THE EDMONTON
PIPE INDUSTRY

Health & Welfare Plan Text

AS AT JULY

2023

APPROVED BY THE BOARD OF TRUSTEES ON AUGUST 31, 2023

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GENERAL PROVISIONS

ESTABLISHMENT OF THE PLAN

The Trustees of the Edmonton Pipe Industry Health and Welfare Fund established a plan of weekly disability, health and dental benefits, referred to as (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, referred to as (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 Canada Life Assurance Company (Canada Life), is the present insurer for the Plan's life insurance, supplemental life insurance, optional life insurance, dependant life insurance, and long-term disability benefits. Chubb Life Insurance Company of Canada (Chubb) is the insurer for the accidental death and dismemberment benefits. The emergency medical travel insurance is held with The Manufacturers Life Insurance Company (Manulife). The member assistance program (MAP) is through Morneau Shepell and provided by the UA Canada National Wellness Program. For the purpose of the 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.
- Once the Plan has not received Employer contributions for twenty (20) consecutive months, the remaining Bank of Credited Hours will be forfeited.

- **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.

GENERAL PROVISIONS

- **Credited Service** means the number of hours reported to The Edmonton Pipe Industry Pension Plan. One year of credited service is equivalent to 1,300 hours.

- **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.

- **Member** 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.

- **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 but they have not yet been initiated as a member of Local 488.

- **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 Member** 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 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	Eligible Employee	Benefits Included
A	Employees with a sufficient bank of credited hours	Health, dental benefits and 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 and dental benefits
AW	Spouses and dependents of deceased employees enrolled in benefit design "A" or "B" immediately prior to death of the employee	Health and dental benefits
RE	Retired employees, under age 65, with a sufficient bank of credited hours or who make the necessary self-payment within the notice period.	Health and dental benefits
RN	Retired employees, over age 65, with a sufficient bank of credited hours or who make the necessary self-payment within the notice period.	Health and dental benefits
REW	Spouses and dependents of deceased retired employees enrolled in benefit design "RE" immediately prior to death of the retired employee	Health and dental benefits
RNW	Spouses and dependents of deceased retired employees enrolled in benefit design "RN" immediately prior to death of the retired employee	Health and 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.

The retired employee may qualify for the retired employee benefits at a cost set by the Trustees, if they remain a member in good standing of the Union.

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

GENERAL PROVISIONS

- Must be a resident of Canada and covered under a provincial health care plan.
- Must be a member in good standing with Local 488

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 in good standing of the Union, 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. Self-payments must be consecutive and can be made to a maximum of 12 consecutive months.

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 Local 488 and have separate eligibility in the Health & Welfare Plan.

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;

GENERAL PROVISIONS

- 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.

A dependant means a spouse and/or an unmarried child under 18 years of age and solely dependent upon the member for support. If in attendance on a full-time basis at an accredited school, college or university, the dependant will remain covered to age 25. Proof of school attendance will be required annually.

Spouse means a person who is:

- Legally 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

An employee making self-payments is not permitted to add a common law spouse as a dependent to the Plan. Children of the employee will remain eligible to be added as a dependent to the Plan.

A retired employee 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.

No person shall be considered a dependent if such person is eligible for coverage under any benefit of the Plan as a member.

RETIREE ELIGIBILITY

To be eligible for coverage, the retired employee and dependents must be covered under a provincial health care plan.

- A retired employee may be eligible for retired employee benefits by remitting the self-payment rate in effect at the time; and
- must have accumulated 15 years of credited service 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 and a minimum 25,000 contributory hours. 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.
- If eligible, a retired employee under the age of 65 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

Dependants who are in the hospital on the date that the employee becomes eligible for benefits, with the exception of a newborn child, will not become eligible until discharged from the hospital.

WEEKLY DISABILITY BENEFIT

ACTIVE MEMBERS COVERED WITH WORKING HOURS ONLY

BENEFIT AMOUNT

$550 per week, 26 week maximum. This is a taxable benefit.

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, they may qualify to receive a weekly disability benefit from the Plan. The covered employee must be under the care of a licensed medical doctor 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. Partial weeks of disability are paid at a daily rate that is one seventh of the weekly benefit.

