IRONWORKERS HEALTH & WELFARE TRUST OF WESTERN CANADA

PLAN BOOKLET

2024

To Eligible Participants:

This information booklet has been prepared to give you an informal summary of the main features of your group benefit program including a brief outline of the benefits, rules covering eligibility and termination, and the procedure to follow in making claims.

This booklet is not an insurance policy and does not grant or confer any contractual rights. All rights under this program shall be governed by the provisions of the Master Policy, by the rules and regulations made by the Trustees and by applicable law.

This booklet is for your reference. Please read it carefully and keep it for future use. If you have any questions or need further clarification of the benefits, terms and conditions outlined in this booklet, please contact your Plan Administrator.

Sincerely,

The Board of Trustees

Benefit	Insurer/Administrator	Policy Number
Basic Life, Dependent Life and Optional Life Insurance	Manulife Financial	2638
Accidental Death & Dismemberment	Industrial Alliance Insurance and Financial Services	100003172
Weekly Disability	Ironworkers Health & Welfare Trust Fund of Western Canada	58569
Out of Province/Canada Medical Emergency Insurance	Zurich	8451460
Extended Health and Dental Care	Ironworkers Health & Welfare Trust Fund of Western Canada	58569
Health Spending Account	Ironworkers Health & Welfare Trust Fund of Western Canada	58569
Member Assistance Program	CEFAP	
Target Extended Disability Benefit	Ironworkers Health & Welfare Trust Fund of Western Canada	

Please note that the Target Extended Benefit – for Accident & Physical Illness, Supplemental Health Care, Dental, Vision and Weekly Disability Income plans are self-insured by the **Ironworkers Health & Welfare Trust Fund of Western Canada**.

Note: Changes to Policy - The Ironworkers Health & Welfare Trust regularly reviews the benefit programs provided to members and reserves the right to change or revoke this policy. Documentation is updated accordingly.

Plan Administrator

Ellement Consulting
10154-108 Street, NW
Edmonton, AB, T5J 1L3

Telephone: 587.405.3196
Toll Free: 1.888.616.3196
Email: abironworkers@ellement.ca
www.abironworkers.ca

CONTENTS

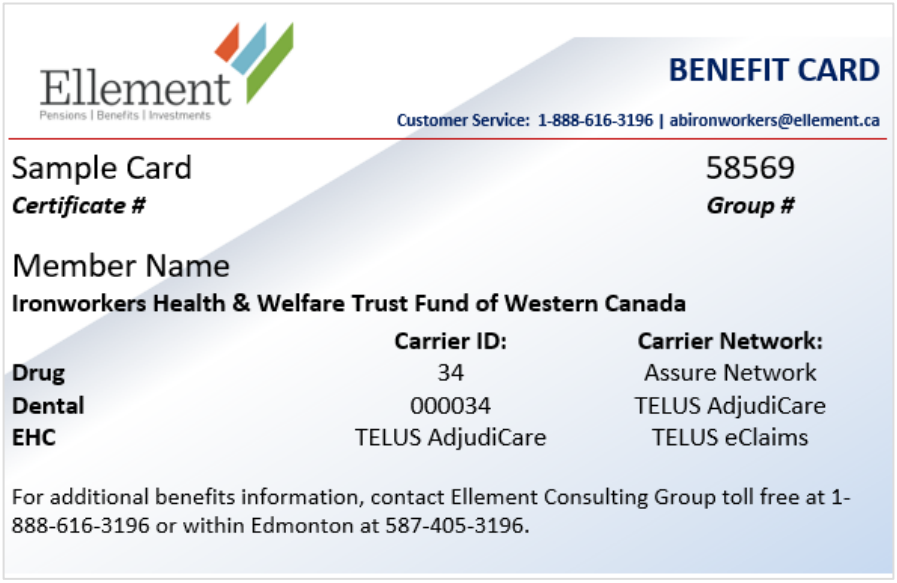
GENERAL INFORMATION

Ellement is the administrator of your benefit plan. If you have any questions about the plan, please contact Ellement.

Phone:	587.405.3196
Toll-free:	888.616.3196
Email:	ironworkers@ellement.ca
Website:	www.abironworkers.ca
Mail:	10154 - 108 Street, NW
	Edmonton, Alberta

Plan and Certificate Numbers

Your Plan Number for Health and Dental benefits is 58569 and your certificate number can be found on the Ellement Benefit Card issued to you in the new eligible package.



Appeals

If there is a claim denied and the member does not agree with the decision, an appeal may be submitted in writing to the Board of Trustees c/o Ellement. Be sure to identify the basis of the appeal and include supporting medical information. The Appeals Policy is found on the Ironworkers website.

Enrollment

It is your responsibility to complete an Enrolment form in full and to update your information with Ellement if it changes. Changes can be made on the Member Portal or by contacting the Ellement office. The beneficiary section of the Enrolment form must be signed in ink and returned to Ellement. If you do not, any death benefits available will be paid to your estate.

Residency Requirement

You and your dependents must live in Canada to be covered by this plan.

Introduction

The Group Benefit Plan is provided by the Board of Trustees of the Ironworkers Health & Welfare Trust Fund of Western Canada which is comprised of an equal number of Trustees appointed by employers participating in the Plan and by Local Unions 720 and 725 of the International Association of Bridge, Structural, Ornamental and Reinforcing Ironworkers. Your Group Benefit Plan is administered by this Board of Trustees representing the Ironworkers Health & Welfare Trust Fund of Western Canada and employers participating in the Plan. Such employers are called "Contributing Employers" in this booklet. Contributing Employers are party to and bound by a Collective Agreement with the Local Unions 720 and 725 of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers. Contributions are made to the Board of Trustees by Contributing Employers as required by Collective Agreements, and those contributions are used, in part, by the Trustees to pay the premiums on, and costs of the group benefit plan.

Hour Bank Account

An Hour Bank Account is kept by the Administrator of the Fund for each Member. After you meet the Plan's initial eligibility requirements, all hours that you work for Contributing Employers (provided that the Contributing Employer pays in full the required contribution under the Collective Agreement for each hour that you have worked) are credited to your Hour Bank Account. New Members who have not yet accumulated 250 hours are immediately eligible for Basic Member Life and Basic Member Accidental Death and Dismemberment insurance, but at reduced face amounts. You become eligible for full Active Member benefits after accumulating a minimum of 250 hours in at least 1 but not more than 3 consecutive months.

The month after you complete the required number of hours and the Plan has received the required employer contributions, is a waiting period. Coverage under an Active Member Class will begin on the first day of the month following the waiting period. If you are not actively at work or available for work on the date this coverage would normally become effective, coverage will begin on the next date you are actively at work or available for work for full pay.

For each month of coverage under the Plan, 125 hours will be deducted from your Hour Bank Account. This is the Coverage Cost. You will be allowed to accumulate excess hours in your Hour Bank Account up to a maximum of 1,250 hours (enough to provide ten months of coverage even though you acquire no hours during that period). Excess hours over this amount will be credited to the general reserves of the Fund.

In general, you continue to be eligible for Plan coverage as long as your Hour Bank Account contains at least 125 hours of work credit (paid employer contributions). Please also refer to the other sections under "Eligibility" such as when you become insured initially, the self-pay provision, reinstatement of coverage, and when your coverage terminates (termination of insurance).

SUMMARY OF BENEFITS

Plan A – Actives with more than 250 Hours

MEMBER LIFE INSURANCE

Plan	Description	Life Insurance Amount
A	To age 59	$125,000
	Active Age 60 - 64	$125,000
	Actives 65 - 69	$50,000
	Active Age 70 Plus	$25,000

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT

Plan	Description	Life Insurance Amount
A	To age 59	$125,000
	Active Age 60 - 64	$125,000
	Actives 65 - 69	$50,000
	Active Age 70 Plus	$25,000

DEPENDENT LIFE INSURANCE

Plan	Description	Life Insurance Amount
A	To age 59	Dependent Spouse - $40,000 Dependent Child - $10,000
	Active Age 60 - 64	Dependent Spouse - $40,000 Dependent Child - $10,000
	Actives 65 - 69	Dependent Spouse - $25,000 Dependent Child - $5,000
	Active Age 70 Plus	Dependent Spouse - $15,000 Dependent Child - $2,500

WEEKLY DISABILITY

Plan	Description	Amount
A	To age 64 only	$668 per week, to a maximum of 104 weeks coordinated with EI Sickness, Elimination period 27 weeks Benefits are payable while you remain disabled for a maximum of 104 weeks of benefit payments, after which the benefit period terminates.

TARGET EXTENDED DISABILITY BENEFIT

Plan	Description	Amount
A	To age 58 only	Benefit amount is $3500 for and $2500 for apprentices. 104 week elimination period Benefits reduced by any amount received by Canada Pension Disability or a pension from the Alberta Ironworkers Pension Fund

EXTENDED HEALTH CARE

Plan	Description	Amount
A	To age 59	$100,000 lifetime maximum per individual for all other benefits (including a $10,000 lifetime maximum for private duty nursing) 100% reimbursement of all other eligible expenses 50% orthopaedic shoes that are not part of a brace
	Active Age 60 - 64	
	Actives 65 - 69	
	Active Age 70 Plus	

PRESCRIPTION DRUG

Plan	Description	Amount
A	To age 59 Active Age 60 - 64 Actives 65 - 69 Active Age 70 Plus	100% of most drug expenses (based on a Managed Formulary and Lowest Cost Alternative pricing) 90% of erectile dysfunction drug expenses up to $750 calendar year $350 per calendar year for Epipen injections $1,000 per lifetime for smoke cessation products $4 per prescription drug dispensing fee deductible

VISION

Plan	Description	Amount
A	To age 59 Active Age 60 - 64 Actives 65 - 69 Active Age 70 Plus	100% of eyeglass frames and lenses or contact lenses, eye examinations, safety glasses for members Eyeglass frames and lenses or contact lenses up to a total maximum of $600 every 2 calendar years from the last date of service (12-month period from the last date of service for persons under 18 years of age); $450 every 2 calendar years for prescription safety glasses for Members only. 50% laser eye surgery expenses to a lifetime maximum of $1,000 Eye examinations – $125 maximum once every 2 calendar years (or every year for insured individuals under age 18)

DENTAL

Plan	Description	Amount
A	To age 59 Active Age 60 - 64 Actives 65 - 69 Active Age 70 Plus	90% basic services, 80% major services to a combined annual maximum of $4,500 80% for Dental Implant procedures to an annual maximum of $3,000 75% for Orthodontic Services to a lifetime maximum of $6,000 $3,000 for Dentures per jaw (every 10 years) Based on the current Dental Fee Schedule for your province of residence. Specialist's fees are covered when recommended by a Physician or Dentist.

MEMBER ASSISTANCE PROGRAM

Plan	Description	Amount
A	To age 59 Active Age 60 – 64 Actives 65 - 69 Active Age 70 Plus	You and your family members are each eligible for up to 12 hours of personal counselling per year plus 2 hours of financial or legal consultation. Coverage terminates the date your Supplementary Health coverage terminates, and as outlined under Termination of Insurance earlier in this booklet

TRAVEL AND ACCIDENT INSURANCE

Plan	Description	Amount
A	To age 59 Active Age 60 – 64 Actives 65 - 69 Active Age 70 Plus	100% of eligible expenses and eligible services are covered Overall Maximum of $5,000,000 per insured person, per trip Coverage is limited to 90 days from the date the insured individual leaves the province of residence. Coverage is limited to 60 days for those 70 - 75. However, any member working in the United States while maintaining their provincial health care coverage as well as the required number of hours in their Hour Bank Account may be covered for a period of up to 12 months. Coverage terminates the date your Supplementary Health coverage terminates.

HEALTH SPENDING ACCOUNT

Plan	Description	Amount
A	To age 59 Active Age 60 - 64 Actives 65 - 69 Active Age 70 Plus	**$1,000 annually** Coverage terminates the date your Supplementary Health coverage terminates The amount of the deposit is determined by the Board of Trustees on an annual basis when it is prudent for the plan to do so.

Plan B – Actives Less than 250 Hours

MEMBER LIFE INSURANCE

Plan	Description	Life Insurance Amount
B	To age 59	$10,000
	Active Age 60 - 64	$10,000
	Actives 65 - 69	$10,000
	Active Age 70 Plus	$10,000

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT

Plan	Description	Life Insurance Amount
B	To age 59	$10,000
	Active Age 60 - 64	$10,000
	Actives 65 - 69	$10,000
	Active Age 70 Plus	$10,000

MEMBER ASSISTANCE PROGRAM

Plan	Description	Amount
B	To age 59	You and your family members are each eligible for up to 12 hours of personal counselling per year plus 2 hours of financial or legal consultation. Coverage terminates the date your Supplementary Health coverage terminates, and as outlined under Termination of Insurance earlier in this booklet
	Active Age 60 – 64	
	Actives 65 - 69	
	Active Age 70 Plus	

Plan C – Fund Paid Retirees to Age 64

MEMBER LIFE INSURANCE

Plan	Description	Life Insurance Amount
C	To age 64	$125,000

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT

Plan	Description	Life Insurance Amount
C	To age 64	$125,000

DEPENDENT LIFE INSURANCE

Plan	Description	Life Insurance Amount
C	To age 64	Dependent Spouse - $40,000 Dependent Child - $10,000

EXTENDED HEALTH CARE

Plan	Description	Amount
C	To age 64	$100,000 lifetime maximum per individual for all other benefits (including a $10,000 lifetime maximum for private duty nursing) 100% reimbursement of all other eligible expenses 50% orthopaedic shoes that are not part of a brace

PRESCRIPTION DRUG

Plan	Description	Amount
C	To age 64	100% of most drug expenses (based on a Managed Formulary and Lowest Cost Alternative pricing) 90% of erectile dysfunction drug expenses up to $750 calendar year $350 per calendar year for Epipen injections $1,000 per lifetime for smoke cessation products $4 per prescription drug dispensing fee deductible

VISION

Plan	Description	Amount
C	To age 64	100% of eyeglass frames and lenses or contact lenses, eye examinations, safety glasses for members Eyeglass frames and lenses or contact lenses up to a total maximum of $600 every 2 calendar years from the last date of service from the last date of service (12-month period from the last date of service for persons under 18 years of age); 50% laser eye surgery expenses to a lifetime maximum of $1,000 Eye examinations – $125 maximum once every 2 calendar years (or every year for insured individuals under age 18) No coverage for safety glasses.

