WELFARE & PENSION PLANS

Carpenters Local 18 Benefit Trust Funds

March 2021

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GENERAL INFORMATION

LETTER FROM THE TRUSTEES:

TO ALL LOCAL 18 HAMILTON/NIAGARA PLAN PARTICIPANTS:

We are pleased to provide you with an updated summary of your insurance benefits provided under your plan.

We know that the benefit plan that has been selected will prove its value to those insured.

In the pages that follow, you will find a brief description of the benefits to which you and your family are entitled, the rules covering eligibility for these benefits and the procedure that should be followed in the event that it is necessary for you to make a claim.

We emphasize that this booklet is informational only and does not constitute the actual Policies of Insurance under which benefits will be paid. The Policies that have been entered into with Canada Life, Allstate and Morneau Shepell can be made available to you on request at the Local 18 Benefits Office. It is those policies that must be referred to as to the final determination of any specific question.

The Fund was established as the result of the bargaining agreement concluded between the employers of the General Contractors' Section of the Hamilton Halton General Construction Association and other participating employers and Local 18 of the United Brotherhood of Carpenters and Joiners of America. Therefore, all members of Local 18 whose employer is obligated to contribute to the Fund by the bargaining agreement, are eligible to enroll.

Sincerely yours,

BOARD OF TRUSTEES

HISTORY & DESCRIPTION OF BENEFIT PLANS

The Carpenters Local 18 Benefit Plans were established as a result of collective bargaining. The Pension Plan began January 1, 1973 and the Welfare Plan began February 1, 1970. Both Plans are governed by Trust Documents, Plan Documents, Governance Documents, Investment Policies and applicable legislation.

Pension and Welfare benefits are financed by contributions received from the employers in accordance with the Provincial Collective Agreement and from income generated through investments. The Trustees, with the aid of consultants, actuaries and investment managers, must ensure that contributions are sufficient to fund the Welfare and Pension benefits provided, while complying with all governing agencies and applicable legislation.

Contributions are remitted monthly by employers based on the current negotiated contribution rate. The members must always maintain pay stubs and all necessary information to check the benefits reported against any records received from the Benefit Plans such as annual pension statements. Record books are available from the Union office to assist in tracking hours earned.

Following is a history of Pension Plan benefit rates since inception:

1992 - 2000 HOURS:		
Jan 1/92	to Dec 31/00	$0.30
All Active hrs Jan/92 (if in good standing at 07/27/94)	to Dec 31/00	$0.42
All Active hrs Jan/92 (if in good standing at 12/31/95)	to Dec 31/00	$0.60
All Active hrs Jan/92 (if in good standing at 12/31/96)	to Dec 31/00	$0.66
All Active hrs Jan/92 (if in good standing at 12/31/97)	to Dec 31/00	$0.69
All Active hrs Jan/92 (if in good standing at 10/31/00)	to Dec 31/00	$0.71
PRE - 1992 HOURS:		
Jan 1/73 (inception)	to Dec 31/78	$0.12
Jan 1/79	to Aug 18/82	$0.18
Aug 19/82	to Dec 31/91	$0.24
All Active hours t• (if in good standing at 12/31/91)	Dec 31/91	$0.26
All Active hours t• (if in good standing at 07/27/94)	Dec 31/91	$0.28
All Active hours t• (if in good standing at 12/31/95)	Dec 31/91	$0.29
All Active hours t• (if in good standing at 12/31/96)	Dec 31/91	$0.33
All Active hours t• (if in good standing at 12/31/97)	Dec 31/91	$0.36
All Active hours t• (if in good standing at 10/31/00)	Dec 31/91	$0.37
2001 TO PRESENT HOURS:		
Jan 1/01	to Present	$0.80

Following is a history of contribution rates since 1994:

WELFARE	DATES	PENSION	DATES
$1.13	Jun/86 - Apr/88	$0.97	Jun/86 - Apr/88
$1.38	May/88 - Dec/89	$1.22	May/88 - Dec/89
$1.00	Jan/90 - Jul/92	$1.60	Jan/90 - Apr/93
$1.15	Aug/92 - Apr/94	$1.90	May/93 - Apr/94
$1.35	May/94 - Oct/94	$2.20	May/94 - Oct/94
$1.65	Nov/94 - Apr/95	$2.45	Nov/94 - Apr/97
$1.67 (+ 8% RST)	May/95 - Oct/97	$2.55	May/97 - Oct/97
$1.77 (+ 8% RST)	Nov/97 - Apr/99	$2.75	Nov/97 - Apr/99
$1.84 (+ 8% RST)	May/99 - Apr/00	$3.39	May/99 - Apr/00
$1.89 (+ 8% RST)	May/00 - Jun 10/01	$4.06	May/00 - Jun 10/01
$0.92 (+ 8% RST)	Jun 11/01 - Apr 30/02	$5.50	Jun 11/01 - Apr 30/02
$1.42 (+ 8% RST)	May 1/02 - Apr 30/03	$5.55	May 1/02 - Apr 30/03
$1.89 (+ 8% RST)	May 1/03 - May 23/04	$5.60	May 1/03 - May 23/04
$2.10 (+ 8% RST)	May 24/04 - Apr 30/05	$5.70	May 24/04 - Apr 30/05
$2.31 (+ 8% RST)	May 1/05 - Apr 30/06	$5.80	May 1/05 - Apr 30/06
$2.52 (+ 8% RST)	May 1/06 - Apr 30/07	$5.90	May 1/06 - Apr 30/07
$2.67 (+ 8% RST)	May 1/07 - Apr 30/08	$6.05	May 1/07 - Apr 30/08
$2.82 (+ 8% RST)	May 1/08 - Apr 30/09	$6.20	May 1/08 - Apr 30/09
$2.97 (+ 8% RST)	May 1/09 - Apr 30/10	$6.35	May 1/09 - Apr 30/10
$2.97 (+ 8% RST)	May 1/10 - Apr 30/11	$6.50	May 1/10 - Apr 30/11
$2.97 (+ 8% RST)	May 1/11 - Apr 30/12	$6.65	May 1/11 - Apr 30/12
$2.97 (+ 8% RST)	May 1/12 - Apr 30/13	$6.80	May 1/12 - Apr 30/13
$3.00 (+ 8% RST)	May 1/13 - Apr 30/14	$6.95	May 1/13 - Apr 30/14
$3.00 (+ 8% RST)	May 1/14 - Apr 30/15	$7.10	May 1/14 - Apr 30/15
$3.00 (+ 8% RST)	May 1/15 - Apr 30/16	$7.25	May 1/15 - Apr 30/16
$3.00 (+ 8% RST)	May 1/16 - Apr 30/17	$7.25	May 1/16 - Apr 30/17
$3.00 (+ 8% RST)	May 1/17 - Apr 30/18	$7.25	May 1/17 - Apr 30/18
$3.00 (+ 8% RST)	May 1/18 - Apr 30/19	$7.25	May 1/18 - Apr 30/19
$3.00 (+ 8% RST)	May 1/19 - Apr 30/20	$7.25	May 1/19 - Apr 30/20
$3.00 (+ 8% RST)	May 1/20 - Apr 30/21	$7.25	May 1/20 - Apr 30/21
$3.00 (+ 8% RST)	May 1/21 - Apr 30/22	$7.25	May 1/21 - Apr 30/22

TRUSTEES AND ADMINISTRATION

EMPLOYER TRUSTEES:

Don Lauppe
Alberici Constructors,
Burlington, ON

Ken Turner
Kemp Construction,
Hamilton, ON

Tom Kemp
Kemp Construction,
Hamilton, ON

David Folk - Auxiliary
PCL Constructors,
Oakville, ON

UNION TRUSTEES:

Greg Reilly
Business Rep
Local 18 Niagara, ON

Matthew Creary
Business Manager
Local 18 Hamilton, ON

Dan Timofejew
Business Rep
Local 18 Hamilton, ON

Garry Baverstock - Auxiliary
Business Rep
Local 18 Hamilton, ON

ADMINISTRATION OFFICES:

For changes of dependants, address, beneficiaries, Sick Benefit (WI Disability) claims, Life Insurance claims, Critical Illness claims, request for forms, all Pension inquiries:

Carpenters Local 18 Benefits Office
1342 Stonechurch Rd. E.,
Hamilton, ON L8W 2C8
Email: benefits@local18.ca

Phone (905) 388-5300 or 5320
Fax (905) 388-7775
Toll Free:1-800-265-6970

Plan Administrator: Christine Selzer-Comeau
Chris@local18.ca
Ex. 233

Insurance Carrier –
Health & Dental Plans
Accidental Death & Dismemberment (AD&D)
Life Insurance
Canada Life
(Renamed from Great West Life)
London Benefit Payments
P.O. Box 5160 Station B
London, ON N6A 0C6
Claims Dept. 1-800-957-9777

Insurance Carrier –
Critical Illness
Allstate Insurance
Company of Canada
PO Box 8100 Station T
Ottawa, ON
K1G 3H6

Insurance Carrier
Employee Assistance Program (EAP)
Morneau Shepell

Pension Plan Actuarial Consultants
Eckler Ltd., Toronto, ON

Welfare Plan Consultants
NFP Canada Corp – Kitchener, ON

Welfare & Pension Plan Auditors
HGK Partners, Hamilton, ON

Investment Consultants
Eckler Ltd., Toronto, ON

IMPORTANT POINTS

This booklet is a summary of the principal features of the plan, describing the provisions of the plans that are of greatest general interest. Not all plan details are included in this booklet, and the policies provided by Canada Life, Allstate Insurance Company and Morneau Shepell are the governing documents. In the event of any variation between information in this summary and the provisions of the policies, the latter will prevail. For further information, contact the Plan Administrator.

MEMBER INFORMATION FORMS/ BENEFICIARY FORMS

All members must complete and maintain the appropriate forms to ensure that benefits are administered correctly. This includes keeping Welfare Beneficiary (Life Insurance) and Pension Beneficiary forms up to date, as well as Spouse and Dependant information current. Any claims submitted for someone not listed on your benefits information with the individual carriers, will not be paid. All changes to your information require the member's signature and should be made at the Local 18 Benefits Office. Please contact the Benefits Office for these forms.

POLICY / REGISTRATION NUMBERS

Welfare Plan -
- Health & Dental Benefits, AD&D, Life Insurance
  Canada Life Insurance Co.
  Policy Number 135427
  Member's Four Digit Identification Number is assigned.
- Critical Illness – Allstate Insurance
  Policy Number 255-0002
- Employee Assistance Program – Morneau Shepell
  1-877-207-8833
- Safety Eyewear Program – self funded by Local 18
  Vision Clinic, Optic House or Optical Clearance Outlet or self-paid.

Pension Plan - Canada Revenue Agency (CRA) & Financial Services Regulatory Authority of Ontario (FSRA)
Registration Number 0368068

SUMMARY OF ALL PLAN BENEFITS

Following is a summary of all your plan benefits. The booklet provides further details.

WELFARE PLAN

Active Members:

Life Insurance for Member	$100,000
Life Insurance for Spouse	$15,000
Life Insurance for Child	$10,000
Accidental Death & Dismemberment	Principle Sum equal to Life Ins.
Short Term Disability (WI)	$500 per week
Maximum 26 weeks (combined with EI sick benefits)	
Critical Illness	$10,000 per covered illness
Spouses/Dependents	$5,000 per covered illness
Out of Country Coverage	unlimited

Active Members over 65 / Retired Members:

Life Insurance for Retired/Active over 65	* $10,000
Life Insurance for Spouse	* $7,500
Life Insurance for Child	* $5,000
* Life insurance goes down every year after 65, see Life insurance section for details	
Out of Country Coverage	$20,000

All Members:

Maximum aggregate per individual $40,000 (excluding Global Medical Assistance and out-of-country emergency expenses and prescription drugs)

Prescription Drugs	100%
($15/$30 deductible per yr; max $10.50 dispensing fee)	*Max. $10,000/calendar year*
(cost at 100% only for generic version when available)	
Erectile Dysfuntion Drugs	$500/year
Smoking Cessation Products	$500/lifetime
Vaccines	Covered
Hospital - semi private	$240/day max
Vision Care	$300 / 24 months
Includes one eye exam Max. $80 every 24 months	
Safety Eyewear (Prescription)	$150 / 24 months
** Provided though Benefits Office at Vision Clinic & Optic House	
Custom made Orthotic Inserts	$500 max per calendar yr

EAP Program - Employee Assistance Program (Service Provided by Morneau Shepell)	1-877-207-8833

Other Healthcare Benefits:

Chiropractor, Psychotherapist, Podiatrist, Osteopath, Massage Therapy, Speech Therapy, Acupuncture, Psychologist, Dietician, Naturopath, Chiropodist, Christian Science Practitioner, Social Worker	$1200 max per calendar yr Max. $80 per visit (maximum combined)
Physiotherapist	$1000 max per calendar yr Max. $60 per visit
Dental Care	
Basic Coverage	100% - unlimited
Major Coverage	100% - max $1500 per yr
Orthodontic Treatment *(covered for children 6 to 20 when treatment starts)*	67% - max $3000 lifetime
Accidental Dental Injury	100% - unlimited

Dental fee guide in effect in your province of residence on date treatment is rendered.

PENSION PLAN

The plan is designed to provide you with an income when you retire. Normal Retirement age under the Plan is 63, however, earlier options are available. Several pension options are available at retirement, and are explained in the Pension section of this booklet. You are eligible for membership in the Plan after 700 hours are received.

The Plan provides for:

- Retirement benefits
- Death benefits
- Termination benefits

CHANGES IN INSURANCE BENEFITS

If your insurance benefits change because of an amendment to the plan, or because of a change in your age, class, earnings, dependant status, etc., the new benefits become effective on the date the change affecting your benefits occurred.

When a change results in increased benefits, you must be active in the plan to be eligible for the new benefits. If you are not active on the date the new benefits would otherwise become effective, the change will not become effective until you return to active status.

PROTECTING YOUR PERSONAL INFORMATION
Canada Life's Privacy Policy

At Canada Life, we recognize and respect the importance of privacy. When you apply for coverage or benefits, we establish a confidential file of personal information. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

We use the personal information to administer the group benefit plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintain records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Canada Life's and its affiliates' internal data management and analytics
- preparing regulatory reports, such as tax slips

We may exchange personal information with your health care providers, your plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.
You may request access or correction of the personal information in your file. A request for access or corrections should be made in writing and may be sent to any of Canada Life's offices or to the Carpenters Local 18 Benefits Office.

RECIPROCITY
TEMPORARY / PERMIT WORKERS

The Trustees want to protect your Welfare and Pension benefits and contributions if you work outside the geographical area of your Home Plan. To do this, the Trustees have signed Reciprocal Agreements with the Trustees of other Carpenters' Welfare and Pension Funds throughout Canada, and these agreements provide for the transfer of Welfare and Pension monies from one fund to another.

If you work outside your geographical area, you must follow the procedures listed below in order to ensure that you will receive credit for Welfare and Pension hours earned in that area.

Please check your annual pension statement received from your Home Plan to make sure all hours have been reciprocated.

Travel Card (Permit Worker)

If you are working temporarily as a travel card member (permit worker) in the geographical area of another Local covered by a fund that the Trustees have a Reciprocal Agreement with, your Welfare and Pension contributions for hours worked/earned at that Local (Related Fund) can be transferred to your Local 18 Welfare Plan / Pension Plan (Home Fund). NOTE: Some administrators expire reciprocal forms after 12 months. It is the member's responsibility to monitor this and arrange to sign a new form.

In order for your contributions to be transferred to your Home Fund, you must do the following:

1. Obtain a Reciprocal Transfer Form at the Local Union or Regional Council Office in the geographical area in which you are working (Related Fund).

2. Complete Section 1 of the form indicating that you wish to have your contributions reciprocated from the "Related Fund" to your "Home Fund".

3. The Union Representative of the "Related Fund" must sign and date the form. The local you are working in must distribute the form to the appropriate Local Union offices and Administrators. When completing the form, make sure to take your signed copy for your records. (Golden copy)

If at any time you wish to inquire if your hours are being reciprocated, please contact the Benefits Office.

