Electrical Workers' Benefits Plan
ALBERTA

PLAN BOOKLET

ECAA
Electrical Contractors Association of Alberta

DATED: May 1, 2024

ELECTRICAL INDUSTRY
INSURANCE BENEFIT TRUST FUND OF ALBERTA

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TABLE OF CONTENTS

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Foreword

To All Plan Members:

This Summary of Benefits is restated and updated as of May 1, 2024. It is intended as a general guide for Plan Members and their families to provide them with eligibility and Coverage provisions and procedures to be followed when making a claim.

Please note, this Summary of Benefits does not create or confer any rights. The exact terms of the Plan are contained in the Direct Reimbursement Agreement, the insurance policies issued by The Manufacturers Life Insurance Company and Industrial Alliance Insurance and Financial Services Inc., and various provisions adopted by the Trustees. The agreement and insurance policies are available for examination at the Fund Office. In the event of a discrepancy between this Summary of Benefits and the Plan documents described above, the exact terms contained in these Plan documents shall apply.

Benefits, eligibility rules and/or claim procedures may change from time to time, as the Trustees deem prudent and necessary. Plan Members should read this Summary of Benefits carefully and acquaint themselves with all Plan provisions. Should any question arise as to the exact nature of Coverage or how to process a claim, please contact the Fund Office for clarification.

Sincerely,

BOARD OF TRUSTEES

SUMMARY OF BENEFITS
SECTION 1 - DEFINITIONS

The definitions of certain capitalized terms used in this Summary of Benefits are contained in this Section I. The definition of a term is applicable unless the context clearly indicates another meaning. References to a Section or Sections mean a Section or Sections in this Summary of Benefits.

1.01 **Administrator:** The Board of Trustees established by the Trust Agreement.

1.02 **Association:** The Electrical Contractors Association of Alberta.

1.03 **Bargaining Employee** and **Non-Bargaining Employee:** A Bargaining Employee means a person who is an Employee working in the classifications of employment set out in the Collective Agreement, providing the Employee is not a Director of the Employer's company, or providing the Employee is not a person owning fifty percent (50%) or more of the Employer's company, in which case, or cases, the Employee shall be categorized as a Non-Bargaining Employee. Non-Bargaining Employees working for an Employer shall also include Managers and/or the Administrative Staff of the Employer.

1.04 **Beneficiary:** The person(s) last designated in writing by the Plan Member (obtained by the Fund office) to receive any Benefit in the event of the death of the Plan Member. In the absence of an effective designation, or in the event that such Beneficiary shall predecease the Plan Member, the Beneficiary is the deceased Plan Member's estate. Any Beneficiary designation must comply with the requirements of applicable insurance laws.

1.05 **Benefit:** A benefit derived from Coverage.

1.06 **Benefit Package:** The Benefits available through the Hour Bank, Self-Payments or Years-of-Service Bank.

1.07 **Board of Trustees:** The Trustees appointed under the terms of the Trust Agreement.

1.08 **Collective Agreement:** An applicable agreement as amended from time to time establishing conditions of employment entered into by and binding on the Local Union and one or more Employers, which requires Contributions by an Employer.

1.09 **Contributions:** The monies paid or payable to the Fund by an Employer for hours worked by an Employee.

1.10 **Coverage:** The entitlement to a Benefit Package under the Plan.

1.11 **Custodial Care:** That type of care which is designed essentially to assist an individual to meet his/her activities of daily living (for example, services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered) and which does not entail or require the continuing attention of trained medical or para-medical personnel.

1.12 **Dentist:** A graduate of an accredited dental school who is duly licensed to practice dentistry.

1.13 **Dependent:**

(a) Each **Child** from live birth of a Plan Member, which includes:

- children of the marriage,
- legally adopted children,
- children of the Plan Member's Spouse under the Spouse's custodial care, and
- foster children who live with the Plan Member and are not covered by any government plan or legislation.

The child must be:

- unmarried,
- rely upon the Plan Member for financial support.

To be a "Dependent" the child outlined above must be:

(i) Under 21 years of age; OR

(ii) Age 21 to 24 inclusive if in full-time attendance at an accredited school, college or university provided the child normally resides with the Plan Member and in Canada. A Plan Member must provide the Fund Office with written evidence from the school confirming the child meets the definition of a full-time student, and that upon completion the student will receive a diploma, degree, or a designation/certification; OR

(iii) Functionally impaired, previously covered under Section 1.13(a)(i), not receiving payments from an aid program, incapable of self-sustaining employment due to a functional impairment specified in a government regulation, and wholly reliant upon the Plan Member for financial support and maintenance. Proof of incapacity must be provided within 31 days following the Dependent's 21st birthday.

Plan Members will be required to confirm their Dependent's status by completing a Dependent Update Form at the beginning of each school term.

The Plan may request court appointed evidence to prove that a Dependent qualifies as a Plan Member's Dependent.

(b) The **Spouse** of a Plan Member, which includes either:

(i) A person married to the Plan Member as a result of a valid civil or religious ceremony who is not subsequently divorced from the Plan Member; OR

(ii) A person whose common-law relationship with the Plan Member existed for a minimum period of 12 consecutive months immediately prior to the date on which a claim arose, provided the Plan Member has appointed this person in writing by filing a Registration and Declaration of Beneficiary Form with the Fund Office. A common-law relationship must include continuous cohabitation in a conjugal relationship.

However, if a person qualifies under Section 1.13(b)(i) and another person qualifies under Section 1.13(b)(ii), then the person designated as Spouse on the last Registration and Declaration of Beneficiary Form filed with the Fund Office shall be deemed the Spouse for the purposes of this Plan.

1.14 **Disease:** A change in physiology at the tissue or organ system level, resulting in an impairment of function, which is determined by standard medical procedures and can be observed pathologically. In the case of psychiatric disease, it means a diagnosis based on the latest version of The Diagnostic and Statistical Manual of Mental Disorders that evidences an impairment of function.

1.15 **Disease Management Programs:** An approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

1.16 **Due Diligence:** A process employed by Manulife Financial to assess services or supplies to determine eligibility under the Policy. This process may use Pharmacoeconomics, cost effectiveness analysis reference information from existing federal or provincial formularies, recognized clinical practice guidelines, or an Advisory Body.

1.17 **Earnings:**

(a) For Bargaining Employees shall mean that amount of money, based on the number of hours in the regular work week, as per Collective Agreement multiplied by the basic hourly wage rate for each particular Bargaining Employee in the wage rate classification to which the Employee belongs; OR

(b) For Non-bargaining Employees shall mean the Employee's normal employment income (including commissions averaged over the previous 24 months of employment) and shall not include bonus, overtime, incentive pay and automobile allowance.

1.18 **EBFA:** Employee Benefit Funds Administration Ltd., the company charged by the Trustees to do the Fund's administrative work.

1.19 **Employee:** Any person who performs work for an Employer and for whom his/her Employer is obligated or permitted to make Contributions.

1.20 **Employer:** Any employer who is required by a Collective Agreement to make Contributions or any employer who makes Contributions with the approval of the Trustees.

1.21 **Extension of Benefits:** The continuation of a Plan Member's and/or Dependent's Coverage for certain Benefits and for limited time periods as outlined in this Summary of Benefits.

1.22 **Fund:** See definition of Health & Welfare Fund.

1.23 **Fund Office:** The office of the Fund, presently located at 4211 - 95th Street NW, Edmonton, Alberta, T6E 5R6 (Telephone: 780-465-2882).

1.24 **Health & Welfare Fund** or **Fund:** The Electrical Industry Insurance Benefit Trust Fund of Alberta established under the Trust Agreement.

1.25 **Health & Welfare Plan** or **Plan:** The Electrical Industry Insurance Benefit Trust Fund of Alberta's health & welfare plan of Benefits and any modification, extension or renewal thereof.

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

1.27 **Hospital Charges:** Charges made by a Hospital for Room and Board plus charges made by the Hospital for other necessary services and supplies furnished to the Plan Member or Dependent for their use while he/she is confined. Hospital charges shall not include charges for private duty nursing services and/or for services of Physicians and Surgeons.

1.28 **Hour Bank:** The record of the number of hours worked by an Employee for which Contributions were paid; the hours are accumulated and diminished on a monthly basis in accordance with the Plan Rules.

1.29 **Identification Number** or **Stakeholder Number:** The specific number issued by the Fund to each Plan Member and Dependent.

1.30 **Injury:** Bodily injury to a Plan Member or a Dependent caused by external violent and accidental means.

1.31 **Insurer:** A company with whom the Trustees have a contract to supply Benefits.

1.32 **Local Union:** Local Union 424 of the International Brotherhood of Electrical Workers.

1.33 **Local Union Member:** A person who is a member in good standing of the Local Union.

1.34 **Loss:** As used with reference to hand or foot, means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg, means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers, means complete severance to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye, means the irrecoverable loss of the entire sight thereof; as used with reference to speech, means the total and irrecoverable loss thereof; as used with reference to hearing, means the total and irrecoverable loss thereof; and as used with reference to quadriplegia, paraplegia or hemiplegia, means the permanent and irrecoverable paralysis of such limbs.

1.35 **Loss-of-Use:** A loss which is permanent, total, irrevocable and continuous for a period of twelve months from the date of the accident.

1.36 **Medically Necessary:** means accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of a phase of an illness or Injury. Manulife Financial has the right after Due Diligence has been completed to determine whether the service or supply is eligible under the Policy.

1.37 **Non-bargaining Employee:** See section 1.03.

1.38 **Non-occupational Injury** or **Non-occupational Disease:** Any Injury or Disease that is not or is not normally covered under Workers' Compensation, Employment Insurance, or similar law.

1.39 **Nurse Practitioner:** A registered nurse with active registration as a nurse practitioner with the provincial nurses association in the nurse practitioner's province of practice (i.e. College and Association of Registered Nurses of Alberta for nurse practitioners practicing in Alberta).

1.40 **Patient Assistance Program**: means a program that provides assistance to Plan Members prescribed select supplies or services. Manufacturers and distributors may provide Patient Assistance Programs that include financial support, along with education and training.

1.41 **Physician** or **Surgeon:** A graduate of an accredited medical school who is duly licensed to practice medicine, to prescribe and administer any drugs or to perform surgical procedures.

1.42 **Plan:** See definition of Health & Welfare Plan.

1.43 **Plan Member:** Any person who is or was an Employee and who is eligible for Benefits through an Hour Bank (including a "frozen" Hour Bank), a Years-of-Service Bank, or Self-Payments.

1.44 **Plan Membership:** The status of a Plan Member.

1.45 **Policyholder:** See definition of Administrator.

1.46 **Provincial Government Plan:** The body of provincially enacted laws, as amended from time to time, governing provincial health insurance plans, provincial hospital insurance plans, provincial medicare plans, provincial medical care and services, and other provincial government sponsored hospitalization, medicare, drug, or dental insurance plans which provide health insurance to residents of Canada.

1.47 **Reasonable and Customary Charge:** A charge made by the provider of health care services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographic area where the charges were incurred when furnishing like or comparable treatment, services or supplies to individuals.

1.48 **Reciprocal Fund:** Another health & welfare plan or fund with which the Health & Welfare Fund has a reciprocal agreement or a reciprocity arrangement.

1.49 **Rehabilitation Hospital:** A licensed, extended Hospital care facility or institution, or chronic care facility or institution, which is regularly engaged in the care of sick persons during the rehabilitation stage of an illness or Injury. Such institution must provide 24 hour nursing service and regular medical supervision. The term Rehabilitation Hospital as used in this policy, shall not include a home for the aged, health spa or hotel, an establishment providing Custodial Care, or an institution for the care and treatment of alcoholism, drug addiction, tuberculosis or mental illness.

1.50 **Rehabilitative Care Services and Supplies:** Room and Board, routine nursing care and such other services and supplies necessary to the health of patients as are generally provided by a Rehabilitation Hospital. Rehabilitative Care Services and Supplies shall not include the services of a private-duty nurse or other private-duty attendant or include any service or supply which would not be provided to an inpatient of a Hospital.

1.51 **Retired Plan Member:** A Plan Member age 55 or over who has maintained Plan Membership since retiring and is no longer working in the electrical industry.

1.52 **Room and Board:** Room, board, general duty nursing, intensive care nursing, and any other professional services regularly provided in a Hospital as a condition of occupancy of the class of accommodations occupied.

1.53 **Schedule of Dental Fees:** A schedule of fees approved by the Board of Trustees as updated and amended from time to time.

1.54 **Self-Payment:** The provision by which the Fund extends Coverage to a Plan Member and his/her Dependents when the Plan Member's Hour Bank falls below 120 hours, or when the Plan Member's Years-of-Service Bank is fully utilized.

1.55 **Special Authorization:** means a claims management feature applied to a specific list of supplies or services to determine eligibility based on predefined clinical criteria and a cost effectiveness evaluation.

1.56 **Stakeholder Number:** See definition of Identification Number.

1.57 **Summary of Benefits:** The general description in this booklet of the Benefits provided subject to various insurance policies maintained by the Trustees.

1.58 **Surgeon:** See definition of Physician.

1.59 **Termination of Coverage:** Coverage shall terminate at the later of:

(a) The end of the month in which a Plan Member's Hour Bank falls below 120 hours after deducting 120 hours for the current month; or

(b) The end of the month in which a Plan Member's Years-of-Service Bank is fully utilized; or

(c) The end of the month for which the last Self-Payment was received by the Fund; or

(d) As provided under Extension of Benefits.

1.60 **Totally Disabled:**

(a) When used under the Weekly Disability Income Benefit, the Plan Member is incapacitated to the extent that he/she is not able to perform any and every duty of his/her occupation or employment; or

(b) When used under the Long-Term Disability Income Benefit, for the first 36 months following the date that the Plan Member ceased to work, the Plan Member is incapacitated by an Injury or Disease to the extent that he/she is not able to perform any and every duty of his/her occupation or employment. After such 36 months, Totally Disabled shall mean the Plan Member is incapacitated to the extent that he/she is not able to perform any and every duty of any occupation or employment for which the Plan Member is reasonably qualified by education, training or experience. Such incapacity must result from a medically determinable physical or mental impairment; or

(c) When used under the Life Insurance Benefit, the Plan Member is incapacitated by Injury or Disease to the extent that he/she is not able to perform any work for compensation or profit and is not able to engage in any business or occupation.

1.61 **Traveler:** An Employee who has authorized the transfer of Contributions on his/her behalf to a Reciprocal Fund.

