Insulators Local 110 Benefit Plan

Member Information Booklet

January 1, 2026

Insulators Local 110 Benefit Plan

Member Information Booklet for active full-time employees and Retirees, and their eligible Dependants.

This booklet provides you with a brief description of the benefits to which you and your family may be entitled, the rules governing eligibility for these benefits and the procedure that should be followed in the event that it is necessary for you to make a claim. The final determination, however, of any claim, question or problem which may arise, will be governed by the Trust Agreement, Plan Text, and the Insurance Policies issued by the Insurance Company.

Health, Dental and Weekly Disability benefits are reimbursed directly from the assets of the Fund. Life, Dependant Life coverage, Out of Province Travel coverage and Accidental Death & Dismemberment coverage are provided through Industrial Alliance Life Insurance Company ("the Insurance Company") under the group policy numbers listed below.

- Life and Dependant Life coverage - 100012991
- Travel Benefits - 100012990
- Accidental Death & Dismemberment coverage - 119-3394

The information contained in this booklet does not create nor confer any contractual or other rights. The Trustees have full authority to resolve all questions related to the provisions of the Plan and may, from time to time, amend the Plan. Detailed information about benefits or other provisions of the contracts or copies of those provisions may be obtained from the Claims Payer.

For eligibility questions, please contact the Administrator:

Insulators Local 110 Benefit Plan
9335-47 Street
Edmonton, AB T6B 2R7
Phone: (780) 426-2874

For claims and coverage questions, please contact the Claims Payer:

The PBAS Group
Suite 101, 46 Hopewell Way, NE
Calgary AB T3J 5H7

Toll Free: 1-866-391-7526
Email: insulators110@pbas.ca
Member Portal: insulators110.pbas.ca

Welcome Eligible Plan Members

This revised booklet has been published to give you an up-to-date description of the benefits provided by the Fund.

We urge you to read your booklet carefully to thoroughly familiarize yourself with the benefits which are available to you and your Dependants. While it is our hope that you and your family will enjoy good health, it is comforting to know that these benefits are available when needed.

With the ever-changing economic environment, the benefits provided in this booklet cannot be guaranteed for the future. In order to protect the Fund, the Trustees have the right to amend, delete, add or change the plan's benefits and eligibility rules as they apply to all current and future members and retirees, including the right to add or delete benefits, monetary or otherwise, as circumstances may warrant.

If at any time you have any questions about the benefits, or would like assistance in filing a claim, please do not hesitate to contact the Administrator or Claims Payer where a member of the team will be pleased to assist you.

Sincerely,
—The Trustees

Privacy of Personal Information

Participation in the Plan depends on the collection, storage, use and, sometimes, the destruction of personal information about the Members, their Dependants, and Beneficiaries. It forms the foundation upon which individual entitlements are built, and from which benefit payments are calculated and made. As well, parts of the personal information are needed to satisfy government demands for facts, to facilitate audits of the Plan, to estimate future operating costs and to transfer data to any replacement program. As well, the information could be called into a court action. In all cases, however, personal information is stored with the utmost attention to security, and deployed, sparingly, to fulfill the requirements of the Plan and the law.

Registration, to participate in the Plan, involves an authorization to allow the Trustees to gather and apply personal information in specific ways. Members may revoke that authorization, subject to certain legal constraints; however, doing so precipitates the destruction of the Member's personal information and may, therefore, render ongoing participation impossible.

Complaints regarding personal information may be directed to the Administrator's Privacy Officer at the address previously noted, by contacting the Office of the Privacy Commissioner of Canada or, if applicable, the Provincial Commissioner.

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Schedule of Benefits

Schedule of Benefits for Active Members

Members Only

Life Insurance	$75,000
Accidental Death and Dismemberment Insurance	$75,000
Weekly Disability Income **1st day accident** **8th day sickness**	$729 per week for maximum of 41 weeks of disability integrated with E.I.

Dependants Only

Dependant Life	$15,000 Spouse $15,000 Each Child

Members and Dependants

Health Care Benefits	80% of eligible generic drug and medication expenses (dispensing fees limited to $5 per prescription). Foot Care expenses, and other eligible expenses; $10,000 lifetime maximum for private duty nursing expenses; $1 million Emergency Medical Travel per trip; $750 per 24 months for Vision Care expenses; $750 per 24 months for safety glasses; $3,000 per eye lifetime maximum for cataract surgery.
Dental Care Benefits *	80% of Routine, 80% of Dentures and 60% of Crowns and Bridgework; $2,500 per calendar year combined maximum per individual.
Orthodontia (Dependent Children age 19 and under) *	50% of eligible expenses; $5,000 lifetime maximum per individual.

* The Dental Fee Guide used to reimburse Dental Expenses is reviewed by the Trustees each January 1st and updated upon their approval to provide reimbursement based on the Alberta Dental Association Guide for Dental Fees for General Dentists in effect at the time of treatment.

The above is a summary of benefits only. You should refer to the relevant section of the booklet to determine whether you or your Dependants qualify for the benefits based on the eligibility requirements for each benefit.

Schedule of Benefits

Schedule of Benefits for Retired Members

Members Only

Life Insurance	$20,000
Accidental Death and Dismemberment Insurance	$20,000

Members and Dependants

Health Care Benefits	80% of eligible generic drug and medication expenses (dispensing fees limited to $5 per prescription). Foot Care expenses, and other eligible expenses; $10,000 lifetime maximum for private duty nursing expenses; $1 million Emergency Medical Travel per trip; $750 per 24 months for Vision Care expenses; $3,000 per eye lifetime maximum for cataract surgery.
Dental Care Benefits *	80% of Routine, 80% of Dentures and 60% of Crowns and Bridgework; $2,500 per calendar year combined maximum per individual.

* The Dental Fee Guide used to reimburse Dental Expenses is reviewed by the Trustees each January 1st and updated upon their approval to provide reimbursement based on the Alberta Dental Association Guide for Dental Fees for General Dentists in effect at the time of treatment.

The above is a summary of benefits only. You should refer to the relevant section of the booklet to determine whether you or your Dependants qualify for the benefits based on the eligibility requirements for each benefit.

Schedule of Benefits for Permit Workers

Permits Only

Life Insurance	$25,000
Accidental Death and Dismemberment Insurance	$25,000

Permits and Dependants

Health Care Benefits	70% of eligible generic drug and medication expenses (dispensing fees limited to $5 per prescription). $750 per 24 months for safety glasses.
Dental Care Benefits *	80% of Routine; $1,500 per calendar year per individual.

* The Dental Fee Guide used to reimburse Dental Expenses is reviewed by the Trustees each January 1st and updated upon their approval to provide reimbursement based on the Alberta Dental Association Guide for Dental Fees for General Dentists in effect at the time of treatment.

The above is a summary of benefits only. You should refer to the relevant section of the booklet to determine whether you or your Dependants qualify for the benefits based on the eligibility requirements for each benefit.

Eligibility

Eligibility for Active Members and Permit Workers

1. Any employee for whom their employer is obligated to contribute to the Fund by an applicable Collective Bargaining Agreement.

2. Any full time salaried officer or employee of any applicable Local for whom coverage under this Plan has been approved by the Trustees.

3. Any employee of the Trustees for whom coverage under this Plan has been approved by them.

4. Any other employee of certain employers for whom coverage under this Plan has been approved by the Trustees.

Eligibility for Retired Members

Initial Eligibility

As of June 1, 2018, to be eligible for benefits under the Retired Members Benefit Plan the member must meet all of the following requirements:

1. Must be a member in good standing of the Union with a minimum of 15 years of Union Affiliation* on the date they retire from employment with participating employers (the date of retirement);

2. Must have worked at least 500 hours per year for participating employers in 13 of the 15 years immediately preceding their date of retirement; or, must have worked at least 1,000 hours for participating employers in each of the five (5) years immediately preceding the date of retirement;

3. Must be in receipt of, or in the process of successfully applying for, a monthly retirement benefit commencing on the date of retirement from the Pension Plan; and

4. Must have been covered as an Active Member under the Plan in the month immediately preceding the date of retirement.

**Union Affiliation means membership in the International Association of Heat & Frost Insulators and Allied Workers Local 110 (and its predecessors).*

If a member does not elect to participate in the Retired Members Plan within 30 days of their effective date of coverage (as defined on page 11), they will not be allowed to participate later.

Eligibility

Eligibility Rules for Active Members and Permit Workers

How an Employee Becomes Eligible

Hours worked for contributing employers, for which contributions have been received, will be credited to the employee's reserve account.

New employees will become eligible for benefits after accumulating a minimum of 360 hours for work performed for contributing employers in not more than three consecutive months. The following month is a waiting period and eligibility will commence on the first day of the month following the waiting period. Also, the member must be at work or available for work and not disabled on the day they become eligible for benefits. Contributing Employer means any employer who is obligated or permitted to contribute to the Fund.

Employees under the Commercial Workers agreement are not obligated to work 360 hours for initial eligibility. Instead their coverage automatically starts on the 15th of the month following their dispatch date.

Continuation of Eligibility

Hours worked for contributing employers, for which contributions have been received, will be credited to the individual's "reserve account". For each month of insurance coverage, 120 hours of work credit will be deducted from each eligible employee's "reserve account" for each month of insurance coverage, and employees will continue to remain eligible as long as their reserve accounts contain at least 120 hours of work credit.

In this connection employees, who are members of the Union in good standing, will be allowed to accumulate excess hours in their reserve accounts, up to a maximum of 600 hours or five months of future coverage.

Continuation of Eligibility While Disabled (Active Members Only)

Whenever an eligible employee is disabled and is receiving Workers' Compensation benefits or Fund Weekly Disability or Employment Insurance Sickness and Accident benefits for such disability for at least two weeks in any calendar month, no deduction will be made from their reserve account for that month. In other words, their reserve accumulation will be "frozen". The maximum period for which such employees' hours will be frozen under this rule for any one continuous period of disability will be the earlier of 12 consecutive months and the date the member returns to work.

If you receive Workers' Compensation benefits or Employment Insurance Sickness and Accident benefits, you must notify the Administrator of the duration of your disability so that your reserve accumulation may be frozen for the period described above. A "Request for Freezing of Hours" form may be obtained at your Local Union Office.

Termination of Benefits

An employee's eligibility under this Plan will terminate at the end of the month in which the work credits in their reserve account fall below 120 hours, after deduction of 120 hours for the current month's coverage.

Eligibility

Reinstatement

An employee whose eligibility has terminated will again become eligible if their reserve account shows a total of at least 120 hours within the four-calendar-month period subsequent to the termination of their eligibility. Such reinstatement will be effective on the first day of the second month, which follows the month in which this requirement is met. If the employee is not reinstated within a four-calendar-month period, any reserve hours in their account will be forfeited. Such an employee will again become eligible for insurance upon completion of the initial eligibility requirements.

Extension of Coverage by Self-Payment (Active Members Only)

An employee who is a member in good standing with the Union and whose eligibility terminates, may continue coverage for themselves (excluding the Weekly Disability Benefit) and their Dependants from month to month provided they are available for work with a contributing employer as determined by the Local Union Office. Coverage may be continued by making self-payments to the Administrator (up to a maximum of 12 consecutive payments) provided the member remains in good standing with the Union.

The current monthly required self-payment contribution amount is $300. The first payment must be made prior to the termination of eligibility; payments must be continuous so long as the employee is eligible to make them, and must be made in advance of the month for which coverage is desired.

Deceased Employee—Length of Dependant Coverage

In the event of any employee dying while they are eligible for Health and Welfare benefits under the eligibility rules, the Health and Dental Care benefits payable under the Plan applicable at the time of death for such deceased employee's Dependants shall continue for either the three calendar months immediately following the date of death or until the deceased employee's bank hours run out in the normal course, whichever is later.

However, coverage will not be provided beyond the date that the Dependant would have ceased to qualify as an eligible Dependant, if the employee was still living.