DENTAL

Plan	Description	Amount
C	To age 64	90% basic services, 80% major services to a combined annual maximum of $4,500 80% for Dental Implant procedures to an annual maximum of $3,000 75% for Orthodontic Services to a lifetime maximum of $6,000 $3,000 for Dentures per jaw (every 10 years)

		Based on the current Dental Fee Schedule for your province of residence. Specialist's fees are covered when recommended by a Physician or Dentist.

MEMBER ASSISTANCE PROGRAM

Plan	Description	Amount
C	To age 64	You and your family members are each eligible for up to 12 hours of personal counselling per year plus 2 hours of financial or legal consultation. Coverage terminates the date your Supplementary Health coverage terminates, and as outlined under Termination of Insurance earlier in this booklet

TRAVEL AND ACCIDENT INSURANCE

Plan	Description	Amount
C	To age 64	100% of eligible expenses and eligible services are covered Overall Maximum of $5,000,000 per insured person, per trip Coverage is limited to 90 days from the date the insured individual leaves the province of residence. Coverage is limited to 60 days for those 70 - 75. However, any member working in the United States while maintaining their provincial health care coverage as well as the required number of hours in their Hour Bank Account may be covered for a period of up to 12 months. Coverage terminates the date your Supplementary Health coverage terminates.

HEALTH SPENDING ACCOUNT

Plan	Description	Amount
C	To age 64	**$1,000 annually** Coverage terminates the date your Supplementary Health coverage terminates The amount of the deposit is determined by the Board of Trustees on an annual basis when it is prudent for the plan to do so.

Plan D – Grandfathered Trustees Self Pay Plan

MEMBER LIFE INSURANCE

Plan	Description	Life Insurance Amount
D	Grandfathered Trustees Self Pay	$125,000

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT

Plan	Description	Life Insurance Amount
D	Grandfathered Trustees Self Pay	$125,000

DEPENDENT LIFE INSURANCE

Plan	Description	Life Insurance Amount
D	Grandfathered Trustees Self Pay	Dependent Spouse - $40,000 Dependent Child - $10,000

EXTENDED HEALTH

Plan	Description	Amount
D	Grandfathered Trustees Self Pay	$100,000 lifetime maximum per individual for all other benefits (including a $10,000 lifetime maximum for private duty nursing) 100% reimbursement of all other eligible expenses 50% orthopaedic shoes that are not part of a brace

PRESCRIPTION DRUG

Plan	Description	Amount
D	Grandfathered Trustees Self Pay	100% of most drug expenses (based on a Managed Formulary and Lowest Cost Alternative pricing) 90% of erectile dysfunction drug expenses up to $750 calendar year $350 per calendar year for Epipen injections $1,000 per lifetime for smoke cessation products $4 per prescription drug dispensing fee deductible

VISION

Plan	Description	Amount
D	Grandfathered Trustees Self Pay	100% of eyeglass frames and lenses or contact lenses, eye examinations, safety glasses for members Eyeglass frames and lenses or contact lenses up to a total maximum of $600 every 2 calendar years from the last date of service from the last date of service (12-month period from the last date of service for persons under 18 years of age); $450 every 2 calendar years for prescription safety glasses for Members only. 50% laser eye surgery expenses to a lifetime maximum of $1,000 Eye examinations – $125 maximum once every 2 calendar years (or every year for insured individuals under age 18)

DENTAL

Plan	Description	Amount
D	Grandfathered Trustees Self Pay	90% basic services, 80% major services to a combined annual maximum of $4,500 80% for Dental Implant procedures to an annual maximum of $3,000 75% for Orthodontic Services to a lifetime maximum of $6,000 $3,000 for Dentures per jaw (every 10 years)

		Based on the current Dental Fee Schedule for your province of residence. Specialist's fees are covered when recommended by a Physician or Dentist.

MEMBER ASSISTANCE PROGRAM

Plan	Description	Amount
D	Grandfathered Trustees Self Pay	You and your family members are each eligible for up to 12 hours of personal counselling per year plus 2 hours of financial or legal consultation. Coverage terminates the date your Supplementary Health coverage terminates, and as outlined under Termination of Insurance earlier in this booklet

TRAVEL AND ACCIDENT INSURANCE

Plan	Description	Amount
D	Grandfathered Trustees Self Pay	100% of eligible expenses and eligible services are covered Overall Maximum of $5,000,000 per insured person, per trip Coverage is limited to 90 days from the date the insured individual leaves the province of residence. Coverage is limited to 60 days for those 70 - 75. However, any member working in the United States while maintaining their provincial health care coverage as well as the required number of hours in their Hour Bank Account may be covered for a period of up to 12 months. Coverage terminates the date your Supplementary Health coverage terminates.

HEALTH SPENDING ACCOUNT

Plan	Description	Amount
D	Grandfathered Trustees Self Pay	**$1,000 annually** Coverage terminates the date your Supplementary Health coverage terminates The amount of the deposit is determined by the Board of Trustees on an annual basis when it is prudent for the plan to do so.

Plan E – Actives Self Pay (Full)

MEMBER LIFE INSURANCE

Plan	Description	Life Insurance Amount
E	Full Self Pay to Age 64	$125,000
	Full Self Pay to Age 69	$50,000
	Full Self Pay Age 70 - 74	$25,000

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT

Plan	Description	Life Insurance Amount
E	Full Self Pay to Age 64	$125,000
	Full Self Pay to Age 69	$50,000
	Full Self Pay Age 70 - 74	$25,000

DEPENDENT LIFE INSURANCE

Plan	Description	Life Insurance Amount
E	Full Self Pay to Age 64	Dependent Spouse - $40,000 Dependent Child - $10,000
	Full Self Pay to Age 69	Dependent Spouse - $40,000 Dependent Child - $10,000
	Full Self Pay Age 70 - 74	Dependent Spouse - $15,000 Dependent Child - $2,500

EXTENDED HEALTH CARE

Plan	Description	Amount
E	Full Self Pay to Age 69 Full Self Pay Age 70 - 74	$100,000 lifetime maximum per individual for all other benefits (including a $10,000 lifetime maximum for private duty nursing) 100% reimbursement of all other eligible expenses 50% orthopaedic shoes that are not part of a brace

PRESCRIPTION DRUG

Plan	Description	Amount
E	Full Self Pay to Age 69 Full Self Pay Age 70 - 74	100% of most drug expenses (based on a Managed Formulary and Lowest Cost Alternative pricing) 90% of erectile dysfunction drug expenses up to $750 calendar year $350 per calendar year for Epipen injections $1,000 per lifetime for smoke cessation products $4 per prescription drug dispensing fee deductible

VISION

Plan	Description	Amount
E	Full Self Pay to Age 69 Full Self Pay Age 70 - 74	100% of eyeglass frames and lenses or contact lenses, eye examinations, safety glasses for members Eyeglass frames and lenses or contact lenses up to a total maximum of $600 every 2 calendar years from the last date of service from the last date of service (12-month period from the last date of service for persons under 18 years of age); $450 every 2 calendar years for prescription safety glasses for Members only. 50% laser eye surgery expenses to a lifetime maximum of $1,000 Eye examinations – $125 maximum once every 2 calendar years (or every year for insured individuals under age 18)

DENTAL

Plan	Description	Amount
E	Full Self Pay to Age 69 Full Self Pay Age 70 - 74	90% basic services, 80% major services to a combined annual maximum of $4,500 No coverage for Dental Implants No coverage for Orthodontic Services Based on the current Dental Fee Schedule for your province of residence. Specialist's fees are covered when recommended by a Physician or Dentist.

MEMBER ASSISTANCE PROGRAM

Plan	Description	Amount
E	Full Self Pay to Age 69 Full Self Pay Age 70 - 74	You and your family members are each eligible for up to 12 hours of personal counselling per year plus 2 hours of financial or legal consultation. Coverage terminates the date your Supplementary Health coverage terminates, and as outlined under Termination of Insurance earlier in this booklet

TRAVEL AND ACCIDENT INSURANCE

Plan	Description	Amount
E	Full Self Pay to Age 69 Full Self Pay Age 70 - 74	100% of eligible expenses and eligible services are covered Overall Maximum of $5,000,000 per insured person, per trip Coverage is limited to 90 days from the date the insured individual leaves the province of residence. Coverage is limited to 60 days for those 70 - 75. However, any member working in the United States while maintaining their provincial health care coverage as well as the required number of hours in their Hour Bank Account may be covered for a period of up to 12 months. Coverage terminates the date your Supplementary Health coverage terminates.

HEALTH SPENDING ACCOUNT

Plan	Description	Amount
E	Full Self Pay to Age 69 Full Self Pay Age 70 - 74	**$1,000 annually** Coverage terminates the date your Supplementary Health coverage terminates The amount of the deposit is determined by the Board of Trustees on an annual basis when it is prudent for the plan to do so.

Plan F – Actives Self Pay Reduced

MEMBER LIFE INSURANCE

Plan	Description	Life Insurance Amount
F	Reduced Self Pay to Age 69	$50,000
	Reduced Self Pay Age 70 - 74	$25,000

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT

Plan	Description	Life Insurance Amount
F	Reduced Self Pay to Age 69	$50,000
	Reduced Self Pay Age 70 - 74	$25,000

DEPENDENT LIFE INSURANCE

Plan	Description	Life Insurance Amount
F	Reduced Self Pay to Age 69	Dependent Spouse - $15,000 Dependent Child - $2,500
	Reduced Self Pay Age 70 - 74	Dependent Spouse - $10,000 Dependent Child - $2,000

EXTENDED HEALTH CARE

Plan	Description	Amount
F	Reduced Self Pay to Age 69 Reduced Self Pay Age 70 - 74	$100,000 lifetime maximum per individual for all other benefits (including a $10,000 lifetime maximum for private duty nursing) 80% reimbursement of all other eligible expenses 50% orthopaedic shoes that are not part of a brace

PRESCRIPTION DRUG

Plan	Description	Amount
F	Reduced Self Pay to Age 69 Reduced Self Pay Age 70 - 74	80% of most drug expenses (based on a Managed Formulary and Lowest Cost Alternative pricing) 90% of erectile dysfunction drug expenses up to $750 calendar year $350 per calendar year for Epipen injections $1,000 per lifetime for smoke cessation products $4 per prescription drug dispensing fee deductible

VISION

Plan	Description	Amount
F	Reduced Self Pay to Age 69 Reduced Self Pay Age 70 - 74	100% of eyeglass frames and lenses or contact lenses, eye examinations, safety glasses for members Eyeglass frames and lenses or contact lenses up to a total maximum of $300 every 2 calendar years from the last date of service from the last date of service (12-month period from the last date of service for persons under 18 years of age); coverage also includes reimbursement of safety glasses for Members. 50% laser eye surgery expenses to a lifetime maximum of $1,000 Eye examinations – $125 maximum every 2 calendar years

DENTAL

Plan	Description	Amount
F	Reduced Self Pay to Age 69	80% basic services, 50% major services to a combined annual maximum of $1,500 No coverage for Dental Implants No coverage for Orthodontic Services Based on the current Dental Fee Schedule for your province of residence. Specialist's fees are covered when recommended by a Physician or Dentist.
	Reduced Self Pay Age 70 - 74	

MEMBER ASSISTANCE PROGRAM

Plan	Description	Amount
F	Reduced Self Pay to Age 69	You and your family members are each eligible for up to 12 hours of personal counselling per year plus 2 hours of financial or legal consultation. Coverage terminates the date your Supplementary Health coverage terminates, and as outlined under Termination of Insurance earlier in this booklet
	Reduced Self Pay Age 70-74	

TRAVEL AND ACCIDENT INSURANCE

Plan	Description	Amount
F	Reduced Self Pay to Age 69	100% of eligible expenses and eligible services are covered Overall Maximum of $5,000,000 per insured person, per trip Coverage is limited to 90 days from the date the insured individual leaves the province of residence. Coverage is limited to 60 days for those 70 - 75. However, any member working in the United States while maintaining their provincial health care coverage as well as the required number of hours in their Hour Bank Account may be covered for a period of up to 12 months. Coverage terminates the date your Supplementary Health coverage terminates.
	Reduced Self Pay Age 70-74	

HEALTH SPENDING ACCOUNT

Plan	Description	Amount
F	Reduced Self Pay to Age 69	**$1,000 annually** Coverage terminates the date your Supplementary Health coverage terminates The amount of the deposit is determined by the Board of Trustees on an annual basis when it is prudent for the plan to do so.
	Reduced Self Pay Age 70-74	

Plan G – Retiree Self-Pay Plan (Ages 69 - 79)

