

**ELECTRICAL INDUSTRY
INSURANCE BENEFIT TRUST FUND OF ALBERTA**

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ELECTRICAL INDUSTRY INSURANCE BENEFIT FUND OF ALBERTA

FOREWORD

To All Plan Members:

This Summary of Benefits is restated and updated as of January 1, 2012. 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 The Industrial Alliance Pacific Life Insurance Company, 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 I – 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 means a Section or Sections in this Summary of Benefits.

- 1.01 “**Administrator**” means the Board of Trustees established by the Trust Agreement.
- 1.02 “**Association**” means the Electrical Contractors Association of Alberta.
- 1.03 “**Bargaining Employee**” means a person who is an Employee working in the classifications of employment set out in the Collective Bargaining Agreement.
- 1.04 “**Beneficiary**” means the person(s) last designated by the Plan Member 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.
- 1.05 “**Benefit**” means a benefit derived from Coverage.
- 1.06 “**Benefit Package**” means the Benefits available through the Hour Bank, Self-Payments or Years-of-Service Bank.
- 1.07 “**Board of Trustees**” means the Trustees appointed under the terms of the Trust Agreement.
- 1.08 “**Collective Bargaining Agreement**” means 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”** means the monies paid or payable to the Fund by an Employer for hours worked by an Employee.
- 1.10 **“Convalescent Care Facility”** means 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 convalescent stage of an illness or Injury. Such institution must provide 24 hour nursing service and regular medical supervision. The term, convalescent care facility, 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.
- 1.11 **“Convalescent Care Services and Supplies”** means Room and Board, routine nursing care and such other services and supplies necessary to the health of patients as are generally provided by Convalescent Care Facilities. Convalescent care services and supplies shall neither include the services of a private-duty nurse or other private-duty attendant nor any service or supply which would not be provided to an inpatient of a Hospital.
- 1.12 **“Coverage”** means the entitlement to a Benefit Package under the Plan.
- 1.13 **“Custodial Care”** means that type of care which is designed essentially to assist an individual to meet his 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.
- 1.14 **“Dentist”** means a graduate of an accredited dental school who is duly licensed to practice dentistry.

1.15 **“Dependent”** means:

- (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.

The child must be:

- unmarried,
- not employed on a regular and full-time basis, and
- 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 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, on a yearly basis; OR
 - (iii) Functionally impaired, previously covered under Section 1.15(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 support and maintenance. Proof of incapacity must be provided within 31 days following the dependent's 21st birthday.
- (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 Card and statutory declaration with

the Fund Office. A common-law relationship must include continuous cohabitation in a conjugal relationship.

However, if a person qualifies under Section 1.15(b)(i) and another person qualifies under Section 1.15(b)(ii), then the person designated as spouse on the last Registration and Declaration of Beneficiary Card filed with the Fund Office shall be deemed the spouse for the purposes of this Plan.

- 1.16 **“Disease”** means 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.
- 1.17 **“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 Bargaining Agreement multiplied by the basic hourly wage rate for each particular Bargaining Employee in the wage rate classification to which he 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”** means Employee Benefit Funds Administration Ltd., the company charged by the Trustees to do the Fund’s administrative work.
- 1.19 **“Employee”** means any person who performs work for an Employer and for whom his Employer is obligated or permitted to make Contributions.
- 1.20 **“Employer”** means any employer who is required by a Collective Bargaining Agreement to make Contributions or any employer who makes Contributions with the approval of the Trustees.

- 1.21 **“Extension of Benefits”** means 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”** means the office of the Fund, presently located at #200, 4224 - 93 Street, Edmonton, Alberta, T6E 5P5.
- 1.24 **“Health & Welfare Fund”** or **“Fund”** means the Electrical Industry Insurance Benefit Trust Fund of Alberta established under the Trust Agreement.
- 1.25 **“Health & Welfare Plan”** or **“Plan”** means 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”** means 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”** means 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 his use while he 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”** means 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”** means the specific number issued by the Fund to each Plan Member and Dependent.
- 1.30 **“Injury”** means bodily injury to a Plan Member or a Dependent caused by external violent and accidental means.
- 1.31 **“Insurer”** means a company with whom the Trustees have a contract to supply Benefits.
- 1.32 **“Local Union”** means Local Union 424 of the International Brotherhood of Electrical Workers.
- 1.33 **“Local Union Member”** means a person who is a member in good standing of the Local Union.
- 1.34 **“Loss”** means, as used with reference to hand or foot, 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, complete severance at or above the elbow or knee joint; as used with reference to thumb and index finger, complete severance at or above the metacarpophalangeal joint; as used with reference to eye, the irrecoverable loss of the entire sight thereof; as used with reference to speech, the total and irrecoverable loss thereof; as used with reference to hearing, the total and irrecoverable loss thereof; and as used with reference to quadriplegia, paraplegia or hemiplegia, the permanent and irrecoverable paralysis of such limbs.
- 1.35 **“Loss-of-Use”** means permanent, total and irrevocable Loss which shall have been continuous for a period of twelve months from the date of the accident.
- 1.36 **“Medically Necessary”** means a particular medical treatment or expense that is broadly accepted and recognized by the Canadian medical profession as effective, appropriate, and essential, and is in accordance with Canadian medical standards. The Trustees and the

Insurers retain the discretion to determine whether or not a particular medical treatment or expense meets the foregoing definition.