Participation of non-bargaining Employees of Contributing Employers and Employees of The Union

Employers may insure themselves and any employees of their organizations who are not covered by a Collective Bargaining Agreement by making the required payments to the Fund as stipulated by the Trustees from time to time.

Non-Bargaining employees may become and remain eligible provided they meet prescribed non-bargaining eligibility rules. The Trustees reserve the right to amend these rules at any time and to require proof that all conditions and requirements are being met. Full information concerning participation of non-bargaining employees can be obtained by contacting the Administrator.

Eligibility

How do I become covered under the Active Members Plan?

Once hours that you have worked for a contributing employer have been reported to the Administrator and contributions have been received, an hour-bank reserve account is established for you.

A "Registration Form & Declaration of Beneficiary" must be completed immediately and returned to the Administrator. Blank Registration Forms are available at your Local Union Office or the Administrator.

What is the individual's Hour-Bank Reserve Account?

This is an account kept by the Administrator for each employee who works for a contributing employer. These employers report the number of hours worked by the employee and make the required contributions to the Administrator. Once this occurs, the hours are placed in the employee's reserve account.

This is similar to a bank account, with hours being deposited instead of dollars. In order to be eligible for coverage, an employee has hours deducted or withdrawn from their account.

For example: Let us have a look at the way a covered employee's account would operate, if he has 180 hours in their bank reserve account at the beginning of the month.

Month	Account Balance at Beginning of Month	Hours Credited for Month	Hours Deducted for Coverage*	Account Balance
1	180 hrs.	116 hrs.	120 hrs.	176 hrs.
2	176 hrs.	185 hrs.	120 hrs.	241 hrs.
3	241 hrs.	75 hrs.	120 hrs.	196 hrs.
4	196 hrs.	Nil	120 hrs.	76 hrs.
5	76 hrs.	100 hrs.	120 hrs.	56 hrs.
6	56 hrs.	125 hrs.	120 hrs.	61 hrs.

** These are the hours worked in the two months preceding the current month. Hours are reported after the end of the month worked. (For example, hours worked in January are reported in February and provide March eligibility).*

Please note that due to employer payroll cut-off dates, there may be some monthly variances between the hours worked and the hours reported on your behalf.

Is a medical examination necessary to obtain initial coverage under the Plan?

No. All benefits for you and your Dependants are available without any test of insurability.

However, medical evidence will be required to qualify for the payment of certain benefits, such as Weekly Disability. The Plan will pay up to $150.00 for completion of the necessary medical forms.

Eligibility

When do my Dependants get coverage under this plan? What benefits do they qualify for?

Your Dependants become covered for Life Insurance (not applicable under the Retired Members Plan), Health Care and Dental benefits at the same time you become eligible, or upon becoming your Dependants, whichever is later. (Please refer to the Eligibility Rules for further details.)

What happens to my coverage under the Active Members Plan if I move from one Employer in the industry to another?

If you are a bargaining employee and your new Employer is required to make contributions to the Fund, your reserve account will continue to be credited with hours reported. Your benefits are portable within the industry in Alberta.

Once I am covered, how do I know if I have sufficient hours in my reserve account to pay for my coverage in future months?

The Administrator will have the latest hour-bank reserve account balances for each eligible employee.

NOTE: Each eligible employee is responsible for knowing what their reserve account balance is at any time.

Do I have to be under a Doctor's care in order to qualify for Weekly Disability benefits?

Yes. You must see a doctor as soon as possible if you have been injured or are sick enough to be unable to work. If you delay going to a doctor, your claim could be refused, reduced, or held up for further investigation.

Are any eligible benefits covered while traveling or vacationing outside Alberta?

Yes, coverage is provided for emergency treatment, as described in this booklet. If you are entitled to coverage, the information explaining how to access your emergency out-of-country coverage can be found later in this booklet or in your travel brochure.

It is your responsibility to ensure you have sufficient medical insurance if you travel outside Canada.

Eligibility Rules for Retired Members

Required Contributions

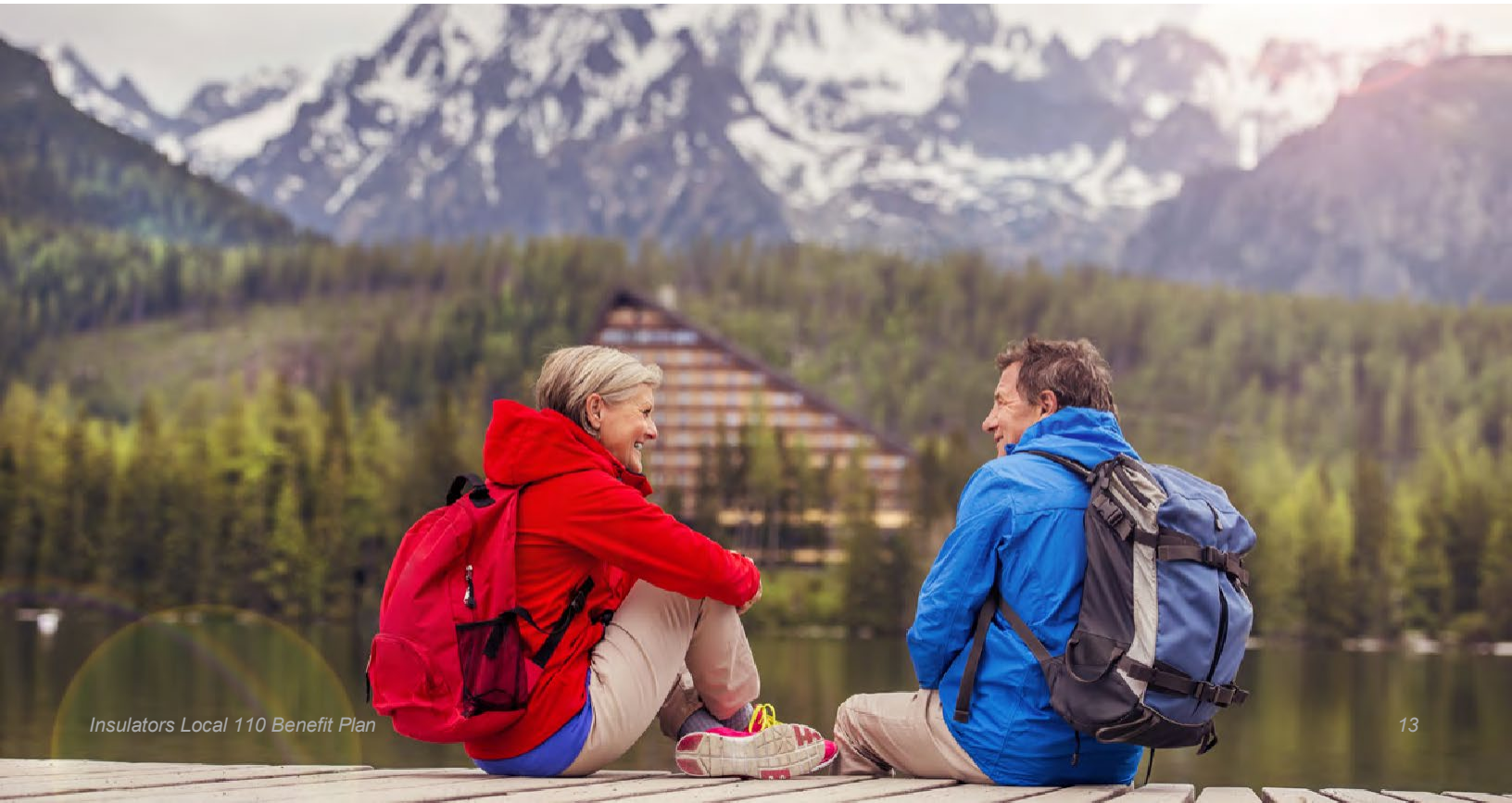
Retired Members who receive a Normal Retirement benefit from the Pension Plan can become eligible for Retired Members coverage by meeting the requirements for initial eligibility and making monthly contributions. The current monthly contribution for existing and new Retired Members is $170.

Retired Members who receive another form of Retirement benefit from the Pension Plan can become eligible for Retired Members coverage by making monthly contributions at the required level and at the required time as determined by the Trustees. The monthly contributions are required on a consecutive basis until the earlier of a) termination of coverage and b) until the member reaches the Pension Plan's Normal Retirement benefit age.

Effective Date of Coverage

The effective date of coverage under this Plan for any Retired Member (or Dependant) is the first day of the month immediately following the month in which Active Member coverage by the Insulators Local 110 Benefit Plan (the Plan) ceases.

If a Dependant is confined for medical care or treatment in any institution or at home when insurance would normally begin, the Dependant will not be insured until given a final release by the licensed doctor (M.D.) from all such confinement. However, this provision is not applicable to Dependants who were insured as an active employee's Dependants as of the last day of active employee coverage.



Termination of Eligibility

Coverage as a Retired Member under this Plan will cease upon the earliest of:

1. The date the Retired Member ceases to be a member in good standing of the Union;
2. The date the Retired Member ceases to make the required monthly Plan contributions to the Administrator;
3. The date coverage commences as an Active Member under the Fund, due to the Retired Member's re-employment with a participating employer;
4. The date the Retired Member is re-employed in the industry by a non-participating employer;
5. The date the Retired Member has been covered as a Retired Member for 60 months (not necessarily consecutive) on or after the Retired Member's Normal Retirement date; and
6. The date of the Retired Member's death.

Important: If a Retired Member's coverage terminates for any reason other than Number 3 above, their coverage cannot be reinstated.

As noted in Number 3 above, should a member become eligible for coverage as a Retired Member and subsequently become eligible as an Active member under the Fund, their eligibility as a Retired Member will cease. If, after that, they terminate eligibility as an Active Member, they will again become eligible as a Retired Member provided they meet all of the Initial Eligibility rules (with respect to the date of retirement) except for Number 2. (Rule Number 4 of the Initial Eligibility rules will be adjusted to the number of months they were covered as an Active Member, if it was less than 12 months.)

Changes in Eligibility Rules

The eligibility rules may be amended by the Trustees at any time without the necessity of prior notice being provided to those individuals affected thereby, including Retired Members covered by this Plan and those not yet eligible for coverage as of the effective date of any such amendment.

The Trustees expressly reserve the right to terminate any or all of the benefits or coverage provided for Retired Members and their Dependants, and expressly reserve the right to provide different benefits to Retired Members or Dependants than the benefits being provided to other members, employees, Dependants or Beneficiaries of the Fund. The Trustees also expressly reserve the right to require contributions to be made by all Retired Members participating in the Plan, and to change the amount of the contributions from time to time.

Eligibility

Eligible Dependants

A Member's eligible Dependants are:

1. the employee's spouse, and
2. unmarried children, stepchildren or legally adopted children, in respect of whom the employee is eligible for deduction for the purpose of calculating taxable income under the Income Tax Act (Canada) who are:
   a) under the age of twenty-one years, or
   b) at least twenty-one years of age but under twenty-five years of age and attending an accredited educational institute, college or university on a full time basis, or
   c) at least twenty-one years of age and dependent upon the employee by reason of mental or physical incapacity, provided the infirmity commenced while the child was insured as a Dependant. (Please refer to Continuation of Health and Dental Care Benefits for Certain Incapacitated Children on Page 15 for further details.)

"Spouse" means either:

a) a person who, as of the time in question, is legally married to the employee, or
b) a person living with the employee who is publicly represented as the employee's "spouse" and is designated by the employee on his or her Registration Form as his or her "spouse", provided, however that if such designated person is not legally married to the employee, the employee must have been living with him or her for at least one continuous year prior to the incurring of the covered expense or service in question, so as to qualify him or her as a "spouse" for the purpose of the payment of such expense or service.

The Administrator may (but is not obligated so to do) require from such employee or such employee's designated "spouse" a statutory declaration or other evidence sufficient to satisfy the Administrator of his or her qualification or otherwise for such payment, and

If a person qualifies under (a) and another person qualifies under (b), then of the two persons so qualified, the one who has been designated to receive the benefit or benefits in question by an instrument in writing, signed by such employee and received by or filed with the Trustees or the Administrator, or in the absence of such designation the person qualified under (a), shall be deemed the "spouse" for the purpose of this plan.

