PLAN TEXT

FOR THE

WEEKLY DISABILITY, HEALTH AND DENTAL BENEFITS

Administered By

THE BOARD OF TRUSTEES
OF
THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE FUND

Schedule as at January 1, 2020

Approved By The Board Of Trustees on December 12, 2019

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ESTABLISHMENT OF THE PLAN

THE TRUSTEES OF THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE FUND (the Trustees) established a Plan of Weekly Disability, Health and Dental Benefits (the "Plan") which has been amended from time to time all as evidenced by resolution of the Trustees. Effective October 1, 2004 the Plan is funded solely by the assets of The Edmonton Pipe Industry Health and Welfare Fund (the "Fund"). Between April 1, 2000 and September 30, 2004 the Plan was administered pursuant to an Administration Services Contract with Maritime Life Assurance Company.

The Trustees provide other benefits such as Life Insurance, Dependent Life Insurance, Accidental Death and Dismemberment Benefits, Burial Benefits and Long Term Disability Benefits under contracts of insurance underwritten by The Great-West Life Assurance Company. For the purpose of this Plan Text the aforementioned insured benefits do not comprise part of the Plan.

DEFINITIONS

- **Administrator** means the Board of Trustees of The Edmonton Pipe Industry Health and Welfare Fund.

- **Bank of Credited Hours** shall consist of all credited hours worked by an Employee on and after the date the Employee becomes an Employee as defined in this Plan. The Bank of Credited Hours does not include any Credited Hour that would increase the total number of Credited Hours in the Bank of Credited Hours beyond 2,600 hours and no such Credited Hour thereafter will be deemed to be a Credited Hour for the purposes of this Plan.

  On the first (1st) day of each Benefit Period, 130 Credited Hours will be deducted from each covered Employee's Bank of Credited Hours.

- **Benefit Period** means a period of one calendar month.

- **Credited Hour** means
  - Any hour that is worked by an Employee of the Union for the Union, or
  - Any hour that is worked by an Employee in respect of which hour, a Participant Employer has, pursuant to a labour contract or agreement with the Union, made a contribution on behalf of the Employee into the Fund.

- **Determination Date** means the last day of any calendar month.

- **Employee** means any person who is employed by the Union on a full-time basis, or who is employed by a Participant Employer in a job classification for which the Union is the collective bargaining agent.

- **Fund** means The Edmonton Pipe Industry Health and Welfare Fund.

General Provisions

DEFINITIONS (CONTINUED)

- **Participant Employer** means the Union or any employer who is required to make payments into the Fund for the purpose of providing insurance benefits for a class or classes of Employees of such employer eligible for insurance under this plan, all pursuant to an agreement with the Union.

- **Permit Worker** means any person who is employed by the Union on a temporary basis, or who is employed by a Participant Employer in a job classification for which the Union is collective bargaining agent.

- **Provincial Health Care Plan** is a publicly funded plan of benefits universally provided to eligible residents of a province and which is governed by a health care insurance act of the province and the Canada Health Act.

- **Retired Employee means:**

    - With respect to Employees who are in receipt of a Pension from the Edmonton Pipe Industry Pension Plan, Alberta Refrigeration Industry Pension Plan, UA Canadian Pipeline Pension Plan, UA Sprinkler Pension Plan, or UA Officers Pension Plan and who are members in Good Standing with the Union, and at the time of retirement had accumulated a minimum of 15 years of Credited Service **and** 25,000 contributory hours earned through employment with a Contributing Employer and within the jurisdiction of UA Local 488. Employees who have not attained the age of 65 years and are in Good Standing with the Union and did not qualify at the time of Retirement with the required years of Credited Service, will be deemed to be active with exception of Disability Benefits.

- **Union** means Local Union 488 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada.

General Provisions

BENEFIT DESIGN

The Benefit Designs applicable under this Plan are as follows:

BENEFIT DESIGN	EMPLOYEES ELIGIBLE FOR BENEFIT DESIGN	BENEFITS INCLUDED IN BENEFIT DESIGN
A	Employees With A Sufficient Bank Of Credited Hours Or An Employee, Under Age 65, Without Sufficient Bank Of Credited Hours And Who Make The Necessary Self Payment Within The Notice Period	Health Benefits Dental Benefits Weekly Disability Benefits
B	Employees, Under Age 65, Without A Sufficient Bank Of Credited Hours And Who Make The Necessary Self Payment Within The Notice Period	Health Benefits Dental Benefits
AW	Spouses And Dependents Of Deceased Employees Enrolled In Benefit Design "A" or "B" Immediately Prior To Death Of The Employee	Health Benefits Dental Benefits
RE	Retired Employees: Under Age 65	Health Benefits Dental Benefits
RN	Retired Employees: Over Age 65	Health Benefits Dental Benefits
REW	Spouses And Dependents Of Deceased Retired Employees Enrolled In Benefit Design "RE" Immediately Prior To Death Of The Retired Employee	Health Benefits Dental Benefits
RNW	Spouses And Dependents Of Deceased Retired Employees Enrolled In Benefit Design "RN" Immediately Prior To Death Of The Retired Employee	Health Benefits Dental Benefits

Once the Employee's Hour Bank is exhausted, Benefit Designs "B" may be elected on a self-payment basis for a maximum of 12 consecutive months. If the Hour Bank has not been exhausted, Benefit Design "A" applies.

A Retired Employee may qualify for Benefit Designs "RE". Once the Hour Bank is exhausted, the Retired Employee may make self-payments for Benefit Design "A" for a period of 12 consecutive months prior to age 65.

Thereafter, the Retired Employee may qualify for the Retired Employee benefits at a cost of set by the Trustees, if he remains a member in good standing of the Union.

General Provisions

EMPLOYEE ELIGIBILITY

To be eligible for coverage, an Employee must be:

- Employed by the Union on a full-time basis, or employed by a Participant Employer in a job classification for which the Union is the collective bargaining agent;
- A permit worker employed by the Union on a temporary basis, or employed by a Participant Employer in a job classification for which the Union is the collective bargaining agent;
- In a class shown in the applicable Benefit Design Schedule; and in all cases
- Covered under a Provincial Health Care Plan.

An Employee will become eligible for coverage:

- On the effective date if the Employee has at least 320 credited hours in his Bank of Credited Hours on the preceding Determination Date; or
- On the first day of the next month following any Determination Date during which the Employee acquired at least 320 credited hours in the Employee's Bank of Credited Hours.

