis:
  (a) for a minimum of 24 months immediately prior to the date you chose to begin RMHP coverage, and for at least 5 of the last 10 years on a cumulative basis; or
  (b) from the date you first became a Member in good standing of U.A. Local 787 (if you have been covered as a Plan Member for less than 5 years); and you have either:
    (c) worked for a Contributing Employer/Contractor, had Employer Contributions made on your behalf, or received Long Term Disability benefit payments within the 6 month period before your RMHP coverage begins; or
    (d) been available for work and on the U.A. Local 787 Out of Work List, or working on a Travel Card within the 24 month period before your RMHP coverage begins; and
- You cease to work, or be available to work for a Contributing Employer, you do not have Employer Contributions being made on your behalf during WSIA (i.e. Workers’ Compensation) benefit receipt, you are not receiving Long Term Disability (LTD) benefit payments (or do not have an application in process for such Benefits, unless you have elected RMHP coverage under the Disabled Member Plan provisions); and
- You satisfy the U.A. Local 787 that you have retired from the Trade, both union and non-union, in accordance with the U.A. Constitution and U.A. Local 787 By-Laws; and
- You are, and remain a Member in good standing of U.A. Local 787 in accordance with the U.A. Constitution & U.A. Local 787 By-Laws.

Disabled Members, who are at least Age 55 after receiving Long Term Disability benefit payments for at least 36 months, may be eligible for coverage under the Retired Member Health Plan. Please refer to the MAINTAINING YOUR HEALTH PLAN COVERAGE WHEN RECEIVING DISABILITY BENEFITS FROM THE PLAN heading in the previous Section of this Booklet for further information about a Disabled Member’s Option to Select Retired Member Health Plan Coverage.
If you are not eligible for RMHP coverage, you may be eligible to make Pay Direct Payments as an Inactive Member. Please refer to the **MAINTAINING YOUR HEALTH PLAN COVERAGE WHEN UNEMPLOYED** Section of this Booklet for further information.

**APPLICATION FOR RETIRED MEMBER HEALTH PLAN COVERAGE**

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

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

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

Once approved for RMHP coverage, Active Member coverage cannot be reinstated even if you work for a Signatory Employer/Contractor and you work a sufficient number of hours to qualify for Active Member coverage.

**DURATION AND COST OF RETIRED MEMBER HEALTH PLAN COVERAGE**

The cost (if any) and the duration of your RMHP coverage are based on your “Plan Membership” at the time your RMHP coverage begins.

**DEFINITION OF “PLAN MEMBERSHIP”**

“Plan Membership” is determined as the average of:

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

**RETIRED MEMBER HEALTH PLAN COVERAGE CLASSIFICATIONS**

There are 3 cost classifications for Retired Member Health Plan coverage as follows:

<table>
<thead>
<tr>
<th>Retired Member Health Plan Coverage Classification</th>
<th>Required Years of “Plan Membership”</th>
<th>Duration of Retired Member Health Plan Coverage</th>
<th>Required Pay Direct Contribution*</th>
<th>Maximum Duration of Pay Direct Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fund Paid Lifetime Coverage</td>
<td>More Than 30 Years of Plan Membership</td>
<td>For Your Lifetime</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Fund Paid Limited Coverage</td>
<td>10 Years to 30 Years of Plan Membership</td>
<td>The Number of Years of Plan Membership</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Pay Direct Limited Coverage</td>
<td>Less Than 10 Years of Plan Membership</td>
<td>The Number of Years of Plan Membership</td>
<td>Pay Direct Contributions Are Required*</td>
<td>10 years</td>
</tr>
</tbody>
</table>

*Please refer to the **COST OF HEALTH PLAN COVERAGE** heading in the previous Section of this Booklet for more information about the required Pay Direct Amounts in effect at the time this Booklet was prepared.
The Retired Member Health Plan Coverage Classifications are further described below.

1. **Fund Paid Lifetime RMHP Coverage** is provided to Members who have completed a minimum of 30 years of Plan Membership upon the date RMHP coverage begins. RMHP coverage will not terminate and no Pay Direct Payments are required.

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

3. **Pay Direct Limited RMHP Coverage** is available to Members who have completed less than 10 years of Health Plan Membership upon the date RMHP coverage begins. RMHP coverage will continue for a period equal to the Member’s years of Health Plan Membership as determined on the date RMHP coverage begins. Pay Direct Payments are required. Pay Direct payments may not be made when this Limited RMHP coverage terminates based on the years of Health Plan Membership.

The Pay Direct Limited RMHP Coverage is provided initially by monthly deductions from your Dollar Bank Account. Once your Account has been depleted, monthly Pay Direct Payments must be made. The applicable Pay Direct Amounts (which are subject to change) at the time this Booklet was prepared are shown in the COST OF HEALTH PLAN COVERAGE Section earlier in this Booklet.

**EXAMPLES OF A HOW “PLAN MEMBERSHIP” IS CALCULATED**

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

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

**Fund Paid Limited RMHP Coverage** - A Member has 18 years of accumulated Health Plan participation and has been a Member of U.A. Local 787 in Good Standing for 18 years. However, the Member has only been a Member in Good Standing for a continuous period during the past 14 years.

This Member’s Plan Membership is calculated as the average, as follows: \( \frac{18 + 14}{2} = 16 \)

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

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

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

**PLAN MEMBERSHIP FOR MEMBERS WHO RETIRED PRIOR TO JULY 1, 2006**

The Administrator’s letter to you confirmed your acceptance into the RMHP and indicated the number of years of Health Plan Membership qualifying you under the Retired Member Health Plan.

**Retired Member Health Plan Coverage**

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

Please see the description of each Benefit for further information about coverage amounts, reduction in coverage and the termination of coverage.
WHEN RMHP COVERAGE BEGINS & HOW IT CONTINUES

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

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

- you remain a Member in good standing of U.A. Local 787 on a continuous basis from the date your RMHP coverage begins and you do not work for a non-union Employer/Contractor in the Trade, in accordance with the U.A. Constitution & U.A. Local 787 By-Laws; and
- you make the necessary RMHP Pay Direct Payments when due (where applicable), on a continuous basis after your Retired Member Health Plan coverage begins.

Once approved for RMHP coverage, Active Member coverage cannot be reinstated even if you work for a Contributing Employer/Contractor and you work sufficient hours to qualify for Active Member coverage.

WHEN RETIRED MEMBER HEALTH PLAN COVERAGE TERMINATES

You will be notified by registered mail when your Retired Member Health Plan coverage is terminated.

RMHP coverage will terminate for Retired Members and their eligible Dependents:

- in accordance with your determined Plan Membership duration as described above (where applicable); or
- in accordance with the coverage and Benefit termination rules described in the WHEN HEALTH PLAN COVERAGE TERMINATES Section of this Booklet; or
- if you work in the Trade for a non-union Employer/Contractor (in accordance with the U.A. Constitution); or
- if you work as a non-union Employer/Contractor (Owner Operator) after your RMHP coverage begins; or
- if any required Pay Direct Amount is not made to the Plan when due. RMHP coverage must be maintained continuously from the time a Member’s RMHP coverage begins.