Effective Date of Coverage

Effective date of coverage for any employee (or Dependant) is the date on which the employee qualified for the coverage in accordance with the following rules—except that no payments are to be made for services rendered prior to that date.

General Provisions

Coordination with other Benefit Plans

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

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

The plan that does not have a coordination of benefits provision pays before the plan that does (most, if not all, Insurance Company plans have such a provision).

The plan that covers the person as:

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

If both parents have their birthday on the same day, benefits under the plan will be shared in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

To implement this provision, the Plan may:

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

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

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

Plan means any contract of group insurance or other arrangement for members of a group (whether on an insured basis or not), prepaid health or dental care coverage, or student accident insurance.

The exclusion of governmental benefits or services under this plan is described in the “Exclusions” section.

Government Coverage for Seniors

Although the plan does not require members or their Dependant's to enroll in Government coverage for seniors, the Trustees request that members make their best efforts to enroll and submit claims to any of the Government sponsored programs before submitting remaining amounts to the Insulators Local 110 Benefit Plan. Doing so will help sustain the Plan so that it can continue to ensure that these benefits are available to your fellow members when needed.

For more information on Government coverage available for seniors, see the table in the "Government Programs for Seniors" section below.

General Provisions

How do I assign a Beneficiary?

For employee death benefits, you may name a Beneficiary(ies) and, from time to time, change such named Beneficiary(ies), subject to Provincial Law, by written request filed at the office of the Administrator. The request will take effect as of the date such request was executed, but without prejudice to the Plan for any payments made before such request is received at the office of the Administrator.

To assign and/or change an assigned Beneficiary, please print the form, or contact the Administrator.

In the event that the Administrator does not receive a Beneficiary designation, the death benefit must be paid to the Member's estate and will be subject to otherwise avoidable probate fees.

Continuation of Health and Dental Care Benefits for Certain Incapacitated Children

If a dependent child is incapable of earning their own living because of physical or mental incapacity, and is chiefly dependent on the employee for support, and is covered under the Plan on the date such coverage would otherwise terminate because the child attained the limiting age, benefits for such a child can be continued for the duration of the incapacity provided coverage does not terminate for any other reason. Proof of incapacity must be furnished to the Claims Payer within thirty-one days after the child has reached the limiting age, and thereafter as requested.

When your Dependency Status Changes

If you marry or have children, a new Registration Form must be completed and forwarded to the Administrator each time you acquire a new Dependant.

Health Benefits at-a-Glance

Health

	Ambulance	100%	Reasonable and Customary charges.
	Foot Care *	80%	Orthotics: $350 every 2 calendar years. Orthopedic Shoes: $350 every 2 calendar years.
	Health Practitioners	80%	$400 per practitioner per calendar year. Includes: Acupuncture Chiropractor Christian Science Practitioner Massage Therapy Naturopathy consultations Osteopathy Physiotherapy Podiatry/Chiropody
	Hearing Care *	80%	$4,000 per ear every 5 calendar years.
	Hospital	80%	Semi-private.
	Insulin and Diabetic Supplies	100%	Reasonable and Customary charges.
	Medical Equipment *	80%	Reasonable and Customary charges.
	Prescription Drugs	80%	Maximum $5 dispensing fee.
	Prescription Safety Goggles	100%	$750 every 24 months (members and permits only)
	Private Duty Nursing	100%	$10,000 per lifetime.
	Psychology *	80%	$2,000 per calendar year.
	Vision Care	100%	$750 every 24 months (12 months for Dependants under age 18); $3,000 per eye per lifetime for cataract surgery*

This is a basic overview of your health plan, created as an easy way to assist Members to maximize coverage. Complete descriptions of all benefits, including specific limits, are listed in the Health Care Benefits Section.

* Referrals may be required.

Health Care Benefits

How long do I have to submit my claims?

Claims must be received by the Claims Payer within eighteen (18) months of the date of the expense. If your coverage terminates, you have six (6) months after the date the coverage terminates.

Change of Address

If you should have a change of address, it is important that you notify the Administrator immediately by completing a new Registration Form.

Description of Benefits

Covered Charges include Reasonable and Customary Charges for medically necessary services or supplies. A Reasonable and Customary Charge is one made by the provider of care, services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.

To be an eligible expense, the treatment or service must be received while the person is covered, for either an illness or injury that is non-occupational. All Health Care Benefits described on the preceding pages will also be payable for expenses incurred while insurance is in force due to pregnancies.

Restoration

On January 1 of each year, the amount which has been counted against any Maximum Lifetime Benefit of an insured family member and not previously restored or reinstated will be automatically restored up to $1,000. No evidence of good health is required for this automatic restoration but it is not available after insurance is terminated.

This section should be read in conjunction with the section entitled “Exclusions”.

Ambulance Service

For transportation in a vehicle regularly used for professional ambulance service to or from a hospital in the local area, covered at **100%**; but limited to one trip to and one trip from the hospital for any one hospital confinement.

Emergency Transportation beyond the local area if:

a) necessary because of any emergency arising while the insurance is in force; and

b) if by professional ambulance, or by scheduled airline or railroad to and from the nearest hospital qualified to provide needed treatment.

Health Care Benefits

Convalescent/Rehabilitation Hospital Board and Room and Other Necessary Services and Supplies

Covered at **80%**, up to the difference between the hospital's daily charge for ward and semi-private accommodations for as many as 120 days during any one period of disability provided the individual is admitted to the convalescent/rehabilitation hospital within 7 days following discharge from a hospital in which the member was confined for at least 5 consecutive days. All confinements in a convalescent/rehabilitation hospital will be considered as one period of disability unless confinements are separated by at least 90 days. The General Provisions section contains a definition of a convalescent /rehabilitation hospital.

Completion of Medical Forms

Covered at **100%**, when they are with respect to a health claim, to a maximum of **$150** per claim.

Diagnostic Procedures for Dental Accidents

Treatment of accidental injuries to the natural teeth or jaw due to a force or blow external to the mouth and occurring while the person was covered by the Plan is covered at **80%.** The treatment must be received and approved for payment within 12 months of the accident. Injuries due to biting or chewing are not covered.

Health Care Benefits

Foot Care

Covered charges for the following are covered at **80%** as listed below:

1. orthopedic shoes (including repairs) to a maximum benefit of **$350** every two calendar years, each calendar year for insured persons under age 18, and
2. orthotics to a maximum benefit of **$350** every two calendar years, each calendar year for insured persons under age 18.

These products must have been specially designed and molded for the insured person and are required to correct a diagnosed physical impairment, provided that the following information is supplied with a diagnosis, including a list of symptoms and the primary complaint, including:

- a description of the physical findings from the clinical examinations;
- a brief description of the gait abnormality associated with the diagnosis; and
- confirmation that the product has been custom-made.

In order to be eligible for reimbursement, orthopedic shoes and orthotics must be prescribed, on an annual basis, and be dispensed by providers with one of the following professional qualifications:

- Medical General Practitioner or Specialist (MD); or
- Podiatrist (DPM); or
- Chiropodist (D CH or D Pod M); or
- Chiropractor (DC); and
- Pedorthist C Ped (C) or C Ped (MC (prescribing only));

Health Practitioners

Covered at **80%,** up to **$400** per calendar year per type of practitioner for the following registered practitioners:

- Acupuncture
- Chiropractor
- Christian Science Practitioner
- Massage Therapy
- Naturopathy (consultations)
- Osteopathy
- Physiotherapy
- Podiatry/Chiropody

However, no benefit will be paid while the individual is entitled to similar benefits under any Provincial Health Plan other than chiropractor or podiatrist charges, regardless of whether the Provincial Plan pays all or only part of some charges.

Health Care Benefits

Hearing Care

Hearing aids are covered at **80%**, when prescribed by an otolaryngologist or audiologist. Any charges in connection with replacement or repair are excluded. Reimbursement will be limited to **$4,000** per ear every 5 calendar years.

Hospital Board and Room and Other Necessary Services and Supplies

Covered at **80%**, up to the difference between the hospital's daily charge for ward and semi-private accommodations. The General Provisions section contains a definition of a hospital.

Charges for ward and semi-private accommodation incurred for palliative care in an extended care facility/ nursing home, with a lifetime maximum reimbursement of **$2,500**.

Out-Patient Hospital Services and Supplies (during a period for which the hospital makes no charge for board and room) in connection with use of an examination or operating room, drugs, dressings or casts, anesthesia in connection with the performance of a surgical procedure, but not charges made by a resident physician or intern of a hospital.

Medical Equipment

Charges for the rental or purchase of medical equipment from a medical supply store, based on the nature and severity of the covered person's medical needs, are covered at **80%** when recommended by a Licensed Doctor (M.D.). Claims for medical supplies are only approved for payment if they are accompanied by a referral from a doctor (M.D), and approved by the Claims Payer. Before incurring any major expenses, it is recommended you submit details to the Claims Payer to determine to what extent Benefits are payable. Covered items include, but are not limited to:

- crutches, canes, walkers, and wheelchairs;
- manual hospital beds, respiratory and oxygen equipment;
- other durable equipment usually found only in hospitals;
- non-dental prostheses and supports;
- external prostheses;
- contact lenses or glasses following cataract surgery, limited to 1 pair per lifetime;
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints;
- surgical stockings (4 per calendar year) and surgical brassieres (4 per calendar year);
- other supplies such as the cost of ileostomy, colostomy and incontinence supplies, oxygen, medicated dressings and burn garments;
- wigs and hairpieces for patients with hair loss as a result of a medical condition (1 per calendar year);
- APNEA devices including CPAP machine and supplies or any other alternatives as prescribed by medical practitioner limited to 1 device every 5 years.

Health Care Benefits

Prescription Drugs

The maximum amount for any Covered Expense is the price of the Lower Cost Alternative Drug that can legally be used to refill the prescription, as listed in the Provincial Drug Benefit Formulary or a Lower Cost Alternative that provides therapeutically similar results as identified by the Claims Payer. Covered at **80%**.

- Drug Dispensing Fee Maximum: **$5** per prescription
- Fertility Drugs: **$5,000** per lifetime
- Drugs and Medicines for Treatment of Illness or Injury

The Plan covers charges for Drugs (including Injectable Drugs) and medicine which is prescribed by a Physician or Dentist (or other professional authorized by provincial legislation to prescribe drugs).

Charges for the following expenses are not covered:

a) the administration of serums, vaccines, or injectable Drugs;

b) Drugs, biologicals and related preparations which are administered in Hospital on an in-patient or out-patient basis;

c) Drugs used in the treatment of a sexual dysfunction; and

d) Drugs determined to be ineligible including but not limited to biologicals and biosimilars;

Preventative Drugs and Medicines:

The Plan covers charges for oral contraceptives, intrauterine devices and diaphragms.

Charges or preventive vaccines and medicines (oral or injected) are covered up to a maximum of **$250** per calendar year.

Charges for dietary supplements, health foods, nutritional products and vitamins (except injectable and hematinic vitamins) are not covered.

Diabetic Supplies and Insulin:

Charges for insulin and standard syringes, test strips, needles and diagnostic aids, required for the treatment of diabetes are covered at **100%** (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered). These items can be obtained by using your Pay Direct Drug Card.

Smoking Cessation Drugs, Medicines, Aids and Treatment:

Charges for prescription smoking cessation drugs are covered. Charges for non-prescription smoking cessation drugs, aids or programs will be limited to a maximum of **$500** per person per lifetime. Please note that smoking cessation programs, such as hypnosis, should be performed by a licensed and certified practitioner.

Health Care Benefits

Prescription Safety Goggles

Covered at 100% for active members and permit workers only, up to a maximum of $750 every 24 months.

Private Duty Nursing Services by a Registered Graduate Nurse (R.N.) Victorian Order Nurse (V.O.N.) and Licensed Practical Nurse (L.P.N.)