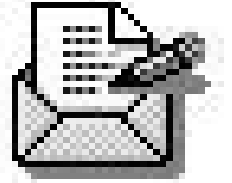
- 1.37 **“Non-bargaining Employee”** means an Employee who is not a Bargaining Employee.
- 1.38 **“Non-occupational Injury”** or **“Non-occupational Disease”** means any Injury or Disease that is not or is not normally covered under Workers’ Compensation, Employment Insurance, or similar law.
- 1.39 **“Physician”** or **“Surgeon”** means 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.
- 1.40 **“Plan”** – see definition of Health & Welfare Plan.
- 1.41 **“Plan Member”** means any person who is or was an Employee and who is eligible for Benefits through his Hour Bank (including a “frozen” Hour Bank), or his Years-of-Service Bank, or Self-Payments.
- 1.42 **“Plan Membership”** means the status of a Plan Member.
- 1.43 **“Provincial Government Plan”** means 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.
- 1.44 **“Reasonable and Customary Charge”** means 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.

- 1.45 **“Reciprocal Fund”** means another health & welfare plan or fund with which the Health & Welfare Fund has a reciprocal agreement or a reciprocity arrangement.
- 1.46 **“Retired Plan Member”** means a Plan Member age 55 or over who has maintained his Plan Membership since retiring and is no longer working in the electrical industry.
- 1.47 **“Room and Board”** means 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.
- 1.48 **“Schedule of Dental Fees”** means a schedule of fees approved by the Board of Trustees as updated and amended from time to time.
- 1.49 **“Self-Payment”** means the provision by which the Fund extends Coverage to a Plan Member and his Dependents when the Plan Member’s Hour Bank falls below 120 hours, or when his Years-of-Service Bank is fully utilized.
- 1.50 **“Stakeholder Number”** – see definition of Identification Number.
- 1.51 **“Summary of Benefits”** means the general description in this booklet of the Benefits provided subject to various insurance policies maintained by the Trustees.
- 1.52 **“Surgeon”** – see definition of Physician.
- 1.53 **“Termination of Coverage”** means 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.

- 1.54 **“Totally Disabled”** means:
- (a) When used under the Weekly Disability Income Benefit, the Plan Member is incapacitated to the extent that he is not able to perform any and every duty of his 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, he is incapacitated by an Injury or Disease to the extent that he is not able to perform any and every duty of his occupation or employment. After such 36 months, Totally Disabled shall mean the Plan Member is incapacitated to the extent that he is not able to perform any and every duty of any occupation or employment for which he 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 is not able to perform any work for compensation or profit and is not able to engage in any business or occupation.
- 1.55 **“Traveler”** means an Employee who has authorized the transfer of Contributions on his behalf to a Reciprocal Fund.
- 1.56 **“Trust Agreement”** means 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.
- 1.57 **“Trustees”** means the trustees established by, appointed under and acting in accordance with the Trust Agreement.
- 1.58 **“Year of Plan Membership”** means at least one month of Coverage in a calendar year.
- 1.59 **“Years-of-Service Bank”** or **“YSB”** means a Benefit available to a Plan Member at age 55 or retirement, whichever is later.

Wherever the singular and/or masculine and/or neuter is used throughout this Summary of Benefits, the same shall be construed as meaning the plural and/or feminine and/or a body corporate where the context so requires.

SECTION II – 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 V)
 - \$100,000
- (b) Plan Member's Accidental Death and Dismemberment Benefit (see Section VI)
 - maximum of \$100,000
- (c) Dependents' Life Insurance Benefit (see Section VII)
 - spouse \$10,000
 - children \$2,000
- (d) Plan Member's and Dependents' Supplementary Health Expense Benefit (see Section VIII)
 - 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 IX)
 - 90% of eligible prescription drugs
 - \$10,000 maximum per person per calendar year
- (f) Plan Member's and Dependents' Vision Care Benefit (see Section X)
 - Plan Members, and Dependents age 18 and over, maximum of \$400 for corrective lenses every two consecutive calendar years

- Dependents under age 18, a maximum of \$400 for corrective lenses every calendar year
 - Plan Members and Dependents, eye examination for visual acuity to a maximum of \$50 once every two calendar years
- (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 Dependent's Family Assistance Program Benefit (see Section XII)
- Personal counseling and advisory service
- (k) Plan Member's Years-of-Service Bank Benefit (see Section XIII)
- 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 XIV)
- A taxable disability benefit of \$468 per week from the 15th day of a Non-occupational Injury or Non-occupational Disease to a maximum of 50 weeks
 - integrated with Employment Insurance
- (m) Plan Member's Long-Term Disability Income Benefit (see Section XV)
- A taxable disability benefit of \$2,028 per month (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 prescription drug, supplementary health expense, vision care, and dental care claims (in English) within 12 months from the date the expense was incurred. Claims submitted 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 submitted within 90 days. For disability claims, refer to Sections XIV and XV.

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.

2.07 Correspondence

The Plan Member's Identification 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 begins a common-law relationship, a new Registration &

Declaration of Beneficiary card must be completed and forwarded to the Fund Office. Please refer to Section 1.15.

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**

For Plan Members who have a change of address, Dependent, or Beneficiary, it is important to notify the Fund Office immediately by completing a new Registration & Declaration of Beneficiary card.

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. Furthermore, Plan Members traveling outside of Alberta may have the ability to transfer contributions to this Fund. 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.

Dependents:

Spouse

- 2. The plan where the spouse is covered as a plan member.
- 3. This Plan.