RMHP coverage for an eligible Dependant of a Retired Member will also terminate when the Member’s coverage terminates as noted above, or on the date when they cease to qualify as an eligible Dependant.

Once your coverage in the Retired Member Health Plan terminates, for any reason, it cannot be reinstated and you will never be eligible for RMHP coverage again. In most cases, coverage termination will take effect immediately, however under the following circumstances, coverage termination will take effect at the end of the month in which:

- you, or your Dependents no longer qualify for RMHP coverage because the duration of coverage (based on “Plan Membership”) is exhausted; or
- you have not made the required RMHP Pay Direct Payment to the Administrator when due (where applicable).
HEALTH PLAN BENEFIT DETAILS

LIFE INSURANCE
All Active, Inactive, Disabled & Retired Members

AMOUNT OF COVERAGE

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

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

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

DESIGNATING A BENEFICIARY

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

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

COVERAGE WHILE DISABLED

If you become a Disabled Member, the amount of your Life Insurance Benefit will not change. If you are still covered under the Health Plan when you attain Age 65 and when Disability Benefits end, the amount of your Life Insurance Benefit will reduce accordingly. If you are under Age 65, not retired, and receiving Long Term Disability Benefits, you will receive the no cost Life Insurance coverage until Age 65 (or recovery, if earlier). You must provide continuing proof of disability as may be requested.

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

DEFINITION OF “DISABLED”

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

CONVERTED LIFE INSURANCE COVERAGE – INDIVIDUAL POLICY

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

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

You can apply for non-convertible term life insurance, a permanent plan that the insurance company offers to the public at the time of conversion; or one-year non-renewable term life insurance which may be converted while it is in force to one of the other plans offered.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)
All Active, Inactive, Disabled & Retired Members

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

PRINCIPLE SUM
The Principle Sum of your AD&D Benefit is based on your Member Classification and your Age, as follows:

<table>
<thead>
<tr>
<th>Classification</th>
<th>Principle Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active, Inactive and Disabled Members</td>
<td>$100,000</td>
</tr>
<tr>
<td>Under Age 65</td>
<td></td>
</tr>
<tr>
<td>Active and Inactive Members Over Age</td>
<td>$25,000</td>
</tr>
<tr>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Retired Members Under Age 65</td>
<td>$50,000</td>
</tr>
<tr>
<td>Retired Members Over Age 65</td>
<td>$25,000</td>
</tr>
</tbody>
</table>

COVERAGE WHILE DISABLED
You can receive the no cost AD&D coverage in the same manner as described earlier in the Life Insurance Section. If you become covered under the Retired Member Health Plan while disabled, the amount of your AD&D coverage will be $50,000, reducing to $25,000 when you become Age 65.

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

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

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

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

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

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

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

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

- Loss of Thumb and Index Finger of the Same Hand
- Loss of Use of Thumb and Index Finger of the Same Hand
- Loss of Four Fingers of the Same Hand
- Loss of Use of One Arm or One Leg
- Loss of One Hand or One Foot
- Loss of Hearing in One Ear
The Insurer will pay 25% of the Principal Sum of $50,000 in the event that you should suffer any of the losses listed below:

- Loss of All Toes of the Same Foot

**“LOSS” IN RELATION TO THE SCHEDULE OF LOSS ABOVE MEANS:**

- Loss of Hand and/or Foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
- Loss of Arm or Leg means complete severance through or above the elbow or knee joint;
- Loss of Thumb and Index Finger means complete severance at or above the metacarpophalangeal joint (or second joint);
- Loss of Toe means complete severance at or above the metatarsalphalangeal (or second joint);
- Loss of an Eye means irrecoverable loss of entire sight of an eye;
- Loss of Speech means complete and irrecoverable loss of speech which does not allow communication in any degree; and
- Loss of Hearing means complete and irrecoverable loss of hearing, which cannot be corrected by any hearing aid or device.

With reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs for one hundred and eighty consecutive days and deemed to be permanent by the Insurer.

- “Brain Death” means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.
- “Loss of Use” means total and irrecoverable for at least 12 continuous months and deemed to be permanent by the Insurer.

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

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

The insurance company has an overall limit of $5,000,000 applicable for all losses resulting from any one accident. If this limit will not fully cover the total of all the AD&D Benefits that would be payable for all insured Members involved in such accident, the amount payable for each Member will be proportionately reduced accordingly, but will not exceed the limits outlined in the Schedule of Loss above.

**ADDITIONAL AD&D BENEFITS:**

**EXPOSURE AND DISAPPEARANCE BENEFIT**

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

**REPATRIATION BENEFIT**

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

**REHABILITATION BENEFIT**

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

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

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

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

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

**SPOUSAL OCCUPATIONAL TRAINING BENEFIT**

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

**HOME ALTERATION & VEHICLE MODIFICATION BENEFIT**

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

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

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

Benefit payments herein will not be paid unless:

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

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

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

**DAY CARE BENEFIT**

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

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

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

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

**SPECIAL EDUCATION BENEFIT**

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

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

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

**In-Hospital Confinement Monthly Income Benefit**

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

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

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

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

**Cosmetic Disfigurement Benefit**

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

<table>
<thead>
<tr>
<th>Body Part</th>
<th>(A) Area Classification</th>
<th>(B) Maximum allowable % for Area Burned</th>
<th>(C) Maximum % of Principal Sum Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face, Neck, Head</td>
<td>11</td>
<td>9.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Hand &amp; Forearm</td>
<td>5</td>
<td>4.5%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Either Upper Arm</td>
<td>3</td>
<td>4.5%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Torso (Front or Back)</td>
<td>2</td>
<td>18.0%</td>
<td>36.0%</td>
</tr>
<tr>
<td>Either Thigh</td>
<td>1</td>
<td>9.0%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Either Lower Leg (below knee)</td>
<td>3</td>
<td>9.0%</td>
<td>27.0%</td>
</tr>
</tbody>
</table>
**SEAT BELT BENEFIT**

This benefit is only payable in the event an insured Member sustains an injury which results in one of the losses payable under the Accidental Death or Dismemberment coverage. The insured Member’s amount of Principal Sum will be increased by 10%, to the maximum amount of $25,000, if, at the time of the accident, the insured Member was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss. “Seat Belt” means those belts that form a restraint system. “Vehicle” means a private passenger car, station wagon, van, or jeep-type automobile.

**IDENTIFICATION BENEFIT**

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

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

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

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

**AD&D COVERAGE EXCLUSIONS**

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

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

b) Declared or undeclared war or any act thereof;

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

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

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

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

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

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

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

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

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

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

WEEKLY INDEMNITY BENEFITS (WI)

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

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

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

If the disability is, or could be, work-related, you must apply for workers’ compensation benefits. Workers’ compensation benefits are paid under the Workplace Safety and Insurance Act. You must notify the Administrator as soon as possible after starting to receive workers’ compensation disability benefits.

