U.A. Local 663
PIPE TRADES UNION

Benefits and Pension Plans Handbook
JANUARY 1, 2015

U.A. Local 663 Pipe Trades Union

BENEFITS PLANS

Dear Member:

This Booklet contains a summary of the Health Benefits and Pension Plans in effect on January 1, 2015. Please destroy the old booklet and keep this new booklet in a safe place for future reference.

This booklet cannot refer to every detail of every Plan. If there are points not covered in this Booklet, or if you think something is not clearly expressed, please contact the Administration Office. If there is any conflict between the Booklet and the documents establishing the Plans, the documents must govern.

These Benefit Plans are administered by a Board of Trustees elected by members of Local 663.

THE TRUSTEES OF THE HEALTH BENEFITS PLAN ARE:

Jim Grasse Jr.
Sandy Hoad
Cory Roe
Bob Sauve

THE TRUSTEES OF THE PENSION PLAN ARE:

Gary Beatty
Dave Currie
Sandy Hoad
Paul Mussio

THE PLANS' ADMINISTRATION OFFICE IS AT:

1151 Confederation Street
Sarnia ON N7S 3Y5

TELEPHONE NUMBERS:

Clara McNaughton
Allison Janson
T: **(519) 337-9781**
F: **(519) 491-7152**

Ross Tius, *Administrator*
T: **(519) 337-6569** or **(519) 337-6261**
F: **(519) 332-3054**

THE INSURANCE CARRIERS ARE:

Great-West Life Assurance Company
RSA
ACE/INA Life Insurance
Family Counselling Centre

Table of Contents

HEALTH BENEFITS PLAN

HEALTH BENEFITS COVERAGE

PENSION PLAN

Health Benefits Plan

INTRODUCTION

The Health Benefits Plan described in this booklet is designed to help protect you and your family against loss of income and to provide reimbursement of expenses of health and dental care.

Loss of income can be caused by:

(i) Sickness or Injury—*see pages 43 – 45*
(ii) Death or Accident—*see pages 36 – 42*

Health care may require the payment of:

(i) Hospital, Drug and Major Medical Expenses—*see pages 45 – 55*
(ii) Dental Expenses—*see pages 56 – 62*

IMPORTANT

The different Health Plan benefits available for active members and retired members are summarized on the following seven pages. Note that these tables are summaries only. For details of coverage see the appropriate section of the booklet.

Benefits will only be paid if you meet the eligibility requirements for benefit coverage at the time of your death or retirement or at the time the expense was incurred. Your spouse or dependent children must also meet eligibility criteria as stated on pages 29 – 32.

SUMMARY OF HEALTH BENEFITS PLAN

BENEFIT FOR MEMBERS AND THEIR DEPENDENTS	ACTIVE MEMBER	RETIRED MEMBER (FULL BENEFITS)
Minimum Hours of Work for Commencement	300 *(See pages 16 – 17)*	See pages 23 – 28 for Eligibility Requirements for Retiree Benefits
Minimum Annual Hours	1,200	N/A
Monthly Pay Direct	Set by Trustees Annually	Set by Trustees Annually
LIFE INSURANCE		
Before age 65	$65,000	$65,000
Age 65 to 69	$50,000	$50,000
Age 70 (and over)	$10,000	$10,000
DEPENDENT LIFE INSURANCE		
Spouse	$10,000	$10,000
Child	$10,000	$10,000

SUMMARY OF HEALTH BENEFITS PLAN CONTINUED...

BENEFIT FOR MEMBERS AND THEIR DEPENDENTS	ACTIVE MEMBER	RETIRED MEMBER (FULL BENEFITS)
ACCIDENTAL DEATH BENEFIT*		
Before age 65	$65,000	$65,000
Age 65 to 69	$50,000	$50,000
Benefit terminates at age 70		

* Maximum payout for one accident (except for paralysis) is $65,000 ($50,000 if member is age 65 to 69)

ACCIDENTAL DISMEMBERMENT BENEFIT*		
Before age 65	Up to $65,000	Up to $65,000
Age 65 to 69	Up to $50,000	Up to $50,000
Benefit terminates at age 70		

* Maximum payout for one accident (except for paralysis) is $65,000 ($50,000 if member is age 65 to 69)

SHORT TERM DISABILITY		
Disability Income for Active Members under age 65.* * Must qualify for E.I. Sick Benefits to be eligible.	Waiting Period: 119 days or the end of the period in which you are entitled to benefits under the Employment Insurance Act of Canada, whichever is earlier Maximum Benefit Period – 37 Weeks Amount of Benefit – Same as Current E.I. Benefit	Not Applicable

BENEFIT FOR MEMBERS AND THEIR DEPENDENTS	ACTIVE MEMBER	RETIRED MEMBER (FULL BENEFITS)
EXTENDED HEALTH BENEFITS		
(a) Hospital Coverage (no age limit)	2 Day Waiting Period Applies *	2 Day Waiting Period Applies *
Semi-Private Hospital Room	100%	100%
Convalescent Care	Up to 90 days	Up to 90 days
Chronic Care	$25 per day up to 90 days	$25 per day up to 90 days
(b) Prescription drugs (Member's and Spouse's coverage ends at age 65)	95% Pay Direct Drug Card $9.00 Max. Dispensing Fee	95% Pay Direct Drug Card $9.00 Max. Dispensing Fee
(c) Vaccinations	Member's and Spouse's coverage ends at age 65	Member's and Spouse's coverage ends at age 65
(d) Major Medical (Member's and Spouse's coverage ends at age 65) Medical Equipment and Services	100% (Subject to per visit and annual maximums) *(See pages 51 – 54)*	100% (Subject to per visit and annual maximums) *(See pages 51 – 54)*

* Member must Complete Questionnaire from Administration Office for Reimbursement.

SUMMARY OF HEALTH BENEFITS PLAN CONTINUED...

BENEFIT FOR MEMBERS AND THEIR DEPENDENTS	ACTIVE MEMBER	RETIRED MEMBER (FULL BENEFITS)
EXTENDED HEALTH BENEFITS		
(Member's and Spouse's coverage ends at 65)		
i. Paramedical: Acupuncture, Dietician, Osteopath, Naturopath, Speech Therapist, Massage Therapist, Psychologist, Chiropractor and Podiatrist/ Chiropodist	$50 per visit, maximum $500/calendar year per practitioner	$50 per visit, maximum $500/calendar year per practitioner
ii. Physiotherapist	$600 per calendar year	$600 per calendar year
iii. Orthopaedic shoes or orthotics	Up to $500 per calendar year	Up to $500 per calendar year
iv. Other eligible services and supplies ***(see pages 52 – 53 for details)***	Reasonable and Customary	Reasonable and Customary

BENEFIT FOR MEMBERS AND THEIR DEPENDENTS	ACTIVE MEMBER AGE 65 AND OVER	RETIRED MEMBER AGE 65 AND OVER
EXTENDED HEALTH BENEFITS		
(e) Major Medical for *Active and Retired Members Only* age 65 and over Medical Equipment and Services	100% (Subject to a per visit and annual maximums) (See pages 51 – 54) (Claims paid by the Administration Office as approved by the Trustees)	Medical Equipment and Services (i – iv) for the Retired Member only are reimbursed by Great West Life at 50% up to a maximum of $300 per calendar year
i. Paramedical: Acupuncture, Dietician, Osteopath, Naturopath, Speech Therapist, Massage Therapist, Psychologist, Chiropractor and Podiatrist/ Chiropodist	$50 per visit, maximum $500/calendar year per practitioner	
ii. Physiotherapist	$600 per calendar year	
iii. Orthopaedic shoes or orthotics	Up to $500 per calendar year	
iv. Other eligible services and supplies *(see pages 52 – 53 for details)*	Reasonable and Customary	

SUMMARY OF HEALTH BENEFITS PLAN CONTINUED...

BENEFIT FOR MEMBERS AND THEIR DEPENDENTS	ACTIVE MEMBER	RETIRED MEMBER (FULL BENEFITS)
VISION CARE		
(i) Eye Exams – Only For Members and Dependents between the ages of 20 and 64	**Claims Paid by** $75 every 24 months	**Administration Office** $75 every 24 months
(ii) Glasses or Contacts (no age limit)	$500/24 months Dependents – $400/24 months	$400/24 months Dependents – $400/24 months
(iii) Laser Eye Surgery (Active Member only)	Up to $2,500 for a 10 Year Period	No coverage
HEARING AIDS		
(no age limit)	**Claims Paid by** Up to $1,000 every 5 years	**Administration Office** Up to $1,000 every 5 years
DENTAL		
(no age limit)	Maximum $2,000/year ($1,000 if coverage begins July 1 or later)	Maximum $2,000/year ($1,000 if coverage begins July 1 or later)
(a) Basic/Preventive	100%	100%
(b) Perio/Endodontic	100%	100%
(c) Major	100%	100%

BENEFIT FOR MEMBERS AND THEIR DEPENDENTS	ACTIVE MEMBER	RETIRED MEMBER (FULL BENEFITS)
DENTAL		
(d) Orthodontic (dependent children 6 years old but not yet 19 only)	50%, $5,000 lifetime max	50%, $5,000 lifetime max
(e) Implants	Lifetime maximum of $6,000	Lifetime maximum of $6,000
(f) Dental Fee Guide	1 year lag *e.g. expenses incurred in 2015 will be paid according to the 2014 ODA Fee Guide*	1 year lag *e.g. expenses incurred in 2015 will be paid according to the 2014 ODA Fee Guide*
DELUXE TRAVEL		
(Member's and Spouse's coverage ends when Member attains age 75)*	*(See Separate Brochure for details)* Out of province/ country coverage while traveling	*(See Separate Brochure for details)* Out of province/ country coverage while traveling
MEMBER/FAMILY ASSISTANCE PROGRAM		
(no age limit) **Confidential counselling for stressful situations such as personal or job stress, family issues, substance abuse, financial or legal concerns**	*(See Separate Brochure for details)* 100% to a Maximum number of sessions	*(See Separate Brochure for details)* 100% to a Maximum number of sessions

* Members under age 70 are eligible for trips lasting up to 60 days. Members between age 70 and 74 are eligible for trips lasting up to 14 days.

BROTHERHOOD PLAN

1. Our Plan does not use an hour bank system (Where a member builds up an individual reserve to fund their Health Benefits). Our plan is a "brotherhood" plan where contributions received are put in a reserve fund to pay for Health Benefits for Active and Retired Members and their dependents. These reserves are also used to pay for Health Benefits for our Active Members and their dependents during periods of unemployment. Active and Retired members must still meet the eligibility criteria of the Plan as outlined in the following pages. Active members must ensure that they work the minimum number of hours as set out by the Trustees. These hours will be reviewed semi-annually by the Trustees.
2. Benefits and eligibility criteria depend both on the contributions received and the Fund Reserves.
3. The Trustees will review the Plan at least once a year for possible changes. All benefits provided by this Plan will be subject to the reserves that are available to pay for benefit costs. **The Trustees may change Active and Retired Member benefits at any time.**

RESIDENCY REQUIREMENTS

1. All active members, retired members and their dependents must be residents of Canada or the United States in order to qualify for benefits of the Plan.
2. **Extended Health Care (excluding vision care and hearing aids) and Deluxe Travel are only available to residents of Canada who have OHIP or comparable provincial medical coverage.**

Active Members

COMMENCEMENT OF COVERAGE

1. When you begin to work for an Employer that is covered under the terms of a Collective Agreement between the U.A. Local 663 and an Employer or an Employer Association:

a) Your Employer is required to make contributions to the Health Benefits Plan on your behalf.

b) You will receive credit for your hours worked if these contributions are made.

2. The hours are recorded in your name. Your benefit coverage begins the first day of the second month after you have worked the minimum number of hours.

EXAMPLE

Minimum number of hours is 300 and you begin to work under a Collective Agreement in March:

Hours worked in March	80
Hours worked in April	123
Hours worked in May	119
Total Hours May 31	322

The Administration Office would receive your hours by June 15, and your benefits coverage would commence on July 1.