If you find that you have not completed the proper paperwork (Reciprocal agreement form) to have your hours reciprocated back to the Benefits Office, please contact the Local 18 union hall or Benefits Office to have a form completed as soon as possible. Not completing the reciprocal form on time could delay your hours being sent back and could affect your benefit coverage.

RECIPROCITY
TRANSFER CARD WORKERS

Transfer Cards
When you transfer your Union membership to another Local covered by a fund that the Trustees have a Reciprocal Agreement with, we will transfer your Welfare Hour Bank as well as any new Welfare / Pension contributions for hours earned in the Local 18 area (Home Fund) after the transfer date, to the fund of the Local (Related Fund) which you transferred into. Pension Plans remain separate although service will be combined for vesting purposes only.

In order to coordinate your Welfare hour bank and coverage, the following steps must be taken:

1. The Benefits Office, once notified by the union hall of your transfer, will send you a letter verifying when your coverage with the Local 18 plan will terminate and an election form that needs to be signed and returned which will then allow the Benefits Office to have your hour bank transferred.

2. You can also obtain a Reciprocal form from your new local and complete Section 2 of the form indicating that you wish to have your contributions from your "Home Fund" to be transferred to the "Related Fund" immediately.

3. Local 18 will cover the member until the end of the month following his transfer deposit, then the balance of his hours will be reciprocated to his new plan up to the maximum allowed at his new plan.

Coverage when transferring from one plan to another:

When a member transfers from one Local/Plan to another that **accepts** transfers of hour banks/dollars, there may be a limitation on how many welfare hours the new Plan will allow transferred in. For example, if a Local 18 member has the maximum hour bank (3,240 hours) and his new Plan only allows 2,000 hours. Any hours that remain in your hour bank will be held and if you transfer back to Local 18, you will be allowed to use any outstanding hours that were left in your hour bank. This is assuming you remained a member in good standing with any of the Carpenter's unions in Canada while you were not a member of Local 18.

When a member transfers to a Local/Plan that **does not accept** hour banks, Local 18 will hold any welfare hours and if you ever transfer back to Local 18, you will be allowed to use any outstanding hours that were kept in your hour bank. This is assuming you remained a member in good standing with any of the Carpenter's unions in Canada while you were not a member of Local 18.

Pay Direct benefits if transferring to another Local / Plan:

As most plans subsidize their Pay Direct benefits, you can only be on Pay Direct benefits through the Plan who's Local you are a member of. Therefore, if you require Pay Direct benefits, please inquire about Pay Direct (self pay) coverage through your new Local Union's Plan.

If you are transferring out of Ontario:
HEALTH INFORMATION YOU SHOULD KNOW

OHIP COVERAGE ACROSS CANADA

An insured person leaving Ontario to travel or work within Canada can continue to receive Ontario health coverage for up to 12 months or until establishing residency in another Canadian province or territory, whichever is sooner. If you plan to work or travel within Canada for more than 212 days in any 12-month period, you need to provide the ministry with a written confirmation of your extended absence. You should provide the ministry with the timing and details of your extended absence as soon as you know that you will be away from Ontario. You should also advise the ministry of your new residential and mailing addresses if you establish temporary residence in another province or territory.

Services Covered Within Canada.

If you are an insured resident of Ontario and you are outside the province temporarily you can use your Ontario health card to obtain insured health services. In most cases, the hospital or physician that you visit while outside Ontario will bill the Ministry of Health and Long-Term Care directly. If you are an insured resident and you are hospitalized in another province or territory while temporarily absent from Ontario, you are eligible for

Ontario health coverage for the duration of your hospitalization up to a maximum of 12 months. If you require hospitalization beyond the 12-month maximum, the province or territory where you are hospitalized will provide you with coverage from the 1st day of the 13th month. If you have to pay for health care that you receive in another part of Canada, such as doctors' services, you may be eligible for reimbursement from the ministry.

Moving to Another Province or Territory

If you are an insured resident moving to another part of Canada you should apply for health coverage in your new province or territory as soon as possible. Your Ontario health coverage will remain in effect until the last day of the second full month after you establish residence in your new location. You can only obtain health coverage from one province or territory at any time. Your new province or territory will notify Ontario's Ministry of Health and Long-Term Care when you apply for your new health coverage.

For more information:

Call **ServiceOntario**, INFOline at:
1-866-532-3161 (Toll-free in Ontario only)
TTY 1-800-387-5559.
Hours of operation : 8:30am - 5:00pm

* Access the ministry website at:
www.health.gov.on.ca

Working Temporarily Out of Province in Canada

While you are covered under the Carpenters Local 18 Welfare Benefit Plan a person may receive medical services or supplies in a Canadian province other than their own province of residence. **Canada Life benefits will only be payable if the person is covered by the government health plan in his home province. (Does not need to be an emergency).**

An employee who may be working out of province is eligible for the same benefits as if he/she were in their home province. Dental benefits are subject to the terms of your regular dental care plan. **Dental Claims** would be assessed according to the fee guide applicable in your home province. **Drug expenses** are subject to your regular healthcare drug coverage applicable in your home province.

WORK-RELATED INJURIES
BILL 162 - WSIB

The Workplace Safety and Insurance Act calls for continuing benefit contributions for up to 12 months following a work-related compensable injury.

If you become injured at work and are receiving Workplace Safety and Insurance Board (WSIB) benefits, the Trust Fund is required to make Health Benefit and Pension contributions on your behalf for a period of up to 12 months following the date of your compensable injury. Your contributions under WSIB for the Welfare plan is currently 90 hours/month and Pension plan is currently 40 hours/week.

You have an obligation to advise the Union Office and Laura in the Benefits Office at Local 18, when you are injured and when your WSIB benefits commence. If not, you may not receive the benefits to which you are entitled. You must also advise the Union Office when your WSIB claim terminates.

To learn more regarding how and when to file a claim, please note the website **www.wsib.on.ca** is a helpful tool, having a section specifically for workers. The **Workers Report of Injury – FORM 6** is also available online at this website.

CANADA LIFE – GROUPNET
ONLINE ACCESS FOR PLAN MEMBERS

Canada Life provides access to Plan members who register for this service. User friendly services are available to members online 24 hours a day, seven days a week:

- Sign up for Direct Deposit Claim Payments (claims paid directly into your bank account
- Submit claims quickly
- Review your coverage and balances
- Find healthcare providers like chiropractors and massage therapists near you
- View your claim status and Explanation of Benefits for the past 24 months
- Check when you're eligible for a benefit, for example, next due for a pair of prescription glasses
- Get notified when your claim have been processed
- And much more….

Please note that although the Local 18 Benefits Office also has access to Groupnet online, the system is only for Plan Administrators and does not give us access to any member information other than names and eligibility of members and their dependents. We cannot access any of the above information.

Visit *www.canadalife.com* or on the GroupNet Mobile app. To register, click "sign in", from there, click "GroupNet for plan members", then follow the instructions to register. Make sure to have your plan (135427) and ID number (found on your benefit card or by calling the Benefits Office) available when registering.

Sign up once and return any time. All you need to remember is the personalized password and username you've selected.

If you do not have access to a computer, the Local 18 Union Office has a kiosk available in the front office, which will connect you directly to Canada Life to access Groupnet.

eClaims – Canada Life has a service to submit your claims on line. To use this convenient service, you must be registered for GroupNet for Plan Members. You will also need to sign up for direct deposit of claim payments and edetails for email notification when your claim has been processed. It is secure, available 24/7 and gives you access to your claims and claim history. Please note: all paper receipts must be kept for a 12 months period in case requested by Canada Life, and some claims may still be required to be submitted as a paper claim. Note: your eclaim may be randomly chosen for audit, when and if this happens, Canada Life will explain what needs to be done. The random auditing is done to prevent fraud. For any further information regarding eclaims, please contact Canada Life at 1-800-957-9777 or the Local 18 Benefits Office.

GroupNet Mobile – Canada Life has now provided online access to your benefits through your Smartphone. Download the app from Google Play, Blackberry App World or the App Store, and access a variety of plan member services while you're on the go. There is a video available on the Canada Life website, which provides a demo of GroupNet Mobile's features.

- Submit claims online with member eclaims – part of Canada Life's GroupNet online services
- access personalized coverage information about benefits, claims and more
- view card information, such as member ID, Drug and Global Medical Assistance when travelling
- locate the nearest provider who has access to Provider eClaims, using a built-in GPS mapping tool

To use GroupNet Mobile, you need to be registered for GroupNet for Plan members, as described above. Go to *www.canadalife.com* and click GroupNet for Plan Members to begin the process. You'll need your group benefits plan number and your plan ID number. To use the app and submit claims, you must also be signed up for Direct deposit of claim payments and eDetails, as described above.

GroupNet Text –By simply texting certain keywords to 204-289-1667, you can get immediate information that's specific to your benefits. For the complete list of keywords, you can text Help. And for a brief description for the type of information that a keyword provides, you can text Help along with the specific keyword. To sign up go to GroupNet for Plan Members and select the Your Profile tab. You can also sign up for text notification of claim payments under the same tab.

HEALTH BENEFIT PROGRAMS

ELIGIBILITY

An account, called an "Hour Bank" is kept by the Fund for each member. This account shows the hours remitted by the contributing employer on the member's behalf. An employer is required by the Collective Agreement to remit contributions by the 20th of the month following the month worked.

No one is eligible for any benefit coverage unless they are a member in good standing with the Carpenters Union Local 18. If the employer is late remitting, coverage may be backdated by contacting the Local 18 Benefits Office.

NEW MEMBERS

New members and their eligible dependents will become eligible for benefit coverage under the Benefit Plan on the first day of the second month following the accumulation of three (3) months coverage (currently 270 hours) in their hour bank. You will receive written notice (Eligibility Notice) from the Plan when your eligibility begins. With the notice, you will also receive a new member package which will include claims forms, a booklet, online information, and any other important information regarding your benefit plan. A few weeks after the package arrives, you will then receive a "benefit card", one will be issued to the member, one for a spouse and one for any fulltime students. This card is to be used to pay for your prescriptions, used when visiting your dentist, or any other provider that requires your policy information and when travelling anywhere in the world.

Example of Eligibility:
John has worked for 2 months, April and May, earning 160 hours per month. His employer remits these hours by June 20th therefore he will become eligible July 1st and will receive written notice of same within the first week of his first month eligible.

Exceptions to this include members serving a probationary period during which no Welfare hours are remitted or when an employer is late remitting.

ONGOING ELIGIBILITY

The monthly deduction for ongoing eligibility is currently 90 hours per month. If you don't have this amount in your account, you may be eligible to Pay Direct (see section).

The maximum hours a member can accumulate in their "Hour Bank" is currently 3 years coverage, or 3,240 hours.

You will receive written notice a month prior to your "Hour Bank" running out ***(Warning Notice)*** and a ***Termination Notice*** when your Hour Bank has been depleted.

REINSTATEMENT

If your coverage has previously terminated because of insufficient hours in your Hour Bank, you will again become covered on the first day of the month following the accumulation of 180 hours, earned and remitted to Local 18. You will receive a ***Reinstatement Notice*** in the mail.

CO-ORDINATION OF BENEFITS

If you or one of your dependants is entitled to benefits for the same expenses

(1) from this plan and some other group insurance plan, or

(2) from this plan and any government insurance plan, or

(3) from this plan and any automobile insurance plan, or

(4) as both a member and a dependent under this plan, or

(5) as a dependent of both parents under this plan

Benefits will be co-ordinated so that the total benefits from all plans will not exceed the expenses actually incurred.

MAKING CLAIMS IF SPOUSE OR DEPENDENTS ALSO COVERED UNDER ANOTHER PLAN

If you, your spouse, or your dependents are also covered by another plan (such as through your spouse's employer) you may need to submit your family's health and dental claims to both plans. This process is called "Co-ordination of Benefits".

If the claim is for the member (you are the patient) – submit the claim to your health or dental plan first, by completing the claim form. Always keep a copy of the claim form. Once you received a written explanation (with or without reimbursement), submit the claim (with the explanation and copy of the original claim form) to your spouse's benefit plan to be reimbursed for the remaining portion.

If the claim is for your spouse (he/she is the patient) – submit the claim to your spouse's health or dental plan first. Complete the claim form for that plan and keep a copy. Once your spouse's plan has assessed and/or paid the claim, then submit the claim to your plan for assessment, including the explanation that the other plan sent to your spouse, along with a copy of the claim form that you kept. You will need to attach and sign a completed Canada Life's claim form.

If the claim is for your dependent child, the parent whose birth date (month and day) occurs first in a calendar year, submits the claim to their plan first. The other parent then submits the remaining portion of the claim to their plan (see above).

BENEFITS FOR RETIRED MEMBERS

A member who retires from Local 18 and remains a member of Local 18 may be entitled to receive Health and Dental coverage to age 65. ** See note below regarding Out of Country coverage for Retirees. Retirees over age 65 will only be eligible for coverage if they are still running out their "Hour Bank".

If when you retire from the trade, you have an "Hour Bank", it will be used up to provide you with the full coverage as an active member as outlined in this booklet (does not include Short Term Disability/WI). Once your hour bank is depleted, see below for options.

If you do not have an "Hour Bank" at retirement but are **between the ages of 53 and 65** and meet the following criteria, you may be eligible for ***Early Retirees Bridging Benefits:***

- 15 years cumulative membership in Local 18
- Minimum of 1,000 earned hours in the 24 months immediately prior to retirement OR a minimum 1,000 hours in your Welfare "Hour Bank" anytime within 24 months prior to retirement.
- In good standing with Local 18 and remain so until age 65

If you meet the above requirements and are between ages 53 and 58, there is a charge of $100 per month for the **PAY DIRECT BRIDGING COVERAGE**. Once you reach age 58, the coverage will continue until age 65 at no cost to the member.

If you meet the above requirement and are between ages 58 and 65, there is no charge for the **EARLY RETIREES BRIDGING COVERAGE**.

Benefits are as listed under "Summary of All Plan Benefits" and include reduced Life Insurance, Prescription Drugs, Extended Health Benefits, Semi-Private hospital, Vision Care, Critical Illness, Employee Assistance Program and Dental Benefits. **Excludes Short Term Disability.**

Special note to Retirees travelling out of country:
Retirees out-of-country coverage has a lifetime maximum of $20,000 per person, with annual reinstatement of $2,000. This is not a significant amount and it is therefore advised that retirees travelling out of country should purchase additional insurance privately.

Retired members returning to work - If the member is still running out an hour bank when they return to work, the contributions made for welfare will be added to the hour bank and could extend their coverage.

If a member qualified and is receiving Early Retiree Bridging coverage (free coverage until the age of 65) after their retirement date, the member will remain at this level of coverage regardless of returning to work and earning additional hours.

OTHER IMPORTANT INFORMATION

TAX ON BENEFITS

The portion of the contribution representing the cost of your Life Insurance, Dependant's Life Insurance, Accidental Death and Dismemberment and Critical Illness is taxable. The required tax receipt will be issued to you each year before tax time, so you can include this amount in your taxable income.

Note: Life Insurance premiums are not taxable for months in which you self pay.

Health expenses that have been reimbursed to you by this plan cannot be claimed as deductible expenses when filing your income tax return.

DISCLAIMER

The Trustees have the authority to determine the nature, amount and duration of benefits to be provided through the Local 18 Benefit Trust Funds. Decisions made by the Trustees about changes to the benefits will be made with the intent of ensuring that the Trust Funds remain in a healthy financial position without accumulating excessive assets.

Please note that any particular benefit that is provided at a particular time cannot be guaranteed for any specific period of time, unless required by legislation. The Trustees reserve the right to amend, suspend, delete or terminate any benefit at any time as in their discretion they deem appropriate.

This booklet is not an Insurance Policy or the Trust Agreement and does not grant or confer any contractual rights. All rights under this Benefits Plan shall be governed by the provisions of the Master Policy issued by Canada Life Assurance Company or Allstate Insurance Company or the Trust Agreement established by the Board of Trustees, and by applicable laws.