Covered at 100% while the patient is not confined to a hospital up to a lifetime benefit maximum of $10,000. The nursing service must have been ordered by a physician as medically necessary and requiring the specialized training of an R.N., V.O.N. or L.P.N. The nurse must not ordinarily reside in the employee's home or be a member of the family.

Psychology

A registered psychologist, therapist or counsellor who is licensed, registered and certified to provide such treatment, covered at 80% to a maximum of $2,000 per calendar year.

Vision Care Expenses

Covered at 100%, up to a maximum of $750 for the purchase of prescription glasses, laser eye surgery for correction of visual acuity*, prescription sunglasses, or contact lenses, every 24 months (every 12 months for Dependant children). Non-corrective lenses (and frames for non-corrective lenses) are not covered.

*Unused Vision Care coverage (that is, $750 every 24 months) can be accumulated towards reimbursement of laser eye surgery expenses only. If no Vision Care expenses have been claimed for a 48 consecutive month period, then up to $1,500 for laser eye surgery can be claimed; and if there have been no Vision Care expenses claimed for 72 consecutive months, up to $2,250 can be claimed. No accumulations beyond 72 months are permitted. During these accumulation periods, the individual must have been insured for at least 6 months for each of the 12-month accumulation periods. **NOTE:** Retirees and their Dependants are not eligible for laser eye surgery coverage.

Eye examination, including refractions, by an ophthalmologist or optometrist are covered if the individual is between 19 and 64 years of age inclusive. Eye exams are included in the $750 overall Vision benefit maximum in any 24-month period.

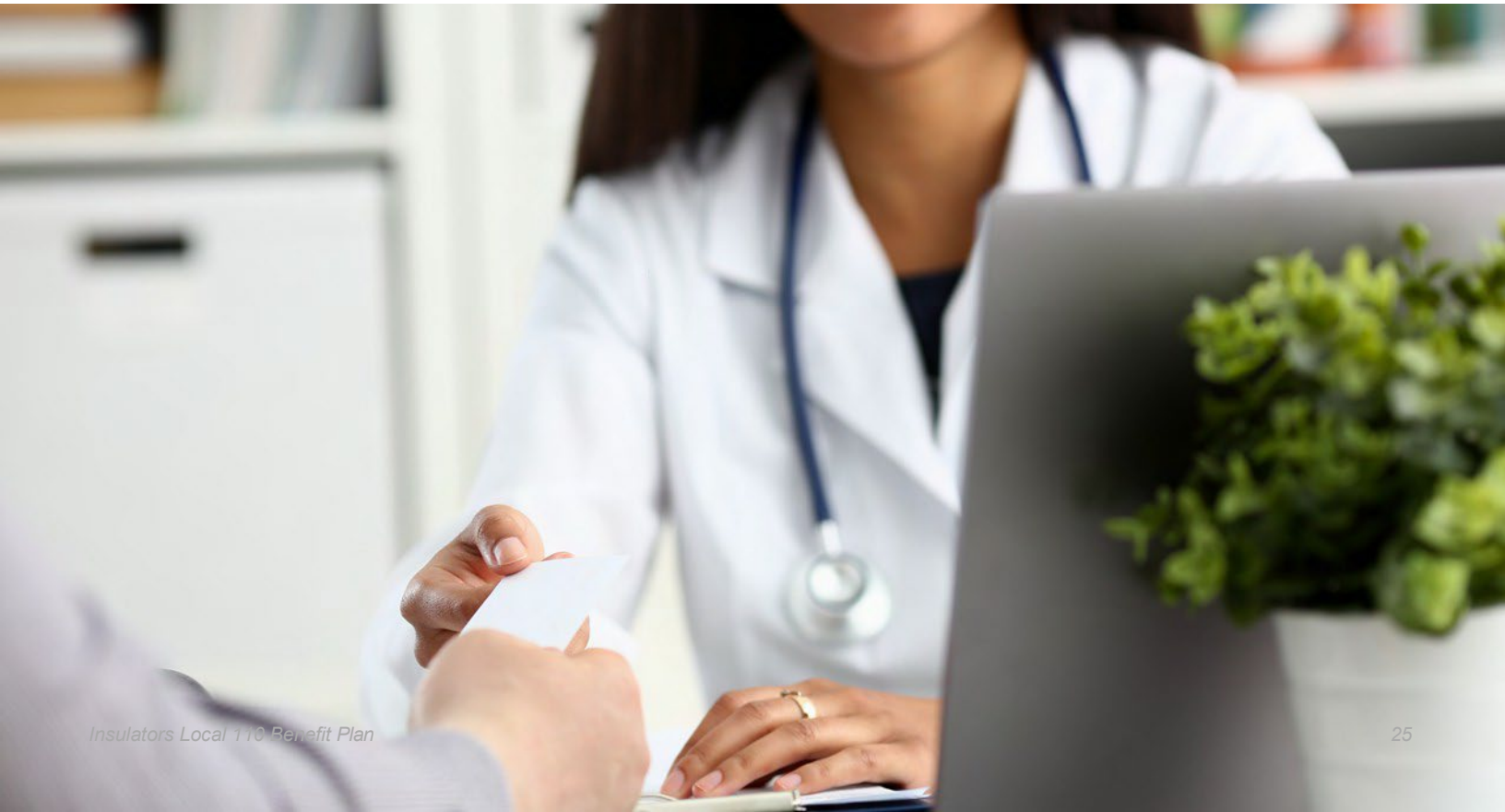
Cataract Surgery, up to a lifetime maximum of $3,000 per eye for intraocular lenses, above government coverage. Referral required.

Exclusions

No benefits are payable under this plan for the charges listed below, and the amount of such charges will be deducted from the individual's expenses which are covered under this plan and from their allowable expenses before the benefits of this plan are determined.

- Charges that would not have been made if no insurance existed or charges that neither the employee nor any of their Dependants are required to pay; or
- charges for services or supplies which are furnished, paid for, or otherwise provided for by reason of the past or present service of any person in the armed forces of a government; or
- charges for services or supplies which are paid for or otherwise provided for under any law of a government except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees and their Dependants; or
- charges for services and supplies which are not necessary for treatment of the injury or sickness or are not recommended and approved by the attending physician, or charges which are unreasonable; or
- charges of a physician or other person or agency in excess of the amount payable under any Provincial Health Plan are not covered except in the case of emergency treatment while travelling outside your normal province of residence; or
- charges for drugs or medicines when administered in a hospital setting, whether administered on an inpatient or outpatient basis, except as provided under the Emergency Out-of-Province Travel Coverage.

No benefits are payable under this plan if the provision of such benefits is prohibited by law.



Travel Benefits

This benefit is underwritten by Industrial Alliance Life Insurance Company, under group contract number 100012990.

Emergency Medical Travel Insurance	
Amount	100% up to $1,000,000 per insured person, per trip
Coverage Period	90 days per trip (unlimited number of trips as long as the Member returns to their province of residence for at least 3 days between trips); coverage ends at the earlier of termination of coverage and age 80

"Insured Person" whenever used in this section means a Member, Retiree, Spouse, and Dependent Child; "the Company" refers to the insurance company; refer to the group contract for all other definitions

Important Notice - Please Read Carefully Before Travelling

This coverage is provided during the first 90 days following the date of the departure while travelling outside the province of Residence.

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that the Member read and understand this policy before travelling as coverage may be subject to certain limitations or exclusions.

A pre-existing exclusion may apply to medical conditions and/or symptoms that existed prior to the trip. Check to see how this applies in this policy and how it relates to the departure date, date of purchase or effective date.

In the event of an Injury or Sickness, the Insured Person's prior medical history may be reviewed when a claim is reported.

If this policy provides travel assistance, the Insured Person may be required to notify the designated assistance company prior to treatment. This policy will limit benefits should the Insured Person not contact the assistance company within a specified time period.

Accidental Dental Reimbursement Benefit

When, as the result of Injury to whole or sound teeth (capped or crown teeth will be considered whole or sound) and due to a force or blow external to the mouth, the Insured Person requires Emergency treatment or service outside his province of Residence by a legally qualified dentist or dental surgeon, the Company will pay the expenses actually incurred by the Insured Person for such treatment or service. Payments under this part will be made in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the province or territory of the Insured Person's Residence in Canada or its equivalent, as determined by the Company. In no event will benefits exceed $3,000.00 with respect to any one Accident.

Travel Benefits

Attendant Transportation Benefit

If, as the result of Injury or Sickness, the attending Physician recommends in writing or the air carrier's rules and regulations require the presence of a medical attendant during the Emergency evacuation of the Insured Person in accordance with the part titled "Evacuation Benefit", the Company will pay the reasonable and necessary expenses actually incurred for the round trip airfare by such medical attendant. Expenses may also include one day accommodation and board for that day. The medical attendant must be qualified to work as such in the place where the Insured Person received Emergency medical attention, does not ordinarily reside in the Insured Person's Residence and is not a Member of the Immediate Family. All covered expenses incurred by such attendant are subject to a maximum of $5,000.00.

Boarding, Lodging and Travel Expenses Benefit

In the event that an Insured Person is confined to a Hospital due to Injury or Sickness for a period of at least five consecutive days and thus prevented from returning to his province of Residence, and the attendance of a Member of the Immediate Family or companion aged 18 or older is certified as medically necessary by the attending Physician, the Company will reimburse the expense incurred by such Member of the Immediate Family or companion for the round-trip economy airfare, subject to pre-approval by the Company. This benefit includes meals and accommodations up to $150.00 per day.

In the event of death of an Insured Person due to Injury or Sickness, the Company will pay a single round-trip economy airfare for a Member of the Immediate Family or companion aged 18 or older to identify the mortal remains, and must be pre-approved by the Company. This benefit includes meals and accommodations, up to a maximum of $150.00 per day and 5 consecutive days.

For Dependent Children (under age 18, or who are mentally or physically handicapped and reliant on the Insured Person for assistance) that must be accompanied by a parent or guardian, costs for boarding, lodging and travel are also considered eligible expenses.

The total maximum amount payable under this part by the Company to or on behalf of any Insured Person will not exceed $3,000.00 as a result of any one Injury or Sickness.

Dental Treatment Benefit

In the event the Insured Person requires Emergency treatment for pain relief, other than a force or blow to the mouth, the Company will pay the expenses actually incurred by the Insured Person for such treatment, subject to a maximum of $500.00. All treatment must be initiated within 48 hours from the time the Emergency began and completed no later than 90 days after the treatment has begun. Payments under this part will be made in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the province or territory of the Insured Person's Residence in Canada or its equivalent, as determined by the Company.

Travel Benefits

Evacuation Benefit

The Company will pay all expenses, up to a maximum of $200,000.00, for transportation, medical services and supplies necessarily incurred in connection with the Emergency evacuation of the Insured Person due to Injury sustained or Sickness commencing during the first 90 days of a trip. Such evacuation must be ordered by a Physician who certifies that the severity of the Insured Person's Injury or Sickness warrants the Emergency evacuation of the Insured Person. All arrangements for evacuation must be recommended by the attending Physician, meet the standard regulations of the conveyance transporting the Insured Person and must also be verified and approved by the Company prior to evacuation. The Company will not cover any expenses provided by another party at no cost to the Insured Person or already included in the cost of the trip.

If the Insured Person is evacuated, the Company will pay the cost of a one-way economy return airfare for Dependent Children (under age 18, or who are mentally or physically handicapped and reliant on the Insured Person for assistance) that must be accompanied by a parent or guardian, and the cost of a one- way economy return airfare for such parent or guardian, to the province of Residence, by the most direct route, subject to a maximum of $5,000.00. Pre-approval by the Company is required prior to evacuation.

Excess Hospital Benefit

If, as the result of Injury or Sickness, an Insured Person is confined during the period this policy is in force in a Hospital as an in-patient, the Company will reimburse the reasonable and necessary Emergency Hospital expenses, up to and including semi-private accommodation, actually incurred during such confinement and payable by the Insured Person.