QUALIFYING PERIOD

Benefits for any (1) one period of disability are payable on the 1st day of a disability resulting from an accident or hospitalization (minimum of 24 hours) or upon the 8th continuous day of disability due to illness.

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 26 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

WEEKLY DISABILITY BENEFIT

when EI benefits terminate, the plan will continue payments if the covered employee provides medical evidence which supports total and continuous disability to a maximum of 26 weeks including EI benefits.

Covered employees should not wait until after receipt of EI Accident and Sickness benefits to file a claim for this Plan's weekly disability benefit. If they do, the covered employee will miss the filing deadline and weekly disability benefits will not be paid.

If a covered employee is unable to work due to disability, then they 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 they become disabled, the covered employee should notify HRSDC of their 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.

EI Accident and Sickness benefits may be paid for up to 26 weeks following the one week waiting period. If you received the full 26 weeks from EI, no payment is payable by the Plan and you would apply for long term disability from our insurer. 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 Accident and Sickness benefits because of entitlement to income from another plan, no weekly disability benefits will be payable by the Plan during the 26-week period EI benefits would otherwise have been paid.

WEEKLY DISABILITY BENEFIT

If, immediately prior to disability, a covered employee is working, but no contributions are remitted to the Fund on behalf of the covered employee, 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.

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 their 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.

WEEKLY DISABILITY BENEFIT

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. In the event that a covered employee provides proof that they have 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 AND EXCLUSIONS

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, the Alberta Refrigeration Industry Pension Plan, UA Canadian Pipeline Pension Plan, UA Sprinkler Pension Plan or UA Officers Pension Plan;
- 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;

WEEKLY DISABILITY BENEFIT

- 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 or specialist deemed appropriate by the Plan for the impairment causing their 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;
- 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; and
- 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 in good standing with Local 488.

MEDICAL BENEFITS

The Plan assists in the payment of reasonable and customary costs for medically necessary expenses for covered employees and their dependants. These expenses must be prescribed or recommended by a medical doctor. In the event that, while covered under the Plan, a covered member incurs any of the eligible expenses listed below, they will be covered, subject to the Plan's limitations and exclusions.

MAXIMUM ANNUAL BENEFIT

The maximum annual benefit allowed by the Plan for covered employees and each covered dependant, is $55,000.

EXTENSION OF DEPENDANTS' COVERAGE

A covered employee's dependants, including a spouse, will continue to be covered for medical and dental benefits without charge by utilizing any remaining hour bank after a covered employee's death, provided that the death occurs while the employee was covered. After that time the spouse/dependants will be allowed to make self-payments to a maximum of 24 months, subject to the following condition:

- Only the dependants eligible for coverage at the date of covered employee's death are eligible for this coverage (includes natural children born within nine months after the covered employee's death).
- A retired employee's dependant may be eligible to continue self-payments at the same rate as the retired employee was eligible for.

PRE-DETERMINATION OF BENEFITS

If a covered employee is about to incur an expense and there is uncertainty about eligibility under the Plan, it is recommended that a pre-determination of benefits be submitted for consideration by Green Shield Canada prior to starting treatment. Most medical equipment, including CPAP, requires an Authorization Form which is available from the administration office.

PRESCRIPTION DRUGS

The Plan covers 90% of the cost of generic prescription drugs that are medically necessary, which by law requires a prescription issued by a medical doctor or any other licensed practitioners and dispensed by a licensed pharmacist.

The Plan will cover erectile dysfunction drugs at an annual maximum of $400 per person with a monthly maximum of 16 pills being eligible for reimbursement.

MEDICAL BENEFITS

The Plan will cover fertility drugs allowing a lifetime maximum of $3,000 per person.

The Plan will not cover any charge for over-the-counter preparations (e.g., vitamins, minerals, foods and dietary supplements) which may be purchased without a medical doctor's recommendation. Medications available over the counter even with a medical doctor's referral are not eligible.

The Plan does not pay for any co-insurance or deductibles required by any government drug plan.

Any forms for extra or balance billing are not reimbursable by the Plan, e.g., a doctor's fee for an office visit or completion of forms.

PARAMEDICAL PRACTITIONERS

Charges, including x-rays, up to a maximum benefit, by a practitioner who is registered and legally practicing within the scope of their license. No amount will be paid for any visit for which any amount if payable under the covered persons provincial health care plan, unless permitted by law.