If the coverage of an Employee is terminated because of an insufficient number of Credited Hours, and if they remain a member their benefits will be reinstated as soon as they get a total of 130 hours including any hour bank left, on any Determination Date, the Employee shall again become eligible for coverage under this Plan on the first day of the Benefit Period next following such Determination Date.

An Employee may select to make the required self-payments to the Health Fund, if they are covered under this Plan and do not have at least 130 Credited Hours in the Employee's Bank of Credited Hours.

Once the Employee's Bank of Credited Hours is exhausted, the Employee will be notified and must make the required payment for self-pay benefits within 31 days of notice.

When the Employee who is subscribing to self-pay benefits subsequently accumulates 130 Credited Hours due to work with Participating Employers, the Employee will be automatically reinstated to Benefit Design "A".

Once the Employee elects the desired self-pay Benefit Design, a change to another Benefit Design cannot be made until the Employee is reinstated with the required Credited Hours to Benefit Design "A".

The Plan permits "dual coverage" for persons where both Spouses are members of UA Local 488 and have separate eligibility in the Health & Welfare Plan.

General Provisions

EFFECTIVE DATE OF EMPLOYEE COVERAGE

An Employee's coverage under this Plan will become effective on the later of the date:

- The Employee becomes eligible;
- If the Employee is absent from work because of disability due to illness or injury on the date the Employee's coverage, or any improvement to such coverage would otherwise become effective, such coverage or improvement will not become effective until the date the Employee returns to active full-time work for one (1) full day.

DEPENDENT ELIGIBILITY

To be eligible for coverage, an Employee's Dependent must be covered under a Provincial Health Care Plan.

An Employee's Dependent becomes eligible for coverage when the Employee becomes eligible or, if acquired later, upon becoming the Employee's Dependent.

The Employee must be covered in order for the Employee's Dependents to be covered.

The Employee must have provided sufficient information, on the form required by the Administrator, for the Administrator to be able to determine whether the Dependent is eligible for benefits.

Dependent means a Spouse and/or an unmarried Child under 18 years of age and solely dependent upon the Employee for support. If the Child is a full-time student, then they are covered until their 25th birthday. Proof of student status is required by this Plan.

Spouse means a person who is:

- Married to the Employee and has not been living separate and apart from the Employee for 1 (one) year or,
- If there is no person to whom (1) above applies, a person who has lived with the Employee in a conjugal relationship for a continuous period of 24 months, or of some permanence if there is a child of the relationship by birth or adoption.

Child means a person who is:

- A natural or legally adopted child, or,
- A step-child, who is dependent upon the Employee for support and lives with the Employee in a regular parent-child relationship, or,
- A foster child or other child, who is dependent upon the Employee for support and lives with the Employee in a regular parent-child relationship and the Employee has legal guardianship.

General Provisions

DEPENDENT ELIGIBILITY (CONTINUED)

Retired Employees may only add a Spouse if said Spouse was acquired by a licensed marriage. Common Law spouses are not permitted to be added as a dependent on the Plan. Children of the Retired Employee will remain eligible to be added as a dependent to the Plan.

RETIREE ELIGIBILITY

To be eligible for coverage, the Retired Employee and Dependents must be covered under a Provincial Health Care Plan.

- A Retired Employee who reaches age 65 may be eligible for Retired Employee Benefits by remitting the self-payment rate in effect at the time.
- A Retired Employee who applies for Plan coverage beyond age 65 must have accumulated 15 years of Credited Service and a minimum of 25,000 contributor hours in The Edmonton Pipe Industry Pension Plan, the UA Canadian Pipeline Pension Plan, the Sprinkler Industry Pension Plan, the Alberta Refrigeration Industry Pension Plan or the UA Officers Pension Plan. The accumulated number of years must be earned through employment with a Contributing Employer, and within the jurisdiction of the Union. Any transfer of Credited Service to The Edmonton Pipe Industry Plans via a Reciprocal Agreement will not qualify towards the requirements for coverage.
- Subject to payment of the prescribed amount, a Retired Employee will be eligible for benefits. Weekly disability coverage is not provided. Eligible dependents of Retired Employees will also be eligible for coverage.
- A Retired Employee may make self-payments for a period of 12 consecutive months once the Hour Bank is exhausted. Thereafter, the Retired Employee may qualify for Retired Employee Benefits at a cost per month, as set by the Trustees if he remains a member in good standing of the Union.

EFFECTIVE DATE OF DEPENDENT COVERAGE

Coverage, or any increase in coverage, for an Employee's Dependent (other than a newborn child who becomes covered within 31 days of becoming eligible) who is because of illness or injury on the date such coverage would otherwise become effective, will not become effective until the date such Dependent is no longer confined.

Weekly Disability Benefit

AVAILABLE FOR ACTIVE MEMBERS AND MEMBERS ENROLLED IN SELF PAYMENT PLAN "A" ONLY

BENEFIT AMOUNT

$550 Per Week, 26 Week Maximum

A Covered Employee is considered to be Totally Disabled if the Covered Employee is unable to perform any and every duty of his own occupation. In the event the Covered Employee becomes Totally Disabled, while eligible for Benefits, due to a sickness or any injury unrelated to work, he may qualify to receive a Weekly Disability Benefit from the Plan. The Covered Employee must be under the care of a licensed Medical Doctor (M.D.) or Specialist. A Specialist is a Medical Doctor who has specialized knowledge deemed appropriate for the impairment causing the Covered Employee's disability (Example: A Psychiatrist, in the case of a psychiatric illness).

Benefits are payable on the basis of a seven (7) day week. Benefits for any one (1) period of disability are payable on the 1st day of a disability resulting from an accident. Benefits due to sickness are payable after the 8th day or the expiry of Employment Insurance (EI) Benefits (see below). Partial weeks of disability are paid at a daily rate that is one seventh of the weekly benefit.

CLAIM FILING

Weekly Disability Benefit claims must be received by the Administration Office within sixty (60) days from the commencement of the Covered Employee's date of disability. The Covered Employee's date of disability, for Benefit purposes, will not be earlier than the date on which the Covered Employee first sees a Physician for his disability. Late filed claims will not be accepted.