In the event that an Insured Person is confined to Hospital on or after the Trip Termination Date and thus prevented from returning to his province of Residence, insurance hereunder will continue for the period of such confinement, but in no event for more than 90 days from the date that the first insured expense was incurred hereunder.

In the event that an Insured Person is discharged from Hospital on or after the Trip Termination Date, coverage will be extended for a maximum period of 72 hours immediately following such discharge.

Excess Medical Benefit

If, as the result of Injury or Sickness, an Insured Person requires treatment for the following services on an Emergency basis:

a) out-patient room charges,

b) treatment by a Physician or surgeon,

c) services of a licensed anaesthetist, subject to the health insurance plan schedule of fees published by the Insured Person’s province of Residence,

d) services of a licensed private duty nurse while the Insured Person is in hospital (when recommended by the attending Physician), subject to a maximum of $10,000.00,

e) x-rays and laboratory examinations which are required for diagnostic purposes,

Excess Medical Benefit (cont'd)

f) rental or crutches or appliances,

g) cost of splints, trusses, braces, or

h) treatment by a licensed physiotherapist, chiropractor, osteopath, chiropodist, podiatrist and acupuncturist, up to a maximum of $500.00 per practitioner, subject to a combined maximum of $2,000.00,

the Company will reimburse the reasonable and necessary expenses actually incurred during the period this insurance is in force for such treatment or services.

Ground and Air Ambulance Expense Benefit

If, as the result of Injury or Sickness, an Insured Person requires transportation to the nearest medical facility qualified to provide the necessary Emergency services, the Company will pay the expense for ground ambulance, subject to a maximum of $500.00 per Injury or Sickness or for air ambulance, subject to a maximum of $5,000.00 per Injury or Sickness.

Hotel Convalescence Benefit

If, as the result of Injury or Sickness, the attending Physician certifies in writing that the Insured Person, due to his medical condition, is prohibited from resuming any travel following discharge from the Hospital where the Insured Person was confined for a period not less than seven days, the Company will pay the reasonable and necessary expenses actually incurred for board and accommodation (in the vicinity of the Hospital where the Insured Person was confined), subject to a maximum of $1,000.00 per Injury or Sickness.

Meals and Accommodation Benefit

In the event that an Insured Person is hospitalized as an inpatient due to Injury or Sickness, the Company will pay up to a maximum of $3,000.00 for additional reasonable living costs, child care costs for accompanying Dependent Children (under age 18 or who are physically or mentally handicapped and reliant on the Insured Person for assistance), and essential telephone calls and taxi fares incurred by the Insured Person.

Prescription Drug Reimbursement Benefit

If, as the result of Injury or Sickness, an Insured Person requires drugs or medicines on an Emergency basis and such drugs or medicines are prescribed by the attending Physician (oral contraceptives, patent medicines, vitamins, repeat prescriptions, maintenance and chronic care drugs are excluded), the Company will reimburse the expenses actually incurred for such drugs or medicines.

Travel Benefits

Repatriation Benefit

In the event of the death of an Insured Person as the result of Injury or Sickness, the Company will pay the reasonable and necessary expenses actually incurred for the transportation of the body to the province of Residence, including the preparation of the body for such transportation, subject to a maximum of $10,000.00.

Return of Vehicle or Watercraft Benefit

If, as the result of Injury or Sickness, the attending Physician certifies in writing that the Insured Person has become disabled and is unable to continue the trip by means of driving the owned or rented motorized vehicle or watercraft used as a conveyance during such trip, the Company will pay the reasonable and necessary expenses actually incurred for the return of such vehicle or watercraft by a commercial agency to the Insured Person's normal place of Residence or to the commercial rental agency, as the case may be. The maximum amount payable under this part by the Company to or on behalf of any Insured Person will not exceed $3,000.00 as a result of any one Injury or Sickness.

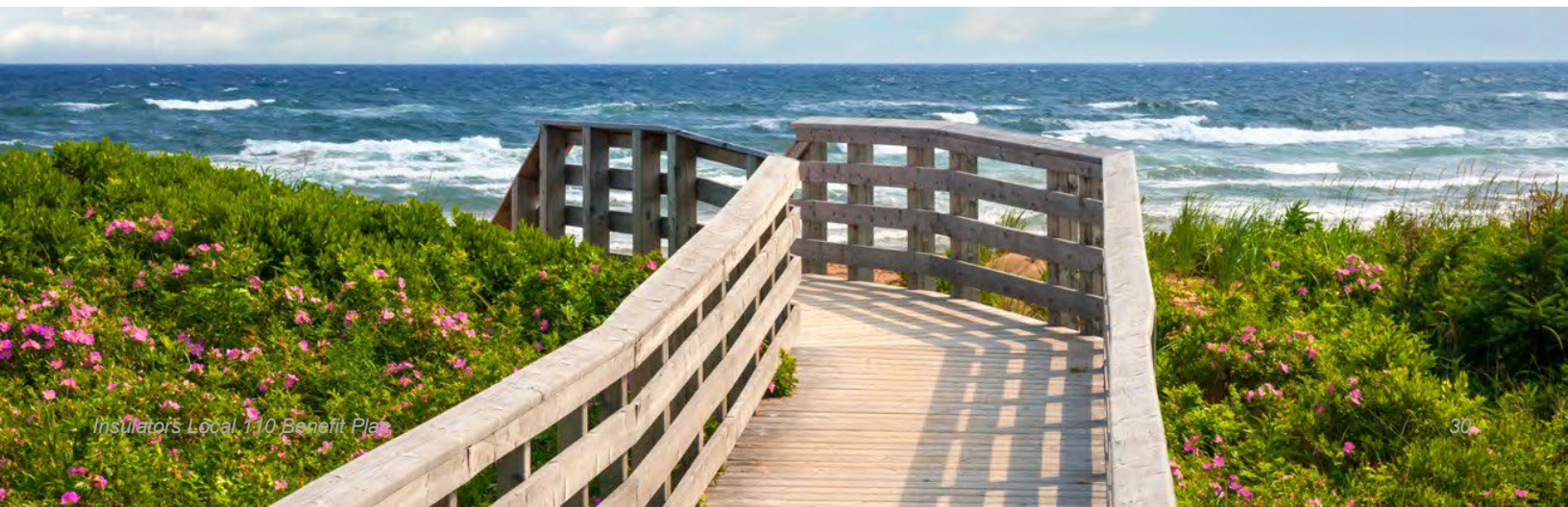
Special Transportation Benefit

If, as the result of Injury or Sickness, an Insured Person requires stretcher accommodation on a regularly scheduled airline for return to his province of Residence during an Emergency evacuation in accordance with the part titled "Evacuation Benefit", the Company will pay the necessary expense incurred, subject to a maximum of $5,000.00.

Emergency Assistance:

If you have an emergency while traveling, you must contact Industrial Alliance immediately before seeking medical treatment. If you are unable to contact Industrial Alliance due to the nature of your emergency, you must have someone else call on your behalf, or you must call as soon as medically possible. Industrial Alliance is available to take your call 24 hours a day, 7 days a week.

From Canada and the US, call toll free 1-800-255-2008
From anywhere else in the world, call collect: 305-865-8895
Policy Number: 100012990



Expenses Not Covered

This policy does not cover loss, fatal or non-fatal, caused by or resulting from:

(a) pregnancy or complications thereof within eight weeks of the expected termination date of pregnancy, or at any time during the pregnancy if the Insured Person's medical history indicates a higher than normal risk of an early delivery or complications;

(b) declared or undeclared war or any act thereof;

(c) any loss as the sole result of the utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined;

(d) active full-time service in the armed forces of any country;

(e) suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;

(f) the commission or the attempt to commit a criminal act by the Insured Person;

(g) alcohol related illness or disease, or the abuse of medication, drugs, alcohol or other toxic substances, non-compliance with prescribed medical therapy or treatment. Alcohol abuse is defined as having a blood alcohol level in excess of 80 mg of alcohol per 100 ml of blood;

(h) mental or emotional disorders, unless hospitalized;

(i) participation in a sport for remuneration or to a sporting event where money prizes are awarded to the winners, any kind of motor vehicle competition or any kind of speeding event including training activities, to a dangerous or violent sport such as but not limited to: off track snow sports, show jumping obstacles, rock climbing or mountain climbing (grade 4 or 5 routes according to the scale of the Yosemite Decimal System – YDS), parachuting, gliding or hang-gliding, skydiving, bungee jumping, canyoning, spelunking, rodeo, paragliding, kite surfing, scuba diving (unless holding a basic SCUBA designation from an internationally recognized and accepted program) and any sport or activity with a high level of stress and risk involved or activities that require signing a waiver for participation;

(j) any loss incurred in a city, region, or country when, prior to the effective date or departure date to that destination,

i. the Department of Foreign Affairs and International Trade of the Canadian Government issued a written warning to avoid all travel to that city, region, or country;

ii. the Department of Foreign Affairs and International Trade of the Canadian Government issued a written warning to avoid non-essential travel to that city, region, or country, and such loss including Sickness or Injury is related or due to the reason for that warning.

If an Insured Person is already at that destination on the date the warning is issued, coverage will be provided for 5 days to allow the Insured Person to leave for a safe location;

(k) expenses incurred as a result of asymptomatic or symptomatic HIV infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions (ARC) or the presence of HIV, including any associated diagnostic tests or charges;

(l) any ailment or condition for which an Insured Person undertakes a journey for the purpose of securing or with the intent of receiving medical attention, prescription drugs or medicine, or hospital services;

(m) any continued treatment, recurrence or complication of a medical condition or related condition, after the initial Emergency Medical situation during the Insured Person's trip has ended. This is subject to the Insured Person being cleared by the Physician and the Insured Person continuing his trip;

(n) a pre-existing or related condition whereby the Insured Person received Medical Treatment or required the use of medication during the three months preceding the date the Insured Person left their province of Residence.

Before the Insured Person's departure from his province of Residence, the Insured Person must be stable under this plan, during the three months leading up to his departure from his province of Residence.

To be stable, the Insured Person must not have:

- been treated, tested or consulted for any new symptoms or conditions;
- had an increase or worsening of any existing symptoms;
- changed treatments;
- changed medications (other than normal adjustments for ongoing care);
- been admitted to the hospital for treatment of the condition;
- been advised of future treatments or tests planned for any existing symptoms or conditions.

This exclusion shall not apply to an Insured Person whose treatment was deemed, by the treating Physician or health care provider, as a routine follow up examination, nor shall it apply to an Insured Person whereby their use of medication is for a controlled and medically Stabilized Condition, which was not medically compromised and whereby there was no change in either the medication or in frequency and usage, or dosage within the three months prior to departure.

(o) any elective (non-Emergency) treatment or surgery:

i. not required for the immediate relief of acute pain and suffering;

ii. which medically could be delayed until the Insured Person has returned to his province of Residence;

iii. which the Insured Person elects to have rendered or performed outside his province of Residence following Emergency treatment for, or diagnosis of, a medical condition which on medical evidence would not prevent the Insured Person from returning to his province of Residence prior to such treatment or surgery.

(p) repatriation is mandatory when it is determined by the Company that the Insured Person is medically fit to travel and appropriate arrangements have been made to admit the Insured Person into the provincial health care system. Benefits will not be paid for any expenses incurred if the Insured Person refuses to travel to his province of Residence.

The Assistance Company, in consultation with the Insured Person's treating Physician, reserves the right to transfer the Insured Person to an appropriate medical facility or to his province or territory of Residence for further treatment. Failure to comply with a transfer request will absolve the Company of any liability to provide benefits for expenses incurred after the scheduled transfer date.

Health Spending Account

From time to time, on a completely discretionary basis, the Trustees may decide to deposit funds into the Health Spending Accounts of eligible employees who

a) complete or have a current Pulmonary Function Test (completed in the last two years). Retirees who have ceased employment in the industry and disabled Plan Members are exempt from this requirement. Pulmonary Function Tests are available at the Wellness of Workers (WOW) Centre; and

b) have been covered under the Plan, without any interruption in coverage, from January through December of the preceding year.