AMOUNT OF WI BENEFIT

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

- $554 Per Week for an Apprentice Level 1 to 4 and Maintenance Mechanics
- $692 Per Week for an Apprentice Level 5 and Journeyman (and above)

Weekly Indemnity Benefits are reduced dollar for dollar by any workers' compensation benefits you receive.

Disability benefits paid to you from an Individual or Association plan do not reduce the Weekly Indemnity benefit payable.

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

DIRECT DEPOSIT OF WI BENEFIT PAYMENTS

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

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

WHEN WI BENEFIT PAYMENTS BEGIN & END

The Plan will provide a Weekly Indemnity Benefit for each calendar week, or portion thereof of total disability:

- Starting on the 8th day, after 7 consecutive days of an absence from work due to a qualifying accidental injury or illness; and

- Payable up to and including the 17th week of a disability.

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

Weekly Indemnity Benefits are paid provided at the time of your disability you are under a physician’s care from the first day you became disabled or confined to a hospital (if due to drug or alcohol addiction). Disability payments will begin no earlier than the first day you see a physician.

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

It is therefore recommended that you do not delay in submitting your disability claim to the Administrator and adhere to the claim submission deadlines outlined in this Booklet.
PSYCHOLOGICAL DISORDERS AND SUBSTANCE ABUSE

Weekly Indemnity Benefits will be paid for these types of disabling conditions, provided you qualify for Benefits and:

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

RECURRENT DISABILITIES

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

EXCLUDED DISABILITIES

No Weekly Indemnity Benefit is payable during the following periods or for disabilities relating to:

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

SUBROGATION OF RECOVERED BENEFITS

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

LONG TERM DISABILITY BENEFITS (LTD)

All Active Members & Disabled Members Who Are Under Age 65

You are covered for the Long Term Disability Benefit if you are a covered Member of the Plan and you have worked for a Signatory Employer/Contractor during the last 2 consecutive months immediately prior to the date you first become disabled.

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

If the disability is, or could be, work-related, you must apply for workers’ compensation benefits. Workers’ compensation benefits are paid under the Workplace Safety and Insurance Act. You must notify the Administrator as soon as possible after starting to receive workers’ compensation disability benefits.

AMOUNT OF LTD BENEFIT

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

- $2,400 Per Month for an Apprentice Level 1 to 4 and Maintenance Mechanics
- $3,000 Per Month for an Apprentice Level 5 and Journeyman (and above)

LTD BENEFIT REDUCTIONS

LTD Benefits are reduced dollar for dollar for workers’ compensation benefits paid to you for the same disability.

If your monthly LTD Benefit amount, plus any or all of the following other sources of income, exceeds 85% of your pre-disability earnings, your monthly LTD Benefit amount will be reduced by the excess:
Canada (Quebec) Pension Plan benefits paid to you (primary and family benefits as of the date of commencement of disability payments); plus

Monthly pension benefits or benefits from an annuity, locked in retirement account, life income fund or other registered plan where the payment was funded by the U.A. Local 787 Pension Plan; plus

Any work-related earnings received while “disabled”, including those from an authorized rehabilitation program; plus

Workers’ compensation benefits paid to you for the same disability; plus

Disability benefits paid to you from any plan or program of any government, or of any subdivision or agency thereof, other than any benefits payable under the Employment Insurance Act.

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

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

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

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

**WHEN LTD BENEFITS BEGIN & END**

If your disability continues beyond the 17 week WI Maximum Duration and your Long Term Disability claim has been approved by the insurance company, the Plan will provide a Long Term Disability Benefit for each month, or portion thereof, of total disability starting in the 18th week of your disability.

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

- for an illness due to drug and/or alcohol addiction, until the earlier of 3 years, the attainment of Age 65, or your recovery; and

- for any other disability, until the earlier of the attainment of Age 65 or your recovery.

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

(a) any and every duty of your regular job for the first 3 years and 17 weeks of a disability; and

(b) any job you are reasonably suited for by education, training or experience for the remainder of your disability (after 3 years and 17 weeks).

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

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

It is therefore recommended that you do not delay in submitting your disability claim to the Administrator and adhere to the claim submission deadlines outlined in this Booklet.

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

**PSYCHOLOGICAL DISORDERS AND SUBSTANCE ABUSE**

Long Term Disability Benefits will be paid for these types of disabling conditions, provided you qualify for coverage and:

1) the treatment program for a psychological disorder is supervised by a psychiatrist or a registered psychologist; and

2) the treatment for substance abuse, including alcoholism and drug addictions, includes participation in a recognized substance abuse withdrawal program.
RECURRING DISABILITIES

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

EXCLUDED DISABILITIES

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

- Any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician or therapist deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program, which must be recommended by a physician;
- Intentionally self-inflicted injuries;
- Participation in a civil disorder, criminal offence or a declared/undeclared act of war while on active military duty;
- Imprisonment in a penal institution or being confined to a hospital as a result of criminal proceedings;
- Any period of time a leave of absence is taken, including any parental or maternity leave;
- Substance abuse (alcohol and/or drug addiction):
  a) for any disability that began before you were covered under the Health Plan for Disability Benefits, unless you were covered under the Health Plan for Disability Benefits for at least 12 months, or in some instances for at least 3 months, without receiving treatment or consulting a physician; and
  b) if not in a recognized substance withdrawal program or for which you received medical attention, consultation, diagnosis or treatment before you become covered by this Plan; and
  c) after 3 years and 17 weeks from the date you first became disabled.

SUBROGATION OF RECOVERED BENEFITS

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

MAJOR MEDICAL BENEFITS

All Active, Inactive, Disabled & Retired Members & Their Eligible Dependents

You are covered for Major Medical Benefits if you are a covered Member of the Plan.

SUMMARY OF BENEFITS

Major Medical expenses such as Prescription Drugs, Medical Practitioners, Vision Care, Medical Services & Supplies and Convalescent Care are eligible for reimbursement as noted in the table below and as described in the pages that follow:

<table>
<thead>
<tr>
<th>Member/Dependant Classification</th>
<th>Level of Reimbursement</th>
<th>Maximum Lifetime Benefit (per person)</th>
<th>Maximum Annual Reinstatement Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active, Inactive, Disabled Member</td>
<td>100%</td>
<td>$200,000 per person</td>
<td>$20,000 per person</td>
</tr>
<tr>
<td>Retired Member (RMHP)</td>
<td>100%</td>
<td>$100,000 per person</td>
<td>$10,000 per person</td>
</tr>
</tbody>
</table>
REIMBURSEMENT OF COVERED ELIGIBLE EXPENSES

The Major Medical Benefit is designed to complement the coverage you and your Dependents are eligible to receive (or would receive) under your government sponsored Provincial Health insurance plan, under which you are required to be enrolled.