3. Before your coverage begins, you must:

- **Be an initiated member of U.A. Local 663** and have 300 hours of Employer Contributions. Hours of Employer Contributions earned in the six months immediately prior to initiation can be credited toward the 300 hour eligibility requirement; **and**
- You must complete your application form for Health Benefits which will include information regarding your marital status and beneficiary designation for life insurance. You must have it signed by the Administration Office staff. *Please refer to page 30 for details.*

CONTINUATION OF COVERAGE

1. You will be eligible for benefit coverage as long as **you are an initiated member of U.A Local 663** and any of the following:

a) You are working for, or are available to work for, a Contributing Employer as determined by U.A. Local 663.

b) You are working on a travel card, under the jurisdiction of another U.A. Local, or you are working under the jurisdiction of another trade union **and the other union local's plan sends reciprocal contributions to our Health Benefits Plan**.

c) You have not reached the age where a specific benefit stops. The age when a specific benefit ceases is shown on the current Benefits Summary.

NOTE:

For a, b & c above, you must have the minimum annual hours of contributions to the plan as shown on your current Benefits Summary to continue your coverage. If you have not worked the minimum number of hours, your coverage must be approved by the Trustees; or you must make Pay Direct payments to the Administration Office to continue your coverage. *Please refer to pages 19 – 20 for details.*

d) If you are receiving benefits from the Workplace Safety Insurance Board (WSIB), your Health Benefits Plan coverage continues as though you were still working. The benefit coverage continues for the time that you are off work and receiving benefits from WSIB, providing that you were an active member of the Plan when you first became disabled. Benefits are continued for a maximum of twelve months as required under the Workplace Safety and Insurance Act. Your benefits may be continued further as approved by the Trustees. It is very important that you notify the Administration Office as soon as possible when you are receiving benefits from WSIB. **The Administration Office will advise you of any required documentation or any forms that you need to provide to the Trustees regarding your WSIB claim.**

e) If you become temporarily or permanently disabled because of an illness or injury that is not work related and you are unable to work for a contributing employer, the continuation of your benefit plan coverage will be considered by the Trustees. It is very important to notify the Administration Office as soon as possible when you become disabled. **The Administration Office will advise you of the required documentation, or any forms that you need to provide to the Trustees regarding your disability**.

NOTE:

If a Member of the U.A. Local 663 Pension Plan terminates their membership from the Pension Plan and withdraws their commuted value or contributions from the Pension Plan, that person will have restrictions placed on eligibility for Health Benefit coverage before retirement or while disabled. ***Please refer to page 25 – 26 for details.***

PAY DIRECT COVERAGE

1. You may pay for the cost of your coverage if you continue to be a member of U.A. Local 663, but you are no longer eligible for the benefit coverage paid for by the Fund because:

a) The Trustees have ruled that you are not eligible because you are not working the required minimum hours; **or**

b) You are not available to work for a contributing Employer because of other interests or you are working at another job outside of the trade. **You must notify the Administration Office immediately when you become unavailable to work for a Contributing Employer.**

2. If you notify the Administration Office immediately once you become unavailable for work because of #1(b) above and you choose the Pay Direct Option then you must remain on Pay Direct until you return to work for a contributing employer

3. If the Trustees have determined that you are no longer eligible for benefit coverage paid for by the fund because of #1(a) above or you did not properly notify the Administration Office because of #1(b) above then you will be notified in writing of the date your benefit coverage will be terminated. If you choose to go on Pay Direct coverage you must remain on Pay Direct until you return to work for a contributing employer and have worked the required minimum hours to be eligible for benefit coverage paid for by the Fund as stated on page 17.

4. Your payments towards the cost of your coverage are called "Pay Direct". The monthly Pay Direct amounts are determined by the Trustees at the end of each calendar year. The fee is based on a standard work year, the current contribution rate, and an administration fee.

5. Please note that if you fail to maintain continuous coverage, you may not be eligible for retired member coverage. Before you begin to Pay Direct, you will be asked to sign a form that **confirms that you understand the eligibility rules for retired member coverage**. *(Please refer to eligibility rules for retired members on pages 23 – 28).*

6. You may continue to Pay Direct for active member benefits as long as you are a U.A. Local 663 member and you have not retired under the U.A. Local 663 Plumbers and Pipefitters Plan.

7. If you stop your Pay Direct payments, your benefit coverage will terminate at the end of the month in which your last payment was made.

8. If you stop your Pay Direct payments, and then later return to work for a contributing employer, you will be treated as a new member of the plan. Your coverage will begin as stated on pages 16 – 17.

TERMINATION OF COVERAGE

1. Your active member benefits will terminate **immediately** if:
   - **a)** You are expelled from U.A. Local 663 (by order of the Executive Board of the Union or through non-payment of union dues as per the Constitution); or
   - **b)** You terminate your U.A. Local 663 membership; or
   - **c)** You reach the limiting age for coverage of a specific benefit.

2. Your active member benefits will terminate at the end of the month in which:
   - **a)** You cease to Pay Direct, or
   - **b)** You retire under the U.A. Local 663 Plumbers and Pipefitters Pension Plan. You may be eligible for

retired members benefit coverage as described on pages 23 – 28.

3. A written notice will be sent by the Administration Office to your last known address to confirm the termination of your benefit coverage.
4. If your benefits are terminated, and you later work for a contributing employer, you will be treated as a new member of the Plan. Your coverage will begin as stated on pages 16 – 17.
5. Your coverage will terminate if you no longer reside in Canada or the United States.
6. Your benefit coverage will terminate if the Trustees discontinue the Plan or if the Insurance policy is terminated and not replaced. You will be advised in writing in advance of the termination of coverage.
7. The Trustees may terminate a specific benefit for which you or your dependents are covered. You will be advised in advance of the termination of a specific benefit.
8. You or your dependents may be eligible for an extension of benefit coverage after your benefits have been terminated, providing that the Plan and the insurance policy have not terminated. These benefits are:

   a) **Member Life Insurance:**

   If your coverage for this benefit terminates before your 65th birthday, your coverage will be extended for 31 days. You have 31 days from the date this benefit terminates to convert your existing coverage to an individual policy. *Please refer to pages 36 – 37 for details.*

   b) **Dependent Spouse Life Insurance:**

   If your spouse is under age 65 when your member life insurance benefit terminates, the spousal life insurance coverage will be extended for 31 days,

to allow for the conversion of the existing spousal life insurance coverage to an individual policy. *Please refer to pages 36 – 37 for details.*

c) Extended Health Benefits:

If you or a dependent are totally disabled when your Major Medical Health Benefits terminate, and you have expenses for that illness which would have been paid had your coverage continued, your benefit payments will continue until the earliest of the following:

i. The second December 31 following the date coverage was terminated. For example, if your coverage was terminated on June 1, 2014, you would be reimbursed for eligible expenses until December 31, 2015.

ii. A period equal to the time the disabled person was continuously covered for benefits prior to the termination date;

iii. The date your spouse or dependent child is no longer eligible for dependent coverage;

iv. 90 days after the insurance company policy terminates;

v. The date on which you have received maximum benefits, if any.

d) Dental Benefits:

i. If benefits for Orthodontic Treatment are in the process of being paid when the dependent's coverage terminates, those benefits for Orthodontic Treatment will be continued during the three month period immediately following termination of benefit.

ii. You may receive payment for accidental injury of your natural teeth. The injury must occur before your dental coverage was terminated, and the injury must be reported to the Insurance Company within the required time. You may receive payment for this expense even if the insurance policy terminates, providing that the accidental injury occurred prior to the termination date of the policy.

Retired Members

COMMENCEMENT OF COVERAGE

1. **You are eligible for FULL Retired Member benefits coverage** if you are a member of U.A. Local 663 when you retire and are receiving a monthly pension from U.A. Local 663 or the U.A. Pipeline Pension Plan, and, you meet one of the following requirements as an Active member of the Health Benefits Plan.

   a) **If you became an active member of the Health Benefits Plan BEFORE June 1, 2007:**

   You were covered continuously as an active member by the Health Benefits Plan for at least **10 consecutive years immediately before retirement**, including periods of active member Pay Direct coverage, providing there was no lapse in payments. You must have had **a minimum of 12,000 hours of contributions** to the Plan during this 10 year period.

   b) **If you became an active member of the Benefits Plan AFTER June 1, 2007:**

   You were covered continuously as an active member by the Health Benefits Plan for at least **15 consecutive years immediately before retirement**, including periods of active member Pay Direct coverage, providing there was no lapse in payments. You must have had **a minimum 18,000 hours of contributions** to the Plan during this 15 year period.

2. **A Tiered Retirement Benefit Plan** has been introduced for those members who do not qualify for Full Retired Member Benefits but could still be eligible for some retiree benefits. Those members will now have the choice of a **Tier II – Intermediate Limited Plan** or a **Tier III – Minimum Limited Plan**. Those retiring members will also have the option of paying the difference to top up to the next tier(s) should they choose to do so, with the approval of the Trustees.

THIS TOP-UP OPTION IS ONLY AVAILABLE PRIOR TO STARTING YOUR RETIREMENT BENEFITS!

a) **Eligibility Requirements for Tier II – Intermediate Limited Plan:**

If you became an active member of the Health Benefits Plan BEFORE June 1, 2007:

You were covered continuously as an active member by the Health Benefits Plan for at least **10 consecutive years immediately before retirement**, including periods of active member Pay Direct coverage, providing there was no lapse in payments. You must have had **a minimum of 10,000 – 12,000 hours of contributions to the Plan during this 10 year period**.

If you became an active member of the Health Benefits Plan AFTER June 1, 2007:

You were covered continuously as an active member by the Health Benefits Plan for at least **15 consecutive years immediately before retirement**, including periods of active member Pay Direct coverage, providing there was no lapse in payments. You must have had **a minimum of 15,000 – 18,000 hours of contributions to the Plan during this 15 year period**.

b) <u>Eligibility Requirements for Tier III – Minimum Limited Plan:</u>

If you became an active member of the Health Benefits Plan BEFORE June 1, 2007:

You were covered continuously as an active member by the Health Benefits Plan for at least **10 consecutive years immediately before retirement**, including periods of active member Pay Direct coverage, providing there was no lapse in payments. You must have had **a minimum of 8,000 – 10,000 hours of contributions to the Plan during this 10 year period**.

If you became an active member of the Health Benefits Plan AFTER June 1, 2007:

You were covered continuously as an active member by the Health Benefits Plan for at least **15 consecutive years immediately before retirement**, including periods of active member Pay Direct coverage, providing there was no lapse in payments. You must have had **a minimum of 12,000 – 15,000 hours of contributions to the Plan during this 15 year period**.

A Benefit Summary for Tier II and Tier III Retired Member Benefits is available from the Administration Office.

3. You will also qualify as a retired member if you retire under the Pension Plan and receive the cash value of your pension because you have a life expectancy of less than two years.

4. Your benefit coverage will change from "active member" to "retired member" benefits when your first pension payment is made from the U.A. Local 663 Plumbers and Pipefitters Pension Plan.

5. Once your retired member benefits commence, you will not be allowed to return to active member status.

6. If a Member of the U.A. Local 663 Pension Plan terminates membership in the Pension Plan and withdraws their

commuted value or contributions from the Pension Plan, that person would have restrictions placed on their U.A. Local 663 health benefits coverage if that person again becomes a Member of the Health Benefit Plan.

That member would not be eligible for retired member health benefit coverage or health benefit coverage while disabled until that person has 15 years of continuous active member health benefit coverage and at least 22,500 hours of employer contributions, from the date the member again becomes an active member of the U.A. Local 663 Health Benefit Plan.

CONTINUATION OF COVERAGE

1. Your coverage will continue if you continue to be a member of U.A. Local 663.

2. The Board of Trustees reviews the retired member coverage on an annual basis. The retired member benefits coverage is determined each January 1 for that calendar year. **The Trustees reserve the right to change or discontinue the benefits coverage.** Alternately, the Trustees may request payment from the retired members to continue the benefits coverage if the reserves of the fund are not sufficient to pay for future benefits coverage.