ACUPUNCTURIST, NATUROPATH, PODIATRIST, SPEECH THERAPIST, CHRISTIAN SCIENCE PRACTITIONER AND OSTEOPATH

100% combined maximum of $400 per person, per calendar year, subject to the overall calendar year maximum.

CHIROPRACTOR

100% to a maximum of $500 per person, per calendar year, subject to the overall calendar year maximum.

REGISTERED MASSAGE THERAPIST

100% to a maximum of $400 per person, per calendar year, subject to the overall calendar year maximum. Massage Therapist must be registered as a Member of an Accredited Association in Canada (NHPCA or a Provincially Regulated Association).

PHYSIOTHERAPIST

100% to a maximum of $700 per person, per calendar year, subject to the overall calendar year maximum.

MEDICAL BENEFITS

PSYCHOLOGIST OR REGISTERED CLINICAL SOCIAL WORKER

100% to a combined maximum of $1,000 per person, per calendar year, subject to the overall calendar year maximum.

VISION CARE

$450 per person is available for purchase of prescription glasses (single vision, bifocal or trifocal lenses, including scratch resistant coating and frames required to accommodate such lenses) and/or contact lenses, subject to the overall calendar year maximum. The benefit renews every 2 calendar years on January 1st of each even year (2024, 2026, 2028). No benefits are payable for non-prescription sunglasses, anti-reflective coatings, or non-prescription industrial safety glasses.

LASER EYE SURGERY

$1,600 lifetime maximum per person. If the laser eye surgery benefit is used, there is no coverage for vision care for 5 years and is subject to the overall calendar year maximum.

SAFETY EYE GLASSES

$400 every 2 years from the last date of service for prescription lenses only, subject to the overall calendar year maximum. This benefit is for active covered employees only. Retired employees and dependants are not eligible.

EYE EXAMS

Eye exams are not a covered expense.

HOSPITAL

100% of the semi-private room rate in the covered persons home province. Subject to overall calendar year maximum benefit.

A hospital is a place that:

- Chiefly provides inpatient medical care of the injured, sick or chronically ill;
- Has a staff of licensed doctors and 24-hour nursing care by registered nurses; and
- Is approved as a hospital for payment of the ward rate under the provincial health care plan.

MEDICAL BENEFITS

CONVALESCENT CARE

Charges for a licensed convalescent care facility in the persons home province, subject to a maximum expense of $10 per day and 120 days of confinement per disability. Convalescent care 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. This benefit is subject to overall calendar year maximum benefit.

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.

PROFESSIONAL AMBULANCE SERVICES

100% of the charges in excess of the amount payable under the covered person's provincial health care plan for professional licensed ambulance service 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.

Transportation by airline or railroad is only covered when authorized in writing by the attending physician and/or surgeon and where there has been prior approval from the administrator. Air ambulance is based on a regular scheduled flight from the original hospital to the nearest hospital in the patient's city of residence. This benefit is subject to overall calendar year maximum benefit.

The response fee is not covered.

PRIVATE DUTY NURSING

Charges for the services of a registered nurse (R.N.), licensed practical nurse, certified nursing assistant (C.N.A.) or a member of the Victorian Order of Nurses (V.O.N.) which are rendered in the patient's home, provided such nurse is not a resident in the covered employee's home nor a relative of the covered employees family. These charges will be considered eligible expenses when medically necessary for a disability that requires the specialized training of a registered nurse and recommended by a physician. Coverage is only applicable for medical treatment and does not include household duties.

MEDICAL BENEFITS

The calendar year maximum is $20,000 per individual covered for this benefit. Preauthorization is required. This benefit is subject to overall calendar year maximum benefit.

DIAGNOSTIC X-RAYS (EXCLUDES CIROPRACTIC)

$60 per disability. This benefit is subject to overall calendar year maximum benefit.

ACCIDENTAL DENTAL TREATMENT

Charges for necessary dental treatment required as the result of a non-occupational accidental injury by external means to sound natural teeth while insured. As determined by the Plan, only charges directly related to the accidental injury are considered a covered medical expense and the dental work must be completed within 12 months of the date of the accident. This benefit is subject to overall calendar year maximum benefit.

