YOUR HEALTH AT WORK

A guide to your U.A. Local 67 Group Benefits Plan

September 1, 2020

Canadian Piping Trades
LOCAL 67

Trustees of the Plumbing and Pipefitting Workers' Welfare Plan

YOUR HEALTH AT WORK

UA Local 67 is a pioneer of organized labour in Canada. Since 1899, we've fought to protect those working in the plumbing and pipefitting industry throughout Hamilton. Your UA Local 67 Group Benefits Plan is one way we help do that.

To make the most of the plan, you need to know how it works. That's where this booklet comes in. It offers a detailed look at what's covered – and, equally important, what's not. It also explains what you need to do and when to make the most of your benefits coverage. We encourage you to read the booklet carefully and to keep it handy for future reference.

ABOUT THIS BOOKLET

This booklet describes your UA Local 67 Group Benefits Plan in simple terms. We've made every effort to ensure the information presented is accurate. However, should there be any differences between the information contained in this booklet and the legal plan documents, including insurance policies and group contracts, the plan documents will apply. Also, keep in mind that all plan rates, benefit maximums and other details presented are subject to change.

Questions?

Most questions about your benefits coverage can be answered by our plan administrator, Reliable Administrative Services Inc.

By phone: 905-387-5861

Tollfree: 1-855-387-5861

By fax: 905-387-4146

General email:
local67@reliableadmin.com

Address:
195 Dartnall Road,
Suite 102
Hamilton, ON L8W 3V9

or

Website: www.reliableadmin.com

For contact information related to your plan claims, please see Important Contacts on page 37.

Online services for plan members

Be sure to register at www.greenshield.ca for easy access to plan info and quick answers to frequently asked questions. The website also allows you to:

- submit claims quickly and easily online;
- print personalized health and dental claim forms;
- find out about coverage eligibility, such as when you can buy your next pair of glasses;
- instantly view your claims history;
- print your claims history for tax purposes or for coordination of benefits;
- have claims payments deposited directly into your bank account.

You can register online using your unique Green Shield ID number and your e-mail address. Once you are registered, a confirmation will be emailed to you.

Submit claims online

You can submit your health and vision care claims quickly and easily through the website. Here's how:

1. Once you have logged in, select "My claims/submit a claim" from the left-hand menu.
2. Select the type of claim you are submitting.
3. Enter your claim details and click "Submit."

Register for direct deposit

You can register at www.greenshield.ca to have claim payments deposited directly to your bank account. Keep in mind that once you arrange for direct deposit, claim payments will be deposited directly into the bank account you've chosen. Statements will no longer be mailed to you — but you will be able to view them online.

What is benefits fraud?

Benefits fraud refers to any abuse, misuse, or over utilization of the plan as well as inappropriate health provider billing practices — whether intentional or not.

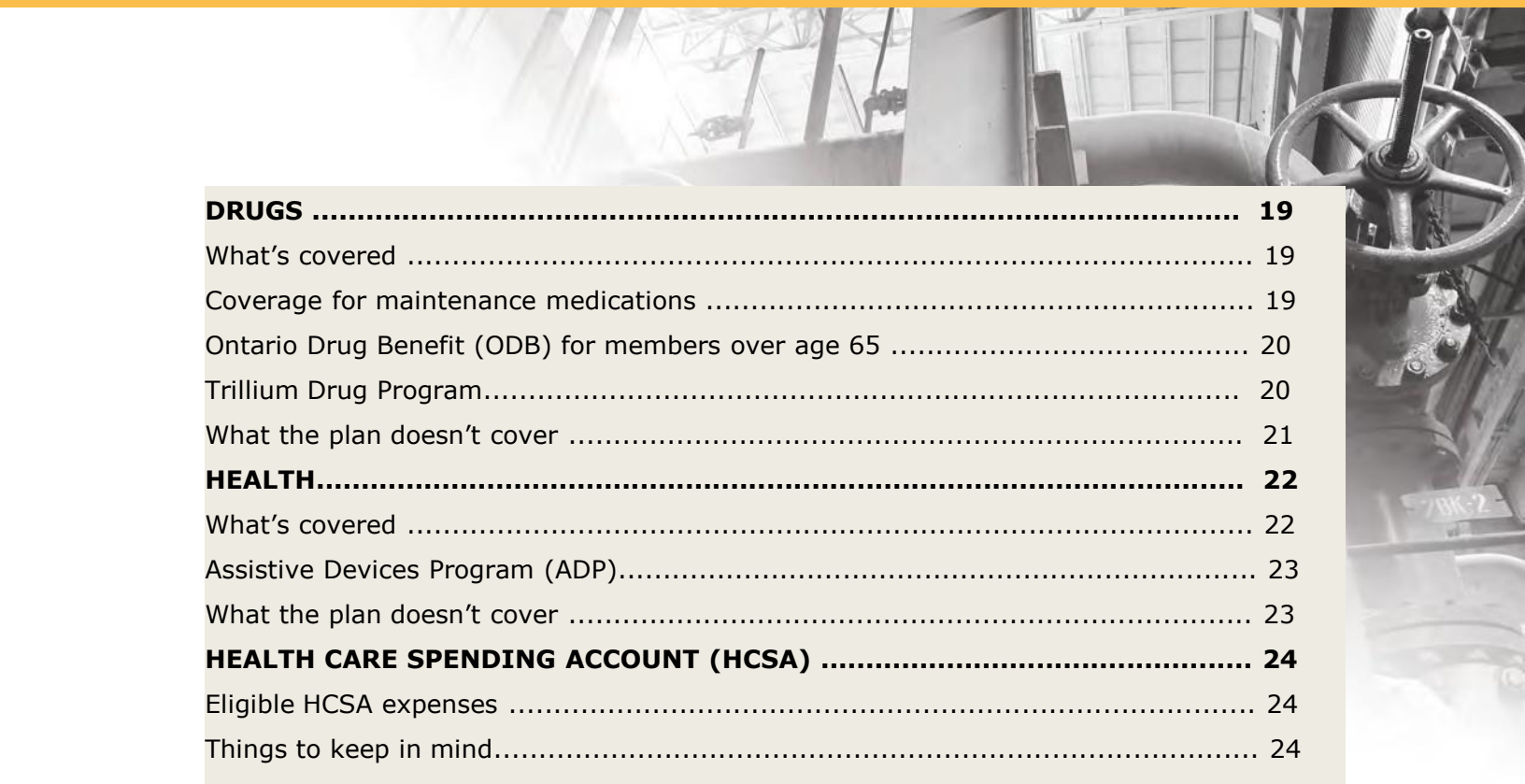
Green Shield's Fraud Prevention Program

Green Shield Canada has a variety of different tools to prevent and detect fraudulent activity. Green Shield's Fraud Prevention Program involves a team dedicated to analyzing claims data and watching for unusual claiming patterns or anything else that stands out as odd. To do this, Green Shield will periodically audit claims. If inappropriate claiming behavior is suspected, they may need to take extra steps when they adjudicate and pay claims.

Suspect Fraud?

If you suspect fraud or the possible abuse of your benefits plan, your concerns can be reported anonymously at (toll free) 1-800-265-5615, ext. 6921, or 1-888-711-1119.
Ask for Green Shield's Confidential TIPS Hotline. You can also email Green Shield at **bmis@greenshield.ca**, or complete the contact form on greenshield.ca.

WHAT'S INSIDE



BENEFITS AT A GLANCE

Dental	Coverage
Claims paid directly from the plan fund and administered by Green Shield Canada.	• 100% for preventive and routine services (such as exams, polishing, routine scaling, extractions, basic surgery); • 100% for minor restorative (such as stainless-steel crowns, fillings, gum surgery, root canal); • 100% prosthodontic services (such as dentures, bridges) • 50% for major restorative (such as inlays, onlays, crowns); and • 100% for orthodontics (such as braces). • $1,500 maximum per covered person, per year for all dental services combined. • Payment of claims is based on the Ontario Dental Association's fee guide that was in place one year prior to current.
Drug	
Claims paid directly from the plan fund and administered by Green Shield Canada.	• **Mandatory generic drug substitution** Based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will only be made up to the cost of the lowest priced equivalent drug. If a medical practitioner indicates a brand name drug is medically required due to a serious medical reaction to at least two generic equivalent drugs, GSC must be provided with a copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (that can be obtained from the Health Canada website) completed by the medical practitioner, to determine eligibility for payment of the cost of the prescribed drug • 100% for Level 1 formulary drugs (based on the Ontario government's drug formulary, and includes at least one drug for every medical condition); • 80% for Level 2 formulary drugs (any drug not included in Level 1 coverage); and • 80% for maintenance drugs (those you are required to take for a long period of time) not purchased through Alliance Pharmacy, regardless of Level 1 or Level 2 status. • You must pay all pharmacy dispensing fees. • Overall maximum of $15,000 per year, per covered person for all health benefits, including drugs.
Disability Income	
Short-Term Disability (STD)	
Claims paid directly from the plan fund and administered by Sun Life Financial.	• Disability due to injury or illness not related to work; • Benefit is only payable if Employment Insurance (EI) is denied or has been exhausted; • Weekly benefit of $450; • If you are disabled for less than a week, the daily benefit rate is $90; • Waiting period for illness of 7 days; • No waiting period for injury; • Maximum disability period is 26 weeks; and • Benefit payments are taxable.
Long-Term Disability (LTD)	
Insured and administered by Sun Life Financial.	• Disability that extends beyond a period of 26 weeks of STD; • Maximum monthly benefit of $2,400; • Maximum benefit period is the last day of the month in which you reach age 62; and • Benefit payments are taxable.