EMPLOYMENT INSURANCE INTEGRATION

The Plan's Weekly Disability Benefit is coordinated with the Human Resources and Social Development Canada (HRSDC) Employment Insurance Accident and Sickness benefit. The Plan will pay Benefits during the Employment Insurance (EI) waiting period which is currently one calendar week. EI will pay Accident and Sickness benefits for a maximum of 15 weeks. If EI has accepted the Covered Employee's claim, but reduced the benefit due to other insurance or income, or if EI refuses to pay a benefit because the Covered Employee breached an EI eligibility rule (Example: left the country or failed to claim EI on time), this Plan will pay no benefit during this period. If the Covered Employee is still totally disabled when EI benefits terminate, the Plan will continue payments if the Covered Employee provides medical evidence which supports total and continuous disability.

Weekly Disability Benefit

EMPLOYMENT INSURANCE INTEGRATION (CONTINUED)

A Covered Employee should not wait until after receipt of EI Accident and Sickness benefits to file a claim for this Plan's Weekly Disability Benefit – if the Covered Employee does, he will miss the filing deadline and Weekly Disability Benefits will not be paid.

If a Covered Employee is unable to work due to disability he should apply for EI Accident and Sickness benefits, not EI Unemployment benefits. If the Covered Employee is already in receipt of EI Unemployment benefits when he becomes disabled, the Covered Employee should notify HRSDC of his disability and switch to Accident and Sickness benefits. In order to receive the Plan's Weekly Disability Benefit after the one week waiting period, the Covered Employee must provide a statement from HRSDC confirming denial of EI benefits or indicating the period during which EI benefits were paid to the Covered Employee.

MAXIMUM BENEFIT PERIOD

Weekly Disability Benefits provided by the Plan will be paid for a maximum of 26 weeks during any one period of disability. If a Covered Employee does not qualify for EI benefits because the Covered Employee does not have sufficient work credits, the Plan will pay Benefits as long as the Covered Employee is totally disabled, up to a Maximum Benefit Period of 26 weeks.

As EI Accident and Sickness benefits may be paid for up to 15 weeks following the one week waiting period, the combined EI and Plan benefits may provide payments for up to 11 weeks. In no event will Weekly Disability Benefits be paid for any week a Covered Employee receives or is entitled to receive EI, or which is more than 26 weeks after your date of disability.

MAXIMUM BENEFIT

Weekly Disability Benefits are intended to assist in replacing the earnings Covered Employees were receiving prior to their illness or accident. The Plan reserves the right to request information regarding any income that a Covered Employee may be receiving during his disability period. In the event that the Covered Employee is receiving, or is entitled to receive, income that provides more than 100% of his pre-disability earnings, Benefits will be reduced, dollar-for-dollar, by the excess above 100%. If the Covered Employee is declined for EI benefits because of his entitlement to income from another plan, no Weekly Disability Benefits will be payable by the plan during the 15 week period EI benefits would otherwise have been paid.

If, immediately prior to disability, a Covered Employee is working, but no contributions are remitted to the Fund on the Covered Employee's behalf, any loss of income benefit the Covered Employee may be entitled to will be a direct dollar for dollar offset against Weekly Disability Benefits that would otherwise be payable under this Plan.

Weekly Disability Benefit

RECURRENT DISABILITIES

Successive periods of disability separated by less than two (2) weeks of work, or availability for work, will be considered one period of disability. The Plan's Maximum Benefit Period will be counted from the Covered Employee's initial date of disability. The exception to this rule is if the next disability is due to a different cause and begins after the Covered Employee has been back at work or available for work for at least one full day.

REHABILITATIVE EMPLOYMENT

Weekly Disability Benefits will continue to be payable if the covered Employee participates in an Approved Rehabilitation Program. If the covered Employee recovers sufficiently to work again at any occupation, the covered Employee may be able to do so without jeopardizing his benefit status. In order to maintain eligibility for Weekly Disability Benefits and Long Term Disability Benefits, it is important to note that any work a Covered Employee performs during rehabilitation must be approved, in writing, by the Plan and his Physician as an Approved Rehabilitation Program.

Participation in an Approved Rehabilitation Program will enable a covered Employee to receive a greater total income than without the program. Covered Employees are not eligible for Weekly Disability Benefits during any period in which they are working, except under an Approved Rehabilitation Program. A covered Employee's Weekly Disability Benefit will be reduced by 50% of the covered Employee's rehabilitation income if the covered Employee is employed in an Approved Rehabilitation Program.

Rehabilitation employment may include:

- The covered Employee's regular occupation on a part-time basis; or
- A formal vocational training program; or
- Any other training program deemed suitable by the covered Employee's Plan.

SUBROGATION

For the purposes of this provision, the term "subrogation" means the Plan's right to recover Weekly Disability Benefits paid to a covered Employee if another party is, or may be, legally liable to compensate the covered Employee for income lost due to the covered Employee's disability.

A Covered Employee may be entitled, as a result of the incident which caused or contributed to the covered Employee's disability, to recover compensation for loss of income from a third party. The Plan will be subrogated to all the covered Employee's rights of recovery for loss of income. The subrogation will apply to the extent of the sum of Benefits paid or payable by the Plan. The covered Employee will be required to provide full disclosure about the recovery or attempted recovery for the loss.

Weekly Disability Benefit

SUBROGATION (CONTINUED)

In the event that a covered Employee provides proof to the Administration Office that he has not recovered full compensation for loss of income, the Plan shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should a covered Employee elect to settle the matter prior to judicial determination, it is important that the covered Employee understand that the sum reached in settlement will be deemed to be full compensation for loss of income, and the Plan's right of subrogation will apply.

The term 'compensation' includes any periodic or lump sum payments a covered Employee receives or is entitled to receive due to past, present or future loss of income. The term "third party" includes a covered Employee's own and any other home or automobile insurer, as well as any individual, business, insurer or government agency against whom the covered Employee may be entitled to claim for loss of income arising from the covered Employee's disability.