1.62 **Trust Agreement:** The agreement between the Association and the Local Union, and any modification, amendment, extension, and/or renewal thereof, establishing the Electrical Industry Insurance Benefit Trust Fund of Alberta.

1.63 **Trustees:** The trustees established by, appointed under and acting in accordance with the Trust Agreement.

1.64 **Year of Plan Membership:** At least one month of Coverage in a calendar year.

1.65 **Years-of-Service Bank** or **YSB:** A Benefit available to a Plan Member at age 55 or retirement, whichever is later.

SECTION 2 - GENERAL REQUIREMENTS

2.01 INTRODUCTION

This Summary of Benefits is issued to Plan Members for general information only. It does not constitute a contractual document. In any circumstances where the wording of this Summary of Benefits differs from the insurance policies, the Direct Reimbursement Agreement, and policies and other provisions adopted by the Trustees, the terms contained in these latter Plan documents govern.

As Employees become eligible for Benefits, they will receive this Summary of Benefits booklet providing they have filed a current mailing address with the Fund Office.

2.02 Benefit Package for Active Plan Members

The Benefit Package and brief description of Benefits for active Plan Members includes:

(a) Plan Member's Life Insurance Benefit (see Section 5)

- $150,000

(b) Plan Member's Accidental Death and Dismemberment Benefit

- See Section 6

(c) Dependents' Life Insurance Benefit (see Section 7)

- Spouse $10,000
- Children $2,000

(d) Plan Member's and Dependents' Supplementary Health Expense Benefit (see Section 8)

- Reasonable and Customary Charges for semi-private Hospital room
- Out-patient Hospital care
- Emergency out-of-province/country Coverage

(e) Plan Member's and Dependents' Prescription Drugs Benefit (see Section 9)

- 90% of eligible prescription drugs
- $10,000 maximum per person per calendar year

(f) Plan Member's and Dependents' Vision Care Benefit (see Section 10)

- Plan Members, and Dependents age 18 and over, maximum of $500 for corrective lenses every two consecutive calendar years

- Dependents under age 18, a maximum of $500 for corrective lenses every calendar year if required due to a change in prescription
- Plan Members and Dependents, eye examination for visual acuity to a maximum of $90 once every two calendar years
- Laser eye surgery for Plan Members and Dependents over the age of 18, who have the services performed by an ophthalmologist.

(g) Plan Member's and Dependents' Dental Care Benefit (Class A) (see Section 11.02(a))

- 90% of the Schedule of Dental Fees
- $3,000 maximum per person per calendar year combined with Class B
- cleanings, recall examinations, and bitewing x-rays allowed once per year

(h) Plan Member's and Dependents' Dental Care Benefit (Class B) (see Section 11.02(b))

- 90% of the Schedule of Dental Fees
- $3,000 maximum per person per calendar year combined with Class A

(i) Plan Member's and Dependents' Dental Care Benefit (Class C) (see Section 11.02(c))

- 90% of the Schedule of Dental Fees
- $2,500 lifetime maximum per person

(j) Plan Member's and Employee Assistance Program Benefit (see Section 12)

- Personal counseling and advisory service

(k) Plan Member's Years-of-Service Bank Benefit (see Section 13)

- 1.5 months of Coverage per Year of Plan Membership for Retired Plan Members age 55 and over

(l) Plan Member's Weekly Disability Income Benefit (see Section 14)

- A taxable disability benefit at the current approved weekly Benefit from the 8th day of a Non-occupational Injury or Non-occupational Disease to a maximum of 51 weeks
- Integrated with Employment Insurance

(m) Plan Member's Long-Term Disability Income Benefit (see Section 15)

- A taxable disability benefit of the currently approved monthly Benefit amount (subject to the All Source Maximum described later in this booklet) from the 53rd week of Total Disability for:

- accident to recovery or age 60, whichever occurs first, OR
- Disease to recovery, 10 years, or age 60, whichever occurs first

2.03 Changes in Plan Rules

This Plan, its eligibility requirements and Benefits, may be altered by the Trustees from time to time without the necessity of prior notice being served to those affected thereby.

2.04 Claims Submission

A Plan Member must submit all supplementary health expense, vision care, and dental care claims (in English) to the Fund Office within 12 months from the date the expense was incurred. Prescription Drug claims not processed electronically (using your drug card) must be submitted to ClaimSecure within 12 months from the date the expense was incurred. Claims received more than 12 months from the date the expense was incurred will not be considered for reimbursement. After Termination of Coverage, claims for supplementary health expense must be received within 90 days of termination. For disability claims, refer to Sections 14 and 15.

2.05 Proof of Claim

The Trustees shall have the right to have a Plan Member or Dependent whose Injury, Disease or death is the basis of a claim examined by a Physician designated by the Trustees when and as often as it may be required at the cost of the Fund.

2.06 Errors and Omissions

If the Trustees or any of their employees, delegates or consultants have inadvertently made any errors or omissions that resulted in payments higher than provided for by this Plan, the Trustees shall have the right to recover and/or offset any overpayments from the recipient including any collection expenses, on a solicitor and client basis.

2.07 Correspondence

The Plan Member's Stakeholder Number and complete name and address must appear on all correspondence sent to the Fund Office. Claim forms should be completed in full.

2.08 Dependent Status Changes

If a Plan Member marries, has a child, or is in a common-law relationship for one year, a new Registration & Declaration of Beneficiary Form must be completed and forwarded to the Fund Office. Please refer to Section 1.13.

2.09 Spouse's Status

(a) The Trustees, in special circumstances which they shall determine in their sole discretion, may obtain from a Plan Member or such Plan Member's executor or power of attorney, a statutory declaration or other evidence sufficient to satisfy the Trustees of the status of a Spouse.

(b) If the Plan Member has been in a spousal relationship with more than one person, the term Spouse shall include only the person to whom the Plan Member was most recently in a spousal relationship. That person must be appointed by the Plan Member in writing and filed with the Fund Office before claims for that person will be eligible for Benefit payments. Only one Spouse will be eligible for Benefit payments at any given time.

2.10 Beneficiary Designation

Any Beneficiary designation must comply with the requirements of applicable insurance laws. Under insurance laws, multiple Beneficiaries will receive equal portions unless stipulated otherwise.

2.11 Change of Address, Dependent, or Beneficiary

Plan Members can change their address, phone numbers or email addresses by calling, emailing or submitting the change on-line with the Fund Office.

2.12 Reciprocal Fund

Travelers coming into Alberta and working for Employers have the ability to transfer Contributions to their home local's health and welfare fund by completing a Contribution Transfer Authorization form. Plan Members traveling outside of Alberta may have the ability to transfer contributions to this Fund by completing a Contribution Transfer Authorization form. Contributions will not be transferred retroactively to the date the Plan Member signed the Contribution Transfer Authorization form. The Local Union or Administrator must be in receipt of a properly executed copy of the Contribution Transfer Authorization form. Please contact the Fund Office for details concerning either situation.

2.13 Coordination of Benefits

Where the total Benefits under this Plan and other group plans would exceed costs incurred for covered expenses, reimbursement from all policies shall be limited to incurred expenses according to the following order of Benefit determination:

(a) Benefits shall be payable first from a group plan which does not have a provision to coordinate benefits, then subsequently in accordance with the rules of this Plan and other group plans which do have coordination of benefits.

(b) Among the plans having coordination of benefits, priority shall be determined in the following order:

Plan Members:

1. This Plan as a Plan Member.
2. Spouse's plan where the Plan Member is covered as a Dependent.

Dependents:

Spouse

1. The plan where the Spouse is covered as a plan member.
2. This Plan.

Children

1. The plan of the parent with the earlier birthdate (month/day) in the calendar year.
2. The plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birthdate.
3. In situations where parents are separated/divorced, then the following order applies:

    (i) The plan of the parent with custody of the child,

    (ii) The plan of the spouse of the parent with custody of the child,

    (iii) The plan of the parent not having custody of the child,

    (iv) The plan of the spouse to the parent in (iii) above.

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

(d) In order to coordinate Benefits, the Insurer and/or Administrator shall release information to and obtain information from such other insurance companies, organizations, or persons having knowledge relevant to claims of the Plan Member and his/her Dependents without further notice.

(e) The Insurer and/or Administrator shall also have the right to pay directly to other insurance companies, organizations, and persons amounts which should have been chargeable under this coordination of Benefits provision. Such payments shall be considered Benefits under this policy and shall discharge the Insurer and/or Administrator from liability, to the extent of the payment. Additionally, the Insurer and/or Administrator shall have the right to recover any amounts paid by the Insurer and/or Administrator which were in excess of the maximum amounts contemplated by the coordination of Benefits provision.

(f) Such recovery shall be made without notice to the Plan Member and his/her Dependents, and the Insurer and/or Administrator may recover such amounts from any other insurance company, organization, or from persons to whom or on whose behalf such payments were made.

(g) The Plan Member must furnish proof of coordination by providing copies of the primary insurance carrier’s statements.

(h) In the event of a coordination of benefits issue arising which cannot be resolved by reference to the foregoing rules, the Trustees will rely on the most recently published CLHIA Coordination of Benefits Policy.

2.14 Third Party Liability

Rights: If a Plan Member is entitled to recover compensation for loss of income or for medical expenses, from a third party, as a result of an incident which was caused or contributed to by such third party, and for which Benefits under this contract are also paid or payable, then the Fund will be subrogated to all of the Plan Member's rights of recovery for loss of income or for medical expenses, to the extent of the amount of Benefits, paid or payable by the Fund, under this contract, unless excluded by legislation. The term "compensation for loss of income," as used herein, includes any and all amounts received by, or owing to, the Plan Member for loss of past or future income, and loss or diminishment of earning capacity, whether or not such amounts are paid in lump sum or by way of periodic payments.

Documents: The Plan Member will execute those documents relating to the Fund's right of subrogation, as may be required by the Fund, including a Reimbursement Agreement. Should the Plan Member/Dependent fail to complete and provide the Fund with any such documents, the Plan Member's and Dependent's Benefits will be suspended by the Fund, until the completion and receipt of the documents.

Pro Rata Recovery: In the event that the Plan Member or Dependent provides proof to the Fund Office that he/she has not recovered full compensation for loss of income or for medical expenses, then the Fund Office will determine the proportion of such compensation actually recovered by the Plan Member or Dependent and will share, pro rata, in that amount.

Settlement: The Plan Member or Dependent is obliged, in any settlement discussions with a third party, to pursue the Fund's subrogated rights under this provision, in good faith. Should the Plan Member or Dependent choose to settle a claim, or a potential claim, against a third party, prior to any judicial or other determination, then the Plan Member or Dependent must provide the Fund Office with a breakdown of the damages he/she has accepted in settlement of his/her claim or potential claim, including separate components for compensation for loss of income, and for medical expenses.

Notification: The Plan Member or Dependent will immediately notify the Fund Office of the commencement of any action, proceeding, or settlement discussions undertaken against a third party, and will provide the Fund Office with information concerning the status of such actions, proceedings or negotiations, at the request of the Fund Office, which will be at reasonable intervals. The Plan Member or Dependent shall notify the Fund Office immediately of any settlement of his/her claim or potential claim against a third party and, given the Fund's rights of subrogation under this provision, such disclosure will not constitute a breach of confidentiality for the purposes of the settlement of the Plan Member's or Dependent's action against the third party.

Failure To Comply: Where a Plan Member or Dependent fails to comply, either with the terms of this provision or of any documents the Fund Office has requested him to sign in relation to this provision, such failure would constitute a breach of contract and the further payment of Benefits under this contract will be suspended pending compliance with this provision or any documents relating to this provision. Additionally, the Fund reserves the right to deduct from any future Benefits payable under this contract to the Plan Member or Dependent, any amount owing to the Fund pursuant to this provision or pursuant to any documents relating to this provision, or to bring any action or proceedings to enforce the Fund's rights under this provision.

2.15 Personal Information Consent Form

It is a requirement of this Plan to provide to the Fund Office a completed Registration and Declaration of Beneficiary Form prior to attaining eligibility.

2.16 Conformity with Applicable Law

If any provision of this Summary of Benefits is in conflict with the applicable law of the Plan Member's province of residence, the provision shall be deemed amended to conform to the minimum requirements of that law.

2.17 Assignment of Claims

Claims cannot be assigned to anyone other than the Plan Member's Dependents without the Plan Member's permission.

2.18 Failure to comply with any or all of the above requirements may result in a delay or loss of Benefits.

2.19 Fraudulent Claims

Should a Plan Member knowingly submit a false claim, which shall be determined solely by the Trustees, the Trustees may forthwith terminate the eligibility and entitlement to Benefits of the Plan Member and his/her Dependents for a length of time to be determined solely by the Trustees. In addition, the Trustees may take action to recover any overpayments as well as all administrative, audit and legal costs, on a solicitor and his/her own client basis, resulting from the false claim. When a Plan Member's Coverage is terminated, the Plan Member's Hour bank will be terminated. Any costs incurred by the Electrical Industry Insurance Benefit Trust Fund of Alberta due to the Plan Member's fraudulent actions are due by the Plan Member. The Board of Trustees reserves the right to recover the costs in due course for any Benefit overpayments, plus additional administration and legal expenses incurred.

2.20 Claim Appeal

In the event of a disagreement with a decision of the Administrator regarding Benefits or the administration of such, a Plan Member, Pensioner or Beneficiary entitled to Benefits under the Trust Fund may appeal the decision to the Board of Trustees. Such appeal to the Board of Trustees must be received, in writing, along with any information or

documents wishing to be considered, by the Board of Trustees, within 60 days of the Administrator's decision. Any decision of the Board of Trustees shall be final and binding.

SECTION 3 - ELIGIBILITY REQUIREMENTS

3.01 Ability to Gain Eligibility for Benefits

(a) All Employees and their Dependents have the ability to gain eligibility.

(b) Dependents gain eligibility through a Plan Member.

(c) For Non-bargaining Employees to have the ability to gain eligibility, their Employer must apply to and be approved by the Trustees and make Contributions on behalf of these Non-bargaining Employees.

3.02 Gaining Eligibility for Benefits

(a) An Employee gains eligibility for Coverage after a minimum of 300 hours are reported for which Contributions were paid by one or more Employers in not less than 2 nor more than 4 consecutive months (the Qualifying Period) based on the Employer's monthly Report of Contribution, followed by one calendar month waiting period. Eligibility for an Employee and his/her Dependents will commence on the first of the month following the waiting period, at which time the Employee becomes a Plan Member.