TERMINATION OF COVERAGE

1. Your retired member benefits coverage will terminate if you:

a) Cease to be a member of U.A. Local 663; or

b) Reach the age when a benefit stops *(refer to your Benefits Summary for details)*.

2. The Trustees may terminate a specific benefit that you or your dependents are covered for. You will be advised in advance of the termination of a specific benefit.

3. Your coverage will terminate if you no longer reside in Canada or the United States.

4. **If your coverage is terminated because you are no longer a member of U.A. Local 663, your coverage cannot be reinstated.**

5. You or your dependents may be eligible for an extension of benefit coverage after your benefits have been terminated providing that the Plan and the insurance policy have not terminated. These benefits are:

   a) **Member Life Insurance:**

   If your coverage for this benefit terminates before your 65th birthday, your coverage will be extended for 31 days. You have 31 days from the date this benefit terminates to convert your existing coverage to an individual policy. *Please refer to pages 36 – 37 for details.*

   b) **Dependent Spouse Life Insurance:**

   If your spouse is under age 65 when your member life insurance benefit terminates, the spousal life insurance coverage will be extended for 31 days, to allow for the conversion of the existing spousal life insurance coverage to an individual policy. *Please refer to pages 36 – 37 for details.*

   c) **Extended Health Benefits:**

   If you or a dependent are totally disabled when your Major Medical Health Benefits terminate, and you have expenses for that illness which would have been paid had your coverage continued, your benefit payments will continue until the earliest of the following:

i. The second December 31 following the date coverage was terminated. For example, if your coverage was terminated on June 1, 2014, you would be reimbursed for eligible expenses until December 31, 2015.

ii. A period equal to the time the disabled person was continuously covered for benefits prior to the termination date;

iii. The date your spouse or dependent child is no longer eligible for dependent coverage;

iv. 90 days after the insurance company policy terminates;

v. The date on which you have received maximum benefits, if any.

d) Dental Benefits:

i. If benefits for Orthodontic Treatment are in the process of being paid when the dependent's coverage terminates, those benefits for Orthodontic Treatment will be continued during the three month period immediately following termination of benefit.

ii. You may receive payment for accidental injury of your natural teeth. The injury must occur before your dental coverage was terminated, and the injury must be reported to the Insurance Company within the required time. You may receive payment for this expense even if the Insurance policy terminates, providing that the accidental injury occurred prior to the termination date of the policy.

Dependents

YOUR DEPENDENT SPOUSE

1. In order for your spouse to qualify as your "dependent spouse" under the Plan, your spouse must be:

- **a)** Legally married to you; **or**
- **b)** A person who has lived with you continuously for at least 12 months and is publicly represented as your common-law spouse. **You must be able to provide proof of this relationship, establish a date of co-habitation and complete the required form.** ***Please refer to page 30 for details.***

2. **You may only cover one spouse at a time.**

YOUR DEPENDENT CHILD

1. Your dependent child is a child who is:

- **a)** Your natural, step-child, adopted child or foster child who resides with you;
- **b)** Dependent on you for financial support and not employed for more than 30 hours a week unless he/she is a full-time student.

Your spouse's child is also eligible if he/she resides with you and your spouse has custody of the child.

2. Your dependent child is covered up to and including age 20. Coverage is continued past age 20 if the child was listed as a dependent at age 20 **and:**

- **a)** Is age 21 to 24 inclusive, and attending a recognized learning institution as a full-time student; or
- **b)** Is age 21 or over and physically or mentally infirm, unable to support himself or herself; and the infirmity began while the child was covered as a dependent

child by the plan. The insurance company will require proof within 30 days that the child becomes eligible for this coverage.

COMMENCEMENT OF DEPENDENT COVERAGE

1. Your dependent spouse and children will be covered the same time your coverage begins, if at the time, they were "dependents" as defined above.
2. You must complete your Application Form and identify your dependents by name and age before their coverage can begin.

DOCUMENTATION REQUIRED FOR MARITAL STATUS AND DEPENDENT CHILDREN

1. **Legally Married**
   - **a)** A copy of your marriage certificate.
   - **b)** A copy of your spouse and dependent children's birth certificates.
2. **Common-Law**
   - **a)** A copy of yours and your spouse's driver's licenses showing that you reside at a common address.
   - **b)** A copy of your T1 Tax Return showing marital status and listing your dependents.
   - **c)** Common law relationship certificate
   - **d)** A copy of your spouse and dependent children's birth certificates.
   - **e)** A date of cohabitation must be established.

CONTINUATION OF DEPENDENT COVERAGE

1. Your spouse and children will be covered for benefits, as long as your coverage continues and they satisfy the definition of dependent as stated above.
2. Your dependent child must be continuously covered as a dependent by the plan. For example, if your child goes to work full-time and later becomes unemployed, their coverage cannot be reinstated.
3. If you removed your spouse as a dependent, their coverage as a dependent spouse may be reinstated at a later date, providing your coverage was not terminated.

IMPORTANT

It is important that you notify the Administration Office immediately if there is any change in your dependent spouse or dependent child status.

If you and your spouse separate and live apart, your spouse will not be eligible for dependent spouse coverage unless you are legally separated. Documentation must be provided to the Administration Office. If you and your spouse divorce, your former spouse will not be eligible for Dependent Spouse coverage.

The Trustees reserve the right to deny the payment of a claim for a benefit and for any future benefits as well as seek reimbursement of past claims, if a member participates in the deliberate provision of wrong information or in any fraudulent practice when filing a claim.

TERMINATION OF DEPENDENT COVERAGE

Your dependents' benefits coverage terminates on the earliest of the date when:

a) Your benefit coverage stops (except in the event of your death);

b) Your dependents become covered as active members by the Plan;

c) Your dependents no longer satisfy the definition of dependent. *Please refer to pages 29 – 30 for details.*

DEPENDENT COVERAGE AFTER YOUR DEATH

If you die while you are covered for benefits, your dependents extended health (as per the benefits summary and subject to applicable age limits), vision care, family assistance program and dental benefits will be continued for up to 36 months following the date of your death. Deluxe travel and dependent life insurance ends upon your death.

Your dependents include your spouse and children who were covered for benefits at the time of your death. It also includes any unborn child(ren), if your wife was pregnant at the time of your death and such child(ren) would have otherwise qualified as "dependent children".

Benefit coverage will continue as long as your dependents satisfy the definition, or up to 36 months, whichever comes first.

Other Information

OPTING OUT OF COVERAGE

If your spouse is employed, he/she may have coverage through another benefit plan.

Your spouse may also be able to cover you and your dependent children for extended health and dental benefits.

You and your spouse should review both plans to decide if you should enroll in this Plan; remain under your spouse's plan, or both. You should pay attention to the differences between

the two plans, and the contributions required. Also note that benefits and coverage during periods of unemployment or disability may differ.

In the event that you decide not to enroll in this Plan within 31 days after you become eligible, you must submit evidence of insurability to obtain coverage for the Deluxe Travel Out of Province/Country Benefits. Evidence of insurability is also required for any of your dependents for whom you do not request coverage within the first 31 days of your eligibility because that dependent is covered by your spouse's plan.

CO-ORDINATION OF BENEFITS

1. In addition to the benefits payable under the extended health and dental coverage under this plan, sometimes a member or dependent is entitled to benefits for the same expenses under an automobile insurance plan or another group or individual insurance plan. For example, both you and your spouse may have family coverage.

2. Should this type of duplication occur, the benefits under this plan will be co-ordinated so that the total benefits from all plans will not exceed the expenses actually incurred. With each claim form you submit, you are required to confirm in writing whether or not coverage is available from another source.

3. Claims are submitted in the following order:

a) Your spouse submits claims to their insurance company, and then to the Plan.

b) If your dependent child is also covered by your spouse's plan, claims should be first submitted to the plan of the adult with the earliest birthday. For example, if your spouse was born in August 1982, and you were born in June 1982, claims would be submitted to your plan first. If the other plan does

not allow for co-ordination, then expenses should be sent to the other plan first.

c) Benefits paid from this Plan may be reduced by the benefits paid from the other plan.

4. The insurance company has the right to collect any excess payments made to you, your dependents and any third parties. The insurance company can also exchange information with others on your expenses if you apply for co-ordination of benefits.

TAX NOTES

The premiums paid for the Life Insurance, Dependent Life Insurance, and AD&D are a taxable benefit. At the end of each year, you will receive a T4A slip showing the premiums paid. This must be included in your income for the year and you must file the T4A along with your annual income tax return. No taxable benefit will be reported for the period during which you paid direct or were on assisted coverage.

You must pay retail sales tax of 8% on all Pay Direct contributions.

CLAIMING YOUR EXPENSES

You must complete, in full, the appropriate claim forms. These forms are available from the Administration Office. You must include all receipts and required documentation before payment will be made. Please also ensure that each receipt shows the patient's name, date, nature of service, and an itemized listing of expenses, along with drug identification numbers and dental procedure codes, if applicable.

Prescription Drugs

For the purchase of prescription drugs, please present your Pay-Direct Drug card to the pharmacist. If your pharmacy is not linked with BCE Emergis, you must complete special

claim forms, which are available at the Administration Office.

Extended Health Care & Dental

These claims should all be submitted to Great-West Life at the address listed below. Please note that a Pre-Authorization must be submitted before any work of $300 or more begins.

Great-West Life Assurance
255 Dufferin Avenue
London ON N6A 4K1
Telephone: 1-800-957-9777
Website: www.greatwestlife.com

No benefits are payable for health expenses submitted more than 15 months after the expense is incurred.

Vision and Hearing Aids

Receipts must be submitted to the Administration Office within one year of the date that a service or supply was received, or within 90 days of the termination of your benefit coverage.

Life Insurance

Please contact the Administration Office for further details.

Accidental Death, Accidental Dismemberment

Claims must be submitted within 90 days of the accident, death, or date of loss. Please contact the Administration Office for further details.

IMPORTANT

The Trustees reserve the right to deny the payment of a claim for a benefit and for any future benefits as well as seek reimbursement of past claims, if a member participates in the deliberate provision of wrong information or in any fraudulent practice when filing a claim.

Health Benefits Coverage

IMPORTANT NOTE:

The information in this section details benefit coverage for active members and retired members eligible for Full Retired Member Benefit coverage subject to the limitations shown on the Benefit Summary pages.

Retired members who are eligible for Tier II or Tier III Retired Member coverage should review their benefit coverage with the Administration Office as some benefit coverage will be reduced or eliminated. *Please refer to pages 23 – 26 for details.*

LIFE INSURANCE

In the event of your death from any cause the Life Insurance benefit will be paid to the beneficiary you have named. This benefit amount will be paid based upon your age. Please refer to your Benefits Summary for details on the amount of coverage and the ages coverage reduces.

The Life Insurance payment will be made to the beneficiary you appointed on your Application Form. If you did not designate a beneficiary, payment will be made to your estate. You may change your beneficiary designation at any time, within limits set by law.

Your beneficiary, or someone acting on their behalf (or on behalf of your estate), should contact the Administration Office to initiate a claim.

The necessary claim forms should be completed and sent to the administrator together with the **ORIGINAL** Death Certificate or the Funeral Director's Statement of Death.

If copies of any of those documents are required, they should be copied **before** submission to the administrator. Neither the originals nor copies will be returned.

Conversion of Member and Spouse Life Insurance:

If any or all of your insurance terminates **at or before age 65**, you may be able to apply for an individual conversion policy.

Application for an individual conversion policy must be made within 31 days after termination of insurance. During this period your life insurance under this plan will remain in force free of charge.

DEPENDENT LIFE INSURANCE

In the event of the death of your dependents the plan will pay the amount listed in the Summary of Benefits on the death of your covered spouse and amount listed in the Summary of Benefits on the death of each of your covered dependent children. Your dependents must be covered for benefits under this Plan when death occurs, and your life insurance coverage must still be in effect.

To initiate processing of a claim, obtain the appropriate forms from the Administration Office. These forms, together with evidence of death and dependent status of the deceased, should be sent to the administrator.

If you require copies of any of those documents, please copy them **before** submission to the administrator. Neither the originals nor copies will be returned.