MEMBER LIFE INSURANCE

Plan	Description	Life Insurance Amount
G	To age 69	$50,000
	Retiree Age 70 - 74	$25,000
	Retiree 75 - 79	None

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT

Plan	Description	Life Insurance Amount
G	To age 69	$50,000
	Retiree Age 70 - 74	$25,000
	Retiree 75 - 79	None

DEPENDENT LIFE INSURANCE

Plan	Description	Life Insurance Amount
G	To age 69	Dependent Spouse - $40,000 Dependent Child - $10,000
	Retiree Age 70 - 74	Dependent Spouse - $15,000 Dependent Child - $2,500
	Retiree 75 - 79	None

EXTENDED HEALTH CARE

Plan	Description	Amount
G	To age 69 Retiree Age 70 - 74 Retiree 75 - 79	$100,000 lifetime maximum per individual for all other benefits (including a $10,000 lifetime maximum for private duty nursing) 80% reimbursement of prescription drugs 80% reimbursement of all other eligible expenses 50% orthopaedic shoes that are not part of a brace

PRESCRIPTION DRUG

Plan	Description	Amount
G	To age 69 Retiree Age 70 - 74 Retiree 75 - 79	80% of most drug expenses (based on a Managed Formulary and Lowest Cost Alternative pricing) 90% of erectile dysfunction drug expenses up to $750 calendar year $350 per calendar year for Epipen injections $1,000 per lifetime for smoke cessation products $4 per prescription drug dispensing fee deductible

VISION

Plan	Description	Amount
G	To age 69 Retiree Age 70 - 74 Retiree 75 - 79	100% of eyeglass frames and lenses or contact lenses, eye examinations, safety glasses for members to a maximum of $300 every 2 calendar years from the last date of service from the last date of service (12-month period from the last date of service for persons under 18 years of age)

DENTAL

Plan	Description	Amount
G	To age 69	80% basic services, 50% major services to a combined annual maximum of $1,500 No coverage for Dental Implants No coverage for Orthodontic Services. Based on the current Dental Fee Schedule for your province of residence. Specialist's fees are covered when recommended by a Physician or Dentist.
	Retiree Age 70 - 74	
	Retiree 75 - 79	

MEMBER ASSISTANCE PROGRAM

Plan	Description	Amount
G	To age 69	You and your family members are each eligible for up to 12 hours of personal counselling per year plus 2 hours of financial or legal consultation. Coverage terminates the date your Supplementary Health coverage terminates, and as outlined under Termination of Insurance earlier in this booklet
	Retiree Age 70 - 74	
	Retiree 75 - 79	

TRAVEL AND ACCIDENT INSURANCE

Plan	Description	Amount
G	To age 69	100% of eligible expenses and eligible services are covered Overall Maximum of $5,000,000 per insured person, per trip Coverage is limited to 90 days from the date the insured individual leaves the province of residence. Coverage is limited to 60 days for those 70 - 75. However, any member working in the United States while maintaining their provincial health care coverage as well as the required number of hours in their Hour Bank Account may be covered for a period of up to 12 months. Coverage terminates the date your Supplementary Health coverage terminates.
	Retiree Age 70 - 74	
	Retiree 75 - 79	

HEALTH SPENDING ACCOUNT

Plan	Description	Amount
G	To age 69	**$1,000 annually** Coverage terminates the date your Supplementary Health coverage terminates The amount of the deposit is determined by the Board of Trustees on an annual basis when it is prudent for the plan to do so.
	Retiree Age 70 - 74	
	Retiree 75 - 79	

Who May Be Insured
This Plan is for:

1. members in good standing of Local Unions 720 and 725 of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers who work for Contributing Employers;
2. full-time employees or Officers of the Union;
3. non-bargaining employees of Contributing Employers or Trustees;
4. surviving dependents of deceased Members;
5. disabled Members on Life Insurance Premium Waiver; and
6. Retired Members/Pensioners as defined below.

These shall be referred to throughout this booklet as Members, and their dependents. All Members and dependents must be residents of Canada and covered by a provincial government health care program.

Retired Member or Retiree, for the purpose of determining whether or not the Trust Fund will pay the full premium for retiree/pensioner coverage under **Plan C,** shall mean any person age 60-64 who:

1. is in receipt of pension benefits from the Alberta Ironworkers Pension Fund;
2. is a current member of Local 720 or 725;
3. has at least 20 cumulative years of union membership in Local 720 or 725; and
4. has remained a member in good standing with the Union on a continuous basis from the date of Retirement.

Retired Member or Retiree, for the purpose of determining whether or not the Member is eligible to Self-Pay retiree/pensioner coverage under **Plans F and G**, shall mean any person age 50 and over but under age 80 who:

1. is in receipt of pension benefits from the Alberta Ironworkers Pension Fund;
2. is a current member of Local 720 or 725; and
3. is retired from active work in the trade (whether unionized or non-bargaining).

When You Become Insured Initially
For Plan B, Basic Member Life Insurance are Accidental Death & Dismemberment are available to Members prior to their accumulating 250 hours in their Hour Bank Account provided they are a member in good standing of the Union and hours have been reported on their behalf. Members of Class 714 are also eligible for Optional Life Insurance for Members and Dependents. Please note that benefit amounts in this class are lower than for other classes.

For all Plans *except* Plan B, Basic Member Life Insurance, Basic Dependent Life Insurance and Accidental Death & Dismemberment coverages become effective on the day following a period of not more than 3 consecutive calendar months during which you have accumulated 250 hours in your Hour Bank Account. For all other coverages, there is a waiting period, and you and your eligible dependents will become insured on the first day of the second month following a period of not more than 3 consecutive calendar months during which you have accumulated at least 250 hours in your Hour Bank Account.

However, you must be Actively at Work on the date your coverages would ordinarily begin, otherwise the insurance for you and your dependents will be delayed until you return to work or become available for work.

For Non-Bargaining Employees of Contributing Employers, Contributing Employers may insure themselves and any non-bargaining employees who are not covered by a Collective Bargaining Agreement by making application for participation in the Plan to the Trustees. If such application is accepted by the Trustees, contributions will be made at the same hourly rate as is paid for bargaining employees based on 160 hours of employment per month. Non-bargaining employees become and remain eligible in accordance with the same initial eligibility rules.

For any Member opting for Optional Life Insurance (for both Member and Dependents), this coverage shall become effective on the date evidence of insurability satisfactory to the insurer is approved.

Age Bands

Generally, if you continue to be eligible, once you reach the maximum age in a particular Plan you will move into the next age band automatically. Note that there are some coverage level differences at older ages. Please pay special attention to the termination age for disability coverage.

Termination of Insurance

The insurance for you and your eligible dependents will terminate the earliest of the following:

1. the last day of the month in which you have less than 125 hours in your Hour Bank Account; (However, you may arrange to have your insurance, except Weekly Disability Income, continued on a Self-Pay basis. See Self-Pay Provision below for details.)
2. upon attainment of an age for which this booklet specifies that coverage shall terminate;
3. the date you cease to be a member in good standing of the Union (if applicable);
4. if you enter Military Service;
5. if the Group Policy terminates;
6. if you discontinue any required Self-Pay contributions;
7. if you retire, and have insufficient hours in your Hour Bank Account;
8. the date you (or your eligible dependent) cease to be covered under a provincial health plan;
9. the date you (or your eligible dependent) cease to be a resident of Canada;
10. the date employment terminates for non-bargaining employees;
11. the date outlined in the Summary of Benefits.

A dependent's coverage will also terminate when he/she is no longer an eligible dependent.

Coverages for Emergency Travel Assistance and Outside Canada Expenses under Supplementary Health are not available during a Leave of Absence.

See the Description of Benefits section for information regarding when the Waiver of Premium benefit shall terminate.

Self-Pay Provision

If at the end of any given month the balance in your Hour Bank Account falls below what is required to meet one month's Coverage Costs (125 hours), you will have the opportunity of contributing the necessary amount of money (monthly premium) so that you may continue to be insured. Under this provision, self-payments may be made on the following basis:

1. monthly payments equal to the Coverage Costs may be made for a maximum of 18 consecutive months by Active Members who have exhausted their Hour Bank Account;
2. Retired Members who meet the four-point eligibility requirement outlined on page 20 will have their coverage under Plan C paid for by the Trust Fund until their attainment of age 65;
3. Retired Members who meet the three-point eligibility requirement outlined on page 20, may self-pay all coverage under Plans F and G to age 79;
4. an Active or Retired Member must remain a member in good standing of the Union to qualify for the Self-Pay Provision; and
5. eligible employees of either the Union or Contributing Employers cannot self-pay.

Reinstatement

If your insurance has previously terminated because of insufficient hours in your Hour Bank Account, you will again become insured on the first day of the month following accumulation of 125 hours in your Hour Bank Account, provided this occurs within 4 months of termination.

If you are not reinstated during this four-month period, the number of hours in your Hour Bank Account will be reduced to zero.

However, you must be Actively at Work on the date your coverage would ordinarily be reinstated, otherwise the insurance for you and your dependents will be delayed until you return to work or become available for work.

If upon termination of your Group Life Insurance you choose to convert it in accordance with the section "Conversion Privilege", it will be necessary for you to submit evidence of insurability satisfactory to the insurer before again becoming insured for Group Life Insurance.

Extension of Coverage

During Disability: If you are absent from work due to injury for at least two consecutive weeks and benefits are payable under the Workers' Compensation Law, Employment Insurance Disability, or the Weekly Disability benefit coverage under this plan, no deduction will be made from your Hour Bank Account for the month you become disabled and for the next 23 months provided you continue to be disabled. All coverage under this Plan will continue for this period and the required premiums will continue to be paid on behalf of the Member by the Trust Fund.

Should the Member then become eligible to receive the Target Extended Benefit – for Accident & Physical Illness, all coverage under this plan will continue, no deduction will be made from the Member's Hour Bank Account, and the required premiums will continue to be paid on behalf of the Member by the Trust Fund for as long as the Member continues to be eligible for this benefit.

While on Waiver of Premium Benefit: For those Members who have been approved for this benefit (under Policy #2638), all Life Insurance coverages will continue but the premiums shall be waived by the insurer.

Supplementary Health, Dental and Emergency Travel Assistance coverages will also continue under the original Plan of coverage, with the premiums for these paid by the Trust Fund, for as long as the Member continues to qualify for the Waiver of Premium and does not qualify for a pension from the Alberta Ironworkers Pension Fund. The Waiver of Premium may continue until attainment of age 65. Plans B through G do not have Waiver of Premium coverage.

Special Extension of Supplementary Health: If a Member or dependent's Supplementary Health coverage under this Plan would ordinarily terminate while the Member or dependent is Totally Disabled[1], Supplementary Health coverage for the Totally Disabled[1] Member or Totally Disabled[1] dependent will receive a special extension, and premiums will continue to be paid by the Trust Fund, for a period of up to three months following the date the Totally Disability[1] commenced.

However, this special extension shall terminate earlier if the dependent ceases to be a dependent as defined in this Plan, the Member or dependent is no longer Totally Disabled[1] or the Member or dependent becomes eligible for similar insurance under another group policy**.**

In the event of the Member's death: Supplementary Health, Dental and Dependent Life coverage for dependents shall continue following the death of the member, and premiums will continue to be paid by the Trust Fund, for a period of up to 24 months following the date that the deceased Member's Hour Bank Account is exhausted as long as the dependent would have remained a dependent as defined in this Plan.

The benefits available to dependents and the coverage levels in place at the time of the Member's death remain in force.

Optional Life is not available to surviving dependents of deceased members.

For spouses, coverage continues for 24 months following the date the deceased Member's Hour Bank Account is exhausted, or the date the spouse attains age 70, whichever is earlier, and as outlined under Termination of Insurance earlier in this booklet.

For children, coverage continues for 24 months following the date the deceased Member's Hour Bank Account is exhausted, as long as the child continues to meet the same qualifications for being a dependent had the Member not passed away, and as outlined under Termination of Insurance earlier in this booklet.

While Attending Trade School: If a Member is attending a Trade School for at least two consecutive weeks, no deductions will be made from his Hour Bank Account for that month. This hold on the Hour Bank Account will continue until the earlier of the end of the third month following the date classes commence or the first day of the second month following the month in which classes end. All coverage will continue during this period and premiums will be paid by the Trust Fund on behalf of the Member, provided the Member provides the required documentation to the Union office, which shall notify the Plan Administrator of individuals attending trade school.

Eligible Dependents

Eligible dependents under this plan shall include the following persons who are resident in Canada:

1. Unmarried children of the Member who are under age 21, or under age 25 if attending an accredited school, college, or university as a full-time student. Dependent children must be dependent on you for support and not employed at a regular full-time job. With respect Dependent Life Insurance, dependent children must be at least 14 days old.

   A dependent child shall include children of the marriage, legally adopted children, foster children, children of the Member's spouse if the spouse is living with the Member and has custody of the child, and grandchildren of the Member provided the Member is eligible for a tax credit for the purpose of calculating taxable income under the Income Tax Act of Canada.

   A functionally impaired child who was insured as a dependent when the infirmity commenced shall remain insured beyond any limiting age for dependents, provided the child is incapable of self-sustaining employment and is wholly dependent upon the Member for support and maintenance. Approval by the insurance carrier is required for this to become effective.