(b) A Non-bargaining Employee's Employer may choose to base the Plan Member's Contributions on 140 hours or 160 hours per month. A Non-bargaining Employee's Employer who chooses Contributions based on 140 hours per month may choose to make Contributions based on 150 hours per month for the first two months of employment. If the Employer also contributes to the Electrical Industry Pension Trust Fund of Alberta on behalf of Non-bargaining Employees, the hours reported by an Employer for Non-bargaining Employees must be identical for the Health and Welfare Fund and the Electrical Industry Pension Trust Fund of Alberta.

(c) Hours existing prior to the Qualifying Period described in Section 3.02(a) above shall be forfeited.

3.03 Continuation of Eligibility

(a) Hours worked by an Employee for which Contributions were paid during and after the Qualifying Period described in Section 3.02(a) shall be accumulated in the Employee's Hour Bank to a maximum of 1,080 hours.

(b) One hundred and twenty (120) hours will be deducted from the Hour Bank for each month of Coverage.

(c) A disabled Plan Member who is receiving Workers' Compensation benefits, Employment Insurance sickness benefits, or the Plan's Weekly Disability Income Benefits, for at least two weeks per month, will have no deductions made from their Hour Bank for a maximum continuous period of four months and their Coverage will continue during this period. A Plan Member must provide evidence from Employment Insurance in order to "freeze" their Hour Bank.

(d) A Plan Member will have Coverage through his/her Hour Bank provided the Plan Member's Hour Bank contains at least 120 hours.

(e) When a Plan Member's Hour Bank falls below 120 hours, he/she may choose to extend his/her Coverage through Self-Payments (see Section 4).

(f) Retired Plan Members also have their Coverage extended through their Years-of-Service Bank Benefit under the provisions of Section 13.

3.04 Termination of Eligibility for Benefits

(a) A Plan Member's Coverage terminates:

- at the end of the month in which the Plan Member's Hour Bank falls below 120 hours; or
- at the end of the month for which the Plan Member's last Self-Payment was received by the Fund; or
- at the end of the month in which the Plan Member's Years-of-Service Bank is fully utilized; or
- at the Plan Member's death.

(b) A deceased Plan Member's Coverage shall continue for the Plan Member's Dependents for the six calendar months following his/her death or until his/her Hour Bank falls below 120 hours, or until his/her Years-of-Service Bank is fully utilized, whichever is later.

(c) In addition to the termination of eligibility described in Section 3.04(a) and (b) above, the Coverage for any Plan Benefit will terminate on the date such Benefit is terminated by the Trustees and/or any Insurer.

3.05 Detailed Accounting Example of the Hour Bank

See Section 16.13.

SECTION 4 – SELF-PAYMENT PROVISIONS

4.01 General Provisions

(a) A Plan Member whose Hour Bank falls below 120 hours or whose Years-of-Service Bank is fully utilized may continue his/her Coverage for the Plan Member and his/her Dependents by making Self-Payments.

(b) The following Sections 4.02 to 4.06 describe the various Self-Payment Benefit Packages that are provided by the Plan, subject to the provisions of Sections 4.07 and 4.08.

4.02 Self-Payment Benefit Package for Plan Members Under Age 65

The Self-Payment Benefit Package for Plan Members under age 65 (including the Plan Members receiving Weekly Disability Income Benefits and Long-Term Disability Income Benefits) includes:

(a) Plan Member's Life Insurance Benefit (see Section 5)

(b) Plan Member's Accidental Death and Dismemberment Benefit (see Section 6)

(c) Dependents' Life Insurance Benefit (see Section 7)

(d) Plan Member's and Dependents' Supplementary Health Expense Benefit (see Section 8)

(e) Plan Member's and Dependents' Prescription Drugs Benefit (see Section 9)

(f) Plan Member's and Dependents' Vision Care Benefit (see Section 10)

(g) Plan Member's and Dependents' Dental Care Benefit (Class A) (see Section 11.02(a))

(h) Plan Member's and Dependents' Dental Care Benefit (Class B) (see Section 11.02(b))

(i) Plan Member's and Dependents' Dental Care Benefit (Class C) (see Section 11.02(c))

(j) Plan Member's and Dependents' Family Assistance Program Benefit (see Section 12)

(k) Plan Member's Years-of-Service Bank Benefit (see Section 13).

Note: A Plan Member's Self-Payments will be subsidized by 50% while he/she receives Long-Term Disability Income Benefits.

4.03 **Self-Payment Benefit Package for Retired Plan Members Age 55 to 64**

A Retired Plan Member after receiving his/her Years-of-Service Bank Benefit may continue his/her eligibility through Self-Payments up to age 65 for the Benefit Package described in Section 4.02 (including the 'Note'), reduced by eliminating the Benefits in Section 4.02(i) and (k).

4.04 **Self-Payment Benefit Package for Plan Members Age 65 and Over**

A Plan Member age 65 and over who has not retired and who has not yet received his/her Years-of-Service Bank Benefit may continue eligibility through Self-Payments for a reduced Benefit Package which includes Section 4.02 (d), (e), (g), (h), (j), and (k).

4.05 **Self-Payment Benefit Package for Retired Plan Members Age 65 and Over**

A Retired Plan Member age 65 and over after receiving his/her Years-of-Service Bank Benefit may continue eligibility through Self-Payments for a reduced Benefit Package which includes Section 4.02(d), (e), (g), (h), and (j).

4.06 **Benefits Excluded from Self-Payment Benefit Packages**

Weekly Disability Income Benefits and Long-Term Disability Income Benefits are excluded from all Self-Payment Benefit Packages.

4.07 **Payment Requirements**

(a) A Plan Member who wishes to make Self-Payments must submit a signed Self-Payment Application and Preauthorized Debit Agreement to the Fund Office prior to the Plan Member's loss of Coverage. Subsequent Self-Payments must be received by the Fund Office prior to the month of desired Self-Payment Coverage.

(b) A Plan Member will be required to pay a non-sufficient funds (NSF) fee for a rejected Self-Payment. No Benefits are payable for the month the Self-Payment had non-sufficient funds.

(c) For Self-Payment rates and forms of payment, please contact the Fund Office.

4.08 **Termination of Self-Payment Coverage**

Coverage through Self-Payments will terminate when:

(a) the Plan Member regains Coverage through his/her Hour Bank, or

(b) at the end of the month when he/she fails to meet the provisions of Section 4.07, or

(c) a Cancellation Notice is received at least 10 (ten) business days before the last business day of the month, or

(d) if the Plan Member incurs more than one NSF payment within 18 months of the first NSF payment. Termination will occur for the month in which the second NSF payment occurred.

SECTION 5 - PLAN MEMBER'S LIFE INSURANCE BENEFIT

POLICY #3602

5.01 Benefit

In the event of a Plan Member's death, and provided the Plan Member was eligible, the Life Insurance Benefit of $150,000 is payable to the Plan Member's Beneficiary.

5.02 Extension of Coverage

If a former Plan Member dies within 31 days after losing Coverage, the amount of Life Insurance Benefit to which the Plan Member would have been entitled upon conversion to an individual policy will be paid to the Plan Member's Beneficiary.

5.03 Conversion Privilege

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

For more information on the conversion privilege, please contact Manulife Financial at 1-800-268-6195.

5.04 Conversion Conditions

The conversion privilege is subject to the following conditions:

(a) The amount of the individual policy shall not exceed the amount of Life Insurance for which the Plan Member was covered when Coverage was discontinued, subject to the lesser of:

- The amount of insurance not replaced under a replacing contract of group Life Insurance, or
- $200,000 for all contracts of the Plan Member's group life insurance with the Insurer.

(b) The individual policy shall be, at the Plan Member's option, in the form of:

- non-convertible term insurance to age 65;
- a permanent plan that the Insurer offers to the public at the time of conversion; or

- one-year non-renewable term insurance which may be converted while it is in force to any plan described above.

This individual policy shall be without disability waiver or other supplementary Benefits.

(c) The premium for the individual policy shall be determined by the Insurer according to:

- The Insurer’s current rates for the Plan Member's attained age at the birthday immediately prior to the date of issue of the individual policy;
- The class of risk to which the Plan Member then belongs; and
- The form and amount of the individual policy.

Note: Non-smoker rates are not available on converted policies.

(d) The written application for the individual policy shall be delivered to the Insurer within 31 days after the date on which the Plan Member's Coverage was terminated.

(e) The Life Insurance under the individual policy shall be effective at the end of the 31-day period described above.

(f) Evidence of insurability shall not be required for such individual policy.

(g) If the Plan Member dies within the 31-day period during which the Plan Member could have converted, the Insurer shall pay the maximum amount of Life Insurance the Plan Member could have converted. If an individual policy has already been issued through conversion, no payment shall be made through this provision unless the individual policy is surrendered without payment of claim. Upon surrender, the Insurer shall refund premiums paid on the individual policy. A Beneficiary designated in any conversion application shall be the Beneficiary under this provision.

5.05 Waiver of Premium

If a Plan Member becomes Totally Disabled for at least six consecutive months before attaining age 65, the Insurer will waive the payment of Life Insurance premiums for this Plan Member until the earlier of the date the Plan Member ceases to be Totally Disabled or attains age 65.

5.06 Insurance While on Waiver of Premium

The amount of Life Insurance shall be the amount in force at the Plan Member's date of death.

SECTION 6 - ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (AD&D) POLICY #119-3183

6.01 Coverage

Any eligible accident resulting in: death, dismemberment, loss of sight, or paralysis - anywhere in the world - 24 hours a day - on or off the job.

6.02 Eligibility

Eligible Plan Members of the Electrical Industry Insurance Benefit Trust Fund of Alberta are covered under the Policyholder's current Group Life policy. The accidental death and dismemberment Benefit does not apply to Dependents.

6.03 Amount of Insurance

The amount of insurance (Principal Sum) is $150,000.00.

6.04 Benefits

(a) Accidental Death, Dismemberment and Specific Loss Indemnity

The AD&D policy provides benefits for Injury resulting in Loss of, **or permanent and total Loss of Use of**, which occurs within **12 months** after the date of the accident as follows:

Life	The Principal Sum
Both Hands	The Principal Sum
Both Feet	The Principal Sum
Entire Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and the Entire Sight of One Eye	The Principal Sum
One Foot and the Entire Sight of One Eye	The Principal Sum
Speech and Hearing in Both Ears	The Principal Sum
One Arm	Three-Quarters of the Principal Sum
One Leg	Three-Quarters of the Principal Sum
One Hand	Two-Thirds of the Principal Sum
One Foot	Two-Thirds of the Principal Sum
Entire Sight of One Eye	Two-Thirds of the Principal Sum
Speech or Hearing in Both Ears	Two Thirds of the Principal Sum
Thumb and Index Finger of Either Hand	One-Third of the Principal Sum
Hearing in One Ear	One-Third of the Principal Sum

(b) Paralysis Benefits

Quadriplegia (complete paralysis of both upper and lower limbs)
…….One Times the Principal Sum
Paraplegia (complete paralysis of both lower limbs)
…….....One Times the Principal Sum

Hemiplegia (complete paralysis of upper and lower limbs of one side of body) …….One Times the Principal Sum

Indemnity provided under this part for losses relating to any one limb will be paid for only one of the losses (greatest amount), sustained by any one Plan Member as the result of any one accident.

Indemnity provided under this part for all losses sustained by any one Plan Member as a result of any one accident will not exceed the Principal Sum.

"Injury" whenever used in the AD&D policy means bodily injury caused by an accident occurring while the AD&D policy is in force as to the Plan Member whose Injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the AD&D policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or Disease, or treatment for the illness or Disease.

"Loss" whenever used in the AD&D policy with reference to hand or foot, means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg, means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers, means complete severance at or above the metatarsophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye, means the irrecoverable loss of the entire sight thereof; as used with reference to speech, means the total and irrecoverable loss thereof; as used with reference to hearing, means the total and irrecoverable loss thereof; and as used with reference to quadriplegia, paraplegia and hemiplegia, means the permanent and irrecoverable paralysis of such limbs.

"Loss of Use" whenever used in the AD&D policy means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

(c) Day Care Benefit

If Injury results in the Plan Member's loss of life and indemnity becomes payable under the AD&D policy, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of the Principal Sum to a maximum of $5,000.00, for each of the Plan Member's dependent children under 13 years of age who (a) are enrolled in a legally licensed day care centre on the date of the Plan Member's death; or (b) enroll in a legally licensed day care centre within 12 months after the date of the Plan Member's death. The Benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled in a legally licensed day care centre, but not to exceed four consecutive annual payments with respect to any one dependent child. If, at the time of loss, the Plan Member has no dependent children eligible for the Day Care Benefit, the Insurer shall pay an additional amount of $2,500.00 to the Plan Member's designated Beneficiary.

(d) Education Benefit

If Injury results in the Plan Member's loss of life and indemnity becomes payable under the AD&D policy, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of the Principal Sum to a maximum of $5,000.00, for each of the Plan Member's dependent children who (a) are enrolled as full-time students in a school for higher learning above the secondary school level; or (b) were enrolled as full-time students at the secondary school level but enroll as full-time students in a school for higher learning within 12 months after the date of the Plan Member's death. The Benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in a school for higher learning, but not to exceed four consecutive annual payments with respect to any one dependent child.

(e) Home Alteration and Vehicle Modification Benefit

If, following an Injury which results in a Loss covered by the AD&D policy, the Plan Member is required to use a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the accident causing such Loss for (a) the cost of alterations to the Plan Member's principal residence; and/or (b) the cost of modifications to one motor vehicle utilized by the Plan Member, when such modifications are approved by the provincial vehicle licensing authorities where required for the purpose of making them wheelchair accessible, subject to a maximum of $10,000.00 as the result of any one accident.

(f) Rehabilitation Benefit

If, following an Injury which results in a Loss covered by the AD&D policy, the Plan Member requires special training in order to be qualified to engage in a special occupation in which the Plan Member would not have engaged except for such Injury, the Insurer will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, subject to a maximum of $10,000.00 as the result of any one accident.

(g) Repatriation Benefit

If Injury results in the Plan Member's loss of life and indemnity becomes payable under the AD&D policy, the Insurer will pay the reasonable and necessary expenses actually incurred for preparation and transport of the Plan Member's body to his/her city of residence, subject to a maximum of $10,000.00.

(h) Spousal Retraining Benefit

If Injury results in the Plan Member's loss of life and indemnity becomes payable under the AD&D policy, the Insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by the Plan Member's Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an

occupation for which the Spouse would not otherwise have sufficient qualifications, subject to a maximum of $10,000.00 for all such expenses.