MISREPRESENTATION

The Trustees have the power to disentitle any person to past, present or future benefits and to take any further action they deem appropriate, including denying membership in a Plan, to any person where the member or personals claiming through the member are found by the Trustees to be abusing the Plan or making false or improper claims under the Plan.

ELIGIBLE DEPENDENTS

Your eligible dependents include your spouse and dependent children as identified below:

Your Spouse

A spouse is insurable if they are your legal spouse, common-law spouse, or former spouse.

You can only insure one spouse at a time. You must insure the same person for all spouse benefits provided under the employer's benefit program.

A legal spouse means the person lawfully married to you according to applicable provincial legislation.

A common-law spouse means a person who is living with the member in a conjugal relationship.

A former spouse means a divorced or ex-common-law spouse of the member.

To add or remove a spouse, contact the Benefits Office because a Group Coverage Change Form must be completed. The change will take effect on the day stated on the form and received in the Benefits Office.

If your spouse changes his/her name, please contact the Benefits Office to complete a

Group Coverage Change Form. Failure to do so could cause claims to be denied by Canada Life.

Your Dependent Children

Children are insurable for health insurance when they are:

- you or your insured spouse's unmarried natural, adopted, or step child
- A child for whom the member or the insured spouse has been appointed guardian is not insurable unless:
    - Canada Life has received satisfactory proof of guardianship; and
    - If the insured spouse is the guardian, the spouse is living with the member.

A child under age 21 is not considered a dependent if he/she is working more than 30 hours a week, unless he/she is a full-time student.

A child age 21 or over is considered a dependent only if:

(1) he/she is a full-time student under age 25, or
(2) he/she is incapacitated for a continuous period beginning
- before age 21 or
- while a full-time student and before age 25.

A child of the insured spouse is considered a dependent only if:

(1) he/she is also the member's child, or
(2) the spouse is living with the member and has custody of the child.

A child for whom you or your insured spouse have been appointed guardian are considered a dependent only if:

- Canada Life has received satisfactory proof of guardianship; and
- If the insured spouse is the guardian, the spouse is living with the member.

A child is considered a full-time student if he/she has been in registered attendance at an elementary school, high school, university, or similar educational institution for 15 hours a week or more sometime in the last 6 months.

A child is **not** considered a full-time student if he/she is being paid to attend an educational institution.

A child is considered incapacitated if he/she is incapable of supporting himself due to a physical or psychiatric disorder.

Incapacitated Dependent:
If an eligible dependent child becomes incapacitated, coverage may be extended indefinitely. In order for a child/student to be set up as a incapacitated dependent, **the disability must have occurred while the dependent was insured for coverage**. To apply for this extended coverage, you must contact the Benefits Office and request the form to be sent. You will take this form to your dependent's doctor to have completed, and return to Canada Life, who will then determine if coverage will be continued and advise the member in writing of same.

**** Student coverage** for dependents between the ages of 21 and 25 – Proof of School is required by the Benefits Office to continue coverage for a dependent after their 21st birthday up to age 25. Canada Life requires the proof of school by the dependent's 21st birthday and updated proof every 12 months (September's enrollment). A request for updated proof will be sent out every August for September's enrollment. Proof of school is any documentation that states the student's name, current academic year and attendance period or confirmation of full-time student from the register's office. (Copy of student card, letter from register office or timetable as long as the document includes all the required information). If no proof of school is provided, the student will be terminated from benefits on October 1st. For any questions regarding specific proof of school requirements, please contact the Benefits Office.

**** Change from Child to Student (Dental)** – if your eligible child qualifies at age 21 for coverage as a Student (21-25) – the Benefits Office will notify you and request Proof of School documentation. At this time, you should also notify your student's dentist that your Child is now eligible as a Student. Most dentists do direct billing and often if the billing goes to Canada Life as "child" from the dentist's office, and we have updated our records to "student", claims will be denied, stating no coverage. If this happens, please contact your dentist and ask them to update the information and re-submit the claim.

Registering Your Dependents for Coverage

Coverage for your spouse and children is not automatic. You must notify the Local 18 Benefits Office to add or change dependents. Forms can be completed or mailed, as requested.

If your spouse has coverage elsewhere – If your spouse also has coverage through their employer, you must co-ordinate your benefits through this plan with your spouse's plan. You must advise the Local 18 Benefits Office if you, your spouse, or dependents are covered under another plan, such as your spouse's benefit plan. (See Section "Co-ordination of Benefits").

TERMINATION OF BENEFITS

TERMINATION OF INSURANCE

Your insurance will terminate:
- on the last day of the month in which you have less than 90 hour bank credits, or
- when the group policy terminates, or
- when you are no longer a union member in good standing.

Your dependents' insurance will terminate when:
- your insurance terminates, or
- your dependent is no longer an insurable dependent, or

If you are an active member, you may elect continued insurance by paying subsidized premiums to the Welfare Fund. Coverage may be continued on a pay-direct basis for a period of 24 months (see section "**Pay Direct**").

If you are an early retiree, your insurance will terminate when you reach age 65. If applicable, your spouse's healthcare insurance will terminate at age 65 or seven years after you reach age 65, whichever is earlier (see section "**Spousal Bridging**").

If you are a retired member, your insurance will be continued until the hour bank is exhausted. If this is prior to age 65, you may be entitled to "Early Retirees Bridging" (see section "**Early Retirees Bridging**").

If your employment ends because of injury, sickness, leave of absence or temporary lay-off, you may be entitled to continued insurance under this plan. ***Please refer to specific sections in the booklet for more information:***

Non-work related injury or sickness – **Weekly Indemnity / Short Term Disability**
Temporary lay-off – **Pay Direct benefits**
Work-related injury – **Bill 162 / WSIB**

Your Plan Administrator will provide you with the details on the types of insurance, if any, that may be continued and the length of the extensions available.

Extended Benefits After Termination

Weekly Income Insurance (Short term disability) - If your insurance terminates while you are disabled you will continue to receive Weekly Income benefits during that period of disability, up to the maximum noted in the Weekly Income benefit description.

Hospital and Healthcare - If your insurance terminates while you or one of your dependents is totally disabled, your benefit payments for that disability will be continued until the earliest of the following:

- the date the disability ends,
- 90 days from the date the group policy terminates,
- the date you or your dependents have received maximum benefits,
- the date you have received benefits for a period equal in length to the period for which you were insured,
- the end of the calendar year next following the calendar year in which you or your dependent's insurance terminates.

Dentalcare - If your insurance terminates due to termination of the Dentalcare benefit, any benefits payable under this plan for accidental injuries to natural teeth will continue after termination as long as the accident occurred while the Dentalcare benefit was still in force.

PAY DIRECT

Pay Direct payments allow you to maintain coverage when your Hour Bank runs out. In order to qualify for the Pay Direct option, you must:

- be a member in good standing with the Union (Local 18)

- be on the Local 18 unemployed list at the Union Hall and available for work
- If not on the unemployed list due to returning to work, the Plan must be receiving monthly remittances on your behalf from a contributing employer within 3 months

Note: If a member is injured and receiving a WSIB benefit, the Welfare and Pension Funds are required under Bill 162 legislation, to provide the member with ongoing coverage up to a maximum of 12 months from the date of injury. If the member is still receiving WSIB benefits after 12 months and his Welfare hour bank becomes exhausted, he will not be entitled to Pay Direct as he will not meet the above criteria.

PAYMENT DETAILS:

- The cost for Pay Direct coverage is currently $100 per month, which includes RST. (Note – the actual cost for benefits are over $300/month but are subsidized by the Welfare Plan).
- For members newly terminated and starting Pay Direct - Payment must be made within 30 days of Termination due to insufficient hours in the Welfare Hour bank. After 30 days, the member will lose the ability to Pay Direct.
- The member is required to read and sign a Pay Direct Information and Commitment letter prior to starting the Pay Direct benefit. This letter outlines the member's responsibility under this benefit. The member will be provided a copy of the letter once it has been signed by the member.
- For members already on Pay Direct - A member on Pay Direct must make his payment for the current coverage month by the last day of the previous month or Pay Direct coverage will cease and no further payments will be accepted unless other arrangements have been made. Example - you must pay for June coverage by May 31st.
- Payments can be made by cash, debit, cheque, or credit card (in person or over the phone) at the Local 18 Benefits Office. Post-dated payments will be accepted.
- Acceptance of payment does not guarantee coverage. If you fail to meet the above criteria, or at the Trustees discretion, Pay Direct coverage can be terminated or extended at any time.

Pay Direct allows all your benefits to continue at the full amount for yourself and dependents, with the exception of Short-Term Disability (Weekly Indemnity) which is not available to members on Pay Direct.

If you accumulate enough hours in your Hour Bank to again qualify for coverage, you will be notified by letter (See Reinstatement) and any Pay Direct payments made in advance for covered months can be refunded. Members require 180 hours to be reinstated.

Administration of Pay Direct –

- 24 months maximum
- Maximum age of 65
- Only active members qualify, not available to retirees collecting a pension even if returning to work after retirement
- 2 returned cheques results in cash, credit cared or debit payments only

- Pay direct Information & Commitment form required to be signed by member before starting this benefit that outlines the member's responsibility while on this benefit
- Clarification of 'available for work' as follows:

While on Pay Direct, you cannot refuse a job. Also, if you do not return calls for jobs, this will be investigated and could also deem you to be unavailable and therefore not be entitled to Pay Direct. The Benefits Office will work with the union office to monitor anyone applying/using Pay Direct benefits. Once terminated, you must wait to be reinstated for benefits. (180 hours in welfare hour bank)

CONTINUATION OF HEALTH BENEFITS FOR DEPENDANTS (SURVIVOR COVERAGE)

If you die, the health and dental benefits for your dependents will be continued for a period of 12 months or until your hour bank is exhausted, whichever is later. If the coverage is for 12 months, the coverage will terminate exactly 1 year to the date of the member's death.

- If your surviving children cease to qualify as eligible (as defined earlier in this booklet), the health benefits being continued after your death will terminate on the date they no longer qualify.

- If a dependent is disabled on the date insurance under this continuation terminates, his/her insurance payments will be continued until the earliest of the following:

    - The date the disability ends,
    - The date your dependent has received maximum benefits,
    - 90 days from the date the insurance terminated.

Please note: If your dependent is in the hospital on the last day of this 90-day period, insurance payments for that dependent will be continued until the hospital confinement ends or until maximum benefits have been paid.

Payments for Survivor benefits are paid to the surviving spouse. If there is no surviving spouse, benefits are paid as follows;

- For a child who has reached the age of majority, to him/her; and
- For a minor child, to his/her legal guardian.

Spouse's – If you are a spouse under the age 65 of a retired member or over age 65 member who passes away, please see the **Spousal Bridging** section of this booklet for details regarding further coverage you may qualify for. Contact the Local 18 Benefits Office for information and to see if you qualify for Spousal Bridging coverage after the 12 month Survivor coverage terminates.

SPOUSAL BRIDGING COVERAGE

If a Retired Member or Active Member reaches age 65 and his coverage terminates, he may be eligible to purchase **SPOUSAL BRIDGING COVERAGE** for his spouse. This benefit is payable to the earlier of the spouse reaching age 65 or 7 years. The cost for this benefit

is currently $100 per month. Dependent children are not covered under spousal bridging. The following requirements must be met:

- Member must have minimum 15 years cumulative Local 18 membership
- Member must be in good standing with Local 18

Benefits will include:

- ✓ Semi-private hospital
- ✓ Extended Health Benefits
- ✓ Dental Benefits
- ✓ Prescription drugs
- ✓ Vision Care
- ✓ Out-of-country coverage has a lifetime maximum of $20,000

When the member reaches age 65 and the Early Retirees Bridging coverage terminates or the Hour Bank runs out, the member will receive a letter indicating entitlement to this benefit, with an application form and instructions regarding payments. If the member dies while his spouse is covered under spousal bridging, the coverage will continue to the maximum allowed. If the member dies prior to his spouse commencing Spousal Bridging, the spouse may still be eligible for Spousal Bridging coverage. Contact the Benefits Office for details.

Special note to Retirees travelling out of country:
Retirees out-of-country coverage has a lifetime maximum of $20,000 per person, with annual reinstatement of $2,000. This is not a significant amount and it is therefore advised that retirees travelling out of country should purchase additional insurance privately.

HEALTH BENEFITS

WHAT IS COVERED?

Healthcare benefits provides protection against the cost of those medically necessary services and supplies for which there is only partial or no reimbursement from the provincial health plans. Healthcare benefits covers only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the injury or illness.

The Health plan covers the following broad categories.
More information is provided on the following pages.

CATEGORY	COVERAGE
Prescription Drugs	Prescription drugs: $10.50 max. for dispensing fee; 100% reimbursement. Drug card available as of Oct1/13.
Smoking Cessation Products	$500 Lifetime
Erectile Dysfunction Drugs	$500 per calendar year
Paramedical Services	Psychologist, Psychotherapist, Osteopath, Podiatrist, Naturopath, Christian Science Practitioner, Chiropractor, Speech Therapist, Dietician, Massage Therapist, Acupuncturist, Chiropodist, Social Worker – Max. $80 per treatment, $1200 per calendar year.
Physiotherapist	Max. $60 per treatment, $1000 per calendar year.
Critical Illness	Member $10,000 per illness Spouse/Dependent $5000 per illness.
Hearing Aids	$1,000 every 5 years
Vaccines	Covered
Vision Care	Prescription eyeglasses, sunglasses, contact lenses and safety glasses to maximum in following pages. One eye exam every 24 months max. $80.
Medical Services and Equipment	Rental or purchase of medical equipment (Braces, crutches, walkers), lab tests, foam back supports, ambulance.
Custom Made Orthotic	$500 per calendar year, only prescribed by a physician, this excludes Chiropractor & Physiotherapist.
Global Medical Assistance (GMA)	Worldwide assistance to travelers in emergency medical situations.
Out of Province/ Country Coverage	Unlimited, except for retirees.
Semi-Private Hospitalization	Semi-private accommodations to maximum $240 per day.

MAXIMUM BENEFIT

The maximum for Prescription Drugs per person per calendar year is $10,000.
A maximum of $10.50 for dispensing fee per prescription.
The maximum for Hearing Aids is $1,000 every 5 years.
The maximum for Blood Glucose Monitoring Machines is $1,000 every 5 years.
Continuous Glucose Monitoring Machines is $4,000.
The maximum for Nursing is $5,000 per year.
CPAP machine and accessories max. integrated with ADP program- recommend having estimate done prior to purchasing.

The maximum for Covered Expenses for Healthcare (including Hearing Aids, Nursing, and Diabetic Equipment etc.) is $40,000 per family member (excluding Out of Country, Global Medical Assistance and Prescription Drugs) with an annual reinstatement amount of $2,000.

PRESCRIPTION DRUGS

Your plan covers the cost of drugs and medicines that you can only obtain with a prescription and are prescribed by a physician or dentist and dispensed by a licensed pharmacist. The Plan will only pay for eligible drugs approved for sale to the general public by the Canadian Government and that has a Drug Identification.

Drug Card
As of October 1, 2013, the plan implemented a pay direct drug card. This card allows the member to purchase a prescription using the card for payment. The same rules apply regarding the drugs allowed to be covered, if they were covered on an expense sheet, they will be covered by your drug card, there is no difference. (See Enhanced Generic Substitution for additional limits to the cost of drugs). You must use this card when purchasing prescription drugs because there are built in safe guards that protect your plan from overcharging for prescriptions.

Drug cards are issued with their name on the card for:
- the member
- the listed spouse
- student (between the ages of 21 and 25, with proof of school on file)

If you lose your drug card, you can order a new one on Groupnet if you have a profile set up or by calling the Benefits Office.

Benefit Card
As of September 1, 2014, Canada Life has implemented a benefit card, that replaces the ID card, drug card and Global Medical Assistance card. The card can be used to pay for prescriptions, at the dentist or any provider that require your policy information and travelling for out of country medical emergency coverage. This card is only available to new members joining the Local 18 plan or any member that has lost his drug or ID cards and need replacements.