ACCIDENTAL DEATH BENEFIT – ACE/INA

If your death is the direct result of an accidental bodily injury, and you have not reached the age when this benefit terminates, an accidental death benefit will be paid. Please refer to your benefits summary for the coverage amounts and the age at which this benefit terminates or reduces.

The accidental death benefit is paid as a lump sum, to the beneficiary entitled to receive the life insurance. The benefit is in addition to any life insurance benefit.

To initiate processing of an Accidental Death Claim, your beneficiary should contact the Administration Office for the necessary forms. Please note that this claim requires additional documentation such as:

a) a copy of the newspaper clipping, if any

b) a copy of the autopsy or police report

c) the original Death Certificate or Funeral Director's Statement of Death.

If copies of any of those documents are required, they should be copied **before** submission to the administrator. Neither the originals nor copies will be returned.

The accidental death policy does not cover loss caused by or resulting from any one or more of the following:

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

b) Declared or undeclared war or any act thereof;

c) Accident occurring while the Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by the Company pro-rata for any such period of full-time active duty);

d) Travel or flight in any vehicle or device for aerial navigation that is:

- used for testing or experimental purpose,
- operated by the insured
- owned or leased by the policyholder
- used for fire fighting, pipeline or power inspection

If benefits are payable for accidental death, the Insurance Company will also pay benefits for:

COVERAGE A

Accidental Death and Dismemberment Benefit - Principal Sum Amount which is an amount equal to the Group Life Insurance Policy

COVERAGE B

Repatriation Benefit Maximum Amount: $15,000.

COVERAGE C

Rehabilitation Benefit Maximum Amount: $15,000.

COVERAGE D

Family Transportation Benefit Maximum Amount: $10,000.

COVERAGE E

Spousal Occupational Training Benefit Maximum Amount: $10,000.

COVERAGE F

Home Alteration & Vehicle Modification Benefit Maximum Amount: $15,000.

COVERAGE G

Day Care Benefit Maximum Amount: $5,000.

COVERAGE H

Continuance of Coverage

COVERAGE I

Seat Belt Benefit Maximum Benefit: 10%

COVERAGE J

Special Education Benefit Maximum Benefit: $5,000.

COVERAGE K

Conversion

COVERAGE L

Waiver of Premium

COVERAGE M

Identification Benefit Maximum Benefit: $5,000.

COVERAGE N

Felonious Assault Maximum Benefit: 10%

COVERAGE O

In-Hospital Confinement Monthly Income Maximum Benefit: $10,000.

COVERAGE P

Critical Illness Benefit 10% to a Maximum Benefit: $5,000.

ACCIDENTAL DISMEMBERMENT BENEFIT

If you suffer an accidental loss of any member of the body (hands or feet), or loss of sight, hearing or speech, as the direct result of accidental bodily injury and occurring within 365 days of the accident, a dismemberment benefit will be paid to you. However, not more than one (the largest) of such benefits shall be paid with respect to all injuries resulting from one accident. *Please refer to your Benefit Summary for details on coverage amount and termination age.*

The Principal Sum will be paid for:

- Loss of Life
- Loss of Both Hands or Both Feet
- Loss of Entire Sight of Both Eyes
- Loss of One Hand and One Foot
- Loss of One Hand and Entire Sight of One Eye
- Loss of One Foot and Entire Sight of One Eye Sum

- Loss of Speech and Hearing
- Loss of Use of Both Arms or Both Hands

Two Times The Principal Sum will be paid for:

Total paralysis including:

- Quadriplegia (both arms and legs)
- Hemiplegia (arms and legs on one side)
- Paraplegia (both legs)

Three-Quarters of The Principal Sum will be paid for:

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

One-Third of The Principal Sum will be paid for:

- Loss of Thumb and Index Finger of Same Hand
- Loss of Four Fingers of Same Hand

One-Quarter of The Principal Sum will be paid for:

- Loss of Hearing in One Ear

One-Eighth of The Principal Sum will be paid for:

- Loss of All Toes of Same Foot

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above

the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger, the actual severance through or above the first phalange; with respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand; with regard to toes, the actual severance of both phalanges of all toes of the same foot.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to the Company to be permanent.

Quadriplegia, Paraplegia and Hemiplegia losses are subject to an all policy combined maximum benefit amount of $1,000,000.00.

To initiate processing of a Dismemberment Claim, contact the Administration Office for the necessary forms. These should be completed and sent within 90 days to the administrator together with a written explanation of how the loss occurred.

SHORT TERM DISABILITY (STD) INCOME BENEFITS (ACTIVE MEMBERS UNDER AGE 65)

The plan provides you with regular income to replace income lost because of a disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled or until the end of the benefit period, whichever comes first. Check the **Schedule of Benefits** for the benefit amount, waiting period and benefit period.

- **You must qualify for E.I Sick Benefits to be eligible.**
- STD benefits are payable after the waiting period if disease or injury prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.
- If you have not seen a physician before the end of the waiting period, benefits will not be payable until after your first visit to the physician.
- Separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 2 weeks of continuous full-time work.
- Because your employer contributes to the cost of STD coverage, benefits are taxable.

Other Income

Your STD benefit is reduced by other income you are entitled to receive while you are disabled.

Earnings received from an approved rehabilitation plan are not used to reduce your STD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your weekly earnings before you became

disabled. If it does, your benefit is reduced by the excess amount.

Vocational Rehabilitation Benefits

Vocational rehabilitation involves part-time work with your employer that is intended to help you return to your job or other gainful employment with your employer on a full-time basis. A plan will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations

No benefits are paid for:

Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

- Depending on the severity of the condition, you may be required to be under the care of a specialist.
- If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.
- The scheduled duration of a lay-off or leave of absence.
- This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.
- Any period of employment, except in an approved rehabilitation plan.

- Any period after you fail to participate or cooperate in an approved rehabilitation plan.
- Any period after you fail to participate or cooperate in a recommended medical coordination program.
- Disability due to or associated with cosmetic treatment.
- Any period of confinement in a prison or similar institution.

HOW TO MAKE A CLAIM

Notify the Administration Office of your disability as soon as possible. Obtain a Claim Submission Guide and follow the guide's instructions. Please ensure that your claim is submitted to Great-West Life within 10 days after the onset of your disability. You must also be eligible and apply for Employment Insurance Sick Benefits in order to qualify for Short Term Disability.

O.H.I.P. AND EXTENDED HEALTH COVERAGE

1. **The Ontario Health Insurance Plan (O.H.I.P) covers residents of Ontario for basic hospital, physician and practitioner fees and expenses. The extended health benefit portion of your Health Benefit Plan complements the coverage that O.H.I.P provides.**
2. **You will remain covered by O.H.I.P. as long as you are a resident of Ontario. It is your responsibility to ensure that you and your dependents are covered by O.H.I.P.**
3. **To be eligible for extended health benefits of the Plan, you and your dependents must be covered by O.H.I.P and meet the eligibility requirements of our Plan.**
4. **If you are covered by a comparable provincial (or territorial) Medicare plan of your province of residence, you and your**

dependents are covered for the extended health benefits if you satisfy the other eligibility requirements of the Plan. The Board of Trustees reserve the right to reimburse expenses in excess of O.H.I.P. only, rather than in excess of the Medicare plan of your province. Please contact the Administration Office to clarify your coverage.

5. If you are travelling or working temporarily outside Ontario, or if you move to another province or country, please contact the following parties before you leave:

a) The O.H.I.P. office nearest to you to determine what O.H.I.P or other provincial Medicare plan coverage is available to you and your dependents, and,

b) The Administration Office to determine what extended health benefit coverage is available to you and your dependents.

6. We suggest that you also contact these parties if you will be outside Canada for 60 days or more, or if you or your dependents are residing outside Ontario or outside Canada (including dependents who are attending an accredited educational institution outside Ontario).

You and your dependents are eligible for the Plan's extended health benefits for expenses for services and supplies that are medically necessary and received because of illness or injury.

Reasonable and customary expenses will be paid up to the maximum amounts shown on the current Benefits Summary for services and supplies listed (if received in Canada).

Expenses will be reduced by any amounts you or your dependent is eligible to receive under the Workplace Safety and Insurance Act for work related illness or injury.

SPECIAL NOTE

In an effort to control increasing Health Care costs, UA Local 663 instituted a 2 Day Deductible for Semi-Private Hospital Accommodations. The intent is to have you help manage and protect your plan. You can do this by:

- Making sure you inform the hospital that there is a TWO-DAY DEDUCTIBLE for Semi-Private Accommodations.
- Asking for a copy of your hospital billing on discharge.
- Making sure that you or your Health Plan are not billed for a Semi-Private Room that has been deemed medically necessary. If there was no standard ward accommodation available, you should not be charged for semi-private accommodation.

Your Health Plan will reimburse you if you are billed for the two days of Semi-Private Room. Member must complete a questionnaire from the Administration Office for reimbursement.

Hospital benefits provide protection against the cost of medically necessary hospital charges for which there is no reimbursement from the provincial hospital plan. Hospital benefits cover only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

- For regular hospital room and board, Great-West Life pays up to the usual daily charge of the hospital concerned for semi-private care.
- For hospital room and board required for treatment of a chronic condition, Great-West Life pays the usual daily charge of the hospital concerned for semi-private care up to a maximum amount per day and up to the maximum number of days listed in the Summary of Benefits.

- For palliative care if a patient has a shortened life expectancy of 12 months or less as certified by a licensed physician.
- For confinement in an Intensive Care Unit, Great-West Life pays the reasonable and customary charges.
- If you or one of your dependents is confined in a convalescent hospital, Great-West Life pays up to the usual daily charge of the hospital concerned for semi-private convalescent care, as long as the confinement is recommended by your doctor.
- If you or one of your dependents requires treatment as an out-patient, Great-West Life pays the reasonable and customary charges incurred for services and supplies received for the treatment.
- Great-West Life pays the reasonable and customary charges for other hospital services and supplies received during confinement as a registered bed-patient.

PLEASE NOTE:

Benefits will not be payable for a hospital confinement which started before your insurance became effective.

PRESCRIPTION DRUGS (MEMBER'S AND SPOUSE'S COVERAGE ENDS AT AGE 65)

Prescription Drug benefits provide protection against the cost of medically necessary prescription drugs. Prescription Drug benefits cover only those expenses which are considered reasonable and customary for the drug provided in the area where the expenses are incurred.

Dispensing Fee Limit

You pay any amount over and above the dispensing fee listed in the Summary of Benefits each time a prescription is purchased.

Co-insurance Percentage

Great-West Life pays 100% of the covered capped dispensing fee portion of the drug charge and 95% of the covered ingredient fee portion of the drug charge.

Covered Expenses

Drugs that require a physician's or dentist's prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including:

- Oral contraceptives
- Injectable drugs including vitamins, insulins and allergy extracts and syringes for self-administered injections
- Disposable needles for use with non-disposable insulin injection devices, lancets and test strips
- Extemporaneous preparations or compounds if one of the ingredients is a covered drug

For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan.

Fertility drugs are limited to a lifetime maximum of $5,000. Smoking cessation drugs have a lifetime maximum benefit of $500.

Managing Prescription Drug Costs

The prescription drug landscape is evolving. There has been an emergence of new, high cost specialty medications and biologic treatments plus there has been drug reform related to generic drugs that are increasing the costs for drug plans. Your drug plan has implemented changes to control costs:

- Enhanced Generic Substitution

Under the standard generic substitution contract wording, a plan member is covered for the cost of a brand name drug if

their doctor writes "no substitution" on the prescription. New contract wording states that, **"unless a plan member provides medical evidence that a prescribed drug cannot be substituted; benefits will be based on the cost of the lowest priced interchangeable drug that has the same medicinal ingredients.**

If your doctor prescribes a brand name drug, you can:

- ask your pharmacist for the more cost-effective generic version of the drug, or
- request the brand name drug your doctor has prescribed, and pay the difference in cost between the lowest-priced generic drug and the brand name drug.

However, if your doctor can provide medical evidence supporting the need for the brand name medication, an exception can be requested by having your doctor complete the ***Request for Brand Name Drug Coverage Form***. If your request is approved, you will be reimbursed the cost of the brand name drug, according to the terms of your benefits plan.

