YOUR HEALTH AND WELFARE PLAN

THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN

MEMBER BOOKLET

Up To Date As At January 1, 2016

This booklet contains important information and should be kept in a safe place
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Introduction

The Board of Trustees is pleased to provide this updated Plan Booklet describing the many Benefits for eligible Members and their Dependents. This Health and Welfare Plan Booklet has been prepared to provide you with an informal summary of your Health and Welfare Plan, referred to as (the “Plan”).

You will find a brief description of the Benefits for which Members and their Dependents are eligible. Additionally, you will find the rules which determine eligibility for Benefits and the procedure for filing a claim. Eligibility in the Plan will be governed by the Trust Agreement, Plan Text and Insurance Policies. These documents are available at the Administration Office.

Every effort has been made to ensure that the many Benefits described in this Plan Booklet are complete and accurate. Should any doubt arise regarding coverage of an expense, please contact the Administration Office.

If you would like to appeal non-payment of any expense, you should appeal in writing, to the Administration Office of the reason.

We encourage you to read through the Health and Welfare Plan Booklet. Should you have any questions, please do not hesitate to contact the Administration Office. The staff members will be happy to assist you.

The Trustees hope that their efforts in developing a sound program of Benefits for Members and their families will be of great value to you.

Yours sincerely,

The Board of Trustees
General Information

ESTABLISHMENT OF THE PLAN

Since July 1965, Employers who are parties to Collective Agreements between the United Association of Journeyman and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, Local 488 (the “Union” and – Construction Labour Relations (CLR), An Alberta Association) have been contributing to The Edmonton Pipe Industry Health and Welfare Fund. This Fund provides a Plan of Benefits for eligible Union Members and their Dependents.

The Fund and Plan are managed by a Board of Trustees. The duties, responsibilities and authority of the Trustees are set out in a Trust Agreement, a copy of which is available for inspection at the Administration Office.

Great-West Life, is the insurer for the Life, Burial Benefit, Optional Life, Dependant Life, Accidental Death and Dismemberment, and Long Term Disability Benefits. The Weekly Disability, Medical, Dental and Emergency Travel Accident Benefits are not insured: they are funded solely by the assets of the Fund. The Member Assistance Program (MAP) is provided by CEFAP.

Your Plan has been updated to reflect the changing needs of the Members and their families and the funding available from Employer contributions. We will advise you if the Plan Benefits change for any reason.

ADMINISTRATION SERVICES

The Trustees have appointed an administrative service provider to manage the Plan and Fund. The Administration Office attends to the day-to-day administration of the Plan and Fund and operates under the direction of the Trustees. The contact information is:

The Edmonton Pipe Industry Health and Welfare Plan

Administration Office

16214 – 118 Avenue

Edmonton, Alberta

T5V 1M6

Telephone: 1-780-452-1331

Fax: 1-780-487-4063

E-mail: questions@epibenefitplans.com

Website: www.epibenefitplans.com
General Information

DEFINITIONS

▪ **Administrator** means the Board of Trustees of The Edmonton Pipe Industry Health and Welfare Fund.

▪ **Bank of Credited Hours** shall consist of all credited hours worked by an Employee on and after the date the Employee becomes an Employee as defined in this Plan. The Bank of Credited Hours does not include any Credited Hour that would increase the total number of Credited Hours in the Bank of Credited Hours beyond 2,600 hours and no such Credited Hour thereafter will be deemed to be a Credited Hour for the purposes of this Plan.

On the first (1st) day of each Benefit Period, 130 Credited Hours will be deducted from each covered Member’s Bank of Credited Hours.

▪ **Benefit Period** means a period of one calendar month.

▪ **Credited Hour** means any hour that is worked by a Member of the Union for the Union, or any hour that is worked by a Member in respect of which hour, a Participant Employer has, pursuant to a labour contract or agreement with the Union, made a contribution on behalf of the Member into the Fund.

▪ **Credited Service** means the number of hours reported to The Edmonton Pipe Industry Pension Plan. One year of Credited Service is the equivalent of 1,300 hours.

▪ **Determination Date** means the last day of any calendar month.

▪ **Employee** means any person who is employed by the Union on a full-time basis, or who is employed by a Participant Employer in a job classification for which the Union is the collective bargaining agent.

▪ **Fund** means The Edmonton Pipe Industry Health and Welfare Fund.

▪ **Member** means any person who is employed by the Union on a full-time basis, or who is employed by a Participant Employer in a job classification for which the Union is the collective bargaining agent.

▪ **Participant Employer** means the Union or any employer who is required to make payments into the Fund for the purpose of providing insurance benefits for a class or classes of Employees of such employer eligible for insurance under this plan, all pursuant to an agreement with the Union.

▪ **Permit Worker** means any person who is employed by the Union on a temporary basis, or who is employed by a Participant Employer in a job classification for which the Union is collective bargaining agent but they have not yet been initiated as a Member of Local Union 488.
General Information

DEFINITIONS (CONTINUED)

- **Provincial Health Care Plan** is a publicly funded plan of benefits universally provided to eligible residents of a province and which is governed by a health care insurance act of the province and the Canada Health Act.

- **Retired Member** means:
  - With respect to Employees who are in receipt of a Pension from the Edmonton Pipe Industry Pension Plan, UA Canadian Pipeline Pension Plan, UA Sprinkler Pension Plan, or UA Officers Pension Plan and who are members in Good Standing with the Union, and at the time of retirement had accumulated a minimum of 15 years of Credited Service earned through employment with a Contributing Employer and within the jurisdiction of UA Local 488. Employees who have not attained the age of 65 years and are in Good Standing with the Union and did not qualify at the time of Retirement with the required years of Credited Service, will be deemed to be active with exception of Disability Benefits.

- **Union** means Local Union 488 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada.

HOW DO I SUBMIT CLAIMS?

Drug claims must be submitted electronically by your pharmacist using your All-In-One Benefit Card. Dental claims can be submitted electronically by your dentist using your All-In-One Benefit Card, online or mail to the Administration Office. Many health care providers (Chiropractors, Massage Therapists, Psychologist, Physiotherapists etc.) will also be able to submit claims electronically for you and your eligible dependants.

Many tools and services are available online for Members. Access to Plan Member Online Services is available at [www.greenshield.ca](http://www.greenshield.ca).

If you are unable to submit claims online, or through your service provider, you may mail your paper claims into the Administration Office. Claim forms are available online at [www.epibenefitplans.com](http://www.epibenefitplans.com) or at the Administration Office.

If you require any assistance, please contact the Administration Office where a staff member will be happy to assist you.

ARE EMPLOYER CONTRIBUTIONS TAXABLE?

Under present legislation, Contributions made to the Plan by the Contributing Employers are not taxable benefits.
General Information

ARE THE PLAN'S BENEFITS TAXABLE?
If you were eligible for Life Insurance Benefits during a calendar year, you will receive a T4A slip. This T4A shows the amount of the Taxable Benefit as a result of the Plan’s payment of Life Insurance Premiums on your behalf.

If you receive Weekly Disability and/or Long Term Disability Benefits from this Plan you will receive a T4A showing the amount of the Benefit paid to you during the year. If you became disabled while making Self Payments you will not receive a T4A for Weekly Disability Benefits.

Certain Benefits provided under some Self Payment Plans would be deemed to be taxable in your hands. Since you are making the Self Payment, the Trustees have established that the Self Payment Premium is applied first to any Benefit which would otherwise create a taxable benefit. Self Payments are currently applied first to Life Insurance and Weekly Disability Benefit costs if they are provided under the Plan you choose.

T4A slips are issued by the end of February for the prior taxation year.
Summary of Benefits

The details of each benefit are discussed fully in the sections which follow:

### ACTIVE MEMBER BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>$100,000 (Member Only)</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment</td>
<td>$100,000 Principal Sum (Member Only)</td>
</tr>
<tr>
<td>Weekly Indemnity</td>
<td>Maximum Benefit of $500/Week. Maximum of 26 Weeks. Integration with Employment Insurance (EI) is required. Benefit payments are taxable.</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>Maximum Benefit of $2,500/Month. $2,500 is the Maximum Benefit Amount from all sources. Maximum to Age 65. Benefit payments are taxable.</td>
</tr>
</tbody>
</table>

### ACTIVE MEMBER AND DEPENDANTS BENEFITS

<table>
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<th>Benefit</th>
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<td>$7,500 (Spouse) &amp; $2,000 (Per Child)</td>
</tr>
<tr>
<td>Dependant Accidental Death and Dismemberment</td>
<td>$15,000 (Spouse Principal Sum) &amp; $4,000 (Per Child Principal Sum)</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>Above Group Life Insurance is provided by the Plan, and may be available through Great-West Life if you are under the age of 70 for Members and their eligible Dependents. Details of premium rates, amounts of insurance, eligible criteria, etc. are available from the Administration Office or on the Plan website.</td>
</tr>
</tbody>
</table>
Summary of Benefits

ACTIVE MEMBER AND DEPENDANTS BENEFITS (CONTINUED)

Medical Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Nil</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>90%</td>
</tr>
<tr>
<td>Miscellaneous Services and Supplies</td>
<td>90% (Subject to Limitations)</td>
</tr>
<tr>
<td>Prescription Drugs for Smoking Cessations</td>
<td>90% (Lifetime Maximum of $1,200)</td>
</tr>
<tr>
<td>Prescription Drugs for Treatment of Erectile Dysfunction</td>
<td>90% (Subject to Quantity Limitations)</td>
</tr>
</tbody>
</table>

Note: Over the counter drugs, vaccines, vitamins and supplements are not covered by the Plan.

Paramedical Practitioners

<table>
<thead>
<tr>
<th>Practitioner</th>
<th>Allowed Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncturist, Naturopath, Podiatrist, Speech Therapist, Christian Science Practitioner and Osteopath</td>
<td>100% Combined Maximum Of $400 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>100% To A Maximum Of $700 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Massage Therapist</td>
<td>100% To A Maximum of $500 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>100% To A Maximum of $700 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Registered Clinical Social Worker</td>
<td>100% To A Maximum of $400 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Psychologist</td>
<td>100% To A Maximum of $1,000 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Diagnostic X-Rays</td>
<td>$60 Per Disability</td>
</tr>
</tbody>
</table>

Ambulance

100% from Point “A” to a Hospital. Response fee is not covered. Air Ambulance and Rail is subject to prior approval from the Administration Office.

Hospital

100% of the Semi-Private Room rate in the province of residence.
Summary of Benefits

ACTIVE MEMBER AND DEPENDANTS BENEFITS (CONTINUED)

Mobility Assistance Equipment Benefit
Reimbursement of 90% of the expenses associated with specific mobility equipment. Require prior approval from Administration Office before purchase.

<table>
<thead>
<tr>
<th>Hearing Aids</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If Hearing Aids are purchased within 2 years</td>
<td>$1,500 Per Person</td>
</tr>
<tr>
<td>from January 1, 2012</td>
<td></td>
</tr>
<tr>
<td>If Hearing Aids are not purchased until</td>
<td>$3,500 Per Person</td>
</tr>
<tr>
<td>after 3 years from January 1, 2012</td>
<td></td>
</tr>
<tr>
<td>If Hearing Aids are not purchased until</td>
<td>$5,000 Per Person</td>
</tr>
<tr>
<td>after 5 years from January 1, 2012</td>
<td></td>
</tr>
<tr>
<td>Audiology Report is required for initial</td>
<td></td>
</tr>
<tr>
<td>claim</td>
<td></td>
</tr>
</tbody>
</table>

Custom Fit Ear Plugs
$300 every 5 years from last date of purchase.

Orthotics (Custom Made)
$400 per person, per calendar year. Medical Doctor or Podiatrist referral stating condition is required every 3 years.

Diabetic Supplies
Reimbursed at 90%. Glucometer is not a covered expense.

Private Duty Nursing
$20,000 per person, per calendar year.

Vision Care
$450 per person is available for purchase of Prescription Glasses and/or Contact Lenses. Benefit renews every 2 calendar years starting January 1st, 2016. Prescription with each claim is required. If the Laser Eye Surgery benefit is utilized, there is no coverage for vision care for 5 years.

<table>
<thead>
<tr>
<th>Safety Glasses (Member only, prescription lenses only)</th>
<th>$400 Every 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exams</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Laser Eye Surgery</td>
<td>$1,600 Per Person Lifetime Maximum</td>
</tr>
</tbody>
</table>
Summary of Benefits

ACTIVE MEMBER AND DEPENDANTS BENEFITS (CONTINUED)

Individual Calendar Year Maximum
$40,000.

Out-of-Provence/Canada Travel Emergency Medical Plan
$100,000 per person lifetime maximum is available. Not subject to co-insurance or calendar year maximum. Limited to a maximum of 180 travel days per trip.

Dental Benefits

Dental Fee Guide
Reimbursement of dental services will not be in excess of the 2014 Alberta Dental Association Suggested Fee Guide.

<table>
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<tr>
<th>Benefit</th>
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<tbody>
<tr>
<td>Deductible</td>
<td>Nil</td>
</tr>
<tr>
<td>Basic Dental Services (Cleaning and check-ups eligible every 6 months)</td>
<td>90%</td>
</tr>
<tr>
<td>Major Dental Services</td>
<td>80%</td>
</tr>
<tr>
<td>Dentures</td>
<td>90%</td>
</tr>
<tr>
<td>Crowns and Bridges</td>
<td>80%</td>
</tr>
<tr>
<td>Dental Implants</td>
<td>80%</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>65%</td>
</tr>
<tr>
<td>Combined Overall Calendar Year Maximum</td>
<td>$3,000 Per Person</td>
</tr>
</tbody>
</table>

Pre-Determination of Dental Benefits
Prior to a planned course of treatment exceeding $500, a Pre-Determination plan, including x-rays, should be submitted to the Administration Office for approval.
Summary of Benefits

ACTIVE MEMBER AND DEPENDANTS BENEFITS (CONTINUED)

Member Assistance Program (MAP)
Provided by: Construction Employee and Family Assistance Program (CEFAP)
Website: www.homewoodhealth.com

CEFAP provides confidential personal assistance and self-development services for employees and their Dependents through Homewood Human Solutions. CEFAP covers counselling, education and self-development services in addition to assessment and referral when required, for a full spectrum of personal issues including, but not limited to:

1. Job Loss
2. Stress Management
3. Personal Issues
4. Marital and Family Issues
5. Financial Planning
6. Legal Counselling
7. Health Management and Retirement
8. Alcohol and Drug Dependency
9. Smoking Cessation
10. Sexual Harassment and Abuse

Rehabilitation Benefit
Plan Members and their eligible Dependents may be entitled to receive up to $5,000 per person as reimbursement towards the cost of attending an in-patient program at an approved addiction Treatment Centre. Please contact the Plan Administration Office should you have any questions regarding this benefit.