New Drug Solutions – Enhanced Generic Substitutions
Effective October 1, 2013, your plan has implemented the enhanced generic substitution program to your drug benefits. Many brand name drugs have generic equivalents, which are often available at a substantially lower cost. Coverage for a drug will be based on the cost of the lower-priced interchangeable drug with the same medical ingredients. The enhanced Generic Substitution program means that where a generic substitute is available, it should be provided. Physicians and pharmacies have been providing the generic substitute when available.

Your plan only covers 100% of the generic substitute when available.

When purchasing a prescription, you will now have the following options:
- If a generic substitute is available, the cost will be covered 100%
- If you still would prefer the brand name drug, you can choose to pay the difference between the cost of the brand name and generic drug.
- If there is a medical reason for using a brand name drug, the Benefits Office has available a "Request for Brand Name Drug" form that is completed by your physician and submitted to Canada Life for consideration to have the brand name covered by our plan. You will be notified by Canada Life of the decision.
- There are also other options thru your doctor's office and pharmacies where the company that makes the brand name will reimburse for the difference in the cost. This option must be investigated and arranged by the member.

Deductible
- You pay a deductible of $15 for all covered expenses.
- You pay the deductible only once for any one family member in any calendar year.
- No more than $30 is required in deductible amounts for all members of your family in any calendar year.

Prior Authorization
In order to determine whether coverage is provided for certain services or supplies, Canada Life maintains a limited list of services or supplies that require prior authorization.

Prior authorization is intended to help ensure that a service or supply represents reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, Canada Life may require the employee or dependent to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Dispense Fee Limit
- You pay any amount over and above $10.50 of the dispensing fee each time a prescription is purchased.

Co-insurance Percentage
- After you have paid the deductible, Canada Life pays 100% of the balance of covered drug expenses.

Covered Expenses
Drugs and drug supplies described below when prescribed by a physician or person entitled by law to prescribe them and dispensed by a pharmacist or person entitled by law to dispense them.

(1) drugs and medicines, including contraceptive drugs and products containing a contraceptive drug, requiring a prescription in accordance with
(a) the Food and Drugs Act, Canada, or
(b) provincial legislation in effect where the drug is dispensed.

(2) injectable drugs, including vitamins, insulins and allergy extracts, and syringes for self-administered injections.

(3) disposable needles for use with non-disposable insulin injection devices, lancets, test strips, and sensors for flash glucose monitoring machines.

(4) extemporaneous preparations or compounds provided one of the ingredients is a covered drug.

(5) drugs and medicines which do not require a prescription if:
(a) they are listed in the current Compendium of Pharmaceuticals and Specialties, and
(b) they are categorized as:
- Antimalarials
- Fibrinolytics
- Muscle relaxants
- Nitroglycerin
- Potassium replacements
- Single entity fluorides
- Single entity iron salts
- Smoking cessation products
- Thyroid agents
- Topical enzymatic debriding agents

(6) preventive immunization vaccines and toxoids, subject to the limitation for interchangeable drugs.

Unless medical evidence is provided to Canada Life that indicates why a drug is not to be substituted, Canada Life can limit the covered expense to the cost of the lowest priced interchangeable drug.

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

The maximum amount payable under this plan is $10,000 per person in any calendar year. If you find that at any time you may be coming close to the yearly limit allowed for prescription drugs, please contact the Benefits Office to see if there are any programs available to help with the cost.

Benefits in respect of expense incurred for smoking cessation products shall not exceed $500 for any one person during his lifetime.

Benefits in respect of expenses incurred for drugs used to treat erectile dysfunction shall not exceed $500 for any one person in any one calendar year.

Exclusions
Canada Life can decline a claim for services or supplies that were purchased from a provider that is not approved by Canada Life.

Canada Life can limit the covered expense for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

In addition to the limitations outlined in the General Limitations and to the extent otherwise required by law, no benefits are paid for the following:

- atomizers, appliances, prosthetic devices, colostomy supplies.
- first aid or diagnostic supplies or testing equipment.
- non-disposable insulin delivery devices or spring-loaded devices used to hold blood letting supplies.
- delivery or extension devices for inhaled medications
- oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions, whether or not prescribed for medical reason, except where federal or provincial law requires a prescription for their sale.
- diaphragms, condoms, contraceptive jellies, foams, sponges or suppositories, contraceptive implants, or appliances normally used for contraception, whether or not prescribed for a medical reason, unless such contraceptive products contain a contraceptive drug as provided under this Benefit Provision.
- Fertility drugs, whether or not prescribed for a medical reason.
- Drugs or medicines administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital.
- any single purchase of drugs or medicines which would not reasonably be consumed or used within a 100 day period, except for certain non-maintenance drugs identified by the employer, which may be dispensed in quantities which would reasonably be consumed or used within a 34 day period.
- Any drug or medicine which does not have a Drug Identification Number as defined by the Food and Drugs Act, Canada.
- non-injectable allergy extracts.
- drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason.
- supplies which are medically necessary for recreation or sports but not for a person's regular daily living activities.
- delivery and transportation charges.
- Breast pumps
- Wigs

HEALTHCARE / PARAMEDICAL SERVICES

Healthcare benefits provides protection against the cost of those medically necessary services and supplies for which there is only partial or no reimbursement from the Provincial Health Plan. Healthcare benefit covers only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

Co-insurance Percentage

- Canada Life pays 100% of all covered expenses, up to the amounts allowable under the plan.

Covered Expenses

The following services and supplies are covered by your Healthcare Insurance **where permitted by law and to the extent they are not covered under your Provincial Health Plan:**

- Doctors' services for emergency treatment provided outside your province of residence
- Radio-active materials
- Compression hose
- Oxygen
- Blood transfusions
- PSA blood test – reasonable and customary 100%
- Ambulance transportation to the nearest centre where adequate treatment is available (including licensed air ambulance).
- Injectable drugs when administered by a doctor for which no injectable alternative is available.
- Rental or, at Canada Life's discretion, purchase of the following supplies, appliances and prosthetic devices prescribed by a doctor:
  - splints (excluding dental splints), canes, walkers, crutches and casts
  - orthotic appliances which are specifically designed and constructed for the patient are limited to $500 in any calendar year
  - Jobst burn garments, Jobst sleeves for lymphoedema following mastectomy, Jobst support hose
  - braces with rigid supports (excluding lumbar supports)
  - stump socks, shoulder harnesses, head halters, traction apparatus and cervical collars
  - colostomy apparatus, ileostomy apparatus and catheters
  - enuretic devices
  - PUVA therapy for psoriasis, when administered by a dermatologist
  - intermittent positive pressure breathing machine
  - aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis, or chronic asthma
  - apnea monitors for respiratory disrhythmias
  - Insulin, insulin syringes and testing supplies for diabetics
  - artificial eyes, including repairs
  - one pair of eyeglasses or contact lenses following cataract surgery, if a corrective lens was not used during surgery
  - artificial limbs (including repairs and replacement but excluding myoelectrical limbs)
  - external breast prostheses, once per calendar year, post-mastectomy
  - transcutaneous nerve stimulator for up to 6 months
  - non-union bone stimulators
  - pacemakers

- Services of an Osteopath, Chiropractor, Massage Therapist, Psychologist, Social Worker, Psychotherapist, Dietician, Speech Therapist, Naturopath, Acupuncturist, Chiropodist/Podiatrist, or Christian Science Practitioner up to a maximum of $80 for each visit. Benefits are limited to $1200 for all visits combined in any calendar year.

- Out of hospital services of a Physiotherapist up to a maximum of $60 for each visit. Benefits are limited to $1000 for all visits combined in any calendar year.

- Out-of-hospital services of a registered nurse, a registered practical nurse if you are a resident of Ontario or a licensed practical nurse if you are a resident of any other province. Benefits are limited to $5,000 for all services in any calendar year.

Limitations
No benefits are paid for services provided by a member of your family or for services which do not require the specific skills of a registered or practical nurse.

Please Note: No benefits will be paid under this plan for treatment by a paramedical practitioner for which the provincial medical plan of your home province covers a portion of the charge until after the provincial health plan has paid out its maximum benefit.

The following service and supplies when prescribed by a physician or surgeon:

- Hearing aids (excluding batteries but including repairs). Benefits for these expenses are limited to $1000 in any 5-year period.

- For an insulin dependant diabetic only, blood glucose monitoring machines. Benefits are limited to $1000 in any 5-year period

- Flash glucose monitoring machines.

- Continuous glucose monitoring machines, including sensors and transmitters. Benefits for these expenses are limited to $4000 in any calendar year.

- CPAP machine (Continuous Positive Airway Pressure machine) is covered by the plan at 100% of a reasonable cost. The Assistive Devices Program (ADP) in Ontario may cover a portion of the expense. Benefits may be reduced by the portion available through ADP. Canada Life recommends that an estimate be done prior to any purchases to verify coverage and any limitations.

GLOBAL MEDICAL ASSISTANCE (GMA)

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Canada Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medial assistance benefits. The following services are covered, subject to Canada Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000.

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment.

- Transportation and lodging for one family member joining a patient hospitalized for

more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket.

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent's medical condition, to a maximum of $1,500.

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation.

- In case of death, preparation and transportation of the deceased home.

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary.

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home described above.

Limitation

Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home.

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges.

Meal expenses are not covered.

Points to Note

Neither the communications network nor Canada Life is responsible for the availability, quantity, quality or results of any medical treatment received by you or a dependent or for unsuccessful attempts by you or a dependent to obtain medical services.

OUT-OF-PROVINCE COVERAGE

OHIP COVERAGE ACROSS CANADA
An insured person leaving Ontario to travel or work within Canada can continue to receive

Ontario health coverage for up to 12 months or until establishing residency in another Canadian province or territory, whichever is sooner. If you plan to work or travel within Canada for more than 212 days in any 12-month period, you need to provide the ministry with a written confirmation of your extended absence. You should provide the ministry with the timing and details of your extended absence as soon as you know that you will be away from Ontario. You should also advise the ministry of your new residential and mailing addresses if you establish temporary residence in another province or territory.

SERVICES COVERED WITHIN CANADA

If you are an insured resident of Ontario and you are outside the province temporarily you can use your Ontario Health Card to obtain insured health services. In most cases, the hospital or physician that you visit while outside Ontario will bill the Ministry of Health and Long-Term Care directly. If you are an insured resident and you are hospitalized in another province or territory while temporarily absent from Ontario, you are eligible for Ontario health coverage for the duration of your hospitalization up to a maximum of 12 months. If you require hospitalization beyond the 12 month maximum, the province or territory where you are hospitalized will provide you with coverage from the 1st day of the 13th month. If you have to pay for health care that you receive in another part of Canada, such as doctors' services, you may be eligible for reimbursement from the ministry.

Working Temporarily Out of Province in Canada
(see Reciprocity section for more information)

While you are covered under the Carpenters Local 18 Welfare Benefit Plan a person may receive medical services or supplies in a Canadian province other than their own province of residence. **Canada Life benefits will only be payable if the person is covered by the government health plan in his home province. (Does not need to be an emergency).**

An employee who may be working out of province is eligible for the same benefits as if he/she were in their home province. Dental benefits are subject to the terms of your regular dental care Plan. **Dental Claims** would be assessed according to the fee guide applicable in your home province. **Drug expenses** are subject to your regular healthcare drug coverage applicable in your home province.

OUT-OF-COUNTRY COVERAGE

Coverage is provided for you and your eligible dependents in the event of a medical emergency which occurs while temporarily traveling outside Canada for business, education or vacation purposes. Please note – this does not cover a pre-existing illness or condition.

A medical emergency is generally considered to be one that arises as a result of:

- A sudden or unexpected injury, or
- A new medical condition which was not identified or being treated prior to your departure from Canada, or
- A previously identified medical condition which was stable and controlled prior to your departure from Canada. In such cases, you may be required to provide medical documentation showing there were no complications such as hospitalizations,

medication changes, or doctors visits. As well as no new or ongoing symptoms for that condition during the three-month period immediately prior to your departure date.

Your Group Plan provides coverage for medical expenses such as physicians' fees, lab fees, and hospital fees that are incurred in the treatment of the initial emergency. Out-of-Country hospital coverage is limited to $200 per day.

The following Out-of-Country expenses are not covered by Canada Life:

- Non-emergency care or follow-up care after the initial emergency treatment.
- Expenses related to pregnancy or delivery after the 35th week of pregnancy or at any time prior to the 35th week if the patient's Canadian physician considers the pregnancy a high risk.
- Continued medical care following an emergency outside Canada if the patient's medical condition permits a return to Canada for treatment.

Please see section on **Global Medical Assistance (GMA)** for additional information when traveling out of Province/Country.

Please note – Plan members and eligible dependents must maintain coverage with their Provincial Health Plan in order to be eligible for benefits under a Canada Life group plan. Therefore, it is critical that you keep your personal information current with the Provincial Health Plan (OHIP).

VISIONCARE

Vision care benefits provides protection against the cost of vision services and supplies rendered or prescribed by an ophthalmologist or an optometrist. Vision care benefits covers only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

Covered Expenses

- Eyeglass frames and lenses, prescription sunglasses (or contact lenses selected in place of lenses and frames). Benefits for these expenses are limited to $300 in any 24 month period.
- Effective October 1, 2013, the plan now allows for the use of the vision care benefit ($300 every 24 months) to be used towards the cost of the laser eye surgery.
- Eye examinations (including refractions) up to but not exceeding $80 for all such services in any 24 month period.

Services Not Paid for by Vision Care Insurance

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

- Services and supplies required by an employer as a condition of employment.

SAFETY EYEWEAR (PRESCRIPTION)

The Local 18 Welfare Plan provides a benefit for Prescription Safety Eyewear in the amount of $150 every 24 months.

The benefit is provided through the Local 18 Benefits Office and is the only vision care benefit not provided by Canada Life. This benefit is in addition to the Vision Care benefits provided by Canada Life. Claims will only be paid if submitted within 15 months of date incurred.

The Safety Eyewear benefit can be processed in either of the following ways:

1) by purchasing prescription safety eyewear from the provider of your choice, paying them directly, then submitting the receipt to the Local 18 Benefits Office for reimbursement to the eligible amount, or
2) by attending one of the clinics listed below, in which case they will bill the Local 18 Benefits Office directly. Note: you must receive an authorization form from the Benefits Office which you take with you to your appointment.

Please note: Local 18 has negotiated a group rate with the clinics listed, therefore in most cases, the required glasses will be provided for around the allowable amount of $150. If you use your own provider, please get an estimate first.

Safety Glasses must meet CSA Safety Standards, including:

- all lens prices include a regular scratch resistant coating.
- a Dura coating is also available when a super hard coating is required.
- all lenses will meet CSA Z94.3 safety standards
- permanent side shields are mandatory
- all frames have a one-year unconditional warranty
- professional eye exams are available by appointment with a licensed optometrist
- 10% discount on all personal eyewear for members and their immediate families
- Frames - only non-spring hinges will be provided, Vision Clinic plastic frames only. Optic House plastic or metal frames.

Note: If purchasing from your own provider, the receipt must state that they are CSA approved Safety glasses, or the claim may not be reimbursed.

VISION CLINIC LOCATIONS:

Niagara Falls	4016 Portage Rd.	(905) 371-0505
Grimsby	65 Main St. East	(905) 945-3344
Fort Erie	235 Garrison Rd.	(905) 994-0494
St. Catharines	553 Ontario St.	(905) 646-3030
St. Catharines	343 Glendale Ave.	(905) 641-1199
Hamilton	640 Queenston Rd.	(905) 561-9911
Burlington	3450 Dundas Rd Unit 8	(905) 319-7559
Welland	112 Division St.	(905) 734-8800
Upper Stoney Ck	1791 Stone Church Rd E	(905) 561-2122
Waterdown	80 Dundas St. E.	(905) 689-1122

OPTIC HOUSE LOCATIONS:

Hamilton	3-1405 Upper Ottawa St.	(905) 318-2020
Hamilton	240 Ottawa St. North	(905) 547-8891

WEEKLY INCOME INSURANCE (Short Term Disability)

If you are unable to earn a living because of an accident or illness, your Weekly Income Insurance would provide you with a weekly income. (See the Summary of Benefits at the front of this booklet for the amount.)