6.05 Aggregate Limit of Indemnity

The AD&D policy is subject to an Aggregate Limit of Indemnity of $10,000,000.00 for all losses resulting from any one aircraft accident. This means that in the event of an aircraft accident that results in an accumulation of losses exceeding $10,000,000.00, the amount payable with respect to each Plan Member will be reduced proportionately.

6.06 Exclusions

Coverage does not apply to any Loss caused or contributed to by:

- declared or undeclared war or any act of war;
- active full-time service in the armed forces of any country;
- suicide or self-destruction, while sane or insane.

6.07 Exposure and Disappearance

If due to an accident, the Plan Member is unavoidably exposed to the elements and such exposure, within 12 months of the date of the accident, results in a Loss for which indemnity would otherwise have been payable under the policy, such Loss will be deemed to be the result of Injury.

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

6.08 Beneficiary

The Beneficiary or Beneficiaries of a Plan Member shall be that person or those persons designated by the Plan Member under the Policyholder's current Group Life policy. If no such designation has been filed, the Beneficiary in respect of loss of life of a Plan Member shall be the estate of the Plan Member. All other indemnities payable will be payable to the Plan Member, with the exception of indemnities payable under "Day Care Benefit", "Education Benefit" and "Spousal Retraining Benefit".

6.09 Termination of Insurance

The Plan Member's insurance will immediately terminate on the earliest of the following dates:

(a) the date the AD&D policy is terminated;

(b) the premium due date if the Policyholder fails to remit the Plan Member's premium to the Insurer, except as the result of an inadvertent error;

(c) the premium due date coinciding with or immediately following the date the Plan Member ceases to be associated with the Policyholder in a capacity making the Plan Member eligible for insurance.

6.10 A.D. & D. Claims Procedures

Written notice of claim is to be given to the Insurer within a period of 30 days from the date of the accident. Claim forms are available from the Fund Office, or from the Insurer at (800) 266-5667. The Insurer reserves the right to request additional information when processing the claim. Completed claim forms are to be filed with the Insurer within 90 days after the date of the Injury, but no later than one year after the date of the Injury, regardless of whether the full extent of loss is known.

Every action or proceeding against an Insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act based on the Plan Member's province of residence, or other applicable legislation.

SECTION 7 - DEPENDENTS' LIFE INSURANCE BENEFIT
POLICY #3602

7.01 Benefit

In the event of the death of one of the Plan Member's Dependents, the Plan Member will receive the amount of Life Insurance shown in the table below:

Spouse	$ 10,000
Children (from birth to 21 years or to age 25 if in school)	$ 2,000

7.02 Conversion Privilege

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

For more information on the conversion privilege, the Plan Member should contact the Insurer. Provincial differences may exist.

7.03 Conversion Conditions

The individual policy shall be subject to the conditions set out under Section 5.04, however, the age and class of risk shall be that of the Spouse (or former Spouse) and the amount of the individual Life Insurance policy shall be the amount for which the Spouse (or former Spouse) was insured when Coverage ceased.

7.04 Converted Policy Owner

The owner of the individual policy shall be the Plan Member. If the Plan Member is not living then the owner will be the Spouse. The Beneficiary of the individual policy shall be designated by the owner.

7.05 Conversion Amount in Case of Spouse's Death

If the Spouse dies within the 31-day period during which the Spouse's Life Insurance could have been converted, the Insurer will pay the maximum amount of insurance that could have been converted. If an individual policy has already been issued through conversion, no payment shall be made through this provision unless the individual policy is surrendered without payment of claim. Upon surrender the Insurer shall refund premiums paid on the individual policy.

7.06 Waiver of Premium

If a Plan Member becomes Totally Disabled and qualifies for the Waiver of Premium under the Plan Member's Life Insurance Coverage, the Insurer will also waive the payment of Dependent Life Insurance premiums for such Plan Member.

7.07 Insurance While on Waiver of Premium

The amount of Dependent Life Insurance shall be the amount in force on the Dependent's date of death.

7.08 Termination of Entitlement to Waiver of Premium

A Plan Member's entitlement to Waiver of Dependent Life Insurance premiums ceases on the earlier of:

(a) The date the Waiver of Premium for the Plan Member's Life Insurance ceases; or

(b) The date the policy or Coverage terminates.

SECTION 8 - PLAN MEMBER'S & DEPENDENTS' SUPPLEMENTARY HEALTH EXPENSE BENEFIT POLICY #6012

8.01 Benefit

This Benefit will help a Plan Member meet some of the medical bills incurred by the Plan Member and his/her Dependents when illness or Injury occurs.

8.02 Additional Eligibility Requirements

The Benefit is only available to Plan Members and Dependents who are covered under a Provincial Government Plan.

8.03 Covered Expenses

Eligible Expenses shall be expenses in excess of those payable by the Provincial Government Health Plan in effect in the insured individual's province of residence. In the event that a province of residence cannot be determined, the Provincial Health Plan of the Province of Alberta shall be employed.

Expenses shown below are covered if they are:

(a) Medically Necessary for the treatment of an illness or Injury of a Plan Member or Dependent and are recommended by a Physician; and

(b) incurred for the care of a Plan Member or Dependent while he/she is insured under this Benefit; and

(c) reasonable taking all factors into account; and

(d) used as prescribed or recommended by a Physician or other qualified medical practitioner deemed appropriate; and

(e) supported by Manulife Financial's Due Diligence process when necessary.

These Expenses are covered to the extent that:

(a) they are Reasonable and Customary, as determined by Manulife Financial; and

(b) they are not insured under the Provincial Government Plan or any other government-sponsored program; and

(c) they can legally be insured; and

(d) Due Diligence for the supply or service has been completed where required.

All Extended Health Care Benefits are paid as if the Plan Member was eligible under the Provincial Government Plan.

In the event that a Provincial Government Plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this Policy will not automatically assume Coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

8.04 **Adherence**

Non-compliance may result in the service or supply no longer being eligible for reimbursement.

8.05 **Patient Assistance Programs**

Manulife Financial may require a Plan Member to apply to and participate in any Patient Assistance Program to which the Plan Member is entitled. Manulife Financial reserves the right to reduce the amount of a Covered Expense by the amount of financial assistance the Plan Member is entitled to receive under a Patient Assistance Program.

8.06 **Disease Management Programs**

Participation in a Disease Management Program may be required. Participation will be at the discretion of Manulife Financial.

8.07 **Covered Expenses**

(a) **Accidental Dental:** Charges for necessary dental treatment required as the result of a Non-occupational accidental Injury external to the mouth to natural teeth provided the accident occurred while insured under this Coverage. Only such charges directly related to such an accidental Injury and approved by the Insurer are considered a covered medical expense;

(b) **Ambulance:** Ambulance and/or emergency transportation by air or rail when transported from the place where injured by accident or stricken by Disease to the nearest medical facility or Hospital, and if medically required, a medical attendant. Ambulance services also include transportation to a mortuary if the patient dies on route to the nearest medical facility or Hospital and is redirected to a mortuary. Responding fees for patients not transported and charges for inter-facility transfers between medical facilities are not covered under the Plan.

(c) **Durable Medical Equipment, Aids and Prostheses:** Rental (or, purchase at the option of the Insurer) of durable medical equipment, aids, and prosthesis, including but not limited to provision of anesthesia, oxygen, treatment by x-rays, radium and radioactive isotopes, artificial limbs, eyes, splints, trusses, crutches, fiberglass casts, compression bras, orthopaedic back braces/supports and corsets*, other hinged braces*, rental of iron lung and other durable medical or surgical

equipment, aids and appliances required because of Injury to bodily organs or parts, when recommended by a Physician or Nurse Practitioner;

*Hinged braces/supports/corsets which are not custom-made will be limited to a maximum Benefit of $100 per body part, twice per calendar year. Referral of a Physician or Nurse Practitioner is required with each item and each referral must contain a medical diagnosis.

*Custom-made braces are payable at 100% and will be payable again within 3 calendar years if required due to a change in physical condition. If there is no change in physical condition, custom-made braces will be allowed once every three years to the day.

Charges for rental or the purchase of durable medical equipment which is designed primarily for use in a Hospital, used primarily for therapeutic purposes and Medically Necessary for treatment of an existing condition, as well as the type of equipment covered and the decision to purchase rather than rent such equipment is at the option of the Insurer.

(d) **Eye Examinations:** Eye examinations required for medical purposes performed by an ophthalmologist and/or optometrist (excluding laser eye surgery assessments);

(e) **Hearing Aids:** Limited to a maximum Benefit of $1,250 per person in any 5 consecutive calendar years for hearing aids prescribed by a hearing aid practitioner or by a clinical or certified audiologist. Expenses for repairs, moulds and batteries are excluded;

(f) **Orthopedic Shoes/Boots:** Custom-made orthopedic shoes/boots are limited to a maximum Benefit of $1,200 per person every 3 consecutive calendar years. The diagnosis of the medical condition provided must warrant the need for custom-made orthopedic shoes/boots that cannot be accommodated by orthotic inserts or conventional support shoes;

(g) **Orthotic Inserts:** Orthotics are limited to a maximum Benefit of $400 per person in any calendar year. These supplies must be prescribed by a Physician, Nurse Practitioner, podiatrist or chiropodist once every 5 calendar years and contain a diagnosis of the condition;

(h) **Out of Province/Country Emergency Expenses:** For emergency services only, semi-private accommodations in a Hospital subject to the following limitations.

Limitations of Out-of-Province/Country Coverage

i. If, while traveling outside the province of residence, hospitalization and/or medical treatment is required due to emergency and non-elective reasons (regular or routine medical check-ups, regular pregnancy expenses, etc. are not covered), the following Reasonable and Customary Charges for expenses in excess of any Provincial Government Plan allowance are

covered provided they are eligible for reimbursement in whole or in part by a Provincial Government Plan:

- semi-private Hospital accommodation;
- the services of a Physician;
- hospital services and supplies furnished during hospitalization;
- x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

ii. Emergency out-of-province/country Coverage for Retired Plan Members and their Dependents is limited to a period of 12 consecutive weeks from the date the Plan Member and his/her Dependents leave their province of residence.

iii. Plan Members and Retired Plan Members who are dispatched from Local Union 424 for an out of country work assignment, shall be covered for emergency out-of-province/country expenses for up to 12 consecutive months provided their coverage under a Provincial Government Plan is in effect. If the Plan Member or Retired Plan Member's coverage under the Provincial Government Plan ceases because their out-of-country work assignment lasts more than 12 months (or for any other reason), out-of-province/country Coverage under this Plan will cease.

In order to meet the claim submission deadlines of this Plan, Plan Members must immediately send the Fund Office a complete copy of the documentation sent to their Provincial Plan for payment.

(i) **Out-patient Services:** The cost of out-patient Hospital care, services and supplies in connection with use of an examination and/or operating room, prescription drugs, dressings, casts, and/or anesthesia in connection with the performance of a surgical procedure, but not charges made by a resident Physician or intern of a Hospital;

(j) **Paramedical:** The services of a qualified osteopath, chiropractor, podiatrist/chiropodist, registered or provisional physiotherapist, registered massage therapist, registered acupuncturist, naturopath and Christian Science practitioner limited to a maximum of $500 per person per calendar year per specialty. Paramedical services are not covered unless Medically Necessary and performed by a practitioner with an acceptable designation and requirements. (e.g. osteopaths are covered, but osteopathic practitioners are not; massage therapists are only covered if they have 2200 hours/2 years schooling program) The most recent Reasonable and Customary Charges per visit apply to all paramedical treatments.

A referral for paramedical services from a Physician, specialist (MD), or Nurse Practitioner is required each year. A referral for chiropractic services can be provided by a chiropractor. All paramedical referrals will remain valid for one year from the date on the referral.

Coverage is provided for diagnostic x-rays ordered by one of the above, limited to $50 per disability;

(k) **Hospital Accommodation:** In patient semi-private Room and Board charges made by a licensed Canadian Hospital;

(l) **Private Duty Nursing:** Charges for the medical services (excluding Custodial Care, psychological or personal counseling) provided by a Registered Nurse (RN), Nursing Assistant (CAN, RNA, RPN, LPN, LNA) or a member of the Victorian Order of Nurses (VON.) while the patient is not confined to a Hospital; provided such nurse does not ordinarily reside in the home of the Plan Member or Retired Plan Member and is not a relative of the Plan Member, the Retired Plan Member, or the Plan Member or Retired Plan Member's Spouse. These charges will be considered eligible expenses only if recommended on a monthly basis by a Physician and if Medically Necessary. This Benefit is limited to an overall maximum of $5,000 per person every 5 calendar years;

(m) **Psychological:** Upon receipt of a referral from a Physician or Nurse Practitioner each year, the services of a chartered, certified, provisional, or registered psychologist, limited to a maximum Benefit of $500 per person per calendar year. The most recent Reasonable and Customary Charges per visit apply. Psychological services must be performed on an individual basis with the provider.

Psychological Benefits exclude any charges for marriage counseling, hypnotherapy, group therapy, testing of children for learning problems and parent interviews regarding children, services performed by a, clinical counselor, or social worker;

(n) **Referral Expenses:** Payment may be made for medical treatment obtained on a referral basis, outside the Plan Member's and/or Dependent's normal province of residence, provided the referral for such treatment is made upon the recommendation of the Plan Member's and/or the Dependent's general practitioner and one Physician who is a certified specialist for the nature of illness for which treatment is required and the treatment is not available in the Plan Member's and/or Dependent's province of residence. Retired Plan Members while making Self-Payments do not qualify for referral expenses;

In addition to medical expenses, the following expenses may be eligible for reimbursement:

(i) Round trip economy airfare, if practical; first class airfare may be considered if the patient is stretcher bound;

(ii) Airfare for one accompanying parent or guardian (on the same basis as Section 8.07 (n)(i) above) if the patient is a Dependent child; and

(iii) An allowance of $200 per day, 7 days per week to cover transportation, meals and other reasonable expenses.

The total amount payable for these referral expenses is $25,000 (Canadian funds) per Plan Member or Dependent per referral.