Diagnostic and Treatment Support Services
Provided by: Best Doctors Canada
Website: www.bestdoctorscanada.com

Best Doctors helps you make medical decisions with confidence. They provide access to the best medical minds in the world so you can be sure you have the right diagnosis and treatment plan. Best Doctors can also help you find specialists and get expert answers to medical questions. Whether you’re dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Best Doctors can guide you in the right direction.
Self Payment Plan Option A

ACTIVE MEMBER ENROLLED IN SELF PAYMENT PLAN “A”

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<tbody>
<tr>
<td>Life Insurance</td>
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<td>$100,000 Principal Sum</td>
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<td>Weekly Indemnity</td>
<td>Maximum Benefit of $500/Week</td>
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ACTIVE MEMBER AND DEPENDANTS ENROLLED IN SELF PAYMENT PLAN “A”

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Self Payment Plan Option A

ACTIVE MEMBER AND DEPENDANTS ENROLLED IN SELF PAYMENT PLAN “A” (CONTINUED)

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Hospital
100% of the Semi-Private room rate in the province of residence.

Mobility Assistance Equipment Benefit
Reimbursement of 90% of the expenses associated with specific mobility equipment. Require prior approval from administration office before purchase.

Hearing Aids

| If Hearing Aids are purchased within 2 years from January 1, 2012 | $1,500 Per Person |
| If Hearing Aids are not purchased until after 3 years from January 1, 2012 | $3,500 Per Person |
| If Hearing Aids are not purchased until after 5 years from January 1, 2012 | $5,000 Per Person |

Audiology Report is required for initial claim
Self Payment Plan Option A

ACTIVE MEMBER AND DEPENDANTS ENROLLED IN SELF PAYMENT PLAN “A” (CONTINUED)

Custom Fit Ear Plugs
$300 every 5 years from last date of purchase.

Orthotics (Custom Made)
$400 per person, per calendar year. Medical Doctor or Podiatrist referral stating condition is required every 3 years.

Diabetic Supplies
Reimbursed at 90%. Glucometer is not a covered expense.

Private Duty Nursing
$20,000 per person, per calendar year.

Vision Care
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Individual Calendar Year Maximum
$40,000

Out-of-Province/Canada Travel Emergency Medical Plan
$100,000 per person lifetime maximum is available. Not subject to co-insurance or calendar year maximum. Limited to a maximum of 180 travel days per trip.
Self Payment Plan Option A

ACTIVE MEMBER AND DEPENDANTS ENROLLED IN SELF PAYMENT PLAN “A” (CONTINUED)

Dental Benefits

Dental Fee Guide

Reimbursement of dental services will not be in excess of the 2014 Alberta Dental Association Suggested Fee Guide.

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Rehabilitation Benefit

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Self Payment Plan Option B

**ACTIVE MEMBER ENROLLED IN SELF PAYMENT PLAN “B”**

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<tr>
<td>Accidental Death and Dismemberment</td>
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**ACTIVE MEMBER AND DEPENDANTS ENROLLED IN SELF PAYMENT PLAN “B”**

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<tr>
<td>Dependant Accidental Death and Dismemberment</td>
<td>$15,000 (Spouse Principal Sum) &amp; $4,000 (Per Child Principal Sum)</td>
</tr>
</tbody>
</table>

Optional Life Insurance

Above Group Life Insurance is provided by the Plan, and may be available through Great-West Life if you are under the age of 70 for Members and their eligible Dependents. Details of premium rates, amounts of insurance, eligible criteria, etc. are available from the Administration Office or on the Plan website.
Self Payment Plan Option C

**ACTIVE MEMBER ENROLLED IN SELF PAYMENT PLAN “C”**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>$100,000 (Member Only)</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment</td>
<td>$100,000 Principal Sum</td>
</tr>
</tbody>
</table>

**ACTIVE MEMBER AND DEPENDANTS ENROLLED IN SELF PAYMENT PLAN “C” (CONTINUED)**

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<tbody>
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</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Nil</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>70%</td>
</tr>
<tr>
<td>Prescription Drugs for Smoking Cessations</td>
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</tr>
<tr>
<td>Prescription Drugs for Treatment of Erectile Dysfunction</td>
<td>70% (Subject to quantity limitations)</td>
</tr>
</tbody>
</table>

Note: Over the counter drugs, vaccines, vitamins and supplements are not covered by the Plan.

**Vision Care**

Not covered.
Self Payment Plan Option C

ACTIVE MEMBER AND DEPENDANTS ENROLLED IN SELF PAYMENT PLAN “C” (CONTINUED)

Individual Calendar Year Maximum
$40,000

Dental Benefits

Dental Fee Guide
Reimbursement of dental services will not be in excess of the 2014 Alberta Dental Association Suggested Fee Guide.

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<tr>
<td>Deductible</td>
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</tr>
<tr>
<td>Basic Dental Services (Cleaning and check-ups eligible every 6 months)</td>
<td>70%</td>
</tr>
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<td>$3,000 Per Person</td>
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Pre-Determination of Benefits
Prior to a planned course of treatment exceeding $500, a Pre-Determination plan, including x-rays, should be submitted to the Administration Office for approval.
Self Payment Plan Option D

ACTIVE MEMBER ENROLLED IN SELF PAYMENT PLAN “D”

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<tbody>
<tr>
<td>Life Insurance</td>
<td>$100,000 (Member Only)</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment</td>
<td>$100,000 Principal Sum</td>
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</tbody>
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ACTIVE MEMBER AND DEPENDANTS ENROLLED IN SELF PAYMENT PLAN “D”

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Note: Over the counter drugs, vaccines, vitamins and supplements are not covered by the Plan.

Individual Calendar Year Maximum
$40,000
Retired Member Benefits

RETIRE MEMBERS UNDER AGE 65 FULL PAYMENT

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<th>Benefit</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>$100,000 (Member Only)</td>
</tr>
</tbody>
</table>

If at retirement, the Member has a full Hour Bank, the Life Insurance Benefit will remain at $100,000 for 20 months or until exhaustion of his Hour Bank account. Thereafter, the Member may choose Self Payment to retain the $100,000.

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<th>Benefit</th>
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<tbody>
<tr>
<td>Accidental Death and Dismemberment</td>
<td>$100,000 Principal Sum</td>
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RETIRE MEMBERS AND DEPENDANTS UNDER AGE 65 FULL PAYMENT

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Note: Over the counter drugs, vaccines, vitamins and supplements are not covered by the Plan.
Retired Member Benefits

RETIRED MEMBERS AND DEPENDANTS UNDER AGE 65 FULL PAYMENT (CONTINUED)

Ambulance
100% from Point ‘A’ to a Hospital. Response fee is not covered.

Hospital
100% of the Semi-Private room rate in the province of residence.

Mobility Assistance Equipment Benefit
Reimbursement of 90% of the expenses associated with specific mobility equipment. Require prior approval from Administration Office before purchase.

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<tr>
<th>Hearing Aids</th>
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<tr>
<td>If Hearing Aids are purchased within 2 years from January 1, 2012</td>
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<td>$5,000 Per Person</td>
</tr>
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</table>

Audiology Report is required for initial claim

Diabetic Supplies
Reimbursed at 90%. Glucometer is not a covered expense.

Private Duty Nursing
$20,000 per person, per calendar year.

Vision Care
$450 per person is available for purchase of Prescription Glasses and/or Contact Lenses. Benefit renews every 2 calendar years starting January 1st, 2016. Prescription with each claim is required. If the laser eye surgery benefit is utilized, there is no coverage for vision care for 5 years.

<table>
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<tr>
<th>Safety Glasses (Member only, prescription lenses only)</th>
<th>$400 Every 2 Years</th>
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<tr>
<td>Eye Exams</td>
<td>Not Covered</td>
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<td>Laser Eye Surgery</td>
<td>$1,600 Per Person Lifetime Maximum</td>
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Retired Member Benefits

RETIRED MEMBERS AND DEPENDANTS UNDER AGE 65 FULL PAYMENT (CONTINUED)

Individual Calendar Year Maximum
$40,000

Dental Benefits

Dental Fee Guide
Reimbursement of dental services will not be in excess of the 2014 Alberta Dental Association Suggested Fee Guide.

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Pre-Determination of Dental Benefits
Prior to a planned course of treatment exceeding $500, a Pre-Determination plan, including x-rays, should be submitted to the Administration Office for approval.

Out-of-Province/Canada Travel Emergency Medical Plan
$100,000 per person lifetime maximum is available. Not subject to co-insurance or calendar year maximum. Limited to 180 travel days per trip.
Retired Member Benefits

RETIREMENT MEMBERS AND DEPENDENTS UNDER AGE 65 FULL PAYMENT (CONTINUED)

**Member Assistance Program (MAP)**
Provided by: Construction Employee and Family Assistance Plan (CEFAP).

Website: [www.homewoodhealth.com](http://www.homewoodhealth.com)

CEFAP provides confidential personal assistance and self-development services for employees and their Dependants through Homewood Human Solutions. CEFAP covers counselling, education and self-development services in addition to assessment and referral when required, for a full spectrum of personal issues including, but not limited to:

1. Job Loss
2. Stress Management
3. Personal Issues
4. Marital and Family Issues
5. Financial Planning
6. Legal Counselling
7. Health Management and Retirement
8. Alcohol and Drug Dependency
9. Smoking Cessation
10. Sexual Harassment and Abuse
Retired Member Benefits

**RETIRED MEMBERS UNDER AND OVER AGE 65**

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<td>Life Insurance</td>
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Note: Over the counter drugs, vaccines, vitamins and supplements are not covered by the Plan.
Retired Member Benefits

RETIRE MEMBERS AND DEPENDANTS UNDER AND OVER AGE 65 (CONTINUED)

Hearing Aids

| If Hearing Aids are purchased within 2 years from January 1, 2012 | $1,500 Per Person |
| If Hearing Aids are not purchased until after 3 years from January 1, 2012 | $3,500 Per Person |
| If Hearing Aids are not purchased until after 5 years from January 1, 2012 | $5,000 Per Person |

Vision Care

$450 per person is available for purchase of Prescription Glasses and/or Contact Lenses. Benefit renews every 2 years starting January 1\textsuperscript{st}, 2016. Prescription with each claim is required. If the laser eye surgery benefit is utilized, there is no coverage for vision care for 5 years.

| Safety Glasses (Member only, Prescription lenses only) | $400 Every 2 Years |
| Eye Exams | Not Covered |
| Laser Eye Surgery | $1,600 Per Person Lifetime Maximum |

Mobility Assistance Equipment Benefit

Reimbursement of 90% of the expenses associated with specific mobility equipment. Require prior approval from Administration Office before purchase.

Individual Calendar Year Maximum

$40,000

Out-of-Province/Canada Travel Emergency Medical Plan

$100,000 per person lifetime maximum is available. Not subject to co-insurance or calendar year maximum. Limited to a maximum of 180 travel days per trip.
Retired Member Benefits

RETIRED MEMBERS AND DEPENDANTS UNDER AND OVER AGE 65 (CONTINUED)

Dental Benefits

Dental Fee Guide

Reimbursement of dental services will not be in excess of the 2014 Alberta Dental Association Suggested Fee Guide.

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Provided by: Construction Employee and Family Assistance Plan (CEFAP).

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5. Financial Planning
6. Legal Counselling
7. Health Management and Retirement
8. Alcohol and Drug Dependency
9. Smoking Cessation
10. Sexual Harassment and Abuse
Retired Member Benefits

RETIREMENT Members AND Dependants UNDER AND OVER AGE 65 (CONTINUED)

Diagnostic and Treatment Support Services
Provided by: Best Doctors Canada
Website: www.bestdoctorscanada.com

Best Doctors helps you make medical decisions with confidence. They provide access to the best medical minds in the world so you can be sure you have the right diagnosis and treatment plan. Best Doctors can also help you find specialists and get expert answers to medical questions. Whether you’re dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Best Doctors can guide you in the right direction.
Surviving Dependants of Deceased Members Benefits

SURVIVING DEPENDANTS OF DECEASED MEMBERS COVERED WITH HOURS

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A Member’s Dependents, who are covered under the Plan at the time of the Members or Retired Members death will continue to be covered, but not beyond the earliest of:

1. The date such Dependents cease to be eligible;
2. The end of the months in the deceased Members hour bank prior to death or if no self payments are received; or
3. The date of coverage for the Dependant terminates for any reason.

Medical Benefits

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Audiology Report is required for initial claim
Surviving Dependants of Deceased Members Benefits

SURVIVING DEPENDANTS OF DECEASED MEMBERS COVERED WITH HOURS (CONTINUED)

Vision Care
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Individual Calendar Year Maximum
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Out-of-Provence/Canada Travel Emergency Medical Plan
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Dental Benefits

Dental Fee Guide
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Surviving Dependents of Deceased Members Benefits

SURVIVING DEPENDANTS OF DECEASED MEMBERS COVERED WITH HOURS (CONTINUED)

Member Assistance Program (MAP)
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10. Sexual Harassment and Abuse

Diagnostic and Treatment Support Services
Provided by: Best Doctors Canada
Website: www.bestdoctorscanada.com

Best Doctors helps you make medical decisions with confidence. They provide access to the best medical minds in the world so you can be sure you have the right diagnosis and treatment plan. Best Doctors can also help you find specialists and get expert answers to medical questions. Whether you’re dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Best Doctors can guide you in the right direction.

Best Doctors Canada
Your Benefit Plan

The following information will assist you in understanding your Health and Welfare Plan:

WHEN DID THE PLAN BEGIN?
The Plan began in July 1965.

WHO ARE THE CONTRIBUTING EMPLOYERS?
The Contributing Employers are those Employers who are parties to a Collective Agreement, or who have signed a Participation Agreement and have Members in (the “Union” – Construction Labour Relations – An Alberta Association (CLR)) in their employ. These Agreements say that the Employer will make Contributions to The Edmonton Pipe Industry Health and Welfare Fund.

WHO CAN PARTICIPATE IN THE PLAN?
Members are eligible to join the Plan if employed under the conditions and jurisdiction of Local 488 the United Association of Journeyman and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada. Members must be Canadian residents and must also be covered under one of the Provincial Health Care Plans.

ARE MY DEPENDANTS COVERED?
All Dependants must be Canadian residents and must also be covered under one of the Provincial health care plans. The Plan will not issue payment for Benefits that are covered under a Provincial Health Care Plan.

A Member’s Dependant becomes eligible for coverage when the Member becomes eligible or, if acquired later, upon becoming the Member’s Dependant and a completed Application Card is received in the Administration Office.

The Member must be covered in order for the Member’s Dependents to be covered.

The Member must have provided sufficient information, on the form required by the Administrator, for the Administrator to be able to determine whether the Dependant is eligible for benefits.