Children

- 4. The plan of the parent with the earlier birthdate (month/day) in the calendar year.
- 5. The plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birthdate.
- 6. 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 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 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

If a Plan Member and/or any of his Dependents receives Benefits under this Plan for loss of income, medical expenses, dental expenses and/or prescription drug costs, for which there may be cause of action against a third party, the Fund and its Insurer (where applicable) are subrogated to any legally enforceable cause of action the Plan Member and/or any of his Dependents may have. Such a Plan Member and/or Dependent, and any Plan Member and/or Dependent receiving Benefits as described above who has a claim for benefits under Workers' Compensation legislation or any other applicable benefit plan, shall be required to complete a Reimbursement

Agreement that will entitle the Fund and its Insurer (where applicable) to be reimbursed for any amount(s), including interest, the Plan Member and/or any of his Dependents recovers from a third party or a Workers' Compensation Board or other benefits plan, for loss of income, medical expenses, dental expenses and/or prescription drug costs, which, together with any amount(s) paid or payable for the Benefits of this Plan, would exceed the Plan Member's and/or any of his Dependents' actual loss.

2.15 Personal Information Consent Form

It is a requirement of this Plan to provide to the Fund Office a completed Personal Information Consent 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 Medical Information Bureau (MIB)

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

The Insurer or its re-insurers may periodically report information to the MIB. For Plan Members or Dependents who apply to receive life, disability or health insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB upon request will supply the other insurer with the information on file.

The Insurer or its re-insurers may also release information in its file to other life and health insurance companies to whom Plan Members or Dependents may apply for insurance or submit a claim for benefits. All information obtained will be treated as confidential.

Upon request, the MIB will arrange disclosure of any information it may have on file. If there is a question concerning the accuracy of information in the MIB file, please contact the MIB and seek a correction. Their address is: MIB, 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7. Telephone: (416) 597-0590.

2.18 Assignment of Claims

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

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

2.20 Should a Plan Member knowingly submit a false claim, the Trustees may forthwith terminate the eligibility and entitlement to benefits of the Plan Member and his Dependents. 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 own client basis, resulting from the false claim.

SECTION III – ELIGIBILITY RULES



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 by working a minimum of 300 hours 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 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 his 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 his Hour Bank for a maximum continuous period of four months and his Coverage will continue during this period. A Plan Member must make an application to freeze his Hour Bank through the forms available from the Local Union or the Fund Office.
- (d) A Plan Member will have Coverage through his Hour Bank provided his Hour Bank contains at least 120 hours.
- (e) When a Plan Member's Hour Bank falls below 120 hours, he may choose to extend his Coverage through Self-Payments (see Section IV).
- (f) Retired Plan Members also have their Coverage extended through their Years-of-Service Bank Benefit under the provisions of Section XIII.

3.04 Termination of Eligibility for Benefits

- (a) A Plan Member's Coverage terminates:
 - (i) at the end of the month in which his Hour Bank falls below 120 hours; OR
 - (ii) at the end of the month for which his last Self-Payment was received by the Fund; OR
 - (iii) at the end of the month in which his Years-of-Service Bank is fully utilized; OR
 - (iv) at his death.
- (b) A deceased Plan Member's Coverage shall continue for his Dependents for the six calendar months following his death or until his Hour Bank falls below 120 hours, or until his 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 IV – 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 Coverage for himself and his 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 these Plan Members (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 V)
- (b) Plan Member's Accidental Death and Dismemberment Benefit (see Section VI)
- (c) Dependents' Life Insurance Benefit (see Section VII)
- (d) Plan Member's and Dependents' Supplementary Health Expense Benefit (see Section VIII)
- (e) Plan Member's and Dependents' Prescription Drugs Benefit (see Section IX)
- (f) Plan Member's and Dependents' Vision Care Benefit (see Section X)
- (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 XII)
- (k) Plan Member's Years-of-Service Bank Benefit (see Section XIII).

Note: A Plan Member's Self-Payments will be subsidized by 50% while he 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 Years-of-Service Bank Benefit may continue his 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 Years-of-Service Bank Benefit may continue his 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 Years-of-Service Bank Benefit may continue his 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**
Please note that 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, in a form provided by the Fund Office, together with his first Self-Payment to be received by the Fund Office prior to his loss of Coverage.
 - (b) Subsequent Self-Payments must be received by the Fund Office prior to the month of desired Self-Payment Coverage.
 - (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 the Plan Member regains Coverage through his Hour Bank, or at the end of the month when he fails to meet the provisions of Section 4.07(b).

SECTION V – PLAN MEMBER’S LIFE INSURANCE BENEFIT



5.01 **Benefit**

In the event of a Plan Member’s death, and provided the Plan Member was eligible, the Life Insurance Benefit of \$100,000 is payable to his Beneficiary.

5.02 **Extension of Coverage**

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

5.03 **Conversion Privilege**

If a Plan Member’s Life Insurance Benefit ceases because he loses eligibility for Coverage and he is under age 65 or has just attained age 65, the Plan Member is entitled to purchase an individual Life Insurance policy issued by the Insurer.

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:
 - (i) The amount of insurance not replaced under a replacing contract of group Life Insurance, or
 - (ii) \$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:
 - (i) non-convertible term insurance to age 65;
 - (ii) a permanent plan that the Insurer offers to the public at the time of conversion; or
 - (iii) 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:
 - (i) 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;
 - (ii) The class of risk to which the Plan Member then belongs; and
 - (iii) 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 VI – ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT



6.01 **Benefit**

This Plan provides Coverage for accidents which occur anywhere, at any time, on or off the job. The Plan Member will be covered, whether he is at home or traveling, including air travel as a passenger, pilot or crew member in any certified aircraft flown by a duly licensed pilot. This provision does not cover any Loss resulting from suicide, self-inflicted injury, or act of war. It also excludes any Loss suffered while on active service in the armed forces.

