YOUR GROUP HEALTH & WELFARE BENEFIT PLAN

SASKATCHEWAN PIPING INDUSTRY HEALTH AND WELFARE TRUST FUND

REVISED MARCH 1, 2022

This booklet contains important information and should be kept in a safe place for future reference.

Where to go for information

All requests for information or forms should be directed to:

The Administrator
Saskatchewan Piping Industry
Health and Welfare Trust Fund

Global Benefits
88 St. Regis Crescent South
Toronto, Ontario M3J 1Y8

Telephone: (416) 635-6000
Toll Free: (800) 810-2086
Fax: (416) 635-6464
Email: saskpipingbenefits@globalben.com

Include the following in your correspondence:

- Full name and **Member ID**, printed clearly.
- Home address and postal code.
- Telephone number.

UA Canada
National Wellness Program
Member Assistance Program

Did you know that UA Canada offers our members and their families free, confidential support to help with work, health and life challenges?

Visit **www.workhealthlife.com** or call **1.833.778.2627** 24/7 for assistance.

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INTRODUCTION

Since 1969, employers who are parties to the Collective Bargaining Agreements between The Unionized Piping, Plumbing and Heating Contractors Signatories to Agreements and The United Association of Journeymen and Apprentices of the Plumbing and Pipe fitting Industry of the United States and Canada, Local 179 have been contributing to the Saskatchewan Piping Industry Health and Welfare Trust Fund to provide benefits for eligible Union members where this is permitted by law.

The Fund is managed by a Board of Trustees, equally represented by the Union and by the Employers. The duties, responsibilities and authority of the Trustees are spelled out in the Trust Agreement, a copy of which is available for inspection at the office of the Local Union.

The Trustees appointed as Administrator:

Global Benefits
88 St. Regis Crescent South
Toronto, Ontario M3J 1Y8
Telephone: 416-635-6000
Toll Free: 800-810-2086
Fax: 416-635-6464
Email: saskpipingbenefits@globalben.com

to attend to the day-to-day administration of the Fund under the overall direction of the Trustees.

Since August 1, 1988, the Great-West Life Assurance Company (now Canada Life), has been appointed the underwriter of the full plan of benefits except for the Weekly Indemnity, Major Medical and Dental benefits. These latter benefits are provided on a self-insured basis by the Trust Fund with claim payments made by the Administrator.

The Plan of Benefits has been continually revised and updated to reflect the changing needs of the members and their families. This booklet contains a description of all Health and Welfare benefits as of March 1, 2022.

The Trustees hope that their efforts in developing a sound programme of protection for members and their families will be of real value to all concerned. We urge you to study this booklet carefully, in order to understand the benefits and your rights thereto. Should you have any questions regarding your benefits, do not hesitate to contact the Administrator where a member of their staff will be pleased to assist you.

Note that this booklet is current as of March 1, 2022. It has been prepared to give you an informal summary of the main features of your group insurance program.

This booklet is not an insurance policy, and does not grant or confer any contractual rights. The final determination of any claim, question or problem which may arise shall be governed by the provisions of the Insurance Policies, Plan Provisions, the Trust Agreement, and by applicable law.

This booklet is for your reference. Please read it carefully and keep it for future use.

Yours truly,
Board of Trustees

Global Benefits Online Access

Using the Global Benefits app or website portal, you can review your Schedule of Benefits booklet, submit a claim, sign up for direct deposit, view your contributions/hours, and more.

On the website portal only, you will be able to review and print T4As.

The username and password will be the same for both the website portal and the mobile app.

- **Website Portal**
  To activate this service
  you must register for Plan Member Online Access by clicking on the *Register Here* link at www.globalben.com

- **Global Benefits App**
  Download for iOS or Android
  Global's free app is optimized for both phone and tablet(iOS and Android).

  The app registration process is similar to the website registration process.

Once the registration setup is complete
you will receive an email asking you to confirm registration by clicking the link in the email. Following confirmation, you will receive another email with a link to personalize your password.

If you have any questions or concerns
call Global Benefits and ask for Online Registration.
416-635-6000 or 1-800-663-4500

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SUBJECT **PAGE**

1. SUMMARY OF BENEFITS

"A" – ACTIVE MEMBERS ONLY

1.	**Life Insurance:**	$100,000
2.	**Accidental Death and Dismemberment Insurance**	$100,000
3.	**Weekly Disability Income (Non-Occupational)**	
	Weekly Payment:	$500
	Payments Begin:	Accident – 1st day.
	Sickness or pregnancy	8th day from date of disability.
	Maximum Benefit Period:	26 weeks from date benefits begin, fully integrated with E.I. benefits.
4.	**Long Term Disability** (Available only to active United Association Members)	
	Monthly Payment:	$2,000
	Payments Begin:	After 26 weeks of total disability and in co-ordination with the expiry of the Weekly Disability and E.I. benefits.
	Maximum Benefit Period:	To age 65 or until retirement under the Saskatchewan Piping Industry Pension Plan, whichever occurs first.
	Offsets:	Benefit payments will be offset by any other disability or sick leave benefits (including CPP, Worker's Compensation, auto insurance or any others).