- To receive Weekly Income benefits you need not be confined at home, but your disability must be severe enough to prevent you from performing your regular work, and you must be under the continuous care and personal attendance of a physician.

- Weekly Income benefits begin with the first day of disability due to injury or the eighth day of disability due to illness. Definition of an accident is interpreted as follows: Damage that is the result of an unexpected or an unforeseen event that occurs by chance and causes bodily injury.

  If you have not seen a physician on or before the date benefits would otherwise start, they will not start until after your first visit to the physician.

  If you are hospitalized for at least 24 hours or have day surgery before the eighth day of illness, benefits will begin on the first day of hospitalization or the date of surgery.

- Weekly Income benefits will be paid for a total of not more than 26 weeks for each period of disability reduced by the number of full or partial weeks for which you are entitled to benefits under the Employment Insurance Act of Canada.

During total disability while covered under Weekly Income benefits (W.I.) a member is eligible to be credited with 25 hours per week that will go back into their hour bank. This weekly credit (3.57 hours a day) is up to a maximum of 650 hours during any 12 consecutive months. You are only eligible for this credit while being paid by either Canada Life or EI sick benefits. This credit does not apply if you are receiving moneys from any other source.

To ensure you receive the credit of 25 hours per week you must notify the administrator/ Benefits Office when;

1. Return to work date.
2. Copy of your E.I. Sick Benefits payments from Service Canada that shows the weeks you were paid while off on medical leave. This proof needs to include your name, the summary page that shows the number of weeks you collected E.I. sick benefits and the weekly payments that shows each week you were paid.

- Canada Life will not pay for
  - disability due to injury sustained while working for pay or profit.
  - disability due to illness for which you are covered under Workers' Compensation or similar program.

- disability due to or associated with treatment rendered for aesthetic purposes.
- disability during a period you are serving a prison sentence.
- disability during the scheduled duration of a leave of absence including maternity leave. Maternity leave is considered to begin on the earlier of the date agreed upon by you and your employer or the date of birth.

  This limitation does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy
- disability resulting from self-inflicted injury, war, or engaging in a riot or insurrection

- Successive absences from work are considered to be in the same period of disability unless
  - the absences are separated by one week of active work or availability for active work, or
  - the second absence is due to a completely different cause and starts after your return to or availability for work.

- Your Weekly Income benefits will be reduced by any amounts payable under an Automobile Insurance Plan where permitted by law.

HOSPITAL

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

- For confinement in an Intensive Care Unit, Canada Life pays the reasonable and customary charges.
- For regular hospital room and board, the plan pays up to $240 per day of the hospital concerned for semi-private care.
- If you or one of your dependents is confined in a chronic or convalescent hospital, Canada Life pays up to the usual daily charge of the hospital concerned for semi-private chronic or convalescent care for a maximum of 180 days, as long as the confinement

  (1) is recommended by your doctor, and

  (2) follows a 5-day confinement in a hospital as a registered bed-patient and is for the same condition.
- If you or one of your dependents requires treatment as an out-patient, Canada Life pays the reasonable and customary charges incurred for services and supplies received for the treatment.
- Canada Life pays the reasonable and customary charges for other hospital services and supplies received during confinement as a registered bed-patient.

Please Note: No benefits will be payable for a hospital confinement which started before your insurance became effective.

EAP (EMPLOYEE ASSISTANCE PLAN)

The EAP (Employee Assistance Plan) benefit is provided by Morneau Shepell previously Ceridian Canada Ltd. and is called "LifeWorks". Whether you have a simple question or a complex concern, LifeWorks is here to help you and your family. LifeWorks is a free member resource program to help make your life a little easier; to balance your work and personal life, so you can focus on what's important. When life's challenges seem too much to handle – Lifeworks is there to help you find the support, advice and resources you need to get back on track. Whether you're trying to find child care, get out of debt, coping with a family problem or personal issue that's weighing you down at home or at work, or just dealing with the ups and downs of everyday life – no matter who you are, no matter what kind of issue you're dealing with you need a helping hand, get in touch with LifeWorks. The service is free and completely confidential. This service is available 24 hours a day, 7 days a week.

What LifeWorks offers:

- phone and electronic access to expert lifeworks consultants
- In-person sessions with local counsellors
- Information and online tools – hundreds of articles, audio and multimedia resources, booklets and quizzes
- Child care and elder care locators
- Podcasts
- Special resources for managers

To get in touch with LifeWorks, you can go to their website, **www.lifeworks.com** or call 1-877-207-8833. You will need the user ID and password when using this benefit on line. If you have misplaced or lost your card with this information on it, please contact the Carpenters Local 18 Benefits Office.

BEST DOCTORS SERVICE

The Best Doctors service is designed to allow access to the expertise of specialists, resources, information and clinical guidance.

You, your dependents, parents and parents in law (each a "person" for the purpose of this service) can generally access this service. This service is made up of a unique step-by-step process that may help address questions or concerns about a serious physical or mental illness or condition. This may include confirming the diagnosis and suggesting the most effective treatment plan by drawing on a global database of up to 50,000 peer-ranked specialists.

What Best Doctors offers:

- Access diagnostic and treatment support services by calling 1-877-419-BEST (2378) toll-free
- The person accessing the service will be connected with a member advocate who will be dedicated to the person's case and will provide support through the process. The member advocate will take the necessary medical history and answer the person's questions. Any information provided is not shared with either your employer or the administrator of your health plan.

- Based on the information provided, the member advocate determines the optimal level of service required.
- The member advocate may provide information, resources, guidance and advice individually tailored to meet the person's health needs and can help identify individual community supports and resources available.
- If it is appropriate, the member advocate may arrange for an in-depth review of the person's medical file to assist in confirming the diagnosis and help develop a treatment plan. This review may include collecting, deconstructing and reconstructing medical records, pathology retesting and analyzing test results. A written report outlining the conclusions and recommendations of the specialists will be forwarded to the person accessing the service. Generally, this process takes 6 to 8 weeks. Time frames may vary depending on the complexity of the case and amount of medical resources to collect.
- If the person decides to seek treatment by a different physician, the member advocate can help identify a specialist qualified to meet the person's specific medical needs.

Limitation

Expenses incurred for travel and treatment are not covered by this service.

If the person decides to seek treatment outside Canada, the member advocate can arrange referrals and can help book accommodations. The member advocate can also assist in accessing hospital and physician discounts, arrange for the forwarding of medical information and monitor the treatment process.

The member advocate may identify a Best Doctors specialist suited to answer basic questions about health concerns and treatment options. Answers will be provided in a written report sent by email to the person accessing the service.

Access to this service may be restricted to persons for whom their physician has made a diagnosis of a serious physical or mental illness or condition for which there is objective evidence, or where a serious physical or mental illness or condition is suspected.

These services are not insured services. Canada Life is not responsible for the provision of the services, their results, or any treatment received or requested in connection with the services.

HEALTH CASE MANAGEMENT

Canada Life may contact you to participate in health case management. Health case management is a program recommended or approved by Canada Life that may include but is not limited to:

- Consultation with your or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- Comparison with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- Identification to the attending physician of opportunities for education and support; and
- Monitoring your or your dependent's adherence to the treatment plan recommended by the attending physician.

In determining whether to implement Health Case Management, Canada Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommend by the attending physician.

Heath Case Management Limitation

Canada Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Canada Life has implemented Health Case Management and you or your dependent do not participate or cooperate; or
- You or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Heath Case Management Expense Benefit

Expenses associated with health case management may be paid for by Canada Life at its discretion. Expenses claimed under this provision must be pre-authorized by Canada Life.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where Canada Life has recommended or approved health case management, Canada Life can require that a service or supply be purchased from or administered by a provider designated by Canada Life, and:

- Limit the covered expense for a service or supply that was not purchased from or administered by a provider designated by Canada Life to the cost of the service or supply had it been purchased from or administered by the provider designated by Canada Life; or
- Decline a claim for a service or supply that was not purchased from or administered by a provider designated by Canada Life.

Patient Assistance Program

A patient assistance program may provide financial, education or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, Canada Life can require you or your dependents to apply to and participate in such a program. Where financial assistance is available from a patient assistance program that Canada Life requires participation in, Canada Life will reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent are entitled to receive for that service or supply.

CRITICAL ILLNESS

As of January 1, 2020, Critical Illness has been added to your Benefit Plan. This benefit is provided by Allstate Insurance Company of Canada.

This coverage provides a cash benefit when a member, dependent child, or spouse is diagnosed with a covered critical illness. The benefit is paid directly to the member and can be used however you wish – for daily living expenses, house payments, childcare and more. Benefits are paid regardless of any other coverage you may have.

Basic Benefit Amount:

- $10,000 for Insured Member
- $5,000 for Insured Spouse
- $5,000 for Insured Child(ren)

Critical Illness covers the following illnesses only:

- Heart Attack
- Stroke
- Major Organ Failure (Transplant or Waiting List)
- Kidney Failure
- Invasive Cancer
- Alzheimer's Disease
- Parkinson's Disease
- Coronary Artery By-Pass Surgery
- Multiple Sclerosis
- Paralysis
- Deafness
- Blindness
- Aortic Surgery
- Benign Brain Tumour
- Coma
- Severe Burns
- Loss of Speech
- Carcinoma In Situ – pays 25% of benefit.

Carcinoma in situ means a cancer wherein the tumour cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in situ includes melanoma not invading the dermis.

For details regarding specific illnesses described above please contact the Local 18 Benefits Office.

Exclusions and Limitations

The policy does not pay benefits for an illness due to or resulting (directly or indirectly) from:

1. Any act of war, whether or not declared, participation in a riot, insurrection or rebellion.

2. Intentionally self-inflicted injuries.
3. Injury incurred while engaging in an illegal occupation or committing or attempting to commit a criminal act.
4. Attempted suicide.
5. Any injury resulting directly or indirectly from the use of alcohol, narcotics, or any other controlled substance or drug unless administered upon the advice of a physician.
6. Participation in any form of aeronautics except as a fare paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
7. Alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

GENERAL LIMITATIONS

Your health insurance does not cover Prescription Drugs, Hospital, Healthcare and Vision care services and supplies in the following situations:

- Illness or injury for which you or your dependants are covered under Workers' Compensation of similar program
- Services received for confinement which is primarily for chronic or custodial care
- Services to which the patient is entitled without charge, or for which there would be no charge if there were no insurance
- Services or portion thereof provided under any government sponsored hospital or medical care program
- Aesthetic surgery (cosmetic surgery for beautification purposes)
- Services furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payments of benefits
- Services received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group
- Service, including part-time or temporary service, in the armed forces of any country
- Services required due to war (declared or undeclared), insurrection or participation in a riot
- Services required due to any intentional self-inflicted injury or disease, while sane or insane

DENTAL BENEFITS

Your dental plan has been designed to help you and your dependents maintain good dental health. The plan covers reasonable and customary charges to the extent they do not exceed the dental fee guide level shown in the Summary of Benefits. The Local 18 Benefits Office has a Dental Summary available which can be given to your dentist at your request.

WHAT IS COVERED?

Your Dental plan covers the following broad categories.
More information is provided on the following pages.

CATEGORY	COVERAGE
Basic Coverage	100% Coverage, no annual maximum. Diagnostics, basic cleaning, scaling, minor restorative, endodontics, oral surgery, wisdom teeth, denture maintenance.
Major Coverage	100% Coverage, $1500 per calendar year per family member. Crowns, onlays, inlays, dentures, bridgework.
Orthodontic Coverage	Children only, ages 6 to 20 years when treatment starts 67% to lifetime maximum $3000 per child.
Accidental Dental Injury Treatment	100% Coverage, no annual maximum.

TREATMENT PLAN – FOR EXPENSES OVER $300

Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dentist to complete a treatment plan/preauthorization and submit it to Canada Life. Canada Life will calculate the benefits payable for the proposed treatment, so you will know in advance the approximate portion of the cost you will have to pay and why.

BASIC COVERAGE

The following expenses will be covered:

- Diagnostic services including:
  - one complete oral examination every 36 months
  - limited oral examinations twice every 12 months, except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
  - limited periodontal examinations twice every 12 months
  - complete series of x-rays every 36 months
  - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered

- Preventive services including:
  - polishing and topical application of fluoride each twice every 12 months
  - scaling, limited to a maximum combined with periodontal root planning of **6 time units every 12 months**
    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - pit and fissure sealants on bicuspids and permanent molars every 60 months
  - space maintainers including appliances for the control of harmful habits

- finishing restorations
- interproximal disking
- recontouring of teeth

- Minor restorative services including:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns for primary teeth

- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months

- Periodontal services including:
  - root planning, limited to a maximum combined with preventive scaling of 6 time units every 12 months
  - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months

  A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval

- Denture maintenance, including:
  - denture relines for dentures at least 6 months old, once every 36 months
  - denture rebases for dentures at least 2 years old, once every 36 months
  - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 months
  - denture repairs and additions and resetting of denture teeth after the 3 month post-insertion care period has elapsed
  - denture adjustments after the 3 month post-insertion care period has elapsed, once every 12 months
  - recementation of bridgework

- Oral surgery – includes wisdom teeth

- Adjunctive services

MAJOR COVERAGE

- Crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns

- Onlays and inlays. Coverage for tooth-coloured onlays or inlays on molars is limited to the cost of metal

Replacement crowns, onlays and inlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable

- Gold foil restorations

- Standard complete dentures, standard cast or acrylic partial dentures or complete over dentures or bridgework when required to replace one or more teeth extracted while the person is covered. Over dentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:
  - the existing appliance is a covered temporary appliance
  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

  If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth

- Denture-related surgical services for remodelling and recontouring oral tissues

- Appliance maintenance following the 3-month post-insertion period including:
  - denture remakes, once every 36 months
  - tissue conditioning
  - repairs to covered bridgework
  - removal of bridgework

ORTHODONTIC COVERAGE

- Orthodontics are covered for children who are between 6 and 20 when treatment starts. Reimbursement will only be made for services already provided.

ACCIDENTAL DENTAL INJURY COVERAGE

- Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition

  A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced

LIMITATIONS

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counselling

- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants

- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations

- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage

- Hypnosis or acupuncture

- Veneers except gold foil restorations, recontouring existing crowns, and staining porcelain

- Crowns, onlays or inlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings

- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

  If over dentures are provided, coverage will be limited to standard complete dentures.

  If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework

  If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework

  Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial over dentures and dentures and bridgework related to implants are provided

- Expenses covered under another group plan's extension of benefits provision

- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services

- Expenses private plans are not permitted to cover by law

- Services and supplies the person is entitled to without charge by law or for which a charge is made only because the person has insurance coverage

- Services or supplies that do not represent reasonable treatment

- Treatment performed for cosmetic purposes only

- Congenital defects or developmental malformations in people 19 years of age or over
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

CLAIMS – HEALTH & DENTAL

HOW TO SUBMIT YOUR CLAIMS

Please see section on "Co-ordination of Benefits" if you are covered by more than one Health and/or Dental insurance plan, to determine which plan to submit to first.

You will need this information on all claim forms or electronic billings by dentists:

CANADA LIFE POLICY NO. 135427
FOUR DIGIT MEMBER IDENTIFICATION NUMBER is assigned

HEALTH BENEFITS (Healthcare, Prescriptions)

As of **October 1, 2013**, the Local 18 Plan implemented a new Drug Card. This card is now used to pay for all prescriptions that were previously reimbursed through Groupnet or on paper expense forms. If you do not use your drug card to pay for prescription drugs, you are still able to submit on Groupnet and on paper forms. **Warning: there are safeguards included when using your Drug/Benefit Card, therefore it is important to use it whenever possible.**

As of **September 1, 2014**, Canada Life has introduced a new Benefit Card. It is used for payment of prescriptions, plan information for your dentist and when travelling anywhere in the world for your out of country coverage. Only new members to the plan, lost or stolen cards will receive the new benefit card.

Claims forms for all other claims can be requested from the Local 18 Benefits Office, printed off the Local 18 website (local18.ca) or printed from the Canada Life website once you register as a user through Groupnet. This form named Healthcare Expenses Statement is used for all expenses that need to be reimbursed by Canada Life. For example, paramedical expenses, glasses, eye exam, ambulance fee etc. are all submitted on the Healthcare Expenses Statement and sent into Canada Life for reimbursement. Groupnet for Canada Life also provides a personal claims history for you and your family, personalized forms with all your information already included, and other useful health and coverage information.