Health	Coverage
Claims paid directly from the plan fund and administered by Green Shield Canada.	• Eligible expenses not covered by OHIP are reimbursed at 100%. See page 22 for a detailed list of covered expenses and claim maximums. • Accidental dental; • Ambulance; • Convalescent hospital; • Diagnostic and outpatient services provided in a hospital; • Hearing aids (excludes costs for testing, repairs and batteries); • In-home care by a registered nurse, with Green Shield approval; • Medical aids and appliances authorized by a doctor; • Medical Alert bracelet, with Trustee approval; • Paramedical – acupuncturist, chiropractor, chiropodist, Christian Science practitioner, naturopath, osteopath, podiatrist or massage therapist if prescribed by a doctor; } Massage therapist is covered for the plan member only, and must be performed by a registered massage therapist; • Psychologist (initial and subsequent), up to a maximum of $400 per calendar year • Physiotherapy, if prescribed by a doctor; and • Prosthetics, if authorized by a doctor.
Health Care Spending Account (HCSA)	
Claims paid directly from your personal HCSA balance.	• Includes all expenses that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) income tax guidelines. • For more information about eligible expenses, visit the CRA website at cra-arc.gc.ca
Life Insurance	
Insured and administered by Sun Life Financial.	• $50,000 to your beneficiary(ies) or estate; $10,000 for Local 666 retirees, unless you have accepted a one-time opt-in to Local 67's benefit. • Advance life insurance payment of up to 50% ($25,000 or $5,000 for Local 666 retirees) of your coverage available for terminal illness with less than two years to live. This amount will be deducted from final payment made to your beneficiary(ies) after your death. • Life insurance applies to your life only.
Supplemental Unemployment Benefits (SUB)	
Benefits paid directly from the plan fund and administered by Reliable Administrative Services.	• If unemployed because of illness or injury not related to work, shortage of work, or attendance at a trade school; • Pays you $175 per week, for up to 10 weeks.
Travel Medical	
Insured and administered by Berkley Canada	• Reasonable expenses for services and supplies required because of a medical emergency while you or your family are travelling outside of your home province or territory. • Coverage is for a maximum of 90 days and up to $2 million per person, per calendar year; 60 days for retirees; and non-retirees under age 70 • Coverage terminates at age 85.
Vision	
Claims paid directly from the plan fund and administered by Green Shield Canada.	• Up to $300 for single vision, bi-focal, tri-focal lenses, frames, safety glasses, contact lenses and eye examination: } Once per calendar year (January to December) for active members; } Once every two calendar years for dependents, retirees and surviving family.

THE BASICS

Joining the plan

To join the plan for the first time, you must either:

- be a member in good standing with UA Local 67 and have enough employer contributions in your benefits account to pay for three months of coverage under the plan; **OR**
- work full-time as a member of the administrative staff or either UA Local 67 or the Board of Trustees.

Coverage starts on the first day of the month following the date you meet the requirements. To join the plan, you must submit an enrolment form to our plan's administrator, Reliable Administrative Services Inc. Claims cannot be paid until the administrator has received your enrolment form.

Paying for your coverage

Contributions

Your employer contributes to both the group benefits plan and the Supplemental Unemployment Benefits (SUB) plan on your behalf. Contributions are made for each hour that you earn. The rates are set under the current collective agreement. The current group benefits plan rate is $2.52 per hour, and the SUB plan rate is $0.20 per hour. At the end of each month, your employer sends Reliable Administrative Services Inc. a report of your hours earned and your contributions.

If you were a member of another UA Local, you may be able to transfer group benefits plan contributions into the UA Local 67 Group Benefits Plan. Check with Reliable Administrative Services Inc. to see if there is a reciprocal agreement between your old Local and Local 67.

Direct payments

If you don't have enough money in your benefits account to cover the cost of your next monthly payment, Reliable Administrative Services Inc. will send you a warning notice. At that point, you can either:

- keep your coverage by making a direct payment out of your own pocket; **OR**
- let your coverage stop. If your coverage stops, it cannot be restarted until you return to work for a contributing employer and build up enough money in your benefit account to cover two months of payments. Coverage will start again on the first day of the following month.

If you choose to make a direct payment, it must arrive at the Reliable Administrative Services Inc. office before the first day of the month in which coverage applies. If you pay by cheque or money order, it should be made out to the ***UA Local 67 Group Benefits Plan*** and should clearly show your name, address and social insurance number. Debit and credit card payments are available (please contact Reliable Administrative Services Inc. office for required forms to be completed). Internet payments are also available, but you must set up a "payee" on your "online banking" as "Local 67 Welfare Plan" and must include your SIN as the account number. See page 2 for contact information.

The following chart outlines current direct payment rates for active members, retirees and surviving family members. Keep in mind that rates are adjusted from time to time to reflect the cost of providing coverage.

Current direct payment rates		
Category	**Coverage**	**Monthly rate (plus 8% retail sales tax)**
Regular	Full Coverage	$315.00
Extended (rate after 12 months of direct payment at the regular rate)	Full Coverage	$368.99
Modified*	Life, STD & LTD	$61.65
Survivor	Dental & Health[1]	$150.33
Retiree (under age 65)	Full Coverage	$315.00
Retiree (age 65 or more)	Life & Health[1]	$155.00
Retiree (over age 65)	Life Only	$40.00
Retiree Survivor	Health Only[1]	$155.00
Local 666 Retiree	Life & Health[1]	$141.58
Local 666 Retiree	Life Only	$20.00

** You can buy modified coverage if you are an active member with no funds left in your benefits account and you can't afford the cost of regular (full) coverage. Your full coverage will be restored once you return to work and your employer has contributed enough to your benefits account to cover the cost of two monthly payments.*

[1] Travel Insurance included until age 85.

How coverage is provided

Employer contributions made on behalf of all plan members are held in a single trust fund, which is used to pay the entire cost of the UA Local 67 Group Benefits Plan. The trust fund is managed by our Board of Trustees (see p. 37), which chooses professional investment managers to invest the fund's assets based on the Board's guidelines.

Health and dental claims are paid directly from the plan trust fund and administered by Green Shield Canada. Short term disability claims are also paid directly from the fund, and are administered by Sun Life Financial. Life and long-term disability benefits are insured and administered by Sun Life Financial. Travel emergency medical coverage is provided by Berkley Canada/Ardent Assistance Company.

See the Benefits at-a-glance chart on page 7 for a summary of your coverage.

Covering your family

You can cover only one spouse at a time under the plan.

Once you are a member of the plan, your spouse and children will be covered under the dental, extended health and travel plans, provided you list them on your enrolment form and they meet the eligibility requirements of the plan under the Canada Revenue Agency.

For the purposes of the UA Local 67 Group Benefits Plan, your spouse is a person of either sex who is living with you and who is either:

- legally married to you; **OR**
- a common-law partner.

Common-law spouses will be covered starting on the first day of the month in which you provide Reliable Administrative Services Inc. with a notarized affidavit (a written sworn statement) confirming that you have been in a conjugal relationship for at least 12 months. A spouse must reside in Canada and be insured under a Provincial Healthcare Insurance Plan, and who is being reported to the CRA (Canada Revenue Agency) as eligible; proof of CRA qualification may be required.

You cannot cover children from both a legal marriage and a common-law relationship at the same time unless they live with you, **OR** don't live with you, but are fully dependent on you for financial support.

The natural, legally adopted, step or foster children of you or your spouse will qualify for coverage under the plan if they are:

- unmarried; **AND**
- dependent on you or your spouse for financial support; **AND**
- under age 21 (under age 25 if a full-time student at a recognized and accredited educational institution).

Coverage will continue after age 21 for unmarried, disabled children who were covered under the plan before age 21 and are not able to support themselves because of their mental or physical disability. You must provide proof of your child's disability to Reliable Administrative Services Inc.

Dependent child(ren) must reside in Canada and be insured under a Provincial Healthcare Insurance Plan, and who is being reported to the CRA (Canada Revenue Agency) as eligible; proof of CRA qualification may be required.

Your group benefits account

Contributions made on your behalf are credited to your group benefits account. You use the funds in your benefits account to "pay" for your plan coverage. The current rate is $315 per month to cover both you and your family. This amount is deducted from your benefits account on the first of each month.

Excess contributions

You can save up to 48 months of monthly premium payments in your group benefits account. On December 31st of each year, any funds in excess of this amount will be transferred to the plan's reserves. These reserves are used, as needed, by the Trustees to pay for benefits on behalf of all members and their families.

Facts on tax

You don't pay any tax on contributions made to the plan by your employers, except those contributions used to provide life insurance coverage. Each year, you will receive a T4A form showing the total employer contributions used to pay for life insurance coverage.

The benefits you receive from the plan are not taxable. The exception is disability benefit payments, including short-term disability and long-term disability. These payments are also reported on your T4A.

Keep in mind that medical expenses already paid under the plan cannot be claimed as a medical expense when filing your income tax return.

When coverage ends

Membership in the UA Local 67 Group Benefits Plan ends automatically on the first of the month after:

- your membership in UA Local 67 ends; **OR**
- you no longer have enough money in your benefits account to pay the cost of one month of coverage and you don't make a direct payment.

You must submit any outstanding extended health and dental claims within 90 days of your coverage ending.

Dental prosthetics (such as bridges or crowns) ordered while you were covered will be reimbursed if they are installed within 90 days of your coverage ending.

If you are no longer a member of the union, your group life Insurance will automatically continue for 31 days from the date your coverage ends. If you'd like to continue your life insurance, you may arrange to buy individual life insurance directly from Sun Life Financial. No medical exam is necessary, but you must submit your application and payment to Sun Life Financial within 31 days of the date your coverage ends.

Keeping your UA Local 67 Group Benefits Plan healthy

Costs for group benefits plans like ours have gone up in recent years. There are many reasons for this increase, including the introduction of new and more expensive drug treatments, and a shifting of coverage away from provincial healthcare plans to plans like ours as governments look to trim costs.

The following are some steps we can all take to help keep benefits costs down and protect our plan.

1. Coordinate your coverage. If you or your spouse are covered by another plan, let Reliable Administrative Services Inc. know. That way, we can make sure both plans pay their fair share. (See page 33 for more on coordinating plan claims).
2. Use it wisely. The UA Local 67 Group Benefits Plan exists to make sure you and your family members have access to the affordable healthcare coverage you need. We encourage you to use your coverage if you need it. But use it wisely.
3. Shop and compare. Spend the plan's money wisely. Take the time to do some comparison shopping before buying healthcare items or services you intend to claim under the plan.

DENTAL

You are covered for dental services up to a combined maximum of $1,500 per covered person, per calendar year. You qualify for an additional $300 every five years to cover the cost of full replacement dentures.

Healthy teeth and gums are an important part of your overall physical well being. But, as we all know, keeping your teeth healthy can be expensive. That's where your UA Local 67 dental coverage comes in. It pays a wide range of dental services and procedures intended to keep you and your family smiling.

What's covered

Covered at 100%

- Anesthetic administered in connection with eligible oral surgery.
- Antibiotic drugs injected by an attending dentist.
- Check-ups, one exam per year; two per year if under age 16.
- Consultations required by an attending dentist.
- Dentures, first installation of partial or full removable dentures to replace one or more natural teeth extracted while covered under the UA Local 67 Group Benefits Plan, including adjustments to these dentures. Separate charges for adjustments are included only if incurred more than three months after first installation.
- Endodontic treatment, including root canal therapy.
- Extractions.
- Fillings.
- Fixed bridgework (including inlays, onlays, and crowns to form abutments), first installation to replace one or more natural teeth extracted while covered under the UA Local 67 Group Benefits Plan.
- Oral surgery, including excision of impacted teeth.
- Orthodontic treatment, including correction of malocclusion (up to $1,500 per covered person, per year).
- Repair or recementing of crowns, inlays, onlays, bridgework, or dentures, or relining of dentures.
- Replacement of existing partial or full removable denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if:
  - } the replacement or addition of teeth is required to replace natural teeth extracted after the existing denture or bridgework was installed while covered under the UA Local 67 Group Benefits Plan;
  - } the existing denture or bridgework was installed at least five years before its replacement and cannot be made serviceable; **OR**
  - } the existing denture is an immediate temporary denture replacing natural teeth extracted while covered under the UA Local 67 Group Benefits Plan.