Eligible Major Medical expenses for you and your Dependents which are medically necessary, will be reimbursed 100% by the Plan, subject to any dollar or frequency limitations described below, and based on the applicable reasonable and customary charges for the cost of medical services and/or supplies incurred. Eligible expenses must be recommended and approved by a licensed physician and for non-occupational injury or disease.

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

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

REASONABLE AND CUSTOMARY FEES

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

MAXIMUM LIFETIME BENEFIT

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

- **Active, Inactive or Disabled Members (regardless of Age)** - $200,000
  - reducing to:
  - **Retired Members (RMHP)** - $100,000

ANNUAL REINSTATEMENT OF MAXIMUM LIFETIME BENEFIT

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

The Maximum Annual Lifetime Benefit reinstatement per each covered person (including Dependents) as follows:

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

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

If your Annual Reinstatement does not fully restore your Maximum Lifetime Benefit, you may apply, providing the Plan proof of your good health, to restore an amount over 10%. Please contact the Administrator for further information, if this would apply to you, or to your eligible Dependents.

Annual Reinstatement amounts restored in a given year or for all years combined as a covered Plan Member cannot ever exceed the applicable Maximum Lifetime Benefit amount for your Member Classification as noted in the table above.
LIFETIME MAXIMUM REINSTATMENT EXAMPLES

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

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

PRESCRIPTION DRUG AND RELATED EXPENSES

The Plan provides 100% reimbursement for eligible prescribed drugs (up to a 90 day supply). The Plan covers most drugs and medicines which by law require a written prescription by a physician or dentist or other licensed practitioner approved for sale in Canada for the purpose identified, which are dispensed by a licensed pharmacist.

The Plan also provides 100% reimbursement for the following eligible drug expenses (up to a 90 day supply, where applicable), when prescribed by a physician or other professional authorized to prescribe (per provincial legislation). The Plan only reimburses the over-the-counter drugs or supplies (those available without prescription) that are specifically noted below and only if they are prescribed accordingly:

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

The Plan will not cover the following drugs which are available without prescription (over-the-counter):

- erectile dysfunction drugs;
- drugs that are not Life Sustaining or medically necessary;
- atomizers, aerochambers, spacer devices, food supplements, contact lenses care products, cosmetic products, non-medicated products, hair restoration products, contraceptives (except oral contraceptives which are covered), non-injectable vitamins; etc.

Ontario residents and other covered individuals Age 65 and over will not be covered for drugs for which they are, or would be covered as an Ontario resident under the Ontario Drug Benefit Formulary. However, if the ODB Formulary covers the cost of a generic drug only and the physician prescribes an alternate drug and verifies in writing “no substitution allowed”, the Plan will pay the cost difference if it meets the qualifications outlined above.

PRESCRIPTION DRUG PRIOR AUTHORIZATION

Certain covered drugs require the prior approval of the insurance company. The insurance company issues a Prior Authorization Drug Listing. It constantly monitors the established criteria to determine which drugs should be added to or removed from the list. If a drug listed on the Prior Authorization Drug Listing has not approved by the insurance company before it is purchased, the insurance company will still review the drug claim for possible approval. Additional information is required from the physician before any such drugs will be approved for payment. It is therefore strongly recommended that you discuss proposed drug therapies with your physician and check the Prior Authorization Drug Listing to ensure the prescriptions your physician prescribes will be covered by the Plan.

The insurance company looks at a number of criteria, such as efficacy and whether or not a drug is medically necessary under the circumstances. Its approval (or disapproval) is based primarily on the information provided by the patient’s physician. The current listing may be obtained from the Administrator, or the U.A. Local 787 office. Periodically, updates to the list will be included in a mail out to Plan Members.
**MEDICAL PRACTITIONERS**

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

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

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

Please consider contacting our MAP provider for confidential counselling services at 1-800-668-9920. Using our MAP means more of your $2,000 practitioner maximum will be available to you and you will not incur any out-of-pocket expenses. More information about our MAP is provided in the MEMBER ASSISTANCE PROGRAM (MAP) BENEFIT Section of this Booklet. Additional information is also available online at http://www.myfseap.com (Group Name: toua787, Password: MAP)

**MEDICAL SUPPLIES**

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

- **Orthopaedic Shoes and Foot Orthotic Appliances** - which are custom made or altered to fit the person’s specific medical needs and prescribed by a physician, up to $500 per person, every 12 months;
- **Hearing Aids** - and adjustments/repairs, up to $1,500 per person, every 3 years;
- **Hearing Aids** - if required due to an accidental injury to the ear are subject to Reasonable and Customary Charges;
- **Medical Equipment** – such as Artificial Limbs, Eyes, Braces, Crutches, Splints, Trusses and up to 2 pairs of Surgical Stockings per person, per calendar year; and
- **Durable Medical Equipment** – including Wheelchairs, Hospital Beds and Oxygen Tents, etc. outside of a Hospital (rental or purchase at the decision of the insurance company).

**MEDICAL SERVICES**

The Plan reimburses 100% of expenses for the following medical services:

- **Private Duty Nursing** - if recommended by a physician and medically necessary, subject to an overall maximum of $7,500 per person, every 12 months. A Private Duty Nurse can be a Registered Nurse, a licensed practical nurse, a Certified Nursing Assistant, or a Member of the Victorian Order of Nurses. Services must be provided in the home and cannot be performed by a family member or resident in your home;
- **Licensed Ambulance Service** - to provide transportation to or from the nearest Hospital for necessary medical treatment. Covers only expenses in excess of OHIP coverage;
- **Emergency Transportation** - within your province of residence by airline (or rail) to or from the nearest Hospital for needed treatment. The Maximum Annual Benefit is $200 per person, per year. Covers only expenses in excess of OHIP coverage;
- **Accidental Dental** - treatment of accidental injuries occurring to natural teeth while covered by the Plan, up to a Maximum Benefit of $5,000 per person, per accident. Treatment must begin within 12 months from the date of the accident;
- **Laboratory Tests and X-Rays** - not covered by OHIP;
- **Blood Transfusions and Oxygen Administration**.
VISION CARE
The Plan reimburses 100% of eligible expenses either for prescription lenses (glasses lenses and frames), or contacts in any consecutive 24-month period or for eye surgery expenses as follows:

(a) Prescription Glasses or Contact Lenses (in a Consecutive 24 Month Period)
   - Prescription eyeglass lenses (subject to Reasonable and Customary Charges); plus
   - up to $150 for attached frames every consecutive 24-month period; or
   - Up to $250 for prescription contact lenses every consecutive 24-month period; and

(b) Eye Surgery (subject to a $1,500 Maximum Lifetime Benefit)
   - Eligible laser eye surgery; or
   - Refractive lens exchange surgery, if an individual is not deemed to be a good laser eye surgery candidate, and elects refractive lens exchange surgery in a private clinic, or
   - If Member elects to have cataract surgery in a private clinic (before OHIP-paid surgery could be scheduled), the cost difference between OHIP paid costs and clinic costs.