All claims must be submitted within 15 months from the date the expense was incurred, or they will not be paid.

If you prefer to have your reimbursements paid directly to your bank account, a form is available through the Canada Life website or from the Local 18 Benefits Office, or can be arrange directly on line thru Groupnet for Plan Members.

STEPS TO SUBMIT A PAPER CLAIM:

1) Get a Healthcare Expenses Statement
2) Complete the form fully.
3) Attach original receipts.
4) Complete section of form regarding Co-Ordination of Benefits, if applicable.
5) Send the form and receipts to:

London Benefit Payments
P.O. Box 5160 Station B
London, ON
N6A 0C6

THE Great-West Life ASSURANCE COMPANY

Healthcare Expenses Statement

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Attach receipts for all services and retain copies for your files as original receipts will not be returned.
3. Send to the appropriate Benefit Payment Office for your plan. See PART 10.

* Did you know that most claims can be submitted online, and you could receive your claim payment faster with direct deposit?
Go to http://groupnet.greatwestlife.com for details.

THIS IS A: ☐ **Claim for benefits** ☐ **Pretreatment/estimate**

PART 1 - Confirmation, Authorization and Signature

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Great-West Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Great-West Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Plan Member signature X _____ **Date:** Day | Month | Year

PART 2 - Plan Member Information - You must complete this section fully. If you are unsure of your plan name, plan number of plan member I.D. number, please contact your plan administrator.

Plan name: TRUSTEES OF CARPENTERS LOCAL 18 WELFARE TRUST FUND

Plan number: 135427 | Plan member I.D. number

Plan Member Name

First name | Last name

Plan Member Address

Number and street | City or town | Province | Postal code

Date of birth: Day | Month | Year

Language preference: ☐ English ☐ French

PART 3 - Coordination of Benefits - Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to insurance under any other plan for the expenses being claimed? ☐ Yes ☐ No
   If yes, please answer the questions below.
2. Who does the other insurance belong to? ☐ Self ☐ Spouse ☐ Child
   First Name _____ Last Name _____
3. If the patient is a dependent child, please provide spouse's date of birth: Day | Month
4. Is the other insurance also with Great-West Life? ☐ Yes ☐ No*
   If yes, please provide: Great-West Life plan number _____ ID Number _____
5. Is treatment required as the result of an accident? ☐ Yes ☐ No
   If yes, what kind of accident? ☐ Motor Vehicle ☐ If other, please explain. _____

*If the other insurance is not with Great-West Life and you have submitted these expenses to your other insurer, please attach the other insurer Explanation of Benefits (EOB) to this claim. An EOB is required even if no benefits were paid by the other insurance.

Page 1 of 2 PLEASE COMPLETE PAGE 2 OF STATEMENT

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PART 4 - Patient Information - Complete for all expenses; one line per patient.

Patient name First name/Last name	Patient's Relationship to plan member Self	Child	Spouse	Patient's Date of birth Day	Month	Year	If child over 18 years: Full time student hours per week	Yes	No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	No
	❑	❑	❑					❑	❑		❑	❑
	❑	❑	❑					❑	❑		❑	❑
	❑	❑	❑					❑	❑		❑	❑
	❑	❑	❑					❑	❑		❑	❑

PART 5 - Claim Details - If additional space is needed, attach a separate page.

Patient Name - First name/Last name	Type of Expense	Nature of Illness

PART 6 - PRESCRIPTION DRUG EXPENSES - Credit card receipts and/or debit slips alone are insufficient. Official pharmacy or clinic/physician receipts are required.

All receipts must include:
- Patient name
- Date of service
- Rx number
- Drug name
- Quantity dispensed
- Drug identification number (DIN)

Please note, receipts for drugs dispensed in Ontario must include the dispense fee.

PART 7 - Paramedical Expenses - For chiropractor, physiotherapist, massage therapist, psychologist, etc.

All receipts must include:
- Patient name
- Date of service
- Name of treatment provided
- Charge for each service
- Provider's name, address, telephone number, professional designation and professional association
- Amount paid by provincial plan if applicable

PART 8 - Medical Expenses - For medical equipment, appliances and services.

All receipts must include:
- Patient name
- Date item was received
- Name of item purchased or a detailed description of the services or supplies
- Charge for each item/service
- Provider's name, address, telephone number and professional designation
- Amount paid by provincial plan if applicable

PART 9 - Visioncare Expenses - Laser eye surgery, glasses, contact lenses and eye exams.

Receipt details

All receipts must include:
- Patient name
- A breakdown of charges for lenses & frames or eye exam
- Date eyewear was received
- Date the eye exam was performed and paid for

Patient Name First name/Last name	Reason for purchase of lenses (check all that apply) Initial prescription	Prescription change	Loss or breakage	None of these reasons
	❑	❑	❑	❑
	❑	❑	❑	❑
	❑	❑	❑	❑

PART 10 - Submitting Your Claim

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

[redacted]

London Benefit Payments
PO Box 5160 Station B
London ON N6A 0C6

For the deaf or hard of hearing:
Toll Free: 1.800.990.6654

Page 2 of 2 YOU MUST COMPLETE BOTH PAGES

eClaims/ On line Claim Submissions – If you have a profile with Groupnet for Plan Members, and direct deposit set up, you have the option to submit most claims on line. When on the homepage of Groupnet for members, you will see Online Claims, click on that and follow the directions. Quick, easy and your money is processed and deposited usually within 2 working days.

For questions or claims status, call Canada Life at 1-800-957-9777.

DENTAL BENEFITS

- If your dentist does direct billing to Canada Life, then no claims form is required. Just provide your dentist with the Policy number and Member I.D. number (see above). If your dentist does not do direct billing, you will need to have your dentist complete the appropriate dental claim form and submit the form to the London Benefits Office (see above).

LIFE INSURANCE

- If you die, your administrator will contact your beneficiary to explain what is required before payment of the insurance money can be made. Please make sure your Beneficiary form is kept up to date. If you have informed your beneficiary that he/she has been named, your beneficiary can also contact the Local 18 Benefits Office once you have passed away for any information. If one of your dependents die, please contact the Local 18 Benefits Office to begin the dependent life claim process.

- For disability waiver of premium benefits, contact the Local 18 Benefits Office for claim forms and procedures.

WEEKLY INCOME INSURANCE (Short term disability)

Contact the Local 18 Benefits Office when you are unable to work for a medial reason, injury, surgery or hospitalization. The Benefits Office will start a file for you and advise you based on a few questions, what paperwork is required to be completed and when.

Note: All information provided to our office will be kept confidential.

VISION CARE INSURANCE

- Claims for vision care, which include glasses, contacts, lens, frames and eye exams are submitted on the regular Healthcare Expense Statement form.

HOSPITAL INSURANCE

- Hospitals do direct billing to the insurance company. It is the member's responsibility to notify the hospital of semi-private coverage and their policy and ID number.

EAP – EMPLOYEE ASSISTANCE PLAN

- Contact LifeWorks by calling 1-877-207-8833 or vising their website at **www.lifeworks.com**

ACCIDENTAL DEATH & DISMEMBERMENT

- Contact the Local 18 Benefits Office for the information and forms you need to proceed with a claim. If you die accidentally, Local 18 Benefits Office will explain the claim requirements to your beneficiary (same as your life insurance beneficiary).

OUT OF COUNTRY CLAIMS

Out-of-country claims (other than those for Global Medical Assistance expenses) should be submitted to Canada Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Canada Life Out-of-Country Claims Department immediately as your Provincial Medical Plan has very strict time limitations.

- Obtain a Statement of Claim Out-of-Country Expenses form from the Local 18 Benefits Office or online at Canada Life. The Canada Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when and if required.

- Ontario residents should complete all applicable forms, making sure all required information is included. Attach all original receipts and forward the claim to the Canada Life Out-of-Country Claims Department. Be sure to keep a copy for your own records. The plan will pay all eligible claims including your Provincial Medical Plan portion. Your Provincial Medical Plan will then reimburse the plan for the government's share of the expenses is anything is covered under your provincial plan.

- Out-of-country claims must be submitted within a certain time period that varies by province. For the claim's submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Canada Life's Out-of-Country Claims Department at 1-800-957-9777.

HEALTH CASE MANAGEMENT

- If you qualify for this benefit, Canada Life will contact you directly.

CRITICAL ILLNESS

You must complete all applicable sections of the claim form and then give it to your attending physician for them to complete their section. Once claim forms are completed, you can submit to:

Allstate Benefits
P O Box 8100 Stn T
Ottawa, Ontario
K1G 3H6

A copy of the claim form can be downloaded and printed on our website or by contacting the Local 18 Benefits Office.

Claims should be submitted within ninety (90) days of diagnosis or treatment for each illness. The proof required must be given to Allstate no later than on (1) year from the time specified unless you are legally incapacitated.

This benefit will make all payments to the member. Any amounts unpaid at the member's death will be paid to the named beneficiary or, if no beneficiary is name, to your estate.

Claims that are denied will be given written notice of;

- The reason for denial;
- The policy provision that relates to the denial
- Your right to ask for a review of your claim; and
- Your right to submit any additional information that might allow us to change the decision.

LIFE INSURANCE

WHAT IS COVERED?

If you die, your beneficiary will be paid the amount of your group life insurance. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate.

If you become disabled while insured and before reaching age 65, Canada Life will waive the premiums on your insurance until the disability ends or you reach age 65 (see **Waiver of Premium** below).

If your insurance terminates or reduces before age 71, you may be able to apply for an individual conversion policy (see **Conversion Privilege** below).

The Life Insurance plan covers the following broad categories.
More information is provided on the following pages.

CATEGORY	COVERAGE
Active Member	$100,000 Amount of insurance for member reduces to $10,000 at age 65. Amount of insurance further reduces by $2,000 on each subsequent birthday to a minimum of $4,000 at age 68.
Retired Member	$10,000
Spouse of Active Member	$15,000 Amount of insurance for spouse reduces to $7,500 on date member reaches 65. Amount of insurance further reduces by $1,500 on each subsequent birthday to a minimum of $3,000 at age 68.
Spouse of Retired Member	$7,500
Child of Active Member	$10,000
Child of Retired Member	$5,000

WAIVER OF PREMIUM

You are entitled to waiver or premium benefits after you have been continuously disabled for nine months. If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period (9 months) as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.

You are considered disabled if disease or injury prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 60% of your pre-disability annual earnings, indexed for inflation. The employment must exist either in the province or territory where you worked when you became disabled or where you now live. Whether or not employment is actually available is not considered in assessing your disability.

If you are not approved for waiver of premium your life insurance will be continued on a premium paying basis until the earlier of the following:

(1) the date your insurance is terminated by your employer, or

(2) the date your insurance would normally terminate under the Termination of Insurance section.

CONVERSION PRIVILEGE

A member or spouse is entitled to obtain an individual life insurance policy without evidence of insurability if he/she meets the following conditions:

- All or part of the life insurance for the person under this policy terminates on or before the person's 71st birthday; and

- The person applies for the individual policy in writing and pays the first premium **within 31 days after the insurance terminates**. In the case of insurance for the spouse, the member or the spouse may apply.

Extension – if the person dies within the 31 days allowed for conversion, the lesser of the following amounts is payable under the death benefit provision of this policy's life insurance benefit as if the death occurred while the insurance was still in force.
The conversion privilege is not available to non-residents of Canada.

LIFE INSURANCE FOR YOUR DEPENDENTS

- If your dependent dies, Canada Life will pay you the amount for which he or she was insured. (See the Summary of Benefits at the front of this booklet for the amount.)

- If you are approved for disability waiver of premium on your employee life insurance, your dependent life insurance will also continue without premium payment until your employee life coverage terminates or your dependents no longer qualify.

- If your spouse's insurance terminates before age 71, your spouse may be entitled to an individual conversion policy.

Either you or your spouse must apply for the individual policy in writing and pay the first premium within 31 days after the insurance terminates.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If you suffer one of the losses listed below as the result of an accident which occurs while you are insured, you will be paid the factor or portion of the Principal Sum shown opposite the loss in the table below. The loss must occur no later than 365 days after the accident. For loss of use, the loss must be continuous for 365 days. If you suffer multiple losses to the same limb as the result of the same accident, only the loss providing the highest amount payable will be paid.

If you die as a result of an accident Canada Life will pay the Principal Sum to your named beneficiary, (same as your Life Insurance beneficiary). If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate.

The Principal Sum is the maximum amount that will be paid for all injuries resulting from the same accident. For paraplegia, hemiplegia, and quadriplegia, the maximum amount that will be paid for all injuries resulting from the same accident is two times the Principal Sum.

Principal Sum is equal to your life insurance amount, currently $100,000.

Schedule of Benefits

	AMOUNT
Loss of Life	Principal Sum
Loss of Both hands	Principal Sum
Loss of Both feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and the Entire Sight of One Eye	Principal Sum
Loss of One Foot and the Entire Sight of One Eye	Principal Sum
Loss of One Arm	3/4 Principal Sum
Loss of One Leg	3/4 Principal Sum
Loss of One Hand	1/2 Principal Sum
Loss of One Foot	1/2 Principal Sum
Loss of the Entire Sight of One Eye	1/2 Principal Sum
Loss of Thumb and Index Finger of the Same Hand	1/4 Principal Sum
Loss of Speech and Hearing	Principal Sum
Loss of Speech or Hearing in both ears	1/2 Principal Sum
Loss of Use of One Arm and One Leg different sides of body	Principal Sum

Quadriplegia (total paralysis of both upper and lower limbs)	2 X the Principal Sum
Paraplegia (total paralysis of both lower limbs)	2 X the Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body	2 X the Principal Sum
Loss of Use of Both Arms or Both Hands	Principal Sum
Loss of Use of One Hand	1/2 Principal Sum
Loss of Use of One Arm or One Leg	3/4 Principal Sum
Loss of Four Fingers of One Hand	1/4 Principal Sum
Loss of All Toes of One Foot	1/8 Principal Sum

ADDITIONAL BENEFITS TO ASSIST YOU

Surgical Reattachment
If you suffer the loss of a limb that is surgically reattached, Canada Life will pay 50% of the amount that would have been payable if the loss had been permanent, regardless of the amount of use regained. The balance of the benefit will be payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

Repatriation
If you die as the result of an accident that is at least 150 kilometres away from your home, Canada Life will pay up to $2,500 for the preparation and transportation of your body to the place of burial or cremation.

Educational Benefit for Dependent Children
If benefits are payable under this benefit provision for your death, Canada life will pay the tuition fees for enrolling your dependent children as full-time students, at a post-secondary institution. To qualify for an educational benefit, a dependent child must have been enrolled:

- As a full-time student at a post-secondary institution at the time of the accident causing your death, or
- As a full-time student at the secondary school level at the time of the accident causing your death and enrols as a full-time student at a post-secondary institution within 365 days after the accident.

Canada Life will pay up to 5% of the Principal Sum, or $5000 whichever is less, for each year of full-time post-secondary school enrolment. Canada Life will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment.

Limitations
No benefits will be paid for tuition expenses incurred before the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Family Transportation Benefit
If you are hospitalized more than 150 kilometres from your home as a result of an injury for

which benefits are payable under this benefit provision, Canada Life will pay up to $2,000 for transportation and lodging expenses for one family member to join you.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $.44 per kilometre travelled.

Limitation
Meal expenses are not covered.

Occupational Training Benefit for Spouses
If benefits are payable under this benefit provision for your death, Canada Life will pay for expenses associate with your spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify.

Canada Life will pay up to 10% of the Principal Sum, or $10,000 whichever is less.

Limitations
No benefits will be paid for expenses incurred more than 3 years after the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Educational Benefit
If benefits are payable under this benefit provision for an injury that requires you to change occupations, Canada Life will pay the tuition fees for enrolling you as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, you must enrol at a post-secondary institution within 365 days after the accident. Canada Life will pay up to $10,000.