WHO QUALIFIES AS MY DEPENDANT?
Dependant means a Spouse and/or an unmarried Child under 18 years of age and solely dependent upon the Member for support. If the Child is a full-time student, then they are covered until their 25th birthday. Proof of student status is required by this Plan.
Your Benefit Plan

WHO QUALIFIES AS MY DEPENDANT? (CONTINUED)

Spouse means a person who is:

1. Married to the Member and has not been living separate and apart from the Member for one (1) or more consecutive years, or,
2. If there is no person to whom (1.) above applies, a person who has lived with the Member in a conjugal relationship for a continuous period of one (1) year, or of some permanence if there is a child of the relationship by birth or adoption.

Child means a person who is:

1. A natural or legally adopted child, or,
2. A step-child, who is dependent upon the Member for support and lives with the Member in a regular parent-child relationship, or,
3. A foster child or other child, who is dependent upon the Member for support and lives with the Member in a regular parent-child relationship and the Member has legal guardianship.

No person shall be considered a Dependant if such person is eligible for coverage under any benefit of the Plan as a Member.

WHEN WILL MY DEPENDANTS BECOME COVERED FOR BENEFITS?

Coverage, or any increase in coverage, for a Member's Dependant (other than a newborn child who becomes covered within 31 days of becoming eligible) who is because of illness or injury on the date such coverage would otherwise become effective, will not become effective until the date such Dependant is no longer confined.

MAY I BE COVERED AS A RETIRED MEMBER?

To be eligible for coverage, the Retired Member and Dependents must be covered under a Provincial Health Care Plan.

- A Retired Member who reaches age 65 may be eligible for Retired Member Benefits by remitting the self-payment rate in effect at the time.
- A Retired Member who applies for Plan coverage beyond age 65 must have accumulated 15 years of Credited Service at the time of Retirement in The Edmonton Pipe Industry Pension Plan, the UA Canadian Pipeline Pension Plan, the Sprinkler Industry Pension Plan or the UA Officers Pension Plan. The accumulated number of years must be earned through employment with a Contributing Employer, and within the jurisdiction of the Union. Any transfer of Credited Service to The Edmonton Pipe Industry Pension Plan via a Reciprocal Agreement will not qualify towards the requirements for coverage.
Your Benefit Plan

MAY I BE COVERED AS A RETIRED MEMBER? (CONTINUED)

- Subject to payment of the prescribed amount, a Retired Member will be eligible for benefits. Disability coverage is not provided. Eligible Dependants of Retired Member will also be eligible for coverage.
- A Retired Member may make Self-Payments for a maximum period of 12 consecutive months once the Hour Bank is exhausted but in no case beyond the month in which the Retired Member attains age 65. Thereafter, the Retired Member may qualify for Retired Member Benefits at a cost of $60 per month, if he remains a member in good standing of the Union.

<table>
<thead>
<tr>
<th>RETIRED MEMBERS AGE</th>
<th>HOUR BANK STATUS</th>
<th>BENEFIT</th>
<th>SELF-PAYMENT</th>
<th>TERMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>55 - 65</td>
<td>Covered via Hour Bank</td>
<td>$100,000</td>
<td>No</td>
<td>When Hour Bank Exhausted</td>
</tr>
<tr>
<td>55 - 65</td>
<td>No Hour Bank</td>
<td>$100,000</td>
<td>Yes</td>
<td>12 Months Following 1st Self Payment</td>
</tr>
<tr>
<td>65 Plus 1 Day</td>
<td>Covered via Hour Bank</td>
<td>$100,000</td>
<td>No</td>
<td>When Hour Bank Exhausted</td>
</tr>
<tr>
<td>55 – 65 With Less Than 15 Years</td>
<td>No Hour Bank</td>
<td>$100,000</td>
<td>Yes</td>
<td>12 Months Following 1st Self Payment</td>
</tr>
<tr>
<td>65 Plus 1 Day With Less Than 15 Years</td>
<td>No Hour Bank</td>
<td>$0</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>65 Plus 1 Day With More Than 15 Years</td>
<td>No Hour Bank</td>
<td>$10,000</td>
<td>Yes</td>
<td>N/A</td>
</tr>
</tbody>
</table>

WHAT CONTRIBUTIONS ARE TO BE MADE TO THE PLAN?

Contributing Employers contribute monthly at the rates stipulated in the Collective Agreement.

A Retired Member who attains age 65 may be eligible for benefits, with the exception of the Weekly Disability and Long Term Disability Benefits, by remitting the Self Payment rate in effect at the time. Eligible Dependents of Retired Member will also qualify for coverage.

A Retired Member who wishes to Self Pay beyond age 65 must have accumulated 15 years of Credited Service at the time of Retirement in The Edmonton Pipe Industry Pension Plan, the UA Canadian Pipeline Pension Plan, the Sprinkler Industry Pension Plan, or the UA Officers Pension Plan. The accumulated number of years must be earned through employment with a Contributing Employer, and within the jurisdiction of the Union. Any transfer of Credited Service to The Edmonton Pipe Industry Pension Plan via a Reciprocal Agreement will not qualify towards the requirements for coverage.
Your Benefit Plan

WHAT CONTRIBUTIONS ARE TO BE MADE TO THE PLAN? (CONTINUED)
If you have become disabled, and provided you have met the Plan conditions, you may have coverage extended without a required Contribution to the Plan. You may contact the Administration Office for more information. There will be neither a withdrawal of hours from your Hour Bank nor a requirement for Self Payments.

Continued eligibility will be dependent upon remaining a Member in good standing in UA Local Union 488.

If the Member was covered for Benefits on the date of death, the surviving Spouse and eligible Dependents will have coverage, by utilizing the deceased Members remaining Hour Bank or on a Self-Pay Basis. The required cost must be confirmed with the Administration Office.

WHAT HAPPENS IF I AM NO LONGER A MEMBER OF THE UNION?
As long as you are a Member of the Union your coverage will continue under this Plan until your Hour Bank falls below the monthly drawdown requirement. Suspended or expelled members will not be eligible for Benefits and their Hour Bank will be frozen until Membership in the Union is re-instated. Expelled Members will have their Hour Bank forfeited.

If you are working on a permanent basis in another jurisdiction which has a current Reciprocal Agreement with this Fund, you may wish to transfer your Hour Bank balance to your new "Home" plan. This helps you to maintain Benefits and avoid duplication of coverage. Upon written notification (an authorization form) to the Administration Office, a transfer will be made and you will no longer be eligible for coverage under this Plan.

WHAT IF THE SAME OR SIMILAR BENEFITS CAN BE PAID UNDER ANOTHER PLAN?
The purpose of medical and dental Benefits is to cover only the actual expenses you incur.

Your Plan will not pay Benefits for any person who is entitled to receive them first from another plan. “Other plans” include medical and dental Benefits provided under a law or governmental program, the group insurance plan of your Spouse, or student coverage obtained through an educational institution.

The Claim filing procedure, agreed to by Canadian Health Insurers and Benefit Plans, is as follows:

1. If the Claim was incurred by you, file the Claim first with this Plan. If there is an unpaid balance, then file the Claim with your Spouse’s plan along with this Plan’s Explanation of Benefits so that your Spouse’s plan can clearly identify what portion of the Claim has already been paid.
2. If the Claim was incurred by your Spouse, file the Claim with your Spouse’s plan first. If there is an unpaid balance, file the Claim with this Plan along with the Explanation of Benefits from your Spouse’s plan identifying the portion of the Claim that has already been paid.
Your Benefit Plan

WHAT IF THE SAME OR SIMILAR BENEFITS CAN BE PAID UNDER ANOTHER PLAN? (CONTINUED)

3. If one of your children incurs the Claim, first submit the Claim to the Plan of the parent who has the earlier birthday in the calendar year. If your Spouse does not have a Benefit Plan then file the Claim with this Plan.

4. If you and your Spouse are both covered by this Plan, attach a note to your Claim, giving your Spouse's full name and Social Insurance Number. The Administration Office will settle your Claim.

This type of Co-ordination of Benefits (COB) provision is common to most group insurance plans. Please contact the Administration Office if you require further explanation.

CAN I OPT-OUT OF THIS PLAN?

If Contributions are required to be made for you under a Collective Agreement, you are a Member of this Plan and you will be unable to opt out.

WHAT HAPPENS IF I GIVE MISLEADING OR INCORRECT INFORMATION TO THE PLAN?

If it is determined that you deliberately obtained, or attempted to obtain, a Benefit under the Plan to which you were not entitled (including a Benefit which is greater than the Benefit to which you were entitled, or a duplicate submission of a Claim) through the submission of false, misleading or inaccurate information, the Board of Trustees may, at their discretion:

1. Refuse payment of every such Benefit;
2. Deny coverage under the Plan;
3. Declare you and your Dependents ineligible for any further Benefits under the Plan unless you can establish that the information submitted was due solely to a bona fide error; and,
4. Seek other remedies permissible by law.

HOW DOES THE PLAN PROTECT MY PERSONAL INFORMATION?

Any personal information obtained from you, or received on your behalf, is disclosed only to those with a legitimate reason for obtaining the information. Personal information will be maintained pursuant to relevant Legislation.

Medical Information Bureau (MIB).

MIB Group, Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its Members.
Your Benefit Plan

HOW DOES THE PLAN PROTECT MY PERSONAL INFORMATION? (CONTINUED)

Great-West Life or its re-insurers may periodically report information to the MIB. If you apply to receive life, disability or health insurance coverage from another MIB Member company or submit a claim for Benefits to such a company, the MIB upon request will supply the other insurer with the information on file.

Great-West Life or its re-insurers may also release information in its file to other life insurance companies to whom you may apply for insurance or submit a claim for Benefits. All information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you can contact the MIB and seek a correction. Their address is:

MIB
Suite 501, 330 University Ave.
Toronto, Ontario
M5G 1R7
Tel: (416) 597-0590

WHICH DOCTORS MAY I USE?

Doctor: any eligible service (described elsewhere in this Booklet) can be performed by a licensed Medical Doctor (M.D.), Dentist, Optometrist, Ophthalmologist, Chiropractor, Naturopath, Osteopath, Podiatrist, Occupational Therapist, Psychiatrist, or Psychologist, practicing within the scope of his or her profession. A Psychologist is considered licensed if certified or registered by the jurisdiction in which he or she practices.

WHICH HOSPITALS MAY I USE?

Hospital: an institution operated by law for the care and treatment of sick and injured persons. The Hospital must be continuously staffed and supervised by licensed Medical Doctor (M.D.) and registered graduate nurses. Such institution must have facilities both for diagnosis and major surgery. The term "Hospital", does not include a rest home, nursing home, convalescent care facility, health spa, a place for custodial care, a home for the aged or an institution used primarily for the confinement or treatment of tuberculosis or mental illness.
Your Benefit Plan

DOES MY PLAN COVER EXPENSES INCURRED WHILE TRAVELING OUTSIDE CANADA, OR MY PROVINCE OF RESIDENCE?

This Plan includes an Emergency Travel Assistance Benefit. In the event that you become ill, or are injured while traveling outside your province of residence or out of the country, you must contact the Emergency Travel Assistance Benefit coordinator for assistance. Should you fail to do so, your Plan will not cover charges incurred as a result of this. Please take note that the Lifetime Maximum Benefit per individual for Emergency Out-of-Country claims is $100,000. Limited to a maximum of 180 travel days per trip.

Global Excel can be contacted from:

Canada & United States: 1-866-870-1898 or;

Elsewhere: 1-819-566-1898
Eligibility Rules

HOW DO I BECOME ELIGIBLE FOR BENEFITS?
You will become eligible for Benefits on the first day of the following month after accumulating 320 working hours. As well, you must remain a Member in good standing with UA Local Union 488.

An example of commencing eligibility is as follows:

If you work in April, those hours are received from the Contributing Employers in May and would be utilized for coverage commencing in June.

The following chart provides the applicable Initial Eligibility Date for each month of the year:

<table>
<thead>
<tr>
<th>MONTH OF</th>
<th>HOURS REQUIRED TO BE ELIGIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>March 1st</td>
</tr>
<tr>
<td>February</td>
<td>April 1st</td>
</tr>
<tr>
<td>March</td>
<td>May 1st</td>
</tr>
<tr>
<td>April</td>
<td>June 1st</td>
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<tr>
<td>May</td>
<td>July 1st</td>
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<td>June</td>
<td>August 1st</td>
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<tr>
<td>July</td>
<td>September 1st</td>
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<tr>
<td>August</td>
<td>October 1st</td>
</tr>
<tr>
<td>September</td>
<td>November 1st</td>
</tr>
<tr>
<td>October</td>
<td>December 1st</td>
</tr>
<tr>
<td>November</td>
<td>January 1st Of The Following Year</td>
</tr>
<tr>
<td>December</td>
<td>February 1st Of The Following Year</td>
</tr>
</tbody>
</table>

*Currently 320 Hours

HOW DO ACTIVE MEMBERS MAINTAIN COVERAGE?
Each month your Contributing Employers are required to remit a dollar amount based on the Collective Agreement Contribution Rate and the number of Hours Earned by you in the previous month. After you have satisfied the initial eligibility, the Administration Office will deduct the monthly drawdown requirement of 130 hours monthly from your Hour Bank to pay for your Benefits. If the amount of Contributions remitted in a month exceeds the drawdown requirement, the excess will be accumulated in your Hour Bank. Contributions will be accumulated in your Hour Bank until it reaches 2,600 Hours.

You must be a Member in good standing of UA Local Union 488 to continue coverage under the Plan.

Contributions over 2,600 Hours are transferred to the Unallocated Reserve of the Fund. This Reserve is used to provide free, or subsidized, coverage to Pensioners, Widows and some Self Payment Plans.
Eligibility Rules

HOW DO ACTIVE MEMBERS MAINTAIN COVERAGE? (CONTINUED)

Besides Employer Contributions, there are other ways in which coverage can be continued:

1. Self Payment Plans
2. Apprentice Coverage
   - Coverage will remain in effect if you are an Apprentice Member, for each month of your attendance at, N.A.I.T., S.A.I.T., or other approved institutions. Eligibility is dependent upon your successful completion of each year of apprenticeship training and on confirmation of your school attendance to UA Local Union 488 Education Department.
3. Total Disability
   - If you are totally disabled, you may be entitled, with limitations, to coverage under the Plan. Continued eligibility will be dependent upon you remaining a Member in good standing of UA Local Union 488. You will be responsible for providing the Administration Office with any documentation required to support your status.

WHAT HAPPENS TO MY COVERAGE IF I AM NO LONGER WORKING?

During periods when you are not working, 130 Hours will continue to be drawn from your Hour Bank until the Hour Bank is insufficient to maintain coverage. At that time, you will be offered Self Payment options. You may then make Self Payments for a maximum of 12 consecutive months. Additionally, you and your Dependents must also be covered under a Provincial Health Care Plan.

There are several Self Payment Plans. Your choice of Plan will depend upon whether you wish to continue full coverage for yourself and your Dependents.