  Replacement by a permanent denture is required and must take place within 12 months from the date of installation of the immediate temporary denture.
- Scaling up to 9 units (8 units for children 15 & under) and 2 units of Polishing. May be performed by an independent registered dental hygienist. All payments are based on the dental fee guide in effect for the plan.
- Space maintainers, including stainless steel crowns, but only if the crown is placed on a primary tooth that has several cavities and would otherwise require fillings, or cannot be repaired using normal restorative dental materials.

Learn how to access free, routine dental services for eligible seniors 65 years or older, visit: www.ontario.ca/page/dental-care-low-income-seniors for more information.

Yearly maximums apply to the calendar year (January to December).

- Topical application of sodium or stannous fluoride. May be performed by an independent registered dental hygienist. All payments are based on the dental fee guide in effect for the plan.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- X-rays, once every three calendar years for full-mouth services of films, and twice per calendar year for bitewing films.

Covered at 50%

- Inlays, onlays and crowns (including precision attachments for dentures).

Dental fee guide

All claim payments are based on the Ontario Dental Association Suggested Fee Guide for General Practitioners released one year before the current fee guide. If your dentist charges fees that are based on a more recent fee guide, you must pay the difference. Any applicable lab, drug and other expenses are eligible to a maximum of 40% (60% on bruxism appliance or 50% on dentures) of the allowable professional fee.

Getting a treatment plan

It's important that you get a treatment plan from your dentist before starting any treatment costing $300 or more. That way you'll know in advance how much the plan will cover, and how much you'll have to pay out of your own pocket.

Ask your dentist to complete a standard dental form (or Green Shield form) describing the treatment and cost. Return the form with your X-rays to Green Shield. Green Shield will let you know how much the plan will reimburse.

Please send in your treatment plan at least one month before treatment begins. Once you receive approval from Green Shield, you must start your treatment within one year.

Alternative treatments

There are often several different ways to treat a particular dental problem or condition, and the costs can vary widely. The plan will reimburse claims based on the least expensive service or supply that provides satisfactory results. You must pay the difference between this amount and the actual cost of your treatment.

What the plan doesn't cover

- Periodontal splinting.
- Replacement of lost or stolen dental appliances.
- Services related to implants, personalization or characterization of dentures, temporomandibular joint dysfunction.
- Services completed after your coverage ends.

You're covered for one exam each year; children under 16 are covered for two (including emergency and specific exams). You're also covered for up to two hours of cleaning every year.

Dental treatment resulting from an accident may be covered at 100% under your group health benefits.

If you aren't sure whether a particular treatment is covered, please show this section of your booklet to your dentist or contact Green Shield at 1-888-711-1119.

DISABILITY

The disability benefits offered under your group benefits plan are designed to help protect your income if you are unable to perform your job for an extended period due to illness or injury not related to work. You can receive short-term disability (STD) benefits for up to 26 weeks, at which point you may qualify for long-term disability (LTD) benefits. The plan's disability coverage is administered by Sun Life Financial. LTD coverage is fully insured by Sun Life Financial, and the STD coverage is paid directly from the plan.

Short-Term Disability

Eligibility and benefits

- If you are disabled because of an illness, you must see a doctor within seven days, or your benefits will be delayed until you do.
- If you are disabled because of an injury, there is no waiting period. Benefits begin from the day you are treated by a doctor. You must see a doctor within seven days.
- You cannot receive disability benefits from both the UA Local 67 disability plan and the Employment Insurance Plan (EI) at the same time. STD benefits will be paid only if you are denied EI sick benefits or your EI benefits run out.
- The disability plan will pay you a weekly benefit of $450.
- If you are disabled for less than a full week, the daily benefit rate is $90. You will not receive disability benefits for any day on which you have worked even part of the day.
- Tax will be deducted from each benefit payment you receive.
- The maximum STD benefit period is 26 weeks.

If your illness or injury is related to work, you must advise your employer.

Length of coverage

Short-Term Disability benefits will be paid to you for up to 26 weeks for each period of disability. To receive benefits, you must remain completely unable to perform a substantial portion of the duties of your regular job and be under the care of a doctor.

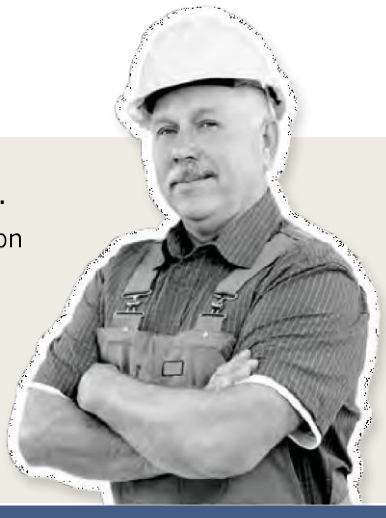
After collecting STD benefits, you can qualify for a new 26-week benefit period if:

- the cause of the latest disability is not related to your last disability, and you have returned to work for at least one full day; **OR**
- You have returned to active work full-time for at least two straight weeks since the last disability ended.

Only regular workdays (Monday to Friday) count as days of disability.

If you're injured and see a doctor on the weekend, your STD benefits will start on the following Monday. If you're injured on a Tuesday, miss work on Wednesday, and see a doctor on Thursday, your STD benefits will start on Thursday.

If your doctor confirms that you are sick and you have missed work since Tuesday, your benefits will start on the following Tuesday, if you are still sick.



If you take an approved leave

You cannot collect disability benefits during a leave of absence. If you become sick or injured during a maternity/parental leave, your STD benefits will start at the end of this leave if you have maintained your group benefits coverage.

Maternity leave starts on the day you have chosen or the date your child is born, whichever comes first. Your maternity leave will end on the date you are scheduled to return to work full time or the date your EI maternity benefits end, whichever is later.

The Trustees will review each case individually if it is not clearly covered by these guidelines, or if interpretation of the guidelines is necessary.

When coverage ends

Your STD benefits will stop immediately if you:

- are no longer under the continuous care of a doctor;
- do any work for which you are paid (except approved rehabilitation);
- do not have proof that you are totally disabled;
- refuse a medical exam;
- retire on a UA Local 67 pension; **OR**
- are imprisoned.

Long-Term Disability

After collecting STD benefits for 26 weeks, you may qualify for Long-Term Disability (LTD) benefits as long as you are totally disabled and:

- the cause of your latest disability is related to a previous disability; **AND**
- your disability started on or after September 1, 2009. If your disability started before September 1, 2009 and you are permanently unable to work in the trade, you may qualify for a disability pension through the UA Local 67 Pension Plan.

Definition of total disability

You will be considered totally disabled:

- If you are continuously unable, due to illness, to do the essential duties of your job during the 26-week period of STD coverage and the following 24 months; **AND**
- afterwards you are continuously unable, due to illness, to do the essential duties of any job for which you may become reasonably qualified for by education, training or experience.

If you have 35 or more years of membership/employment in the local, you will be considered totally disabled if illness prevents you from performing the essential duties of your own job.

Eligibility and benefits

- You must be a member in good standing in UA Local 67 and have enough employer contributions in your benefits account to pay for three months of coverage, and thereafter have enough funds in your account to pay for each month's premium.
- You must have been employed through the local or its sister locals, or have been actively looking for work through the local immediately before your date of disability.

- Your LTD coverage will start after 26 straight weeks of uninterrupted disability, or the last day you are paid benefits under any STD, loss of income or other salary continuation plan, whichever is later.
- You must have been following a treatment plan for your disabling condition from the start.
- The maximum LTD benefit you may receive is $2,400 per month.
- If you are totally disabled for any part of any month, you will receive 1/30 of the monthly benefit for each day you are totally disabled.
- Your LTD coverage under the plan will end when you turn age 62, or the date when you retire, whichever is earlier.

Your LTD coverage under the plan will end when you turn age 62, or the date when you retire, whichever is earlier.

Whatyour LTD benefits will pay

Here is how Sun Life calculates LTD payments:

- The maximum benefit amount of $2,400; **MINUS**
- any income you receive under:
  - } any government plan, law or agency for the same or an additional disability, excluding dependent benefits, employment insurance benefits and automatic cost of living increases that occur after benefits begin;
  - } any Workers' Compensation Act or similar law for the same or an additional disability, excluding automatic cost of living increases that occur after benefits begin;
  - } any auto insurance plan which provides disability benefits;
  - } a group plan, including any coverage resulting from your membership in an association of any kind;
  - } any criminal injuries compensation or similar law; **AND/OR**
  - } the Quebec Parental Insurance Plan.

This payment will be further reduced if the amount calculated is more than 85% of your pre-disability basic earnings.

Sun Life Financial won't take into account any benefits that began before your disability began. But any increases in those benefits as a result of your disability will be taken into account.

Sun Life has the right to adjust benefit payments when necessary.

If you have received LTD benefits from Sun Life after September 1, 2009, you will get extra pension credits for each complete month of disability up to age 62. The amount of pension credits will be determined by the Board of Trustees based on advice from the pension plan actuary.

Your responsibilities during total disability

During any period of total disability, you must make reasonable efforts to:

- recover from the disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from UA Local 67;
- return to your own occupation during the first 24 months;
- Get training in order to qualify for an other occupation if it becomes apparent that you won't be able to return to your own occupation within the first 24 months that benefits are payable;
- try to get work in another occupation after the first 24 months; **AND**
- get benefits that may be available from other sources.

If you fail to do any of these things, your LTD benefits may be stopped.

Interrupted periods of totaldisability

Periods of disability shorter than 26 weeks will be added together for a total of up to 26 weeks, as long as all of the following conditions are met:

- the plan's LTD benefit is still in force;
- the first period of total disability lasts for at least 30 days without interruption;
- any further interruption lasts no more than 30 days;
- each period of disability is due to the same or related causes; **AND**
- each period of disability is completed within 12 months of the first period of disability.