The Plan also reimburses 100% of expenses for:

(a) The following medically necessary cataract surgery tools or lenses not covered by OHIP:
   - Diagnostic measurement tools
   - Foldable, or soft lenses, in lieu of hard lenses;

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

CONVALESCENT CARE
The Plan reimburses Convalescent Care, in a licensed Convalescent Care facility, excluding a Chronic Care facility, up to $35 a day for 120 days if the person is transferred from a hospital, following a hospital stay of 3 or more days.

The Plan does not reimburse for semi-private or private room expenses in excess of hospital ward room charges.

- Your may be required to provide your Provincial Medical Insurance plan ID Number when claiming for Emergency Travel Assistance benefits.

OUT-OF-PROVINCE TREATMENT
If you are planning to receive treatment outside of your province of residence, you must obtain approval from your Provincial Medical Insurance plan (OHIP in Ontario) before treatment is received to ensure you will be reimbursed for eligible expenses by your Provincial Medical Insurance plan.

TIPS TO BEING BETTER MEDICAL CONSUMERS
To provide you with a valued Plan we have to manage our costs, and we need you to share this responsibility. This is why we ask you to be smart health care consumers. With your help, we can control our costs and maintain a valued Plan.

The following can help you be better health care consumers:

- When you get a prescription filled, there’s a dispensing fee. If you regularly buy a prescribed drug, e.g. insulin or birth control, you help lower the cost by buying a 90-day supply rather than filling the prescription on a more frequent basis. This Plan limits single purchase of drugs to a 90 day supply.
- Dispensing fees for prescription drugs can vary from approximately $5.00 to $12.00 – so it pays to shop around a little for the best deal.
- A lot of prescribed drugs end up being thrown away because the drug caused side effects or was ineffective, or the amount too large. Ask your doctor or pharmacist if you have any concerns.
- Requesting generic drugs, when possible and where less expensive, because generics may lower the Plan’s costs.
MAJOR MEDICAL EXPENSES NOT COVERED

Benefits are not paid for any medical expenses related to the following:

- Services or expenses covered by a provincial government program, e.g. OHIP or workers’ compensation or another government sponsored or legally mandated program, or which would have been covered if the patient was a resident of Ontario and had properly applied for OHIP coverage;
- Any illness or injury covered by workers’ compensation or similar legislation;
- Prescription drugs that are also available over the counter unless otherwise noted;
- Charges for safety glasses, special lenses, or tinting of eyeglass lenses;
- Hospital room charges, such as semi-private, in excess of ward (ward is covered by OHIP);
- General health examinations;
- Unnecessary medical treatment, or services you or your Dependents would not normally be billed for or pay for, or for which you are not legally required to pay;
- Surgical procedures, hospitalization or treatment performed for cosmetic reasons;
- Services or supplies you or your Dependents receive when not covered by the Plan;
- Services or expenses covered by OHIP; and
- Transportation and travel charges for medical treatment or surgical procedures or other charges not specifically listed in this information material.

COORDINATION BETWEEN BENEFIT PLANS

If someone has major medical coverage under another group benefit plan, they can submit claims under both plans. In this way, they may receive up to 100% reimbursement on all eligible expenses. Claims are submitted in the following order:

- If both plans include a co-ordination of benefits provision, send your claims first to the plan under which you are enrolled as a “Member” (or an “employee”). Once you receive your reimbursement from the first plan, send all information regarding that claim to the other plan;
- If your Dependant Spouse has a plan, send all of your Spouse’s claims to that plan for reimbursement first; and
- For your Children, send claims first to the plan of the parent whose birthday is earlier in the year. For example, if the Spouse’s birthday is in June and the Member’s birthday is in December, claims for your Children are paid first by the Spouse’s plan; any remaining balance is filed with this Plan by the Member.

MEDICAL CLAIM SUBMISSION

Claim forms may be mailed, emailed, faxed or submitted in person to the Administrator at the Benefits Administration Office. If claims are submitted by a method other than mailing, all original documents should be kept in a safe place as the Administrator may request the original documents from you for a period of up to 24 months after you submit the claim. If emailing claims information to the Administrator, please consider encrypting all attached documents to protect your personal information.

EMERGENCY TRAVEL ASSISTANCE (ETA) BENEFITS

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

INTRODUCTION

You and your eligible Dependents are covered for Emergency Travel Assistance (ETA) Benefits if you are an Active, Inactive, or Disabled Member and are under Age 65. For your Spouse to be covered, he/she must also be under Age 65. You must also be covered under your provincial Medicare program to have ETA coverage.

Retired Members and Disabled Members selecting the RMHP coverage option are not eligible for ETA Benefits. The ETA Benefit provides emergency medical coverage and travel assistance services while travelling or vacationing (for non-medical reasons) outside your home province. ETA coverage is limited to the first 60 consecutive days of travel (or vacation).
**WHEN YOU ARE TRAVELLING**

ETA services are administered by Allianz Global Assistance, part of a global travel assistance company. If you require emergency medical or travel assistance while travelling or vacationing, contact Allianz Global Assistance as soon as possible before seeking treatment. Allianz will ensure you get the proper care and assistance you need without incurring unnecessary expenses. Because Allianz guarantees payment for many services, your out-of-pocket costs will be minimal.

It is important to carry your Personal ETA card and your Provincial Medical Insurance plan ID# with you with you at all times when travelling or on vacation. This is the only way Allianz Global Assistance can verify your coverage and guarantee payment to the facility where you are receiving care.

In case of an emergency, call one of the telephone numbers listed on your Personal ETA card. The Allianz Global Assistance multilingual Call Centre is available 24 hours a day, 365 days a year, worldwide. You can contact Allianz at either of the telephone numbers listed on your Personal ETA card.

You will find your Allianz Global Assistance ID # 9087 on the reverse side of your card. You need to quote this ID number when you call Allianz Global Assistance for emergency assistance. Also, know your Plan number, which is 901437, and certificate number, which is your Union Card Number preceded by two zeros so that your certificate number is 9 digits long.

**ALLIANZ GLOBAL ASSISTANCE**

Use the following information to contact Allianz for ETA services:

- In Canada and U.S. call toll-free: 1-800-265-9977
- Elsewhere call collect: 1-519-741-8450
- Allianz Global Assistance ID#: 9087
- Insurance Policy Number: 901437
- Your Certificate Number: Union Card Number (preceded by “00” so that the total number of digits is 9)

**IS ETA COVERAGE PROVIDED AT YOUR INTENDED DESTINATION?**

It's important to call Allianz Global Assistance in advance of your travels, as there may be a chance the country you will be travelling to is in distress or strife (i.e. experiencing a military uprising, war, labour disturbance, or even hurricanes or other severe weather patterns), in which case ETA coverage may not be provided. Coverage may also be cancelled for certain reasons, depending upon the events in some countries.