You should choose your Self Payment Plan carefully. Once the choice is made, and you are remitting Self Payments, you may not switch to a Plan with greater Benefits. You may, however, switch to a Plan with lesser Benefits.

Self Payments must be received within 31 days after going out of Benefit. If payment is not received within the 31 day period, reinstatement in the Plan will only be available by working hours.

WHAT IS THE COST OF THE SELF PAYMENT OPTIONS?

Please verify the current costs with the Administration Office.

WILL SELF PAYMENT RATES CHANGE?

The Self Payment rates will change from time to time, based on the cost of Benefits and the Funds’ ability to subsidize Benefits.
Eligibility Rules

WHAT HAPPENS WHEN I RETURN TO WORK?
If your coverage has been terminated for any reason, it will be reinstated on the first day of the second month following the day you have worked sufficient hours so that your Hour Bank has a balance of at least the monthly draw down amount. If you have continued your coverage by making Self Payments, you will be reinstated on the first day of the month following the day on which you have worked sufficient hours.

SELF PAYMENT PLANS

<table>
<thead>
<tr>
<th>PLAN NAME</th>
<th>WHO CAN BE COVERED</th>
<th>BENEFITS COVERED</th>
<th>BENEFITS UNAVAILABLE</th>
<th>MAXIMUM SELF PAYMENT PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Active Members &amp; Dependants</td>
<td>Life Insurance Dependant Life Accidental Death &amp; Dismemberment Weekly Disability Medical Dental CEFAP Rehabilitation Benefit Out of Country</td>
<td>Long Term Disability Best Doctors</td>
<td>12 Consecutive Months</td>
</tr>
<tr>
<td>B</td>
<td>Active Members &amp; Dependants</td>
<td>Life Insurance Dependant Life Accidental Death &amp; Dismemberment</td>
<td>Weekly Disability Long Term Disability Medical Dental CEFAP Rehabilitation Benefit Best Doctors Out of Country</td>
<td>12 Consecutive Months</td>
</tr>
<tr>
<td>C</td>
<td>Active Members &amp; Dependants</td>
<td>Life Insurance Dependant Life Accidental Death &amp; Dismemberment Reduced Medical Reduced Dental</td>
<td>Weekly Disability Long Term Disability CEFAP Rehabilitation Benefit Best Doctors Out of Country</td>
<td>12 Consecutive Months</td>
</tr>
<tr>
<td>D</td>
<td>Active Members &amp; Dependants</td>
<td>Life Insurance Dependant Life Accidental Death &amp; Dismemberment Reduced Medical</td>
<td>Weekly Disability Long Term Disability Dental CEFAP Rehabilitation Benefit Best Doctors Out of Country</td>
<td>12 Consecutive Months</td>
</tr>
</tbody>
</table>
Eligibility Rules

WHEN WILL MY COVERAGE AS AN ACTIVE MEMBER END?

Coverage for you, and your Dependents, will end on the first of the following to occur:

1. The last day of the month in which you have less than the monthly drawdown requirement (130 Hours) in your Hour Bank, except if you elect to make Self Payments;
2. The date you enter active duty in the armed forces of any jurisdiction;
3. The last day of the month prior to your retirement if you do not have sufficient hours in your Hour Bank and you are not making Self Payments;
4. If you discontinue any required Contributions under the Self Payment Plans;
5. For the Long Term Disability Benefit, the earlier of age 65 or the date you commence receiving a pension from The Edmonton Pipe Industry Pension Plan;
6. For the Weekly Disability Benefit, the date you commence receiving a pension from The Edmonton Pipe Industry Pension Plan.

A Dependant’s coverage will end when the person is no longer an eligible Dependant or the active member’s coverage is terminated.
Termination of Coverage

MEMBER AND DEPENDANT COVERAGE
Coverage for a Member and a Member’s Dependents will terminate on the earliest of:

1. The date the Plan is discontinued for any reason;
2. The date immediately prior to the first day of a Benefit Period if; as of the preceding Determination Date, there were less than 130 Credited Hours in the Members Bank of Credited hours; or
3. The Member ceases to be a Member in good standing of the Union, or the Member or Retired Member does not pay the required self-payment amount, or the maximum self-payment period has expired.

Coverage for a Member's Dependant will terminate on the date such Dependant ceases to be eligible.

In the case of a Member whose coverage would otherwise terminate in accordance with the foregoing item (2.) because of retirement, such Member's coverage may be deemed to continue until he ceases to be a Retired Member as defined in the "Definitions" section of this Booklet.

TEMPORARY ABSENCE FROM WORK
A Member and a Member’s Dependents may continue to be covered at the Administrator’s option, if such Member’s absence from work is not due to termination of employment but due to:

- Illness or injury but not beyond age 65 (or, if such Member is age 65 or older and eligible for coverage); and
- The Administration Office has received the required medical information.

CONTINUATION OF HEALTH AND DENTAL BENEFITS FOR INCAPACITATED CHILDREN
Health and Dental Benefits will continue beyond the date an unmarried Child attains the limiting age for coverage, provided proof is submitted to the Administrator within 31 days after such date that such Child:

- Is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
- Became so incapacitated prior to attainment of the limiting age; and
- Is chiefly dependent upon the Member for support and maintenance.

Thereafter, such proof must be submitted to the Administration Office as required.

CONTINUATION OF HEALTH AND DENTAL BENEFITS AFTER THE MEMBER’S DEATH
A Members Dependents, who are covered under the Plan at the time of the Member’s, or Retired Member’s, death, will continue to be covered, but not beyond the earliest of:

- The date such Dependants cease to be eligible;
- The end of the month in the deceased Members hour bank prior to death or no self payments received; or
- The date coverage for the Dependant terminates for any reason.
Termination of Coverage

CONTINUATION OF HEALTH AND DENTAL BENEFITS AFTER THE MEMBER’S DEATH (CONTINUED)
Upon the Member’s death, benefits are payable to the Spouse, if living. If the Spouse is not living benefits are payable to the Child if the Child is of majority age. If benefits are payable to the Child and the Child is not of majority age, benefits will be payable to the legal guardian.

AMENDMENT OF THE PLAN’S BENEFITS AND DISCONTINUANCE OF THE PLAN
The Trustees manage the Benefits of the Plan pursuant to their rights established in the Amended and Restated Health and Welfare Trust Agreement dated August 13, 2007. Pursuant to that Agreement, the Trustees retain the sole right to adopt, administer amend (retroactively or otherwise) or replace the Plan for the benefit of Members, their beneficiaries or Dependents, as the case may be. These rights include the determination of the type, amount and duration of benefits to be provided and to determine all eligibility requirements. The establishment, suspension, deletion, amendment or termination of benefits and eligibility requirements will be affected solely by resolutions of the Trustees.

While it is the intention of the Trustees to continue the Plan indefinitely, in the event the assets of the Fund are insufficient to provide for any, or all, of the benefits of the Plan, the Trustees will amend the Plan as they, in their sole discretion, shall decide. The fact that any particular benefit is provided at a particular time does not guarantee that such benefit will be provided for any specific period of time. The continued payment of a benefit lies within the sole discretion of the Trustees.

In the event the Plan is to be discontinued, the mutual agreement of the Union and the Association, as provided for under the Trust Agreement, is required.

No Benefit will be paid or become payable for claims received after the date the Plan is discontinued. The Administrator will allow a period of time after the discontinuance of the Plan for claims to be submitted after which time no claims will be considered.
Life Insurance

FOR MEMBERS

In the event of your death while insured, the amount of your Life Insurance will be payable to your Beneficiary(ies), if living, or to your Estate. You may change your Beneficiary at any time, by submitting a new Application Card to the Administration Office. The assignment of a Beneficiary is subject to Provincial Laws. If you have not named anyone as your Beneficiary at the time of your death, the Life Insurance Benefit will be payable to your Estate.

FOR SPOUSES AND DEPENDANTS

If a Spouse or Dependant dies while his or her life is insured, Great-West Life will pay the amount of the Dependant Life Insurance Benefit to the Member.

OPTIONAL LIFE INSURANCE

Optional Life Insurance, over and above the group Life Insurance that is provided by the Plan, is available through Great-West Life for Members and their eligible Dependents under age 70. All Members with Supplementary Life Insurance are eligible, except Members who are permit workers and disabled Members who retire before age 65. A person who is insurable as both a Member and as a Spouse is still limited to the $500,000 maximum

- **Member Amount**: Any multiple of $25,000 up to $500,000.
- **Spouse Amount**: 10% of the Member amount, up to $50,000.
- **Child Amount**: 5% of the Member amount, up to $25,000.

CONVERSION PRIVILEGE

Life Insurance will continue for 31 days following the termination of your coverage. Should this Benefit terminate due to employment, change in classification or because you are no longer eligible for coverage, you may convert your Life Insurance within 31 days provided you are under the age of 65. You may choose to convert to either:

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

No evidence of health will be required and the premium rate will be determined based on your age and class of risk at the time of conversion. Should you die during this 31 day period, the amount of insurance which could be converted would be payable even if you had not applied for an individual policy.
Life Insurance

CONVERSION PRIVILEGE (CONTINUED)
If you wish to convert your Life Insurance Benefit you must contact Great-West Life.

Please quote Group Policy Number 167248.

BURIAL BENEFIT
A Burial Benefit is payable in the amount of $2,500 to the Beneficiary of a Member in good standing of Local Union 488, upon the Member’s death.

Please contact the Administration Office for further details.
Accidental Death and Dismemberment

FOR MEMBERS AND DEPENDANTS

The Accidental Death and Dismemberment Benefit is payable in addition to the Life Insurance Benefit. Benefits will be payable to you, with the exception of loss of life. Loss of life Benefits will be made payable to your named Beneficiary(ies) at the time of your death.

If you or your eligible Dependant sustain an accidental bodily injury while insured and suffers a loss within 365 days from the date of the accident, the amount shown in the Schedule of Benefits will be payable to you, if you are living, otherwise to the named Beneficiary(ies), if living, or to your Estate. Coverage is provided on a 24 hour basis without geographical restriction and regardless of whether the loss results from an occupational or non-occupational injury.

SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>Loss Of</th>
<th>Amount Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Both Hands</td>
<td>100%</td>
</tr>
<tr>
<td>Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of Both Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Foot and Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and Hearing in Both Ears</td>
<td>100%</td>
</tr>
<tr>
<td>One Arm</td>
<td>¾ of the Principal Sum</td>
</tr>
<tr>
<td>One Leg</td>
<td>¾ of the Principal Sum</td>
</tr>
<tr>
<td>One Hand</td>
<td>½ of the Principal Sum</td>
</tr>
<tr>
<td>One Foot</td>
<td>½ of the Principal Sum</td>
</tr>
<tr>
<td>Sight of One Eye</td>
<td>½ of the Principal Sum</td>
</tr>
<tr>
<td>Speech</td>
<td>½ of the Principal Sum</td>
</tr>
<tr>
<td>Hearing in Both Ears</td>
<td>½ of the Principal Sum</td>
</tr>
<tr>
<td>Thumb and Index Finger</td>
<td>¼ of the Principal Sum</td>
</tr>
<tr>
<td>Four Fingers of One Hand</td>
<td>¼ of the Principal Sum</td>
</tr>
<tr>
<td>All Toes on One Foot</td>
<td>1/8 of the Principal Sum</td>
</tr>
<tr>
<td>Both Arms and Both Legs (Quadriplegia)</td>
<td>200%</td>
</tr>
<tr>
<td>Both Legs (Paraplegia)</td>
<td>200%</td>
</tr>
<tr>
<td>Upper And Lower Limbs of One Side of Body (Hemiplegia)</td>
<td>200%</td>
</tr>
<tr>
<td>One Arm and One Leg on different Side of the Body</td>
<td>100%</td>
</tr>
<tr>
<td>Both Arms</td>
<td>100%</td>
</tr>
<tr>
<td>Both Hands</td>
<td>100%</td>
</tr>
<tr>
<td>One Arm and One Leg</td>
<td>100%</td>
</tr>
<tr>
<td>One Arm</td>
<td>¾ of the Principal Sum</td>
</tr>
<tr>
<td>One Leg</td>
<td>¾ of the Principal Sum</td>
</tr>
<tr>
<td>One Hand</td>
<td>½ of the Principal Sum</td>
</tr>
</tbody>
</table>
Accidental Death and Dismemberment

IN NO EVENT WILL MORE THAN ONE OF THE LOSSES, THE GREATEST, SUSTAINED BY ANY ONE PERSON AS A RESULT OF ANY ONE ACCIDENT, BE PAID. "PRINCIPAL SUM" MEANS THE AMOUNT OF INSURANCE SPECIFIED IN THE SUMMARY OF BENEFITS.

DEFINITION OF DISMEMBERMENT LOSS

- For hands and feet, complete severance through or above the wrist or ankle joints;
- For arms and legs, complete severance through or above the elbow or knee joints;
- For thumb and big toe, complete severance of one entire phalange;
- For fingers and other toes, complete severance of two (2) 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 (1) year after the reattachment was performed.

SIGHT, SPEECH AND HEARING LOSS

The loss of sight, speech or hearing means total 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 the loss of use if benefits for loss of dismemberment of the same arm, leg or hand are paid or payable as a result of the same accident.

REPATRIATION

Repatriation means the return of your body to your home. Benefits are payable under this provision for loss of life which occurred at least 150 kilometers from the person’s place of residence. Great-West Life will pay the actual expense incurred for preparation of the body and its transportation to the place of burial or cremation. The maximum amount payable under this provision is $2,500.
Accidental Death and Dismemberment

FAMILY TRANSPORTATION BENEFIT
If you suffer an accidental injury and are confined to a hospital that is more than 150 kilometers from your home, your Plan will pay the reasonable and customary costs of your family Members so that they can visit you in the hospital. Please note that only your immediate family will have their costs covered under this Benefit to a maximum of $2,000.

Your Plan considers immediate family as persons at least 18 years of age who are your Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included. Meal expenses are not covered.

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

EDUCATIONAL BENEFIT FOR DEPENDANT CHILDREN
If benefits are payable under this provision for loss of a Member’s life, Great-West Life will pay the tuition fees for enrolling his or her Dependant Children as full-time students at a post-secondary institution. To qualify for an Educational Benefit, a Dependant Child must satisfy one (1) of the following conditions:

1. He or she must have been enrolled as a full-time student at a post-secondary institution at the time of the accident causing the Member’s death; or
2. He or she must have been enrolled as a full-time student at the secondary school level at the time of the accident causing the Member’s death and enrolls as a full-time student at a post-secondary institution within 365 days after the accident.