LIMITATIONS

Benefits are not payable for the following:

- Any period during which a covered Employee is receiving or entitled to receive an income replacement benefit or loss of earning capacity benefit under a motor vehicle accident insurance plan or policy;
- Any day that a covered Employee does any kind of work for pay or profit other than in an approved Rehabilitation Program;
- The period in which a covered Employee is entitled to maternity leave of absence by statute, contract or employer agreement;
- Any disability for which benefits are payable under a Workers' Compensation law or similar law;
- Any day for which a covered Employee receives a pension from The Edmonton Pipe Industry Pension Plan;
- Intentionally self-inflicted injuries, whether the covered Employee is sane or insane;
- Any disability arising from an insurrection, rebellion or participation in a riot or civil commotion;
- Any disability arising from participation in, or attempt to commit, a criminal act;
- Any disability resulting from injury or disease which occurred while the covered Employee was on active duty
- In the armed forces of any country, state or international organization or any disability
- Resulting from war or act of war, whether declared or undeclared;
- Claims that are not filed within sixty (60) days of the start of a disability;
- More than one disability absence (regardless of the cause) per calendar year once a covered employee is over age 65;
- Any period of disability during which a Covered Employee is not receiving ongoing supervision/treatment by a licensed Medical Doctor (M.D.) or Specialist deemed appropriate by the Plan for the impairment causing his disability. A covered Employee will not be compensated for any period of disability during which the covered Employee does not participate in the treatment program recommended by his Doctor or Specialist;

Weekly Disability Benefit

LIMITATIONS (CONTINUED)

- Any period of disability resulting from substance abuse including alcoholism and drug addiction, unless the covered Employee is participating in a recognized substance withdrawal program.
- Weekly Disability Benefits will not be paid if a covered Employee fails to provide information on other income sources when such information is requested;
- Weekly Disability Benefits will not be paid if the covered employee is not a Member in Good Standing of UA Local 488.

Health Benefit

BENEFIT DESIGN SCHEDULES FOR "A", "B" "AW", "RE", "RN", "REW", "RNW"

BENEFIT DESIGN SCHEDULE "A" "B" "AW" "RE" "RN" REW" RNW" PARAMETER	BENEFIT DESIGN SCHEDULE "A" "B" "AW" "RE" "RN" REW" RNW" FEATURES
Coverage Available To	All Eligible Employees And Their Dependents
Lifetime Maximum Benefit For Out of Province	$5,000,000. (60 Day Trip Limit). Maximum Benefit Is Not Subject To The $40,000 Overall Calendar Year Maximum Benefit)
Overall Calendar Year Maximum Benefit	$40,000 (Exclusive Of Benefit For Out Of Province And Dental Is Separate)
Percentage of Class I Expenses Payable	As Prescribed Below
Percentage of Class II Expenses Payable	90%
Percentage of Class III Expenses Payable	90%

BENEFIT MAXIMUM OVERVIEW FOR CLASS I COVERED CHARGES

BENEFIT TYPE	MAXIMUM BENEFIT PAYABLE AND APPLICABLE TIME LIMIT, IF ANY	PLAN TEXT REFERENCE PAGE
Hospital: In Home Province	Semi-Private Room Subject To Overall Calendar Year Maximum Benefit	14
Convalescent Hospital: In Home Province	$10 Per Day, Maximum Stay: 120 Days Per Disability Subject To Overall Calendar Year Maximum Benefit	14
Nursing Care: Out Of Hospital	$20,000 Per Calendar Year Subject To Overall Calendar Year Maximum Benefit	15
Orthotics: Custom Made	$400 Per Calendar Year, Subject To Overall Calendar Year Maximum Benefit Medical Doctor or Podiatrist Referral Stating Condition Is Required Every 3 Years	16
Hearing Care: Hearing Aids (Initial Cost And Installation, Repair, Replacement Or Purchase Of Additional Hearing Aid)	$4,000 every 5 years from date of last purchase Audiology Report Required For Initial Claim Subject To Overall Calendar Year Maximum Benefit	15

Health Benefit

HEALTH PRACTITIONERS' BENEFIT FOR CLASS I COVERED CHARGES

HEALTH PRACTITIONER	MAXIMUM BENEFIT
Speech Therapist, Osteopath, Podiatrist, Naturopath, Acupuncturist, or Christian Science Practitioner combined*Science Practitioner	100% Combined Maximum Of $400 Per Person Per Calendar Year Benefit For All Health Practitioners $60.00 Per Disability For Diagnostic X-Rays When Ordered By Practitioner Subject To Overall Calendar Year Maximum Benefit
Chiropractor	Adjustments at 100% To A Maximum Of $500 Per Person Per Calendar Year Benefit Subject To Overall Calendar Year Maximum Benefit
Physiotherapist	100% To A Maximum Of $700 Per Person Per Calendar Year Benefit Subject To Overall Calendar Year Maximum Benefit
Massage Therapy	100% To A Maximum Of $400 Per Person Per Calendar Year Benefit Subject To Overall Calendar Year Maximum Benefit Must Be A Member In Good Standing Of An Accredited MT Association in Canada
Psychologist and Registered Social Worker	$100% To A Combined Maximum of $1,000 Per Person Per Calendar Year Maximum Benefit Subject To Overall Calendar Year Maximum Benefit

VISION CARE BENEFIT FOR CLASS I COVERED CHARGES

VISION CARE BENEFIT	MAXIMUM BENEFIT
Single Vision, Bifocal Or Trifocal Lenses And Or Contact Lenses	$450 Per Person For Purchase Of Prescription Glasses Or Contact Lenses Benefit Renews Every 2 Years On January 1st Prescription Required With Each Claim Eye Exams Are Not A Covered Expense Subject To Overall Calendar Year Maximum Benefit
Laser Eye Surgery	$1,600 Per Lifetime subject to Overall Calendar Year Maximum Benefit
Safety Glasses *(Member Only)*	$400 Every 2 Years Prescription Lenses Only Prescription Required With Each Claim Subject To Overall Calendar Year Maximum Benefit

Health Benefit

ADDICTIONS TREATMENT BENEFIT FOR CLASS I COVERED CHARGES

ADDICTION TREATMENT BENEFIT	MAXIMUM BENEFIT
Use Of Addiction Treatment Centres	$5,000 Lifetime Maximum, Per Person Subject To Overall Calendar Year Maximum Benefit Available To Active Members and Self-Payment Benefit Class "A" Only Excludes: Tobacco Addictions

PERCENTAGE PAYABLE

This is the part of Covered Charges shown in the applicable Benefit Design Schedule that the Administrator pays.

Covered Charges are reasonable and customary charges for needed medical care, services or supplies, as described below, and received while the person is covered, for either an illness or injury that is non-occupational or for pregnancy.