Limitations
No benefits will be paid for tuition expenses incurred before the accident, expenses incurred more than 2 years after the accident causing the injury, or room or board or other ordinary living, travelling, or clothing expenses.

Wheelchair Benefit
If benefits are payable under this benefit provision for an injury that requires the use of a wheelchair for you to be ambulatory, Canada Life will pay for alterations to your principal residence to make it wheelchair accessible and habitable, and modifications to motor vehicle you use to make it accessible to and driveable by you.

Benefits for home alterations are payable only if the person or persons making the changes are experienced in home alterations for wheelchairs and recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if the person or persons making the changes are experienced in vehicle modification for wheelchairs, and the modifications are approved by the provincial vehicle licensing authority.

Canada Life will pay the actual expense incurred less any amount paid for the same expenses under this plan's healthcare benefit, up to $10,000 for all home and vehicle modifications combined.

Limitations
No benefits will be paid for expenses incurred more than 365 days after the accident, or for subsequent alterations to your home or vehicle after an initial claim for benefits has been made under this wheelchair benefit provision.

General Limitations
No benefits are paid for injury or death resulting from:

- Intentionally self-inflicted injury or suicide, regardless of your state of mind and whether or not you were able to understand the nature and consequences of your actions
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed
- Disease or infirmity
- Medical or surgical treatment, except surgical reattachment
- War, insurrection, or voluntary participation in a riot
- Service, including part-time or temporary service, in the armed forces of any country.
- Air travel, ascent, or descent, except as a passenger in a licensed aircraft flown by a pilot certified to fly the aircraft. Under no circumstances will benefits be paid where the aircraft is owned, leased, or rented by the employer or where the person who suffers the loss is acting as a crew member

DEFINITIONS AND DETAILS

Dismemberment Loss - loss by dismemberment means:
a) for hands and feet, complete severance through or above the wrist or ankle joint
b) for arms and legs, complete severance through or above the elbow or knee joints
c) for thumb and big toe, complete severance of one entire phalange
d) for fingers and other toes, complete severance of two entire phalanges

Surgical reattachment – an amount equal to 50% of the dismemberment benefit is payable if a dismembered part is surgically reattached, regardless of the use regained. The balance of the dismemberment benefit is payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

Sight, speech, and hearing loss – loss of sight, speech, or hearing means total and irrecoverable loss beyond correction by surgical or other means.

Loss of use – loss of use means total and irrecoverable loss of the ability to perform every action the arm, leg, or hand was able to perform before the accident occurred. Beyond correction by surgical or other means. No benefits will be paid for loss of use if benefits for loss by dismemberment of the same arm, leg, or hand are paid or payable as a result of the same accident.

"Loss" as used above with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing in both ears.

"Loss" as used with reference to "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss is determined to be permanent.

Indemnity provided under this Section will not be paid under any circumstances, for more than one of the losses, the greatest sustained by any one Insured Person as the result of any one accident.

PENSION PLAN

INTRODUCTION

The Carpenters Local 18 Pension Plan ('the Plan") was established January 1, 1973 to provide retirement benefits to eligible members and their families. The benefits provided by the Plan are paid in addition to and to supplement the benefits provided under the Canada Pension Plan and the Old Age Security Act.

The benefits provided by the Plan are financed by the contributions made by your employer(s), on your behalf, in accordance with the Collective Agreement. The Plan is a defined benefit multi-employer plan, which means you do not have a break in your pension plan membership when you work for different employers who are also party to our Collective Agreement.

The Plan provides a pension upon retirement. There is also a Pre-Retirement Death Benefit payable upon the Member's death before retirement. In addition, the Plan provides a benefit in the event of termination of Union membership. Descriptions of these benefits appear in the following pages.

All of the assets of the Plan belong to the members and are held in the Carpenters Local 18 Pension Trust Fund ("Pension Fund"). The Trustees review the Plan's funding status, investment policies, and legislative requirements on a regular basis, as part of plan governance. They are assisted by actuaries and investment consultants and the Plan is monitored as part of regular reporting to the pension regulator.

This booklet isn't a legal document and the information on the following pages is only a general summary of the main features of the Plan. The official rules of the Plan will govern in the event of any conflict with this summary, and a copy of the complete Plan Text and Trust Agreement may be viewed by any member at the Benefit Plans Administration Office of Local 18.

This summary applies only to active members of the Plan on and after January 1, 1987. Members who terminated or retired from active membership prior to then are governed by the terms of the Plan as it existed when they terminated.

Please read this summary carefully so that you will be familiar with all aspects of the Plan and the valuable benefits to which you will become entitled.

Sincerely yours,

BOARD OF TRUSTEES

PENSION PLAN MEMBERSHIP

Effective Date

Although the Plan was effective from January 1, 1973, past service credit was given for hours worked between June 1, 1971, and the Effective Date.

Eligibility

If you first worked for a participating employer before July 1, 2012 and were a member of the Local in good standing you became a member of the Plan immediately. If, however, you first worked for a participating employer after July 1, 2012, you become a member of the Plan after 700 hours (the "700 hour rule") are contributed to the Plan on your behalf.

A Beneficiary Designation Form is provided upon joining the Plan, and your Beneficiary can be changed at any time. If you appoint a child or children as your Beneficiary, an adult Trustee must also be named. If you have a Spouse but wish to appoint someone else as Beneficiary, a waiver form must be signed by your Spouse. It is important that you keep your Beneficiary appointment up to date. These forms are available at all Local 18 Benefit Office or can be mailed to you for completion.

Vesting

Vesting means owning or having a right to the pension benefit earned under the Plan. If you are not Vested, you or your Beneficiary are not entitled to any pension benefits.

You are automatically "Vested" if you terminate Plan membership on or after July 1, 2012. Anyone who terminated prior to July 1, 2012, became "Vested" once they have completed two or more years as an active member of the Plan.

Effective September 1, 1999, if a member takes an Honorary Withdrawal from Local 18 and has 24 months or more membership in Local 18 and at least 1,000 Pensionable Hours under this Plan, they too will be deemed Vested and entitled to pension benefits.

If you transfer into or out of Locals that are signatory to a Reciprocal Agreement, the years you have accumulated in both/all Plans shall be combined for vesting purposes only under both/all Plans.

DEFINITIONS

"Spouse" means a person who is:

a) married to the Member, or
b) not married to the member and living in a conjugal relationship with the Member
   (i) continuously for a period of not less than 3 years, or

(ii) in a relationship of some permanence, if they are the parents of a child as set out in section 4 of the Children's Law Reform Act (Ontario)

"Break in Continuous Service" - means the cessation of Service which is deemed to have occurred

(i) immediately if a Member ceases to be a member of the Brotherhood, or
(ii) 24 months from the date a Member applies for transfer out of Local 18, or
(iii) at the end of two consecutive years during each of which no Credited Hours were granted to the Member, unless the Member is classified, as determined by the Trustees, as being prevented from earning any Credited Hours due to membership in another registered pension plan of the Brotherhood, in which case the period hereunder will be extended indefinitely.

If a member having had a Break in Service commences to work for a participating employer again, the pension earned up to the Break is considered Inactive and therefore not eligible for any future increases to the benefit rate. Such member would then have to complete the "700 hour rule" for new Plan members after which he would be treated as a new Plan member.

If you have a Break in Service and do not become active in the Plan again but remain a member of Local 18, you may be eligible for termination benefits (see section entitled Termination Benefits). It should be noted, as indicated in the **Termination Benefits** section, that if you elect to transfer your Inactive pension out of the Plan (after January 1, 2000), those years of service will not count towards any membership requirements for Special Early Retirement.

"Contributions"

Members are not required nor permitted to make contributions to the Pension Fund.

All contributions to the Plan are made by your employer on your behalf in accordance with the applicable Collective Agreements, so you cannot deduct them from your income for tax purposes. Similarly, they will not be added to your income, and you will have no additional tax to pay. However, they will affect how much you can contribute to your own RRSP.

The amount contributed is negotiated as part of your total wage package, and therefore changes periodically. The amount an employer contributes on your behalf should be reported on your T4 slip in Boxes 50 and 52 (Pension Adjustment) together with the **Plan Registration number 0368068.**

You will be required to pay income tax on monthly pension payments which you receive from the Plan at retirement.

All the pension contributions are invested by professional investment managers. These investments are made in accordance with the Plan's SIP&P, Trust document, and Applicable Legislation.

The Pension Fund is for the benefit of the Plan Members and can only be used to pay benefits to Members and their beneficiaries and for the administration of the Pension Plan.

"Vested Status" - for a Member whose Termination is

a) Prior to July 1, 2012, means the completion of two or more continuous years as a Member or, if earlier, means the completion of 24 months of membership in Local 18 for Members who have taken an honorary withdrawal from Local 18 and who have had at least 1,000 Pensionable Hours under this Plan, or

b) On or after July 1, 2012, means immediately upon becoming a Member of this Plan (you become a Member of the Plan the first of the month after earning 700 hours in the Pension Plan).

"Applicable Legislation" - Means

a) the Pension Benefits Act, R.S.O., 1990 c, P.8 (Ontario) or
b) the Income Tax Act (Canada)

"Actuary" means Fellow of the Canadian Institute of Actuaries or a firm employing such a person, retained and appointed by the Trustees to perform the duties for the Plan.

ELIGIBILITY REQUIREMENTS FOR RETIREMENT

To be eligible to retire and receive a pension under the Plan, a member must meet the following criteria:

a) be at least 53 years of age
b) have attained "Vested Status"
c) if Early or Special Early retirement, must discontinue employment through Local 18

In addition, members who have attained age 63 but have not applied for pension benefits, may continue to be employed and receive Credited Hours until the end of the calendar year in which they reach age 71, after which no further Credited Hours will be earned under the Plan and at which time you must apply to commence your pension. By law, you must start collecting your pension by December 1 in the year you turn age 71.

Credited Hours

A credited hour is an hour earned for which a participating employer has remitted a contribution to the Pension Fund. You do not receive a credited hour:

a) after the calendar year in which you reach age 71,
b) if you are drawing a pension under the Plan,
c) for a period prior to a break-in-service if no vested pension had been earned, or
d) If you fail to qualify for Plan membership under the "700 hour rule" after July 1, 2012.

RETIREMENT DATES

You can retire with an unreduced pension at age 63, postpone your retirement past 63 or retire early any time after age 53 but reductions may apply due to starting your pension early. Below are further descriptions of the types of retirement available, any reductions for early retirement that may apply, and the pension options available to you.

➢ Normal Retirement Date (NRD)

Normal Retirement Age under this Plan is sixty-three (63). On a member's Normal Retirement Date (first of the month following the 63rd birthday), a member with Vested Status shall become entitled to retire and receive a pension. All eligible members can begin their full unreduced pension at age 63, regardless of membership status or years of service. Retirement prior to or after the Normal Retirement Date is described below.

The Benefits Office will notify you prior to your 63rd birthday to begin the application for your pension. Should you wish to retire earlier than age 63, you can contact the Benefits Office to begin the process.

➢ Early Retirement

If you are eligible, you may elect to retire early on the first day of any month after you reach age 53. To qualify for Early Retirement you must meet the following criteria:

- Have attained Vested Status and
- Discontinue employment through Local 18

If you retire prior to age 63, your pension will be reduced as follows:

AGE AT EARLY RETIREMENT	PERCENTAGE OF TOTAL PENSION CREDITED
62	98%
61	95%
60	89%
59	83%
58	77%
57	71%
56	65%
55	59%
54	53%
53	47%

➢ **Special Early Retirement**

If you are eligible and elect to retire early after age 53, you qualify for **Special Early Retirement** if you meet the following criteria:

- have completed 240 months (20 years) of membership in Local 18, and
- are a member in good standing with Local 18 at the time of application for pension and on Early Retirement Date, and
- Discontinue employment through Local 18

In meeting the 20-year requirement above, membership in Local 18 does not include any service for which a member earned a normal pension benefit and elected to withdraw such pension from this Plan (only if withdrawn after January 1, 2000).

If you qualify for Special Early Retirement and retire on or after age 60, your pension will not be reduced. If you retire before age 60, your pension will be reduced according to the following table:

AGE AT SPECIAL EARLY RETIREMENT	PERCENTAGE OF TOTAL PENSION CREDITED	MINIMUM SERVICE REQUIRED (YEARS)
60	**100%**	**20**
59	**100%**	**21**
58	**98%**	**20.667**
57	**92%**	**20**
56	**86%**	**20**
55	**80%**	**20**
54	**74%**	**20**
53	**68%**	**20**

Postponed Retirement

If you postpone your retirement until after age 63, you will continue to accrue benefits at the normal rate. By law, your pension must begin by December 1 of the calendar year in which you reach age 71.

Commutation of Retirement Benefit due to Shortened Life Expectancy

A member or former member who is entitled to a pension benefit, may make a request to receive a one-time lump sum payment in lieu of his/her retirement benefit if the member has a physical or mental disability that is likely to shorten the member's life expectancy to less than 2 years. The member's spouse must also agree to this application. The disability must be confirmed and certified in writing to the Trustees by a medical doctor who is licensed to practice in a jurisdiction in Canada. The member's request must be approved by the Board of Trustees and is only permitted in accordance with Applicable Legislation. Once you receive this one-time lump sum payment, no further payments from the Plan will be made to you or your survivors.

AMOUNT OF PENSION

Your annual pension is determined by multiplying the pension rate by the total number of your Credited Hours at your retirement date. If you retire early, the applicable early or special early retirement factor will be applied to the pension. The pension rate has changed over the years as follows:

a) If you are a member in good standing on December 31, 2000, the pension rate is $0.37 per year for each Credited Hour earned prior to January 1, 1992, and $0.71 per year for each Credited Hour earned between January 1, 1992 and December 31, 2000, and $0.80 per year for each Credited Hour earned after December 31, 2000.

b) If you are not a member in good standing on December 31, 2000 but were in good standing on December 31, 1997, the pension rate is $0.36 per year for each Credited Hour earned prior to January 1, 1992, and $0.69 per year for each Credited Hour earned after December 31, 1991.

c) If you are not a member in good standing on December 31, 1997 but were in good standing on December 31, 1996, the pension rate is $0.33 per year for each Credited Hour earned prior to January 1, 1992, and $0.66 per year for each Credited Hour earned after December 31, 1991.

d) If you are not a member in good standing as of December 31, 1996 but were in good standing as of December 31, 1995, the pension rate is $0.29 per year for each Credited Hour earned prior to January 1, 1992 and $0.60 per year for each Credited Hour earned after December 31, 1991.

e) If you are not a member in good standing as of December 31, 1995 but were in good standing as of July 27, 1994, the pension rate is $0.28 per year for each Credited Hour earned prior to January 1, 1992 and $0.42 per year for each Credited Hour earned after December 31, 1991.

f) If you were not a member in good standing as of July 27, 1994 but were in good standing as of January 1, 1992, the pension rate is $0.26 per year for each Credited Hour earned prior to January 1, 1992 and $0.30 per year for each Credited Hour earned after December 31, 1991.

g) If you are not a member in good standing as of January 1, 1992, but were in good standing as of August 19, 1982, the pension rate is $0.24 per year for each Credited Hour earned.

h) If you were not a member in good standing as of August 19, 1982, but were in good standing as of January 1, 1979, the pension rate is $0.18 per year for each Credited Hour earned.

i) If you were not a member in good standing as of January 1, 1979, the pension rate is $0.12 per year for each Credited Hour earned from June 1, 1971.

DIFFERENCE BETWEEN "CONTRIBUTION" AND "BENEFIT"

As indicated on the previous page under (a), the current hourly benefit rate is $.80 per hour, and as shown in the General Information section of this booklet, the

current contribution rate for employers is $7.25 per hour. You may wonder why $7.25 per hour is contributed, but only $0.80 per hour is paid out at retirement.

The $7.25 per hour contributed is a one-time contribution made for that hour of pension credit earned, whereas the $0.80 paid out is per hour **per year** of retirement.