The maximum amount payable under this provision for each year of full-time post-secondary school enrolment is the lesser of:

1. $10,000

Great-West Life will pay the Educational Benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment. A Dependant child is considered a full-time student if he is in registered attendance for 15 hours a week or more. A post-secondary institution means an accredited university, general and vocational school, trade school, community college, or private college that provides an education above the secondary school level. This Benefit will not be paid for if tuition expenses incurred before the accident causing death of the Member or room or board or other ordinary living, travelling, or clothing expenses.
Accidental Death and Dismemberment

OCCUPATIONAL TRAINING BENEFIT FOR SPOUSES
If Benefits are payable under this benefit provision for loss of a Member’s life, the Plan will pay for expenses associated with his or her 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 for. The maximum amount payable under this provision is the lesser of:

1. 10% of the Principal Sum; and
2. $10,000

No benefits will be paid for:
1. Expenses incurred more than 3 years after the accident causing the Member’s death.
2. Room and board or other ordinary living, travelling, or clothing expenses.

EDUCATIONAL BENEFIT FOR MEMBERS AND SPOUSES
If Benefits are payable under this benefit provision for a Member or Spouse, for a loss that requires the person to change occupations, the Plan will pay the tuition fees for enrolling the person as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, the person must enroll at a post-secondary institution within 365 days after the accident. The maximum amount payable under this provision is $10,000.

A post-secondary institution means an accredited university, general and vocational school, trade school, community college, or private college that provides an education above the secondary school level.

No Benefits will be paid for if tuition expenses incurred before the accident, or if the expenses incurred more than 2 years after the accident causing the loss. Room, board or other ordinary living, travelling, or clothing expenses are also not covered.

REHABILITATION BENEFIT
In the event that you have an accidental injury which results in your inability to continue your occupation, you will receive special training to become qualified in a new occupation. The new occupation must be one that you were not qualified to perform before your accident. Your Plan will pay the reasonable and customary expenses for this retraining for you up to a maximum of $10,000.

WHEELCHAIR BENEFIT
If Benefits are payable under this benefit provision for a loss due to an injury that requires the use of a wheelchair for the Member to be ambulatory, the Plan will pay for expenses association with:
Accidental Death and Dismemberment

WHEELCHAIR BENEFIT (CONTINUED)

1. Alterations to the Member’s principal residence to make it wheelchair accessible and habitable; and
2. Modifications to a motor vehicle used by the Member to make it accessible to and drive-able by the Member.

Benefits for home alterations are payable only if the person or persons making the changes are:

1. Experienced in home alterations for wheelchairs; and
2. Recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if:

1. The person or persons making the changes are experienced in vehicle modification for wheelchairs; and
2. The modifications are approved by the provincial vehicle licensing authority.

The maximum amount payable for all home and vehicle modifications combined is $10,000.

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

LIMITATIONS AND EXCLUSIONS

The plan will not cover Benefits payable for loss resulting from or associated with the following items:

1. Suicide while sane or insane;
2. Intentionally self-inflicted injury while sane or insane;
3. Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed;
4. Disease or infirmity;
5. Medical or surgical treatment, except surgical reattachment;
6. Service, including part-time or temporary service, in the armed forces of any country;
7. War, insurrection, or voluntary participation in a riot;
8. An accident occurring while operating a motor vehicle while the person is under the influence of any intoxicant, or has a blood alcohol level higher than 80 milligrams of alcohol per 100 milliliters of blood;
9. Air travel, ascent, or descent, except as a passenger in a licensed aircraft flown by a pilot certified to fly the aircraft. Under no circumstance will benefits be paid where the aircraft is owned, leased, or rented by his or her employer or where the Member who suffers the loss is acting as a crew member.
Weekly Disability Benefit

FOR ACTIVE MEMBERS AND MEMBERS ENROLLED IN SELF PAYMENT PLAN A

MAXIMUM BENEFIT AMOUNT
$500 per Week, 26 Week Maximum, Taxable

A Member is considered to be Totally Disabled if you are unable to perform any and every duty of your own occupation. In the event you become Totally Disabled, while eligible for Benefits, due to a sickness or any injury unrelated to work, you may qualify to receive a Weekly Disability Benefit from the Plan. You must be under the care of a licensed Medical Doctor (M.D.) or Specialist. A Specialist is a Medical Doctor who has specialized knowledge deemed appropriate for the impairment causing the Members disability (Example: A Psychiatrist, in the case of a psychiatric illness).

Benefits are payable on the basis of a seven (7) day week. Partial weeks of disability are paid at a daily rate that is one seventh of the weekly benefit.

QUALIFYING PERIOD
Benefits for any one (1) period of disability are payable on the 1st day of a disability resulting from an accident or hospitalization (minimum of 24 hours) or upon the 8th continuous day of disability due to illness.

CLAIM FILING
Weekly Disability Benefit claims must be received by the Administration Office within sixty (60) days from the commencement of the Members date of disability. The Members date of disability, for Benefit purposes, will not be earlier than the date on which the Member first sees a Physician for his disability. Late filed claims will not be accepted.

EMPLOYMENT INSURANCE INTEGRATION
The Plan’s Weekly Disability Benefit is coordinated with the Human Resources and Social Development Canada (HRSDC) Employment Insurance Accident and Sickness Benefit. The Plan will pay Benefits during the Employment Insurance (EI) waiting period which is currently two calendar weeks. EI will pay Accident and Sickness Benefits for a maximum of 15 weeks. If EI has accepted the Members claim, but reduced the benefit due to other insurance or income, or if EI refuses to pay a benefit because the Member breached an EI eligibility rule (Example: left the country or failed to claim EI on time), this Plan will pay no benefit during this period. If the Member is still totally disabled when EI Benefits terminate, the Plan will continue payments if the Member provides medical evidence which supports total and continuous disability.
Weekly Disability Benefit

EMPLOYMENT INSURANCE INTEGRATION (CONTINUED)
Members should not wait until after receipt of EI Accident and Sickness Benefits to file a claim for this Plan's Weekly Disability Benefit – if they do, Members will miss the filing deadline and Weekly Disability Benefits will not be paid.

EMPLOYMENT INSURANCE INTEGRATION (CONTINUED)
If a Member is unable to work due to disability then they should apply for EI Accident and Sickness Benefits, not EI Unemployment Benefits. If a Member is already in receipt of EI Unemployment Benefits when they become disabled, then they should notify HRSDC of their disability and switch to Accident and Sickness Benefits. In order to receive the Plan's Weekly Disability Benefit after the two week waiting period, a Member must provide a statement from HRSDC confirming denial of EI Accident and Sickness Benefits or indicating the period during which these benefits were paid.

MAXIMUM BENEFIT PERIOD
Weekly Disability Benefits provided by the Plan will be paid for a maximum of 26 weeks during any one period of disability. If you do not qualify for EI Benefits because you do not have sufficient work credits, the Plan will pay Benefits as long as you are totally disabled, up to a Maximum Benefit Period of 26 weeks.

As EI Accident and Sickness Benefits may be paid for up to 15 weeks following the two week waiting period, the combined EI and Plan Benefits may provide payments for up to 41 weeks. In no event will Weekly Disability Benefits be paid for any week you receive or are entitled to receive EI, or which is more than 42 weeks after your date of disability.

MAXIMUM BENEFIT
Weekly Disability Benefits are intended to assist in replacing the earnings the Member was receiving prior to their illness or accident. The Plan reserves the right to request information regarding any income that you may be receiving during this disability period. In the event that you are receiving, or are entitled to receive, income that provides more than 100% of his pre-disability earnings, Benefits will be reduced, dollar-for-dollar, by the excess above 100%. If you are declined for EI Accident and Sickness benefits because of entitlement to income from another plan, no Weekly Disability Benefits will be payable by the plan during the 15 week period EI Benefits would otherwise have been paid.

If, immediately prior to disability, you are working, but no contributions are remitted to the Fund on your behalf, any loss of income benefit you may be entitled to will be a direct dollar for dollar offset against Weekly Disability Benefits that would otherwise be payable under this Plan.
Weekly Disability Benefit

RECURRENT DISABILITIES
Successive periods of disability separated by less than two (2) weeks of work, or availability for work, will be considered one period of disability. The Plan’s Maximum Benefit Period will be counted from the Member's initial date of disability. The exception to this rule is if the next disability is due to a different cause and begins after the Member has been back at work or available for work for at least one full day.

REHABILITATIVE EMPLOYMENT
Weekly Disability Benefits will continue to be payable if the Member participates in an Approved Rehabilitation Program. If the Member recovers sufficiently to work again at any occupation, the Member may be able to do so without jeopardizing their benefit status. In order to maintain eligibility for Weekly Disability Benefits and Long Term Disability Benefits, it is important to note that any work a Member performs during rehabilitation must be approved, in writing, by the Plan and his Physician as an Approved Rehabilitation Program.

Participation in an Approved Rehabilitation Program will enable a Member to receive a greater total income than without the program. Members are not eligible for Weekly Disability Benefits during any period in which they are working, except under an Approved Rehabilitation Program. A Member's Weekly Disability Benefit will be reduced by 50% of the Member's rehabilitation income if the Member is employed in an Approved Rehabilitation Program.

Rehabilitation employment may include:

- The Member's regular occupation on a part-time basis; or
- A formal vocational training program; or
- Any other training program deemed suitable by the Member’s Plan.

SUBROGATION
For the purposes of this provision, the term “subrogation” means the Plan’s right to recover Weekly Disability Benefits paid to a Member if another party is, or may be, legally liable to compensate the Member for income lost due to the Member’s disability.

A Member may be entitled, as a result of the incident which caused or contributed to the Member's disability, to recover compensation for loss of income from a third party. The Plan will be subrogated to all the covered Member’s rights of recovery for loss of income. The subrogation will apply to the extent of the sum of Benefits paid or payable by the Plan. The Member will be required to provide full disclosure about the recovery or attempted recovery for the loss.
Weekly Disability Benefit

SUBROGATION (CONTINUED)

In the event that a Member provides proof to the Administration Office that they have not recovered full compensation for loss of income, the Plan shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should a Member elect to settle the matter prior to judicial determination, it is important that the Member understand that the sum reached in settlement will be deemed to be full compensation for loss of income, and the Plan’s right of subrogation will apply.

The term “compensation” includes any periodic or lump sum payments a Member receives or is entitled to receive due to past, present or future loss of income. The term “third party” includes a Member’s own and any other home or automobile insurer, as well as any individual, business, insurer or government agency against whom the Member may be entitled to claim for loss of income arising from the Members disability.

LIMITATIONS

Benefits are not payable for the following:

- Any period during which a Member is receiving or entitled to receive an income replacement benefit or loss of earning capacity benefit under a motor vehicle accident insurance plan or policy;
- Any day that a Member does any kind of work for pay or profit other than in an approved Rehabilitation Program;
- The period in which a Member is entitled to maternity leave of absence by statute, contract or employer agreement;
- Any disability for which benefits are payable under a Workers’ Compensation law or similar law;
- Any day for which a Member receives a pension from The Edmonton Pipe Industry Pension Plan, UA Canadian Pipeline Pension Plan, UA Sprinkler Pension Plan or UA Officers Pension Plan;
- Intentionally self-inflicted injuries, whether the Member is sane or insane;
- Any disability arising from an insurrection, rebellion or participation in a riot or civil commotion;
- Any disability arising from participation in, or attempt to commit, a criminal act;
- Any disability resulting from injury or disease which occurred while the Member was on active duty in the armed forces of any country, state or international organization or any disability;
- Resulting from war or act of war, whether declared or undeclared;
- Claims that are not filed within sixty (60) days of the start of a disability;
- More than one disability absence (regardless of the cause) per calendar year once a Member is over age 65;
Weekly Disability Benefit

LIMITATIONS (CONTINUED)

- Any period of disability during which a Member is not receiving ongoing supervision/treatment by a licensed Medical Doctor (M.D.) or Specialist deemed appropriate by the Plan for the impairment causing his disability. A Member will not be compensated for any period of disability during which the Member does not participate in the treatment program recommended by his Doctor or Specialist;

- Any period of disability resulting from substance abuse including alcoholism and drug addiction, unless the Member is participating in a recognized substance withdrawal program.

- Weekly Disability Benefits will not be paid if a Member fails to provide information on other income sources when such information is requested.
Long Term Disability

FOR ACTIVE MEMBERS ONLY

MAXIMUM BENEFIT AMOUNT
$2,500 per Month, Taxable

While eligible for Benefits under the Plan, should you become Totally Disabled, you may be considered for a monthly Long Term Disability Benefit if:

1. You are seen or treated by a licensed Medical Doctor (M.D.) or Specialist within 31 days of the date you became Totally Disabled. A Specialist is a Medical Doctor who has specialized knowledge deemed appropriate for the impairment causing your disability (for example, a psychiatrist in the case of a psychiatric illness); and
2. You are absent from work for more than the Waiting Period; and
3. The Total Disability commences prior to age 65.

Long Term Disability Benefits for any one period of Total Disability will commence following the “Waiting Period”. The Waiting Period will start on your date of disability and end on the later of the expiration of Weekly Disability Benefits or 26 weeks after the date of disability. If you remain continuously disabled, the Long Term Disability Benefit will be payable up to age 65.

You must submit your Long Term Disability claim form, including proof of your accident or sickness, within one (1) year of the date of disability. Late claims will not be accepted. The proof of claim must be signed by the Medical Doctor(s) or Specialist(s) whose care you are directly under.

DEFINITION OF TOTAL DISABILITY
You are considered Totally Disabled during the Waiting Period following the date of your accident or illness plus the immediately following 24 months if you are prevented from performing the essential duties of your regular occupation. After this period, you are considered disabled if disease or injury prevents you from being gainfully employed.

Gainfully employed means work:

1. A person is medically able to perform;
2. For which he/she has at least the minimum qualifications;
3. That provides income of at least 60% of his/her monthly earnings;
4. That exists either in the province or territory where he/she worked when he became disabled or where he/she currently lives.

The availability of work will not be considered in assessing disability.
Long Term Disability

LOSS OF LICENSE
Loss of any license required for work will not be considered in assessing disability.

No Benefits are payable for any Total Disability commencing within six (6) months of the effective date of your coverage in the Plan if the disability is caused or contributed to by, or is a consequence of, a sickness or injury for which you received medical treatment or services or took a prescribed drug or drugs or medicine at any time within ninety (90) days before the effective date of your coverage.

DISABILITY PERIOD
A disability period is

1. The Waiting Period; plus
2. The benefit period.

WAITING PERIOD
The Waiting Period starts when the person first becomes disabled and lasts, if disability is continuous. If the disability is not continuous, the days the person is disabled will be accumulated to satisfy the Waiting Period as long as

3. No interruption is longer than 2 weeks; and
4. The disabilities arise from the same disease or injury.

The Waiting Period is the later of 26 weeks or the expiration of the Member’s WI disability income benefit period.