(o) **Rehabilitation Hospital:** Charges for Rehabilitation Hospital when admitted within 14 days of Hospital confinement provided confinement is for the continued care of the same condition for which the Plan Member or Dependent was hospitalized and is limited to semi-private accommodation for 120 days for each period of disability;

(p) **Speech Therapy:** Services of a duly qualified speech therapist, upon referral of a Physician or Nurse Practitioner for services rendered out of a Hospital, limited to 20 treatments per person per calendar year;

(q) **Support Stockings:** Elastic support stockings with a Physician's or Nurse Practitioner's referral, to a maximum Benefit of $50 per person per calendar year provided that the stockings contain a compression value range of at least 20 millimeters of mercury pressure.

8.08 **Exclusions**

The foregoing list of covered expenses excludes:

(a) Charges for general health examinations, and examinations required for use of a third party;

(b) Charges for a surgical procedure or treatment performed primarily for beautification, including charges for Hospital confinement for such surgical procedure or treatment;

(c) Charges for medical treatment and surgical procedure by a Physician other than specifically provided in Section 8.07(h);

(d) Charges for transport and/or travel, other than as specifically provided in Section 8.07(b) and (n);

(e) Any expenses not specified in Section 8.07;

(f) Charges which are from an occupational Injury or Disease covered by any Workers' Compensation law or similar legislation;

(g) Charges considered an insured service of any Provincial Government Plan;

(h) Charges which would not normally have been incurred but for the presence of this Coverage or which the Plan Member or Dependent is not legally obligated to pay;

(i) Charges which the Insurer is not permitted, by any law or regulation, to cover;

(j) Charges for dental work where a third party is responsible for payment of such charges;

(k) Charges for Injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;

(l) Charges resulting from any intentionally self-inflicted wound;

(m) Charges for drugs;

(n) Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;

(o) Charges made by a Physician for travel, missed appointments, communication costs, filling in of forms, and/or Physician's supplies;

(p) Charges for vaccines and serums taken by injection or orally;

(q) Paramedical services are not covered unless performed by a practitioner with an approved designation (e.g. Osteopaths are covered, but osteopathic practitioners are not.);

(r) Charges which are not Medically Necessary to the care and treatment of any existing or suspected Injury, Disease or pregnancy; and

(s) Charges submitted prior to or after a claim has been deemed false.

8.09 **Extension of Benefits**

For Dependents of a Deceased Plan Member see Section 3.04(b).

8.10 **Coordination of Benefits**

See Section 2.13.

8.11 **Third-Party Liability**

See Section 2.14.

SECTION 9 - PLAN MEMBER'S & DEPENDENTS' PRESCRIPTION DRUGS BENEFIT POLICY #37217

9.01 Certificate Number

Any claim forms being submitted to ClaimSecure must contain the Plan Members "Certificate #" including claims for the Plan Member's Spouse or Dependents. The 10 digit certificate number is comprised of the Plan Member's Stakeholder number with the suffix EW (Electrical Workers) and applicable zeros in front to form a 10 digit number (i.e. 00**123456**EW).

Eligible Plan Members are provided with a drug card from ClaimSecure containing their Certificate Number.

9.02 Benefit

Under this Benefit, the Plan provides 90% of the covered expenses (ingredient and dispensing fee) for a Plan Member and his/her Dependents. The overall maximum Benefit is $10,000 per person per calendar year for a Plan Member or a Dependent.

9.03 Covered Expenses

Covered expenses include prescription drugs, medicines, diabetic medicines and birth control devices,

a) for the medically necessary treatment of Non-occupational Injury and/or Non-occupational Disease, and for pregnancy,

b) that can be obtained only upon the written prescription of a Physician or Dentist,

c) that have a drug identification number (DIN#), and

d) are dispensed by a registered pharmacist.

9.04 Lower Cost Alternative (LCA)

All prescriptions filled for drugs with a Lower Cost Alternative will have the LCA pricing applied to the claim, meaning that the claim will be eligible up to the amount of the LCA drug. If the Plan Member decides to purchase a product other than the LCA product, the Plan Member will be responsible for the amount in excess of the LCA product.

9.05 Biosimilar Drugs

Any drug with a biosimilar equivalent will be paid as a biosimilar drug. Biosimilar drugs accomplish the same therapeutic and clinical result of the LCA drug. If the Plan Member decides to purchase a product other than the biosimilar product, the Plan Member will be responsible for the amount in excess of the biosimilar product.

9.06 **Dispensing Fee Limitation**

The Plan has a maximum allowable Dispensing Fee of $13.00 per prescription. If the submitted Dispensing Fee is greater than $13.00, the Plan Member will be responsible for the amount in excess of $13.00.

Compound dispensing fees limited to the wholesale cost plus provincial markups.

9.07 **Special Authorization Drugs**

Special Authorization of specified drugs ensures that only drugs required for Medically Necessary treatments are covered. Special Authorization drugs are specified drugs that must meet the pre-established clinical review process referred to as a Special Authorization. Plan Members are required to complete a Special Authorization request form and provide supporting documentation from their Physician directly to ClaimSecure. The Special Authorization request will be reviewed by ClaimSecure's clinical team and the Plan Member will be advised if approval is granted.

Special Authorization is the process of selecting the right drug for the right person at the right time. The process ensures that drugs are prescribed and used only for approved indications. Higher cost drugs are reserved as a second line treatment, after prior therapy of more cost-effective drugs have proven unsuccessful.

ClaimSecure publishes a list of drugs that require Special Authorization along with the criteria for approval. This can be accessed through the ClaimSecure's website at: www.claimsecure.com/forms.

Plan Members are recommended to obtain/download a copy of the Special Authorization criteria and Special Authorization Request Form to take with them when visiting a doctor. Plan Members and their Physicians can then review and discuss the criteria before being prescribed a new drug. The form can be downloaded from the ClaimSecure website at: https://www.claimsecure.com/content/pdfs/en-CA/Forms/specialauth_en.pdf

Further details on the Special Authorization process can be found at: www.claimsecure.com/forms.

Special Authorization forms may be obtained by calling the ClaimSecure Customer Response Centre at 1-888-513-4464 or obtaining the forms off the ClaimSecure website at www.claimsecure.com.

This Plan, its eligibility requirements and Benefits, may be altered by the Trustees from time to time without the necessity of prior notice being served to those affected thereby.

9.08 Provided the requirements of section 9.02 for covered expenses are met, the following drugs are covered under the Plan:

(a) **Fertility Drugs**

Eligible Fertility Drugs are eligible to a lifetime maximum of $15,000.

(b) **Erectile Dysfunction Drugs**

Prescription drugs for erectile dysfunction have a maximum limit of $500 per person per calendar year.

(c) **Smoking Cessation Aids**

Prescription drugs for smoking cessation have a maximum limit of $500 per person per lifetime.

(d) **Birth Control**

Birth control drugs and any intrauterine device (IUD) are covered under the Plan, provided they are accompanied by a doctor's prescription.

(e) **Injectable Vitamins**

Are covered under the Plan if the vitamin requires a prescription in Canada and the drug is purchased through a registered pharmacy.

(f) **Diabetic Drugs**

The Plan provides 90% of the lower cost alternative for diabetic drugs (i.e. insulin).

(g) **Diabetic Supplies**

Will be reimbursed at 100% for test strips, syringes, needles and lancets, but limited to the wholesale cost plus allowable provincial markup as set for each province from time to time.

(h) **FreeStyle Libre System**

FreeStyle Libre Readers are payable at 90% and are limited to wholesale costs plus provincial markups. There will be a Reasonable and Customary fee applied on each Reader.

FreeStyle Libre Sensors are payable at 90% and are limited to wholesale costs plus provincial markups. The Plan allows a maximum of 26 sensors per person per calendar year.

(i) **EpiPens**

EpiPens are covered under the Plan. There is a maximum of $250 per person per calendar year.

(j) **Compound Drugs**

Compound drugs will be covered provided one of the ingredients in the compound drug contains a prescription drug. Compound dispensing fees are limited to the wholesale cost plus allowable provincial markup as set for each province from time to time.

(k) **Nitroglycerin Products**

Will be reimbursed at 90% of the LCA provided a doctor's prescription is received and the drug is dispensed through a registered pharmacy.

(l) **Steroids**

Will be reimbursed at 90% of the LCA provided the drug meets the requirements of Article 9.02.

9.10 Applying Drug Maximums

Prescription drug maximums are applied according to the date the prescription and/or medicine was purchased and not when the medicine was prescribed or will be used.

9.11 Deadline for Submitting Claims

Prescription receipts must be submitted to ClaimSecure within 12 months from the date of purchase.

9.12 Maximum Purchase Exemption

The Plan allows for the maximum purchase of a 100 day supply of prescription drugs.

Exceptions may be granted for over 100 days' supply subject to the following criteria:

- Up to a maximum of 200 days' supply available only for Plan Members or Dependents leaving the Province for more than 100 days;
- Only one authorization per calendar year; and
- A fully completed application being received by the Fund Office 7 business days prior to departure.

9.13 Exclusions

The following are not covered:

(a) Subject to the provisions of Section 9.12, a single purchase of prescription drugs and/or medicines which would not reasonably be consumed or used within 100 days;

(b) Prescription drugs and/or medicines received while in Hospital;

(c) Any drug and/or medicine which does not require a written prescription in Canada, such as, but not limited to, glucose tablets, diet foods, food supplements, aspirin, alcohol swabs, diabetic wipes, tape;

(d) Charges arising in connection with an occupational Injury or illness, if covered by Workers' Compensation;

(e) Serums and vaccines, whether taken by injection or orally;

(f) Prescription drugs in excess of their maximum limit;

(g) Unapproved experimental drugs;

(h) Charges for drugs, injectable drugs, or supplies which are not approved by Health Canada or are not approved for the purpose used or are experimental;

(i) Prescription drugs specifically excluded by the Board of Trustees; and

(j) Vitamins and minerals, except prescribed injected vitamins that require a written prescription in Canada.

(k) Allergy testing materials,

(l) Medicinal Marijuana;

(m) Pregnancy Termination Drugs;

(n) Injection service fees;

(o) Hair loss and weight loss drugs;

(p) Sclerotherapy

(q) Drugs used for cosmetic purposes.

9.14 **Quebec Residents**

The Plan will consider payment of prescription drugs in compliance with the Regie de l'assurance maladie du Quebec (RAMQ) for Plan Members and Dependents under age 65.

Plan Members and their Dependents who are 65 and over must maintain coverage through RAMQ. This Plan will be a supplementary plan to RAMQ and will only consider payment of non-RAMQ drugs in accordance with the rules and regulations of this Plan.

9.15 **Extension of Benefits**

See Section 3.04(b).

9.16 **Coordination of Benefits**

See Section 2.13.

9.17 **Third-Party Liability**

See Section 2.14.

SECTION 10 – PLAN MEMBER'S & DEPENDENTS' VISION CARE BENEFIT

10.01 Benefit

Under this Benefit, the Plan provides 100% of the covered expenses described under Section 10.02(a) and (c) for a Plan Member and his/her Dependents age 18 and over, to a maximum of $500 per person for expenses incurred during two consecutive calendar years. For Dependents under age 18, the Plan provides 100% of the covered expenses described under Section 10.02(a) for expenses incurred up to a maximum of $500 during every calendar year if required due to a change in prescription. The Plan also provides eye examinations under Section 10.02(b) to a maximum of $90 for expenses incurred once during every two calendar years.

10.02 Covered Expenses

(a) Prescription eyeglasses and/or contact lenses prescribed by an ophthalmologist or optometrist.

(b) Eye examination required for visual acuity and performed by an ophthalmologist or optometrist.

(c) Laser eye surgery for Plan Members and Dependents over the age of 18, who have the services performed by an ophthalmologist.

10.03 Exclusions

The following are not covered:

(a) Charges which are considered an insured service of any Provincial Government Plan; and

(b) Non-corrective lenses, frames purchased without prescription lenses, cleaners, cloths, sideshields, sunglass clips, and repairs to glasses and frames.

10.04 Extension of Benefits

For Dependents of a Deceased Plan Member see Section 3.04(b).

10.05 Coordination of Benefits

See Section 2.13.

10.06 Third-Party Liability

See Section 2.14

SECTION 11 – PLAN MEMBER'S & DEPENDENTS' DENTAL CARE BENEFIT

11.01 Benefit

The Dental Care Benefit pays 90% of the Schedule of Dental Fees. The maximum Benefit for all Class A and Class B Expenses combined is $3,000 per calendar year for a Plan Member or a Dependent. For Class C Expenses, a separate lifetime maximum of $2,500 for a Plan Member or a Dependent applies.

11.02 Covered Expenses

Covered expenses include the following dental services:

(a) **Class A Expenses:**

- Oral recall examinations, polishing and bitewing x-rays, but not more frequently than once every calendar year;
- Topical application of sodium or stannous fluoride;
- One full mouth series of dental x-rays every two calendar years;
- Extractions;
- Oral surgery, including excision of impacted teeth;
- Fillings;
- Diagnostic x-rays, laboratory procedures and anesthetics required in relation to oral surgery or other covered dental services;
- Treatment of periodontal and other Disease of the gums and tissues of the mouth;
- Endodontic treatment, including root canal therapy;
- Space maintainers including stainless steel crowns, but only if the crown is placed on a deciduous tooth which has several cavities that would otherwise require filling or is non-restorable using normal restorative dental material;
- Injection of antibiotic drugs by the attending Dentist;
- Repair and relining of dentures;
- Repair and/or recementing of crowns, inlays, onlays or bridgework; and
- Pit and fissure sealant treatment.

(b) **Class B Expenses:**

- Initial installation (including adjustments) of a removable partial or full denture to replace one or more extracted natural teeth, but separate charges for adjustments will only be included if they are incurred more than three months after the initial installation;

- Replacement of an existing removable partial or full denture/bridge by a new denture/bridge, or the addition of teeth to an existing removable partial denture/bridge to replace extracted natural teeth, but only if:

    i. satisfactory evidence is presented that the existing denture/bridge was installed at least 5 years prior to its replacement and that the existing denture/bridge cannot be made serviceable, or

    ii. the existing denture/bridge is an immediate temporary denture/bridge and replacement by a permanent denture/bridge is required and takes place within 12 months from the date of its installation;

- Inlays, onlays, gold fillings and crowns (including precision attachments for dentures, and including inlays, onlays and crowns to form abutments);
- Initial installation of fixed bridgework (including inlays, onlays and crowns to form abutments) to replace one or more extracted natural teeth;
- Replacement of existing fixed bridgework, or the addition of teeth to existing bridgework to replace extracted natural teeth, but only if satisfactory evidence is presented that the existing bridgework was installed at least five years prior to its replacement and that the existing bridgework cannot be made serviceable;
- Surgical preparation of dental ridges for prosthetic appliances; and
- If alternate services may be performed for the treatment of a dental condition, the covered expense will be the amount specified for the least expensive service and/or supply which will produce a professionally adequate result.