Also, the following changes have been introduced. Please contact the Administration Office for details on these changes.

- Prior Authorization
- Patient Assistance Programs
- Health Case Management

These changes plus the 95% co-insurance and capped dispensing fee are designed to optimize your drug plan's value and support the health coverage available to you.

If you are receiving benefits from the Workplace Safety Insurance Board (WSIB), you should first submit your drug claims to the Workplace Safety Insurance Board. Please contact the Administration Office for details.

ATTENTION: MEMBERS AND SPOUSES AGE 65 AND OVER

Prescription drug coverage under the Benefits Plan ends when the member reaches age 65. This also applies to the member's spouse (if applicable) when he or she reaches age 65. The Ontario Drug Benefit Program (ODB) is available through OHIP to residents of Ontario aged 65 and over. If you qualify, ODB will, in most cases, pay the costs of you and your spouse's prescription drugs subject to an annual deductible. Effective August 1, 2011 the $100 ODB deductible will be reimbursed by the Administration Office once proof of payment has been submitted.

VACCINATIONS (MEMBER'S AND SPOUSE'S COVERAGE ENDS AT AGE 65)

The plan will also pay for preventative immunization vaccines and toxoids.

MAJOR MEDICAL BENEFITS

Covered Expenses (Member's and Spouse's coverage ends at age 65)

Purpose

The purpose of the Major Medical and Drug plans is to help 'cushion the blow' in the event that you or your dependents run into high medical expenses. You and the insurance company share the expenses. The insurance company pays for expenses that are:

a) Reasonable and customary for the area where the service or supply is received.

b) Up to the dollar maximum for each service or supply; **and**

c) Incurred by you, or your dependents, before you, your spouse or dependent child have reached the maximum age as described in the Benefits Summary.

Major Medical will pay 100% of all covered expenses for the cost for reasonable and necessary medical services and medical supplies prescribed by a legally qualified physician or surgeon, and in excess of O.H.I.P, where permitted by law.

The maximum amount paid for each visit or calendar year for each practitioner is shown in the current Benefits Summary.

NOTE

Full major medical coverage for **active members** age 65 and over can continue with approval from the trustees.

Effective January 1, 2015 **limited** major medical coverage for **retired members only** age 65 and over was introduced. See benefits summary for details.

Medical Charges

- Doctors' services for treatment provided outside your province of residence
- Ambulance (including licensed air ambulance)
- Treatment by x-ray, radium and radio-active isotopes
- Oxygen
- Blood transfusions
- Injectable drugs when administered by a doctor
- Rental of wheelchair, hospital bed or iron lung
- Splints, trusses, braces, crutches, casts, artificial limbs and eyes and any other prosthetic device required after surgery
- Out-of-hospital services for the following:
  - Treatment of a fractured jaw or of accidental injury to natural teeth within 12 months after the accident.
  - Dental surgery for specific procedures.
  - Lab tests if not covered by your provincial government plan.
  - Out-of-hospital x-rays if not covered by your provincial government plan.

- Out-of-hospital services of a physiotherapist. Benefits are limited to the amount listed in the Summary of Benefits for all visits in any calendar year.
- Services of a Chiropractor, Dietician, Osteopath, Naturopath or Podiatrist/Chiropodist, up to a maximum amount listed in the Summary of Benefits for each visit. Benefits are limited to the amount listed in the Summary of Benefits for all visits by any one type of practitioner in any calendar year.
- Out-of-hospital services of a psychologist up to a maximum of the amount listed in the Summary of Benefits for each visit. Benefits are limited to the amount listed in the Summary of Benefits for all visits in any calendar year.
- Out-of-hospital services of a speech therapist for correction of speech impairments up to a maximum of the amount listed in the Summary of Benefits for each visit. Benefits are limited to the amount listed in the Summary of Benefits for all visits in any calendar year.
- Out-of-hospital services of a licensed massage therapist up to a maximum of the amount listed in the Summary of Benefits for each visit. Benefits are limited to the amount listed in the Summary of Benefits for all visits in any calendar year.
- Out-of-hospital services of a licensed acupuncturist up to a maximum of the amount listed in the Summary of Benefits for each visit. Benefits are limited to the amount listed in the Summary of Benefits in any calendar year.

- Elastic support hose prescribed by a physician.
- Reasonable and customary expenses for one pair of lenses and frames or multi focal lens implant following cataract surgery to a lifetime maximum of $450 for each eye.
- Orthopedic shoes prescribed by a doctor, including custom-made foot orthotics and modifications and adjustments to stock item footwear. Benefits for these expenses are based on reasonable and customary charges limited to the amount listed in the Summary of Benefits in any calendar year.

Expenses Not Paid by Major Medical

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid for the following:

- Dental services, except those listed as covered expenses
- Cosmetic surgery or hospital confinement for cosmetic surgery, except to correct deformities resulting from illness or injury or such congenital defects as interfere with function
- Routine medical examinations
- Pregnancy tests
- Eye tests and eyeglasses
- Hearing tests and hearing aids
- Hospital charges (These services are covered under the Hospital Insurance described earlier in this booklet.)

NOTE:

It is illegal for the plan to pay for any doctor's services if those services are performed in the Province of Ontario or Province of residence. These services are covered by the Provincial Government Plan. It is also illegal for the plan to pay the difference between the doctor's charge and the government payment.

VISION CARE (NO AGE LIMIT EXCEPT FOR EYE EXAMS)

The plan will assist you or your dependents with your vision care expenses received in Canada or the United States.

You and your dependents are each entitled to receive benefits for the expenses of prescription lenses and attached frames, or contact lenses each 24 months. The maximum amount paid is shown on the Benefits Summary.

Eye Exams for Members and Dependents between the ages of 20 and 64 are eligible for reimbursement for one Eye Exam every 24 months. The maximum amount paid is shown on the Benefits Summary.

The expenses for vision care are paid from the Fund, and they are not covered by a policy with an insurance company. The payment of the vision care expenses is dependent on the availability of reserves in the Fund.

If you or your dependents have cataract surgery, the insurance company will pay reasonable and customary expenses of one pair of lenses and frames or multi focal lens implant following cataract surgery to a LIFETIME MAXIMUM OF $450. **Note: This only applies to members and spouses under the age of 65.**

Active Members Only:

Active members who decide to have laser eye surgery can have expenses reimbursed up to a maximum amount shown on the Benefit Summary. If you use this benefit, you will not be eligible for Vision Care Coverage for up to 10 years. You must sign a waiver form which releases Local 663 and the Health Benefit Trustees from any liability as a result of complications of your laser eye surgery. **Your dependents are not eligible for this benefit.**

HEARING CARE (NO AGE LIMIT)

You and your dependents are entitled to receive benefits for hearing aids (and their replacement and repair) expenses received in Canada or the United States, up to the maximum amount shown on the Benefits Summary.

The covered expenses for hearing aids are paid from the Fund. That is, the expenses are not covered by a policy with an insurance company. The payment of the hearing aid expenses is dependent on the availability of reserves in the Fund.

DENTAL CARE (NO AGE LIMIT)

Dental Care Benefits have been designed to help you pay for your family's dental expenses, both for routine care and for expensive and unforeseen treatments.

The insurance company shares in your dental expenses by paying for covered expenses:

a) That are reasonable and customary for the area where the service is received,

b) That are necessary treatments for the prevention of, or correction of, dental disease or defect or the correction of accidental dental injury,

c) Up to the fees for each service or supply listed in the Ontario Dental Association (ODA) Fee Guide in the year approved by the Trustees,

d) Up to the dollar maximum amount paid for routine and major dental services for each person or the lifetime dollar maximum for orthodontic treatment, and

e) Up to the percentage of the expenses covered by the Plan.

The approved ODA Fee Guide, the dollar maximum amounts paid and the percentage paid by the plan are shown on the current Benefits Summary. The Trustees intend to cover expenses up to the ODA Fee Guide amounts of one calendar years earlier. **For example, in 2015, the fees listed in the 2014 ODA Fee Guide will be the maximum fees paid by the Plan.**

The general practitioner fees in the ODA Fee Guide will apply unless the service is rendered by:

a) A specialist and the fee guide includes a separate guide for that specialty, or

b) A dental assistant or denturist that is a member of a group with their own official fee guide (in which case such official fee guide maximum will apply)

We refer to the expenses or charges of a dentist in this booklet.

A "dentist" includes:

a) A dentist or oral surgeon qualified and legally licensed to practice dentistry where the service provided is within the scope of his license,

b) A physician or surgeon legally licensed to practice medicine,

c) A dental assistant qualified to perform the service such as a dental hygienist working under the direct supervision of a dentist, and

d) A denturist, such as a dental therapist, and denturoligist, qualified to perform the service and who practices in a geographic location where he is legally permitted to deal with the public.

Covered Expenses

The following expenses will be paid up to the amounts as described in your Benefits Summary, for dental treatments in Canada or the United States, that began after you or your dependents became covered by the plan.

Routine Maintenance and Preventative Services

1. Oral examinations, topical application of fluoride solutions and bite wing X-rays, twice in any calendar year but not more than once in any five-month period.

2. Scaling of teeth including supra and sub-gingival scaling (one unit) and polishing twice in any calendar year but not more than once in any five month period.

3. Full mouth series of X-rays once every twenty-four months.

4. Extractions and alveolectomy at the time of tooth extraction.

5. Amalgam, silicate, acrylic and composite fillings.

6. Necessary treatment for relief of dental pain.

7. Antibiotic medication administered in the dentist's office.

8. Provision of space maintainers for missing primary teeth and provision of habit breaking appliances.
9. Consultations required by the attending dentist.
10. Surgical removal of tumours, cysts, neoplasm, incision and drainage of abscesses.
11. Surgical extraction of impacted teeth and surgical preparation of dental ridges for prosthetic appliances.
12. Pit and fissure sealant.
13. Diagnostic X-ray and laboratory procedures required in relation to oral surgery.
14. General anaesthesia required in relation to oral surgery.

Endodontics/Periodontics

1. Endodontics (root canal therapy).
2. Periodontal treatment or the prevention and treatment of the disease of the bone and from around the teeth, including up to 6 units of scaling per year.

Major Treatments

1. Crowns and inlays (including gold fillings).
2. Initial bridgework or partial, or complete removable dentures or implants if required because at least one additional natural tooth had to be extracted after Plan coverage began. Implants are covered to a LIFETIME maximum amount listed in the Summary of Benefits.
3. Partial or complete dentures including denture repair, replacement, relining and rebasing, and addition of new teeth.
4. Replacement bridgework (fixed partial denture) or partial or complete removable dentures or implants if:

i) required because of the extraction of at least one additional natural tooth after Plan coverage began and the existing appliance could not be made serviceable. If the appliance could be made serviceable, only the expense for the portion of the appliance that replaces the extracted teeth is covered.

ii) the existing appliance is at least 5 years old and cannot be made serviceable, or

iii) the existing appliance was temporarily installed within the last 12 months and while the person was covered under the Plan, or

iv) the replacement appliance is required because of an opposing denture or bridge that was initially installed when the person was covered under the Plan, or

v) the replacement appliance is required because of accidental bodily injury to the person while covered under the Plan.

The Plan will pay for the least expensive treatment that is consistent with generally accepted dental practice.

For example, use of gold is covered only if the treatment could not be rendered at a lower cost by other means.

THE MAXIMUM ANNUAL BENEFIT FOR ROUTINE AND MAJOR TREATMENT PER INDIVIDUAL IS LISTED IN THE BENEFITS SUMMARY (COVERAGE THAT BEGINS JULY 1ST OR LATER IS HALF OF THE ANNUAL BENEFIT)

Orthodontic Treatments

1. **Orthodontic Treatments:** for dependent children that begin during the allowed ages as shown on the Benefits Summary. Orthodontic treatment includes the diagnosis or correction of teeth irregularities and malocclusion of the jaw by wire appliances, braces or other mechanical aids, including orthodontic appliances for the purposes of moving or repositioning the teeth.