For example, if you earn 1,000 hours at $0.80, you will receive $800.00 per year of pension payable for your lifetime. That 1,000 hours when contributed, cost the employer $7,250 (assuming a $7.25 contribution rate). If you receive 20 years of pension, total pension payments for that 1,000 hours would be $16,000 (1,000 hours X $0.80 per year X 20 years), or $16.00 for each credited hour.

Compared to the current contribution rate, this works out to 2.20 times the contribution. The growth from $7.25 contributed to $16.00 paid out during retirement, comes from investment earnings made by the Pension Fund on the contributions.

It should also be noted that all of this does not include any pension paid to your Spouse, who will also receive a continuing pension for her lifetime (at the level chosen at retirement) should you pre-decease her.

HOW AND WHEN TO APPLY FOR PENSION

When your retirement date approaches, you are required to notify the Benefits Office.

The Local 18 Benefits Office will also attempt to contact you at age 63 to inform you of your entitlement to an unreduced pension. At that time, we will send you an Election Form which will advise us if you wish to retire at that time or postpone your retirement to a later date.

If you are no longer an active member of Local 18, please keep your address and beneficiary information up to date with the Local 18 Benefits Office, so we can reach you regarding your pension.

The Local 18 Pension Plan uses their actuary to provide estimates to all those receiving a pension benefit, when requested.

Our office will send you the estimates based on the information provided/on record, for your review. The estimates can be discussed with the Benefits Office, or even the actuary, if further explanation is required. Once you have made a decision regarding the option and date of retirement, please contact the Local 18 Benefits Office to make an appointment to complete the application forms.

At the application appointment, we will require the following information:

- Proof of age for you and your Spouse (if you have a Spouse)
- Your Spouse's Social Insurance Number (SIN)

- Your date of marriage, if applicable
- Void cheque (if direct deposit is requested)

Proof of age for the member and his/her Spouse must also be provided at the time of application. Acceptable proof of age includes:

i) a Birth Certificate, or
ii) a Baptismal Certificate, or
iii) any other document that is acceptable to the Government as satisfactory proof of age for receipt of Canada Pension benefits.

At the appointment (or by letter / phone, if application forms mailed) we will also address your Welfare benefits after retirement, and your Union Dues status.

PENSION PAYMENTS

When are pension payments effective?
Pension payments are effective on the first day of the month indicated on the application forms and are payable on that day and the first day of each month thereafter for your lifetime. Note that initial payments may be delayed if eligible hours are still to be received or if application documentation is incomplete.

Re-employment of a Pensioner
If the member returns to work after retirement, he or she is not entitled to pension benefits based on the hours worked after retirement. Monthly pension payments will continue at the amount currently in pay and no further pension will be earned. This is in accordance with pension legislation. If this legislation changes in the future, those affected will be advised of the change.

RETIREES SOCIAL CLUB

The Carpenters Local 18 have a Retirees Social Club that meets regularly for lunch and also offers planned excursions, card nights, and many other activities. It is a supportive and fun group and allows the retired members and their spouses to stay connected. If you have any interest in joining this group when you retire, please reach out to the Union office for the current contact information for the Club. This club is run directly by the retirees and any information can be obtained from the group's administration.

FORMS OF PENSION PAYMENTS

Your pension is paid to you for as long as you live. There are a number of options available to you which will determine what happens to your pension after you die.

If you **do not have a Spouse** when you retire, your pension will be paid to you for as long as you live and as a minimum, it is guaranteed for 120 monthly payments (10 years). Therefore, if you die before receiving the minimum number of guaranteed payments, your nominated Beneficiary will receive any remaining balance of payments. This is the Normal Form of pension for a member with no Spouse.

If you **have a Spouse** when you retire, your pension will be paid to you for as long as you live and after your death to your Spouse, with payments reducing by 40% on the later of your death or the payment of 60 months (5 years) of pension. If neither you nor your Spouse survive for 5 years, the commuted value of the remaining payments will be paid to the estate of the last survivor. This is the Normal Form of pension for members with Spouses.

A "Spouse" who is living separate and apart from you when your pension begins is not entitled to survivor benefits. If you chose a survivor pension at the time of retirement, and your marriage ends during your retirement, your spouse at retirement will still receive the survivor benefits elected at the time of retirement should you pre-decease your former spouse.

When you retire, you may elect a different form of payment in order to provide for some additional protection for your Beneficiary or to suit your particular needs. The following optional pensions are also available to you. All optional pensions are actuarially equal to the normal form of pension.

When you apply for your pension, you will receive a statement and election form which sets out these options for you.

a) **Life, guaranteed 15 years** (members without Spouses only)
Similar to the Normal Form of Pension with payments guaranteed 15 years instead of 10 years. Your pension is reduced because of the longer guarantee.

b) **Level Joint and Survivor**, guaranteed 10 years
Payments continue for as long as you live. After your death, payments continue in the same amount to your Spouse for her remaining lifetime. If neither you nor your Spouse survive for 10 years, the commuted value of the remaining payments will be paid to the estate of the last survivor.

c) **Joint and Survivor, reducing by 1/3**, guaranteed 10 years
Payments continue at the initial amount for as long as your live, or for 10 years if you do not live that long. Following your death, or 10 years if later, payments reduce by one third and continue to your Spouse for her remaining lifetime, if any. If neither you nor your Spouse survive for 10 years, the commuted value of the remaining payments will be paid to the estate of the last survivor.

d) **Joint and Survivor, reducing by 40%**, guaranteed 10 years
Same as option c) above with payments reducing by 40% on the later of 10 years or your death.

e) **Reducing Joint and Last Survivor Integrated with CPP and OAS**
A higher amount of pension between retirement and age 65 in exchange for a lower amount after age 65. This option helps you to level out your income from this Plan, the Canada Pension Plan (CPP and Old Age Security (OAS). After your death, your Beneficiary will receive the same benefit that would

have been paid under the Normal Form of Pension.

f) **Reducing Joint and Last Survivor Integrated with OAS**
A higher amount of pension between retirement and age 65 in exchange for a lower amount after age 65. This option helps you to level out your income from this Plan, the Canada Pension Plan (CPP) and Old Age Security (OAS). After your death, your Spouse/Beneficiary (depending on your marital status) will receive the same benefit that would have been paid under the Normal Form of Pension.

g) **Lump Sum Option – Only for Small Pensions**
Applicable Legislation allows the Trustees to pay a lump sum benefit only if a Member's normal annual pension payable is not more than 4% of the Year's Maximum Pensionable Earnings (YMPE) of the Canada Pension Plan. If the pension qualifies, a Member will have the option to receive a lump sum payment instead of the monthly pension. The lump sum payment is equal to the Commuted Value of your accrued pension under the Plan payable in the Normal Form of Pension multiplied by the latest transfer ratio, where such transfer ratio shall be determined by the Actuary on a quarterly basis in accordance with Applicable Legislation. Instead of receiving the lump sum in cash, the Member may transfer the amount to a registered retirement savings plan (RRSP) or a registered retirement income fund (RRIF).

PRE-RETIREMENT DEATH BENEFIT

If you die before you retire, your Beneficiary will receive a lump sum death benefit equal to the minimum death benefit required under Applicable Legislation which is equal to the commuted value of the pension you earned on or after January 1, 1987.

If you had reached Retirement Age (**53 or older**), the lump sum death benefit would not be less than 120 times the monthly pension you would have received as if you had retired on that day.

If your Beneficiary is your Spouse, the death benefit can be paid as a:

1) lump sum cash payment (subject to withholding tax), or
2) transfer to a registered retirement savings plan, or
3) transfer to an insurance company to purchase an annuity, or
4) as a monthly payment to your Spouse.

Note that by law this pre-retirement death benefit has to be paid to your Spouse, regardless of whom you designate as your Beneficiary. Your Spouse may, however, waive the right to this entitlement by signing a prescribed waiver form which is available from the Plan Administrator.

TERMINATION BENEFITS

Termination occurs:

a) immediately when you cease to be a member of the Brotherhood,
b) after a period of 24 months from the last contribution received if you have transferred out of Local 18, or
c) at the end of two consecutive years during each of which you have not earned any Credited Hours.

If you are **53 or over** when termination occurs, you are entitled to commence your pension at any time, in accordance with the early, normal, or postponed retirement provisions.

If you are **under age 53** when termination occurs, instead of receiving a deferred pension, you may elect a lump sum payment equal to the Commuted Value of your accrued pension under the Plan payable in the Normal Form of Pension multiplied by the latest transfer ratio, where such transfer ratio shall be determined by the Actuary on a quarterly basis in accordance with Applicable Legislation:

a) to a pension fund related to another registered pension plan if the administrator of the other plan agrees to accept the payment, or
b) into a registered retirement savings plan prescribed by Applicable Legislation, or
c) for the purchase of a deferred life annuity contract as permitted and prescribed by Applicable Legislation under which payment will not commence earlier than that provided under this Plan.

Please note:
If your membership in the plan is terminated and you elect to transfer the funds out of the Local 18 Plan as described above, after January 1, 2000, those years of service will not count towards any membership requirements for Special Early Retirement.

If termination occurs, you will receive a termination package as required under legislation, within 30 to 60 days.

ADMINISTRATION

The **Board of Trustees** is responsible for administering the Plan. The Trustees have appointed a **Plan Administrator** to handle the day-to-day administration.

Subject to the direction and guidance of the Trustees, the Plan Administrator maintains a record of the hours you have worked, as reported by the contributing employers, and determines the amount of your benefits upon death, retirement or termination. In addition, your Board of Trustees has the authority to appoint actuaries, accountants and legal counsel, and is responsible for all procedures necessary to operate your Plan efficiently.

The Plan Administrator of your Pension Plan is located at the Local 18 Benefits Office:

Christine Selzer-Comeau
Carpenters' Local 18 Benefits Office
1342 Stone Church Rd. East
Hamilton, Ontario L8W 2C8

Telephone (905) 388-5300 or 5320 Ext. 233
Fax (905) 388-7775
Toll Free 1-800-265-6970

Office Hours – Monday to Friday
8:00 am. to 4:30 pm.
EMAIL chris@local18.ca

Other Information about your Plan

Changes at your request
If you are in receipt of a monthly pension payment from the Plan and wish to make any changes such as address, bank information, beneficiary, or have any questions regarding your pension, please direct your inquiry to the Local 18 Benefits Office.

Pension Information Statements
At the end of each year, Active pension plan members will receive a Pension Statement (Statement of Accrued Benefits) showing the number of pension hours credited to that date, including all hours received by the Plan for the previous calendar year. You should always keep these statements for reference. This should be cross-checked to your pay stubs and any discrepancy reported to the Local 18 Benefits Office. Your pension statement will also include other information as may be required by Applicable Legislation. Furthermore, should our Plan be amended or revised, you will be notified by newsletter or special mail-out, and booklets will be updated as required.

Inactive (Deferred) Members, Retirees, Spouses in Pay and Beneficiaries in Pay will also receive a Pension Statement every other year. Their statements will also list any plan changes, as well as confirm their hours / dollars on record or being paid by the Local 18 Pension Plan.

Plan Administration

The Pension Plan Trustees meet regularly to discuss any issues related to the Plan, to review the finances, and to approve all applications for benefits. The Trustees have employed the services of actuaries, investment managers and other consultants, where applicable, to assist with all matters pertaining to this Plan.

An audit of the Plan is done by an outside organization at the end of every fiscal year. Some members may receive a letter from the auditing firm requesting details such as hours earned for a particular period, be confirmed for this purpose.

The Plan's actuary must submit a report at least once every three years concerning the financial position and experience of this Plan. They also recommend any changes in pension benefits, contributions or otherwise, which they deem necessary or advisable.

The Pension Fund is invested by the Trustees in accordance with the Trust Agreement, the Statement of Investment Policies & Procedures, and Applicable Legislation.

Beneficiary Appointments

Each member is responsible for completing and maintaining a current Pension Beneficiary form. This form is available from the Local 18 Benefits Office. Your annual pension statement will indicate your Beneficiary of record. It is very important that you keep your Beneficiary appointment up to date.

If you have a Spouse (see definition of "Spouse") but choose to appoint someone other than your Spouse as Beneficiary of your Pension Plan, there is a waiver form that must be signed by both you and your Spouse. This form is also available from all Local 18 offices and should accompany the corresponding Beneficiary form.

If you appoint a minor child or children as beneficiary of your Pension Plan, you must appoint a Trustee to administer any funds payable. This appointment is made on the Beneficiary form.

You should always advise the Beneficiary and/or Trustee of your decision to make them the Beneficiary of your Pension Plan.

Marriage Breakdown

Under Ontario's Family Law Act, accrued pension entitlements are assets that are subject to equalization when a marriage dissolves. Effective January 1, 2012, the Ontario government passed new legislation which changed the access to information from pension plans relating to marriage breakdown situations. A summary of the major reforms is summarized below.

Immediate payment of pension assets – Former Spouses of plan members will be able to receive an immediate payment of their share of the pension assets. The form of payment will be either as a lump sum transfer or a division of

monthly pension payments, depending on the plan member's status at the date of separation.

Valuation of pension assets – The valuation of the pension assets will be calculated by the Plan Administrator, in accordance with formulas set out in the new family law regulations made under Applicable Legislation.

Application to Plan Administrator – The parties must apply directly to the Plan Administrator to get the valuation of pension assets for the division of the pension assets. The Plan Administrator will charge a fee of $600 to provide the calculations. Applications should not be submitted to the Financial Services Regulatory Authority of Ontario (FSRA).

FSRA Family Law Forms – FSRA has developed approved forms that relate to the valuation and division of pension assets on breakdown of a spousal relationship. These FSRA family law forms must be used by lawyers, plan administrators and Spouses when pension assets are to be valued and/or divided.

FSRA has developed a number of Questions and Answers regarding the changes in effect on January 1, 2012 which can be accessed through their website.

Please Note: The old rules that govern the division and payment of pension assets on breakdown of a spousal relationship will continue to apply until December 31, 2011. A former Spouse is not entitled to receive his or her share of the Plan member's pension benefits until a triggering event occurs if the court order, family arbitration award or domestic contract was made before January 1, 2012. A triggering event occurs when the plan member terminates employment or plan membership, retires, dies, or reaches the normal retirement date under the pension plan (whichever event occurs first).

Plan Amendments

The Trustees may revise the Plan whenever a revision is deemed by them to be in the best interest of members and their beneficiaries. All revisions must be submitted for approval to the Canada Revenue Agency and the Financial Regulatory Authority of Ontario.

Plan Funding and Pension Benefits Guarantee

Since this is a negotiated cost multi-employer pension plan, the pension benefits provided under the Plan are not guaranteed by the Ontario Pension Benefits Guarantee Fund. Benefits earned under this Plan are supported solely by the Pension Fund assets. If there is a funding surplus, the Trustees may at their discretion improve benefits or retain such surplus as a safety margin. If there is a funding shortfall at any time, the Trustees may be required by law to reduce benefits.

Because it is highly unusual for multi-employer pension plans to shut down, Applicable Legislation includes special rules that allow multi-employer plans that meet certain conditions to register as a Specified Ontario Multi-Employer Pension

Plan (SOMEPP). The Plan is currently registered as a SOMEPP. SOMEPPs don't have to pass the "solvency" funding test that applies to single employer defined benefit (DB) pension plans (which face a higher risk of shutting down). This solvency test checks to see what would happen if a pension plan ended immediately and had to pay out the total benefits earned by active and retired members all at once. SOMEPPs are, however, required to meet the "going-concern" funding requirements, which assume the plan continues indefinitely. By registering as a SOMEPP, the Trustees are able to focus on maintaining the financial health of the plan over the long term.

The Trustees expect the Plan will continue indefinitely. However, in the unlikely event that the Plan is terminated and wound up, all the assets, including any surplus, will be used to provide benefits for members. If assets are less than the value of the benefits promised, the Trustees may be required by law to reduce benefits.

Statement of Investment Policies and Procedures (SIPP)

The plan is required by law to have a formal SIPP that contains the investment policies and procedures in respect of the plans' portfolio of investments and loans. Also, the SIPP must describe if, and how, environmental, social and governance (ESG) factors are taken into account when choosing investments. The SIPP can be made available to members for inspection, or upon written request, a copy can be provided for a fee. Members can also inspect this document at the FSRA offices.