6.02 **Schedule of Payments**

This Plan provides for payment for Injury resulting in Loss, or permanent and total Loss-of-Use, which occurs within one year (365 days) of the date of accident as follows:

Life	\$ 100,000
Both Hands	\$ 100,000
Both Feet.....	\$ 100,000
Entire Sight of Both Eyes	\$ 100,000
One Hand and One Foot	\$ 100,000
One Hand and Entire Sight of One Eye	\$ 100,000
One Foot and Entire Sight of One Eye	\$ 100,000
Speech and Hearing	\$ 100,000
One Arm	\$ 75,000
One Leg	\$ 75,000
One Hand.....	\$ 67,000
One Foot	\$ 67,000
Entire Sight of One Eye	\$ 67,000
Speech or Hearing.....	\$ 67,000
Thumb and Index Finger of Either Hand	\$ 33,000
Hearing in One Ear	\$ 33,000

PARALYSIS BENEFITS

Quadriplegia	\$ 100,000
Paraplegia	\$ 100,000
Hemiplegia.....	\$ 100,000

Only one Benefit payment under the above schedule, the largest, is payable for all Losses resulting from one accident. If the Plan Member's Coverage is terminated, this

Benefit will be extended during the 31-day period following such termination.

OTHER BENEFITS (Please phone the Fund Office for details.)

Day Care Benefit.....	Up to \$ 5,000
Home Alteration and Vehicle Modification Benefit.....	Up to \$ 10,000
Occupational Training Benefit.....	Up to \$ 10,000
Rehabilitation Benefit	Up to \$ 10,000
Repatriation Benefit	Up to \$ 10,000
Special Education Benefit	Up to \$ 5,000

6.03 Accidental Death Benefit Payment

The Benefit of Accidental Death, \$100,000, is payable to the Beneficiary and is independent of and in addition to any payments under the Life Insurance Benefit.

6.04 Payment for Losses Other Than Accidental Death

Payment will be made to the Plan Member in accordance with Section 6.02.

6.05 Aggregate Limit

The policy is subject to an aggregate limit of indemnity of \$7,500,000 for all Losses resulting from any one aircraft accident. This means that in the event of an aircraft accident which results in an accumulation of Losses exceeding \$7,500,000 the amount payable with respect to each Plan Member will be reduced proportionately.

6.06 Third Party Liability

See Section 2.14.

SECTION VII – DEPENDENTS’ LIFE INSURANCE BENEFIT



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**

A Plan Member, or in the event of the Plan Member’s death his spouse, may convert the spouse’s (or former spouse’s) Life Insurance Benefit to an individual Life Insurance policy issued by the Insurer if the spouse (or former spouse) is under age 65 or has just attained age 65 providing:

- (a) The Plan Member’s Coverage ceases; or
- (b) The spouse’s Dependent status ceases.

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 his 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 VIII – PLAN MEMBER’S & DEPENDENTS’ SUPPLEMENTARY HEALTH EXPENSE BENEFIT



8.01 **Benefit**

This Benefit will help a Plan Member meet some of the medical bills incurred by him and his 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**

Covered expenses consist of Reasonable and Customary Charges for the following:

- (a) **Accidental Dental:** Necessary dental treatment for the prompt repair of natural teeth required as a result of a Non-occupational Injury external to the mouth that occurs while covered under this Plan;
- (b) **Ambulance:** Ambulance and/or emergency transportation by air when transported from the place where injured by accident or stricken by Disease to the nearest medical facility, or from a medical facility to a convalescent Hospital and, if medically required, a medical attendant. Ambulance transportation between medical facilities is not a covered expense;
- (c) **Convalescent Care Facility:** Limited to semi-private accommodation for 120 days for each period of disability when admitted within 14 days of Hospital confinement;
- (d) **Durable Medical Equipment, Aids and Prostheses:** Upon the recommendation of a Physician, provision of anesthesia, oxygen, blood and blood products, treatment by x-rays, radium and radioactive isotopes, artificial limbs, eyes, splints, trusses, crutches, fiberglass casts, orthopedic back supports, braces made of polyurethane and metal including replacement if replacement is required because of a change in the Plan Member’s or Dependent’s physical condition, rental of iron lung and other durable medical and/or surgical equipment, aids and

appliances required because of Injury to bodily organs or parts;

- (e) **Eye Examinations:** Eye examinations required for medical purposes performed by an ophthalmologist and/or optometrist;
- (f) **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;
- (g) **Orthotics:** Orthotics are limited to a maximum Benefit of \$400 per person in any calendar year. These supplies must be prescribed by a medical general practitioner or specialist, podiatrist or chiropodist (once every 5 calendar years);
- (h) **Orthopedic Shoes/Boots:** 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 orthopedic shoes/boots. The shoes/boots must be custom-made by the supplier and prescribed by a medical general practitioner, specialist, podiatrist or chiropodist (once every 3 calendar years);
- (i) **Out of Province/Country Expenses:** For emergency services only, semi-private accommodations in a Hospital subject to the following limitations;

Limitations of Out-of-Province/Country Coverage

- (i) 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 Dependents leave their province of residence.
- (ii) Plan Members and Retired Plan Members who accept an out-of-country work assignment with the approval of the Board of Trustees, 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.