2. Because orthodontic treatment is normally provided over a long period, expenses are considered to be spread over the "treatment period", regardless of the way in which the orthodontist's bill is actually paid. Benefits will be paid to you at the end of each three months during the treatment period.

   a) **Single Charge Basis:** If your orthodontist submits a cost estimate showing a single charge for the total treatment, then the single charge is divided by the number of months of the treatment period. The covered amount is then paid each month.

   b) **Itemized Basis:** If your orthodontist estimates a separate cost for initial appliances (i.e. braces) the first month's covered expense is considered to be the lesser of:

      - The estimated cost of these appliances, or
      - 25% of the total estimated orthodontic covered expense.

The remainder of the orthodontic expenses are averaged over the remaining months of the treatment period.

The amounts that are paid may be adjusted if the actual expenses or the treatment period change.

Dental Expense Pre-authorization

Any dental treatment, or series of treatments, expected to result in a charge in excess of $300 must be submitted to the insurance company before treatment begins. A "treatment plan" is the dentist's written report, describing the recommended necessary treatment and the estimated cost.

A treatment plan must be submitted for all major and orthodontic treatment.

Note that for any claim to be paid you must be eligible for benefits when the procedures are performed or when any appliances are installed.

Exclusions

1. Treatment rendered mainly for cosmetic purposes (simply to improve appearance).

2. Treatment furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits.

3. Treatment received from a dental or medical department maintained by an employer.

4. Fixed bridgework which is in excess of the reasonable and customary charge that would have been made if the replacement of teeth could have been accomplished by a partial denture.

5. Replacement of an existing appliance (e.g. fixed bridgework, removable partial or complete denture) unless:

- **a)** the replacement appliance is required because of the extraction of one or more natural teeth after the effective date of coverage, or
- **b)** the existing appliance is at least five years old and cannot be made serviceable, or
- **c)** the existing appliance is only temporary and is replaced with a permanent appliance while the coverage is in effect and within 12 months of installation of the temporary appliance, or
- d) the replacement denture or bridgework is made necessary as the result of an initial placement of an opposing denture while covered, or
- **e)** the replacement denture or bridgework is made necessary as the result of an accidental bodily injury while covered.

6. Replacement of dentures lost, mislaid, or stolen.

7. Dental treatment resulting from war, engaging in a riot, or self-inflicted injury.

8. Charges made by a dentist for broken appointments or for completion of claim forms required by the plan.
9. Services or supplies rendered for full mouth reconstructions, for vertical dimension correction or for correction of temporal mandibular joint dysfunction.
10. Treatment that is experimental in nature.
11. Expenses for accidental injury to natural teeth incurred more than 6 months after the accident.
12. Orthodontic treatment except for dependent children who are at least 6 years old but not yet 19.
13. Services or supplies received while not ordinarily resident in Canada.

RSA DELUXE TRAVEL (MEMBER'S AND SPOUSE'S COVERAGE ENDS WHEN MEMBER ATTAINS AGE 75)

You and your dependents are eligible for out of province/country coverage while traveling.

This includes reasonable and customary fees for unexpected illness or accident for the first 60 days of a valid trip for members under the age of 70 and the first 14 days of a valid trip available for members age 70 up to age 75.

Note: Benefits are not payable for a medical condition for which prior to departure medical evidence would suggest a reasonable expectation that treatment or hospitalization would be required on your trip. See separate brochure for more details.

MEMBER/FAMILY ASSISTANCE PROGRAM (NO AGE LIMIT)

You and your dependents are eligible for confidential counselling in dealing with stressful situations such as personal or job stress, family issues, substance abuse, financial or legal concerns.

See separate brochure for more details.

Pension Plan

GOVERNMENT REGISTRATION

The U.A. Local 663 Plumbers and Pipefitters Pension Plan (the Pension Plan) is registered with the Financial Services Commission of Ontario – Pension Plans Branch, in accordance with the Pension Benefits Act of Ontario, and with the Canada Revenue Agency, in accordance with the Income Tax Act, under Registration Number **0547927**.

PURPOSE

The purpose of the Pension Plan is to help you meet your financial needs during retirement. You must be retired from the U.A. Local 663 and the trade to qualify for a pension.

The Pension Plan may not provide for all of your retirement needs when added to the government benefits that you may receive. You will probably want to, or need to, increase your pension income by saving now. The earlier you start to plan and save, the earlier you will be able to retire.

EFFECTIVE DATE

The Effective Date of the Pension Plan is May 1, 1968.

1. WHEN AND HOW DO I JOIN THE PENSION PLAN?

If you are an initiated member of U.A. Local 663, you will become an active member of the Pension Plan on the first day of the month following the month in which you earned 700 hours for which Employer contributions have been remitted to the Pension Plan on your behalf within a continuous 24-month period.

You must also complete an application form that includes your marital status *(see questions 2 and 3)* and the Beneficiary that you designate to receive any death benefit paid from the Pension Plan. If you wish to designate a Beneficiary who is not your Spouse, you and your Spouse must complete and sign a prescribed Spousal Waiver of Pre-Retirement Death Benefit form. It is very important that you contact the Administration Office as soon as possible if there are any changes in your marital status or your designated Beneficiary. All changes must be documented and, if applicable, written documentation containing your date of legal separation or divorce must be provided.

Your Pension Plan membership is the years and months you continue to be in the Pension Plan (including any transferred pension plan membership under a Reciprocal Agreement) before you terminate, retire or die.

You have an irrevocable entitlement to the pension that you have earned under the Pension Plan once you become vested. The vesting requirement for the Pension Plan, is immediate (i.e., is achieved as soon as you become a member of the Pension Plan). Please note that even though your pension is vested, it is still subject to future increases or decreases *(see question 7)*.

2. WHO IS A SPOUSE?

A Spouse is a person to whom you are:

a) Legally married and who is not living separate and apart from you; **or**

b) Not married but who is living with you in a conjugal relationship which:

- **i.** has continued for a continuous period of not less than three years; or
- **ii.** is of some permanence, where the two of you are the natural or adoptive parents of a child.

The determination of a Spouse is done at your date of retirement or, if you die prior to your retirement, your death. You can have only one Spouse under the Pension Plan.

3. WHAT INFORMATION IS REQUIRED AS PROOF OF MARITAL STATUS?

If you do not have a Spouse, no proof of marital status is required.

If you are legally married to your Spouse, you will be required to provide:

a) A copy of your marriage certificate; **or**

b) A copy of your most recent T1 tax form (that contains *Married* marital status on the upper-right corner of the first page).

If you are in a common-law relationship, you will be required to provide the date on which your common-law union commenced. In addition, you will be required to provide:

a) A copy of your and your common-law spouse's driver licenses (showing the same address); or

b) A copy of your most recent T1 tax form (that contains *Living common-law* marital status on the upper-right corner of the first page).

c) Common law relationship certificate.

4. WHAT INFORMATION WILL I GET ON MY PENSION BENEFITS?

Each year, you will receive a statement showing the amount of pension benefit that you have earned under the Pension Plan and when you can retire.

When you are ready to retire, you will be provided with a retirement statement setting out your pension entitlement and the options available to you.

5. HOW DOES MY MEMBERSHIP IN THE PENSION PLAN AFFECT MY INCOME TAX AND RRSP ROOM?

All contributions to the Pension Plan are made by your Employer, not by you, so you cannot deduct them from your income for tax purposes. By the same token, they will not be added to your income so you will have no additional tax to pay. However, they will affect how much you can contribute to your own RRSP.

The amount of the contributions will be reported as a Pension Adjustment on your T4.

The maximum contribution that you can make to your RRSP is 18% of your earned income in the previous year (to a maximum of $24,930 for 2015 and indexed thereafter) minus the Pension Adjustment reported on your T4 for the previous year. Any unused RRSP contribution room can be carried forward. The Canada Revenue Agency will report to you the amount that you can contribute to your RRSP each year as part of your annual Notice of Assessment.

6. WHO ADMINISTERS THE PENSION PLAN AND THE TRUST FUND?

The Pension Plan and Trust Fund are administered by a Board of Trustees. The Trustees are elected by members of the Plan.

The Trustees appoint professional advisors to assist them in the administration of the Pension Plan and the Trust Fund.

7. HOW IS THE PENSION PLAN FINANCED?

Your Employer makes contributions on your behalf to the Pension Plan for the hours that you work. The contribution amounts that are to be paid to the Pension Plan are set out in the applicable Collective Agreements.

Contributions are credited for the first twelve months that you receive workers' compensation benefits. Contributions may be received from another pension plan if you are on a travel card or on permit *(see question 27)* and there is a Reciprocal Agreement between that plan and your Pension Plan.

Your contributions and hours will be recorded under your name and will help to determine the amount of your Pension Plan benefit.

The contributions are deposited into a Trust Fund with a professional trust company. The Plan's assets are professionally managed by the investment managers. The Board of Trustees appoints both the trust company that holds the assets of the Trust Fund and the investment managers.

At least every three years, the Trustees must ask the actuary to evaluate the Pension Plan. The actuary compares the assets of the Trust Fund to the liabilities (the present value of future benefit payments). The Trustees then decide if benefit changes are to be made.

The Trustees reserve the right to increase or decrease the benefits to be paid in the future to all members and beneficiaries under the Pension Plan based upon the valuation completed by the actuary. The investment earnings of the Trust Fund, the actual experience of the Plan compared to the assumptions made by the actuary, and the costs of administering the Pension Plan will determine the benefit amounts that can be paid.

8. WHAT ARE MY RIGHTS TO MY PENSION PLAN BENEFIT?

The Pension Plan Trust Fund is the sole source for the payment of benefits. Any Pension Plan benefits due to you or your Spouse, former Spouse, dependents, Beneficiary, or estate will be due and paid only from the Trust Fund. All benefits that are payable will be paid under the terms of the Pension Plan.

As a general rule, the contributions and benefits in the Pension Plan may not be sold, used as collateral for a loan, given away, or otherwise transferred. In addition, your creditors may generally not attach or garnish the contributions or benefits.

Any benefits paid to you or your Spouse, dependents, Beneficiary, or estate will be subject to any payments due to your former Spouse as determined by a Court Order or through a Domestic Contract as defined in the Family Law Act.

9. WHAT IS MY NORMAL RETIREMENT DATE?

The normal retirement date is the first day of the month coinciding with or next following your 65th birthday. Normal retirement is the point at which you are entitled to receive your full pension for all of your service.

10. MAY I RETIRE EARLIER THAN AGE 65?

Yes. You may retire with a reduced pension any time after you have attained age 55. The reduction addresses the fact that since your pension starts earlier, you are expected to collect it for more years.

11. EARLY RETIREMENT FACTORS

If you satisfy one of the following two criteria:

a) You joined the Pension Plan prior to January 1, 2005; or

b) You joined the Pension Plan on or after January 1, 2005 and have at least fifteen (15) years of Continuous Plan Membership as an Active Member immediately before retirement;

then, if you retire prior to age 65, the Trustees **may** give their consent to apply one of the following enhanced early retirement factors:

- If you retire on or after age 60, there will be no reduction; **or**
- If you retire between age 55 and 60, the pension benefit will be reduced by 0.5% for each month that your retirement precedes age 60.

The following table shows what your pension amount would be if the above enhanced early retirement factors were applied, assuming that you were entitled to a pension of $100.00 per month if you retired at age 65, and decided to retire early on the 1st of the month following attainment of the ages shown in the following table:

EARLY RETIREMENT FACTORS WITH TRUSTEE CONSENT	
EARLY RETIREMENT AGE	MONTHLY EARLY RETIREMENT PENSION EQUIVALENT TO $100 FROM AGE 65
55	$70.00
56	$76.00
57	$82.00
58	$88.00
59	$94.00
60	$100.00
61	$100.00
62	$100.00
63	$100.00
64	$100.00

If the Trustees do not give their consent for an enhanced early retirement factor or you do not meet the 15 years of Plan membership criterion for members who joined the Plan on or after January 1, 2005, your pension will be actuarially reduced so that the cost to the Plan for starting your pension early is the same cost as if you waited and started it at age 65. This type of reduction depends on current interest and mortality rates, but usually results in a reduction of approximately 0.5% for each month prior to age 65.