(c) **Class C Expenses:**

- Upon receipt of a treatment plan, orthodontic treatment rendered by orthodontists for the correction of malposed teeth; and
- If alternate services may be performed for the treatment of a dental condition, the covered expense will be the amount specified for the least expensive service and/or supply which will produce a professionally adequate result.

11.03 **Special Requirement**

X-rays may be required to be submitted to the Fund Office and will be returned promptly to the Dentist.

11.04 Predetermination of Benefit

When a Plan Member or his/her Dependent requires proposed dental treatment involving expenses over $750, it is recommended that a “Predetermination of Benefits” be submitted to the Fund Office before any of the services are performed.

A Predetermination of Benefits is a plan of dental treatment (including x-rays if required) showing the patient’s dental needs, a written description of the proposed treatment necessary in the professional judgment of the Dentist and the cost of the proposed treatment.

After reviewing the completed Predetermination of Benefits, the Fund Office will notify both the Plan Member and the Dentist of the estimated payment.

The submission of a Predetermination of Benefits is intended to avoid any misunderstanding as to the extent of Coverage. It permits the review of the proposed treatment in advance and allows for resolution of any questions before rather than after the work has been done. Additionally, both the Plan Member and the Dentist will know in advance what is covered and payable under the Plan. It is not intended to limit the Plan Member’s choice of Dentist, or to tell the Plan Member or the Dentist what treatment should be performed, or to suggest what fee should be charged.

11.05 Exclusions and Limitations

The following are not covered:

(a) Charges for services and supplies that are basically cosmetic in nature, including charges for personalization or characterization of dentures;

(b) Charges for the replacement of a lost or stolen prosthetic device;

(c) Charges for pantographic records;

(d) Charges for completion of claim forms;

(e) Charges for missed or cancelled dental appointments;

(f) Charges for nutritional counseling, oral hygiene instruction, and/or protective athletic appliances;

(g) Dental treatment received or started before the effective date of Coverage;

(h) Charges for any dental procedure which is paid for or otherwise provided for under any law of a government;

(i) Services and/or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants, other than implant related crowns, dentures and bridges which will be paid at the cost of a standard crown, denture or bridge;

(j) Services and/or supplies rendered for a full mouth reconstruction, for a vertical dimension correction, and/or for diagnosis or correction of a temporamandibular joint dysfunction;

(k) Consultations required by the attending Physician or Dentist; and

(l) Any dental charges paid for under Supplementary Health Expense Benefit, see Section 8.03(a).

11.06 **Extension of Benefits**

(a) For Dependents of a deceased Plan Member, see Section 3.04(b).

(b) After Coverage terminates, the Fund will pay for bridges, crowns, dentures, and the fitting thereof during the subsequent 90 days provided the device was ordered and the impression taken prior to Termination of Coverage. However, this Benefit is not provided if covered under another plan.

11.07 **Coordination of Benefits**

See Section 2.13.

11.08 **Third-Party Liability**

See Section 2.14.

SECTION 12 - PLAN MEMBER'S & DEPENDENTS' EMPLOYEE ASSISTANCE PROGRAM

12.01 Benefit

The Employee Assistance Program (EAP) is available to all Plan Members and their Dependents.

12.02 Coverage

The EAP is a confidential personal counseling and wellness service for eligible Plan Members and their Dependents, provided through TELUS Health. No one, including your employer, will ever know that you have used the program unless you choose to tell them.

EMPLOYEE ASSISTANCE PROGRAM

There are many ways to get help today – all completely confidential.

Through the EAP you and your eligible Dependents can receive support over the telephone, in person, online, and through a variety of health and wellness resources. For each concern you are experiencing, you can receive a series of private sessions with an expert. You can also take advantage of online tools to help manage your and your family's health. You'll get practical and fast support in a way that is most suited to your preferences, learning preferences, and lifestyle.

WHAT DOES THE PROGRAM OFFER?

Solutions for a wide range of life's challenges.

TELUS Health support related to:

Health	Tackle addictions	Nutrition support
• Identify Concerns • Prevent illness • Manage symptoms • Discover natural healing strategies • Create a plan for better health	• Alcohol • Tobacco • Drugs • Gambling • Post-recovery support	• Weight management • Boost energy and resilience • High cholesterol • High blood pressure • Diabetes • Heart disease
Manage relationships and family	**Financial Support**	**Legal support Services**
• Separation and divorce • Elder care • Relationship conflict • Parenting • Blended family issues	• Credit and debit management • Budgeting • Bankruptcy • Financial emergencies • Changing circumstances	• Separation and divorce • Civil litigation • Custody and child support • Wills and estate planning

Deal with workplace challenges	Find child and elder care resources
• Work-life balance • Conflict • Career planning • Bullying and harassment	• Maternity and parental leave • Adoption • Child care services • Schooling • Adult day programs • Nursing and retirement homes

TELUS HEALTH SERVICES

Referrals: You may contact TELUS Health any time to request a referral to a specialized consultant such as a legal or financial professional. These types of referrals require a scheduled call-back and the consultant can only leave a message if you grant permission to do so.

Research Requests: Requests or inquiries related to support groups such as elder care, childcare, community information and other unique requests, generally take three to five business days to process depending on the nature of the request. The Plan Member should specify if the request is urgent. Research can be provided directly to your email account.

Counselors: TELUS Health counselors are fully qualified professionals with a minimum of a Master's Degree in social work, psychology or related field. They are carefully screened and have a minimum of five years' experience in counseling.

Appointments: In any urgent situation, your consultant will connect you right away by phone with a Master's level counselor who can support you through a crisis. Depending on the urgency of your situation, TELUS Health may refer you to a counselor for in-person sessions immediately (same day), or the next business day. In a non-urgent situation, TELUS Health may refer you for telephone, in person or video counseling live via Webcam, depending on your preference and clinical appropriateness. Your counselor should connect with you within two business days to arrange an appointment that is suitable to your schedule.

Counseling Sessions: TELUS Health's counseling is flexible, short-term solution-focused and geared towards your specific and individual needs. Once your counselor has assessed your situation, their clinical team will work with your counselor to determine the appropriate number of sessions to provide within this short-term counseling model. In the event when counseling may be ongoing or long-term, your counselor will make treatment recommendations outside of the EAP and accessible in your community and will work with you to identify appropriate support.

Additional Costs: If you were to accept a referral for specialized counseling or to a service for ongoing support outside the EAP Benefit, you may be responsible for those costs. For example, if TELUS Health referred you to a counselor for long-term or specialized counseling you may incur fees charges by that specialist. Depending on your medical Benefits, you may have to cover those costs. Another example would be if you were referred to an attorney for a legal matter, your initial consultation would be free, but if you decided to retain ongoing legal professional services, that would be your financial responsibility. TELUS Health consultants will work with you to find you the most appropriate, cost-effective support and will inform you that you may incur costs if applicable.

Missed Appointments: TELUS Health Counselors require 24 hours' notice to cancel or reschedule an appointment. If you cancel with less than 24 hours' notice, or do not show up, you will be charged for a missed appointment, according to the individual counselor's cancellation policy.

TO ACCESS THE PROGRAM

With the innovative TELUS Health One app, you can access qualified support for your mental, physical, social, and financial wellbeing, any time, form anywhere.

- Search for resources and tools on topics ranging from family and life to health, money, and work;
- Receive support on your own schedule with CareNow;
- Access the Total Wellbeing Assessment to help identify your wellbeing strengths and opportunities for improvement.

Feel supported and connected wherever you are.

1. Download the free app on Android or iOS – simply search for 'TELUS Health One';

2. Open the app, click on 'Log in' and enter your shared log-in credentials or you may also visit your EPA program website at www.one.telushealth.com, using the

Username: ebfa

Password: mywellness

Telephone 24/7: English:1-877-207-8833

French: 1-877-370-1080

TTY: 1-877-371-9978

SECTION 13 - PLAN MEMBER'S YEARS-OF-SERVICE BANK BENEFIT

13.01 **Benefit**

A Retired Plan Member who meets the following requirements shall be entitled to 1.5 months of Coverage for each Year of Plan Membership since April 1, 1971, to a maximum of sixty (60) months.

13.02 The Years-of-Service Bank is only available at retirement.

13.03 Plan Members must maintain eligibility through hours reported for which Contributions were paid, or by making Self-Payments, for each and every month after January 2004. If the Plan Member loses eligibility even for one month their Years-of-Service Bank accumulated to the month of lapsed Coverage is lost.

13.04 If a Retired Plan Member who is covered by his/her Years-of-Service Bank becomes eligible for Coverage through re-employment, the Plan Member's Years-of-Service Bank is temporarily frozen, but additional hours worked for which Contributions were paid, or otherwise, will not increase his/her Years-of-Service Bank.

13.05 A Year of Plan Membership for the Years-of-Service Bank is defined as at least one month of Coverage in any one calendar year.

13.06 To establish a Retired Plan Member's Years-of-Service Bank, a one-time calculation will be performed by the Fund Office to the Plan Member's age 55 or his/her retirement date, whichever is later.

13.07 The Benefit Packages available for the Years-of-Service Bank, depending on the Retired Plan Member's age, are described in Section 4 - Self-Payment Provisions.

13.08 The provision of this Years-of-Service Bank and the rules relating to its eligibility requirements are expressly subject to the Board of Trustees' power to revoke or amend as deemed appropriate.

13.09 The Benefit Package for the Years-of-Service Bank will continue for the Plan Member's registered Dependents, in the event of the Plan Member's death.

SECTION 14 – PLAN MEMBER'S WEEKLY DISABILITY INCOME BENEFIT POLICY #6012

14.01 Benefit

A Plan Member who is not on Self-Payment or Years-of-Service Bank Coverage and becomes Totally Disabled will be paid the current approved weekly benefit amount after the first 8 days of disability. At the time of his/her disability, the Plan Member must be eligible through hours worked for which Contributions were paid.

14.02 Commencement and Duration of Benefit

(a) The Benefit is unavailable before the 8th day of disability; and, if the Plan Member qualifies for sickness benefits from Employment Insurance (E.I.) his/her Benefit will not commence until the Plan Member's E.I. sickness benefits are exhausted;

(b) The maximum payment duration for this Benefit is 51 weeks from the 8th day of disability (including the time for which E.I. sickness benefits are payable) or for as long as the Plan Member is disabled, whichever is shorter;

(c) Successive periods of Total Disability separated by less than two weeks of active employment, or availability for active employment, shall be considered as one period of disability, unless the subsequent disability is due to Injury or Disease entirely unrelated to the causes of the previous disability and commences after return to, or availability for, active employment; and

(d) A Plan Member must make sure to apply for E.I. sickness benefits as soon as he/she becomes disabled. If the Plan Member does not qualify for E.I. sickness benefits or Workers' Compensation benefits, he/she should contact the Fund Office immediately.

14.03 Exclusions

No Benefit shall be payable:

(a) For any disability resulting from intentionally self-inflicted injuries, whether the Plan Member is sane or insane;

(b) For any disability resulting from voluntary participation in war, riot or insurrection;

(c) Prior to the 8th day of a period of disability;

(d) For the period of disability during which the Plan Member, regardless of service, is entitled to pregnancy or parental leave by reason of statute, contract or agreement with their Employer;

(e) For any day on which the Plan Member is not under the care of a Physician; no period of care shall be considered to have started until the Plan Member has been seen and treated personally by a Physician;

(f) For any day on which the Plan Member is performing work of any kind, anywhere, for compensation or profit;

(g) For any day on which the Plan Member receives disability benefits under any Automobile Insurance Act;

(h) For a disability covered under any Workers' Compensation Law;

(i) For the portion of a period of disability during which the Plan Member is imprisoned in a penal institution or confined in a Hospital, or similar institution, as a result of criminal proceedings;

(j) For a disability incurred prior to a Plan Member's effective date of Coverage;

(k) For any period during which the Plan Member receives E.I. sickness benefits;

(l) For a period of E.I. sickness benefits which was disqualified because of late filing;

(m) For claims submitted after twelve months from the first date of the Plan Member's disability; or

(n) For expenses incurred by the Plan Member's Physician to complete a Disability Notice or Attending Physician Statement.

14.04 **Extension of Benefits**

If a Plan Member loses Coverage during their disability, the Plan Member's Weekly Disability Income Benefit will continue until the end of the Benefit period described in Section 14.02 or until the Plan Member recovers, whichever occurs first.

14.05 **Third Party Liability**

See Section 2.14.

SECTION 15 - PLAN MEMBER'S
LONG - TERM DISABILITY INCOME BENEFIT
POLICY #3602

15.01 **Benefit**

(a) A Plan Member who has been Totally Disabled for 52 consecutive weeks prior to age 60, will receive a Long-Term Disability Income Benefit of the current approved Benefit monthly amount.

(b) In addition to this monthly disability payment, a Plan Member who has been a Plan Member for at least ten years on their day last worked as an Employee shall have 85 hours per month of pension contributions made on his/her behalf to the Electrical Industry Pension Trust Fund of Alberta provided that the Plan Member:

- has worked at least 100 hours for which Contributions were paid in the three consecutive calendar months prior to his/her disability; and
- is not a pensioner of the Electrical Industry Pension Trust Fund of Alberta; and
- the pension contributions will cease at the end of the Plan Member's disability, or at the end of his/her Benefit period as described in Section 15.02, or when he/she becomes a pensioner of the Electrical Industry Pension Trust Fund of Alberta, or at age 60, whichever occurs first.

Note: For the purpose of Section 15.01(b), a Year of Plan Membership shall mean at least one month of Coverage in a calendar year.

15.02 **Commencement and Duration of Benefit**

(a) Basic provision:

- For Total Disabilities as a result of an Injury, the Benefit commences after the expiry of the 52 consecutive weeks of Total Disability and is payable until no longer Totally Disabled or until age 60, whichever occurs first; and
- For all other Total Disabilities, the Benefit commences after 52 consecutive weeks of Total Disability and is payable until no longer Totally Disabled, or for 10 years, or until age 60, whichever occurs first.

(b) A Plan Member will be considered Totally Disabled under the Long-Term Disability Income Benefit for the first 36 months following the date that the Plan Member ceased to work if he/she is incapacitated by an Injury or Disease to the extent that he/she is not able to perform any and every duty of his/her occupation or employment. After such 36 months, Totally Disabled shall mean the Plan Member is incapacitated to the extent that he/she is not able to perform any and every duty of any occupation or employment for which he/she is reasonably qualified by education, training or experience. Such incapacity must result from a medically determinable physical or mental impairment.