If you were paid LTD benefits and then returned to work, additional periods of disability due to the same or related causes will be considered a continuation of your disability if they happen within six months of the end of the previous period. *You must be covered by UA Local 67's STD and LTD plans when the disability reoccurs.* In such cases, benefits will be paid to you based on the coverage in force on your original date of total disability.

Partial disability program

Sun Life may require you to take part in an approved partial disability program. Under this program, you return to your own occupation for a reduced number of hours per week. While you participate, you may receive your regular salary for any hours worked, plus LTD payments. These LTD payments will be reduced by the percentage of your normal work week that your partial disability program hours represent. If your total income from the partial disability program plus LTD payments is more than 100% of your pre-disability basic earnings, your LTD payments will be reduced by the excess amount.

When LTD payments end

Your LTD payments will stop on the earliest of:

- the date you are no longer totally disabled;
- the date you reach age 62;
- the last day of the month in which you start your UA Local 67 pension; **OR**
- the last day of the month of your death.

When coverage ends

Your LTD coverage will end on the earliest of:

- the date your membership in UA Local 67 ends, or you are no longer a full-time member or employee of either UA Local 67 or the Board of Trustees administrative staff;
- the first day of the month after you no longer have funds in your benefits account, if you have not made a direct payment;
- the first day of the month after you fail to pay the required monthly premium, if you have started direct payments;
- the end of the period for which premiums have been paid to Sun Life Financial to cover you; **OR**
- the date the contract ends.

DRUGS

For many Canadians, prescription drug coverage is one of the most important parts of their group benefits plan. This section outlines what you need to know to make the most of your drug coverage under the plan.

What's covered

- Drugs that require a prescription by law;
- Birth control pills;
- Diabetic supplies, including insulin, needles, syringes, chemical testing agents and glucometers (for diabetic appliances, see the Health section on page 22); and
- Injectable allergy sera and some injected vitamins.

Mandatory Generic Drug Substitution
Based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will only be made up to the cost of the lowest priced equivalent drug. If a medical practitioner indicates a brand name drug is medically required due to a serious medical reaction to at least two generic equivalent drugs, GSC must be provided with a copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (that can be obtained from the Health Canada website) completed by the medical practitioner, to determine eligibility for payment of the cost of the prescribed drug

The overall maximum for all health benefits combined, including drugs, is $15,000 per covered person, per year.

Your prescription drug claims will be paid to you based on a list of drugs called a "formulary." There are two formulary levels in your plan – Level 1 and Level 2. Any claims you submit will be reimbursed based on the level your drug falls under. The plan pays 100% of the cost of Level 1 drugs, and 80% of the cost of Level 2 drugs. You are responsible for paying dispensing fees, which are charged by all pharmacies.

The prescription drugs covered under Level 1 are based on the Ontario government's drug plan formulary. This formulary includes a Level 1 drug available for every medical condition. Our plan's Level 1 coverage also includes over 2,500 drugs considered "life- sustaining," including things like diabetic medication and insulin. The Ontario formulary is reviewed and revised from time to time, and our plan's Level 1 coverage is updated accordingly.

Any eligible drug not included in Level 1 will be covered under Level 2. Level 2 drugs are generally more expensive than those covered under Level 1. The plan pays 80% of the cost of these drugs. Before you have your prescription filled, ask your pharmacist to identify whether your drug falls under the plan's Level 1 or Level 2 coverage. If your prescription is for a Level 2 drug, you may wish to ask your doctor or pharmacist to recommend a less expensive medication covered under Level 1.

Coverage for maintenance medications

On average, more than half of all drug claims submitted to the plan are for maintenance medications. These are drugs which you (or your family members) have been taking for at least six months, and which you are required to take for a long period of time for a particular condition.

You should use your Green Shield card for all medications – including those from Alliance Pharmacy Group – regardless of where you buy them.

To help keep costs down, the plan has established a relationship with the Alliance Pharmacy Group to provide maintenance medications. Alliance Pharmacy Group can dispense medications anywhere in Canada.

Alliance Pharmacy offers the following:

- dispensing fee for active members of $8.00* per prescription;
- dispensing fee of $4.11* per prescription for members over age 65, for drugs covered under the Ontario Drug Benefit (ODB) program;
- dispensing fee of $5.00 per prescription for members over age 65, for drugs not covered under ODB;
- free delivery of your medications via FedEx, to your home or any other location you designate; and
- lower mark-up on prescriptions due to the company's lower overhead costs.

*Dispensing fees are subject to change.

What does this mean for you?

If you choose to buy maintenance drugs through your local pharmacist, the plan will only pay 80% of the cost, whether your medication is a Level 1 or Level 2 drug. All Level 1 drugs considered non-maintenance will be covered at 100%, regardless of where you buy them.

	Purchased through AlliancePharmacy	Purchased through local pharmacy
Non-Maintenance Drugs		
Level 1	100% ingredient cost covered	100% ingredient cost covered
Level 2	80% ingredient cost covered	80% ingredient cost covered
Maintenance Drugs		
Level 1	100% ingredient cost covered	80% ingredient cost covered
Level 2	80% ingredient cost covered	80% ingredient cost covered

We encourage all plan members to enroll with Alliance Pharmacy, and to use the service for maintenance drugs. You can enroll in the following ways:

Online: www.apgrx.ca

By fax: 1-877-835-8329

By mail: Alliance Pharmacy Group
20 Furbacher Lane, Unit 2
Aurora, ON L4G 6W1

If you need help enrolling, you can contact Reliable Administrative Services Inc. for help.

You cannot typically buy more than a three-month supply of a prescription at any one time without the use of a special pharmacist code (such as a vacation supply code) or approval from Green Shield.

Ontario Drug Benefit (ODB) for members over age 65

For covered members over age 65, the plan will pay 100% of the annual ODB program deductible, less dispensing fees.

You should not submit a claim to the plan for the annual ODB deductible before the end of the ODB program year (currently July 31), unless the full $100 deductible has already been reached. (Special rules apply for Quebec residents; please check with Reliable Administrative Services Inc.)

Trillium Drug Program

This program helps to cover the cost of drugs if this is high compared to your income level. If you or a family member have a serious illness and higher than normal drug costs, you can combine benefits from the Trillium Drug Program and benefits from your UA Local 67 Group Benefits Plan to cover up to 100% of costs.

You may qualify for the Trillium Drug Program if you meet all of this criteria:

- your private insurance does not cover 100% of your prescription drug costs;
- You have valid coverage through the Ontario Health Insurance Plan (OHIP); **AND**
- You do not qualify for drug coverage under the Ontario Drug Benefit (ODB) Program.

The program has a deductible that is applied quarterly and is based on your family size and the combined net income of your family members (in most cases, it ranges from 3% to 5% of your combined family net income). To see if you qualify under Trillium, check with your pharmacist or doctor to make sure your prescriptions are eligible.

What the plan doesn't cover

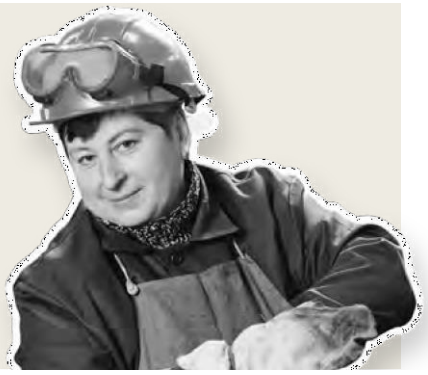
- Contraceptives (other than oral);
- Fertility drugs;
- Items or products considered to be household remedies;
- Non-injectable vitamins, minerals and other dietary supplements or substitutes;
- Over-the-counter products, whether prescribed or not; **AND**
- Treatments to help you stop smoking.

Need help?

Should you or your dependent require assistance with your application or more information regarding the Trillium Program or Compassionate Care programs, please contact Reliable Administrative Services Inc. at 905-387-5681 or Toll Free at 1-855-387-5681 or via email at local67@reliableadmin.com. All information is confidential.

Shop around!

You are responsible for paying dispensing fees charged by the pharmacy. Pharmacists receive this fee to cover services such as medical records and talking to you about your medication. Each pharmacy sets its own dispensing fees. You should shop around to find a pharmacy lowest fees.



innoviCares

The innoviCares card is a free prescription savings card available to all Members of the UA Local 67 Benefit Plan, and is funded by participating pharmaceutical manufacturers. Present your innoviCares card at your pharmacy and ask for the brand-name medication. Your card will automatically cover a portion of the cost of the original brand. Your innoviCares card will coordinate with our existing UA Local 67 Group Benefit Plan or if you don't have insurance, it can be used on its own.

An innoviCares card will be sent to you and your eligible dependents. The card will always belong to you and won't expire. There are no additional forms to fill out or waiting periods for coverage.

Take this card and your benefits card to your Pharmacy:
Present your innoviCares card along with your benefit card and the prescription and ask for the original brand-name medication.
The pharmacy will process your card just like any other drug card.
Your card will automatically cover a portion of participating brands.

HEALTH

The Ontario Health Insurance Plan (OHIP) provides all provincial residents with basic medical coverage, including hospital care, drugs and services administered in a hospital, doctors' services and some paramedical treatments. Your UA Local 67 Group Benefits Plan covers you for many important health services not covered by the province.

This section includes information on what the plan does and does not cover, and any maximums that apply.

What's covered

- **Accidental dental :** Up to 100% of the cost of treatment to repair natural teeth damaged by an accidental blow to the mouth while covered under the plan; treatment must be pre-approved, start within 90 days of the accident and be completed within one year, or before age 22 if under age 21 at the time of the accident.
- **Convalescent hospital:** Up to $10 per day for room, board and services, for a maximum of 120 days per disability, if admitted within 14 days of your stay in a general hospital (periods of disability less than 90 days apart are treated as one period of disability).
- **Emergency transportation:** Licensed ambulance to the closest hospital, if part of the cost is covered by your provincial health plan (does not include an ambulance home from the hospital).
- **Hearing aids:** if prescribed by a doctor – up to $500 per person every five calendar years (excludes hearing/ear tests, repairs and batteries).
- **Hospital:** Charges for diagnostic and outpatient services.
- **Medical aids and appliances** authorized by a doctor, including:
  - compressor, nebulizer, apnea monitor, aerochamber;
  - crutches, cane, standard type walker;
  - diabetic appliances – up to $500 per person, per calendar year for appliances used to monitor or treat diabetes, other than those supplies listed under prescription drugs (see p. 19);
  - rental or pre-approved purchase of standard type manual hospital bed (including mattress) or standard type manual wheelchair (electric hospital beds, wheelchairs and scooters are excluded unless medically required and recommended in writing by a doctor)
  - hospital bed, wheelchair and scooter repairs, when required as a result of normal wear and tear (excluding replacement of batteries);
  - oxygen and equipment necessary for its administration;
  - respirator (for the purpose of providing artificial respiration over a prolonged period of time when respiratory muscles are non-functioning).
- **Medical alert bracelet:** With Trustee approval
- **Nursing:** In-home care by a registered nurse (RN), if preapproved by Green Shield, and approved each month after 30 days (maximum $10,000 per lifetime). This coverage excludes:
  - charges by a nurse who is related by birth or marriage or who lives with you;
  - charges for services which could be provided by someone who is not a registered nurse;
  - agency fees;
  - commissions; **AND**
  - overtime.
- **Paramedical:** Treatment by a licensed acupuncturist, chiropractor, chiropodist, Christian Science practitioner, naturopath, osteopath, podiatrist or

massage therapist. Massage therapy is covered for the plan member only, and service must be performed by a Registered Massage Therapist (RMT) upon written authorization of a medical doctor. Maximum $400 per covered person, per year combined for paramedical treatments, paid at 80%. Paramedical assessments are paid over and above the $400 combined maximum and will be paid to a $50 maximum.