The HSA deposit for eligible employees has been **$800** in recent years, prorated in the year the Pulmonary Function Test is completed based on the date of completion.

What is a Health Spending Account (HSA)

If you have any credits in your HSA, the credit may be used to reimburse health-related expenses not covered by the Benefit Plan provided you continue to be eligible for Benefit coverage (including through using bank hours or making self-payments).

Generally, any expense that would be considered deductible on your income tax return would be eligible for reimbursement. These could include charges such as co-payment amounts, orthodontia for adults, vision care expenses that exceed the Benefit Plan's maximum, and many other expenses.

The money credited to your HSA is not taxed either when it is deposited or when you receive your reimbursement. Reimbursements you receive from the HSA do not have to be claimed as income for income tax purposes. However, expenses which are reimbursed through the HSA also cannot be claimed as deductions on your tax return.

How the HSA Works

When you have a health care expense, you pay the provider for the service or product, just as you do now. Next, you submit your claim for reimbursement to any applicable insurance plan(s). Any amount that is not paid by the insurance plan(s) could then be eligible for reimbursement from the HSA. Reimbursements will be paid to you directly; they cannot be paid to providers of care.

You should note that any balance remaining in your HSA after the end of the year in which it was credited can be carried forward, for one year. In accordance with restrictions imposed by the Income Tax Act, any of these amounts that remain unused at the end of the second year cannot be carried forward and will be forfeited at that time.

Please Note: If you lose eligibility for coverage under the Plan, any balance remaining in your HSA at that time will be forfeited for the period you remain ineligible.

Health Spending Account

Eligible Expenses

Some expenses that will qualify for reimbursement from your HSA include:

- Deductibles
- Co-Payments
- Vision Care above Plan benefits
- Hearing Care above Plan benefits
- Dental expenses above Plan benefits
- Other medical and dental expenses not covered by the Plan as permitted by the Canada Revenue Agency Expenses reimbursed may be for either you or your Dependants. However, if the expense is for a Dependant, he or she must be registered in the Plan for the expense to be considered eligible.

Receiving Reimbursement

All information required for a regular claim will also be required for a reimbursement from your HSA. That is, you should attach your original bill or receipt clearly indicating:

- The person receiving the service,
- The type of service or supply,
- The name and address of the person providing the service or supply,
- The amount charged and paid, and
- The date the service was provided.

Submit the claim and the supporting documentation to the Claims Payer as you would normally and indicate that you wish to use your HSA. Keep a copy of everything you send for your own records.

The Claims Payer will reimburse the expenses under the regular Benefit Plan coverage first. Any expenses not fully reimbursed will then be paid from your HSA account, up to the amount you have remaining in that account.

Dental Care Benefits at a Glance

Dental Care	
Routine Care	80% up to $2,500 combined max per calendar year
Diagnostic and Preventative Care	Examinations, X-rays, Cavity Prevention
Restorative	Fillings, Retentative Pins, Pre-Fabricated Restorations Relining, Repairs, and Rebasing of Dentures Repairs of Crowns, Inlays, Onlays, Bridges
Endodontics & Periodontics	Root Canals, Management of Oral Disease, Root Planing
Oral Surgery & Anesthesia	Extractions, Residual Root Removal
Dentures	80% up to$2,500 combined max per calendar year
Crowns and Bridgework	60% up to$2,500 combined max per calendar year
Orthodontics	$5,000 per lifetime for Dependants (under 19) of Active members only. This benefit is not available on the Retiree Benefit Plan.

This is a basic overview of your Dental Plan. For complete descriptions of all Benefits, including specific limits, see Dental Care Benefits. Payment under the Plan will be based on the Alberta Dental Association Guide for Dental Fees for General Dentists in effect as determined by the Trustees at the time of treatment.

Description of Benefits

If you incur covered Dental Expenses in any calendar year, the Plan pays you **80%** of Routine expenses, **80%** of Dentures and **60%** of Crowns and Bridgework expenses, and **50%** of Orthodontic expenses subject to applicable maximums*. Charges for the completion of medical forms with respect to a dental claim are covered, to a maximum of **$150** per claim.

NOTE: Coverage provided under the Retired Members Plan is **80%** of Routine and Denture expenses and **60%** of Crowns and Bridgework expenses. Orthodontic expenses are not covered under the Retired Members Plan.

*The maximum benefit for covered Routine, Dentures, Crowns and Bridgework incurred in any calendar year is **$2,500** combined for each insured family member. The maximum for Orthodontic treatment is **$5,000** per individual per lifetime. Only dependent children age 19 or less are eligible for Orthodontic coverage.

Dental Care Benefits

Routine Expenses (Payable at 80%)

Routine care includes:

- complete oral examinations, once per 3 calendar years
- full mouth x-rays, 1 per 36 months
- recall examinations, bitewing x-rays, one unit of polishing, fluoride treatment, once in any period of 12 consecutive months
- routine diagnostic and laboratory procedures
- ten units of light scaling or root planing, combined, per calendar year (more than 10 units per year may be considered if pre-approved by the Claims Payer)
- pit and fissure sealants on permanent teeth (for dependent children age 16 and under)
- space maintainers (excluding appliances placed for orthodontic purposes)
- fillings, (amalgam, silicate, acrylic and composite), retentive pins and pit and fissure sealants. Replacement fillings are covered only if
    - i) the existing filling is at least 12 months old and required due to significant breakdown of the existing filling or recurrent decay; or
    - ii) the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- pre-fabricated full-coverage restorations (metal and plastic)
- minor surgical procedures, simple extractions, and post surgical care
- complicated extractions including impacted and residual roots
- anaesthetics administered in connection with oral surgery or other covered dental services
- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- injection of antibiotic Drugs when administered by a Dentist in conjunction with dental surgery
- Implant-related treatment will be covered up to the maximum that would have been paid for prosthodontic treatment such as bridgework or a partial denture. Charges for implant-related periodontic or oral surgery will not be an eligible expense.

Dentures (Payable at 80%)

1. Initial installation of partial or full removable dentures and adjustments to such dentures, but separate charges for adjustments will only be included if they are incurred more than three months after the initial installation; or the replacement or addition of teeth required to replace one or more additional teeth extracted after the existing denture was installed;
2. Replacement of an existing partial or full removable denture by a new denture, or the addition of teeth to an existing partial removable denture to replace extracted natural teeth, but only if evidence satisfactory to the Claims Payer is presented that:
    a) the replacement or addition of teeth is required to replace one or more additional natural teeth extracted after the existing denture was installed and while the family member is covered; or
    b) the existing denture was installed at least five years prior to its replacement and that the existing denture cannot be made serviceable; or
    c) the existing denture is an immediate temporary denture replacing one or more natural teeth extracted while the family member is covered, and replacement by a permanent denture is required, and takes place within twelve months from the date of installation of the immediate temporary denture.

Dental Care Benefits

Crowns and Bridgework (Payable at 60%)

1. Inlays, onlays, gold fillings, crowns and initial installation of fixed bridgework (including inlays, onlays and crowns to form abutments);
2. Replacement of an existing fixed bridgework by a new bridgework, but only if evidence is presented that:
   a) the replacement is required to replace one or more additional natural teeth extracted after the existing bridgework was installed and while the family member is covered; or
   b) the existing bridgework was installed at least five years prior to its replacement and that the existing bridgework cannot be made serviceable.

Orthodontic Expense (Payable at 50%)

For the Dependant children (age 19 and under) of active plan members. Dependant children of retirees and members of the union in good standing classified as Helpers or Improvers are not eligible. The charges made for Orthodontic treatment for eligible Dependant children (including the correction of malocclusion) can continue to age 25 provided the initial treatment began prior to age 19.

Other Practitioners

Services and supplies, in the case of each Dental Expense, must have been rendered and dispensed by a legally qualified dentist except that:

- cleaning or scaling of teeth may be performed by a licensed dental hygienist if such treatment is rendered under the supervision and direction of such dentist, and
- installation, adjustments, repairs and relining of complete dentures may be made by a dental mechanic or denturist legally practicing within the scope of their license, but any charges in excess of the amount specified for such services and supplies in the dental mechanics' or denturists' tariff of the Province where such services and supplies are received will be disregarded.

Reasonable and customary charges by an anaesthetist for the administration of a general anaesthetic in connection with a covered dental procedure are covered.

Alternative Services

If alternative services may be performed for the treatment of a dental condition, the maximum amount payable will be the amount shown in the Fee Guide for the least expensive service or supply required to produce a professionally adequate result. It is recommended that you submit a treatment plan from your dentist to Claims Payer before incurring any expenses over $400.

Dental Care Benefits

Expenses not Covered

No benefit is payable for any expense which is directly or indirectly related to:

a) a charge, or a portion of a charge, which is eligible for reimbursement under any other part of this Plan, or through a government plan or legally mandated program;

b) war, insurrection, the hostile action of any armed forces or participation in a riot or civil commotion;

c) the committing of or the attempt to commit an assault or criminal offence;

d) injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the insured person's blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of injury;

e) charges for broken appointments, third party examinations, travel to and from appointments, or completion of claim forms;

f) charges for services or supplies:

  i) when there would have been no charge at all in the absence of coverage;

  ii) which are received from a medical or dental department maintained by an employer, association or trade union; or

  iii) which are performed or provided by the insured person, an Immediate Family Member or a person who lives with the insured person;

  iv) which are not specified as a Covered Expense under this Benefit;

g) treatment rendered for a full mouth reconstruction, for a vertical dimension, or for a correction of temporomandibular joint dysfunction;

h) cosmetic treatment, unless this is needed because of an accidental injury which occurred while the person was covered under this Plan;

i) implants, or any services rendered in conjunction with implants, for Retired Members, members of the Union in good standing classified as Helpers or Improvers, non-bargaining employees, and active employees without coverage in the Plan in any of the last three (3) years;

j) anti-snoring or sleep apnea devices; (CPAP machines and Mandibular Advancement Devices are covered under Medical Equipment in the Health Care section of this Booklet)

k) treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition;

l) the replacement of removable appliances which are lost, mislaid or stolen; or

m) laboratory fees which exceed Reasonable and Customary charges, as determined by the Claims Payer.

Weekly Disability Benefit

Weekly Disability Benefit	
Weekly Benefit	$729 for a maximum of 41 weeks of disability integrated with E.I.
Commencement	Injuries and Hospitalization: 1st day Illnesses: 8th day

Active Members Plan Only

The plan provides a weekly benefit of **$729** for disability absences which prevent you from working, and are a result of a non-occupational accidental bodily injury or sickness which occurs after your effective date of coverage. Your benefit will commence on the first day of disability due to injury and on the eighth day of disability due to sickness and is payable for a maximum of 41 weeks during any one period of disability. Charges for the completion of medical forms with respect to a weekly disability benefit claim will also be covered, to a maximum of $150 per claim. As weekly disability benefits are deemed to be taxable income by Canada Revenue Agency, income tax will be deducted at source from your weekly benefit, to comply with government requirements.

Benefits from the Plan will cease when Employment Insurance (E.I) Sickness and Accident benefits would normally begin. When E.I. Sickness and Accident benefits terminate, additional benefits from the Plan will be paid for a total maximum benefit payment from the Plan and E.I. of 41 weeks. If you are not eligible for E.I Sickness and Accident benefits, the Plan will provide benefits for a maximum of 41 weeks.

Be sure to apply to Employment Insurance for Sickness and Accident benefits in the first week of your disability. Failure to do so may affect your disability benefits from the Plan.

If you are entitled to pregnancy or parental leave of absence, no benefits are payable for the period during which you would be away from work on pregnancy or parental leave of absence, except where benefits are provided during the post-natal recovery period.