- (iii) 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 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:
 - (iv) semi-private Hospital accommodation;
 - (v) the services of a Physician;
 - (vi) Hospital services and supplies furnished during hospitalization;
 - (vii) for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.
- (j) **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;
- (k) **Paramedical:** The services of a qualified osteopath, chiropractor, podiatrist/chiropract, 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 performed by a practitioner with an acceptable designation. (i.e. osteopaths are covered, but osteopathic practitioners are not.) Reasonable and Customary fees per visit apply. Coverage is provided for diagnostic x-rays ordered by one of the above, limited to \$50 per disability;
- (l) **Preferred Accommodation in Hospitals:** Semi-private accommodation;

- (m) **Private Duty Nursing:** Must be recommended by a Physician on a monthly basis and is limited to an overall maximum Benefit of \$5,000 per person every 5 calendar years.
- (n) **Psychological:** The services of a chartered, certified or registered psychologist, if recommended by a Physician, limited to a maximum Benefit of \$500 per person per calendar year, excluding any charges for marriage counseling, hypnotherapy, group therapy, testing of children for learning problems and parent interviews regarding children, services performed by provisional chartered psychologist or social workers;
- (o) **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 his 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 8.03(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;
- (p) **Speech Therapy:** Services of a duly qualified speech therapist, if recommended by a Physician, for services rendered out of a Hospital, limited to 20 treatments per calendar year per person;

- (q) **Support Stockings:** Elastic support stockings recommended by a Physician to a maximum Benefit of \$50 per person per calendar year provided that the stockings have a compression value of at least 20 millimetres of mercury pressure; and
- (r) **Smoking Cessation:** Aids that can be obtained only upon the written prescription of a Physician (excludes over the counter smoking cessation aids) to a lifetime maximum Benefit of \$500 per person.

8.04 Exclusions

The foregoing list of covered expenses excludes:

- (a) Charges which are considered an insured service of any Provincial Government Plan;
- (b) Charges for general health examinations, and examinations required for use of a third party;
- (c) Charges for a surgical procedure or treatment performed primarily for beautification, including charges for Hospital confinement for such surgical procedure or treatment;
- (d) Charges for medical treatment and surgical procedure by a Physician other than specifically provided in Section 8.03(i);
- (e) Charges for transport and/or travel, other than as specifically provided in Section 8.03(b) and (o);
- (f) Any expenses not specified in Section 8.03;
- (g) Charges for services and supplies which are furnished without the recommendation and approval of a Physician acting within the scope of his license;
- (h) Charges which are not Medically Necessary to the care and treatment of any existing or suspected Injury, Disease or pregnancy;
- (i) Charges which are from an occupational Injury or Disease covered by any Workers' Compensation law or similar legislation;
- (j) 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;
- (k) Charges which the Insurer is not permitted, by any law or regulation, to cover;
- (l) Charges for dental work where a third party is responsible for payment of such charges;

- (m) 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;
- (n) Charges resulting from any intentionally self-inflicted wound;
- (o) Charges for drugs;
- (p) Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
- (q) Charges made by a Physician for travel, broken appointments, communication costs, filling in of forms, and/or Physician's supplies; and
- (r) Charges for vaccines and serums taken by injection or orally.

8.05 Extension of Benefits

See Section 3.04(b).

8.06 Coordination of Benefits

See Section 2.13.

8.07 Third-Party Liability

See Section 2.14.

SECTION IX – PLAN MEMBER’S & DEPENDENTS’ PRESCRIPTION DRUGS BENEFIT



9.01 Benefit

Under this Benefit, the Plan provides 90% of the covered expenses for a Plan Member and his Dependents. Prescription drugs for erectile dysfunction have a maximum limit of \$500 per person per calendar year. The overall maximum Benefit is \$10,000 per person per calendar year for a Plan Member or a Dependent.

9.02 Covered Expenses

Covered expenses include prescription drugs, medicines, diabetic syringes and test strips and birth control devices, for the necessary treatment of Non-occupational Injury and/or Non-occupational Disease, and for pregnancy, that can be obtained only upon the written prescription of a Physician or Dentist and which are dispensed by a registered pharmacist. EpiPens will be limited to two EpiPens per person per calendar year and must be prescribed by a physician.

9.03 Exclusions

The following are not covered:

- (a) A single purchase of prescription drugs and/or medicines which would not reasonably be consumed or used within a three month period;
- (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 and alcohol swabs;
- (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 for erectile dysfunction in excess of \$500 per person per calendar year;
- (g) Unapproved experimental drugs;

- (h) Prescription drugs for smoking cessation. See Section 8.03 (r);
- (i) Charges for drugs, injectible drugs, or supplies which are not approved by Health and Welfare – Canada or are not approved for the purpose used or are experimental;
- (j) Prescription drugs specifically excluded by the Board of Trustees;
- (k) Vitamins, except prescribed injected vitamins that require a written prescription in Canada; and
- (l) Prescription drugs 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.

9.04 Extension of Benefits

See Section 3.04(b).

9.05 Coordination of Benefits

See Section 2.13.

9.06 Third-Party Liability

See Section 2.14.

SECTION X – 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) for a Plan Member and his Dependents age 18 and over, to a maximum of \$400 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 \$400 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 \$50 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

See Section 3.04(b).

10.05 Coordination of Benefits

See Section 2.13.

10.06 Third-Party Liability

See Section 2.14.