RECURRENT DISABILITY
After the Waiting Period, a disability is recurrent if it arises from the same disease or injury and starts:

1. Within six (6) months after the previous disability ends; or
2. Within six (6) months after the end of an approved rehabilitation plan; or

AMOUNT PAYABLE
If your total monthly income while disabled plus any income specified below exceeds 85% of your gross monthly earnings as of the date your disability commenced, your Long Term Disability Benefit will be
Long Term Disability

AMOUNT PAYABLE (CONTINUED)

reduced accordingly. The income benefit is payable to the disabled Member monthly in arrears. One thirtieth of the income benefit is payable for each day of any period less than a full month.

At the insurer’s discretion, the income benefit may be paid more frequently than monthly, on a pro-rated basis.

The income used in the offset and all source maximum provisions is the income payable for the same period as the income benefit. Except for Retirement benefits, all income is considered payable when a Member is entitled to it, whether or not it has been awarded or received. If it has not been awarded, the insurer will have the right to estimate it according to the terms of any plans or legislation involved. Retirement Benefits are considered payable when they are actually received.

If income is payable in a lump sum, the amount used will be the portion payable for loss of income during the benefit period.

Monthly earnings are 1/12 of annual earnings.

OFFSET PROVISION

Under this provision, the Member’s LTD benefit is reduced by the following income:

1. Disability or retirement benefits to which he/she is entitled on his/her own behalf under:
   - The Canada Pension Plan;
   - The Quebec Pension Plan; or
   - A similar plan in another country which has a reciprocal agreement with Canada or Quebec.
   This does not include retirement benefits that were payable for each of the 12 months before a disability period.

2. Benefits under any Workers’ Compensation Act or similar law except for:
   - Permanent partial disability awards that were payable for each of the 12 months before a disability period; and
   - Benefits related to employment with another employer.

3. Employer sponsored disability or sick leave benefits

4. Loss of income benefits under an automobile insurance plan, to the extent permitted by law/

5. 50% of earnings received for an approved rehabilitation plan.

ALL SOURCE MAXIMUM PROVISION

Under this provision, the Member’s LTD Benefit is reduced if the total of the following income and income benefit exceeds 85% of his/her monthly earnings. If it does, his/her LTD Benefit is reduced by the amount in excess of 85%.
Long Term Disability

ALL SOURCE MAXIMUM PROVISION (CONTINUED)

1. Loss of income benefits available through legislation to which he or another member of his/her family is entitled on the basis of his/her disability, except for Employment Insurance Benefits and automobile insurance benefits.

2. The wage loss portion of any criminal injury award, except for awards that included the LTD Benefit available under this Plan in the calculation of the award.

3. Disability benefits under a plan of insurance available through an association, except for benefits that were payable for each of the 12 months before a disability period.

4. Employment income, disability benefits, or retirement benefits related to any employment, except for:
   - Disability benefits that are prepayments of life insurance/
   - Benefits for retirement plans to which an employer has not contributed.
   - Any amount that is related to employment other than with the employer and that was payable for each of the 12 months before a disability period. All employment income, disability benefits, and retirement benefits resulting from the same employment are considered together in satisfying the 12-month condition as long as there is no interruption from one to the other. Waiting Periods for disability benefits do not count as interruptions.
   - Employer sponsored disability or sick leave benefits.
   - Income from an approved rehabilitation plan. This income is considered under the offset and rehabilitation incentive provisions.

Termination pay, severance benefits, and any similar termination of employment benefits, including any salary paid in lieu of noticed, are considered employment income under this provision.

If income under this provision is payable on a commission basis, the income used will not be reduced by commission related expenses.

REHABILITATIVE EMPLOYMENT

Benefits will continue to be payable if you participate in an Approved Rehabilitation Program. If you recover sufficiently to work again at any occupation, you may be able to do so without jeopardizing your benefit status.

In order to maintain eligibility for Long Term Disability Benefits, any work you perform during rehabilitation must be approved, in writing, by the Insurer and your Physician as an Approved Rehabilitation Program.

Participation in an Approved Rehabilitation Program will enable you to receive a greater total income than without the Program. Rehabilitation employment may include:
Long Term Disability

REHABILITATIVE EMPLOYMENT (CONTINUED)

1. Your regular occupation on a part-time basis; or
2. A formal vocational training program; or
3. Any other training program deemed suitable by the Insurer.

REHABILITATION INCENTIVE PROVISION

Earnings a Member receives from an approved rehabilitation plan are not used to reduce a Member’s LTD benefit unless 50% of those earnings, his/her income from the LTD Benefit, and the income described under the offset and the all-source maximum provisions would exceed 100% of his/her monthly earnings. If it does, his/her income benefit is reduced by the amount in excess of 100%.

SUBROGATION

For the purposes of this provision, the term “subrogation” means the Insurer’s right to recover Long Term Disability Benefits paid or payable to you if another party is, or may be, legally liable to compensate you for income lost due to your disability.

You may be entitled, as a result of the incident which caused or contributed to your disability, to recover compensation for loss of income from a third party. The insurer will be subrogated to all your rights of recovery for loss of income. The subrogation will apply to the extent of the sum of Benefits paid or payable by the Insurer. You will be required to provide full disclosure about the recovery or attempted recovery, for the loss.

In the event that you provide proof to the Insurer that you have not recovered full compensation for loss of income, the insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you elect to settle the matter prior to judicial determination, it is important that you understand that the sum reached in settlement will be deemed to be full compensation for loss of income, and the insurer’s right of subrogation will apply.

The term “compensation” includes any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income. The term “third party” includes your own and any other home or automobile insurer, as well as any individual, business, insurer or government agency against whom you may be entitled to claim for loss of income arising from your disability.
Long Term Disability

TERMINATION OF BENEFITS

Benefit payments will be terminated if you:

1. Do not provide medical evidence which supports your claim;
2. Do not undergo a medical examination as required by a licensed Medical Doctor (M.D.) or Specialist and required by the Insurer;
3. Refuse to participate in an Approved Rehabilitation Program described in the Rehabilitative Employment provision set out above;
4. Fail to provide information on other income sources when such information is requested;
5. Fail to complete the required documentation or refuse to follow the terms of the Subrogation provision;
6. The date you begin receiving a pension from The Edmonton Pipe Industry Pension Plan, UA Canadian Pipeline Pension Plan, UA Sprinkler Pension Plan, or UA Officers Pension Plan.

LIMITATIONS AND EXCLUSIONS

Benefits are not payable for the following:

1. Any portion of a period of disability unless you are receiving ongoing supervision/treatment by a licensed Medical Doctor (M.D.) or Specialist deemed appropriate by the Insurer for the impairment causing disability. You will not be compensated for any portion of a period of disability during which you do not participate in the treatment program recommended by your Medical Doctor or Specialist;
2. A disability resulting from injury or disease which occurred while you were on active duty in the armed forces of any country, state or international organization or for a disability resulting from war or act of war, whether declared or undeclared;
3. Any portion of a period of disability resulting from substance abuse including alcoholism and drug addiction, unless you are participating in a recognized substance withdrawal program;
4. A disability resulting from intentionally self-inflicted injury or disease or attempted self-destruction, whether you are sane or insane;
5. The portion of a period of disability during which you are:
   - Imprisoned in a penal institution; or
   - Confined in a hospital, or similar institution, as a result of criminal proceedings;
6. A disability arising as a result of participation in a war, riot, insurrection or criminal act;
7. Any period of disability, or portion thereof, during any leave of absence (including maternity leave);
8. Any disability resulting from an accident which occurs while you are operating a motor vehicle and the blood contains more than 80 milligrams of alcohol in 100 milliliters of blood (.08%).
Long Term Disability

LIMITATIONS AND EXCLUSIONS (CONTINUED)

9. Any disability which commences on or after the date a strike begins, however you can fulfill the waiting period during a strike, subject to any provincial Employment or Labour Standards Act;

10. Any period of disability, or portion thereof, during which you refuse to participate in an Approved Rehabilitation Program which is deemed appropriate by the Insurer or your attending Medical Doctor (M.D.) or Specialist.

11. Any portion of a period of disability you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer.
Medical Benefits

FOR ALL MEMBERS, DEPENDANTS & WIDOWS EXCLUDING THOSE ENROLLED IN SELF PAYMENT PLANS B, C & D

Your Plan assists in the payment of reasonable and customary costs for medically necessary expenses for you and your Dependents. These expenses must be prescribed or recommended by a medical doctor (M.D.). In the event that, while covered under the Plan, you incur any of the eligible expenses listed below, you will be covered, subject to the Plan’s limitations and exclusions.

MAXIMUM BENEFIT

The Yearly Maximum Benefit allowed by the Plan for you and each covered Dependant, is $40,000, excluding Out of Country expenses which are limited to a Lifetime Maximum of $100,000 per insured individual.

EXTENSION OF DEPENDANTS’ COVERAGE

Your Dependents, including your Spouse, will continue to be covered for Medical and Dental Benefits without charge by utilizing any remaining Hour Bank after your death, provided that your death occurs while you were covered. After that time your Spouse/Dependants will be allowed to make Self Payments subject to the following condition:

1. Only the Dependents eligible for coverage at the date of your death are eligible for this coverage (includes natural children born within nine months after your death).

PRE-DETERMINATION OF BENEFITS/TREATMENT PLAN

If you are about to incur an expense and there is uncertainty about eligibility under the Plan, we recommend that a treatment plan be submitted for consideration by the Administration Office prior to starting treatment.

ELIGIBLE EXPENSES

Prescription Drug Expenses

- The Plan covers any medically necessary drugs or medicine, which by law requires a prescription. The Plan will consider prescriptions issued by a medical doctor (M.D.) or any other licensed practitioners and dispensed by a licensed pharmacist. Oral contraceptives are covered.
- Your Plan will pay 90% of the cost of the prescription drugs.
- Eligible expenses do not include any charge for off-the-shelf preparations (e.g., vitamins, minerals, foods and dietary supplements) which may be purchased without a medical doctor’s (M.D.) recommendation. Medications available over the counter even with a medical doctor's referral are not eligible.
Medical Benefits

ELIGIBLE EXPENSES (CONTINUED)

IMPORTANT INFORMATION

- The Plan does not pay for any co-insurance or deductibles required by any government drug plan.
- Any forms for extra or balance billing are not reimbursable by the Plan, e.g. medical doctor’s (M.D.) fee for an office visit or completion of forms.

Vision Care

FOR ALL MEMBERS & DEPENDANTS EXCLUDING THOSE ENROLLED IN PLANS B, C & D

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<tbody>
<tr>
<td>Prescription Glasses and/or Contact Lenses</td>
<td>$450 (Benefit Renews Every 2 Years)</td>
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<tr>
<td>Safety Glasses (Member only, prescription lenses only)</td>
<td>$400 Every 2 Years</td>
</tr>
<tr>
<td>Eye Exams</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Laser Eye Surgery</td>
<td>$1,600 Per Person Lifetime Maximum</td>
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- No Benefits are payable for:
  - Non-prescription sunglasses;
  - Anti-reflective coatings; or
  - Non-prescription industrial safety glasses.

Hospital Expenses in Home Province

- The difference between the charges for a ward and semi-private room and board. User fees are covered where not prohibited by legislation.

Professional Ambulance Service

- Professional Ambulance Services are covered when used to transport you or your dependants from the place of injury resulting from an accident or when stricken by a disease, to the first hospital where treatment is provided. Transportation by airline or railroad is subject to prior approval from the Administrator. Air ambulance is based on a regular scheduled flight from the original hospital to the nearest hospital in the patient’s city of residence. It is only covered when authorized in writing by the attending physician and/or surgeon and where there has been prior approval from the Administrator.
Medical Benefits

ELIGIBLE EXPENSES (CONTINUED)

Convalescent Care Expenses
- Charges for a licensed Convalescent Care Facility, subject to a maximum expense of $10 per day and 120 days of confinement per disability. Convalescent Care must begin within 14 days of hospital discharge.

Private Duty Nursing
- Charges for the services of a registered nurse (R.N.), licensed practical nurse, certified nursing assistant (C.N.A.) or a Member of the Victorian Order of Nurses (V.O.N.) which are rendered in the patient's home, provided such nurse is not a resident in your home nor a relative of your family. These charges will be considered eligible expenses when medically necessary and recommended by a Physician. Coverage is only applicable for medical treatment and does not include household duties.
- The calendar year maximum is $20,000 per individual covered for this Benefit.

Other Health Practitioners

<table>
<thead>
<tr>
<th>PRACTITIONER</th>
<th>ALLOWED EXPENSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncturist, Naturopath, Podiatrist, Speech Therapist, Christian Science Practitioner and Osteopath</td>
<td>Covered At 100% Combined Maximum Of $400 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Covered At 100% To A Maximum Of $700 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Massage Therapist</td>
<td>Covered At 100% To A Maximum of $500 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>Covered At 100% To A Maximum of $700 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Psychologist</td>
<td>100% To A Maximum of $1,000 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Registered Clinical Social Worker</td>
<td>Covered At 100% To A Maximum Of $400 Per Person Per Calendar Year.</td>
</tr>
<tr>
<td>Diagnostic X-Rays</td>
<td>$60 Per Disability</td>
</tr>
</tbody>
</table>
Medical Benefits

ELIGIBLE EXPENSES (CONTINUED)

FOR ALL MEMBERS AND DEPENDANTS EXCLUDING THOSE ENROLLED IN SELF PAYMENT PLAN B, C & D

Accidental Dental Treatment
- Charges for necessary dental treatment required as the result of an accidental injury by external means to sound natural teeth while insured. As determined by the Plan, only charges directly related to the accidental injury are considered a covered medical expense and the dental work must be completed within 12 months of the date of the accident.

Other Services and Supplies
- The charges for the following medical services and supplies. Some services may require prior approval from the Administration Office:
  - Rental (or, at the Plan's option, purchase) of an iron lung, oxygen tent, hospital bed, wheelchair, electronic heart pacemaker, or other durable medical or surgical equipment required for therapeutic purposes and as approved by the Administration Office;
  - Rental (or, at the Plan's option, purchase) of casts, splints, trusses, braces, crutches and prostheses (artificial limbs, eyes, larynx, etc.);
  - Laboratory tests and x-rays not covered by any provincial government plan;
  - Orthopedic lifts, and insoles when prescribed by an Orthopedic surgeon, Podiatrist or Rheumatologist;
  - Intrauterine devices when inserted by a Physician;
  - Oxygen and rental of equipment for its administration;
  - Anesthetics; and
  - Diabetic supplies

Hearing Expenses

FOR ALL MEMBERS & DEPENDANTS EXCLUDING THOSE ENROLLED IN SELF PAYMENT PLANS B, C & D

- Hearing Aids and Custom Made Ear Plugs: Charges for the purchase and installation of hearing aids, including replacement and repairs, when recommended by an otolaryngologist or audiologist, subject to a maximum Benefit shown in the “Summary of Benefits”.