- **Physiotherapy:** Treatment by a registered physiotherapist, if prescribed by a doctor in accordance with Ontario Physiotherapist Association guidelines. Maximum 20 visits per calendar year; up to $85 for a first assessment, and up to $55 per visit there after.
- **Prosthetics:** If authorized by a doctor, including:
  - } braces, splints, trusses, casts, cervical collars ("brace" means a rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding braces used to correct dental defect, deficiency or injury);
  - } breast prostheses –external breast prostheses and up to a maximum of six surgical brassieres per calendar year when required as a result of mastectomy;
  - } catheters, urinary kits;
  - } lenses – corrective prosthetic lenses and frames, once only, following cataract surgery or when a person lacks an organic lens;
  - } limb and eye – artificial limbs and eyes (myoelectric or sport prostheses reimbursed based on the amount that would otherwise be paid for standard type artificial limbs);
  - } orthopedic shoes which are attached to and form part of a brace. If shoes do not form part of a brace, payment is limited to $15 per pair per person per calendar year;
  - } orthotics – up to $300 per person every two calendar years for custom moulded Orthotics excluding orthotics for sport purposes (Doctor referral required) Please refer to the Green Shield website for a list of documents that **must** be submitted with your claim;
  - } ostomy supplies (excluding gloves), where a surgical stoma exists;
  - } repairs to prosthetic appliances, when required as a result of normal wear and tear;
  - } stockings – six pairs of surgical elastic stockings per calendar year;
  - } stump socks;
  - } tracheotomy supplies (excluding gloves); and
  - } wigs, only after radiation or chemotherapy ($500 lifetime maximum per person).
- Psychologist (initial and subsequent), up to a maximum of $400 per calendar year

You are **NOT** covered for semi-private or private hospital rooms.

You may be eligible for coverage under Ontario's Assistive Devices Program for medical devices such as wheelchairs, braces and hearing aids. Ask your doctor or Green Shield for more information.

Assistive Devices Program (ADP)

If you need a medical device, you may qualify for benefits from the Ontario Ministry of Health's Assistive Devices Program (ADP). Devices covered under this program include wheelchairs, artificial limbs, braces, hearing aids, voice amplifiers, respiratory equipment, colostomy supplies, and visual aids.

ADP keeps a list of eligible devices and their approved prices, and will contribute up to 75% toward their approved cost, up to certain limits. If you or a family member needs the type of equipment mentioned here, you should ask your family doctor to help you in filing a claim with ADP. Please contact Green Shield for more information.

What the plan doesn't cover

- Rest cures, travel for health reasons, periodic check-ups, examinations for use by a third party; **AND**
- Services provided in a nursing home, home for the aged, health spa, chronic care or psychiatric facility (or unit of a general hospital).

HEALTH CARE SPENDING ACCOUNT(HCSA)

HCSA is a spending account that you can use to pay for health and dental expenses not covered by your group benefits plan or your provincial health plan. All UA Local 67 members who are eligible for Extended Health and/or Dental benefits automatically qualify for the HCSA.

Each family is given $750 per calendar year to apply against qualifying Extended Health and Dental expenses.

A $750 HCSA will also be made available to members who are currently ineligible for full benefits. These members must also be in good standing and have worked 1200 hours in the last 12-months. Members in this category will be registered for the **HCSA only plan** through Reliable Administrative Services Inc..

Claims can be submitted to the HCSA either manually or online using Green Shield's "Member Online Services". Any unused portion of the maximum amount granted in the HCSA will not roll forward to the next calendar year.

The Board of Trustees will review the financial status of the Welfare Plan and determine, on an annual basis, future allocations (if any) to the HCSA.

Eligible HCSA expenses

Eligible HCSA expenses include all expenses that qualify for the medical expense tax credits under the Canada Revenue Agency (CRA) income tax guidelines (but not limited to), such as:

- Payments to medical practitioners, hospitals, orthodontics, etc.
- Artificial limbs, aids, and other medical equipment
- Eyeglasses and contact lenses
- Rehabilitative therapy
- Dentures and/or other dental coverage

For more information about eligible expenses, visit the CRA website at cra-arc.gc.ca or call toll free 1-800-959-8281

Things to keep in mind

- You should confirm your expense is eligible under your HCSA. A list of eligible expenses is available on the Plan Member Online Services through GSC or on the CRA website.
- Some amounts are not eligible for reimbursement, for example, sales tax or shipping and handling fees, so deduct them from the total before submitting your claim online.
- Expenses paid with a gift certificate or card are also not eligible for reimbursement.
- If your expense is eligible under your traditional health or dental benefits, be sure, to submit your claim to that plan first, then submit any unpaid balance under your HCSA.
- Avoid duplicate claims! Don't submit a claim under your HCSA until you're sure it has not already been reimbursed by your HCSA or your traditional health or dental benefits. Take a look at your claims history just to be certain.
- If you coordinate your benefits, don't forget to submit your claim to the other plan first, then submit any unpaid balance (not covered under your primary or secondary plan) under your HCSA.

LIFE EVENTS

Keep us informed!

You must let Reliable Administrative Services know immediately if there is any change in your personal or family status, including:

- change of name or address;
- marriage or divorce;
- coverage for a common-law partner;
- birth or adoption of a child;
- death of a spouse or other family member;
- status of a child who reaches age 21 and is a full-time student (status must be updated with Reliable Administrative Services every year)

If you die, your spouse has the option to continue coverage through direct payments.

Death

If you die before you retire, your spouse and children will continue to be covered by the plan until your benefits account falls below one month's payment. Your spouse then has the option to continue dental and health coverage by paying the direct payment rate for survivors (see page 10). The first direct payment must be received by Reliable Administrative Services by the 25th of the month after your benefits account falls below one month's payment. Your surviving family members' coverage will end if your spouse remarries.

If you die after you retire, but while you are still covered under the regular plan, your surviving spouse and children can continue their full health and dental coverage by making direct payments. If you die while you are covered under the retiree plan, your surviving spouse and children can continue their retiree coverage by making direct payments. Coverage for your surviving family members will end if your spouse remarries.

Illness or injury

If you are collecting benefits from the Workplace Safety and Insurance Board (WSIB), you will continue to receive full coverage under the UA Local 67 Group Benefit Plan for up to 12 months, with contributions paid from the plan. Your employers contribute to the cost of this coverage by hourly contributions on your behalf as required under Ontario legislation.

Naming or changing your beneficiary

Your beneficiary is the person you name to receive any death benefits from the plan. You may change your beneficiary(ies) for life insurance at any time. Beneficiary change forms are available from Reliable Administrative Services Inc.

Benefits paid directly to a named spouse, child, grandchild or parent are protected from creditors. If you name more than one person as beneficiary, your death benefits will be divided in equal shares unless you indicate otherwise.

If you name a minor, you should consider consulting a lawyer to help you appoint a trustee to look after your child's benefit. If you don't appoint a trustee, the plan can pay the benefit to a legal guardian who has been appointed by the court. If no guardian is appointed, current Ontario law states that any amount above $10,000 must be paid to the Accountant of the Superior Court, who will hold the money until the minor reaches 18.

If you don't name a beneficiary or your named beneficiaries are not alive when you die, your death benefits will be paid to your estate. This means that the full amount of your death benefits may be exposed to probate fees, estate taxes, and creditors. It's a good idea to name a back-up beneficiary to avoid having payments made to your estate.

Retirement

When you retire, your membership in the regular benefit plan will continue until you reach age 65. If your benefits account falls below the amount needed to cover the cost of one month of coverage, you must continue to pay the full cost by direct payment until you turn 65.

If you reach age 65 and you still have enough funds in your benefits account to continue your coverage, you can choose to continue regular coverage, or begin retiree coverage. When your benefits account falls below one month's payment, you may choose to continue either regular coverage or retiree coverage by direct payment if:

1. You are a member in good standing with UA Local 67;
2. You are receiving a pension from the Local 67 pension plan; **AND**
3. You were covered by the Local 67 benefit plan immediately before you retired.

After you retire, you may stop your coverage at any time by contacting Reliable Administrative Services Inc. But, if you do this, you cannot change your mind and get your coverage back at a later date unless you return to work for a contributing employer and earn the required contributions.

To help retirees over age 65 that have run out of funds in their benefits account and don't want to continue their group benefits coverage, the Trustees have introduced a life-only program that provides $50,000 in life insurance ($10,000 in life insurance for Local 666 retirees, unless one time opt-in was accepted). To qualify, you must satisfy **ALL** of the following conditions:

1. Be over 65 years old;
2. Be covered under the active or retiree group insurance premium;
3. Remain a member in good standing with the local;
4. Have a monthly premium payment of $40 ($20 for Local 666 retirees) plus 8% retail sales tax deducted directly from your monthly pension benefits; **AND**
5. Let Reliable Administrative Services Inc. know you intend to convert to the life-only program and sign a written declaration.

Once you convert to the life-only program, you will not be able to restart your coverage in the health and dental plans unless you return to work and earn the required contributions.

LIFE INSURANCE

Life insurance can help to protect those closest to you in the event of your death.

Benefit amount

If you die while covered by the plan, the plan will pay $50,000 in life insurance (or $10,000 in life insurance for Local 666 retirees, unless one-time opt-in was accepted) to your beneficiary(ies) or estate. This amount is paid tax-free to your beneficiary as a one-time payment.

If you have a terminal illness with a life expectancy of 24 months or less, you may request an advance life insurance payment of up to 50% of your coverage. This amount will be deducted from the final payment made after your death.