SECTION XI – 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:**

- (i) Oral recall examinations, polishing and bitewing x-rays, but not more frequently than once every calendar year;
- (ii) Topical application of sodium or stannous fluoride;
- (iii) One full mouth series of dental x-rays every two calendar years;
- (iv) Extractions;
- (v) Oral surgery, including excision of impacted teeth;
- (vi) Fillings;
- (vii) Diagnostic x-rays, laboratory procedures and anesthetics required in relation to oral surgery or other covered dental services;
- (viii) Treatment of periodontal and other Disease of the gums and tissues of the mouth;
- (ix) Endodontic treatment, including root canal therapy;
- (x) 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;
- (xi) Injection of antibiotic drugs by the attending Dentist;
- (xii) Repair and relining of dentures;

- (xiii) Repair and/or recementing of crowns, inlays, onlays or bridgework; and
 - (xiv) Pit and fissure sealant treatment.
- (b) **Class B Expenses:**
- (i) 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;
 - (ii) 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 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 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;
 - (iii) Inlays, onlays, gold fillings and crowns (including precision attachments for dentures, and including inlays, onlays and crowns to form abutments);
 - (iv) Initial installation of fixed bridgework (including inlays, onlays and crowns to form abutments) to replace one or more extracted natural teeth;
 - (v) 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; and
 - (vi) Surgical preparation of dental ridges for prosthetic appliances.
 - (vii) 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:

- (i) Orthodontic treatment rendered by orthodontists for the correction of malposed teeth; and
- (ii) 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 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 proposed course of treatment, 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 and his 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 temporomandibular joint dysfunction;
- (k) Consultations required by the attending Physician or Dentist.
- (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 XII – PLAN MEMBER’S & DEPENDENTS’ FAMILY ASSISTANCE PROGRAM BENEFIT



12.01 Benefit

A Family Assistance Program Benefit is available to all Plan Members and their Dependents. The Trustees have chosen a renowned and respected provider of human support services to provide this Benefit.

12.02 Coverage

The Plan Member’s and Dependents’ Family Assistance Program (EFAP) is a confidential personal counselling and wellness service for employees and their eligible dependents, provided through Human Solutions™.

YOUR EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

Everybody faces difficult or stressful events in their lives. Most of the time, we handle these personal issues fairly well. Other times, our personal issues can become large enough to interfere with our effectiveness and happiness both at home and at work.

Your EFAP provides totally confidential, professional counselling for a broad range of personal and family issues. While the program can be used for crisis intervention, the ideal time to use the program is before problems get out of hand.

The EFAP is a pro-active option for helping you manage your personal health and happiness.

What benefits are available to me?

Together, you and your dependents can receive short term counseling from a professional counselor either in person, over the phone or through our internet site www.humansolutions.ca.

WHAT DOES THE PROGRAM OFFER?

Counselling Services:

The EFAP program offers confidentiality, professional assessments, guidance, and counselling (and referrals when required) for personal difficulties such as:

- Career counselling
- Work related stress
- Relationship and family problems
- Separation/divorce/custody
- Financial and legal difficulties
- Alcohol and drug dependency
- Gambling and other addictions
- Eating disorders
- Difficulties with children
- Psychological disorders
- Anger management
- Sexual harassment and abuse
- Bereavement
- Aging parents
- Child/eldercare resources
- Retirement planning.

HOW DOES THE COUNSELLING PROGRAM WORK?

When you need to speak with someone, simply call Human Solutions™. Human Solutions™ staff will ask you for some basic information (to establish your eligibility for this benefit) and will help set up an initial appointment at a time and office location that is convenient for you. An experienced psychologist or counselor will help assess your concerns and aid you in developing practical solutions. All Human Solutions™ counsellors have extensive experience in helping individuals with their problems. If longer term counseling, hospital treatment or specialized services (such as medical, legal or financial help) are required, your counselor will arrange an appropriate referral and follow up with you.

PLAN SMART™ SERVICES

Plan Smart™ is a series of work life services that include caregiving, life planning, and health management services. Each of the services included in Plan Smart™ has been developed to allow you to take a proactive approach to managing everyday challenges and life transitions, and get the information and support you need to suit your unique situation. For the most part, all of these services are delivered by phone or online and often include a personalized package of information and useful tools with your best interests in mind.

The Plan Smart™ Services include:

Caregiver Services

- ✓ **New Parent Support** - *Provides individuals who have recently become or are about to become a new parent a support process designed to empower them with knowledge and skills.*
- ✓ **Childcare and Parenting** - *Provides support for parents who may be struggling with any number of parenting and family issues.*
- ✓ **Elder and Family Care** - *Providing support for employees caring for aging parents or loved ones.*

Life Planning Services

- ✓ **Financial Consultation** - *Helping employees enjoy financial peace of mind.*
- ✓ **Legal Advisory** - *Providing sound advice and peace of mind on legal matters.*
- ✓ **Career Counselling** - *Assists employees in identifying and articulating skills, aptitudes, values, personality traits, and interests as they relate to their career.*
- ✓ **Pre-Retirement Planning** - *Advance planning can help ensure a worry free retirement.*
- ✓ **Shift Worker Support** - *Helping make shift work easier and shift workers healthier.*
- ✓ **E-Learning Courses** - *Empower learners to better manage their personal health and expand work related skill sets.*

- You will have access to the latest in leading-edge learning with self-paced, confidential and interactive online courses, such as:
 - Taking Control of Stress
 - Taking Control of Your Mood
 - Responsible Optimism
 - Resilience
 - Foundations of Effective Parenting
 - Resolving Conflict in Intimate Relationships
 - Taking Control of Alcohol
 - Use Taking Control of Job Loss and Transition
 - Taking Control of Your Career
 - Embracing Workplace Change
 - Taking Control of Anger
 - Taking Control of Your Money
 - Stop Smoking: Get Your Life Back!
 - Leading the Human Side of Change
 - Values-Based Leadership
 - The Fundamentals of Effective Supervision
 - Managing Sensitive Employee Issues.

Health Management Services

- ✓ Smoking Cessation Program
- ✓ 12 Weeks to Wellness
- ✓ Nutritional Counselling
- ✓ Health and Wellness Companion
 - A personal health risk questionnaire
 - A Wellness Action Plan
 - A comprehensive health library

HOW DO I ACCESS THE E-SERVICES?