Third Party Liability

If you receive benefit payments under this plan for loss of income for which there may be cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will enable the Claims Payer to be reimbursed for any amount(s) including interest, you recover from a third party for:

- loss of income; or
- medical or dental expenses;

which together with any amount(s) paid or payable under any of the Benefits of this plan, would exceed your actual loss.

Following notification to the Claims Payer of payment by a third party of any judgment or settlement, further disability payments under this plan will terminate until the Claims Payer has been reimbursed the amount set out in the Reimbursement Agreement.

If a lump sum payment is made under judgment or settlement for loss of future income, no further disability benefits will be paid until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

Weekly Disability Benefit

Disability benefit payments will cease on the earliest of the date you: cease to meet the definition of Totally Disabled; you work in any occupation for wage or profit; do not supply the Claims Payer with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing your job duties; do not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by the Claims Payer; are not receiving accepted standard professional treatment for the condition being treated and, where appropriate, treatment by relevant and certified specialists; you refuse or fail to complete and return or comply with the terms of the Reimbursement Agreement in accordance with the Subrogation provision; on which benefits have been paid up to the Maximum Benefit Period shown in the Benefit Schedule; you retire; or, you die.

What is not Covered

No benefits are payable for any Disability directly or indirectly related to:

a) the period you are receiving pregnancy or parental income replacement payments by statute, contract or employer agreement. This plan will, however, pay benefits for the post-natal recovery period of maternity leave in accordance with the Claim Payor's claim practices;

b) any illness or injury for which workers' compensation benefits are payable, or which arises out of or in the course of employment;

c) any illness or injury for which benefits are payable under the Quebec Automobile Insurance Act;

d) medical or surgical care which is not medically necessary;

e) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;

f) the committing of or the attempt to commit an assault or criminal offence; or

g) self- inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness.

Successive periods of disability which are separated by less than one week of active work shall be considered as one continuous period of disability unless the subsequent disability is due to injury or sickness entirely unrelated to the causes of the previous disability. Disabilities arising from different and unrelated causes will be considered as a new disability providing they commence after you return to full-time work for at least one full day. Disabilities arising from the same or a related cause will be considered as a new disability provided you returned to regular full-time work for a period of at least one week

Please Note: Where successive periods of disability are separated by return to work, medical evidence confirming that you were fit to resume regular duties during that period would be required. Without such evidence, the periods of disability may be treated as one continuous disability.

Note: Disability claims must be submitted within six (6) months following commencement of disability.

Life Insurance and Dependant Life Insurance

This benefit is underwritten by Industrial Alliance Life Insurance Company, under group contract number 100012991.

Active Members	
Member Only	$75,000
Dependant Life	Spouse: $15,000; Each Child: $15,000
Permit Workers	
Member Only	$25,000
Retired Members	
Member Only	$20,000

The Life Insurance is payable in the event of your death from any cause at any time or place while you are insured. Payment will be made in a lump sum to the beneficiary or beneficiaries designated by you. The beneficiary or beneficiaries may be changed whenever you wish in accordance with Provincial Laws.

Dependant Life Insurance is payable in the event of the death of a dependant (spouse or child) from any cause at any time or place while you are insured. Payment will be made in a lump sum to you.

You must be an Eligible Member of the Plan before age 70 for Life Insurance coverage. Coverage ends for Members, Dependants, and Retirees at the earlier of termination of coverage and age 80. Dependant Life Insurance is not applicable to Retirees.

Continuation of Life Insurance During Disability

(Not applicable to Retired Members)

If an insured employee:

- becomes Totally and Permanently Disabled while insured;
- continues to be so disabled for the next 6 months; and
- is under age 65;

the Employees' Life Insurance Coverage at the time the employee becomes so disabled will continue while so disabled, but not beyond the employee's 65th birthday, subject to any reduction or termination indicated in the Schedule due to a change in class. The insured employee must submit proof satisfactory to Industrial Alliance, within 12 months of the date of cessation of active work, that the employee is so disabled.

Totally and Permanently Disabled means that solely because of an illness or injury, an insured employee is, and will continue to be, unable to work at any occupation for which the employee is, or may reasonably become, fitted by education, training or experience.

If Employee Life Insurance is being continued, Dependant Life Insurance will also be continued.

Life Insurance and Dependant Life Insurance

Conversion Privilege Members

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Life Insurance coverage to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received within 31 days of the termination or reduction of your Member Life Insurance. If you die during this 31-day period, the amount of Member Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

Spouses

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your application for the individual policy, along with the first monthly premium, must be received within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for spousal coverage.

For more information on the conversion privilege, please contact the Administrator.

Members and Spouses

Note: The conversion privilege does not apply to reduction of life insurance or termination of insurance which became effective at specified ages, or upon your retirement.

The individual policy may be:

- a permanent plan that the Insurer offers to the public at the time of conversion;
- non-convertible term insurance to age 65; or
- one-year non-renewable term insurance which may be converted while it is in force to any plan described above.

In no event may the converted policy exceed $200,000, nor may it include disability or other added benefits. You or your Spouse must apply, in writing, and pay the first premium to the Insurer within 31 days of the date insurance terminates. The premium rates will be based on age and class of risk at the time of conversion. No medical exam or health questionnaire will be required.

Extension of Benefits

If you or your Dependant dies within 31 days of the date the Life Insurance terminates, the amount that could have been converted will be paid as a death benefit under this plan even if there was no application for conversion.

Accidental Death & Dismemberment Benefit

This benefit is underwritten by Industrial Alliance Life Insurance Company, under group contract number 119-3394.

AD&D Benefits for all Active Members and Retirees	
Principal Sum	$75,000 for Active Members; $25,000 for Permit Workers; $20,00 for Retirees
Claim submission time frame	3 months after the Date of Loss

Coverage

Coverage is provided for accidents which occur anywhere, at any time, on or off the job. You will be covered whether you are at home or travelling, including air travel as a passenger, pilot or crew member (some limitations apply) in any certified aircraft flown by a duly licensed pilot.

The plan provides benefits for injury resulting in a loss which occurs within one year after the date of accident. Benefit payments are based on a Principal Sum of $75,000 for Active Members and $20,000 for Retirees and are payable in accordance with the following schedule. Coverage ends for at the earlier of termination of coverage and age 85 for Active Members and age 80 for Retirees.

Schedule of Benefits

The plan provides benefits for injury resulting in a loss which occurs within one year after the date of accident. Benefit payments are based on a Principal Sum of $75,000 for Active Members and $20,000 for Retirees and are payable in accordance with the following schedule:

Life	The Principal Sum
Both Hands	The Principal Sum
Both Feet	The Principal Sum
Entire Sight of Both Eyes	The Principal Sum
One Hand and the Entire Sight of One Eye	The Principal Sum
One Foot and the Entire Sight of One Eye	The Principal Sum
Speech and Hearing	The Principal Sum
One Arm	3/4 of the Principal Sum
One Leg	3/4 of the Principal Sum
One Hand	2/3 of the Principal Sum
One Foot	2/3 of the Principal Sum
Entire Sight of One Eye	2/3 of the Principal Sum
Speech or Hearing	2/3 of the Principal Sum
Thumb & Index Finger of Either Hand or Four Fingers of One Hand	1/3 of the Principal Sum
Hearing in One Ear	1/3 of the Principal Sum

Paralysis Benefit

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

Accidental Death & Dismemberment Benefit

Only one of the amounts shown above (the largest applicable) will be paid for injuries to the same limb resulting from any one accident. Notwithstanding the amounts specified above, the maximum payable under this policy for all losses sustained by an Insured Person as a result of the same accident shall not exceed the Principal Sum.

Definitions

"Injury" means bodily injury caused by an accident occurring while the policy is in force with respect to the Insured Person for whom a claim is presented and resulting in loss covered by the policy.

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

Limitations

This policy is subject to an Aggregate Limit of Indemnity of $2,000,000.00 for all losses resulting from any one aircraft accident. This means that in the event of an aircraft accident which results in an accumulation of losses exceeding $2,000,000.00, the amount payable with respect to each Insured Person will be reduced proportionately.

The Plan does not cover any loss:

- resulting from suicide or from self-inflicted injury,
- resulting from war or any act of war (declared or undeclared)
- occurring while you are on active service in the armed forces,

Coverage is provided for air travel as a passenger on an aircraft which has a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license for such aircraft. However, there are coverage limitations applicable to air travel coverage, details of which can be obtained from the Administrator.

Online Services

What advantages are there to registering my account on the website?

By registering your account online at insulators110.pbas.ca, you will have access to submit your claims online, view and print your claims history, review your benefit balances, update your personal information, register for direct deposit reimbursements and so much more.

How do I register my account?

The portal offers a variety of services and is designed to be user- and mobile-friendly. It provides an online single-point-of-contact to access your current information and manage your Benefits. It even has a digital copy of your benefit card!

If you are an eligible member of the Plan, you must complete a Registration Card and return it to the Claims Payer before you will be able to access the portal. Once received, you simply visit insulators110.pbas.ca.

You will then have the option to create a new account, or log in if you have a current account.

Will I receive a benefit card?

You will receive a benefit card in the mail. Once you are eligible for coverage, have completed and returned a Registration Card, and have registered at insulators110.pbas.ca, you will be able to download or print the following personalized benefit cards under the Download Centre.

Prescription Drug Card

This card should be presented to your pharmacist (along with your prescription) in order to access the electronic pay-direct system. Your claim is processed immediately without the need for you to mail in a claim. Your pharmacist will advise you of any amount owing.

Pay-Direct Card – Health and Dental Practitioner

This card should be presented to the health or dental practitioner, in order to access the electronic pay-direct system. Your claim is processed immediately without the need for you to mail in a claim form. Your practitioner will advise you of any amount owing.

Travel Card

This card gives you coverage for 90 days while you are traveling. If you have a medical emergency, you must contact the travel insurance provider prior to receiving services or making a travel claim. The contact numbers are on the back of the card.

Online Services

How do I register or update my information for direct deposit?

You can always take advantage of direct deposit for your claim reimbursements once you have updated your profile on insulators110.pbas.ca. You will begin to receive reimbursements by direct deposit 2-3 business days after you submit your request.

If you previously utilized direct deposit with the previous provider, please note you must register your banking information and email address in your Profile, found in the left hand menu.

To make this process simple, have a blank cheque or direct deposit form from your bank on hand when you register. These documents include all the information required to set up direct deposit. Your payments can be deposited into a chequing or savings account. If you have another kind of account, please call your financial institution to find out what accounts you can use for direct deposit. Alternatively, you can complete the enclosed Direct Deposit form and submit it to the Claims Payer. You can change your direct deposit at any time by updating your information under your profile.

Before the payment has been deposited into your account, you will receive an email detailing the payment. This is called an Explanation of Benefits. With normal bank clearing procedures, your payment should be deposited within 2-3 business days

Can I view my claims and payments on the website?

Claim history is available on the website, and updated daily, so that you will always have the most up to date information regarding claims submitted January 1st, 2023 onward.

You have the option to print the EOB for any claim that has been processed. The EOB outlines claim information and payments made by the Plan. Having this information easily accessible will make it easier for you to submit the information to any alternative insurance you may have, or provide you the information you may require for income tax purposes.

How do I know when my Benefit Maximums have been reached?

You can view your benefit balances under the Claims menu option. You will have access to view the remaining balance of any benefit. This option is particularly helpful when you have repeat treatments for a specific benefit type.

What is the new process for drugs that require pre-authorization?

Effective immediately, if your doctor prescribes any medication that requires pre-authorization, please visit the Document menu section to download a pre-authorization form. The pre-authorization form should be completed by your doctor and submitted to the Claims Payer for review. If authorization is granted, the approval will be updated to your Benefit Card to facilitate prescription drug claim payment thereafter. To find out if a drug is covered under the Plan, visit click on the Tools menu option on the left, and click on Drug Search.

Claim Provisions

How do I submit a claim?

Online claim submission is an easy and convenient way to submit your health or dental claims. Simply complete the required fields in the claim form, use your smart phone to upload pictures of your receipts, or attach scanned copies. By submitting your claim electronically, you avoid waiting for your claim to reach us by mail. By clicking the Claims menu option on the left, you will find a claim submission option.