Maximum from all Sources	The total of the LTD benefits plus any income received plus any other disability income benefits received may not exceed 85% of your earnings when you were disabled.

5. Surgical Dismemberment Benefit

Members:	$50,000 principal sum

"B" – DEPENDENTS ONLY

1. Dependent Life Insurance:

Spouse	$20,000
Children	$10,000

C" – ACTIVE MEMBERS AND THEIR DEPENDENTS

1. Accidental Death and Dismemberment Insurance (24 Hour Coverage)

Members:	$100,000 principal sum
Spouses:	$20,000 principal sum

2. Major Medical Insurance (including Drugs, Nursing and other Medical Benefits)

Benefit:	Plan pays 85% of eligible expenses.
Annual Maximums:	$100,000 for you and each dependent (overall maximum).
Drugs Annual Maximum:	$15,000 for you and each dependent
Lifetime Maximums:	$25,000 – Nursing Care. HCSA:
Benefit:	Plan pays 85% of eligible expenses.

3. Dental Insurance

Dental benefits are based on the current Saskatchewan Dental Association Fee Guide.

a) Benefits other than for Orthodontics

Co-Insurance:	85%
Individual Maximum:	$2,500 each Calendar year

b) Orthodontic Benefits (for dependent children only)

Co-Insurance:	60%
Lifetime Maximum:	$3,000 per person

c) Implants

Co-Insurance:	85%
Annual Maximum:	$2,000 per person

"D" – PENSIONERS

A person who is a member of the United Association and is receiving a pension from the Saskatchewan Piping Industry Pension Plan.

Life Insurance:	$20,000 (effective Sep. 1, 2021, this will only apply to pensioners who are enrolled in the optional Retired Member's Health and Welfare Plan)
Major Medical Annual Maximums:	$100,000 for you and each dependent (overall maximum). $5,000 per individual (for Drugs)
Lifetime Maximums:	$25,000 – Nursing Care.

THESE BENEFITS ARE DESCRIBED IN MORE DETAIL ON LATER PAGES.

2. SUMMARY OF THE EMPLOYEE BENEFIT PLAN

To understand the Employee Benefit Plan, the following are some important definitions and explanations.

When did the plan start?

The Plan became effective on April 1, 1969.

Who are the contributing employers?

The Contributing Employers are those Employers who are parties to the Collective Bargaining Agreement, or who have signed the applicable Participation Agreement and have members in their employ. The Participation Agreement stipulates that such Employers shall now or hereafter make contributions to the Saskatchewan Piping Industry Health and Welfare Trust Fund to provide health and welfare benefits for those of their members subject to the various Agreements.

What are the categories of plan membership?

There are three main categories:

1. **Active United Association Members –** an employee for whom Contributing Employers are required to contribute.

2. **Pensioners** – a person who is a member of the United Association who is receiving a pension benefit from the Saskatchewan Piping Industry Pension Plan.

3. **Support Staff Members** – these are Union/Employer Support Staff.

Who is eligible to join the plan?

You will be eligible to join the plan provided you fall into one of the aforementioned categories.

In order to join the Plan, you must complete a Member Information Card and forward it to the Administrator. This

card will be given to you upon request at your Local Union office, or from the Administrator.

What contributions are to be made to the plan?

No contributions will normally be required from the member, unless self-contributions are being made (as described later). Each Contributing Employer will contribute monthly in respect of each member, at the rates stipulated in the pertinent Collective Bargaining Agreements in effect from time to time.

How do I become eligible?

You will become eligible for benefits on the first day of the second month following a period (of no more than six months) in which Contributing Employers were obligated to make contributions on your behalf for at least 420 earned hours, provided you are a member of the United Association. Also, for Non United Association Members, in order to become eligible for benefits, you must be employed as a Non United Association Member in that month. These hours will be accumulated in your Hour Bank and be used to provide coverage (as described later).

An example of commencing eligibility is as follows:

- If a member has 420 earned hours by March 31st, he will be eligible May 1st.
- If a member has 420 earned hours by April 15th, he will be eligible June 1st.

How do I continue to be covered?

After you have satisfied the initial accumulation of 420 hours, the Administrator will deduct 140 hours monthly from your Hour Bank in order to pay for your benefits for that month. Also, for Non United Association Members, you must be employed as a Non United Association Member during that month to be eligible for benefits in that month. If the number of hours for which contributions are remitted in a month exceeds 140, the excess will be maintained in your Hour bank in order to pay for coverage in months in which less than 140 hours of contributions are received.