Go to www.humansolutions.com member's area.

Step 1:

- a) Log on to the Human Solutions web site:
www.humansolutions.ca
- b) Click on "Member Area"

- c) Click on your EFAP contact number. (Your number can be found on the brochure, wallet card or magnet provided)
- d) Click “Register”.

Step 2:

This will open the Register for Member Services page. First time users are required to complete the registration process. When you have completed all fields, you will be automatically logged in to the Member Services area.

Step 3:

When you arrive in the Member Services area, you will be able to access a variety of online services offered by your EFAP program. Links are provided in the navigation bar located at the left hand side of the screen. You will be required to confirm your enrolment and will be automatically logged in to the online service you have selected.

Step 4:

When you are finished accessing the online service, please remember to Log Out and close your web browser. For your convenience, an email will be sent to you containing instructions and an access code to log on to the Member Services area and access any of the online services which you might use in the future.

WHAT ABOUT CONFIDENTIALITY?

Human Solutions counselors are required by law to maintain the strictest confidentiality. Everybody who inquires about services available through their EFAP program will not be identified to anybody including their employer.

Crisis Line (available 24 hours a day, seven days a week)

In times of crisis and emotional distress, Human Solutions staff is prepared to take your call 24 hours a day, seven days a week. Help is always available. Signs of a crisis can include:

- Feeling overwhelmed
- Constant irritation or anger
- Abusing drugs or alcohol
- Thoughts of suicide or death
- Taking your frustrations out on people you love.

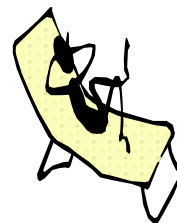
Whether in concern or in crisis, you and your family members are encouraged to take the first step, and access support through your Employee and Family Assistance Program.

WHO DO I CONTACT?

To speak to someone in confidence, call the Human Solutions™ number below. For crisis services (24 hours a day) or to book an appointment (regular office hours) call one of the following numbers:

Toll Free English	1-800-663-1142
Toll Free French	1-800-361-4858
TTY (Hearing Assistance)	1-888-384-1152

SECTION XIII – 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 or age 55, whichever is later.

13.03 Plan Members must maintain eligibility through hours worked 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 his 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 Years-of-Service Bank becomes eligible for Coverage through re-employment, his Years-of-Service Bank is temporarily frozen, but additional hours worked for which Contributions were paid, or otherwise, will not increase his 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 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 Sections 4.03 and 4.04.

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 XIV – PLAN MEMBER’S WEEKLY DISABILITY INCOME BENEFIT



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 \$468 per week after the first 14 days of disability. At the time of his 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 15th day of disability; and, if the Plan Member qualifies for sickness benefits from Employment Insurance (E.I.) his Benefit will not commence until his E.I. sickness benefits are exhausted;
- (b) The maximum payment duration for this Benefit is 50 weeks from the 15th 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.

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) For the first 14 days 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 his 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; or
 - (m) For claims submitted after twelve months from the first date of the Plan Member's disability.

14.04 **Extension of Benefits**

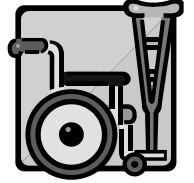
If a Plan Member loses Coverage during his disability, his Weekly Disability Income Benefit will continue until the end of the Benefit period described in Section 14.02 or until the Plan Member recovers, whichever occurs first.

14.05 **Third Party Liability**

See Section 2.14.

* **Note:** A Plan Member must make sure to apply for Employment Insurance sickness benefits as soon as he becomes disabled. If the Plan Member does not qualify for Employment Insurance sickness benefits or Workers' Compensation benefits, he should contact the Fund Office immediately.

SECTION XV – PLAN MEMBER’S LONG-TERM DISABILITY INCOME BENEFIT



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 \$2,028 per month.
- (b) In addition to this monthly disability payment, a Plan Member who has been a Plan Member for at least ten years on the day he last worked as an Employee shall have 85 hours per month of pension contributions made on his behalf to the Electrical Industry Pension Trust Fund of Alberta provided that:
 - (i) he has worked at least 100 hours for which Contributions were paid in the three consecutive calendar months prior to his disability; and
 - (ii) he is not a pensioner of the Electrical Industry Pension Trust Fund of Alberta; and
 - (iii) the pension contributions will cease at the end of the Plan Member’s disability, or at the end of his Benefit period as described in Section 15.02, or when he becomes a pensioner of the Electrical Industry Pension Trust Fund of Alberta, or at his 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:
 - (i) 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
 - (ii) 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 is incapacitated by an Injury or Disease to the extent that he is not able to perform any and every duty of his occupation or employment. After such 36 months, Totally Disabled shall mean the Plan Member is incapacitated to the extent that he is not able to perform any and every duty of any occupation or employment for which he 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 original disability, he 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 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; or
 - (k) For claims submitted later than six months after 52 consecutive weeks of Total Disability.

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 pre-disability Earnings.
- (b) If the disabled Plan Member's total monthly income from all sources exceeds 80% of pre-disability Earnings, his 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 Long-Term Disability Income Benefits continue for up to 24 consecutive months from the date he 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 All Source Maximum Benefit as described in Section 15.04 cannot exceed 100% of pre-disability Earnings and his 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:

- (i) Long-Term Disability Income Benefit;
- (ii) Income from any pension plan;
- (iii) Income or benefits under any other plan or program provided by or through any employer;
- (iv) Income from Workers' Compensation;
- (v) Income from Employment Insurance or primary Canada Pension Plan benefits (excluding CPP dependent amounts); and
- (vi) Income a Plan Member receives under a program of rehabilitation.