CLASS I COVERED CHARGES

Hospital (Within Home Province)
Daily charges in excess of the ward rate up to the room and board limit shown in the applicable Benefit Design Schedule plus user fees.

A hospital is a place that:

- Chiefly provides inpatient medical care of the injured, sick or chronically ill;
- Has a staff of licensed doctors (M.D.) and 24-hour nursing care by registered nurses (R.N.); and
- Is approved as a hospital for payment of the ward rate under the Provincial Health Care Plan.

Convalescent/Rehabilitation Hospital (Within Home Province)
Daily charges in excess of the ward rate up to the room and board limit shown in the applicable Benefit Design Schedule plus user fees, but not beyond the Maximum Stay shown in the applicable Benefit Design Schedule. Confinement must begin within 14 days of hospital discharge. A new Maximum Stay will apply if the covered person has not been confined in a convalescent hospital for at least 90 days.

A convalescent hospital is a place that:

- Has a transfer arrangement with hospitals;
- Provides inpatient nursing care (that meets minimum Provincial regulations) for the convalescent stage of an injury or illness; and
- Is approved as a convalescent hospital for payment of the ward rate under the Provincial Health Care Plan.

Health Benefit

CLASS I COVERED CHARGES (CONTINUED)

Ambulance
100% of the charges in excess of the amount payable under the covered person's Provincial Health Care Plan for professional licensed ambulance service, including air or rail ambulance service subject to prior approval of the Administrator, to transport the covered person:

- From the place of injury (or where illness struck) to the nearest hospital where treatment is available;
- From a hospital to a convalescent hospital.

Air ambulance is based on a regular scheduled flight from the original hospital to the nearest hospital in the patient's city of residence, where the required treatment is available, when authorized in writing by the attending physician and/or surgeon.

Response fee is not covered.

Out-of-Hospital Nursing
Charges for home nursing care, up to the Maximum Benefit shown in the applicable Benefit Design Schedule, by a registered nurse (R.N.) who:

- Is not a member of the Employee's family; and
- Does not normally live in the Employee's home;

when ordered by a licensed doctor (M.D.) as medically necessary for a disability that requires the specialized training of a registered nurse (R.N.).

Out-Patient Care Expenses
Charges made by a hospital while the covered Employee’s family member is an out-patient of the hospital and during a period for which the hospital makes no charge for board and room, for the following services and supplies:

- Use of an examination or operating room;
- Drugs, dressings, or casts;
- Anesthesia in connection with the performance of a surgical procedure.

Provided, however, that no benefit shall be payable with respect to charges made by a resident physician or intern of a hospital.

Hearing Care
Charges for the cost and installation, including replacement and repairs, of hearing aids, excluding batteries, when recommended by an otolaryngologist or audiologist, up to the Benefit Maximum shown in the applicable Benefit Design Schedule.

Health Benefit

CLASS I COVERED CHARGES (CONTINUED)

Physiotherapy
Charges by a physiotherapist who is registered and legally practicing within the scope of his license. No amount will be paid for any visits for which any amount is payable under the covered person's Provincial Health Care Plan, unless permitted by law.

Health Practitioners
Charges, including x-ray charges, up to the Maximum Benefit shown in the applicable Benefit Design Schedule, by a practitioner who is registered and legally practicing within the scope of his license as:

- A chiropractor, osteopath, naturopath, podiatrist, masseur, Christian science practitioner, speech therapist, or specialist in orthopedic exercises;
- A psychologist;
- An acupuncture therapist; or
- A registered clinical social worker (who is a member of the professional organization of social workers and has at least 2 years of experience) for treatment of emotional or psychological difficulties for the betterment of the individual, including complete family involvement. Does not include treatment for weight loss, cigarette smoking, alcohol abuse, drugs, or any other self-inflicted problems.

No amount will be paid for any visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.

Foot Care
Charges up to the Maximum Benefit shown in the applicable Benefit Design Schedule for orthotics, but not for sports, when recommended by a licensed doctor (M.D.), or podiatrist.

Vision Care
Charges up to the Maximum Benefit shown in the applicable Benefit Design Schedule for:

A. Single vision, bifocal or trifocal lenses prescribed by an ophthalmologist or optometrist, including scratch resistant coating and frames required to accommodate such lenses;
B. Contact lenses prescribed by an ophthalmologist or optometrist;
C. Laser eye surgery; and
D. Safety glasses (covered employee only)

No amount will be paid for sunglasses.

If the laser eye surgery benefit is utilized, there is no coverage for lenses for the above A and B for 5 years.

Health Benefit

CLASS I COVERED CHARGES (CONTINUED)

Out-Of-Province
These are the charges as described below incurred in connection with the emergency treatment while the individual is traveling or vacationing outside the province in which he normally resides.

- Charges by a general practitioner or specialist in excess of the amount allowed under the Provincial Hospital and Medical Plans in the individual's normal province of residence provided such charges are reasonable and customary in the area in which they were incurred.
- Charges for hospital confinement in excess of the allowance for ward accommodation payable by the Provincial Hospital Plan in the individual's normal province of residence. However, no charges will be considered,
  - Unless all or part of the daily charge is payable under such Provincial Hospital Plan, or
  - For any type of accommodation for which the individual would not have been covered under this Plan had he been hospitalized in his normal province of residence.

Out-Of-Province Air Transport Expenses
These are the charges for air transport (not the patient's fare) from the place in which the illness occurs to the home city in Canada (as follows), but only when supported by an authorization in writing from the attending physician:

- To a maximum cost of one economy seat, return fare, for an attendant (not a relative).
- If return by stretcher is required to a maximum cost of two seats, one for accommodation of the stretcher, one (return fare) for an attendant (not a relative).

Payment is made only if an attendant or stretcher is required on the written order of a physician. Claims must be accompanied by a physician's written order of authorization.