Such excess hours will be accumulated in your Hour Bank until it reaches a maximum of 1,680 hours, which is sufficient to maintain full coverage for 12 months should you be unemployed for this period of time.

Excess hours over this amount are transferred to the general reserves of the Trust Fund.

Besides employer contributions, there are several other ways in which coverage can be continued:

1. Self-contributions – as described in the next section.
2. Trade School – on the approval of the Joint Training Committee, your Hour Bank will remain unchanged ("frozen") for two months.
3. Total Disability – if you are totally disabled and are in receipt of disability payments from Weekly Indemnity, Long Term Disability, accident disability insuranceor Workers' Compensation benefits, upon proper notification from the Union Office to the Administrator, your Hour Bank will remain unchanged ("frozen") indefinitely up to age 65.

Freezing of your Hour Bank (as mentioned above) is a system whereby premiums for the coverage are paid from the Trust Fund and your Hour Bank has no deduction from it during the period of freezing.

What happens if I am unemployed?

You will become "Out of Benefit" when your Hour Bank has a credit of less than 140 hours in it and, for Non United Association Members, at the end of the month you are no longer employed as a Non United Association Member. You will be notified by the Administrator when your personal credits are less than 140 hours. All members other than Non United Association Members may then make self-contributions to the Trust Fund through the Administrator's Office for a period of up to twelve months from the time the member goes out of benefit, provided he maintains his Union Membership. Weekly Indemnity and Long Term Disability Benefits are not covered while making self contributions.

The current monthly amount (subject to change by the Trustees) payable for self-contribution is:

- Regular Member without dependents – $90, with a 12-month coverage limit.
- Regular Member with dependents – $110, with a 12-month coverage limit.
- Retired Member in receipt of a pension and a member in good standing – $150, with lifetime coverage available.
- Surviving spouse of an active member – $110 untilage 65 and $150 after age 65, with lifetime coverage available. Major Medical and Dental benefits will be reimbursed under the active benefit plan prior to age 65 and under the retiree benefit plan after age 65.
- Surviving spouse of a retired member – $150, with lifetime coverage available. Major Medical and Dental benefits will be reimbursed under the retiree benefit plan.
- In the event of a conflict between more than one surviving spouse, the surviving spouse is the one listed on the Member Information Card on file with the Administrator.

All self-contributions must be received before the end of the month for which the payment is being made (otherwise coverage terminates effective at the beginning of that month).

For each month that self-contributions are made, your Hour Bank is increased by the number of hours which are required to provide coverage (140 hours). The normal deduction of 140 hours is then taken by the Administrator to pay forthe benefits (the net effect is that the Hour Bank remains unchanged).

What happens when I return to work?

If your coverage has been terminated for any reason, it will be reinstated on the first day of the second month following the date on which you have worked sufficient hours so that your Hour Bank has a credit of at least 280 hours, provided you are a member in good standing of the Union at that time.

For example, if your coverage terminated and you have 125 hours in your Hour Bank and you then earn an additional 155 hours by the end of April, you and your eligible dependents will again be covered on June 1st.

If no hours are credited to your account during any 12 consecutive months, then any reserve hours in your bank will be forfeited and you will become eligible for coverage upon completion of the initial eligibility requirement of 420 paid hours.

When will my coverage as an active member cease?

The insurance for you and your eligible dependents will terminate on the first to occur of the following:

1. the last day of the month in which you have less than 140 hours in your Hour Bank account, except if you elect to self-contribute as described earlier;
2. the last day of the month in which you ceased to be a member of the United Association;
3. the last day of the month prior to your retirement (if you are receiving a pension from the Saskatchewan Piping Industry Pension Plan); except that if you have hours in your hour bank account on your retirement date, the last day of the month in which you have less than 140 hours in your hour bank account; or
4. if you discontinue any required contributions (under the self-contribution options).

Dependent's coverage will also terminate when the dependent is no longer eligible as a dependent.

Some benefits have an extension of coverage provision which continues insurance for a specified duration (please refer to the Description of Benefits sections).

Pensioners' Life Insurance coverage continues for as long as you continue to receive a pension from the Saskatchewan Piping Industry Pension Plan and maintain your Union Membership.

Are my dependents covered?

Yes, your spouse and unmarried dependent children under age 21 and unmarried dependent, full time students up to age 25 will become eligible for benefits at the same time you become eligible for benefits.

Your spouse is the person to whom you are married or a person with whom you reside and whom you have represented as your husband or wife for at least one year. Only one person may qualify as your spouse at any one time.