If you are eligible for a Terminated Pension benefit *(see questions 23 and 24)*, regardless of the above, your pension will be reduced if you decide to start receiving your pension any time within the 10 years prior to your reaching age 65. The amount of reduction will depend on the Plan provisions in effect on your date of termination. You should contact the Administration Office to determine the reduction applicable to your specific situation.

12. MAY I RETIRE LATER THAN AGE 65?

Yes, but you must start collecting your pension benefit by December 1st of the year that you reach age 71, even if you continue to work.

You will continue to earn additional pension credits after age 65 provided that pension contributions continue to be made on your behalf. However, contributions and hours cannot be credited on or after December 1 of the calendar year in which you reach age 71.

13. MAY I RETURN TO WORK AFTER RETIREMENT?

Yes. If you return to work after you have retired and contributions are being remitted to the Trust Fund on your behalf, the Income Tax Act gives you two options:

a) You may continue to receive your monthly pension as a retired member. No additional contributions, hours, or pension will be credited to you during your period of re-employment; or

b) You may stop your monthly pension payments and earn additional pension benefits under the Pension Plan during your period of re-employment. You will become an active member of the Pension Plan on the date you return to work. When you decide to retire again, you will once again commence to receive your monthly pension payments earned prior to your re-employment. In addition, you will receive the additional benefit earned during your period of re-employment.

Prior to your re-employment, you must complete and file a Re-Employment Election Form with the Administrative Office. **If you do not file this election form prior to your re-employment, you will be deemed to elect option (a) above.** If you elect or are deemed to elect option (a) above, you will have no claim on any contributions made on your behalf during your period of re-employment.

14. HOW DO I APPLY FOR MY PENSION?

You should contact the Administration Office at least three months before you plan to retire to allow enough time to complete all of the necessary paperwork. You will be asked to make your pension election in writing, confirming your marital status and your Beneficiary if the death benefit is not paid to your Spouse *(see question 1)*. You will also need to provide proof of your age and, if applicable, your Spouse's age or your dependent's age.

15. WHEN DO PENSION PAYMENTS COMMENCE?

All pensions are paid on the first day of the month. The first payment is for the month after your completed application is approved by the Trustees and received by the administrator or on a later date if that is what you have requested. Your pension will be paid to you on the first of every month for the rest of your lifetime.

16. HOW MUCH PENSION WILL I RECEIVE?

Your pension is the sum of your Past Service Pension and your Future Service Pension.

1. **Past Service Pension**

   For each year of Past Service, you receive a monthly pension of $8.33.

   Your Past Service is the number of years and completed months that you were a member of U.A. Local 663 from your most recent initiation date up to and including April 30, 1968, calculated to the nearest $^{1}/_{10}{}^{th}$ of a year to a maximum of ten years.

2. Future Service Pension

Your Future Service Pension is based on hours worked. The current pension rates per 100 hours are:

Future Service	Monthly Pension
Prior to January 1, 2001	$4.48
January 1, 2001 to December 31, 2008	$4.68
On and after January 1, 2009	$5.06

Your Future Service is the hours that you worked or earned after April 30, 1968 for which contributions were made to the Pension Plan. Hours are also credited for:

a) contributions or funds transferred from another pension plan under a Reciprocal Agreement; **and**

b) contributions received from your Employer during the first twelve months you are receiving workers' compensation benefits as a Pension Plan member.

If you became a Pension Plan member after January 1, 1996 and the Employer contributions were at a lower rate, because, for example, you were an apprentice, your Future Service pension will be reduced accordingly. If, for example, your Employer contributed at half the journeyman rate, your pension will be half the regular Future Service Pension (i.e., $5.06 for each 100 hours would be reduced to $2.53).

17. PENSION EXAMPLES

These pension amounts are payable in the Normal Form *(see question 20)*. Optional forms *(see question 21)* are available subject to an adjustment in the amount of monthly pension.

EXAMPLE 1

Assumptions:

1. You are age 65 and retiring on your normal retirement date.
2. You have earned 41,700 hours of Future Service up to January 1, 2001, 18,300 hours of Future Service between January 1, 2001 and December 31, 2008, and 11,200 hours of Future Service after December 31, 2008.

Your monthly pension would be:

(a)	Pre-2001 Service:		
	41,700 hrs x $4.48/100 hrs	=	**$1,868.16**
(b)	2001 – 2008 Service:		
	18,300 hrs x $4.68/100 hrs	=	**$856.44**
(c)	Post-2008 Service:		
	11,200 hrs x $5.06/100 hrs	=	**$566.72**

Total Monthly Pension: **(a) + (b) + (c)**	=	**$3,291.32**

EXAMPLE 2

Assumptions:

1. You are age 60.
2. You have at least fifteen (15) years of continuous Plan membership as an Active Member immediately before retirement or you joined the Pension Plan prior to January 1, 2005.
3. You are retiring on the first day of the month following your 60th birthday.
4. You have earned 26,000 hours of Future Service up to January 1, 2001, 16,600 hours of Future Service between January 1, 2001 and December 31, 2008, and 10,000 hours of Future Service after December 31, 2008.
5. The Trustees give their consent to apply the enhanced early retirement factors applicable between the ages of 55 and 65 years.

Your monthly pension at retirement would be:

(a)	Pre-2001 Service: **26,000 hrs x $4.48/100 hrs**	=	**$1,164.80**
(b)	2001 – 2008 Service: **16,600 hrs x $4.68/100 hrs**	=	**$776.88**
(c)	Post-2009 Service: 1**0,000 hrs x $5.06/100 hrs**	=	**$506.00**
(d)	Early retirement reduction factor:		**100%**

Total Monthly Pension:
[**(a)** + **(b)** + **(c)**] x **(d)** = **$2,447.68**

EXAMPLE 3

Assumptions:

1. You are age 58.
2. You are retiring on the first day of month following your 58th birthday.
3. You have at least fifteen (15) years of continuous Plan membership as an Active Member immediately before retirement or you joined the Pension Plan prior to January 1, 2005.
4. You have earned 27,500 hours of Future Service up to January 1, 2001, 11,950 hours of Future Service between January 1, 2001 and December 31, 2008, and 10,250 hours of Future Service after December 31, 2008.
5. The Trustees give their consent to apply the enhanced early retirement factors applicable between the ages of 55 and 65 years.

Your monthly pension at retirement would be:

(a)	Pre-2001 Service:		
	27,500 hrs x $4.48/100 hrs	=	**$1,232.00**
(b)	2001 – 2008 Service:		
	11,950 hrs x $4.68/100 hrs	=	**$559.26**
(c)	Post-2009 Service:		
	10,250 hrs x $5.06/100 hrs	=	**$518.65**
(d)	Early retirement reduction factor:		**88%**

Total Monthly Pension:		
[**(a)** + **(b)** + **(c)**] x **(d)**	=	$2,032.72

Any pension benefit paid from this Pension Plan is paid in addition to any benefit you, or your Spouse, may receive from the Canada Pension Plan, Old Age Security, your personal RRSPs, or any other pension plan.

If your pension begins before all of the contributions have been received from your Employer, the pension will be increased when the contributions have been received and processed by the Administration Office. The increase in your pension will be retroactive to the date on which you retired.

18. DO I PAY TAXES ON MY PENSION?

You will be required to pay income tax on any amounts that you may receive from the Pension Plan. In certain circumstances, however, you may be able to transfer the amount of the benefit to another retirement savings vehicle without any tax being withheld. Starting in 2007, you may be able to split your pension income with your Spouse for the purpose of preparing your income taxes *(see question 22)*.

19. MAY I RECEIVE BENEFIT INCREASES?

Periodically, improvements in the pension rates may be given to "Active" members. An "Active" Member is a member of the Pension Plan who has not retired and who is a member of U.A. Local 663, and has had a contribution made on his or her behalf to the Pension Plan for hours worked or earned in the last 24 months, unless contributions have not been made because a member is disabled *(see question 30)*, as approved by the Board.

If a Pension Plan member does not qualify as an "Active" Member, the benefit improvements do not apply to that member. For example, if a U.A. Local 663 member last worked for a contributing employer in January 2013 and the pension is improved for all "Active" Members on May 1, 2015, this member will not be eligible for the improvement.

Each statement that you get from the Administration Office will show the amount of Pension Benefit that you have earned.

Periodically, the Board of Trustees may increase the pensions being paid to retired members. These increases also apply to Spouses or Beneficiaries who are receiving monthly pension payments from the Pension Plan.

20. WHAT IS THE NORMAL FORM OF PENSION?

Normal Form – Member with a Spouse

If you have a Spouse on your date of retirement, your pension will be paid for at least 60 months after you retire. In other words, if you die before you have received payments for 60 months, the full amount of your monthly pension will continue to be paid to your Spouse, if still living, for the remaining months.

After your death (or the 60 guaranteed months), your Spouse will receive a monthly pension of 65% of the monthly pension that you were receiving immediately prior to your death for the rest of his or her lifetime.

EXAMPLE 1

Assumptions:

1. You retired on the first day of the month following your 65th birthday and your Spouse was age 61.
2. Your pension was $2,500 per month.
3. You died exactly four years (that is, 48 months) after starting to receive your monthly pension payments and your Spouse is still alive.

Your Spouse would receive a monthly pension of $2,500 per month for the remaining 12 months of the guaranteed period and, thereafter, $1,625 (65% of your monthly pension) per month for the rest of his or her lifetime.

If you die before you have received payments for 60 months and your Spouse is not alive, or dies before the remainder of the 60 monthly payments have been made, then the Beneficiary you have designated, or your Estate, will receive a lump sum equal to the actuarial present value of the 60 monthly payments, less the number of payments made to you and your Spouse.

EXAMPLE 1A

Using the same scenario as Example 1, assume that you die at age 85 – after 20 years of retirement.

You will have received your full pension ($2,500 per month) until your death. After that, your Spouse will receive a monthly pension of $1,625 for the rest of his or her life. There are no further pension benefits payable after both you and your Spouse have died, since you have received more than the guaranteed 60 months of pension.

EXAMPLE 2

Assumptions:

1. You retired on the first day of the month following your 65th birthday and your Spouse was age 61 years.
2. Your pension was $2,500 per month.
3. You died exactly two years (that is, 24 months) after starting to receive your monthly pension payments and your Spouse was still alive.
4. Your Spouse died exactly 1 year (that is, 12 months) after you died.

Your Spouse would receive a monthly pension of $2,500 for the remainder of his or her lifetime (12 months) and your designated Beneficiary, or Estate, would receive the lump sum value of the remaining 24 monthly payments (i.e., 60 monthly payments guaranteed MINUS 24 monthly payments made to you MINUS 12 monthly payments made to your Spouse = 24 monthly payments remaining).

Normal Form – Member without a Spouse

If you do not have a Spouse at retirement, then your pension will be paid for at least 180 months (15 years) after you retire. If you die during the first 180 months after retirement, the pension will be continued to your designated Beneficiary for the remainder of the 180 months. Your Beneficiary may elect to receive a lump sum payment equal to the actuarial present value of the 180 monthly payments, less the number of payments made to you, instead of periodic monthly payments. If you have not designated a Beneficiary, this lump sum value will be paid to your Estate.

21. ARE THERE OPTIONAL FORMS OF PENSION?

Yes. If you are planning to retire you should contact the Administration Office and they will explain the different optional forms of pension available to you.

You can elect one of the following optional forms of pension by filing the appropriate forms with the Administrative Office before you retire *(see question 14)*.

Once you commence your pension, you cannot change the form of pension that you elected prior to your retirement. The optional forms of pension include:

a) A pension payable for your lifetime, guaranteed for 120 monthly payments, with 60% of your pension continuing to your Spouse after your death;

b) A pension payable for your lifetime only with no death benefit payable;

c) A pension payable for your lifetime, guaranteed for a minimum of 60, 120, or 180 monthly payments; **and**

d) A pension payable for your lifetime with a percentage (between 50% and 100%) of your pension continuing to your Spouse or qualifying dependent after your death. The Administrative Office will provide information on who qualifies as a dependent if you are considering this option.