Durable Medical Equipment and Supplies
Charges for supplies and the rental of or, at the Administrator's option, the purchase of durable medical equipment of the type and model adequate for the covered person's medical needs based on the nature and severity of the disability, such as, but not limited to equipment and supplies to be used in the home of the Employee or Dependent:

- Hospital beds, wheelchairs, canes, crutches, walkers and trusses; rental of an iron lung;
- Rigid or semi-rigid braces for back, neck, arm or leg and non-dental prostheses, such as artificial limbs and eyes, including replacement if required because of a change in physical condition;
- Respiratory equipment, including oxygen;
- Anesthesia, blood and blood products;
- Three external breast prostheses and three surgical brassieres (per calendar year);
- Orthopedic lifts, and insoles when prescribed by an orthopedic surgeon, podiatrist, or rheumatologist;
- Materials used for allergy testing; but excluding personal comfort, convenience, exercise, safety, self-help or environmental control items, or items which may also be used for non-medical reasons, such as, but not limited to heating pads or lamps, communication aids, air conditioners or cleaners, and whirlpool baths or saunas.
- Diabetic Supplies are covered at 90%. Glucometer is not a covered expense.

Health Benefit

CLASS I COVERED CHARGES (CONTINUED)

Durable Medical Equipment and Supplies (Continued)
Before incurring any major expenses the covered Employee should submit details to the Administrator to determine to what extent benefits are payable.

In any event, a letter will be required from a licensed doctor (M.D.) describing the nature of the disability and the type, medical need and estimated duration of any required durable medical equipment.

Dental Benefits for Accidental Injury
Charges for Dental services performed by a licensed dentist for the prompt repair of sound natural teeth when required for a non-occupational accidental injury, external to the mouth, which occurs while the person is covered.

Miscellaneous Expenses
- Diagnostic laboratory and x-ray expenses;
- Physicians charges in connection with the psychoanalysis treatment, for Quebec residents only;
- Diagnosis and assessment (but not treatment), by a person duly qualified and registered and legally engaged in the practice of psychology.

CLASS II COVERED CHARGES

Drugs
All prescription Drugs and Medicines obtainable only upon a physician's or dentist's prescription and dispensed through a registered pharmacist, plus drugs that, regardless of their legal status, are not normally sold by a pharmacist except on a physician's or dentist's prescription will be reimbursed at 90% based on the Lower Cost Alternative (LCA) drug. LCA is also referred to as generic. The Drug Identification Number must accompany the claim.

Prescription Drugs for the treatment of Erectile Dysfunction will be reimbursed on a reasonable and customary basis at 90% to an annual maximum of $400 with a monthly cap of 16 pills.

Prescription Smoking Cessation Drugs will be reimbursed at 90% to a lifetime maximum of $1,200 per person. Products such as Nicorette gum or “the patch” are not covered.

All claims for prescription drugs must be submitted electronically by your pharmacist via the Plan’s “All-In-One Benefit Card”.

Medical Cannabis

Coverage limited to $1,500 per person per calendar year. Reimbursement, at 90%, will be made for the following health conditions only:

1. Chronic neuropathic pain and/or refractory pain in palliative cancer care
2. Chemotherapy induced nausea or vomiting; and
3. Spasticity symptoms from multiple sclerosis.

Claimants must have received pre-authorization by Green Shield Canada using a Medical Cannabis Special Authorization Request Form. No other Pre-Authorization Forms will be accepted.

The Plan will only reimburse medical cannabis purchased from an Authorized Licensed Producer with Health Canada and all claims for medical cannabis may be submitted to Green Shield Canada or to the Plan Administration Office.

Medical Cannabis cannot be the first course of treatment for the conditions noted above.

Vaccines

Coverage for vaccines, except those noted below is 90% subject to the overall calendar year maximum.

Vaccines not eligible for reimbursement are:

FSME-IMMUM (D.I.N. 2264625)
IXIARO (D.I.N. 2333279)
YELLOW FEVER (D.I.N. 428833)
IMOVAX RABBIES (D.I.N. 1908286)
RABAVERT (D.I.N. 1908286)
B.C.G. - ONCOTICE (D.I.N. 2267667)
IMMUCYST INJ (D.I.N. 2194376)

All claims for vaccines must be submitted electronically by your pharmacist via the Plan's "All-In-One Benefit Card."

EXTENSION OF BENEFITS

If coverage with respect to a covered family member (Employee or Dependent) terminates while he is totally disabled, any benefits, other than any Dental expense benefits, for that family member, but for no other family member, will continue to be available for expenses incurred during the uninterrupted continuance of such total disability but not beyond the period of three months immediately following such termination of coverage and in no event beyond the date the family member becomes covered under any other group plan, whether issued by the Administrator or any other insurer, for benefits of a type similar to that provided for in this Plan. The words "totally disabled" and "total disability" mean for the purposes of this paragraph that the family member, if an Employee, is prevented, solely because of injury or disease, from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit, or if a Dependent is prevented, solely because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Health Benefits

LIMITATIONS

No amount will be paid for care, services or supplies:

- For any expense related to a motor vehicle accident;
- If payment is prohibited by law;
- That a covered person may obtain as a benefit under any governmental plan or law;
- Paramedical services when performed by a family member;
- For which no charge would have been made in the absence of this coverage; or
- For Dental work, except as provided under the Dental benefit for Accidental Injury.

No amount will be paid for any charge incurred that results from or is contributed by:

- War, whether declared or not;
- Insurrection, rebellion or participation in a riot or civil commotion;
- Purposely self-inflicted injury; or the covered person's commission of, or attempt to commit an assault or a criminal offence.

The Plan does not cover Over-The-Counter Drugs, Immunizations, Vitamins and Supplements.

Dental Benefit

BENEFIT DESIGN SCHEDULES “A”, “AW”, “RE”, “RN” “REW”, AND “RNW”

BENEFIT DESIGN “A” ”B”“AW” “RN” “RE” “REW” “RNW” PARAMETER	**BENEFIT DESIGN “A” “AW” “RN” “RE” “REW” “RNW” FEATURES**
Coverage Available To	All Eligible Employees And Their Dependents
Fee Guide	2018 Alberta Dental Association
Calendar Year Maximum Benefit	$2,500 Yearly Maximum Per Person
Deductible	Nil
Percentage of Class I Expenses Payable	90%
Percentage of Class II Expenses Payable	65%
Percentage of Class III Expenses Payable	80%

Dental Benefit

DESCRIPTION OF CLASSES

CLASS	DESCRIPTION OF SERVICES
Class I Expenses	Basic Dentistry Services: Diagnostic, Preventive and Restorative, Dentures
Class II Expenses	Orthodontics - $3,000 Lifetime Maximum per Person
Class III Expenses	Extensive Restorative Dentistry Services

PERCENTAGE PAYABLE

This is the part of Covered Charges shown in the applicable Benefit Design Schedule that the Administrator pays.