If you leave the plan, your group life insurance coverage automatically continues for 31 days from the date you leave. If you'd like to continue your coverage, you can buy individual life insurance directly from Sun Life Financial. No medical exam is necessary, but you must return your application form and payment to Sun Life Financial within 31 days of the date your coverage ends.

Under current tax law, premiums paid for life insurance are taxed as income. The exact amount is shown on the T4A form that you receive every year.

Naming a beneficiary

You may name anyone you wish as your beneficiary for life insurance, and you may name more than one person. If you name more than one person, your death benefits will be divided according to your instructions.

Benefits paid directly to a beneficiary are protected from creditors. If you name more than one person as beneficiary, your death benefits will be divided in equal shares unless you indicate otherwise.

If you name a child, you should consider consulting a lawyer to help you appoint a trustee to look after your child's benefits. If you don't appoint a trustee, the plan can pay the benefits to a legal guardian appointed by the court. If no guardian is appointed, current Ontario law states that any amount above $10,000 must be paid to the Accountant of the Superior Court, who will hold the money until the child turns 18.

Your death benefits will be paid to the most recently named beneficiary on file with Reliable Administrative Services Inc., unless you have a more recent will that makes specific reference to your life insurance. If you don't name a beneficiary, or your named beneficiary(ies) are not alive when you die, your death benefits will be paid to your estate. This means that the full amount of your death benefits may be exposed to probate fees, estate taxes, and creditors. It's a good idea to name a back-up beneficiary to avoid having payments made to your estate.

You can change your beneficiary at any time. Beneficiary change forms are available from Reliable Administrative Services Inc.

What the plan doesn't cover

Life insurance applies to your life only. No life insurance benefits will be paid on the death of a spouse or child.

SUPPLEMENTAL UNEMPLOYMENT BENEFITS (SUB) PLAN

The Supplemental Unemployment Benefits (SUB) Plan tops up the income of members who are receiving Employment Insurance (EI) benefits due to an illness or injury, shortage of work, attendance at a trade school, or a maternity/parental leave.

The SUB plan is funded through employer contributions. Employers contribute $0.20 for each SUB hour earned. You will receive $175 each week for up to 10 weeks per year.

You cannot receive more than $1,750 in a calendar year.

How to qualify for SUB benefits

To qualify for benefits, you need to have earned at least 1,800 SUB hours during the previous 24 months. You must also be receiving EI benefits (or be completing the EI waiting period) **AND**:

- Have signed the out-of-work list at the local union office and be available for work; **OR**
- Have signed the out-of-work list at the local union office and be attending trade school or a government-sponsored or J.A.T.C.- approved training course related to your trade; **OR**
- be unable to work due to an illness or injury that is not related to work and for which you are not receiving UA Local 67 short term disability benefits; **OR**
- be on maternity or parental leave.

If you are retired and already receiving (or have received) retirement benefits from any UA sponsored pension plan, you do **NOT** qualify for SUB benefits.

Keep in mind that to receive benefits, you must submit your EI stub within 90 days of the date you receive your weekly EI payment.

Making a claim

To start receiving benefits, contact Reliable Administrative Services Inc. You must submit your EI stub within 90 days of the date you receive your weekly EI payment. If you don't, you won't receive SUB benefits for that week.

Multiple claims

You can file a claim for SUB benefits more than once. To make another claim, you must have earned at least 600 SUB hours during the last 12 months. Once you've received benefits for the full 10-week period, you can't make another claim until the next calendar year.

Effective April 1, 2020 the rate applied will be the rate applicate to the time period for which the benefit is being paid.

Maximum benefit

Your SUB payments will stop as soon as:

- you return to work or stop receiving EI benefits; **OR**
- you reach the $1,750 maximum within a calendar year.

SUB benefits and income tax

You must report any SUB payments as income on your tax return. You will receive a T4A slip each year from Reliable Administrative Services Inc.

TRAVEL MEDICAL COVERAGE

This benefit provides you and any family member insured under this plan with assistance 24 hours a day, 7 days a week for costs incurred as a result of an unexpected medical emergency while travelling outside of your province or territory of residence.

This booklet outlines the main features of your group travel medical insurance plan through UA Local 67, but the policy issued by Berkley Canada/The Assistance Company is the governing document. If there are any variations between this booklet and the provisions of the policy, the policy will prevail.

How coverage works

Your Canadian health insurance is generally not valid outside of Canada. Your provincial or territorial plan may cover your medical treatment in other Canadian provinces, but not all additional expenses such as ambulance services or transporting a family member to your bedside are included. Your provincial or territorial plan may cover none of your costs outside of Canada or only a small percentage and will never pay costs up front.

Provided you and your eligible family members are under age 85 and covered under your provincial or territorial government health insurance plan, your emergency travel medical insurance will help you avoid paying these costs yourself.

You are covered for up to a maximum of 90 days (60 days if you are retired or 70 years of age or over) outside of your province of territory of residence per trip and up to $2 million per covered person, per calendar year, over and above the costs covered by your provincial or territorial healthcare plan.

Spouses and dependent children are covered under the same terms as the insured member.

What to do in an emergency

It is your responsibility to ensure that Berkley Canada/The Assistance Company has been contacted prior to receiving treatment. Benefits will be limited to 80% of eligible expenses to a maximum of $25,000 if you fail to do so, other than in extreme circumstances when treatment is required to resolve a life-threatening medical crisis.

The Assistance Company is available to assist 24-hours day, 7 days a week and will:

- help you locate the most appropriate medical facility;
- confirm your coverage with the medical facility;
- guarantee payment for hospitalization, if necessary;
- arrange for admission to a hospital;

Contact: The Assistance Company at the following numbers:

- 1-844-879-8379 (Toll-Free from U.S.A and Canada)
- +1-416-285-1722 (collect)
- claims@ardentassistance.com

An operator will ask the following:

- your name and the patient's name, location and the details of the emergency;
- the group name of the policy: **UA Journeymen and Apprentices of Plumbing and Pipefitters Industry of the U.S. and Canada Local 67**;
- the policy number: **BC05840**

What's covered

- **Hospital Accommodation:** Up to semi-private room rates: emergency room fees and emergency out-patient services. Your hospital stay benefit will continue until you are discharged up to a maximum of 365 days.
- **Medical Services:** Treatment by a physician, surgeon, anaesthetist or registered graduate nurse and blood plasma and oxygen.

- **Diagnostic Services:** Laboratory tests and x-rays ordered by the physician as a result of the emergency.
- **Prescriptions:** Prescription drugs required due to the medical emergency up to a maximum 30-day supply outside of a hospital. There is no daily limit while hospitalized.
- **Private Duty Nurse:** Professional services of a registered private duty nurse up to $10,000.
- **Paramedical Services:** Licensed chiropractor, chiropodist, physiotherapist, podiatrist, osteopath or acupuncturist, to a maximum of $500 per insured person, per profession.
- **Dental:** Treatment by a licensed dentist or oral surgeon up to $2000 for a blow to the face and $500 for relief of dental pain.
- **Medical Appliances:** Minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers; and/or the temporary rental of a hospital type bed, wheelchair, iron lung or other durable equipment for therapeutic treatment.
- **Prescription Replacement:** Visit to a physician to obtain a replacement prescription to replace lost, stolen or damaged prescription medication up to $250. Does not include the cost of the medication.
- **Emergency Transportation:**
  Ambulance (or taxi fare) for transport to a hospital or between hospitals when ordered by a physician.

  Air transportation to return to Canada by economy airfare; return economy airfare for a qualified medical attendant if required by a physician; air ambulance if medically necessary.
- **Transportation to Bedside:** Up to $15,000 for return transportation and meals and accommodation for one person of your choice to be with you if you are travelling alone and hospitalized for at least 3 consecutive days.
- **Identification:** Up to $5,000 for return transportation and meals and accommodation for one immediate family member to identify the body if you die as the result of a covered sickness or injury.
- **Repatriation benefit:** Up to $15,000 to cover the costs of returning your body home or $5,000 for the costs of burial or cremation at the place of death if you die as the result of a covered sickness or injury.
- **Meals and Accommodation:** Up to $5,000 for meals and accommodation if your trip is extended beyond the expiry date due to a covered sickness or injury.
- **Hospital Allowance:** Up to $500 for out-of-pocket expenses while you are hospitalized for a covered emergency.
- **Return and Escort of Children:** Economy airfare to return children under age 16 travelling with you to the place of departure if you are hospitalized for a covered emergency or returned home.
- **Pet Return:** Up to $500 to return a dog or cat travelling with you if you are hospitalized for a covered emergency or returned home.
- **Return of Travelling Companion:** Economy airfare to return one travelling companion to Canada if you are returned home.
- **Vehicle Return:** Up to $10,000 to return a private passenger vehicle to a commercial agency or your home in Canada if you or your travelling companion are unable to drive due to a covered sickness or injury.
- **Excess Baggage Return:** Up to $500 to transport your baggage to the departure point if you are returned to Canada
- **Alternate Transportation:** Up to $5,000 for economy airfare to return you to your province or territory of residence if your vehicle is stolen or rendered inoperable due to an accident during your trip.

What the plan doesn't cover

The plan will not cover any losses caused by or resulting in whole or in part from the following:

- Sickness, injury or medical condition that was not stable:
  - in the **90 days** prior to the departure date if the insured is under the age of 70; or
  - in the **180 days** prior to the *departure date* if the *insured* is between the age of 70 and 84 years of age.
- Sickness, injury or medical condition for which an ordinarily prudent person would have sought treatment in the 90 days prior to departure or for which there was a reasonable expectation that treatment would be required during the trip.
- Medical treatment that is not emergency medical treatment.
- Medical treatment that can be delayed until your return to your province or territory.
- Any costs incurred if you are travelling against the advice of a physician.
- Any loss due to a terminal illness diagnosed before your trip.
- Expenses incurred for a trip taken specifically to obtain medical treatment.
- Transplants.
- Prescription replacement and over the counter drugs and medications.
- Loss or damage to hearing devices, eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices.
- Any benefit which required pre-approval if such approval was not obtained.
- Any medical treatment of an ongoing condition, regular care of a chronic condition, home health care, investigative testing, rehabilitation or ongoing care, or medical treatment of an acute sickness and/or injury after the initial emergency has ended.
- Non-compliance with any prescribed therapy or treatment.
- Mental, psychological or emotional conditions unless hospitalized.
- Any loss caused by chronic use of alcohol or drug impairment.
- Any loss if you are operating a vehicle when your blood alcohol, THC, other drug impairment or any combination exceeds the level permitted by law.
- Routine pre-natal care or costs related to a pregnancy within 8 weeks before or after the expected due date.
- Committing or attempting to commit a criminal act.
- Suicide, attempted suicide, self-inflicted injury or attempted self-inflicted injury.
- Rock or mountain climbing, hang gliding, parachuting, bungee jumping, or skydiving; participation in any motorized race or speed contest; participation in any sport as a professional athlete; scuba diving.
- Sustained while operating, learning to operate or instructing others to perform in any aircraft as pilot or crew.
- Travel to an area for which there is a government of Canada warning against travel.
- War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, riot, rebellion, revolution or military power or an insured person's unlawful visit in any country.
- Contamination resulting from radioactive material or nuclear fuel or waste or the release of weapon(s) of mass destruction (nuclear, chemical or biological).
- Service in, or training for, the armed forces, national guard or organized reserve corps of any country or international authority.
- Upgrading charges and cancellation penalties for airline tickets.
- The cost of any airline ticket covered under this policy where the insured person's ticket may be exchanged or used for the same purpose.
- Treatment or services received in the country where an insured person attends school or works on a full-time basis, or in his/her home country, if such insured person is a foreign student studying in Canada or a non-resident working in Canada.
- Medical treatment or services normally covered or reimbursable under a government health insurance plan or under other insurance.