Call 1-800-265-9977 to verify that the country you are travelling to is approved for coverage. Allianz Global Assistance won’t be able to verify your eligibility for coverage in the Plan, only whether coverage will be extended in the country (or countries) you are visiting.

The Department of Foreign Affairs and International Trade publishes and updates a list of countries that are currently under travel advisory. You can obtain this list by calling Allianz Global Assistance.

**ETA BENEFITS**

Emergency Travel Assistance provides coverage for unforeseen medical emergencies and other travel assistance services while travelling or vacationing (for non-medical reasons) outside your province of residence. If you and/or your Dependant(s) require emergency medical assistance while travelling, contact Allianz Global Assistance as soon as possible before seeking treatment. The Allianz Global Assistance multilingual Call Centre is available 24 hours a day, 365 days a year worldwide. There is an unlimited overall dollar maximum for the Benefits indicated below during the first 60 days of travel or vacation. All eligible expenses must be:

- **Medically Necessary** for the treatment of an illness or injury and recommended by a dentist, or physician, as applicable;
- **Reasonable and Customary** and not experimental or investigational in nature; and
- **Not covered under OHIP** or another government-sponsored or legally mandated program, or which would have been covered if the patient was a resident of Ontario and had properly applied for OHIP coverage.
EMERGENCY MEDICAL CARE

Coverage is provided for the following eligible expenses:

- **Emergency hospital inpatient services.** For example, if you or your Dependants suffer an illness or injury that requires an overnight stay in a hospital, you will be covered for:
  - Semi-private room and board expenses in excess of the ward rate covered by your Provincial Health Insurance Plan (OHIP);
  - Medical and surgical fees including physician fees; and
  - Cost of prescription drugs, x-rays, and other inpatient expenses incurred during your stay.

- **Emergency hospital outpatient services.** For example, if you or one of your Dependents should break a leg and are treated at a hospital as an outpatient, you will be covered for:
  - Physician fees, laboratory tests and medical supplies or appliances (e.g., casts);
  - Physiotherapy and/or other paramedical expenses, resulting from an outpatient emergency, will be reimbursed when covered inside Canada.

MEDICAL ASSISTANCE SERVICES

If you or your Dependant(s) become sick or injured while you are travelling or vacationing, Allianz Global Assistance will help you locate a doctor or medical facility and will follow up to ensure you receive adequate medical care. Allianz will also confirm your coverage with the Administrator and, wherever possible, advise the service provider that payment for the covered services has been guaranteed. In this way, Allianz eliminates the burden of most up-front payments for emergency medical care.

TRAVEL ASSISTANCE TRANSPORTATION SERVICES

Please call Allianz Global Assistance to help you with the following eligible travel services. The cost of these expenses will be provided, or reimbursed for charges incurred for:

- **Ambulance Services** (land, air, rail) if it is necessary to transport you or your Dependant(s) to a different hospital or treatment centre, either within the province or country where the illness or injury happened or to your province of residence. Medical supervision will also be provided if necessary;

- **Vehicle Return Benefits**, up to $500 Canadian, if your vehicle is left behind due to illness, injury or death and no alternative driver is available, Allianz will arrange to have the vehicle returned to your home province or to the rental agency (Commercial transport vehicles are not covered);

- **Transportation Costs** up to a combined Maximum Benefit of $5,000 per emergency;

- **Return Travel Costs** of a one-way economy fare ticket for you and your insured travelling companion(s) to your province of residence if a medical emergency and hospitalization delays your trip home;

- **Dependant Travel Costs** for the cost of transporting them home, if hospitalization leaves your eligible Children unattended. Allianz will arrange such transportation and may include an escort if necessary;

- **Visitation Travel Costs** of return, economy fare for one immediate family member (i.e., spouse, parent, child, brother or sister) to visit you if you have been travelling alone and are hospitalized for more than seven days;

- **Returning Deceased Costs** to return the deceased to their place of former residence, or cremation at the place of death will be covered up to $5,000 Canadian in the event a covered individual dies while travelling;

- **Accommodation and Meals** while staying with a hospitalized family member will be covered up to $700 per family if a trip is delayed due to an illness or accident;

- **Convalescent Care** following hospitalization for accommodation while recovering will be covered up to $75 per day for 5 days per person, if required by you or your eligible travelling companions.

TRAVEL ASSISTANCE PERSONAL AND LEGAL SERVICES

Please call Allianz Global Assistance to help you with the following eligible travel services. The cost of these expenses will be provided, or reimbursed for charges incurred for:
• **Pre-Trip Services** for information concerning any passport, visa, inoculation or immunization requirements of the destination to which you will be travelling, or to help you find the nearest embassy or consulate;

• **Legal Services** to help locate a lawyer or arrange bail, if required or to arrange for the secure pick-up and delivery of any important documents (where possible);

• **Personal Travel Assistance** for help:
  - in obtaining funds by wire or bank transfer (the funds and any costs of wire transfer would be your responsibility);
  - to leave or receive messages during an emergency, 24 hours a day (to keep family members informed during a critical situation);
  - with reporting missing baggage and following up with the transportation company;
  - if your luggage has been lost or stolen;
  - if you need assistance in obtaining replacement travel documents or tickets (the cost of a replacement would be your responsibility);
  - with translation services required during a travel emergency.

### Claiming ETA Expenses You Paid For

If the medical expense you incur is $200 or less, you will be required to pay these costs yourself and seek reimbursement from the Plan upon your return. Please ensure you keep your receipts for these expenses to submit to either your Provincial Health Insurance Plan (OHIP) or the Health Plan upon your return.

The Administrator can assist you with these types of claims.

### ETA Exclusions

The Emergency Travel Assistance Benefit does not cover charges for expenses that are included under your Provincial Health Care plan or another government sponsored or legally mandated program, or which would have been covered if the patient was a resident of Ontario and had properly applied for OHIP coverage.

Eligible expenses must be as a result of an unforeseen medical emergency while travelling.

### DENTAL BENEFITS

**All Active, Inactive, Disabled & Retired Members & Their Eligible Dependents**

You are covered for Dental Benefits if you are a covered Member of the Plan.

### Summary of Benefits

The following is an overview of your Dental coverage.

<table>
<thead>
<tr>
<th>Dental Service</th>
<th>Level of Reimbursement</th>
<th>Maximum Benefit (per person)</th>
<th>Fee Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative/Maintenance Services</td>
<td>100%</td>
<td>$2,500 per calendar year combined</td>
<td>2011 ODA</td>
</tr>
<tr>
<td>Basic Services</td>
<td>100%</td>
<td>$2,500 per calendar year combined</td>
<td>2011 ODA</td>
</tr>
<tr>
<td>Major Services</td>
<td>80%</td>
<td>$2,500 per calendar year combined</td>
<td>2011 ODA</td>
</tr>
<tr>
<td>Orthodontic Services (children under Age 21)</td>
<td>60%</td>
<td>$2,000 per lifetime</td>
<td>2011 ODA</td>
</tr>
</tbody>
</table>
**Covered Eligible Expenses**

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

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

Effective with Dental claim expenses incurred on or after January 1, 2012, the Plan will reimburse the incurred cost of these expenses based on the 2011 Ontario Dental Association (ODA) Suggested Fee Guide amounts for General Practitioners. You will be advised in writing of any updates to the 2011 Fee Guide.