The amount of your optional pension will depend on the amount of normal pension that you have earned, your age at retirement, your marital status, and your Spouse's or dependent's age, if applicable, at your retirement. Election of one of the optional forms of pension will result in a change in the amount of your monthly pension. The amount of your pension under the optional form may be higher or lower than your normal pension amount; however, the present value of the total benefit to be paid to you and your survivors will be the same as the present value of your normal pension.

When considering an optional form of pension payment, you should note that pension legislation requires that if you have a Spouse at retirement, your Spouse must receive a survivor pension of not less than 60% of your pension in the event of your death. This requirement can be waived if both you and your Spouse sign a prescribed waiver form within 12 months before you retire. We suggest that you and your Spouse seek independent legal advice before signing the waiver form.

22. HOW DO I SPLIT MY PENSION WITH MY SPOUSE?

The Income Tax Act allows you to split your pension with your Spouse for purposes of paying taxes. Some retirees are able to reduce the total amount of income taxes that they pay by splitting their pension. You should check your personal tax situation carefully before using this potential tax advantage.

To take advantage of this option, you do not physically split your pension. The pension paid from your Pension Plan remains fully payable to you. The splitting of your pension only occurs on your tax return. Each year, you may elect how much of your pension to transfer to your Spouse's income tax return. You may transfer any amount from zero to half of your total pension received in the year. You may change the amount of pension transferred to your Spouse each year.

You should check your income tax package for eligibility conditions and rules for pension splitting. This decision is a matter between you, your Spouse, and the Canada Revenue Agency. The Administration Office cannot help you with your pension splitting. If you do need help, you should speak to an income tax preparer.

23. WHEN IS MY MEMBERSHIP IN THE PENSION PLAN TERMINATED?

Your membership under this Pension Plan will terminate before your normal retirement date if:

a) Your membership in the U.A. Local 663 is terminated; or

b) You elect to terminate your membership in the Pension Plan because there have been no Employer contributions made to the Pension Plan on your behalf for at least 24 continuous months.

24. WHAT BENEFIT AM I ENTITLED TO WHEN MY MEMBERSHIP IN THE PENSION PLAN IS TERMINATED?

If your membership terminates before your normal retirement date, you will receive a pension from the Pension Plan.

You will have the following options with respect to your pension:

a) A deferred pension starting at age 65. You may elect to start this pension at a reduced amount any time after age 55 *(see questions 10 and 11)*; **or**

b) If you have not yet attained age 55, you may transfer the value of your pension, **reduced to reflect the funded status of the Pension Plan as at your date of termination**, to one of the following:

- **i.** A locked-in prescribed retirement savings arrangement, such as a life income fund or a locked-in retirement account. Locked-in means that you cannot use your pension for any purpose other than to provide a retirement pension (i.e., you cannot take a cash payment);
- **ii.** The registered pension plan of your new employer, provided that the new plan is willing to accept the transfer; or

iii. A company licensed to provide annuities in Canada for the purchase of a life annuity that will commence no earlier than age 55.

You will receive a statement shortly after you apply for termination status, advising you of your pension amount and the options available. You will have 90 days from receiving that statement to make your choice. If you do not respond within that time, you will automatically receive option (a) above.

25. AM I ABLE TO RECEIVE THE VALUE OF MY PENSION AS A LUMP SUM CASH PAYMENT?

Yes, if you meet the conditions described below. The value of your pension may be paid to you as cash in a lump sum (less applicable withholding taxes) only if:

a) Your pension is less than 4% of the Year's Maximum Pensionable Earnings (as defined by the Canada Pension Plan; $178.67 per month in 2015) **(excluding rehired pensioners)**; or

b) The actuarial present value of your pension is less than 20% of the Year's Maximum Pensionable Earnings (as defined by the Canadian Pension Plan; $10,720 in 2015) (**excluding rehired pensioners**); or

c) You have a life expectancy of less than 24 months by reason of illness or disability. You will have to provide the Administration Office with the required documentation such as a witness statement from a qualified medical practitioner before this payment can be made to you.

26. WHAT HAPPENS IF I TRANSFER PERMANENTLY TO ANOTHER U.A. LOCAL OR ANOTHER UNION COVERED BY A RECIPROCAL AGREEMENT WITH THE PENSION PLAN?

If you permanently transfer to another U.A. Local or another Union that has a pension plan with a Reciprocal Agreement with this Pension Plan, you may have your U.A. Local 663 pension entitlement transferred to the new plan.

Contact the administrators of both plans and tell them that you are considering a transfer of pension. You should find out the amount of pension from this Pension Plan that you would be giving up and the amount of pension that you would get from the new plan in return for the transfer. These two amounts may not be the same.

Alternatively, you may elect to terminate your membership under the Pension Plan and receive one of the termination benefits detailed under question 24.

27. WHAT HAPPENS IF I TEMPORARILY WORK ON TRAVEL CARD OR PERMIT?

If you temporarily work in Canada under the jurisdiction of another U.A. Local (Travel Card) or under the jurisdiction of another trade union Local (Permit), your pension plan contributions will be sent back to this Pension Plan as long as there is a Reciprocal Agreement in effect.

If you temporarily work in the United States on Travel Card, your pension plan contributions cannot be reciprocated back to this Pension Plan. Instead, you will earn pension benefits under the Plumbers and Pipefitters National Pension Fund (PPNPF, registered in the US).

You should contact the Administration Office prior to working on Travel Card under the Pipeline sector in Canada, working on Travel Card in the United States, or working on Permit to verify which Reciprocal Agreements are in place and to fill out any necessary forms to facilitate reciprocation.

You cannot terminate from this Pension Plan if contributions are being received, or are due, under the Reciprocal Agreement.

28. MAY I REJOIN THE PENSION PLAN?

Yes. It is not unusual for a member to leave the jurisdiction of U.A. Local 663 and return months or years later. If you return after your Pension Plan membership has terminated, you must become a new member of the Pension Plan *(see question 1)*.

If you become a new Pension Plan member, your new benefit will be kept separate from the benefit that you earned during your previous membership (your termination benefit). Your new hours will earn you a pension based on current rates. When you retire, the two amounts will be added together.

29. WHAT HAPPENS IF I DIE BEFORE I RETIRE?

Death Before You Attain Age 55

If you die before retirement and before you reach age 55, your Spouse will receive the following death benefit options:

a) a lump sum payment equal to the greater of the total contributions made on your behalf to the Pension Plan with accumulated interest and, the value of your pension earned, and increases granted, after 1986 (this value is determined assuming Trustee consent is not granted); **or**

b) a monthly pension, if you have met the vesting requirement prior to your death, with value equal to the value of your pension earned, and increases granted, after 1986.

The lump sum payment can be either transferred to a prescribed retirement savings arrangement, such as a RRSP or a registered retirement income fund, or paid as cash less applicable withholding taxes. Alternatively, your Spouse may elect to transfer it to a company licensed to provide annuities in Canada and receive this benefit in the form of an immediate or a deferred life annuity.

The monthly pension is payable for your Spouse's lifetime; your Spouse can also elect that the pension be guaranteed for 60, 120, or 180 months.

If you do not have a Spouse, the value of (a) will be paid to your designated Beneficiary or your estate in a lump sum cash payment.

Death After You Attain Age 55

If you die before you retire but after you reach age 55, your Spouse will receive the following death benefit options:

i) a lump sum payment equal to the value of (a) above; **or**

ii) a monthly pension with value equal to the value of 60 monthly payments of your pension (calculated as though you had retired the day before you died) **plus** 65% of your pension paid to your Spouse for his or her lifetime after the 60 months.

If you do not have a Spouse, your designated Beneficiary or estate will receive a lump sum cash payment equal to the greater of the value of (a) above and the value of 180 monthly payments of your pension (calculated as though you had retired the day before you died).

Reminder: It is very important that you notify the Administration Office **as soon as possible** if there is any change to your marital status or designated Beneficiary *(see questions 1, 2, and 3)* to ensure that any death benefit is paid to the appropriate person.

30. WHAT HAPPENS IF I BECOME DISABLED?

If you become disabled and provide the required documents to the Administrative Office (proof of disability to the satisfaction of the Trustees), you will be entitled to benefit rate increases on your accrued Future Service only. Your Employer will stop making contributions on your behalf and you will not earn any benefits during your period of disability (other than for the first 12 months in the case of benefits under workers' compensation legislation.)

If you return to work, you will immediately start earning benefits under the Pension Plan.

Total and Permanent Disability

You are considered to be totally and permanently disabled if you meet the following critera:

a) You are entitled to recieve a disability pension under the Canada Pension Plan;

b) You have been certified as totally and permanently disabled by a medical doctor who is qualified to practise under the laws of Ontario; and

c) You are not engaged in any paid occupation (except such occupations as may be approved by the Trustees for purposes of your rehabilitation).

If you are totally and permanently disabled and you satisfy one of the following two criteria:

a) You joined the Pension Plan prior to January 1, 2005; or

b) You joined the Pension Plan on or after January 1, 2005 and have at least fifteen (15) years of Continuous Plan membership as an Active Member immediately prior to retirement; then, the Trustees may give their consent to apply no reduction to your pension benefit if you retire after you have reached age 55.

If you are totally permanently disabled, you joined the Pension Plan on or after January 1, 2005, and you have less than fifteen

(15) years of Continuous Plan membership as an Active Member immediately prior to retirement; then, the Trustees may give their consent to apply one of the following ehanced early retirement factors;

i) If you retire on or after age 60, there will be no reduction to your pension benefit; or

ii) If you retire between age 55 and 60, your pension benefit will be actuarially reduced for each month that your retirement precedes age 60.

Other Disability

If you become disabled (but do not meet the above Totally and Permanently Disabled criteria) and provide the required documents to the Administrative Office (proof of disability to the satisfaction of the Trustees), you will be entitled to benefit rate increases on your accured Future Service only. Your employer will stop making contributions on your behalf and you will not earn any benefits during your period of disability (other than the first 12 months in the case of benefits under workers' compensation legislation.)

If you return to work, you will immediately start earning benefits under the Pension Plan.

31. WHAT HAPPENS IF I HAVE A BREAKDOWN OF MY SPOUSAL RELATIONSHIP?

Under the Family Law Act of Ontario, the value of your pension that was accrued during your spousal relationship must be included as family property for the purposes of the calculation and division of net family property. However, you are **not required** to divide your pension.

Once your spousal relationship has ended, you (or your former Spouse) may request pension valuation information from the Administrative Office. Upon receipt of $600 from you (or your former Spouse) as well as completed prescribed forms, the

Administrative Office will provide you and your former Spouse with a statement of pension values within 60 days.

If you and your former Spouse agree to divide your pension, the agreed division must be provided to the Administrative Office on the prescribed form. The requested division will then occur within 60 days of receipt of the completed form, as follows:

- If your relationship ended before you retired, your former Spouse's share (limited to 50%) of your pension will be paid in the form of a lump sum transfer to a prescribed locked-in retirement savings arrangement; **or**
- If your relationship ended after you retired, your former Spouse's share (limited to 50%) of your pension will be paid as a monthly payment.

Your pension will be adjusted to reflect the agreed division.

32. CAN THE PENSION PLAN BE CHANGED OR DISCONTINUED?

Although the Trustees intend to continue the Pension Plan indefinitely, they reserve the right to amend or terminate the Pension Plan at any time, subject to any Collective Agreement or legislation requirements.

33. PENSION PLAN DOCUMENTS

This portion of the booklet has been designed to provide you with a summary of the main features of the Pension Plan in an easy-to-understand format. Every effort has been made to ensure that it reflects the terms and provisions of the official Pension Plan documents. **If there is a conflict between the information contained in this booklet and the official Pension Plan documents, the official Pension Plan documents will govern.** If you want to see a more detailed description of the benefits, you may review the official Pension Plan documents by contacting the Administrative Office.

NOTES

NOTES

NOTES

NOTES

NOTES

Printed by

THISTLE PRINTING LIMITED
35 Mobile Drive • Toronto • Ontario • M4A 2P6
Phone: (416) 288-1288 • Fax: (416) 288-0737

591G 707