Foot Care (Custom Made Orthotics)
- Charges for Custom Made Orthotics, not for the purpose of sports, when recommended by a licensed doctor (M.D.) or Podiatrist and subject to a calendar year maximum of $400.
- Referral from a licensed doctor (M.D.) or Podiatrist every 3 years.
Medical Benefits

ELIGIBLE EXPENSES (CONTINUED)

Out of Province / Canada Travel Emergency Medical Plan

FOR ALL MEMBERS & DEPENDANTS EXCLUDING THOSE ENROLLED IN SELF PAYMENT PLANS B, C & D

- The Plan provides coverage for any number of trips of up to 180 consecutive days in the event of an emergency arising from sudden or unforeseeable circumstances while eligible persons are traveling outside the province of residence. The charges will be reasonable and customary, in excess of those covered by the Government Health Insurance Plan or other insurance policies for which you have coverage. The Lifetime Maximum Benefit for the Emergency out of Country claim is $100,000 (Canadian Funds) per eligible person. It is at your discretion to purchase additional coverage before leaving Canada.

- Global Excel Management Inc. (called “Global Excel”) will provide medical assistance and claims services and is available to take calls 24 hours a day, 7 days a week:
  - Emergency Call Centre - No matter where you travel, professional assistance personnel are ready to take your call. Global Excel can also provide you with Canada Direct instructions and codes so that you only deal with Canadian telephone operators;
  - Referrals - Global Excel can refer you to the preferred medical providers (Hospitals, clinics and Physicians) that are closest to where you are staying. With a referral, it is less likely that you will have to pay for services out-of-pocket;
  - Benefit Information – Explanation of your coverage is available to you and to the medical providers who are treating you;
  - Medical Consultants – Global Excel’s team of medical professionals, available 24 hours a day, will monitor the services provided in the event of a serious Emergency. If necessary, Global Excel will help you to return to Canada for the care you need;
  - Urgent Message Relay – In the event of a medical Emergency, Global Excel will contact your traveling companion to keep him/her apprised of your medical situation and will help you to exchange important messages with your family;
  - Interpretation Service – Global Excel can connect you to a foreign language interpreter when required for emergency services in foreign countries;
  - Direct Billing – Whenever possible, Global Excel will instruct the Hospital or clinic to bill Global Excel directly;
  - Claims Information – Global Excel will answer any questions that you have regarding the eligibility of your claim, standard procedures and the way that the Benefits under the plan are administered.

- The following expenses are eligible for coverage under the Emergency Medical Plan when medically necessary through Global Excel Management Inc.:
  - Hospital Accommodation - Up to the semi-private room rate charged by the Hospital. If medically necessary, expenses for treatment in an intensive or coronary care unit is also available.
  - Physician Charges - For treatment rendered.
Medical Benefits

ELIGIBLE EXPENSES (CONTINUED)

Out of Province / Canada Travel Emergency Medical Plan (Continued)

- **Diagnostic Services** - Such as laboratory tests and x-rays prescribed by the attending Physician and that form a portion of the Emergency treatment. Coverage for magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms, ultrasounds or biopsies are covered only when authorized in advance by Global Excel.

- **Paramedical Services** - Of a licensed Chiropractor, Physiotherapist, Podiatrist or Osteopath, to a maximum of $250 per eligible person per profession, when approved in advance by Global Excel. Includes coverage for x-rays.

- **Prescription Drugs** - Including injectable drugs and sera that can only be obtained upon medical prescription, prescribed by a Physician and supplied by a licensed pharmacist when medically necessary for Emergency treatment, except when needed to stabilize a chronic or medical condition present prior to the trip. This benefit is limited to a 30 day supply per prescription unless you are hospitalized.

- **Ambulance Services** - To the nearest medical facility limited to a reasonable charge.

- **Medical Appliances** - When approved in advance, minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and / or the temporary rental of a wheelchair when prescribed by the attending Physician, obtained outside your province of residence.

- **Registered Private Duty Nurse** - When medically necessary and while hospitalized to a maximum of $5,000 per eligible person, when approved in advance.

- **Emergency Air Transportation** - When arranged in advance:
  - Air ambulance to the nearest appropriate medical facility or to a Canadian Hospital for immediate emergency treatment;
  - Transport on a licensed airline with an attendant (where required) to return the eligible person to the province of residency for immediate Emergency treatment.

- **Transportation to Bedside** - When approved in advance, a single round-trip economy airfare from Canada plus up to $150 per Member, per day to a maximum of $3,000 for the cost of meals and commercial accommodation for one of the following: Spouse, parent, child, brother, sister or business partner, to:
  - Be with you if traveling alone and have been hospitalized as the result of an Emergency. To be payable, this benefit requires that you eventually be hospitalized as an in-patient for at least three (3) consecutive days outside your province of residence and that the attending Physician provide written certification that the situation warranted the visit; or
  - Identify the deceased eligible person prior to the release of the body, where necessary.

- **Return of Travelling Companion** - If you have been returned to your province of residence under the Emergency Air Transportation benefit or the Return of Deceased Benefit, Global Excel will reimburse the cost of a single one-way economy airfare for a travelling companion to return to Canada, when approved in advance by Global Excel.
Medical Benefits

ELIGIBLE EXPENSES (CONTINUED)

Out of Province / Canada Travel Emergency Medical Plan (Continued)

- **Treatment for a Dental Accident** - Up to $2,000 per eligible person for emergency dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth provided the injury was caused by an external, accidental blow to the mouth or face. You must consult a Physician or dentist immediately following the injury. Treatment must begin during the coverage period and be completed prior to returning to your province of residence. An accident report is required from a Physician or dentist for claims purposes.

- **Meals and Accommodation** - Up to $150 per Member, per day to a maximum of $3,000 for the cost of commercial accommodation and meals for you and / or your Dependents when your trip is extended beyond the last day of the scheduled trip due to the sickness and / or injury suffered by any eligible person. The benefit must be authorized in advance by Global Excel. If you are unable to travel, that fact must be certified by the attending Physician and supported with original receipts from commercial organizations.

- **Vehicle Return** - Up to $5,000 per Member, if neither you, nor someone traveling with you are able to operate your vehicle, whether owned or rented, during your trip due to sickness and/or injury. Arrangements and payment will be made for the return of the vehicle to your home in your province of residence or the nearest appropriate rental agency. Benefits will only be payable for a single person to return the vehicle when approved and / or arranged in advance by Global Excel.
  - This benefit does not cover wages lost by the person driving the vehicle. Global Excel will only reimburse covered expenses evidenced by original receipts.

- **Return of Deceased** - Up to $5,000 per eligible person towards the cost of preparation and transportation of the deceased eligible person to their province of residence in the event of death due to sickness and / or injury. In the case of cremation and / or burial at the place of death of the eligible person, this benefit is limited to $2,500. The cost of the casket or urn is not covered.

- **Incidental Expenses** - Up to $250 per Member will be reimbursed for your out-of-pocket expenses such as telephone charges, television rental and parking while you are hospitalized for an Emergency and the expenses are incurred as a direct result of such hospitalization. Global Excel will only reimburse covered expenses evidenced by original receipts.

- You will be provided with a Medical Assistance Card. In the event of an emergency, you must call Global Excel immediately.

- Failure to follow the appropriate procedures may result in extra time for settling of claim.

**Global Excel can be contacted at:**

<table>
<thead>
<tr>
<th>From Canada &amp; United States:</th>
<th>1-866-870-1898</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elsewhere, Call Collect:</td>
<td>1-819-566-1898</td>
</tr>
</tbody>
</table>
Medical Benefits

LIMITATIONS AND EXCLUSIONS
The Plan does not cover losses or expenses caused, directly or indirectly, in whole or in part by:

- Treatment or services normally covered or reimbursable under a Government Health Insurance Plan or under any insurance you might have.
- Any trip booked or commenced contrary to medical advice or after you are diagnosed with a terminal illness.
- Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that you elect to have provided outside your province of residence when medical evidence indicates that you could return to your province of residence to receive such treatment. The delay to receive treatment in your province of residence has no bearing on the application of this exclusion.
- Treatment or surgery during a trip when the trip is undertaken for the purpose of securing or with the intent of receiving medical or hospital services, whether or not such trip is taken on the advice of a Physician.
- Cardiac catheterization, angioplasty, and / or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by Global Excel prior to being performed, except in extreme circumstances where such surgery is performed on an emergency basis immediately upon admission to the hospital.
- Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel.
- Hospitalization or services rendered in connection with general health examinations for “check-up” purposes, treatment of an ongoing condition, regular care of a chronic condition, home health care, investigative testing, rehabilitation or ongoing care or treatment in connection with drugs, alcohol and any other substance abuse or non-compliance with any prescribed medical therapy or treatment and medical treatment of an acute sickness and / or injury after the initial emergency has ended (as determined by Global Excel).
- A disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless hospitalized.
- Emergency air transportation and / or car rental unless approved and arranged in advance by Global Excel.
- Treatment not performed by or under the supervision of a Physician or licensed dentist.
- Treatment or hospitalization of mother or child as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the four (4) weeks before or after the expected delivery date.
- War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, rebellion, revolution, insurrection or act of military power.
LIMITATIONS AND EXCLUSIONS (CONTINUED)

- Terrorism or by any activity or decision of a government agency or any other entity to prevent, respond to or terminate terrorism regardless of any other cause or event that contributes concurrently or in any sequence to the loss or damage except for ensuing loss or damage which results directly from fire or explosion.
- Committing or attempting to commit an illegal or a criminal act.
- Suicide (including any attempt thereat) or intentional self-inflicted injury, whether or not you are sane.
- Service in the armed forces.
- Participation in any sport as a professional athlete (for which you are remunerated), or in motorized or mechanically-assisted racing or speed contests (defined as an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event).
- Loss or damage to eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices and resulting prescription thereof.
- The replacement of an existing prescription whether by reason or loss, renewal or inadequate supply or the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada or which are not required as a result of an emergency.
- Upgrading charges and cancellation penalties for airline tickets, unless approved in advance by Global Excel.
- The cost of any airline ticket covered under the plan where your ticket may be exchanged or used for the same purpose.
- Crowns and root canals;
- Treatment or services received in the province where you attend school on a full-time basis or in your home country. If you are a foreign student studying in Canada or a non-resident working in Canada;
- Any service or supply not listed herein as an eligible expense.
Dental Benefits

**FOR ALL MEMBERS, DEPENDANTS & WIDOWS EXCLUDING THOSE ENROLLED IN SELF PAYMENT PLANS B & D**

The Plan helps to pay the reasonable cost of necessary Dental expenses for you and your Dependents. Any eligible claim incurred will be payable in accordance with the “Summary of Benefits”.

**DEDUCTIBLE**

There is no deductible for you or your Dependents.

**MAXIMUM BENEFIT**

The maximum benefit payable is subject to that specified in the “Summary of Benefits”. The Maximum applies separately to you and each of your Dependents.

**EXTENSION OF DEPENDANTS’ COVERAGE**

Your Dependants, including your Spouse, will continue to be covered for Benefits without charge, by utilizing any remaining hours in your Hour Bank at the time of your death provided that your death occurs while covered. After that time your Spouse will be allowed to make Self Payments subject to the following conditions:

- Only the Dependents eligible for coverage at the date of your death are eligible for this coverage (includes natural children born within nine months from the date of your death);

The Self Payment amount must be confirmed with the Administration Office.

**ALTERNATIVE SERVICES**

Several dental conditions can be adequately treated in more than one way. The Benefit covered under your Plan will be based on the least expensive method of the delivery of services that will provide for good dental care.

**PRE-DETERMINATION OF BENEFITS / TREATMENT PLAN**

If you are uncertain about coverage for a proposed course of dental treatment in excess of $500, it is strongly recommended that you submit a Pre-Determination of Benefits or Treatment Plan for consideration by the Administration Office prior to starting treatment. A Treatment Plan is normally not necessary for routine dental services (examinations, x-rays, fillings, etc.) or for emergency care. Prior submission is encouraged and recommended for major services such as crowns, bridges and dentures, and is required for all Orthodontic expenses.
Dental Benefits

PRE-DETERMINATION OF BENEFITS / TREATMENT PLAN (CONTINUED)
A Treatment Plan is the Dentist’s written report that:

- Itemizes the recommended services; and,
- Shows the charge for each service; and,
- When requested by the Administration Office, is accompanied by supporting pre-operative x-rays.

ALTERNATE BENEFIT CLAUSE
A policy applied to all coverage that has an implant and/or bridge treatment as a benefit, to determine the amount payable. The attending dentist and patient choose the course of treatment, but payment for the procedure may be based on the “limited treatment” principle. Basically, if two procedures treat the same condition, payment may be limited to the most cost effective treatment. The Alternate Benefit Clause is simply a financial limitation and not intended to dissuade from the treatment recommended or performed by a dentist. In the application of this, both courses of treatment must be an eligible benefit.

DEFINITION OF A DENTIST
The term "Dentist" means a legally qualified Dentist practicing within the scope of his license. For the purposes of this Plan, the term "Dentist" also includes a legally qualified medical doctor authorized by his license to perform the particular services rendered and a Licensed Denture Therapist when charges are incurred for full upper and/or lower dentures.

ELIGIBLE EXPENSES
Coverage under your Plan includes charges for supplies and services up to the amount specified in the Alberta Dental Association Suggested Fee Guide for Alberta as outlined in the “Summary of Benefits”.

Diagnostics
- Procedures required to assist the Dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:
  - Oral examinations: recall oral examinations limited to once every six (6) months, complete oral exam and diagnosis is covered once every year;
  - X-rays: complete series or equivalent once every year;
  - Study casts.

Preventive Therapy
- Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:
  - Scaling (8 to 10 units of time) once per year;
  - Polishing (prophylaxis), topical fluoride (once per six (6) months);
  - Oral hygiene instruction - once every calendar year.
Dental Benefits

ELIGIBLE EXPENSES (CONTINUED)

Basic Restorative Dentistry
- The basic procedures used to restore natural teeth to their normal functions with the use of silver amalgam, silicate, or synthetic restorations (fillings).

Extractions
- Removal of teeth.

Endodontics
- Emergency endodontic procedures and conservative root canal therapy.

Periodontics
- Adjunctive Services as follows: Scaling, Root planning, Acute infections, Occlusal Adjustment, Provisional splinting;
- Surgical Services as follows: Gingival curettage, Gingivoplasty, Gingivectomy or Osseous surgery;
- Periodontal Applications: bruxism guards only.

Oral Surgery
- Routine oral surgical procedures as follows: Surgical removal of impacted teeth, residual roots and associated post-operative care.

Anesthesia
- Anesthesia where reasonably and customarily required in connection with other covered procedures.

Repairs, Relining, and Rebasing of Dentures
- Repair or relining and rebasing of dentures including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

Removable Prosthetic Devices (Dentures)
- The initial installation of partial or full dentures.
- Replacement of existing dentures is not covered unless:
  - The replacement is required because of extractions, loss or fracture of one or more sound natural teeth while insured; or,
  - The existing denture must be at least five years old.
- Replacement of lost or stolen dentures, the duplication of dentures and personalized characterization of dentures is not covered.