Eligible Dental expenses are covered provided they are:

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

**Preventive / Maintenance Services – 100% Reimbursement**

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

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

**Basic Services – 100% Reimbursement**

These are procedures to eliminate or reduce dental treatment:

- **Consultations** – not related to orthodontics;
- **Study casts** – once each calendar year;
- **Amalgam, Silicate, Acrylic and Composite Fillings and Sedative Dressings**;
- **Extraction and Oral Surgery** – including removal of impacted teeth and general anaesthesia;
- **Endodontic Treatment** – therapy dealing with Root Canal Therapy;
- **Periodontic Treatment** – prevention and treatment of diseases of the bone and gums around the teeth is provided up to 8 units each calendar year, and includes periodontal scaling as noted above;
- **Medication and its Administration** - if provided by injection in a dentist's office;
- **Relining, Rebase and Repairs to Existing Dentures** - including the addition of new teeth and new stainless steel crowns, but excluding the cost of initial dentures, their replacement or duplication; and
- **Passive Space Maintainers** - for primary teeth and habit breaking appliances (Children under Age 21 only).
MAJOR SERVICES – 80% REIMBURSEMENT

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

- **Initial Installation of Partial/Full Dentures** - to replace one or more natural teeth that were extracted or fractured while the person is covered by this Plan; and

- **Replacement of Existing Dentures** – if the existing denture is no longer serviceable or replacement is required because an extraction, loss or fracture of a natural tooth occurred while covered by this Plan, or if the existing denture is at least 5 years old and no longer serviceable and the person has been covered by the Plan for at least 12 months; and

- **Crowns** (other than stainless steel), Inlays and Onlays - if a tooth cannot be restored with a filling; and

- **New Bridges** – if a new bridge is required because an extraction, loss or fracture of natural teeth which occurred while the person is covered by this Plan (if there are three or more teeth missing in the arch, the Plan will provide reimbursement for a denture); and

- **Replacement of an Existing Bridge** – if bridge replacement is required because an extraction, loss or fracture of natural teeth occurred while the person is covered by this Plan, or if the existing bridge is at least 5 years old and no longer serviceable and the person has been covered by the Plan for at least 12 months; and

- **Dental Implants** – may be paid as an alternative procedure, up to the cost of the procedure covered by the Plan (i.e., bridge or denture expenses).

ORTHODONTICS – 60% REIMBURSEMENT

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

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

BASIS OF DENTAL BENEFIT PAYMENTS

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

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

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

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

DENTAL CLAIM SUBMISSION

Your Dentist may submit claims to the Plan via CDA Net, which is an approved, electronic claim submission network for dental practitioners.

Claim forms may also be mailed, emailed, faxed or submitted in person to the Administrator at the Benefits Administration Office.

If claims are submitted by a method other than mailing, all original documents should be kept in a safe place as the Administrator may request the original documents from you for a period of up to 24 months after you submit the claim.

If emailing claims information to the Administrator, please consider encrypting all attached documents to protect your personal information.
DENTAL PRE-APPROVAL AND ALTERNATE TREATMENT

Pre-Approval: Before treatment begins for dental work anticipated to cost more than $500, or for a crown, bridge, denture or orthodontic work, you must send a Dental Treatment Plan to the Administrator.

The Administrator will tell you the amount of the dental expenses the Plan will reimburse. The Plan may pay for the expenses of an alternate treatment only.

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

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

Treatment Plans can be sent electronically to the Administrator.

Alternate Treatment

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

DIRECT DEPOSIT OF DENTAL BENEFIT PAYMENTS

You may enrol to have the Plan deposit payment of your dental claims directly to your personal bank account at your selected financial institution. You will need to complete the necessary Direct Deposit forms. Please contact the Administrator for the applicable form or for more information. Forms are also available from the U.A. Local 787 Office, or online from the Plan’s website.

DENTAL EXPENSES NOT COVERED BY THE PLAN

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

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

TIPS TO BEING BETTER DENTAL CONSUMERS

Here are some suggestions that might help you contain costs and help us maintain a valued Plan:

- Not all dentists use the current fee guide (or schedule) – know what fee guide your dentist uses – it may be a less expensive fee guide (this Plan usually reimburses on the previous year’s guide);
- Ask about less expensive, but equally effective alternative treatments; and
- Due to scientific advances and improved oral health – a visit to your dentist every six months for cleaning, scaling and x-rays may not be necessary (once every nine months is often adequate).
CO-ORDINATION BETWEEN BENEFIT PLANS

If someone has dental coverage under another group benefit plan, they can submit claims under both plans. In this way, they may receive up to 100% reimbursement on eligible expenses. Claims are submitted in the following order:

- If both plans include a co-ordination of benefits provision, send your claims first to the plan under which you are enrolled as a “Member” (or an “employee”). Once you receive your reimbursement from the first plan, send all information regarding that claim to the other plan;
- If your Dependant Spouse has a plan, send all of your Spouse’s claims to that plan for reimbursement first; and
- For your Children, send claims first to the plan of the parent whose birthday is earlier in the year. For example, if the Spouse’s birthday is in June and the Member’s birthday is in December, claims for your Children are paid first by the Spouse’s plan; any remaining balance is filed with this Plan by the Member.

MEMBER ASSISTANCE PROGRAM (MAP) BENEFIT
All Active, Inactive, Disabled & Retired Members & Their Eligible Dependents

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

INTRODUCTION

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

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

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

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

- www.myfseap.com
- Log-in using Group Name: toua787
- Password: MAP

SUMMARY OF THE SERVICES PROVIDED

Your MAP provides direct access to experienced professional Counsellors who can assist you in finding the services that are right for you. Confidential assistance is available for a broad range of personal and work-related issues such as:

- Personal or Job Stress
- Relationship Issues
- Depression/Anxiety
- Eldercare and Childcare
- Addictions (including gambling)
- Separation and Divorce
- Parenting
- Balancing Work and Family Life
- Financial and Legal Difficulties
- Nutritional Consultation
- Smoking Cessation
Below are details of some of the services available to Members and their eligible Dependents.

**CONFIDENTIAL COUNSELLING SERVICES**

Immediate access to professional Counsellors is available by phone 24/7 through the toll-free line. If face-to-face counselling is required, an appointment will be scheduled. For added convenience, you can also arrange telephone or Web-based (e-counselling) sessions. Anything you or a family Member discuss with the Counsellor is kept absolutely confidential. Counsellors will not release any information to anyone without your prior written consent except where legally required.