2. Your spouse which includes a person legally married to you as a result of a valid civil or religious ceremony, or a person whose common-law relationship with you has existed for a minimum of 12 consecutive months immediately prior to the date on which a claim arose, provided the existence of such a relationship could be established to the satisfaction of the insurer. A common-law relationship must include continuous cohabitation and public representation of married status. In the event of a common law spouse, one year must have elapsed from the time of receipt by your Plan Administrator of a Registration/Change of Registration and Declaration of Beneficiary Form in which you designate such person as your spouse, before your common-law spouse is covered under this Plan. If a Member has been married to more than one person, the term spouse shall mean the spouse designated in writing by the Member. In the absence of such written designation, spouse shall mean the Member's spouse by a legal marriage. Only one spouse may be covered under this policy at any given time.

Dependent shall *not* include:

1. a person divorced from the Member;
2. a person separated from the member where such separation is pursuant to a court order or a legal separation agreement; (If there is no court order or legal separation agreement, the Member must designate in writing that the separated spouse is to be his dependent spouse for the purposes of this policy.) or
3. a person cohabiting with the member without public representation of married status.

LIFE INSURANCE

In the event of your death while insured, the amount of your Life Insurance is payable to your beneficiary. You may change your beneficiary at any time, subject to the applicable laws of your province of residence, by completing a new registration form and submitting it to the Plan Administrator. The change will become effective on the date the Plan Administrator receives your new form.

Name a Beneficiary

It is very important to name a beneficiary. If you do not, benefits will be assigned to your estate.

Conversion Privilege

Your Life Insurance continues for 31 days following the termination or reduction of coverage due to insufficient hours in your Hour Bank Account. During this 31 day period you may be eligible to convert the amount of your Group Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by the insurer within 31 days of the termination or reduction of your Member Life Insurance. If you die during this 31-day period, the maximum amount of Member Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion. The conversion privilege does not apply for loss of insurance as a result of any age reduction or if insurance terminates when you reach the age specified in the Summary of Benefits section or upon your Retirement. For more information on the conversion privilege and the limitations regarding this provision, please see your Plan Administrator. Provincial differences may exist.

Waiver of Premium Benefit

If while a Member of this plan and in an eligible class, you should become Totally Disabled[3] for at least 6 consecutive months before attaining age 65, the premiums for Basic Member Life Insurance, Basic Dependent Life Insurance, Optional Life Insurance, and Accidental Death and Dismemberment coverages will be waived by the insurer(s); and the required premiums for Supplementary Health, Emergency Travel Assistance, Dental and Member Assistance Program will continue to be paid on behalf of the Member by the Trust Fund.

In order to qualify for the waiver of premium benefit, the member must notify the insurer through the Plan Administrator within 12 months of the last active day at work and must furnish proof of disability, satisfactory to the insurer, within 18 months of the last active day at work. Premiums will be waived starting with the date the required proof is approved by the insurer. From time to time during the first 2 years that premiums are waived, the insurer shall have the right to require proof that the Member's remains Totally Disabled[3]. After 2 years, proof shall be required no more than once a year. The Member may be required to be examined by a medical examiner designated by the insurer, at the insurer's expense.

The amount of life insurance for which premiums shall first be waived shall be the amount in force on the Member's date of disability. If the amount of insurance would have reduced at a later date based on the Schedule of Insurance in force on the Member's date of disability, then the amount of insurance for which premiums are waived will be reduced in like manner. If the member dies while insurance is being

continued in accordance with this provision, the amount of insurance that the insurer will pay will be the amount of insurance for which premiums are being waived at the time of death.

No further Waiver of Premium benefit shall be provided if:

1. the Member ceases to be Totally Disabled[3];
2. the Member fails to submit proof of continuance of Total Disability[3] when required;
3. the Member fails to be examined by a qualified Physician when required; or
4. the Member attains age 65.

Conversion Privilege

If the Member does not return to active work within 31 days after the Waiver of Premium Benefit ceases, the Member may convert the amount of life insurance that was subject to this provision as though the insurance had ceased on that date due to termination of employment. Please see the above sections on Basic Member Life Insurance, Basic Dependent Life Insurance and Optional Life Insurance for Members and Dependents for further description of the Conversion Privilege.

Subrogation

If an employee is entitled to recover compensation for benefits from a third party as a result of the incident which caused or contributed to the disability for which benefits are paid or payable, the insurer will be subrogated to all rights of recovery of the employee to the extent of the sum of benefits paid or payable by the insurer.

As it relates to the Waiver of Premium Benefit, the insurer will calculate the amount of premium that would have been required, but for this provision, and will provide that information to the employee from time to time so that the employee can put forward the subrogated claim of the insurer. In the event that the insured employee provides proof to the insurer that he was unable to recover full compensation for this benefit, the insurer shall determine the proportion of the damages actually recovered and share pro rata in that amount. Should the employee choose to settle the matter prior to judicial determination, the employee understands that the insurer's right of subrogation still applies and that the employee has an obligation to put forward the insurer's subrogated interest in this regard.

ACCIDENTAL DEATH AND DISMEMBERMENT

Your Accidental Death & Dismemberment insurance covers any accident, anywhere in the world, at any time, on or off the job, which results in death, dismemberment, loss of sight, or paralysis, with the exception of the exclusions listed later in this section. For those eligible for AD&D coverage, the amount of your coverage shall be determined by the Principal Sum, which is equal to the amount of your Basic Member Life Insurance benefit. Please see the table in the Member Classification section above for a list of those eligible, and the Summary of Benefits section above for the amount of your Principal Sum.

If, within 12 months of the date of the accident, Injury results in any of the following losses, the insurer will pay a benefit for Loss of or permanent and total Loss of Use of:

Life	▪ The Principal Sum
Both Hands	▪ The Principal Sum
Both Feet	▪ The Principal Sum
Entire Sight of Both Eyes	▪ The Principal Sum
One Hand and One Foot	▪ The Principal Sum
One Hand and the Entire Sight of One Eye	▪ The Principal Sum
One Foot and the Entire Sight of One Eye	▪ The Principal Sum
Speech and Hearing	▪ The Principal Sum
One Arm	▪ Three-Quarters of the Principal Sum
One Leg	▪ Three-Quarters of the Principal Sum
One Hand	▪ Two-Thirds of the Principal Sum
One Foot	▪ Two-Thirds of the Principal Sum
Entire Sight of One Eye	▪ Two-Thirds of the Principal Sum
Speech or Hearing	▪ Two-Thirds of the Principal Sum
Thumb or Any Finger of the Same Hand	▪ One-Third of the Principal Sum

If, within 12 months of the date of the accident, Injury results in the following loss, the Insurer will pay for Loss of:

First Phalange of a Thumb or Finger	▪ One-Fiftieth of the Principal Sum

Paralysis Benefits

Quadriplegia (complete paralysis of both upper and lower limbs)	▪ One Times the Principal Sum
Paraplegia (complete paralysis of both lower limbs)	▪ One Times the Principal Sum
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	▪ One Times the Principal Sum

Indemnity provided under this part for losses relating to any one limb, will be paid for one of the losses, the greatest, sustained by any one insured person as the result of any one accident. Indemnity provided under this part for all losses sustained by any one insured person as a result of any one accident will not exceed the Principal Sum.

In addition, the following benefits may also be payable:

Bereavement Benefit

If Injury results in the loss of your life, the insurer will pay the reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six sessions of grief counselling, by a professional counsellor, subject to a maximum of $2,000.

Day Care Benefit

If Injury results in the loss of your life within 12 months of the date of the accident, the insurer will pay 5% of your Principal Sum to a maximum of $5,000 for each year your dependent child is enrolled in a legally licensed Day Care (not to exceed four years) for each of your dependent children who are under 13 years of age and are enrolled in a legally licensed Day Care Centre on the date of the accident or are enrolled in a legally licensed Day Care Centre within 12 months after your death.

Education Benefit

If Injury results in your loss of life, the insurer will pay, in addition to all other benefits, 5% of your Principal Sum to a maximum of $5,000 to your dependent child, who on the date of the accident was enrolled as a full-time student in any institution of higher learning above the secondary school level, or was enrolled as a full-time student at the secondary school level and enrols as a full-time student in any institution of higher learning within 12 months after your death, but not to exceed four consecutive annual payments.

Eyeglasses, Contact Lenses and Hearing Aids Benefit

If, as the result of an Injury, an insured person requires and receives treatment by a Physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the accident, when none of which were previously required or worn, the insurer will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.

Family Transportation Benefit

When, as a result of Loss covered by the policy, you are confined as an inpatient in a Hospital located from a point of not less than 150 kilometres from your normal place of residence, the insurer will pay the reasonable expenses actually incurred by any member of your immediate family for hotel accommodation and transportation by the most direct route to you, not to exceed in the aggregate the amount of $15,000 for all such expenses.

Funeral Expense Benefit

If an Injury sustained by an insured person results in loss of life, and indemnity for such loss becomes payable in accordance with the terms of this policy, an additional amount is payable for reasonable and necessary funeral expenses actually incurred, subject to a maximum of $5,000.

Home Alteration and Vehicle Modification Benefit

In the event you sustain a Loss for which indemnity becomes payable under the part titled “Accidental Death, Dismemberment and Specific Loss Indemnity” and subsequently require the use of a wheelchair to be ambulatory, the insurer will pay the cost of alterations to your principal residence and/or the cost

of modifications to one motor vehicle utilized by you, when such modifications are approved by licensing authorities where required for the purpose of making them wheelchair accessible to a maximum of $15,000.

Identification Benefit

If an Injury sustained by an insured person results in loss of life, and indemnity for such loss becomes payable in accordance with the terms of this policy, whose body requires identification, the insurer will pay the reasonable and necessary expenses actually incurred by a member of the immediate family for:

1. lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of three consecutive nights); and
2. transportation by the most direct route from his normal place of residence to such location and return to his normal place of residence,

provided the body is located not less than 150 kilometers from the said member of the immediate family's normal place of residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling, or clothing expenses, other than stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

The maximum amount payable under this part is $5,000 for all such expenses.

Rehabilitation Benefit

If Injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such Injury, the insurer will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, subject to a maximum amount of $15,000 as the result of any one accident.

Repatriation Benefit

If Injury results in your loss of life, the insurer will pay the actual expense incurred for the transportation of your body to your city of residence, including the preparation of your body for such transportation, subject to a maximum amount of $15,000.

Spousal Retraining Benefit

In the event you lose your life as the result of an Injury, the insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by your spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he or she would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of $15,000 for all such expenses.

Workplace Modification Benefit

In the event you sustain an Injury which results in a Loss under this benefit, and you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active full-time employment, the reasonable and necessary expenses actually incurred by the workplace employer will be reimbursed, provided:

1. the workplace employer agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs; and
2. the workplace employer acknowledges in writing that the performance of the essential duties of such Member's occupation may be altered.

The proposed special adaptive equipment and/or workplace modification must have prior written approval by the insurer and incurred expenses will be reimbursed to the workplace employer provided the Member has returned to active full-time employment, and this reimbursement is subject to a maximum amount of $5,000.

Exposure and Disappearance

If due to accident you are unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the accident, you suffer a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of Injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and if your body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you suffered loss of life as a result of Injury.

Aggregate Limit of Indemnity

The AD&D policy is subject to an Aggregate Limit of Indemnity of $5,000,000 for all losses resulting from any one aircraft accident. This means that in the event of an aircraft accident that results in an accumulation of losses exceeding $5,000,000 to the insurer, the amount payable with respect to each insured person will be reduced proportionately.

Exclusions

The AD&D policy does not cover loss, fatal or non-fatal, caused by, contributed to, or resulting from:

1. declared or undeclared war or any act of war;
2. active full-time service in the armed forces of any country;
3. suicide or self-destruction, while sane or insane;
4. flying as a pilot or crew member in any aircraft;
5. flying in owned, operated or leased aircraft of the Policyholder, which is the Ironworkers Health & Welfare Trust Fund of Western Canada.

Beneficiary

Indemnity payable in the event of the loss of life of an insured person is payable to the beneficiary or beneficiaries designated in writing by the insured person and on file with the Plan Administrator. If

there is no such beneficiary designated, the indemnity is payable to the estate of the insured person. All other indemnities are payable to the insured person, with the exception of indemnities payable under Bereavement Benefit, Day Care Benefit, Education Benefit, Family Transportation Benefit and Spousal Retraining Benefit and Workplace Modification and Accommodation Benefit.

DEPENDENT LIFE INSURANCE

Basic Dependent Life Insurance

In the event of the death of your spouse and/or dependent children while insured, the amount of Dependent Life Insurance is payable to you.

Conversion Privilege

The Dependent Life Insurance for your spouse continues for 31 days following your death, or your termination of coverage due to insufficient hours in your Hour Bank Account. If your spouse's insurance terminates, they may be eligible to convert the terminated insurance to an individual policy, without medical evidence. The application for this individual policy, along with the first monthly premium, must be received by the insurer, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Dependent Life Insurance available for conversion will be paid to you, even if they did not apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance.

The conversion privilege does not apply for loss of insurance as a result of any age reduction or if insurance terminates when you reach the age specified in the Summary of Benefits section or upon your retirement. For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Waiver of Premium

If you qualify for the Waiver of Premium benefit under Basic Member Life, then the premiums for Basic Dependent Life shall also be waived.

OPTIONAL LIFE INSURANCE

In the event of your death while insured, the amount of your Optional Life Insurance is payable to your beneficiary. In the event of the death of your spouse or dependent child while insured, the amount of your dependent's Optional Life Insurance is payable to you.