OTHER MEDICAL SERVICES AND SUPPLIES

90 % of the reasonable and customary 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. This is 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 covered employee or their dependant:

- Hospital beds, wheelchairs, canes, crutches, walkers, trusses; rental of an iron lung, oxygen tent, electronic heart pacemaker, or other durable medical or surgical equipment required for therapeutic purposes;
- Casts, splints, trusses, crutches, rigid or semi-rigid brace for back, neck, arm, or leg and non-dental prostheses (artificial limbs, eyes, larynx, etc.), including replacement if required because of a change in physical condition;
- Respiratory equipment, including oxygen, CPAP;
- 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.
- Laboratory tests and x-rays not covered by any provincial government plan;
- Intrauterine devices when inserted by a physician;
- Oxygen and rental of equipment for its administration; and
- Diabetic supplies are covered at 90%. Glucometer is not a covered expense.

MEDICAL BENEFITS

Before incurring any major expense, the covered employee must submit the appropriate preauthorization form to Green Shield Canada to determine to what extent benefits are payable. This benefit is subject to overall calendar year maximum benefit.

HEARING AIDS

Reimbursement of up to $4,000 per person every five (5) years from the date of last purchase for the installation, including replacement and repairs of hearing aids, excluding batteries, when recommended by an Otolaryngologist or Audiologist. An audiology report is required for initial claim. This benefit is subject to overall calendar year maximum benefit.

COMPRESSION STOCKINGS

- 2 pairs per calendar year covered at 90% with a doctor's referral. Stockings must be 20-30 mmHg compression. This benefit is subject to overall calendar year maximum benefit.
- Must be submitted electronically by an approved provider with Green Shield Canada.

CUSTOM MADE ORTHOTICS

Charges for custom made orthotics, not for the purpose of sports, when recommended by a licensed medical doctor or podiatrist, up to a calendar year maximum of $400 and subject to the overall calendar year maximum. Referral from a licensed medical doctor or podiatrist stating the condition is required every 3 years.

- Orthotics must be purchased from an approved provider with Green Shield Canada. You may search a provider on your member online services or contact the administration office.

MEDICAL CANNABIS

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

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

The covered employee 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. Medical cannabis cannot be the first course of treatment for the conditions noted above.

MEDICAL BENEFITS

VACCINES

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

Vaccines not eligible for reimbursement are:

- FSME-1MMUM (DIN 2264625)
- IXIARO (DIN 2333279)
- YELLOW FEVER (DIN 428833)
- IMOVAX RABBIES (DIN 1908286)
- RABAVERT (DIN 1908286)
- BCG ONCOTICE (DIN 2267667)
- IMMUCYST INJ (DIN 2194376)

All claims for vaccines must be submitted electronically by your pharmacist via the Plan's all-in-one benefit card.

REHABILITATION BENEFITS

Active employees and their dependants may be entitled to receive up to $5,000 per person subject to the overall calendar year maximum as reimbursement towards the cost of attending an in-patient program at an approved addiction treatment centre.

Please take note of the following conditions:

- The lifetime maximum benefit payable from the Plan is $5,000 per person towards the cost of the program only. Travel and incidental costs are not eligible for reimbursement. Costs related to an assessment fee are not reimbursed through this benefit.
- Payment from the Plan will only be issued once a letter has been received from the treatment centre which specifies the date entered and released and successful completion of the program which was attended.
- A payment receipt from the treatment centre must also be submitted.
- Treatment centres located outside Canada are not eligible
- Member may apply for weekly disability benefits and EI disability benefits.

MISCELLANOUS EXPENSES

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

LIMITATIONS AND EXCLUSIONS

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

MEDICAL BENEFITS

- 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;
- Over-the-counter preparations (e.g., vitamins, minerals, foods and dietary supplements) which may be purchased without a medical doctor's recommendation;
- Medications available over the counter even with a medical doctor's referral;
- Paramedical services when performed by a family member;
- Eye exams;
- 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 result 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.

EXTENSION OF BENEFITS

If you have become disabled, and provided you have met the Plan's conditions, you may have coverage extended without a required contribution to the Plan. Disability credits will be granted for a maximum period of 24 consecutive months. After the 24 months, members will be offered the opportunity to make self-payments to the Plan to maintain coverage. You may contact the administration office for more information.