**FAMILY CONNEXIONS**

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

**LEGAL SERVICES**

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

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

**FINANCIAL CONSULTATION SERVICES**

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

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

**TEEN/PARENT HELPLINE**

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

**TAKE 10 HELPLINE**

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

**CAREER CONNEXIONS**

Career Consultation Specialists offer personalized consultations to address your specific career needs including:

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

**LIFE COACHING**

This service is an effective resource for someone who is looking to make a positive change in almost any area of their life. Life Coaching is an energizing process that helps you to plan your life goals.
VACATION & STATUTORY HOLIDAY PAY PLAN

AN OVERVIEW

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

Vacation Pay can only be paid to you if Vacation Pay contributions are received by the Fund from your Employer/Contractor on your behalf.

The Trustees and U.A. Local 787 will make every effort to collect delinquent Vacation Pay contributions from Employers/Contractors; however, the Fund cannot guarantee that you will receive Vacation Pay if your Employer/Contractor is delinquent in making contributions.

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

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

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

“The Administrator” refers to Employee Benefit Plan Services (EBPS).

AUTOMATIC BENEFIT PAYOUTS

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

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

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

OPTIONAL BENEFIT PAYOUTS

You may request one Optional Payment each calendar year by completing the application form and returning it to the Administrator.

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

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

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

The Member must demonstrate that there are extraordinary personal or financial circumstances necessitating the additional payment. Such additional payments are subject to the Board of Trustees’ procedures.
An Administrative fee will be deducted from all Optional Payments. The fee is $30.09 per payment. The fee is subject to adjustment. Optional Payments are not made from May 1 to the May payment date or from November 1 to the November payment date. An Optional Payment cannot be made because you change your Employer/Contractor.

**VACATION PAY PLAN DETAILS**

**FUND ADMINISTRATION**

The Vacation Pay contributions received from Employers/Contractors each month under the terms of the U.A. Local 787 Collective Agreements are paid into the Fund. The Fund is invested in short-term guaranteed interest investments.

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

**REPLACEMENT CHEQUES**

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

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

**DEATH BENEFIT**

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

**ASSIGNING YOUR VACATION PAY**

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

**BANKRUPT OR INSOLVENT EMPLOYERS/CONTRACTORS**

**CONTACTING U.A. LOCAL 787**

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

**HOW TO CLAIM VACATION PAY DUE FROM BANKRUPT OR INSOLVENT EMPLOYERS**

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

**DIRECT DEPOSIT OF VACATION PAY BENEFITS**

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

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

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

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

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

“The Administrator” refers to Employee Benefit Plan Services (EBPS).

“Pension Plan Account Value” and “Pension Plan Account” means the Pension Plan Member’s accumulated contributions submitted by Employers/Contractors under a U.A. Local 787 Collective Agreement and under Reciprocal Agreements, plus a prorated portion of the Fund’s interest, dividends, net realized and unrealized capital gains and losses less a prorated share of the Fund’s operational costs.

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

BECOMING A PENSION PLAN MEMBER

If you are working under a U.A. Local 787 Collective Agreement, you will become a Pension Plan Member, if before November 30th of the year in which you reach Age 71; you have had contributions remitted to the Plan on account of 700 hours within a period of 18 consecutive months.

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

RECEIVING PENSION BENEFITS FROM THE PLAN

IF YOU ARE RETIRING

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

IF YOU HAVE TERMINATED

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

IF YOU HAVE DIED - BENEFICIARY OR SPOUSE PENSION BENEFIT APPLICATION

Your Designated Beneficiary (or Spouse) or other representative should contact the Administrator in the event of your death.
IF YOU ARE SEPARATING, DIVORCING, OR IF YOU ARE SUBJECT TO A DOMESTIC CONTRACT, COURT ORDER OR SEPARATION AGREEMENT

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

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

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

CONTRIBUTIONS TO THE PENSION PLAN

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

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

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

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

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

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

RECIPROCAL AGREEMENTS

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

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

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

YOUR PENSION PLAN ACCOUNT

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

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

OTHER NOTES OF INTEREST

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

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

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

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

TAXES

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

ACHIEVING YOUR RETIREMENT GOALS

Virtually everyone’s personal goal includes a financially secure future, and the Pension Plan can help you achieve this goal. Your Pension Plan provides an excellent foundation to build your retirement income. The Pension Plan, the voluntary U.A. Local 787 Group RRSP, government plans such as CPP and OAS, and your personal savings, including RRSPs and TFSAs, combine to carry you through the retirement years.

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

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

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

WHEN CAN YOU RETIRE

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

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

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

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

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

APPLYING FOR YOUR RETIREMENT BENEFITS

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

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

1. **MONTHLY LIFETIME PENSION (Annuity)**

   A monthly lifetime pension (annuity) can be purchased for you through an insurance company prior to the end of the calendar year in which you reach Age 71. The amount of the monthly pension will depend on several factors:
   
   a) the amount of your Pension Plan Account;
   b) your marital status;
   c) your Age at retirement;
   d) interest rates at the time you retire;
   e) the form of monthly pension (annuity) purchased.

**LIFETIME PENSION OPTIONS**

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

**Life Only Pension** – provides a monthly pension for your lifetime only and no Death Benefits are paid to a Beneficiary. If you have a Spouse on the date of your retirement a Waiver of Joint and Survivor Pension will be required.

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

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

If you have a Spouse on the date of your retirement a Waiver of Joint and Survivor Pension will be required. As with all options available to you, careful planning is necessary for this option. The Pension Plan’s calculation will assume you will be eligible for full CPP/OAS benefits at age 65. No provision will be made for reduced or delayed CPP or OAS benefits.

No matter which option you choose, a monthly pension (annuity) is always paid to the Pension Plan Member for their lifetime.

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

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

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

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

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

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

4. **CASH PAYMENT**

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

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

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

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

GOVERNMENT PENSION BENEFITS

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

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

PENSION DEATH BENEFITS BEFORE RETIREMENT

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

DESIGNATING A BENEFICIARY

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

Your Spouse is deemed to be your Designated Beneficiary, unless your Spouse signs a Waiver of Pre-Retirement Death Benefit. A Waiver is not required for contributions made before 1987 payable on death before retirement.

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

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

YOUR SPOUSE

Your “Spouse” is either:

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

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

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

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

The Plan will determine if the agreement you signed is compliant with pension legislation.
ELIGIBILITY FOR A TERMINATION BENEFIT

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

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

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

YOUR TERMINATION BENEFIT OPTIONS

You may choose from the following Termination Benefit options:

PENSION PLAN ACCOUNT OPTION

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

LOCKED-IN PENSION PLAN ACCOUNT OPTIONS

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

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

NOT LOCKED-IN PENSION PLAN ACCOUNT OPTIONS

a) Portion not Locked-in

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

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

b) 100% not Locked-in

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

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