However, if you, your spouse or dependent child dies due to self-destruction, the insurer will not pay any part of the Optional Life Insurance which became effective less than two years prior to the date of death. Misstatement of Non-Smoker status by you, your spouse or dependent child shall constitute fraud, and the insurer will not pay any part of the Optional Life Insurance, regardless of the cause of death.

Conversion Privilege

Optional Life Insurance continues for 31 days following the termination of coverage due to insufficient hours in your Hour Bank Account, or your death. During this 31-day period you or your spouse may be eligible to convert the amount of the Optional Life Insurance to an individual policy, without medical evidence. The application for the individual policy along with the first monthly premium must be received by the insurer within 31 days of the termination or reduction of the Optional Life Insurance. If the covered person dies during this 31-day period, the maximum amount of Optional Life Insurance available for conversion will be paid to the covered person's beneficiary or estate, even if he or she did not apply for conversion. The conversion privilege does not apply for loss of insurance as a result of any age reduction or if insurance terminates when you reach the age specified in the Summary of Benefits section or upon your Retirement. For more information on the conversion privilege and the limitations regarding this provision, please see your Plan Administrator. Provincial differences may exist.

Waiver of Premium

If you qualify for the Waiver of Premium benefit under Basic Member Life, then the premiums for Optional Life shall also be waived.

WEEKLY DISABILITY BENEFIT (FOR PLAN A ONLY)

The Weekly Disability Income benefit is not guaranteed, nor is it insured by an insurance provider. Rather it is self-insured by the Ironworkers Health & Welfare Trust Fund of Western Canada. The Trustees have the sole authority, from time to time, to terminate, waive or change any of the benefits, conditions or provisions of this Plan, and the Board of Trustees also expressly reserves the right to terminate or substitute the Plan. This includes not only termination of coverage but also termination of future benefit payments for approved claimants.

In the event that a Plan A Member becomes Wholly Disabled by a non-occupational accident or sickness, he shall become entitled to a Weekly Disability Income benefit of $668 effective January 1, 2024 per week, provided that he is and remains under the continual treatment of a qualified and licensed Physician. This benefit becomes payable on the first day of such disability resulting from an accident or sickness, and continues, while disability remains, for not more than 104 weeks of payments during any one period of disability. However, no benefit is payable during the 26 week period commencing with the date Employment Insurance Sickness benefits would normally commence, unless proof is provided that the Member is not eligible for Employment Insurance benefits.

The Ironworkers Health & Welfare Trust Fund of Western Canada provides a Claims and Disability Management program through HHI (Homewood Health Inc.) to assist Members in recovery during times of illness or injury. This service is designed to assist Members, their physicians and other health care providers in coordinating medical care to facilitate a safe and medically appropriate recovery and return to work. If a disability is likely to last beyond 30 days, an HHI case manager may contact the Member to assist with the claim.

This benefit is payable during the post-natal recovery period of maternity leave.

If the Member becomes disabled from the same or related causes within two weeks of returning to active work, it will be considered one continuous period of disability. If the Member returns to active

work for at least two weeks, a recurrence of this same disability will be considered a new period of disability. If the Member has returned to active work for one full day and becomes disabled from different and unrelated causes, it will also be considered a new period of disability.

Coverage and benefits terminate the date the Member attains age 65, and as outlined under Termination of Insurance earlier in this booklet.

Exclusions

Benefits are not payable for the following:

1. For any disability resulting from intentionally self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness**.**

2. For the portion of a period of disability during which the Member is not under treatment by a physician.

3. Disabilities arising from voluntary participation in a war, riot, or insurrection.

4. For the portion of a period of disability during which the Member is imprisoned in a penal institution or confined in a hospital, or similar institution, as a result of criminal proceedings.

5. During any leave of absence (including maternity leave), except where benefits are provided during the post-natal recovery period of maternity leave.

6. For a disability which commences on or after the date a strike begins, subject to any provincial Employment or Labor Standards Act. However, a member can fulfill his/her Qualifying Disability Period during a strike.

7. After 17 weeks (once the 26-week period of Employment Insurance Act benefits ends), for a disability resulting from any automobile accident whether the Member is riding as a passenger or is a driver of a vehicle involved in the accident, or is a pedestrian, if the claimant can recover from a third party, the loss of income resulting from the accident. Vehicle shall mean any motorized vehicle or bicycle. If the circumstances of the automobile accident are such that the claimant is precluded from any recovery from a third party for the loss of income resulting to the claimant from the accident, then the claimant is eligible to receive this benefit provided that any Section B benefits paid or payable from an Automobile Insurance Policy (irrespective of whether the claimant has in place an Automobile Insurance Policy) shall be deducted from the amount of the benefit otherwise payable to the claimant.

Subrogation

If the Member is entitled to recover compensation for loss of income, medical or dental expenses from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the insurer will be subrogated to all the Member's rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the insurer. The Member shall execute such documents as required by the insurer.

In the event that the Member provides proof to the insurer that he has not recovered full compensation for loss of income, the insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should the Member choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the insurer's right of subrogation will apply.

The term compensation shall include any lump sum or periodic payments which the Member receives or is entitled to receive on account of past, present, or future loss of income.

Extension of Benefits

If the contract with the insurer terminates, or the Weekly Disability Income benefit is removed from this Plan, and the Member becomes Wholly Disabled prior to these occurrences, the insurer continues to be liable to this Member as though the provision remained in force. If a disability recurs within 6 consecutive months after termination of this benefit, the insurer will continue to pay benefits to the Member, but only for the remainder of the original maximum benefit period. Such disability must have been caused by an accident or sickness that occurred before termination of the contract or benefit. The insurer shall not be liable for benefits after such termination once a replacing insurer is bound contractually or as a matter of law.

TARGET EXTENDED BENEFIT – FOR ACCIDENT AND PHYSICAL ILLNESS – (FOR PLAN A ONLY)

The Target Extended Benefit (TEB) is labelled by the term “Target” because it is not guaranteed, nor is it insured by an insurance provider. Rather it is self-insured by the Ironworkers Health & Welfare Trust Fund of Western Canada. The Trustees have the sole authority, from time to time, to terminate, waive or change any of the benefits, conditions or provisions of this Plan, and the Board of Trustees also expressly reserves the right to terminate or substitute the Plan. This includes not only termination of coverage but also termination of future benefit payments for approved claimants.

In the event that a Plan A Member becomes Totally Disabled[2], as defined in the Plan Document, while covered under this Plan, and if such Physical disability continues for at least the Elimination Period, and if the Board of Trustees are satisfied using their reasonable discretion that the Member satisfies the definition of total disability, the Ironworkers’ Health & Welfare Trust Fund of Western Canada will pay the Member a benefit from the day following the Elimination Period, after the Weekly Disability Income benefit has expired. The amount of such benefit is described in the Schedule of Benefit below and is payable only if the Member remains Totally Disabled[2].

In order receive any benefits under this Plan, the Member must provide written notification of Physical disability and application for benefits to the Trustees via the Plan Administrator within 6 months from the expiration of the Elimination Period. Entitlement to benefits shall be determined by the provisions of this Plan in effect on the last day of the Elimination Period of any claim.

Once the application form is complete, the Administrator will forward it to the Claims Assessor, Homewood Health Inc. (HHI), for their review. HHI’s role is to assist the Trustees by assessing each claim based on medical evidence provided. They will provide a recommendation based on eligibility to the Trustees who will make the final decision on each claim. HHI will also be involved with disability care

management. HHI will work with the Member to facilitate a safe and medically appropriate recovery and return to work. The HHI Care Manager will be in regular contact with the Member throughout the care management process. HHI is committed to holding all medical information in the strictest of confidence.

Benefits are payable immediately following the expiration of the Elimination Period. The amount of this benefit is based on your Pre-Disability Monthly Earnings level prior to the first day of the Elimination Period just described.

- For Members paid a base hourly wage rate as per the Collective Agreement based on pre-Apprentice, 1st Level, 2nd Level and 3rd Level hourly wage rates, a flat gross monthly benefit of $2,500 will be paid.
- For Members paid a base hourly wage rate as per the Collective Agreement based on 4th Level, Generalist 4th Level, Journeyman, Leadhand or Foreman hourly wage rates, a flat gross monthly benefit of $3,500 will be paid.
- For eligible non-bargaining employees of Contributing Employers a benefit amount equal to 60% of Pre-Disability Monthly Salary, prior to the first day of the Elimination Period, up to a maximum of benefit amount of $3,500 will be paid.

This is a taxable benefit. The amount of the gross monthly benefit is directly reduced by other disability, compensation or pension benefits, from both public and private sources, that you may also be entitled to. You must provide written notification of disability and application for benefits to the Trustees via the Plan Administrator within 6 months from the expiration of the Elimination Period. Medical proof of Total Disability[2] must be provided to the Trustees to receive and continue to receive the Target Extended Benefit (TEB). The benefit offsets, terms and conditions of the TEB are explained in more detail in the Description of Benefits section later in this booklet.

Coverage terminates the earlier of the date you attain age 58 or the date of exhaustion of your Hour Bank Account, and as outlined under Termination of Insurance earlier in this booklet. Benefits remain payable up to the day in which the Member reaches age 60 or dies, whichever is earlier.

For complete details please refer to the Target Extended Benefit – for Accident & Physical Illness Plan Document, which can be obtained from the Plan Administrator.

Once a claim is adjudicated, any benefits payable will be processed and paid by the Administrator on behalf of the Trust Fund. In the event that an adjudication decision is appealed, the appeal will be dealt with in accordance to the TEB Plan Document. In addition, at any point, if any one of the Board of Trustees obtains information that may call into question continuing eligibility for this benefit, the Claims Assessor will review the new information and make a recommendation as to continued eligibility.

Any benefit received under this plan is taxable as income and receipt of the benefit may also require the Member to pay an amount to Employment Insurance and to Canada Pension. The Fund is not required by law to deduct and withhold the tax amounts. This is the Member's responsibility. The Member is encouraged to apply for Canada Pension Plan disability benefits as these benefits are an offset under this plan.

Exclusions

Benefits are not payable for any period of Total Disability[2] during which the Member:

1. does not provide further proof of Total Disability[2], as required by the Trustees. This may include requirement of the Member to provide a complete copy of the Member's Income Tax Return and any Notice of Assessment or Re-Assessment made by the Canada Revenue Agency, so as to evidence to the Board of Trustees whether the Member is engaged in Gainful Employment, and the extent of such income received by the Member while the Member is receiving benefits under the TEB plan.

2. is not under the regular care of the Member's Physician and following their recommended course of treatment. Should the Trustees and the Member's Physician disagree on appropriate treatment, then an independent Physician may provide a second opinion. The course of treatment recommended by this independent Physician will become binding upon the Member for the purposes the Plan benefit.

The recommendation of the independent Physician is only for the purpose of the Plan, and the determination of whether benefits are payable and does not replace nor substitute so far as the Member is concerned a course of treatment that the Member and the Member's Physician may choose or wish to follow. All reasonable costs of independent medical consultations shall be paid for by the Trustees, including reasonable travel expenses.

3. fails to take a physical examination and/or mental evaluation as reasonably required by the Trustees.

4. fails to enter into Rehabilitation Employment when it is available and when recommended by the Member's Physician or an independent Physician and concurred in by the Trustees.

5. temporarily or permanently moves to and resides in a location where medical treatment or Rehabilitation Employment opportunities are not available which are equivalent to the medical treatment or Rehabilitation Employment opportunities which were available to the Member if the Member resided in either the City of Calgary or the City of Edmonton.

6. engages in any occupation or employment for wage or profit (other than approved Rehabilitation Employment or approved Accommodation Employment).

During such Rehabilitation Employment or Accommodation Employment, the Member's Plan benefit shall be reduced by 50% of any compensation the Member receives from such employment. A Member's combined monthly income from gross monthly Rehabilitation Employment or Accommodation Employment Earnings and the net monthly disability benefit payable by this Plan shall not exceed the Member's gross monthly Pre-Disability Monthly Earnings.

Benefits are not payable for any period of Total Disability[2] when the Total Disability[2] is due to, or results from:

1. active participation in a war or act of war (declared or not).

2. active duty in any military, militia, or peacekeeping force.

3. a term of imprisonment resulting from an offence under the Criminal Code of Canada, or the equivalent criminal legislation of a jurisdiction outside of Canada, and which results in a conviction and term of imprisonment of more than two years.

4. the abuse of drugs or alcohol.

For complete details of all exclusions, and for precise definitions of the terms Rehabilitation Employment and Accommodation Employment, please see the Plan Document.

Offsets and Subrogation

The amount of the TEB Gross Monthly Benefit is directly reduced by income or benefits payable or received by or from any of the following sources:

1. Disability or pension benefits to which the Member is entitled under a public pension plan (CPP/QPP).

2. Amounts payable or received under Workers' Compensation or similar legislation, or under any compulsory disability benefit legislation.

3. Amounts payable or received under any automobile insurance policy for a disability resulting from any accident involving a motor vehicle, if the Member can recover from a third party, the loss of income resulting from the accident.

4. Amounts payable from any Section B benefit paid or payable from an automobile insurance policy (irrespective of whether the claimant has in place an automobile insurance policy) if the circumstances of the automobile accident are such that the Member is precluded from any recovery from a third party for the loss of income resulting to the Member from the accident.

5. Disability or pension benefits received from the Alberta Ironworkers Pension Fund or any other pension plan.

6. Benefits received from any other sick leave or disability plan sponsored by Local Unions 720 and 725 of the International Association of Bridge, Structural, Ornamental and Reinforcing Ironworkers or the International Association of Bridge, Structural, Ornamental and Reinforcing Ironworkers or any other sick leave or disability plan.