- Any services or supplies provided by an insured person or an immediate family member of the insured person or an individual who resides in the insured person's home.
- Any sickness or injury, if at the time of the sickness or injury you are under the influence of drugs, alcohol (blood level in excess of 80 mg of alcohol per 100 ml of blood) or other intoxicant (unless administered on, and in strict accordance with the advice of a legally qualified physician);
- Emotional or mental disorders, unless confined to a hospital;
- Sickness or injury due to participation in professional sports;
- Treatment or services that contravene any GHIP plan in Canada;
- Expenses incurred on an elective (non-emergency) basis;
- Suicide or any attempt at suicide while sane or insane;
- Intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury, while sane or insane;
- An act of declared or undeclared war, civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority;
- Any services or supplies provided by you or your covered family, or immediate family members;
- A sickness or injury that, at the time of departure, might reasonably be expected to require treatment, surgery or hospitalization;
- Any service, treatment, surgery or hospital stay not required for the immediate relief of acute pain or suffering or which is not medically necessary;
- Any treatment or surgery which reasonably could be delayed until you or your family member returns to your province of residence;
- Anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known prior to departure;
- That portion, if any, of any expenses for treatment, advice or hospitalization which are not reasonable and customary.

When coverage ends

Coverage ends on the earliest of:

- The date the plan ends;
- The date your required plan premium is not paid;
- The date you or your family are no longer covered by the plan; **OR**
- The first day of the month following the date you no longer belong to an eligible class of members.

Coverage for a child will end once he or she no longer qualifies for coverage.

VISION CARE

Many members require corrective glasses or contact lenses to improve their vision. This benefit can help cover the cost of these important items.

What's covered

Up to $300 for:

- contact lenses, single-vision, bi-focal and tri-focal lenses, frames, safety glasses and eye exam. Claim frequency is based on your member category, as follows:
  - Once per calendar year (January to December) for active members and retired members paying the full rate by direct payment.
  - Once every two calendar years for dependents, retirees and surviving family.

What the plan doesn't cover

- Non-prescription reading or sunglasses.

SPENCER HEALTH NETWORK

Members who are working but do not have enough hours to meet the eligibility criteria, or members who are not working enough to stay in benefit once they are eligible will be signed up to receive additional savings through the Spencer Health Network. Members must be in good standing in order to qualify.

What is it?

Spencer Health Network provides pharmaceutical, dental, vision, paramedical, and hearing aid saving programs, with their main objective to reduce your out-of-pocket costs. Using the network is fast and easy, and there are no annual maximums or deductibles.

To register with Spencer Health please contact Reliable Administrative Services Inc.

How it works

Paramedical & Dental

Simply present your Spencer Health card when paying for your services at an affiliated Spencer Health Network provider and savings will be automatically applied.

Pharmaceutical

When picking up your prescription from a Spencer Health Network affiliated pharmacy you could save up to $8.00 on dispensing fee costs as well as up to an additional $2.50 on the cost of the drug. The table below outlines potential savings when using a Spencer Health Network pharmacy.

Pharmacy 1 – Not part of Spencer Health Network	Dispensing Fee: $12.00 Reimbursement: $6.50 Out-of-Pocket Expenses: $5.50 & no drug savings
Alliance Pharmacy – Part of Spencer Health Network	Dispensing Fee: $6.49 Reimbursement: $6.49 Out-of-Pocket Expenses: $0 + lower drug cost
Sobey's & National Banners – Part of Spencer Health Network	Dispensing Fee: $8.83 Reimbursement: $8.83 Out-of-Pocket Expenses: $0 + $2.00 off drug cost
Wal-Mart Pharmacy – Part of Spencer Health Network	Dispensing Fee: $7.47 Reimbursement: $7.47 Out-of-Pocket Expenses: $0 + $2.50 off drug cost

MAKING CLAIMS

This section outlines what you need to know to claim expenses under the plan.

Green Shield card

As a plan member, you will receive a Green Shield card showing your Plan Member Identification number(s), which must be used on all health and dental claims and correspondence. Your number(s) appear on the front of the card and end in -00; numbers for each of your covered family members will be shown on the back of the card.

Submit claims online

If somebody else is liable for paying some or all of your claim because it resulted from fault or neglect, please check with Reliable Administrative Services before you sign any settlements or agreements that could affect the level of benefits paid under this plan.

Did you know you can submit health and vision care claims quickly and easily online? To do so, simply register at www.greenshield.ca using your unique Green Shield ID number and your e-mail address.

Once you are registered, here's how to submit claims for processing:

1. Once you have logged in, select "My claims/submit a claim" from the left hand menu.
2. Select the type of claim you are submitting.
3. Enter your claim details and click "Submit."

What's covered

Expenses must be:

- medically necessary;
- made while under the active care of a legally licensed doctor (unless otherwise indicated in the plan);
- not normally covered by any government plan or agency, including the Workplace Safety and Insurance Board (WSIB) or provided free of charge in absence of coverage;
- not prohibited by law; **AND**
- supported by written proof.

What the plan doesn't cover

Claims must not be related to:

- occupational illness or injury;
- self-inflicted injury;
- completion of forms, reports, documentation, assessments, tests or evaluations, unless otherwise indicated;
- failure to keep a scheduled appointment;
- injuries or illnesses due to civil disorder or war (declared or undeclared) or while serving in the armed forces;

Health and dental claim forms can be downloaded from the Green Shield website at www.greenshield.ca. They are also available from Reliable Administrative Services.

- cosmetic services;
- lifestyle choices;
- services or supplies that are experimental or which are not approved by the Health Protection Branch of Health & Welfare Canada for use in Canada;
- services or supplies that are educational or primarily for research;
- committing or attempting to commit a criminal act;
- services or products that are self-prescribed or prescribed by a family member; or
- Any eligible service that relates to treatment of injuries arising out of a motor vehicle accident.

Claims relating to automobile accidents for which coverage is available under an auto insurance policy providing no-fault benefits will be considered only if:

- the service or supplies being claimed is not eligible; **OR**
- the financial commitment is complete.

You will need to submit a letter from your auto insurance provider.

Coordinating claims

Many working couples have coverage under more than one group benefits program. If you're covered under your spouse's plan, you and your spouse may be able to claim up to 100% of your family's medical, dental and vision expenses. For example, if your glasses cost more than the $300 allowed under the UA Local 67 plan, you may be able to submit the balance under your spouse's plan.

There are certain rules you must follow to ensure you maximize your reimbursement and ensure each plan pays its fair share of the cost. First, you need to check whether the other plan's rules allow claiming from more than one plan. Then, make your claims as outlined in the tables below.

Be sure to keep copies of all original receipts. You'll need them to submit claims to your spouse's plan.

Coordinating claims with your spouse		
Plan rules	**For your expenses**	**For your spouse's expenses**
If your spouse's plan has rules on how to make claims from more than one plan	Make your first claim to the UA Local 67 plan.	Make the first claim to your spouse's plan.
	Claim any unpaid amount to your spouse's plan.	Claim any unpaid amount to the UA Local 67 plan.
If your spouse's plan doesn't have rules on how to make claims from more than one plan	Make the first claim to your spouse's plan	Make the first claim to your spouse's plan.
	Claim any unpaid amount to the UA Local 67 plan.	Claim any unpaid amount to the UA Local 67 plan.

You must tell Reliable Administrative Services if your spouse is covered under another plan or if there is a change in that coverage.

Coordinating claims for your children	
If you are living with the child's other parent	**If you are separated or divorced**
Submit claims in the following order: 1. To the plan of the parent whose birthday comes earlier in the calendar year; then 2. To the plan of the parent whose birthday comes later in the calendar year.	Make claims for each child in the following order: 1. To the plan of the parent with custody; 2. To the plan of the spouse of the parent with custody; 3. To the plan of the parent not having custody; then 4. To the plan of the spouse of the parent not having custody.

Coordinating claims if you are retired

If you're a retired member with coverage under more than one plan, submit your claims in the following order:

1. To the plan where you are an active member.
2. To the plan where you are covered as a dependent.
3. To the plan where you have retiree coverage.

Your combined reimbursement from all plans cannot be more than the actual amount paid out.

Direct payment to your healthcare provider

Present your Green Shield Identification Card to your healthcare service provider and they may bill Green Shield directly. In many cases, your provider will be paid directly.

Dental claims

You may use a dental claim form, or your dentist may submit claims electronically to Green Shield for payment.

You must use a separate form for each person covered under your plan. Claims must be submitted within 12 months of the treatment date. The "assignment" part of the form, which allows the plan to pay your dentist directly, may only be signed by you (not your spouse or children). The plan has the right to cancel this assignment privilege at any time.

Disability claims

STD claims must be filed with Sun Life within 90 days of the first day of disability. Benefits are paid weekly.

You should first make a claim to the Employment Insurance plan (EI), and let Reliable Administrative Services Inc. know at the same time that you are filing an EI claim. The period when you are collecting EI won't count towards your 26-week STD maximum.

Your EI benefit will be reduced by:

- any benefits due to you under provincial auto insurance; **AND**
- any other income or retirement benefits received by you if, together with your UA Local 67 disability benefits, your total disability income is higher than your weekly pre-disability income.

An LTD proof of claim must be submitted to Sun Life no later than 90 days after the end of your 26-week STD maximum period. Contact Reliable Administrative Services Inc. for more information.

Health, drug or vision care claims

Claim forms for your health, drug and vision care expenses should be completed in full, and all original itemized paid receipts should be attached (cash receipts or credit card receipts alone are not acceptable).