Continued eligibility will be dependent upon remaining a member in good standing of Local 488.

DENTAL BENEFITS

The Plan will assist in paying the reasonable and customary cost of medically necessary dental expenses for covered employees and their dependants as outlined below. In the event that, while covered under the Plan, a covered employee incurs any of the eligible expenses listed below, they will be covered, subject to the Plan's limitations and exclusions.

MAXIMUM ANNUAL BENEFIT

Dental benefits payable are subject to the maximum annual benefit, which is presently $2,500 per covered person, per calendar year, and applies separately to each covered employee and each dependent.

Orthodontic services are available and are subject to a lifetime benefit of $3,000 per person for individuals under age 25 at beginning of treatment.

ALTERNATIVE 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.

PRE-DETERMINATION OF BENEFITS

A dental treatment plan (pre-determination of benefits) is strongly recommended for major services such as crowns, bridges, implants and dentures in excess of $500. This is required for all orthodontic expenses and must be submitted electronically by the dentist to Green Shield Canada.

A pre-determination of benefits permits the review of the proposed treatment and costs in advance and allows for resolution of any questions before the work has been performed.

A pre-determination of benefits also provides advance information so both the patient and the dentist know the amount of benefit that would be reimbursed by the Plan and, so that the patient is aware of any costly expenses not covered by this Plan.

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.

DENTAL BENEFITS

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

DENTAL FEE GUIDE

Coverage under the Plan includes charges for supplies and services up to the amount specified in the 2022 Alberta Suggested Dental Association Fee Guide for dentists.

BASIC SERVICES

Covered at 90% - Diagnostic procedures, preventative procedures, restorative procedures and dentures are covered at 90%. Cleaning and check-ups are eligible every 6 months per covered person.

BASIC DIAGNOSTIC SERVICES

Diagnostic procedures that are required to assist a dentist in evaluating existing dental conditions and determine whether further dental care may be necessary, are subject to the following limitations:

1. Oral examinations: Recall or specific examinations are limited to once every 6 months;
2. Dental x-rays: Complete series or equivalent once every year;
3. Study casts: Eligible once per year.

BASIC PREVENTIVE SERVICES

These are intended to eliminate or reduce the need for future dental treatment. The Plan provides the following preventative services:

1. Scaling (limited to 8 units of time) once per year;
2. Topical applications of sodium or stannous fluoride, polishing (prophylaxis) once per 6 months.

BASIC RESTORATIVE SERVICES

These are the basic procedures used to restore natural teeth to their normal functions with the use of silver amalgam, silicate, or synthetic restorations (fillings).

EXTRACTIONS

Removal of teeth including the excision of impacted wisdom teeth.

DENTAL BENEFITS

BASIC ENDODONTIC SERVICES

Emergency endodontic procedures and conservative root canal therapy.

BASIC PERIODONTIC SERVICES

These are services related to the supporting structures and tissues of teeth (gums and bone) and the conditions that affect them.

3. Adjunctive services: scaling, root planning, acute infections, occlusal adjustment, provisional splinting;
4. Surgical services: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;
5. Periodontal applications: bruxism appliances (night guards to prevent teeth grinding) only.

ORAL SURGERY

Routine oral surgical procedures are covered by the Plan as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.

ANESTHESIA

Anesthesia drugs in connection with oral surgery or other covered dental services. The cost to administer the anesthetic is not covered.

DENTURE REPAIRS, RELINING, AND REBASING

Coverage is provided for repairs or relining and rebasing of dentures, including the addition of new teeth, but not including the cost of dentures, their replacement or duplication.

REMOVABLE PROSTHETIC DEVICES (DENTURES)

The initial installation of partial or full dentures is covered at 90%. Pre-authorization is required to be submitted electronically by the dentist to Green Shield Canada. Replacement of existing dentures is only covered when:

- The replacement is required because of extractions, loss or fracture of one or more sound natural teeth while insured; or,
- The existing denture must be at least 5 years old and is unserviceable.

Adjustments to dentures will only be covered if they are incurred more than 3 months after the initial installation.

DENTAL BENEFITS

Replacement of lost or stolen dentures, the duplication of dentures and personalized characterization of dentures is not covered.