7. Any remuneration received from an employer (except if received under the Rehabilitation Employment or Accommodation Employment provisions), or any Income from Self Employment, that is, any income earned by the Member through active participation in a business or corporation in which the Member holds an interest, as defined in the Plan Document.

For complete details of all offsets, please see the Plan Document.

EXTENDED HEALTH

The Supplementary Health benefit is not guaranteed, nor is it insured by an insurance provider. Rather it is self-insured by the Ironworkers Health & Welfare Trust Fund of Western Canada.

The Trustees have the sole authority, from time to time, to terminate, waive or change any of the benefits, conditions or provisions of this Plan, and the Board of Trustees also expressly reserves the right to terminate or substitute the Plan. This includes not only termination of coverage but also termination of future benefit payments for approved claimants.

In the event that you or your dependents incur any of the eligible expenses listed in this section, you will be reimbursed a percentage (coinsurance) of such expenses. Such expenses must be reasonable and customary, medically necessary and prescribed by a physician or other qualified medical practitioner deemed appropriate by the insurer. A Member or dependent must be residing in Canada and eligible for coverage under a provincial health care plan to be eligible for this supplementary coverage. ~~T~~

The following list provides brief descriptions of all eligible expenses and applies to all PLANS, unless otherwise indicated.

1. **Preferred Accommodation in Canadian Hospitals -** Semi-private or private room and board in a licensed Canadian Hospital.
2. Charges for accommodation in a licensed **Rehabilitation Hospital**, subject to a maximum benefit of $20 per day. Confinement must be for the continuous care of the same condition for which the insured was hospitalized.

2. Charges for the services of a certified, registered, or licensed **Christian Science Practitioner, Acupuncturist and Osteopath** to a maximum of $75 per visit and $1,000 (or $400 for Plans F and G) per calendar year per specialty per insured individual.

3. Charges for the services of a certified, registered, or licensed **Naturopath** to a maximum of $75 per visit and $1,000 (or $400 for Plans F and G) per calendar year per specialty per insured individual.

4. Charges for the services of a certified, registered, or licensed **Massage Therapist** and **Reflexologist** to a combined maximum of $75 per visit and $1,000 (or $400 for Plans F and G) per calendar year per specialty per insured individual.

5. Charges for the services of a certified, registered, or licensed **Physiotherapist** to a maximum of $75 per visit to a maximum of $1,000 (or $400 for Plans F and G) per calendar year. The services of a Physiotherapist must be recommended by a Physician.

   Charges for the services of a certified, registered, or licensed **Chiropractor** to a maximum of $75 per visit and $1,000 (or $400 for Plans F and G) per calendar year per specialty per insured individual. Services are provided from first-dollar coverage.

   Charges for the services of a certified, registered, or licensed **Podiatrist** to a maximum of $75 per visit and $1,000 (or $400 for Plans F and G) per calendar year per specialty per insured individual. Services are provided from first-dollar coverage.

   Charges for the services of a certified, registered, or licensed **Psychologist** to a maximum of $115 per hour, and $1,000 (or $500 for Plans F and G) per insured individual per calendar year.

   Charges for the services of a certified, registered, or licensed **Speech Therapist** to a maximum of $25 for the initial assessment, $75 for each subsequent visit and $1,000 (or $400 for Plans F and G) per insured individual per calendar year when recommended by a Physician.

   Charges for the services of an **Occupational Therapist** up to a maximum of $75 per visit and $1,000 per calendar year per insured individual (or $400 for Plans F and G) and reducing to $400 per calendar year at age 70.

Charges for the services of a certified, registered, or licensed **Athletic Therapist** to a combined maximum of $75 per visit and $1,000 (or $400 for Plans F and G)per calendar year per specialty per insured individual.

This plan will only reimburse you for Paramedical expenses (except for Podiatry services) if the Provincial Government has not paid all or part of the expense. Charges for x-rays are covered up to a maximum of $25 per disability.

6. Charges for the medical services (excluding custodial care, psychological or personal counselling) provided by a **Registered Nurse** (R.N.), **Nursing Assistant** (C.N.A., R.N.A., R.P.N., L.P.N. or L.N.A.) or a member of the Victorian Order of Nurses (V.O.N.) which are rendered while the insured is not confined to a Hospital subject to a lifetime maximum benefit of $5,000 provided such nurse is not a resident in your home or a relative of your family.

These charges will be considered eligible expenses only if recommended by a physician and only if medically necessary. For the purpose of this policy, custodial care is defined as assistance with daily living or tasks which a layperson could perform.

7. Charges for rental (or, at the insurer's option, purchase) of **durable medical equipment** required for therapeutic purposes and as approved by the insurer, including but not limited to wheelchairs, hospital beds, oxygen equipment. Portable or fixed oxygen concentrators are subject to a lifetime maximum of $5,000. Phototherapy light equipment used for the treatment of Seasonal Affective Disorder (SAD) is subject to a lifetime maximum of $300 (excluding repairs).

8. Charges for rental (or, at the insurer's option, purchase) of **medical aids and prostheses**, including but not limited to braces, crutches, and purchase of prostheses.

9. Charges for necessary **dental treatment** required as the result of an **accidental injury** to natural teeth or for cosmetic surgery necessary for prompt repair of an accidental injury to natural teeth, provided the accident occurred while insured under this coverage. Only such charges directly related to such an accidental injury and approved by the insurer are considered a covered medical expense.

10. Unlimited charges for professional **ambulance service**, other than airline, to and from the nearest Hospital qualified to provide the necessary treatment.

11. Emergency transportation by airline to and from the nearest Hospital qualified to provide the necessary treatment. Such emergency transportation is subject to a maximum benefit equal to the economy airfare for the insured, and, if medically required, a medical attendant who is neither a resident in your home nor a relative of your family.

12. Charges for **orthopedic shoes (including repairs) and/or orthotics** which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

a. a diagnosis, including a list of symptoms and the primary complaint;
b. a description of the physical findings from the clinical examination;
c. a brief description of the abnormal walking pattern associated with the diagnosis; and

d. Charges for orthopedic shoes, including repairs, and orthotics are limited to a maximum of $400 per insured individual every 36 calendar months. confirmation that the product has been custom made.

Your orthopedic shoes and/or orthotics must be prescribed on an annual basis by a provider with one of the following professional qualifications:

a. Medical General Practitioner or Specialist (MD);
b. Podiatrist (DPM); or
c. Chiropodist (D CH or D Pod M); and

must be dispensed by one of the following provider types:

a. Medical General Practitioner or Specialist (MD);
b. Orthotist Co(c) or CPO(c);
c. Pedorthist C Ped (C) or C Ped (MC);
d. Podiatrist (DPM); or
e. Chiropodist (D CH or D Pod M).

13. For **Plans A, C, D, E, F and G** charges for the purchase of **hearing aids**, including replacement and audiologist testing, but not including batteries, are covered, up to a maximum benefit of $5000 in any 60 consecutive months.

For **Plans A, C, D, E, F and G**, custom fitted earplugs (for the Member only), for preventative hearing protection purposes and when not prescribed by a physician or otolaryngologist, are covered up to a maximum of $100 every 2 calendar years. Custom fitted earplugs (for the Member only), which are deemed medically necessary and prescribed by a physician or otolaryngologist are covered up to a maximum of $400 per person every 5 calendar years.

14. Charges for **outpatient hospital** care, services and supplies not covered by any Provincial Government plan.

15. Provision of **anaesthesia, oxygen, blood, and blood products**.

16. Charges for **elastic support stockings** to a maximum of 3 pairs and $150 per person per calendar year.

17. Charges for medication required for **sclerotherapy** to a maximum of $60 per visit and a lifetime maximum of $360.

18. Charges for **laser surgery to correct sleep apnea** and the purchase and/or repairs of sleep apnea treatment equipment subject to a combined maximum of $2,500 every 5 years when recommended by a Physician.

19. Charges for **endo-venous laser therapy** for treatment of varicose veins, including physician fees and facility fees up to a lifetime maximum benefit of $3,000. No coverage for **Plan F and G**.

PRESCRIPTION DRUGS

Members have a Pay-Direct Benefit Card through TELUS Health. TELUS Health uses a managed formulary. The dispensing fee deductible for drug expenses is $4 per script. This $4 dispensing fee deductible must be paid by you.

This Plan covers reasonable and customary charges incurred for medically necessary drugs and medicines on the managed formulary which:

1. are dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines; and
2. are prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of an illness or injury and are either:
    a. drugs requiring a prescription in accordance with the Food and Drugs Act of Canada;
    b. other specified drugs and medicines which have been identified by the Insurer as covered expenses and are by convention usually not dispensed without a prescription;
    c. injectable preparations identified by the Insurer, insulin preparations and supplies, and allergy serums;
    d. smoking cessation aids which require a physician's prescription are covered, subject to a lifetime maximum benefit of $1,000 per individual, including nicotine patches and charges by a registered acupuncturist, laser treatment therapist or hypnotherapist legally practicing within the scope of their license, when recommended by a Physician;
    e. drugs required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes, and parkinsonism.
    f. erectile dysfunction drugs to a maximum of $750 per year;
    g. The drug Neovisc to a maximum of $400 per year per insured individual;
    h. Epipen injections to a maximum of $350 per year per insured individual; or
    i. all items falling into the following categories are considered Life Sustaining over-the counter drugs:

        i. anti-anginal agents
        ii. anticholinergic
        iii. antiparkinsonian agents
        iv. anti-arrhythmic therapy
        v. bronchodilators
        vi. enzymatic zonulolytic
        vii. fluorides
        viii. glaucoma therapy
        ix. topical enzymatic debriding agents
        x. hyperthyroidism
        xi. insulins
        xii. oral fibrinolytic
        xiii. parasympathomimetic
        xiv. potassium replacement therapy
        xv. TB therapy
        xvi. hypercholesterolemia therapy
        xvii. the drug “Pancreas”.

When there is more than one drug that is suitable to treat your condition, your plan allows for reimbursement ***based on the lowest priced drug***. Should you decide to purchase a higher priced drug, you must pay the difference between the ingredient cost for the drug purchased and the ingredient cost for the lowest priced drug. No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase. Fertility Drugs are excluded.

Certain drugs covered by this plan require approval through the **Special Authorization** process prior to reimbursement. This means that you will have to advise your physician that your plan has this process

and will have to follow the protocol for submitting the proper information prior to claiming certain drugs. Members who meet the approval criteria will be reimbursed for the medication they require. This process reduces drug benefit costs while ensuring that members receive the most appropriate and cost-effective drug therapies. Refer to the Ironworkers website for instructions on this process and for a list of affected drugs.

VISION

Generally, Reduced Self-Pay Members are not covered for eye exams or safety glasses. Retirees/Pensioners are not covered for safety glasses, corrective eye surgery or lens implants.

1. For **Plans A, C, D, E, F and G**, eye examinations up to a maximum benefit of $125 per eye exam once every 2 calendar years (or every calendar year for insured individuals under age 18).

For **Plans F and G**, eye examinations are included in the lens and frames maximums listed in the following paragraph.

2. **For all covered Classes**, lenses and frames for eyeglasses (including prescription sunglasses), lens tinting, protective coating or contact lenses not covered in item (3) below and prescribed by an optometrist or ophthalmologist and the cost of material for repair of eyeglasses to a maximum of $600 every 2 calendar years (or every calendar year for insured individuals under age 18) for Plans F and G; $300 every 2 calendar years (or every calendar year for insured individuals under age 18)

3. **For all covered Classes**, contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea) or aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses to a maximum of $200 in any period of 2 years.

4. **For all covered Classes except Plans C and G**, Physician surgical fees (but not facility or any other charges, or professional fees related to cataract surgery) for treatment related to Photorefractive Keratectormy (PRK) and Laser Assisted In-Situ Keratomileusis (LASIK) are covered to a lifetime maximum of $3,000. Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK) are not eligible procedures. A claim under this category of laser eye surgery will disqualify an insured from Vision Care benefits for a period of three months prior to eye surgery.

5. **For Plans A, D and E,** prescription safety glasses (for the Member only) to a maximum of $450 every 2 calendar years.

6. **For all covered Classes except Plan C and Plan G**, lens implants up to a lifetime maximum benefit of $3,000. A claim under this category will disqualify an insured from Vision Care benefits for a period of three months prior to eye surgery, and six years from the date of eye surgery.

Exclusions

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

1. Charges which are considered an insured service of any provincial government plan.

2. Charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended, or discontinued.
3. Charges for general health examinations, and examinations required for use of a third party.
4. Charges for eye examinations, except where included as an eligible expense.
5. Charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment.
6. Charges for medical treatment or surgical procedure by a physician other than as specifically provided under Out of Province Expenses or for laser surgery for sleep apnea under the Supplementary Health Expense section.
7. Charges for transport or travel, other than as specifically provided under eligible expenses.
8. Charges not specified in the foregoing list of eligible medical expenses.
9. Charges for services or supplies which are furnished without the recommendation and approval of a physician or other qualified medical practitioner acting within the scope of his license.
10. Charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease, or pregnancy.
11. Charges which are from an occupational injury or disease covered by any Workers' Compensation law or similar legislation.
12. Charges which would not normally have been incurred but for the presence of this insurance or for which you are not legally obligated to pay.
13. Charges which the insurer is not permitted, by any law or regulation, to cover.
14. Charges for dental work where a third party is responsible for payment for such charges.
15. Charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind.
16. Charges for services or supplies resulting from any self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness.
17. Charges for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare Canada or are experimental or limited in use whether or not so approved.
18. Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society.
19. Charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies.
20. Charges which are not incurred as a result of an emergency while travelling.
21. Charges in connection with childbirth and medical complications resulting from childbirth when the delivery takes place after the beginning of the 32nd week of pregnancy and occurring while travelling.
22. Charges for care, treatment, services or supplies which are furnished or paid for, or with respect to which benefits are provided, under any law of a government (national or otherwise) by reason of the past or present service of any person in the armed forces of a government.
23. Charges for care, treatment, services or supplies other than those referred to in item 22 above, which are paid for, or with respect to which benefits are provided, under any law of a government (national or otherwise) except where such payments are made, or such benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents.
24. Charges incurred for care, treatment, services or supplies as a result of any group or employer-sponsored treatment, inoculation, or examination.