Extensive Restorative Dentistry
- Those procedures, including gold inlays, onlays and crowns, used to restore the natural teeth to their normal function where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, Benefits will be determined based on the usual costs of such a restoration.
Dental Benefits

ELIGIBLE EXPENSES (CONTINUED)

Fixed Prosthetic Devices (Bridges & Dental Implants)
- The initial installation of fixed prosthetic devices.
- Re-cementing and replacement of the facing of the fixed prosthetic device.
- The replacement of existing fixed prosthetic devices is not covered unless:
  - The existing fixed prosthetic device is at least five years old and no longer serviceable.

Orthodontics
- Adults and children are covered for this Benefit. Coverage includes the diagnosis and correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as straightening of the teeth. This includes active space retainers, or orthodontic appliances, used to reposition or move teeth. An Orthodontic Treatment Plan must be submitted to the Administration Office and returned to the Dentist indicating estimated benefits.
- An "Orthodontic Treatment Plan" is a report that is satisfactory to the Administration Office which includes the recommended type of treatment, duration of treatment and estimated charge. The Treatment Plan is accompanied by cephalometric x-rays, study models and other supporting evidence. The Claim will be paid once the treatment has begun.
- In any event, the following expenses are not eligible:
  - Charges for a procedure for which an active appliance was installed before the patient was covered; or
  - An expense incurred while the patient's coverage was not in effect.

LIMITATIONS AND EXCLUSIONS

The foregoing list of eligible expenses does not include any of the following:
- Any expense resulting from a Motor Vehicle Accident.
- Services or supplies that are primarily cosmetic dentistry;
- Services or supplies which are not furnished by a legally qualified Dentist or Denturist acting within the scope of his license (except x-rays ordered by a Dentist or a dental hygienists work under the Dentist’s supervision);
- The eligible services of a licensed denture therapist, except for full upper and/or lower dentures, and relining or repairs to full dentures;
- Expenses incurred following accidental injury to natural teeth (this is covered under the Medical Benefit);
- Dental treatment which is not approved by the Canadian Dental Association and which is clearly experimental in nature;
- Any miscellaneous charges such as counseling, travel, broken appointments, communication costs or completion of forms;
- Any charge resulting from any intentionally self-inflicted injury;
Dental Benefits

LIMITATIONS AND EXCLUSIONS (CONTINUED)

- Any services covered in whole or in part by any government plan (including Workers’ Compensation Board), services for which no charge is made, or services which the Insurer is not permitted by law to cover;
- A dental procedure covered by a provincial hospital plan. You will receive reimbursement from the government plan for that procedure. Legislation prevents private plans from making any payment;
- Services or supplies for personalization or characterization of dentures;
- Replacement of lost or stolen prosthetic devices;
- Diagnostic procedures in connection with any Benefit categories excluded as eligible expenses;
- Any dental examinations required by a third party;
- Any charge for services which would not normally have been incurred, but for the presence of this coverage, or for which you or your Dependant is not required to pay;
- Any hospital charges for room and board and related services and supplies;
- Any charge for an injury resulting from war, riot, insurrection or participation in a criminal act; or
- Any service or supply not listed herein as an eligible expense.
Member Assistance Program

The Member Assistance Program (MAP) provides confidential personal assistance services 24 hours a day, 7 days a week for Members and their Dependants provided through Construction Employee & Family Assistance Plan (CEFAP).

From time to time we all face difficult of stressful events in our lives. Most of the time we handle these personal challenges fairly well but, other times, personal issues can become significant enough that they begin to interfere with our effectiveness, happiness or safety, both at work and at home. CEFAP is a plan designed to provide confidential counselling, educational and self-development services to people employed in the unionized construction and plant maintenance industries to help manage these issues.

CEFAP provides counselling, education and self-development services in addition to assessment and referral when required, for a full spectrum of personal issues including, but not limited to:

- Separation, Divorce, Custody;
- Financial and Legal Difficulties;
- Alcohol and Drug Dependency;
- Gambling and other Addictions;
- Smoking Cessation;
- Difficulties with Children;
- Anger Management;
- Sexual Harassment and Abuse;
- Bereavement;
- Child and Elder Care Resources;
- Retirement Planning;
- Dietician Services;
- Physical Fitness Assessment;
- And many more.

At Homewood Human Solutions, health professionals are registered psychologists or registered counsellors chosen specifically for their extensive experience in dealing with a variety of psychological and health issues. They provide a non-judgmental and unbiased source of expertise and support, ready to listen to your concerns to help guide you towards positive outcomes.

CEFAP provided through Homewood Human Solutions offers you and your eligible Dependants counselling in person, by phone, or through the internet. Contact Homewood Human Solutions and you will be assisted in setting up an appointment at a time and office location convenient to you. Education and self-development services can be accessed through the Homewood Human Solutions website.

There is no cost to Members or eligible Dependants to use these services and everything is confidential. Human Solutions counsellors are required by law to maintain the strictest confidentiality. No one who inquires about or receives services under this plan will be identified to anyone without your written approval. The only exception to this is where the law would require disclosure.

Homewood Human Solutions provides multi-language options in all offices. For Aboriginal workers, Human Solutions also provides the option of receiving assistance from approved Healers, Elders and Aboriginal treatment facilities.

Website: [www.homewoodhealth.com](http://www.homewoodhealth.com)
Rehabilitation Benefit

Active Plan Members and their eligible Dependents may be entitled to receive up to $5,000 per person as reimbursement towards the cost of attending an in-patient program at an approved addiction Treatment Centre.

Please take note of the following conditions:

1. Active Plan Member is defined as a Member who is covered for benefits by way of hours remitted to the Plan by a Contributing Employer or a Member who is making Self Payments to the Plan under Plan A.
2. The lifetime maximum benefit payable from the Plan is $5,000 per person towards the cost of the program only. Travel and incidental costs are not eligible for reimbursement. Costs related to an Assessment Fee are not reimbursed through this benefit.
3. Payment from the Plan will only be issued once a letter has been received from the Treatment Centre which specifies the date entered and released and successful completion of the program which was attended.
4. A payment receipt from the Treatment Centre must also be submitted.
5. Treatment Centres located outside Canada are not eligible.
6. Member can apply for Short Term Disability and EI Disability Benefits.

Listed below are the approved Treatment Centres in the provinces of Alberta, British Columbia and Ontario. Members requesting to attend a Treatment Centre other than those listed must receive prior approval from Homewood Human Solutions. Dependents may elect to attend an alternate Treatment Centre provided it is located in Canada.

<table>
<thead>
<tr>
<th>NAME</th>
<th>CITY</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Landers Treatment Centre</td>
<td>Claresholm, AB</td>
<td>1-403-625-1395</td>
</tr>
<tr>
<td>Northern Addictions Centre</td>
<td>Grande Prairie, AB</td>
<td>1-780-538-5210</td>
</tr>
<tr>
<td>Last Door - Recovery Acres - 1835 House</td>
<td>Calgary, AB</td>
<td>1-888-525-9771</td>
</tr>
<tr>
<td>Action North Recovery Centre</td>
<td>High Level, AB</td>
<td>1-780-926-3113</td>
</tr>
<tr>
<td>South Country Treatment Centre</td>
<td>Lethbridge, AB</td>
<td>1-403-329-6603</td>
</tr>
<tr>
<td>Thorpe Recovery Centre</td>
<td>Lloydminster, AB</td>
<td>1-877-875-8890</td>
</tr>
<tr>
<td>Poundmakers Treatment Centre</td>
<td>St. Albert, AB</td>
<td>780-458-1884</td>
</tr>
<tr>
<td>Simon House</td>
<td>Calgary, AB</td>
<td>1-403-247-2050</td>
</tr>
<tr>
<td>Calgary Dream Centre</td>
<td>Calgary, AB</td>
<td>1-403-243-5598</td>
</tr>
<tr>
<td>Fresh Start</td>
<td>Calgary, AB</td>
<td>1-403-387-6266</td>
</tr>
<tr>
<td>Recovery Acres</td>
<td>Edmonton, AB</td>
<td>780-471-2969</td>
</tr>
<tr>
<td>Our House</td>
<td>Edmonton, AB</td>
<td>1-780-474-8945</td>
</tr>
<tr>
<td>Pacifica Treatment Centre</td>
<td>Vancouver, BC</td>
<td>1-866-446-0668</td>
</tr>
<tr>
<td>Homewood Health Centre</td>
<td>Guelph, ON</td>
<td>1-519-824-1010 Ext. 2551</td>
</tr>
</tbody>
</table>

Please contact the Administration Office should you have any questions regarding this Benefit.
Diagnostic and Treatment Support Services

FOR ALL ACTIVE MEMBERS, QUALIFIED RETIRED MEMBERS & THEIR DEPENDANTS

The Diagnostic and Treatment Support Service is provided by Best Doctors Canada.

Best Doctors provides Members access to the top medical minds in the world to ensure they have the right diagnosis and correct treatment plan. Best Doctors helps Members navigate the healthcare system through one-on-one coaching and connect seriously ill individuals and their treating physicians with world renowned specialists, without the Member having to leave home. Best Doctors provides answers that mean having the correct diagnosis and treatment options, fewer invasive procedures, fewer complications and better outcomes.

Members do not need to leave home or incur any additional cost, and every step of the way a dedicated Member Advocate, each of them a Registered Nurse, is available for one-on-one support and guidance.

HOW IT WORKS
One call initiates the service. Best Doctors then collects the Members medical information and records. All of the information is sent to a multi-disciplinary team of Harvard-trained physicians whose role is to perform an exhaustive review of the material, identify the pertinent issues, and formulate the clinical questions.

Once a clinical synopsis has been complete, the team then searches the Best Doctors, global network of 53,000 top specialists to find the appropriate medical expert(s) to review the case.

The Best Doctors expert physician reviews the analysis and submits their written report of specific diagnosis and treatment options to the Best Doctors member and their treating physician, including written answers to the Members questions. Working collaboratively with the treating physicians, Best Doctors is able to provide the Member with the right diagnosis and correct treatment options, without the Member having to leave home or change doctors.

CONTACT BEST DOCTORS
Tel: 1-877-419-2378
Website: www.bestdoctorscanada.com
Co-ordination of Benefits

**FOR HEALTH AND DENTAL BENEFITS ONLY**

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

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

The plan that does not have a coordination of benefits provision pays before the plan that does.

The plan that covers the individual as:

- Other than a Dependant pays before the plan that covers such person as a Dependant; or
- A Dependant child of the parent, covered as a Member, whose birthday occurs first during the calendar year pays first.

The same order of benefit determination will apply if a person is covered in more than one capacity under the same plan, including this Plan, or is covered as a Dependant of more than one person under the same plan, including this Plan.

If priority cannot be established in the above manner, the Allowable Expense shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

To implement this provision, the Administrator may:

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

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

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

For the purpose of this Co-ordination of Benefits provision "plan" means any plan of group insurance or other arrangement for members of a group (whether on an insured basis or not), prepaid health or dental coverage, or student accident insurance.

* Includes Co-ordination With Workers Compensation Board Claims For Health Benefits Only.
Miscellaneous Provisions

PROOF OF LOSS
Written proof, on a form acceptable to the Administrator, stating the occurrence, character and extent of loss must be submitted for each benefit to the Administrator as noted below:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>12 Months following the date of Death</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment</td>
<td>12 Months following the date of Death/Loss</td>
</tr>
<tr>
<td>Dependant Life Insurance</td>
<td>12 Months following the date of Death</td>
</tr>
<tr>
<td>Weekly Disability Benefit</td>
<td>Within 60 Days of the Disability</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>Within 12 Months of the Disability</td>
</tr>
<tr>
<td>Medical Benefits</td>
<td>Within 12 Months from the date of the expenses</td>
</tr>
<tr>
<td>Dental Benefits</td>
<td>Within 12 Months from the date of the expenses</td>
</tr>
</tbody>
</table>

The Administrator shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pendency and payment period, if any, of such claim.

PAYMENT OF CLAIMS
All payments shall be payable to the Member. At the Administrator’s option, a Member may, by written request, direct that all or part of the benefits for Health and Dental Benefits be paid directly to the hospital or person rendering such care. Payments due from this Plan otherwise payable to a deceased Member will be made to the estate of the deceased covered Member. Any payment by the Administrator in good faith pursuant to this provision shall fully discharge the Trustees to the extent of such payment.

RIGHT OF RECOVERY
If a Member is entitled to Benefits under the provisions of this Plan as a result of Total Disability and subsequently receives a settlement from a third party because of an occurrence which was wholly or partially the cause of the Total Disability, the Member shall repay the Plan to the extent that such settlement provides compensation for loss of time, whether recovery is made by settlement, judgment or otherwise, from any person or organization responsible for causing the disability, or from their insurers, and the trustees will have a lien upon such recovery. In no event will the Member be required to make reimbursement to the Plan in an amount exceeding that portion of the recovery which provides compensation for loss of time.

At the option of the Trustees, exercisable at any time, the Trustees shall be subrogated to all rights of recovery of the Member from any person or organization responsible for such disability, or from their insurers.
Miscellaneous Provisions

RIGHT OF RECOVERY (CONTINUED)
The Member shall execute and deliver such instruments and papers as may be required by the Trustees and do whatever else is necessary to secure the rights of the Trustees under this provision.

The Trustees are under no obligation under this Plan to recover such reimbursement from a Member nor to exercise such right of subrogation.

LEGAL ACTIONS
No action at law or in equity shall be brought to recover on this Plan prior to the expiration of 60 days after written proof of loss has been provided in accordance with the requirements of this Plan. No such action will be brought after the expiration of 2 years after the time written proof of loss is required to be provided to the Plan.
Service Providers

ADMINISTRATION OFFICE
The Edmonton Pipe Industry Benefit Plans
16214-118 Avenue
Edmonton, AB
T5V 1M6

Tel: 1-780-452-1331
Fax: 1-780-487-4063
E-mail: questions@epibenefitplans.com
Plan Website: www.epibenefitplans.com

ADMINISTRATION SERVICE PROVIDER
Employee Benefit Plan Services Limited

INSURANCE PROVIDERS
Great-West Life
Group Policy Number: 167248

Expert Travel Financial Security Inc. (E.T.F.S.) and Global Excel Management Inc.
Contact From Canada & U.S.A.: 1-866-870-1898
Contact From Elsewhere: 1-819-566-1898

MEMBER ASSISTANCE PROGRAM PROVIDER
CEFAP (Homewood Human Solutions)
English Tel: 1-800-663-1142
French Tel: 1-866-398-9505
Hearing Impaired Tel: 1-888-384-1152
Collect Tel: 1-604-689-1717
Website: www.homewoodhealth.com

TREATMENT AND DIAGNOSTICS PROVIDER
Best Doctors Canada
Tel: 1-877-419-2378
Website: www.bestdoctorscanada.com