OTHER BASIC DENTISTRY ITEMS

- Space maintainers, including stainless steel crowns for baby teeth that have several cavities which would otherwise require filing or which are non-restorable using normal restorative dental material;
- Antibiotic injections by the attending dentist; and
- Pit and fissure sealants.

ORTHODONTIC SERVICES

Covered at 65% - up to the benefit maximum of $3,000 per person per lifetime. Adults under the age of 25 at the start of treatment and children are covered for this benefit. This includes:

- Diagnostic procedures and correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids commonly known as straightening of the teeth. This includes active space retainers or orthodontic appliances used to reposition or move teeth

An orthodontic treatment plan must be submitted to Green Shield Canada and returned to the dentist indicating estimated benefits. Treatment plans must include:

- Type of treatment
- Duration of treatment
- Estimated charges
- Cephalometric x-rays
- Study models
- Any other supporting evidence

The claim will be paid once treatment has begun.

In any event, the following expenses are not eligible:

- Charges for a procedure for which an active appliance was installed before the patient was covered; or
- An expense incurred while the patient's coverage was not in effect.

MAJOR SERVICES

Major services are covered at 80%. Pre-authorization is required.

DENTAL BENEFITS

MAJOR RESTORATIVE SERVICES

Covered expenses include:

- Inlays, onlays, gold fillings, crowns and initial installation of fixed bridgework (including inlays, onlays and crowns to form abutments) used to restore the natural teeth to their normal function where the tooth as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration.
- Implants
- 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.

FIXED PROSTHETIC DEVICES (BRIDGES)

Covered expenses include:

- The initial installation of fixed prosthetic devices, re-cementing and replacement of the facing of the fixed prosthetic device.
- The replacement of existing fixed prosthetic devices is not covered unless:
  - The existing fixed prosthetic device is at least 5 years old and no longer serviceable.

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 incurred; or
- The 2022 Alberta Suggested Dental Association Fee Guide for dentists.

DENTAL BENEFITS

LIMITATIONS AND EXCLUSIONS

The foregoing list of eligible expenses does not include any of the following:

- Any expense resulting from a motor vehicle accident;
- A full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- Services or supplies that are primarily cosmetic dentistry;
- Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license (except x-rays ordered by a dentist or a dental hygienists work under the dentist's supervision);
- The eligible services of a licensed denture therapist, except for full upper and/or lower dentures, and relining or repairs to full dentures;
- Expenses incurred following accidental injury to natural teeth (this is covered under the medical benefit);
- Dental treatment which is not approved by the Canadian Dental Association and which is experimental in nature;
- Miscellaneous charges such as counseling, travel, broken appointments, communication costs or completion of forms;
- Charge resulting from any intentionally self-inflicted injury;
- Services covered in whole or in part by any government plan (including Workers Compensation Board), services for which no charge is made, or services which the Insurer is not permitted by law to cover;
- A dental procedure covered by a provincial hospital plan. Legislation prevents private plans from making any payment;
- Services or supplies for personalization or characterization of dentures;
- Replacement of lost or stolen prosthetic devices;
- Diagnostic procedures in connection with any benefit categories excluded as eligible expenses;
- Dental examinations required by a third party;
- Charge for services which would not normally have been incurred, but for the presence of this coverage, or for which you or your dependant is not required to pay;
- Hospital charges for room and board and related services and supplies;
- Charge for an injury resulting from war, riot, insurrection or participation in a criminal act;
- Dental expenses submitted for reimbursement that are not accompanied by a dental receipt; or
- Any service or supply not listed herein as an eligible expense.

CO-ORDINATION OF BENEIFTS

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. This includes co-ordination with Workers Compensation Board claims for health benefits only.

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. For the purpose of this co-ordination 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.

CO-ORDINATION OF BENEIFTS

This type of co-ordination of benefits (COB) provision is common to most group insurance plans. A Co-ordination of Benefits form must be completed when you or your dependants are covered under more than one Plan. This form is available by contacting the administration office.

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.

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 may 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 incapacitation 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

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 employees, 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 employee's 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.

MISCELLANOUS 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 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. This includes 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.

MISCELLANOUS PROVISIONS

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.