(c) A successive Total Disability is considered to be the same disability if separated by less than six months of active full-time employment. If, however, the Plan Member returns to active full-time employment for at least one full day and becomes Totally Disabled from a cause that is different and unrelated to his/her original disability, the Plan Member will begin a new 52 week waiting period for Long-Term Disability Income Benefits.

15.03 **Exclusions**

No Benefit shall be payable:

(a) To Plan Members who became Totally Disabled while on Self-Payment or while on Years-of-Service Bank Coverage;

(b) For any portion of a period of disability unless the Plan Member is receiving ongoing supervision and/or treatment by a Physician deemed appropriate by the Insurer for the impairment which is causing the disability;

(c) For any portion of a period of disability during which the Plan Member does not participate in the treatment program recommended by his/her Physician;

(d) For any portion of a period of disability resulting from substance abuse, including alcoholism and drug addiction, unless the Plan Member is participating in a recognized substance withdrawal program;

(e) For disability resulting from Injury or Disease which occurred while the Plan Member was on active duty in the armed forces of any country, state or international organization or for disability resulting from war or act of war, whether declared or undeclared;

(f) For disability resulting from participation in the commission of a criminal offence; however, this exclusion shall not serve to limit payment of Benefits for any offence under the Criminal Code of Canada related to the operation of a motor vehicle;

(g) For the portion of a period of disability during which the Plan Member is imprisoned in a penal institution or confined in a Hospital, or similar institution, as a result of criminal proceedings;

(h) For disability resulting from intentionally self-inflicted Injury or Disease or attempted self-destruction, whether the Plan Member is sane or insane;

(i) For a period during which the Plan Member is entitled to pregnancy leave by reason of statute, contract or agreement with her Employer;

(j) To a Plan Member who refuses to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending Physician or on the advice of independent medical opinion;

(k) For claims submitted later than six months after 52 consecutive weeks of Total Disability; or

(l) For any claims that are fraudulently submitted.

15.04 **All Source Maximum Benefit**

(a) A Totally Disabled Plan Member's monthly income from all sources as described in Section 15.06 cannot exceed 80% of his/her pre-disability Earnings.

(b) If the disabled Plan Member's total monthly income from all sources exceeds 80% of pre-disability Earnings, his/her Long-Term Disability Income Benefit will be reduced to a level which allows the monthly income from all sources to be 80% of pre-disability Earnings.

15.05 **Rehabilitative Employment**

(a) In order to promote rehabilitation, a disabled Plan Member who engages in any approved occupation to earn income will have his/her Long-Term Disability Income Benefits continue for up to 24 consecutive months from the date the Plan Member commences such approved rehabilitative employment, reduced by 50% of the income earned under rehabilitative employment.

(b) If the disabled Plan Member is participating in approved rehabilitation employment, his/her All Source Maximum Benefit as described in Section 15.04 cannot exceed 100% of pre-disability Earnings or his/her Long-Term Disability Income Benefit will be reduced accordingly.

15.06 **Total Monthly Income**

All sources of a disabled Plan Member's monthly income shall include:

(a) Long-Term Disability Income Benefit;

(b) Income from any pension plan;

(c) Income or benefits under any other plan or program provided by or through any employer;

(d) Income from Workers' Compensation;

(e) Any income or benefit payable under any other plan or program of any government or of any subdivision or agency of the government, including Employment Insurance benefits and any plan or program established pursuant to a provincial automobile insurance act;

(f) Income a Plan Member receives under a program of rehabilitation; and

(g) Any Canada Pension Plan or Quebec Pension Plan (Primary benefits) but not including any increase in such benefits by reason of a change in the Consumer Price Index after the commencement of the period of total disability.

15.07 **Extension of Benefits**

If a Plan Member loses Coverage during his/her disability, the Plan Member's Long-Term Disability Income Benefit will continue until the end of the Benefit period described in Section 15.02.

15.08 **Canadian Residency Requirement**

No Benefits are payable if the Plan Member resides outside Canada for any period exceeding 90 consecutive days or for a total of 180 days in a calendar year, unless:

(a) The Plan Member has previously notified, and received approval in writing from, the Insurer;

(b) The Plan Member remains under the regular care of a Physician deemed appropriate by the Insurer; and

(c) Proof of the ongoing disability can be determined on evidence satisfactory to the Insurer (in English or French) within 30 days of request.

15.09 **Third Party Liability**

See Section 2.14.

SECTION 16 - PLAN MEMBER'S QUESTIONS & ANSWERS

16.01 **Where do I find my Stakeholder Identification Number?**

Your Stakeholder Identification Number is issued to you by the Fund Office with your eligibility package. Your Stakeholder Identification Number differs from your Certificate Number used for claiming Prescription Drug Benefits (see Article 9.01)

16.02 **When do I need my Stakeholder Identification Number?**

You will have to provide your Stakeholder Identification Number on your non-prescription drug claims forms, on any correspondence submitted to the Fund Office, or when calling the Fund Office.

16.03 **When will I receive my eligibility package?**

The eligibility package will be mailed to you during the waiting period prior to eligibility.

16.04 **How soon can I become eligible for Benefits?**

If you have 150 hours or more reported in each of two consecutive months for which Contributions were paid, you will be eligible for Benefits on the first day of the fourth month.

16.05 **How soon can my Dependents become eligible for Benefits?**

Your Dependents become eligible for Benefits on the same day you do. Make sure that an updated Registration & Declaration of Beneficiary Form is on file at the Fund Office.

16.06 **Is my common-law spouse eligible for Benefits?**

Yes, for claims that arise after a continuous relationship of 12 months if the qualifications in Section 1.13(b)(ii) and Section 2.09(b) are met.

16.07 **Am I eligible for Benefits during periods of unemployment?**

You may continue to be eligible through the hours that you have accumulated in your Hour Bank. After your Hour Bank falls below 120 hours, you have the option to continue your eligibility through Self-Payment. However, the Fund Office must receive a Self-Payment Application and Preauthorized Debit Agreement prior to losing your Hour-Bank (eligibility terminating). See Section 4 for details.

16.08 **What happens if I forget to update my Registration & Declaration of Beneficiary Form?**

(a) If you do not update your address with the Fund Office, mail from the Fund Office will be mailed to your old address that we have on file for you;

(b) If you have a new Spouse/Dependent, claim payments would be delayed; and

(c) If you intended to change your Beneficiary, your existing Beneficiary would receive the applicable Benefits in case of your death.

16.09 **When are Employers required to report my hours worked?**

As per the Collective Agreement.

16.10 **When will I be notified of Self-Pay requirements?**

The Fund Office will forward documentation to the Plan Member in the month their Hour Bank is due to fall below 120 hours or whose Years-of-Service (YSB) may soon be fully utilized in order that that he/she may continue Coverage for the Plan Member and his/her Dependents by making Self-Payments in accordance with Section 4 of the Plan Rules.

16.11 **How can I secure my Years-of-Service Bank?**

You must maintain your Plan Membership each and every month, either through your Hour Bank or through Self-Payment.

16.12 **Am I entitled to Benefits while I'm traveling/working outside of Alberta?**

Yes, subject to the limitations of the Supplementary Health Expense Section and providing you are eligible for health benefits under a Provincial Government Plan. Certain restrictions apply, see Article 8.07(h) of the booklet.

16.13 **How, exactly, is an Hour Bank administered?**

For each month, the Employer must report the hours worked by an Employee, and the Fund Office records these hours for which Contributions were paid in the Employee's Hour Bank account. The overtime contributions received are divided by the straight time contributions and credited to the Employee's Hour Bank. An Hour Bank account is similar to an ordinary bank account, with hours being deposited and withdrawn instead of dollars. In order to pay for Coverage, (e.g. become a Plan Member), an Employee or former Employee has 120 hours withdrawn from their Hour Bank on a monthly basis. (See examples below.)

The following table shows the transactions for an Employee's initial eligibility:

Month	Account Balance at start of Month	Hours* Worked During Month	Hours Credited to the Hour Bank	Hours Deducted for Coverage	Balance of Hours in the Hour Bank
1	0	120	0	0	0
2	0	151	0	0	0
3	0	142	120	0	120
4	120	0	151	0	271
5	271	0	142	120	293
6	293	0	0	120	173
7	173	0	0	120	Insufficient
8	Insufficient	0	0	Insufficient	0

For an Employee who starts with an Hour Bank balance of 380 hours, the following table shows possible transactions for hours worked for which Contributions were paid:

Month	Account Balance at start of Month	Hours* Worked During Month	Hours Credited to the Hour Bank	Hours Deducted for Coverage	Balance of Hours in the Hour Bank
1	380	116	0	120	260
2	260	185	0	120	140
3	140	75	116	120	136
4	136	0	185	120	201
5	201	100	75	120	156
6	156	125	0	120	36
7	36	0	100	120	16
8	16	0	125	120	Insufficient
9	Insufficient	0	0	Insufficient	0

*Hours worked in any one month by an Employee for which Contributions were paid, as reported by the Employer in the second month and credited by the Fund in the third month.

16.14 **Is eligibility under a Provincial Government Plan required for all Benefits?** No. This requirement applies only for the Benefits provided under Supplementary Health Expenses.

16.15 **I hear much about privacy issues. What private information does the Fund Office require of me and my Dependents?**

The Fund Office requires you and your Dependents to provide:

(a) Your legal names;

(b) Your mailing address(es);

(c) Your birth date(s) – some Benefits are limited by age;

(d) Your Social Insurance Number(s) – your T4A Tax slip(s) require this;

(e) Your Personal Health Number(s) of a Provincial Government Plan – for eligibility verification;

(f) The name of your Beneficiary – in case of your death; and

(g) Co-ordination Statements

For more complete information about privacy issues, please see the Privacy Code available on the website.

16.16 **What can I do to deal with my or my Dependent's personal problems?**

Access your TELUS Health EAP 24/7 by phone, web, or mobile app.

1-877-207-8833 (English), 1-877-370-1080 (French), or TTY 1-877-371-9978

one.telushealth.com

16.17 **If I'm dissatisfied with the reasons from the Fund Office for rejecting my claim, to whom can I turn?**

You can write a letter to the Board of Trustees explaining your situation and extenuating circumstances. The Trustees will give consideration to your case at their earliest convenience, guided by the parameters of the Plan rules. See Article 2.20.

SECTION 17 - CLAIMS INSTRUCTIONS

17.01 To assist you in filing a claim with the Fund Office, you will find below a step-by-step outline of the procedures that you should follow. With the exception of your prescription drug claims, claim forms can be submitted through the Fund Office website www.ebfa.ca or by mail, facsimile, or electronically (claims@ebfa.ca) to:

EMPLOYEE BENEFIT FUNDS ADMINISTRATION LTD.
4211 - 95 Street NW
Edmonton, Alberta
T6E 5R6

FOR LIMITATION PERIODS OF CLAIM SUBMISSIONS SEE SECTION 2.04.

Note: Some claim forms are located on our website, at "www.ebfa.ca".

17.02 **Life Insurance**

(a) Notify the Fund Office immediately of the Plan Member's or Dependent's death.

(b) The Fund Office will forward the claim form required for completion.

(c) The completed claim form and a copy of the Funeral Director's Certificate of Death should be submitted to the Fund Office as soon as it can be obtained.

(d) The Life Insurance Benefit will be paid as soon as satisfactory proof of death is furnished to the Fund Office and the claim has been approved by the Insurer.

17.03 **Accidental Death and Dismemberment**

(a) Notify the Fund Office immediately of the Plan Member's accidental death or Loss.

(b) The Fund Office will forward the claim forms required for completion.

(c) The completed claim forms and a copy of the Medical Examiner's, Police and Toxicology Reports should be submitted to the Fund Office as soon as they can be obtained.

(d) The Accidental Death and Dismemberment Benefits will be paid as soon as proof of such Loss has been verified by the Fund Office and the claim has been approved by the Insurer.

17.04 **Weekly Disability and Long-Term Disability**

(a) Make application to Employment Insurance (E.I.) for sickness benefits in the first week of your disability.

(b) Obtain a "Disability Notice" from the Fund Office or its website.

(c) Complete your portion and have your Physician complete their portion. This should be done 2-3 weeks prior to your E.I. Sickness and Accident benefits terminating.

(d) Forward the form directly to the Fund Office along with a copy of your last E.I. sickness benefit pay-stub.

(e) Once the claim is processed and approved, payment will be issued.

17.05 **Supplementary Health Expense (Private Duty Nursing)**

(a) Obtain the applicable “Private Duty Nursing” claim form from the Fund Office.

(b) Ask your Physician for the monthly contract letter. A letter will also be required from the nursing agency.

(c) Contact the Fund Office for complete details regarding the documents required to claim for Private Duty Nursing.

17.06 **Supplementary Health Expense (Supplies and Equipment / Paramedical Expenses)**

(a) Obtain the applicable “Supplementary Health Expense” form from the Fund Office or its website.

(b) Complete your portion and have your Physician or health practitioner complete their portion.

(c) Attach your paid receipts (and proof of payment when required) or, if you wish to have payment made directly to the supplier, complete the assignment portion of the claim and attach an invoice.

(d) Send the completed form directly to the Fund Office.

(e) After the claim is processed, the Fund Office will issue payment for approved expenses.

17.07 **Supplementary Health Expense (Orthotics and Orthopedic Shoe/Boot Benefit)**

(a) Obtain the applicable “Supplementary Health Expense” form from the Fund Office or its website.

(b) Follow the instructions on the front of the claim form. Complete your portion and have your Physician or health practitioner complete their portion.

(c) Attach your paid receipts and proof of payment (credit card receipt, debit receipt, copy of bank statement) and send the form directly to the Fund Office. Claim payments will not be assigned.

(d) After the claim is processed, the Fund Office will issue payment for approved expenses.

17.08 **Prescription Drugs - Manual Claims**

(a) Obtain a Drug Claims Transmittal Form from the Fund Office or its website.

(b) Attach your paid prescription receipts and send the form directly to ClaimSecure or email your claim to service@claimsecure.com. You may also download and use ClaimSecure's mobile App to submit your claims. Claim payments will not be assigned.

(c) You must state the Policy Number "37217" on all claim forms.

(d) The Plan Member's Certificate Number must be shown on the claim form. See Article 9.01.

(e) ClaimSecure will issue payment for approved expenses.