COVERED CHARGES

These are charges up to the amount shown in the 2018 Alberta Dental Association Fee Guide for needed dental services or supplies, as described below, and received while that person is covered, for either a disease or injury that is, non-occupational:

CLASS I EXPENSES - BASIC DENTISTRY: DIAGNOSTIC, PREVENTIVE AND RESTORATIVE

Charges up to the Benefit Maximum shown in the applicable Benefit Design Schedule for:

- Oral exams, including the scaling and cleaning of teeth (limited to 8 units per calendar year), but not more than one examination every 6 months;
- Topical applications of sodium or stannous fluoride, but not more than once in every 6 month period;
- Dental x-rays;
- Extractions;
- Oral surgery, including excision of impacted wisdom teeth;
- Fillings;
- Anesthetic drugs (cost to administer the anesthetic is not covered) in connection with oral surgery or other covered Dental services;
- Treatment of periodontal and other diseases of the gums and tissues of the mouth;
- Endodontic treatment, including root canal therapy;
- Initial installation of partial or full removable dentures and adjustments to such dentures but separate charges for adjustments will only be included if they are incurred more than 3 months after the initial installation; replacement of an existing partial or full removable denture, if it: was installed at least 5 years before and cannot be made serviceable; or
- Space maintainers, including stainless steel crowns for baby teeth that have several cavities which would otherwise require filling or which are non-restorable using normal restorative dental material;
- Antibiotic drug injections by the attending dentist;
- Pit and fissure sealants;

Dental Benefit

CLASS I EXPENSES - BASIC DENTISTRY: DIAGNOSTIC, PREVENTIVE AND RESTORATIVE (CONTINUED)

- Diagnostic procedures;
- Repair, re-cementing, or relining of dentures;
- Periodontal appliances for bruxism.

CLASS II EXPENSES: ORTHODONTICS

Charges up to the Benefit Maximum shown in the applicable Benefit Design Schedule for:

- Diagnostic procedures, including models;
- Therapy and appliances;
- Correction of malocclusion; and
- Benefit limited to $3,000 lifetime for individuals under age 25 at beginning of treatment.

CLASS III EXPENSES: EXTENSIVE RESTORATIVE DENTISTRY

- Inlays, onlays, gold fillings, crowns and initial installation of fixed bridgework (including inlays, onlays and crowns to form abutments);
- Implants
- Replacement of an existing fixed bridgework by a new bridgework, or the addition of teeth to an existing bridgework to replace extracted natural teeth, but only if evidence satisfactory to the Administrator is presented that the existing bridgework was installed at least 5 years prior to its replacement and that the existing bridgework cannot be made serviceable;
- Repair, resurfacing or re-cementing of crowns, inlays, onlays or bridges; and
- Stainless steel crowns on permanent teeth; if the stainless steel crown is replaced by a gold or porcelain crown, the amount paid for the stainless steel crown will be deducted from the claim for the gold or porcelain crown.

OTHER DENTAL PRACTITIONERS

Dental services or supplies must be rendered and dispensed by a licensed dentist, except that:

- Scaling and cleaning of teeth may be done by a licensed dental hygienist; and
- Installation, adjustment, repair, relining or rebasing of full dentures, may be done by a denturist, denture therapist, technician or mechanic, who is registered and practicing within the scope of his license.

Charges for such care, services and supplies will be deemed to be Covered Charges up to the lesser of:

- The amount shown in the practitioner's tariff of the province where the charges are incurred; or
- The 2018 Alberta Dental Associated Fee Guide for dentists.

Dental Benefit

PRE-DETERMINATION OF BENEFITS

If charges for a planned course of treatment by a licensed dentist would exceed $300, a treatment plan and X-rays should be submitted to the Administrator for approval. Failure to do so may result in payment of a lesser benefit amount because of the difficulty in determining the need for such treatment after it has been provided. Dental X-rays will be promptly returned to the dentist.

Course of Treatment means one or more services rendered by one or more dentists for the correction of a dental condition diagnosed as a result of an oral exam starting on the date the first service to correct such condition is rendered.

LIMITATIONS

No amount will be paid for charges for:

- For any expense related to a motor vehicle accident;
- Prostheses, including implants and bridgework, and the fitting thereof which were ordered while the person was not covered, or which were ordered while the person was covered but which were finally installed or delivered after this Benefit is discontinued or more than 31 days after termination of coverage for any other reason; replacement of a lost or stolen prosthesis;
- Personalization or characterization of dentures;
- Dental expenses submitted for reimbursement that are not accompanied by a dental receipt; or
- A full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction.

ALTERNATE BENEFIT CLAUSE

A policy applied to all coverage that has implant and /or bridge treatment as a benefit, to determine the amount payable. The attending dentist and patient choose the course of treatment, but payment for the procedure may be based on the "limited treatment" principle. Basically, if two procedures treat the same condition, payment may be limited to the most cost effective treatment. The Alternate Benefit Clause is simply a financial limitation and not intended to dissuade from the treatment recommended or performed by a dentist. In the application of this, both courses of treatment must be an eligible benefit.

Co-Ordination of Benefits

FOR HEALTH AND DENTAL BENEFITS ONLY

If a person covered under this Plan is also covered under another plan, benefits under all plans are adjusted so as to limit the combined payment to 100% * of the total allowable expense.

The manner in which this is done is to determine which plan pays first (thus, determine where to submit the claim first) and which plan(s) pays next.

The plan that does not have a coordination of benefits provision pays before the plan that does.

The plan that covers the person as:

- Other than a dependent pays before the plan that covers such person as a dependent; or
- A dependent child of the parent, covered as an employee, whose birthday occurs first during the calendar year pays first.

The same order of benefit determination will apply if a person is covered in more than one capacity under the same plan, including this Plan, or is covered as a dependent of more than one person under the same plan, including this Plan.

If priority cannot be established in the above manner, the Allowable Expense shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

To implement this provision, the Administrator may:

- Subject to the consent of the covered person, if required by law, obtain from or release to any other person, corporation or organization any information deemed to be needed; or
- Pay to or recover from any other person, corporation or organization any excess payment; any payment so made will be deemed to be benefits paid and, to the extent of such payment, will fully discharge the Administrator from all liability under this Plan.