While the online claim submission has proven to be the most efficient way to submit claims for reimbursement, you can also submit your claims by email, mail or fax, for review.

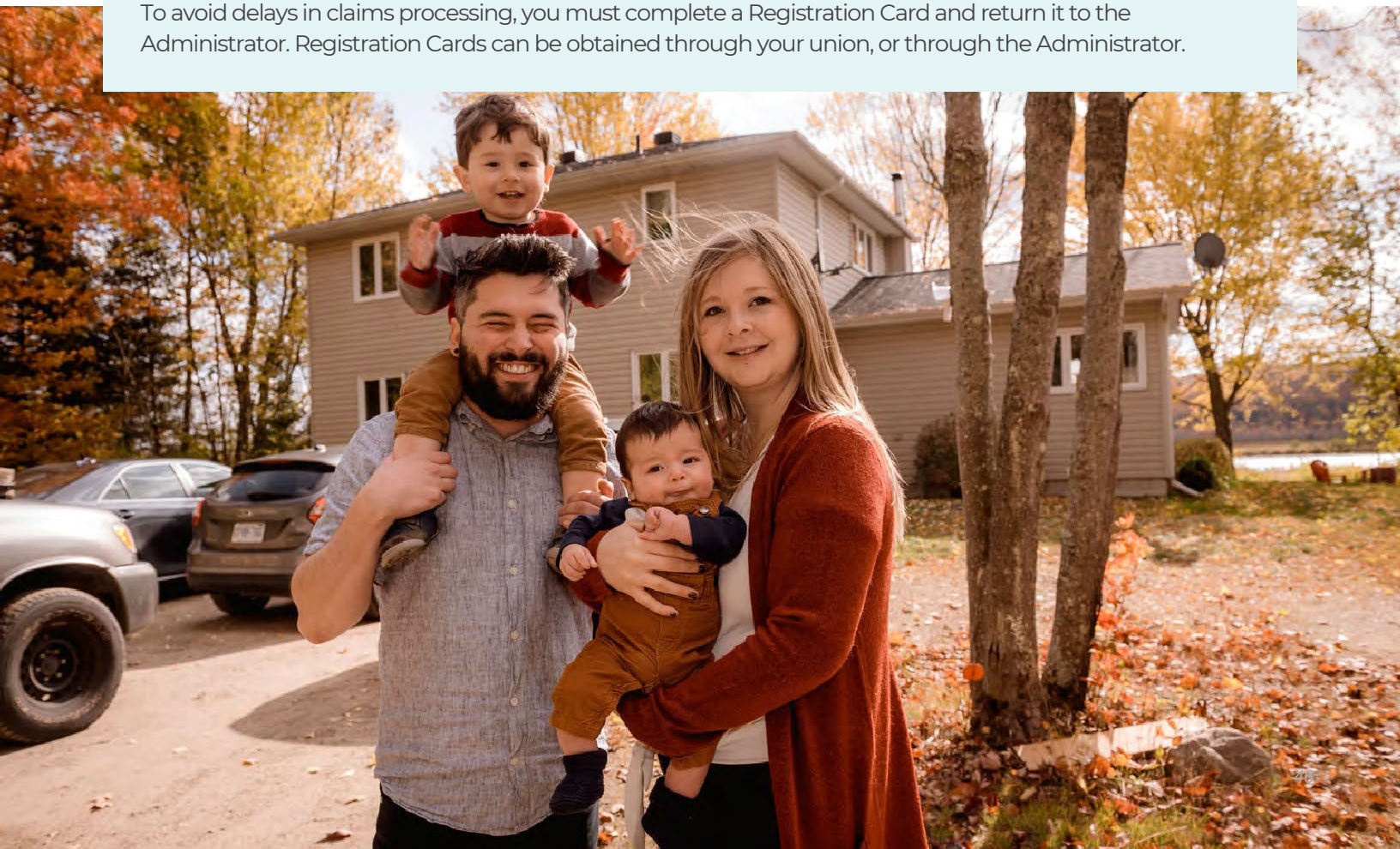
- For health claims, send us a completed claim form, available in the Document menu, along with your receipts and any required referrals.
- For dental claims, a Standard Dental Claim Form can be obtained from your dental office.

Remember to complete each section of the claim form in full, including your certificate number, signatures, and correct mailing address, in order to avoid delays. When submitting a claim online, you are required to retain your original receipt(s) for 12 months, as the Claims Payer may request them at any time.

You can submit claims:

1. Via email: insulators110@pbas.ca
2. Via mail: Suite 101, 46 Hopewell Way, NE Calgary AB T3J 5H7

To avoid delays in claims processing, you must complete a Registration Card and return it to the Administrator. Registration Cards can be obtained through your union, or through the Administrator.



Claim Provisions

How long do I have to submit my claim?

Written proof stating the occurrence, character, and extent of loss must be submitted for each Benefit to the Claims Payer within:

- 24 months after the date of death under the Death Provision for Life Insurance Benefits;
- 12 months after the last date you were actively at work (regardless of the date you became disabled) under the Disability Provision for Life Insurance Benefits;
- 90 days after the date of the loss for Accidental Death and Dismemberment Benefits (or within 12 months if it was not reasonably possible to submit within 90 days);
- 6 months after the start of Disability for the Member Weekly Disability Benefit
- 18 months after the date the expense was incurred, but not more than 6 months after the date coverage terminated, for Health Care, Vision Care, and Dental Care Benefits.

Legal action to recover benefits under the Plan must begin within two (2) years [six (6) years for Life Insurance] of the Date of Loss. The Claims Payer shall have the right and opportunity to examine any one person whose injury or illness is the basis of claim, when and as often as it may be reasonably required during the pending period and payment period, if any, of such claim.

Can I assign my benefit reimbursement to a provider?

The Plan allows you to assign your reimbursement to your provider.

For prescription drug claims, simply present your benefits card to your pharmacist. The pharmacist will submit your claim electronically to the Claims Payer on your behalf. You will be responsible for the co-pay of the cost of the prescription.

Other providers may allow you to manually assign your benefit. When a health provider is submitting a claim on your behalf, the claim must include an Assignment of Benefits form which allows us to pay the provider directly. A dental claim requires a Standard Dental Claim Form issued by your dental office, indicating that you are assigning your benefit, which both parties have signed.

It is your responsibility to ensure you are eligible on the date of service, and pay any outstanding amounts not covered by the Plan.

How long does it take to receive reimbursement?

It normally takes 3-5 business days to be processed and for payment to be issued from the date your claim is received. If the information you submit is incomplete or additional information is required, there will be a delay in payment.

If you currently receive payments by cheque, you can now take advantage of direct deposit for your claim reimbursements.

Appeals Policy

The Trustees are committed to treating the employees, their families, Dependants, and beneficiaries of the Plan with respect and consideration. However, situations may arise where you feel that you have not been treated fairly. These matters should be resolved in a timely and effective manner. If you feel a claim has been improperly denied or adjudicated, the general process to resolve the matter is as follows:

For all benefits you should contact the Claims Payer or Industrial Alliance as soon as you receive your denial, explanation of benefits, or payment. The Claims Payer or Industrial Alliance will address the complaint according to their policies and procedures. In most circumstances this should resolve the situation properly and promptly.

- With respect to Health Care, Dental Care, and Weekly Disability Benefits please contact the Claims Payer no later than 6 months from the date of denial or adjudication of your claim. You may be required to submit medical or other supportive documentation to support your appeal. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.
- With respect to all other benefits, you must submit a written notice of appeal, outlining the reasons for your disagreement to Industrial Alliance within 60 days of the date of the denial/termination notice and be accompanied by additional evidence to support your position. Medical or other supportive documentation must be submitted to Industrial Alliance no later than 6 months from the date of the denial/termination notice. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.
- If you are of the opinion that the Claims Payer or Industrial Alliance has not satisfactorily dealt with the situation, you may bring the matter to the attention of the Administrator. This appeal should be in writing and include any relevant information regarding the claim (e.g. prescription receipts, note(s) from your doctor, evidence of extenuating circumstances). The Administrator will review the appeal in accordance with the provisions of the Plan and determine if further discussion is warranted.
- As a final step, you may contact the Trustees in writing and describe: the details of the decision you are appealing, the grounds for the appeal, the relevant information in support of the appeal and the decision you are seeking. You must also provide your consent for the Trustees to discuss the matter with the Administrator and Consultant. The Trustees expect that contact with them should be made within 12 months of the time that the Claims Payer or Industrial Alliance has advised you of its decision. The Trustees will then discuss the matter with the Administrator to ensure that all relevant information has been considered and determine if further discussion with either party is warranted.

Please also be aware of the following:

- Contacting the Trustees to intervene on your behalf is the FINAL step in the appeals process, other than you initiating legal action to recover benefits. Any expenses incurred in connection with obtaining and securing legal counsel would be your responsibility.
- Under the Plan Text and Insurance Policy, there are time limitations on when a legal action must be commenced by a claimant, if the claim has been denied. Please remember to consult a lawyer about those time limitations. Those time limitations are not extended because you are waiting for a decision from the Claims Payer, Industrial Alliance, or from the Trustees.

The above is a summary of the Appeals Policy of the Plan. A complete copy of the Appeals Policy may be obtained from the Administrator.

Government Programs for Seniors

Alberta

Plan Name	Coverage for Seniors
Benefits Provided	Generic Prescription Drugs, Diabetes Supplies, Ambulance Services, Clinical Psychological Services, Home Nursing Care, Chiropractic Services
Eligibility Requirements	65 years of age or older (proof required)
How to enroll	You should be enrolled automatically when you turn age 65 and you should receive a package from the AHCIP office indicating your enrollment. If you have not received a package you can submit a proof-of-age declaration form to Alberta Health.
Website	https://www.alberta.ca/coverage-for-seniors-program

British Columbia

Plan Name	Medical Services Plan (MSP) and Fair PharmaCare
Benefits Provided	Generic Prescription Drugs, Eye Exams, Medically Required Dental Surgery. Medical Devices, Pharmacy Services Supplementary Benefits (Eligibility Based on Income): Acupuncture, Chiropractic, Massage Therapy, Naturopathy, Physiotherapy, and Podiatry.
Eligibility Requirements	Resident of British Columbia; Supplementary Benefits require adjusted net income below $42,000
How to enroll	You can enroll for MSP, Fair Pharmacy and Supplementary Benefits online here: https://www2.gov.bc.ca/gov/ content/health/health-drug-coverage/ahdc
Websites	https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/who-we-cover/fair-pharmacare-plan

Government Programs for Seniors

Ontario

Plan Name	Ontario Health Insurance Plan (OHIP), Ontario Drug Benefit (ODB) Program with Seniors Co-Payment Program, and Ontario Seniors Dental Care Program (OSDCP)
Benefits Provided	Eye Examinations (over age 65), Generic Prescription Drugs, Diabetes Supplies. Dental Surgery, Routine Dental care for those eligible for the OSDCP, Assistive Devices, Mental Health Services, Smoking Cessation Counselling and Drugs
Eligibility Requirements	Resident of Ontario physically present in the province for 153 days per year; Seniors Programs for those with income under $25,00 per year (single) or $41,500 per year (couple)
How to enroll	You must apply for OHIP in person at a ServiceOntario centre. If you are enrolled in OHIP you will be automatically enrolled in the ODB Program when you turn 65. You can apply online here for the Seniors Co-Payment Program. You can apply online here for the Ontario Seniors Dental Care Program.
Website	https://www.ontario.ca/document/guide-programs-and-services-seniors/health-and-well-being

Administrator:

Insulators Local 110 Benefit Plan
9335-47 Street
Edmonton, AB T6B 2R7
780-426-2874

Claims Payer:

The PBAS Group
Suite 101, 46 Hopewell Way, NE
Calgary AB T3J 5H7
Toll Free: 1-866-391-7526