You should keep a copy of all your receipts for your own records.

Claims may be submitted electronically by your healthcare provider to Green Shield for payment.

Receipts for prescription drugs must reflect the prescription number, drug identification number (DIN), and the name, strength and quantity of the drug or medicine.

For vision claims, the date of service is the date your glasses or contacts are picked up.

Send your claim form and original receipts to Green Shield. Addresses are listed on page 36. All claims must be submitted within 12 months of the date of the expense.

Life insurance claims

Your beneficiary or executor should contact Reliable Administrative Services Inc. to complete the forms necessary to file a life insurance claim with Sun Life Financial.

SUB claims

You must submit your EI payment stub or proof of training school attendance to Reliable Administrative Services Inc. EI payment stubs received after 3:00 p.m. Thursday will be processed for payment the following week. Make sure to include your name, address and social insurance number on your EI payment stub.

Travel medical claims (Berkley Canada/The Assistance Company)

For expenses associated with minor medical emergencies (less than $250), keep your receipts and file your claims with your provincial or territorial health plan first, and then send claims to:

Ardent Assistance Inc. (The Assistance Company)
25 Millard Avenue West
Second Floor
Newmarket, ON L3Y 7R6

For major emergencies that require hospitalization or day surgery, Ardent Assistance will coordinate services between the healthcare provider and the insurance company to ensure direct billing of your expenses. Ardent Assistance can be reached toll-free at 1-844-879-8379.

An operator will ask for the following:

- The insured member's name and the patient's name, location and the details of the emergency;
- The group name of the policy: **UA Journeymen and Apprentices of Plumbing and Pipefitters Industry of the U.S. and Canada Local 67**; **AND**
- The policy number: **BC05840**.

IMPORTANT CONTACTS

Questions?

Most questions about your benefits coverage can be answered by our plan administrator, Reliable Administrative Services Inc.

By phone: 905-387-5861

Tollfree: 1-855-387-5861

By fax: 905-387-4146

General email:
local67@reliableadmin.com

Address:
195 Dartnall Road,
Suite 102
Hamilton, ON L8W 3V9

or

Website:
www.reliableadmin.com

If you have questions about specific benefits or submitting claims, contact the relevant provider listed on the next page.

For claims related to	Address/contact information	Contract number
Dental	Green Shield Canada Dental claims P.O. Box 1608, Windsor, ON N9A 7G1 **Toll Free:**1-888-711-1119 **Web:** www.greenshield.ca	30982
Disability – STD & LTD	Sun Life Group Disability Claims P.O. Box 100, Stn. C Kitchener, ON N2G 3W9	100171
Drugs	Green Shield Canada Drug claims P.O. Box 1652 Windsor, ON N9A 7G5 **Toll Free:**1-888-711-1119 **Web:** www.greenshield.ca	30982
Health/Vision	Green Shield Canada Health Claims P.O. Box 1623, Windsor,ONN9A7B3 **Toll Free:**1-888-711-1119 **Web:** www.greenshield.ca	30982
Health Care Spending Account (HCSA)	Green Shield Canada HCSA claims P.O. Box 1652 Windsor, ON N9A 7G5 **Toll Free:**1-888-711-1119 **Web:** www.greenshield.ca	
Life insurance	Sun Life Insurance Claims 1155 Metcalfe Street Montreal, QC H3B 2V9	100171
Maintenance medication	AlliancePharmacy Group Inc. 20 Furbacher Lane,Unit 2, Aurora, ON L4G 6W1 **Toll Free:** 1-877-796-7979 **Web:** www.apgrx.ca	
Travel medical	Berkley Canada/The Assistance Company (Ardent Assistance) 25 Millard Avenue West Second Floor Newmarket, ON L3Y 7R6 **Toll Free:** 1-844-879-8379 **Collect:** 1-416-285-1722 **Email:** claims@ardentassistance.com	BC05840

WHO MANAGES THE GROUP BENEFITS PLAN?

Trustees

The Employer Life and HealthTrust is administered by an independent Board of Trustees. The Board is made up of eight Trustees who have a "fiduciary duty" – a legal responsibility – to act in the best interests of all plan members. Seven Trustees are elected by the union membership, plus the Business Manager of the union is appointed as a Trustee.

The Trustees' job is to manage our plans in the best interests of all plan members. Because the Trustees aren't group benefits plan experts, one of their key responsibilities is to choose professionals who can help them run the plan effectively. Once they've chosen these professionals, it's up to the Trustees to carefully monitor their performance.

Our current Trustees are:

- Steve Foffano (Chairman)
- Ross French (Secretary)
- Victor Langdon
- Nathan Bergstrand
- Leslie Ellerker
- Ken Luxon
- Dave Marcus
- Bill Stanger

Plan administrator

The Board delegates day-to-day administration of the plan to Reliable Administrative Services Inc. As administrator, Reliable handles a number of tasks, including enrolling new members, receiving contributions from employers, administering agreements with other unions, keeping track of bank hours, collecting union field dues, answering member questions, preparing statements, etc. The administrator reports directly to the Board of Trustees.

Our group benefits plan has helped to protect the health and financial security of thousands of UA Local 67 members and their families for more than 40 years.

Privacy

It's impossible to administer your group benefits without using personal information. That said, the Trustees are committed to protecting your privacy and have strict safeguards in place to protect your information from unauthorized access or use. In addition, you have the right to see the information on file for you, and to update or correct it as necessary. For more information, please contact Reliable Administrative Services Inc.

DEFINITIONS

A

Assistive Devices Program – A program run by the Ontario Ministry of Health that provides personalized assistive devices to Ontario residents with long-term physical disabilities.

B

Beneficiary– The person(s) you've named to receive your life insurance benefits. You can name anyone you want as your beneficiary. If you name more than one person, the benefit will be divided according to your instructions. If you don't appoint a beneficiary, the benefit will be paid to your estate and may be subject to probate fees, estate taxes and creditors.

C

Child(ren) – To qualify for coverage under the UA Local 67 Group Benefits Plan, children must be yours or your spouse's by birth, adoption or foster arrangement, and be:

- unmarried;
- dependent on you or your spouse for financial support; **AND**
- Under age 21 (under age 25 if a full-time student at a recognized and accredited educational institution).

Coverage continues after age 21 for unmarried, disabled children who were covered under the plan before age 21 and who are not able to support themselves because of their mental or physical disability. You must provide proof of your child's disability to Reliable Administrative Services Inc.

Dependents may only be eligible under the plan if they meet the criteria above and are listed as a dependent under the Canada Revenue Agency.

Coverage limit – This refers to the total amount the UA Local 67 Group Benefits Plan will reimburse for each covered member within a certain period. Examples include per-visit limits for paramedical treatment, per-year maximums for dental treatments, and lifetime limits on in-home nursing.

D

Dental fee guide– The schedule of fees published annually by each provincial dental association that outlines the typical cost of dental services. All payments under the UA Local 67 dental plan are based on a one - year lag in the Ontario Dental Association Suggested Fee Guide for General Practitioners. If your dentist uses a more recent fee guide, you must pay the difference.

Disability – An illness or injury that leaves you unable to do your job for an extended period of time.

Doctor – A medical practitioner who is licensed, certified or registered where his or her practice is located.

E

Employer – A company or organization that makes contributions to the UA Local 67 Group Benefits Plan on your behalf.

M

Member in good standing – A fully paid-up member of UA Local 67.

O

Ontario Drug Benefit Program (ODB) – A program of the provincial government geared towards seniors and those who require long-term care or social assistance. ODB covers most of the cost of many prescription drugs and is a major source of drug coverage once you turn 65.

S

Spouse – For the UA Local 67 Group Benefits Plan, your spouse is a person of the same or opposite sex who is living with you and who is either:

- married to you; **OR**
- not married to you, but who has been living with you in a conjugal relationship for more than 12 months (in other words, a common-law partner).

T

Transfers – If you were a member of another UA local, you may be able to transfer group benefits plan contributions into the UA Local 67 Group Benefits Plan. Check with Reliable Administrative Services to see if there is a reciprocal agreement between your old local and Local 67.

Treatment plan – A treatment plan is a form your dentist fills out detailing what procedures you are going to have, and how much they'll cost. You should get this form filled out if you are going to start dental treatment costing $300 or more. Green Shield will review your treatment plan and tell you how much the plan will cover.

Y

Yearly maximums – Yearly maximums listed in the booklet are referring to the calendar year (January to December).

UA Local 67 Benevolent Fund

As part of the collective agreement, Local 67 has initiated a Benevolent Fund to assist its members in times of need. This is a trust fund governed by an elected board of trustees by the Local 67 membership.

Members will be entitled to $700 per week, up to 3 weeks, for a total of $2,100 from the Benevolent Fund in times of need, one occurrence every 12 months. The fund will cover members who are off sick or injured, with a completed application that meets all requirements. To qualify for the benefits of the fund the member must not be in receipt of WSIB, Employment Insurance, Disability Benefits or any other monies.

The Trustees of the Benevolent Fund shall be authorized to pay out the sum of $700 for each bereavement benefit claim. The bereavement benefit shall be paid to union members who meet the following criteria:

- At the time the bereavement leave is taken by the union member, they are required to be members in good standing;
- At the time that bereavement leave is taken by the union member, they were working on a job obtained through Local 67, or affiliated union;
- The union member has taken at least one day off work to attend the funeral of a family member;
- The claimant provides:
    1. A copy of the death certificate of the deceased for which bereavement leave was taken;
    2. A statement of their relationship to the deceased;
    3. A copy of pay stub of the claimant confirming that time off was taken;
    4. A marriage certificate, signed affidavit, or obituary showing relationship.
- A “Family Member” is defined as:
    1. A Spouse;
    2. A Common-Law Spouse as defined in the *Family Law Act* of Ontario;
    3. A Parent which includes an adoptive parent;
    4. A child, which includes an adopted child;
    5. A brother or sister;
    6. A current mother or father in law, or (as of January 1, 2017)
    7. An active member’s grandparent. (as of January 1, 2017)

All inquiries regarding this fund should be directed to Local 67 Union Office at 905-385-0043.

The Final Word

This booklet describes your UA Local 67 Group Benefits Plan in simple terms. It isn’t a legal document and doesn’t cover every detail, but it does give you the basic facts. We’ve made every effort to make sure this booklet is accurate, but if there is any difference between the information contained here and the legal plan documents, including insurance policies and group contracts, the plan documents will apply.

Canadian Piping Trades
LOCAL 67

Trustees of the Plumbing and Pipefitting Workers' Welfare Plan

www.ualocal67.ca