Allowable Expense means any necessary, reasonable and customary item of expense, at least a portion of which is covered under at least one of the plans covering the person for whom a claim is made.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.
For the purpose of this Coordination of Benefits provision "plan" means any plan of group insurance or other arrangement for members of a group (whether on an insured basis or not), prepaid health or dental coverage, or student accident insurance.

** Include Coordination With Workers Compensation Board Claims For Health Benefits Only.*

Termination of Coverage

EMPLOYEE AND DEPENDENT COVERAGE

Coverage for an Employee and an Employee's Dependents will terminate on the earliest of:

- The date the Plan is discontinued for any reason;
- The date immediately prior to the first day of a Benefit Period if; as of the preceding Determination Date, there were less than 130 Credited Hours in the Employee's Bank of Credited hours; or
- The Employee ceases to be a member in good standing of the Union, or the Employee or Retired Employee does not pay the required self-payment amount, or the maximum self-payment period has expired.

Coverage for an Employee's Dependent will terminate on the date such Dependent ceases to be eligible.

In the case of an Employee whose coverage would otherwise terminate in accordance with the foregoing item (2) because of retirement, such Employee's coverage may be deemed to continue until he ceases to be a Retired Employee as defined in the "Definitions" section of this Plan Text.

TEMPORARY ABSENCE FROM WORK

An Employee and an Employee's Dependents may continue to be covered at the Administrator's option, if such Employee's absence from work is not due to termination of employment but due to:

- Illness, injury or pregnancy or parental leave but not beyond age 65 (or for up to 12 months, if such employee is age 65 or older and eligible for coverage); or
- Temporary lay-off or leave, but not beyond the end of the calendar month following the calendar month in which such absence began.

CONTINUATION OF HEALTH AND DENTAL BENEFITS FOR INCAPACITATED CHILDREN

Health and Dental Benefits will continue beyond the date an unmarried Child attains the limiting age for coverage, provided proof is submitted to the Administrator within 31 days after such date that such Child:

- Is incapable of self-sustaining employment by reason of mental incapaciation or physical handicap;
- Became so incapacitated prior to attainment of the limiting age; and
- Is chiefly dependent upon the Employee for support and maintenance.

Thereafter, such proof must be submitted to the Administrator as required.

Termination of Coverage (continued)

CONTINUATION OF HEALTH AND DENTAL BENEFITS AFTER THE EMPLOYEE'S DEATH

An Employee's Dependents, who are covered under the Plan at the time of the Employee's, or Retired Employee's, death, will continue to be covered, but not beyond the earliest of:

- The date such Dependents cease to be eligible;
- The end of the months in the deceased Employees hour bank prior to death or no self payments received; or
- The date coverage for the Dependent terminates for any reason.

Upon the Employee's death, benefits are payable to the Spouse, if living. If the Spouse is not living benefits are payable to the Child if the Child is of majority age. If benefits are payable to the Child and the Child is not of majority age, benefits will be payable to the legal guardian.

AMENDMENT OF THE PLAN'S BENEFITS AND DISCONTINUANCE OF THE PLAN

The Trustees manage the benefits of the Plan pursuant to their rights established in the Amended and Restated Health and Welfare Trust Agreement dated August 13, 2007. Pursuant to that Agreement, the Trustees retain the sole right to adopt, administer amend (retroactively or otherwise) or replace the Plan for the benefit of Employees, their beneficiaries or dependents, as the case may be. These rights include the determination of the type, amount and duration of benefits to be provided and to determine all eligibility requirements. The establishment, suspension, deletion, amendment or termination of benefits and eligibility requirements will be affected solely by resolutions of the Trustees.

While it is the intention of the Trustees to continue the Plan indefinitely, in the event the assets of the Fund are insufficient to provide for any, or all, of the benefits of the Plan, the Trustees will amend the Plan as they, in their sole discretion, shall decide. The fact that any particular benefit is provided at a particular time does not guarantee that such benefit will be provided for any specific period of time. The continued payment of a benefit lies within the sole discretion of the Trustees.

In the event the Plan is to be discontinued, the mutual agreement of the Union and the Association, as provided for under the Trust Agreement, is required.

No benefit will be paid or become payable for claims received after the date the Plan is discontinued. The Administrator will allow a period of time after the discontinuance of the Plan for claims to be submitted after which time no claims will be considered.

Miscellaneous Provisions

PROOF OF LOSS

Written proof, on a form acceptable to the Administrator, stating the occurrence, character and extent of loss must be submitted for each benefit to the Administrator within:

- **60 Days** after the start of Disability, for the Employee Weekly Disability Benefit; and
- **12 Months** after the date of expense or procedure for all Medical, Dental and Vision Care benefits.

The Administrator shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pendency and payment period, if any, of such claim.

PAYMENT OF CLAIMS

All payments from this Plan shall be payable to the covered Employee. At the Administrator's option, an Employee may, by written request, direct that all or part of the benefits for Health and Dental Benefits be paid directly to the hospital or person rendering such care. Payments due from this Plan otherwise payable to a deceased Employee will be made to the estate of the deceased covered Employee. Any payment by the Administrator in good faith pursuant to this provision shall fully discharge the Trustees to the extent of such payment.

RIGHT OF RECOVERY

If an Employee is entitled to benefits under the provisions of this Plan as a result of total disability and subsequently receives a settlement from a third party because of an occurrence which was wholly or partially the cause of the total disability, the Employee shall repay the Plan to the extent that such settlement provides compensation for loss of time, whether recovery is made by settlement, judgment or otherwise, from any person or organization responsible for causing the disability, or from their insurers, and the trustees will have a lien upon such recovery. In no event will the Employee be required to make reimbursement to the Plan in an amount exceeding that portion of the recovery which provides compensation for loss of time.

At the option of the Trustees, exercisable at any time, the Trustees shall be subrogated to all rights of recovery of the Employee from any person or organization responsible for such disability, or from their insurers.

The Employee shall execute and deliver such instruments and papers as may be required by the Trustees and do whatever else is necessary to secure the rights of the Trustees under this provision.

The Trustees are under no obligation under this Plan to recover such reimbursement from an Employee nor to exercise such right of subrogation.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this Plan prior to the expiration of 60 days after written proof of loss has been provided in accordance with the requirements of this Plan. No such action will be brought after the expiration of 2 years after the time written proof of loss is required to be provided to the Plan.