25. Charges for drugs, sera, injectable drugs or supplies when administered in a hospital setting, whether administered on an inpatient or outpatient basis, except as provided for under the Outside of Province/Canada Expenses or Outside Canada Referral sections, where provided under the Supplementary Health Expense.

26. Charges not listed as an eligible expense in this booklet.

DENTAL

The Dental benefit is not guaranteed, nor is it insured by an insurance provider. Rather it is self-insured by the Ironworkers Health & Welfare Trust Fund of Western Canada. The Trustees have the sole authority, from time to time, to terminate, waive or change any of the benefits, conditions or provisions of this Plan, and the Board of Trustees also expressly reserves the right to terminate or substitute the Plan. This includes not only termination of coverage but also termination of future benefit payments for approved claimants.

In the event that you or your dependents incur any of the eligible expenses listed below, you will be reimbursed a percentage of such expenses, to the extent that they do not exceed the applicable Dental Fee Guide. Please see the table in the Member Classification section above for a list of those eligible, and the Summary of Benefits section above for the categories of treatments available to you, the amount of your coinsurance and the maximum benefits available.

The Dental Fee Guide used shall be the current year Fee Guide for General Practitioners for your province of residence (except Alberta). If you reside in Alberta, the current year Dental Fee Guide of the insurer shall be used. Specialist's fees are covered when recommended by a Physician or Dentist.

Coverage under this age band terminates the earlier of the date you attain age 79, the date of exhaustion of your Hour Bank Account, or the date you cease making the required Self-Pay premiums, and as outlined under Termination of Insurance earlier in this booklet.

Eligible Expenses

1. The following **Minor Procedures** are eligible:

a. **Diagnostics:** Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:
   i. oral examinations limited to 1 every 12 consecutive months adults; 1 every 6 consecutive months for children
   ii. complete oral exam and diagnosis 1 every 30 consecutive months;
   iii. x-rays: single diagnostic x-rays, complete series or equivalent 1 every 30 consecutive months;
   iv. consultations; and
   v. study casts once per year.

b. **Preventative Therapy:** Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:
   i. cleaning of teeth (prophylaxis) once every 6 consecutive months;
   ii. topical fluoride once every 9 months (for dependents age 16 and under only);
   iii. passive space maintainers for dependent children;
   iv. mouth guards other than athletic appliances;
   v. polishing of teeth when provided in a dental office; and
   vi. pit and fissure sealants (procedures 13401 and 13409) to a maximum of $100 per person per calendar year.

c. **Basic Restorative Dentistry:** The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, or synthetic restorations

(fillings) or prefabricated full coverage restorations. In addition, sedative dressings are covered.

d. **Extractions:** Removal of teeth.
e. **Endodontics:** Emergency endodontic procedures and conservative root canal therapy.
f. **Periodontics:** (Unit of time = 15 minutes)
    i. adjunctive services as follows: 8 units per calendar year of occlusal equilibration, 10 units of periodontal scaling and root planing combined, acute infections, provisional splinting;
    ii. surgical services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;
    iii. special periodontal appliances.
g. **Oral Surgery:** Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.
h. **Anaesthesia:** Anaesthesia where reasonably and customarily required in connection with other covered procedures. Facility fees associated with anaesthesia used in connection with the removal of wisdom teeth are limited to a maximum of $100 per calendar year.
i. **Repairs, Relining and Rebasing of Dentures:** Repair or relining and rebasing of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

2. The following **Major Procedures** and **Dental Implant Procedures** are eligible:

a. **Removable Prosthetic Devices:** The following coverages apply with respect to dentures; standard or equilibrated: (The replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.)
    i. the initial installation of partial or full dentures;
    ii. replacement of existing dentures which are at least 5 years old and no longer serviceable;
    iii. replacement of immediate temporary dentures by required permanent dentures within 12 months from the date of installation of the immediate temporary dentures.
b. **Extensive Restorative Dentistry:** Those procedures, including inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. The replacement of inlays, onlays and crowns are covered only if such replacement is more than 12 months after the individual became insured under this coverage, and the existing inlay, onlay, or crown is at least 5 years old and no longer serviceable. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration. Such procedures are subject to the pre-existing condition limitations on teeth missing, extracted, or fractured prior to becoming insured.
c. **Fixed Prosthetic Devices:**
    i. the initial installation of fixed prosthetic devices, including dental implants;
    ii. recementing and replacement of the facing or veneer of the fixed prosthetic device;

iii. replacement of existing fixed prosthetic devices provided the existing fixed prosthetic device is at least 5 years old and no longer serviceable.

3. Charges for **Orthodontics**, which is the diagnosis and correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces, or other mechanical aids, commonly known as "straightening of the teeth". These include active space retainers, or orthodontic appliances, for the purpose of repositioning or moving of the teeth.

Alternate Benefits and Submission of Treatment Plan

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, the insurer reserves the right to determine eligible expenses on the basis of an alternate benefit. This alternate benefit clause will not apply if a dentist recommends a bridge instead of a denture, even if the bridge is replacing three or more teeth.

When a proposed course of treatment includes major restorative dentistry or orthodontics, or any treatment above $500, you should have your dentist complete a treatment plan, including pre-treatment x-rays if the proposed treatment involves crowns or bridgework, on forms available from your Plan Administrator. This treatment plan should be submitted to the insurer, which after review, will inform you of the amount of coverage you will receive for such treatment in an Explanation of Benefits, which will remain valid for a period of 90 days.

Exclusions and Limitations

Payments will not be made for any dental procedure in respect of any injury or dental disease for which the Member or dependent was advised to receive treatment or for which treatment first began before the Member or dependent became insured for that dental procedure.

No benefit is payable for the following:

1. Services or supplies that are primarily for cosmetic dentistry including teeth bleaching and whitening.

2. Charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended, or discontinued.

3. Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license.

4. Any charge for an injury resulting from war (whether declared or undeclared), riot, insurrection hostilities of any kind or participation in a criminal act. Services or supplies which are necessitated either wholly or partly, directly, or indirectly as the result of committing, attempting, or provoking an assault or criminal offence, or by a war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind.

5. Any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or filling in of forms.

6. Any charge resulting from any self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness.

7. Any services covered in whole or in part by any government plan, services for which no charge is made, or services which the insurer is not permitted by law to cover.

8. Any charge for services which would not normally have been incurred, but for the presence of this insurance, or for which you are not required to pay.

9. Any hospital charges for board and room and related services and supplies.

10. Any dental examinations required by a third party.

11. Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease.

12. Any services or supplies in connection with the following dental procedures:

a. oral hygiene instruction;
b. nutritional counselling;
c. protective athletic appliances; and

13. Services or supplies rendered for a full mouth reconstruction, for a vertical dimension correction or for diagnosis for correction of a temporomandibular joint dysfunction (TMJ).

14. Services or supplies in connection with any procedure excluded as an eligible expense.

15. Services or supplies for or in connection with a procedure which is not listed as an eligible expense in this booklet.

HEALTH SPENDING ACCOUNT

A Health Spending Account (HSA) is like a bank account into which the Trust Fund deposits dollars for eligible members and may be used to cover expenses not covered by the Ironworkers existing group health plan or to top-up expenses not fully covered by the Ironworkers group health plan, including co-payment amounts (the amount of eligible expenses that you have to pay) and out-of-pocket expenses. Since your HSA allocations would be provided to you by the Trust Fund as pre-tax dollars, the HSA is a tax-effective way of paying for your eligible health-related expenses.

Your HSA is an allocation carry-forward plan which means that your annual HSA allocations can carry-forward for 12 months from the end of the plan year. However, for an HSA to maintain its tax-exempt status, the Canadian Income Tax Act requires that if these allocations are not used by the end of the HSA year following the year in which they were allocated, they are forfeited back to the plan for global reallocation.

Unlike your HSA allocations, you cannot carry forward expenses after the end of the plan year. Expenses incurred within the HSA year can only be claimed in that same year. There will be a claims run-off period of 60 days following the end of each HSA plan year during which time you can submit HSA claims for expenses incurred up to the end of the plan year.

Eligible Expenses

Eligible expenses are those currently listed as eligible medical expense tax credits in the Income Tax Act, Section 118.2(2), and further clarified in Canada Revenue Agency's Interpretation Bulletin IT-519R2.

You can find the most current Canada Revenue Agency guidelines on the following website:

https://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/lines-33099-33199-eligible-medical-expenses-you-claim-on-your-tax-return.html

Not all items listed on the CRA website are covered by the plan, from time to time the Board of Trustees will decide to specifically exclude some items for reimbursement. For example, medical marijuana and gluten free products are not eligible under the Health Spending Account.

Dependents

Your dependents may be eligible for coverage through your HSA. The definition of eligible dependents under the HSA is actually broader than for the Ironworkers group Extended Health Care and Dental Care benefit plans. An HSA-eligible dependent is defined by Canada Revenue Agency (CRA) guidelines – your HSA may reimburse eligible expenses incurred by you, your spouse, your children, and any other dependents that qualify on your income tax return. This may include your grandchild, parent, grandparent, brother, sister, uncle, aunt, nieces, and/or nephews, depending on your situation. If you are unsure of the status of a dependent, you can contact the CRA for clarification.

MEMBER ASSISTANCE PROGRAM

The Ironworkers Health & Welfare Trust Fund of Western Canada Member Assistance Program (MAP) is designed to offer confidential, short-term counseling to help Members and their family members overcome any personal problems. This service is for Members working for employers who do not participate in the Construction Labour Relations Association – Construction Employee & Family Assistance Plan (CEFAP). The MAP provides up to 12 hours of counseling in any given year and is available 24 hours a day, 7 days a week. Also included at no cost is 2 hours of certain financial and legal counseling or consultations.

There are no direct costs to the eligible Members or their eligible family participants when they receive any of these services. The cost of the service is provided as a benefit under the Ironworkers Health & Welfare Trust Fund of Western Canada. Members and their dependents are eligible for MAP from the first hour reported.

Counseling services include:

- Marital and family discord
- Psychological stress
- Work related problems
- Alcohol and drug dependencies
- Gambling
- Grief and bereavement
- Lifestyle problems
- Traumatic distress
- Retirement issues and problems
- Elder care/childcare
- Legal and financial counselling
- Career transition adjustment
- Mental/physical health concerns

To access this service or for more information, call the Homewood Health Inc. office at 1-800-663-1142 or visit www.homewoodhealth.com.

EMERGENCY TRAVEL ASSISTANCE

The information below summarizes your Emergency Medical Travel Insurance coverage. It contains important information with respect to certain eligibility and benefits limits that apply to your coverage, but it does not reference all the terms, conditions, limitations, and exclusions that apply to your insurance coverage. Please refer to the policy for complete benefit details. All amounts indicated are in Canadian currency, unless otherwise stated.

Policyholder Name	**Ironworkers' Health & Welfare Trust Fund of Western Canada**
Policy Number	**8451460**
Description of Classes	**Class I:** All eligible Active members of the Policyholder. **Class II:** All eligible Active members of the Policyholder working in the United States. **Class III:** All eligible retired members of the Policyholder under age 80.
Termination	**Class I & II:** Terminates at the earlier of the Members attainment of 80 years of age or retirement **Class III:** Terminates at the attainment of age 80
Covered Trip Duration	**Class I:** Up to a maximum of 90 days per trip **Class II:** 180 days per Trip **Class III:** Up to a maximum of 90 days per trip
Pre-existing Medical Condition Stability Period*	**Class I & II:** SECTION IV – Emergency Medical Insurance Exclusions 4.a. points (1) and (2) ONLY applies after age 75. At age 75: 60 days **Class III:** 60 days
Emergency Medical Treatment	$5,000,000 **Reduction of coverage:** Age 75 -80: $2,000,000
Hospital Allowance	$50 per day to a maximum of $500
Paramedical Services	$500 per practitioner for up to 180 days
Ground Ambulance	Maximum $5,000
Emergency Dental Treatment	(1) $2,500 (2) $300
Medical Evacuation	Maximum $300,000
Resumption of Work	Maximum $1,000
Bedside Companion	Round-trip economy airfare & up to $5,000 for meals and accommodation
Meals and Accommodation	$250 per day to a maximum of $5,000
Repatriation of Remains	(1) $5,000 (2) $300
Return of Dependent Child(ren)	One way economy airfare up to a maximum of $5,000
Childcare	$75 per day to a maximum of $500
Return of Travelling Companion / Business Colleague	One-way economy airfare up to a maximum of $1000
Vehicle Return	$10,000
Return of Dog or Cat	$500
Dispatch of a Physician or Specialist Benefit	$75,000
Trip Cancellation and Trip Interruption	$5,000
Lost Baggage	$500 per item or up to a maximum of $1,000 for a set of items
Lost Travel Documents	$250
Lost or Damaged Business Equipment	$1,000

GENERAL PROVISONS

Coordination of Benefits

Payment of Supplementary Health, Emergency Travel Assistance and Dental benefits shall be coordinated so that the sum of all benefits payable, from this Plan *and any other plan* from which the Member or dependents may have coverage, does not exceed 100% of the eligible claim. For this purpose, the insurer and Plan Administrator have a right to receive and release information on benefits and if necessary, collect any overpayments made.