17.09 **Dental**

(a) When you or your Dependents have incurred covered dental expenses, please obtain a "Dental – Direct Reimbursement" form from the Fund Office or its website, and have your Dentist complete their portion. We also accept completed standard dental claim forms from your dentist.

(b) A separate claim form must be used for the Plan Member and each Dependent.

(c) Complete your portion of the form and send it directly to the Fund Office.

(d) If you wish to have payments made directly to your Dentist, complete the assignment portion of the claim form.

(e) The Fund Office will issue payment for approved expenses.

17.10 **Vision**

(a) Obtain a "Vision – Direct Reimbursement" form from the Fund Office or its website.

(b) Complete your portion of the claim form using a separate claim form for the Plan Member or Dependent. Attach the prescription details from the provider to the claim form prior to submission.

(c) Attach your paid receipts and send directly to the Fund Office or, if you wish to have payments made directly to the provider, complete the assignment portion of the claim form.

(d) Once the claim is processed, payment for approved expenses will be issued.

17.11 **Forms**

Forms are available upon request from the Fund Office or on the website located at: www.ebfa.ca

SECTION 18 - PLAN HISTORY

Effective April 1, 1971

This Health & Welfare Plan is a result of Collective Agreements between Local Unions 254 and 424 of the International Brotherhood of Electrical Workers and the Electrical Contractors Association of Alberta. The Health & Welfare Plan is supported solely by Employer Contributions as specified in the Collective Agreements.

Since its inception, significant improvements have been made to the Health & Welfare Plan as follows:

Effective August 1, 1971

Benefits for Employees include $2,000 Life Insurance Benefit, $2,000 Accidental Death & Dismemberment Benefit and $100 Weekly Disability Income Benefit. Benefits for Employees and Dependents include Supplementary Health Expense Benefit including semi-private accommodation, major medical with 80% co-insurance and $5,000 maximum, prescription drugs with 80% co-insurance and Dental Care Benefits with 80% co-insurance for routine and 50% for major ($500 maximum per person per year).

Effective February 1, 1973

Plan Member's Life Insurance and Accidental Death and Dismemberment Benefits increase to $3,000 and a Vision Care Benefit with 80% co-insurance and scheduled allowances (50% for contact lenses) is added.

Effective April 1, 1974

Plan Member's Life Insurance and Accidental Death and Dismemberment Benefits increase to $15,000 and the Dental Care Benefit annual maximum increases to $1,000 per person per year.

Effective July 1, 1975

Plan Member's Life Insurance and Accidental Death and Dismemberment Benefits increase to $20,000 and vision schedule allowances increase by 20%. Hearing aid Benefit is introduced with a $250 lifetime maximum and orthodontic Benefit is introduced with 50% co-insurance and $1,000 per person per year maximum.

Effective February 1, 1976

Plan Member's Life Insurance and Accidental Death and Dismemberment Benefits increase to $25,000 and Long-Term Disability Income Benefits of $400 per month for a maximum period of 5 years is added. Major medical co-insurance increases to 100% (certain maximums apply).

Effective July 1, 1977

The Long-Term Disability Income Benefit increases to $640 per month and a Dependent Life Insurance Benefit of $5,000 for a spouse and $2,000 for children is added. Routine and major Dental Benefits increase to 100% of the 1977 Alberta Dental Association Fee Guide.

Effective January 1, 1978

The annual maximum Benefit for the routine and major Dental Care Benefits increase to $2,000 per calendar year.

Effective February 1, 1978

Dependent Life Insurance Benefit increases to $10,000 for Spouse.

Effective May 1, 1982

The Long-Term Disability Income Benefit increases to $910 per month and all Vision Care Benefits increase by 25%.

Effective October 1, 1984

Medical treatment obtained on a referral basis outside the Employee's province of residence is added.

Effective October 1, 1989

The Vision Care Benefit increases to $250 for each two calendar years for adults and $250 for each calendar year for Dependents under 18.

Effective January 1, 1990

The Long-Term Disability Income Benefit increases to $1,305 per month. Hearing aid Coverage increases to $750 every three calendar years.

Effective April 1, 1991

Plan Member's Life Insurance and Accidental Death and Dismemberment Benefits increase to $50,000.

Effective April 1, 1993

Long-Term Disability Income Benefit is changed to a maximum of 2 years of payments from 5 years. Reimbursement levels for the Prescription Drugs Benefit and Dental Care Benefit are reduced from 100% to 75%. The Vision Care Benefit is suspended.

Effective July 1, 1994

Initial eligibility changed from 2-3 consecutive months to 2-4 consecutive months, followed by a one-month waiting period.

Effective January 1, 1996

The Vision Care Benefit is reintroduced, and eye examinations are added at $40 every two calendar years. The Hour Bank deduction for one month of Coverage is increased from 100 hours to 110 hours and the Hour Bank maximum is increased from 600 hours to 660 hours.

Effective May 1, 1998

The maximum Long-Term Disability Income Benefit duration increases to 5 years. Reimbursement levels for Prescription Drugs Benefit and Dental Care Benefit Coverage is increased to 80%.

Effective January 1, 2000

Weekly Disability Income Benefit increases to $410 per week, Long-Term Disability Benefit increases to $1,775 per month, Vision Care Benefit increases to $300, and Prescription Drugs Benefit and Dental Care Benefit reimbursement levels increase to 85% of eligible expenses.

Effective January 1, 2001

Plan Member's Life Insurance and Accidental Death and Dismemberment Benefits for the Employee increase to $75,000, Vision Care Benefit increases to $350, eye examinations increase to $50 every two calendar years, and the maximum Dental Care Benefit per calendar year increases to $2,500 ($2,500 maximum per person per lifetime for Orthodontia). Orthotics is added.

Effective March 1, 2001

A Plan Member's and Dependents' Family Assistance Program Benefit is added.

Effective January 1, 2002

Vision Care Benefit increases to $400, and Prescription Drugs Benefit and Dental Care Benefit reimbursement levels increase to 90%. The Benefit period for Long-Term Disability Income increases from 5 years to 7 years. As part of the Long-Term Disability Income Benefit, the Health and Welfare Fund begins making contributions to the Electrical Industry Pension Trust Fund of Alberta for Future Hours Credit while receiving Long-Term Disability Income Benefit.

Effective October 1, 2002

A Years-of-Service Bank Benefit is added to provide eligible Plan Members at retirement or age 55, whichever is later, with 1.5 months of Benefits for each year of Health and Welfare Plan Membership since April 1, 1971, to a maximum of sixty months.

Effective January 1, 2003

The Long-Term Disability Income Benefit maximum duration for Injury due to accidental means is improved to age 60, or until no longer Totally Disabled, whichever occurs first, and for all other Total Disabilities to 10 years, age 60, or until no longer Totally Disabled, whichever occurs first.

Effective April 1, 2003

Schedule of Dental Fees for the Dental Benefits is increased by 3.67%.

Effective February 1, 2004

If a Plan Member loses eligibility for even one month, their Years-of-Service Bank Benefit accumulated to the month of lapsed Coverage is lost.

Effective July 1, 2004

Hearing Aid Benefit increases to $1,250 every 5 calendar years, Private Duty Nursing Benefit improves to $5,000 every 5 calendar years, and Out-of-Province/Country Emergency Coverage for all Retired Plan Members increases to 12 weeks.

Effective April 11, 2005

Overall maximum Prescription Drugs Benefit of $5,000 per calendar year for a Plan Member or a Dependent is added.

Effective October 1, 2005

Services of registered massage therapists and services of registered acupuncturists are added to Supplementary Health Expense Benefit. Schedule of Dental Fees is increased to a 2005 fee schedule. The Hour Bank deduction for one month of Coverage is increased from 110 hours to 120 hours and the Hour Bank maximum is increased from 660 hours to 720 hours.

Effective January 1, 2006

Prescribed injected vitamins are added to Prescription Drugs Benefit.

Effective January 1, 2007

Plan Member's Life Insurance and Accidental Death and Dismemberment Benefits increase to $100,000. Orthotic Boots Benefit of $1,200 every 3 calendar years and a Smoking Cessation Benefit of $500 per person per lifetime are introduced. Weekly Disability Income Benefit increases to $413 per week and Long-Term Disability Benefit increases to $1,790 per month. The overall maximum for Prescription Drugs Benefit increased to $7,500 per calendar year for a Plan Member or a Dependent.

Effective October 1, 2007

The Hour Bank maximum is increased from 720 hours to 1,080 hours. A deceased Plan Member's Coverage increased to at least six months.

Effective January 1, 2008

Services of a specialist under Supplementary Health Expense Benefit increase to $500 per calendar year. Weekly Disability Income Benefit increases to $463 per week and Long-Term Disability Benefit increases to $2,006 per month. The maximum Dental Care Benefit per calendar year increases to $3,000 (Orthodontia remains at a maximum per person per lifetime of $2,500). The overall maximum Prescription Drugs Benefit increases to $10,000 per person per calendar year for a Plan Member or a Dependent.

Effective April 1, 2009

Laser eye surgery performed by an ophthalmologist is added to Vision Care Benefit.

Effective August 20, 2009

Self-Payment provisions are modified to eliminate union approvals and to eliminate the previous maximum of 36 months.

Effective April 1, 2009

Schedule of Dental Fees is increased to a 2009 fee schedule.

Effective March 1, 2010

Schedule of Dental Fees is increased to a 2010 fee schedule.

Effective June 10, 2010

The aggregate limit of AD&D indemnity for all Losses resulting from any one aircraft accident is increased to $15,000,000.

Effective March 1, 2011

Schedule of Dental Fees is increased to a 2011 fee schedule.

Effective April 4, 2011

Effective May 1, 2011 - The overtime contributions received shall be divided by the straight time contributions and credited to the Employee’s Hour Bank.

Effective May 17, 2011

EpiPens are now a covered expense, subject to a limit of two per person, per calendar year. A Physician’s referral is required with the first EpiPen purchase.

Effective June 1, 2011

The aggregate limit of AD&D indemnity for all Losses resulting from any one aircraft accident is changed to $7,500,000.

Effective January 1, 2012

An Employee's hours worked will only be credited to his/her Hour Bank if Contributions were received for same.

Weekly Disability Income Benefit increases to $468 per week and Long-Term Disability Benefit increases to $2,028 per month.

Effective January 1, 2013

Plan Member's Life Insurance and Accidental Death and Dismemberment Benefits increase to $125,000.

Effective April 1, 2013 - 2016

Schedule of Dental Fees is increased to the current year's fee schedule.

Effective October 1, 2013

The aggregate limit of AD&D indemnity for all Losses resulting from any one aircraft accident is changed to $10,000,000.

Effective June 1, 2015

Life Insurance and Accidental Death and Dismemberment increased to $150,000. Long Term Disability amount increased to $2,269 per month. Weekly Disability amount increased to $524 per week. Vision Benefits increased to $500 and eye examinations increased to $90. NexgenRx Inc. became the prescription drug Administrator through electronic claims submission.

Effective January 1, 2017

Lower Cost Alternative pricing, dispensing fee limitation, Prior Authorization drugs introduced. Fertility drug maximum changed to $5,000 per year with a $15,000 lifetime maximum. Weekly Disability waiting period reduced from 2 weeks to 1 week.

Effective April 1, 2017 - 2018

Schedule of Dental Fees is increased to the current year's fee schedule.

Effective March 1, 2018

Self-Payments must be made using a Pre-Authorized Debit Plan Agreement.

Effective April 1, 2019

Schedule of Dental Fees is increased to the current year's fee schedule.

Effective April 1, 2020

Schedule of Dental Fees is increased to the current year's fee schedule.

Effective March 1, 2021

ClaimSecure became the new drug provider of the prescription drug benefits.

Fertility drug maximum changed to remove calendar year maximum, lifetime maximum remains at $15,000.

Effective April 1, 2021

Schedule of Dental Fees is increased to the current year's fee schedule.

Effective April 7, 2021

Compound dispensing fees limited to the wholesale cost plus provincial markups.

Effective July 4, 2021

Diabetic supplies limited to the wholesale cost plus provincial markups.

Effective November 1, 2021

EpiPen's will no longer require a Physician's referral.

Effective January 1, 2022

The FreeStyle Libre System Readers and Sensors will be a covered under the Prescription Drug benefit.

Effective April 1, 2022

Schedule of Dental Fees is increased to the current year's fee schedule.

A maximum purchase exemption may be granted for a travel supply of prescription drugs up to 200 days.

Effective May 1, 2022

A referral for paramedical services can be obtained from a Nurse Practitioner.

Effective October 1, 2022

Services of a Provisional Psychologist can be considered under the Psychological Benefit.

Effective November 2022

Dexcom (Continuous Glucose Monitor) systems and supplies moved to Prescription Drug Administrator for adjudication

Effective January 1, 2023

Schedule of Dental Fees is increased to the current year's fee schedule.

Effective January 1, 2024

Schedule of Dental Fees is increased to the current year’s fee schedule.

HEALTH AND WELFARE CONTRIBUTION RATES

REGULAR TIME

April 1, 1971	$0.15
April 1, 1974	$0.20
April 1, 1976	$0.25
May 1, 1977	$0.27 North
October 1, 1977	$0.27 South
December 1, 1978	$0.30
May 1, 1980	$0.40
May 1, 1981	$0.46
May 1, 1982	$0.51
November 1, 1982	$0.56
October 1, 1984	$0.60
October 1, 1989	$0.70
May 1, 1992	$0.85
June 21, 1993	$1.15
May 1, 1994	$1.22
May 1, 1999	$1.27
May 1, 2000	$1.37
May 10, 2001	$1.47
May 1, 2002	$1.52
May 2, 2005	$1.62
May 1, 2006	$1.72
August 12, 2007	$1.77
May 4, 2008	$1.82
May 3, 2009	$1.87
May 2, 2010	$1.92
November 2, 2014	$2.00
March 26, 2023	$2.15

APPENDIX A

Actively at Work shall mean a plan member is working for a Contributing Employer or is available for work.

Adherence shall mean use of service or supply in accordance with the terms for which it was prescribed.

Advisory Body shall mean Manulife Financial approved external experts that may provide Manulife Financial with recommendations, applying a Pharmacoeconomic or cost effectiveness evaluation.

Exclusive Distribution means Manulife Financial approved vendors.

Experimental or Investigational means not approved as an effective, appropriate and essential treatment of an illness or injury.

Pharmacoeconomics means the scientific discipline that compares the value of one pharmaceutical drug or drug therapy to another. Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by Manulife Financial.