15.07 Extension of Benefits

If a Plan Member loses Coverage during his disability, his 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 XVI – PLAN MEMBER’S QUESTIONS & ANSWERS



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

Yours and your Dependents’ Identification Number is issued to you by the Fund Office with your eligibility package.

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

You will have to provide your Identification Number on claims forms and correspondence relating to your claim.

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 work 150 hours or more 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. However, make sure that an updated Registration & Declaration of Beneficiary card 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 1.15(b)(ii) and Section 2.09(b) are met.

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

Yes. Initially, you are eligible through your Hour Bank. After your Hour Bank falls below 120 hours, you can continue your eligibility through Self-Payment. However, you must apply for Self-Payment to the Fund Office and make your first Self-Payment before your Hour-Bank eligibility terminates. See Section IV for details.

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

- (a) If you have a new address, mail from the Fund Office could go astray;
- (b) If you have a new 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 Bargaining Agreement.

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

EBFA shall, one month in advance, notify a Plan Member whose Hour Bank may fall below 120 hours or whose Years-of-Service (YSB) may soon be fully utilized that he may continue his Coverage for himself and his Dependents by making self-payments in accordance with Section IV of the Plan Rules.

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

You must maintain your Plan Membership either through your Hour Bank or through Self-Payment.

16.12 Am I entitled for Benefits while I'm traveling 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.

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 shall be divided by the straight time contributions and credited to the Employee's Hour Bank. In some respects, 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 his Coverage, i.e., become a Plan Member, an Employee or former Employee has 120

hours withdrawn from his Hour Bank on a monthly basis. (See examples on the following page.)

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	53
8	53	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	21
9	21	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, and why?

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 at the Fund Office.

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

Call the Human Solutions Canada Inc. help line at:
1-800-663-1142 (English) or 1-800-361-4858 (French).

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 documents.

SECTION XVII – CLAIM 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 procedure that you should follow. Send all completed claim forms to:

**EMPLOYEE BENEFIT FUNDS
ADMINISTRATION LTD.
#200, 4224 - 93 Street
Edmonton, Alberta
T6E 5P5**

FOR LIMITATION PERIODS OF CLAIM SUBMISSIONS
SEE SECTION 2.04.

Note: Some claim forms are located 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 an original Death Certificate as issued by Vital Statistics 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.

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.

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 your Local Union Office, the Fund Office or its website.
- (c) Complete your portion and have your Physician complete his portion.
- (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 “Supplementary Health Expense” form or “Private Duty Nursing” form from your Local Union Office, the Fund Office or its website.
- (b) Ask the Hospital or health practitioner to complete the claim form.
- (c) Send this completed form directly to the Fund Office.
- (d) If you wish to have payments made directly to the Hospital or health practitioner, complete the assignment portion of the claim form.

Note: Some Hospitals may be able to provide a standard Hospital claim form and bill the Fund Office directly. You may wish to pursue this option.

17.06 Supplementary Health Expense (Supplies and Equipment)

- (a) Obtain the applicable “Supplementary Health Expense” form from your Local Union Office, the Fund Office or its website.
- (b) Complete your portion and have your Physician or health practitioner complete his portion.
- (c) Attach your original paid receipts or, if you wish to have payments made directly to the supplier, complete the assignment portion of the claim.
- (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 your Local Union Office, the Fund Office or its website.
- (b) Complete your portion and have your Physician or health practitioner complete his portion.
- (c) Attach your original paid receipts 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

- (a) Obtain a “Prescription Drug – Direct Reimbursement” form from your Local Union Office, the Fund Office or its website.
- (b) Attach your original paid prescription receipts and send the form directly to the Fund Office every 90 days. Claim payments will not be assigned.
- (c) The Fund Office 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 your Local Union Office, the Fund Office or its website, and have your Dentist complete his portion.
- (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 your Local Union Office, the Fund Office or its website.
- (b) Using a separate form for the Plan Member or Dependent, have the provider complete his portion including the prescription details.
- (c) Attach your original 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

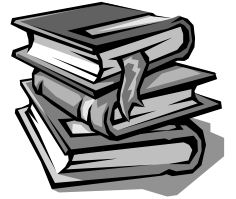
Forms available upon request from the Local Union Office, Fund Office, or at its website located at ‘www.ebfa.ca’:

- (a) Prescription Drug – Direct Reimbursement
- (b) Vision – Direct Reimbursement
- (c) Dental – Direct Reimbursement
- (d) Supplementary Health Expense (physiotherapy, chiropractic, psychological, osteopath, registered massage therapist, registered acupuncturist, naturopath, podiatrist, chiropodist and Christian Science practitioner)
- (e) Supplementary Health Expense (Supplies and Equipment)
- (f) Supplementary Health Expense (Orthotics and Orthopedic Shoes/Boots Benefit)
- (g) Disability Notice
- (h) Supplementary Health Expense (Private Duty Nursing)
- (i) Personal Information Consent Form.

Forms available upon request only from the Fund Office:

- (j) Life Insurance
- (k) Accidental Death and Dismemberment.

APPENDIX – HEALTH & WELFARE PLAN HISTORY



Effective April 1, 1971

This Health & Welfare Plan is a result of Collective Bargaining 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 Bargaining Agreements.

Since its inception, significant improvements have been made to your 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, his 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 November 1, 2009

Human Solutions Canada Inc. becomes the Plan's new provider of the Family Assistance Program Benefit.

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

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.

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 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.

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	\$0.27North
October 1, 1977	\$0.27South
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