Order of Benefit Determination

In the case of multiple parallel coverages, it is necessary to determine where to submit the claim first and which plan pays next. The following rules shall determine the order in which benefits are paid:

1. The plan that does not have a coordination of benefits provision pays before the plan that does. (Most insurance company plans have such a provision.)
2. Among the policies having coordination of benefits, priority shall be determined in the following order:

   For Members:

   a. The plan where the person is covered as a member.
   b. If a person is eligible for member coverage under more than one plan, priority goes to:
      i. the plan where the member is an active, full-time member;
      ii. the plan where the member is an active, part-time member;
      iii. the plan where the member is a retiree.

   For spouses:

   a. The plan where the spouse is covered as a member.
   b. The plan where the spouse is covered as a dependent.

   For dependent children whose parents are *not* separated/divorced:

   a. The plan of the parent with the earlier birth date (month/day) in the calendar year.
   b. The plan of the parent whose first name begins with the earlier letter in the alphabet if the parents have the same birth date.

   For dependent children whose parents are separated/divorced:

   a. The plan of the parent with custody of the child.
   b. The plan of the spouse of the parent with custody of the child.
   c. The plan of the parent not having custody of the child.
   d. The plan of the spouse to the parent in (c) above.

If priority cannot be established according to the above rules, the benefits shall be paid under both plans in a ratio proportionate to the amounts that would have been paid under each plan had there been coverage under just that plan.

Change in Amounts of Insurance

A change in the amount of your insurance shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are Actively at Work.

The Actively at Work requirement will be waived for members who are receiving Workers' Compensation benefits and are covered under the "Extension of Coverage" clause in the "Eligibility" section of this booklet.

Change in Government Sponsored Programs

The medical, dental and hospital benefits under this group benefit plan are provided in conjunction with government sponsored provincial programs. In the event that coverage under any provincial program is modified, suspended, or discontinued, the group benefit plan will not automatically assume responsibility for any services or products previously covered under the provincial programs. All Members and dependents must be covered by a provincial government health care program to continue to be eligible for this group benefit plan.

Application for Optional Life Insurance

The Application for Optional Life Insurance for either yourself or a dependent can be obtained from the Ironworkers website or though the Ellement app. Once the form is completed, please forward to Manulife for further information.

Initial Registration and Change of Status or Address

A form must be completed by you and forwarded to the Plan Administrator:

1. when you initially register with the Plan, so that claims can be paid;
2. upon marriage, divorce, beginning or ending of a common law relationship, birth, or adoption of first child, dependent child reaching age 21 or change in coordination of benefits;
3. when you wish to change your beneficiary; and
4. when you have a change of address.

These forms can be obtained from either your Union Office or your Plan Administrator. Notice must be made to the Plan Administrator within 31 days.

Establishing Proof of Common-Law Spouse

With respect to establishing that your common-law spouse has been living with you for at least one year, a form must be completed, naming your common-law spouse. This form must then be received and on file with your Plan Administrator for a period of one year before coverage under this Plan is available to your common-law spouse.

If your common-law spouse has not been registered with your Plan Administrator for one year, the one-year period may be waived by completing the "Declaration of Common-Law Spouse" section of the form, and having it sworn before a Commissioner for Oaths, if you have been living together for more than one year.

Correspondence

Be sure that you indicate your Certificate Number and complete name and address on all correspondence sent to the Plan Administrator.

Access to Plan Documents

You or any of your covered dependents have the right to request a copy of any or all of the following items:

- the sections of the Group Policies and/or Plan Documents that apply to you and your dependents;
- your application for group benefits; and
- any Evidence of Insurability you submitted as part of your application for benefits.

The insurer(s) reserves the right to charge you for such documentation after your first request.

HOW TO CLAIM

Log into your Ironworkers profile to get everything you need to know about your coverage, recent plan announcements how to submit claims, sign up for direct deposit and more. Visit www.abironworkers.ca to log in.

Required Information

In order to process your claim quickly, the following information is required:

- Your full name and address
- The name of your employer
- Your Certificate (Identification) Number
- Your Group Policy Number:
  - #2638 for Life Insurance
  - #100003172 for Accidental Death & Dismemberment
  - #58569 TELUS for Supplementary Health, Dental, and Weekly Disability Income
  - #8451460 for Emergency Travel Assistance

For Prescription Drug Expenses

The Prescription drug, Dental, and Supplementary Health benefits are administered through TELUS Health, which also handles the reimbursement of claims. The Pay Direct Benefit Card must be presented each time a claim is made at any pharmacy in Canada. There are some prescription drugs which may require prior approval through the Special Authorization process. Please refer to the Ironworkers website at www.abironworkers.ca to access those forms.

This card cannot be used outside of Canada and, if any drugs are required while outside Canada, or if there is a problem using the card at any pharmacy within Canada, those drugs should be purchased directly. To then arrange for payment for an eligible expense under this Plan, please contact your Plan Administrator.

Your benefit card is valuable and should be protected like a credit card. If it is lost or stolen, you should report the fact to your Plan Administrator. The card must be returned when your coverage terminates.

For Emergency Travel Assistance

Dial the number on the back of your identification card and you will be connected with your Emergency Travel Assistance provider. Be sure to carry your identification card (supplied by your Plan Administrator) with you when you travel. This card contains the information you are required to give to the provider in the event that you need assistance.

If your claim is for $200 or less, you will be asked to make the payment and keep the receipts. Your provincial health plan and the insurer will then reimburse you for the eligible expenses upon your return. If your claim is for greater than $200 (CAD), payment of such expenses will be arranged, and claims coordinated on your behalf by the travel assistance provider.

All claims (with original receipts attached) should be forwarded to the Plan Administrator at:

Ellement Consulting

10154-108 Street, NW
Edmonton, AB, T5J 1L3

Telephone: 587.405.3196
Toll Free: 1.888.616.3196
Email: abironworkers@ellement.ca
www.abironworkers.ca

Time Limitations

A claim for a Waiver of Premium Benefit must be submitted within 12 months of the date of disability.

A claim for Accidental Death & Dismemberment must be submitted within 12 months of the date of the accident.

A claim for Weekly Disability Income benefits must be submitted within 6 months of the date you become disabled.

A claim for Target Extended Benefits must be submitted within 6 months following expiration of the Elimination Period.

A claim for any other loss must be submitted within 15 months following the date the loss is incurred. However, in the event of termination of insurance, a claim must be submitted within 90 days following the date of termination of your insurance or the date following termination of a particular coverage or the entire plan or policy.

You may not commence legal action against the insurer(s) less than 30 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against the insurer(s) for the recovery of money payable under the plan is absolutely barred unless commenced within the time period set out in the Insurance Act or applicable legislation.

This Group Benefit Plan shall be interpreted in accordance with the laws of the province of Alberta. Please refer to the Insurance Act of Alberta and the Limitations Act of Alberta with regard to time limitations for bringing legal action against the Trust Fund or any of its underwriting partners.

GLOSSARY OF TERMS

Actively at Work shall mean that a member is working for a Contributing Employer or available for work as determined by his name appearing on the out-of-work list of the Union.

Calendar year shall mean the 365-day period commencing on January 1st of each year.

Coinsurance shall mean the percentage of the total eligible expense incurred that is covered by the insurer.

Contributing Employers shall mean those who are a party to, or bound by, a Collective Agreement with the Local 720 and Local 725 of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers or such other definition as given in the Collective Agreement.

Contributions shall mean the cents per hour worked which an employer is bound to remit to the Ironworkers Health & Welfare Trust Fund of Western Canada, under the Collective Agreement.

Coverage Costs shall mean the amount of funds in a Member's account provided by 125 hours of service which are required to maintain benefit coverage for one month under this Group Benefit Plan.

Drug shall mean a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Earnings shall mean that amount of money, based on the number of hours in the regular work week, as per the Collective Agreement, multiplied by the hourly wage rate for each particular Member in the wage rate classification to which he belong.

Health Spending Account shall mean the Trust Fund deposited dollars for eligible members to use to cover expenses not covered by the Ironworkers existing group health plan or to top-up expenses not fully covered by the Ironworkers group health plan, including co-payment amounts and out-of-pocket expenses.

Hospital shall mean an institution operated pursuant to law for the care and treatment of sick and injured persons. The hospital must be continuously staffed and supervised by licensed Physicians and registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term hospital as used in this Group Benefit Plan, shall not include a rest home, nursing home, convalescent home, chronic care facility, health spa, a place for custodial care, a home for the aged or an institution used primarily for the confinement or treatment of alcoholism or drug addiction, tuberculosis or mental illness.

Hour Bank Account shall mean the accumulated hours you work for Contributing Employers after meeting the initial eligibility requirements of the Plan, provided that those contributions have been received by the Plan, less 125 hours deducted for each month of coverage under the Plan. The maximum amount of your Hour Bank Account shall not exceed 1250 hours (or ten months of coverage).

Injury, for the purposes of the Accidental Death & Dismemberment benefit, shall mean bodily injury caused by an accident occurring while the policy is in force as to the insured person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease.

Leave of Absence shall mean a period of time away from work mutually agreed to by you and your employer. In the case of maternity leave of absence, the leave shall begin and finish on the dates agreed to by you and your employer or as required by provincial or federal law.

Loss of Use shall means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

Loss, with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to the first phalange of a thumb or finger means severance at or above the distal interphalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

Lowest Cost Alternative pricing means that when there is more than one drug that is suitable to treat a condition, the plan allows for reimbursement based on the lowest priced drug. Should the Member decide to purchase a higher priced drug, he must pay the difference between the ingredient cost for the drug purchased and the ingredient cost for the lowest priced drug.

Medically Necessary shall mean accepted and recognized by the Canadian medical profession and the insurer as effective, appropriate, and essential treatment of an illness or injury. The insurer has the right after Due Diligence has been completed to determine whether the Drug, service or supply is covered under the Policy.

Non-Occupational, with respect to injury or accident, shall mean an injury or accident which does not arise in the course of any employment for wage or profit. With respect to disease, it shall mean a disease where a person is not entitled to any benefits under the Workers' Compensation law or similar legislation.

Non-Smoker shall mean a person who has totally abstained from using any form of tobacco or cannabis products for a one year period immediately preceding the date of his or her application for Non-Smoker status as outlined in the master policy. The insurer reserves the right to request evidence of continued Non-Smoker status at any time in connection with Optional Life Insurance coverage.

Physician shall mean only a person who is duly licensed to prescribe and administer any drugs or to perform surgical procedures.

Reasonable/customary, when used to describe a charge made by the provider of health care, shall mean that the charge does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.

Rehabilitation Hospital shall mean a licensed, extended hospital care facility or institution, or chronic care facility or institution, which is regularly engaged in the care of sick persons during the convalescent stage of an illness or injury. Such institution must provide 24 hour nursing service and regular medical supervision. The term rehabilitation hospital as used in this booklet shall not include a home for the aged, health spa or hotel, an establishment providing custodial care or an institution for the care and treatment of alcoholism or drug addition, tuberculosis or mental illness.

Retirement shall mean the end of active employment with Contributing Employers.

Subrogation shall mean the right of the Trustees or insurer to reclaim their payments made to the Member to the extent that a Member or dependent recovers damages from a third party. This places the Trustees or insurer in the position of the Member so that the Trustees or insurer can recover the amount of a claim which the Trustees or insurer have paid to the Member or dependent, but which the Member or dependent can recover or has recovered from a third party.

Totally Disabled[1], or Total Disability[1], for the purposes of the **Special Extension of Supplementary Health Expense**, shall mean that the Member is prevented because of injury or disease from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit, or it shall mean that the dependent is prevented solely because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex in good health, whichever is applicable.

Totally Disabled[2], or Total Disability[2], for the purposes of the **Target Extended Benefit - for Accident & Physical Illness**, shall mean a restriction or lack of ability due to a Physical illness or Physical injury which prevents the Member from performing any Gainful Employment during the elimination period and beyond. **Physical** means any bodily injury or illness that is not caused or contributed to, directly or indirectly, primarily by psychological or mental illness or disease, or treatment for such illness or disease. The intent of the TEB plan is not to cover all types of disability. Gainful Employment is defined as suitable work in any occupation for which the Member is medically capable of performing, for which the Member has the necessary education, skills, training and experience; and which could provide the Member with at least 60% of Pre-Disability Monthly Earnings (or Pre-Disability Monthly Salary for non-bargaining employees).

Totally Disabled[3], or Total Disability[3], for the purposes of the **Waiver of Premium Benefit**, shall mean the Member is physically or mentally incapacitated to the extent that the member is not able to work regularly at any job. The disability must be severe and prolonged. "Severe" means the Member's condition prevents him from working regularly at any job, and "prolonged" means the Member's condition is long term or may result in his death.

Wholly Disabled, for the purposes of the **Weekly Disability Income**, shall mean that the Member is incapacitated to the extent that the Member is not able to perform any and every duty of the Member's occupation or employment.