An unmarried child who is wholly dependent on you for support and maintenance will be considered eligible if under age 21 or, under age 25 if in attendance on a full time basis at an accredited School, College or University.

Stepchildren, foster children and legally adopted children may be included the same as natural children provided they depend upon you for support and maintenance, it being understood that foster children are covered for benefits only to the extent that these benefits are not provided by a Government agency.

A child who is physically or mentally incapable of self-support may have coverage continued beyond age 21 provided the child remains incapacitated and unmarried,and subject to your own coverage continuing in effect. To continue a child under this provision, proof of incapacity must be received by the Administrator within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

Dependents confined in hospital will not become eligible until discharged from the hospital (except for newborn infants).

If you have eligible dependents, they must be enrolled on the proper forms. If you marry or have children, you must notify the Administrator by completing a new Member Information Card. It is your responsibility to notify the Administrator in

writing within 30 days of the date you acquire an eligible dependent or when a previously eligible dependent no longer qualifies.

No one will be eligible as a dependent while covered as a member under the Plan.

How do I appoint a beneficiary?

It is IMPORTANT to file with the Administrator a completed Member Information Card when initially joining the Plan and whenever any changes to it are required (as mentioned above).

The Card provides vital information on the member's name, SIN, address, date of birth and date of initiation. The most important information on the Card is the designation of beneficiary. The beneficiary designation can be revoked by filing with the Administrator a new Member Information Card. Each Card must be signed and dated by the member. The beneficiary on the Card with the latest date that was received by the Administrator prior to the member's death will usually be the final named beneficiary of the member, subject to the laws of the Province of residence.

The Member Information Card also provides information on the dependents of the member. This is especially important in determining the eligibility of certain health benefits. It is important that such information be updated by the member within 30 days of any change in dependents.

A supply of Member Information Cards can be obtained from the office of the Local Union or the Administrator's office.

What happens if I transfer my membership to another local?

Eligible members who are working on a permanent basis in another jurisdiction which maintains a current reciprocal agreement with this Plan may wish to transfer their Hour Bank balances to their new "Home" plan in order to effect

coverage or to avoid duplication of coverages. Upon written notification (an executed Travel Card Reciprocity Authorization by the member) to the Plan Administrator, such a transfer will be performed and the member will not be eligible for coverage under this Plan from the end of the month in which the transfer was made.

What if the same or similar benefits are paid under another plan as well?

The purpose of the medical and dental expenses insurance is to help meet the actual expenses of you and your family. You should not receive more from the Plan than your actual expenses. As a result, your benefits under the Plan may be reduced so that you will not receive more in benefits from "all plans" covering you and your dependents than your actual expenses. "All plans" include medical and dental care benefits provided under a law or governmental program and Group Insurance or other coverage for a group of individuals (including student coverage obtained through an educational institution above the high school level).

Are the contributions or benefits taxable income to me?

The current income tax regulations affecting the contributions and benefits are as follows:

1. Contributions made for Life insurance, Dependent Life insurance and AD&D insurance are taxable. However, the death benefits and dismemberment benefits arenot taxable. You will receive a T4A to report the contributions made as a taxable benefit and pay the taxes when your income tax return is filed.
2. Contributions made for Weekly Indemnity and Long Term Disability benefits are not taxable. However, Weekly Indemnity and Long Term Disability benefits received are taxable. Taxes will not be deducted from the benefits payable and you will need to pay taxes when your income tax return is filed. You will receive a T4A for any Weekly Indemnity or Long Term Disability benefits received.
3. Both the contributions made to and the benefits received from Major Medical or Dental are not taxable.

4. Self-contributions (i.e. Pay Direct) made for Major Medical or Dental may be tax deductible if they exceed 3% of your taxable income for the year. After the end of the year, you will receive a statement for the self-contributions made for Major Medical or Dental.

What happens if misleading or incorrect information is provided?

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

(a) refuse payment of every such benefit;
(b) deny coverage under the Plan;
(c) declare you and your dependents ineligible for any further benefits under the Plan unless you can establish that the information submitted was due solely to a bona fide error; and
(d) seek other remedies as allowed by law.

Which doctors may I use?

Any eligible services (described elsewhere in this booklet) can be performed by a licensed physician, dentist, optometrist, ophthalmologist, chiropractor, naturopath, osteopath, podiatrist or psychologist, practicing within the scope of his or her profession. A psychologist is considered licensed if certified or registered by the jurisdiction in which he or she practices.

Note: If, at any time during a period of total disability, you are totally disabled primarily because of a mental, psychoneurotic or personality disorder, the legally qualified physician must either specialize in the practice of psychiatric medicine or have, by reason of training and/or experience, a specialized competency in the field of psychiatric medicine sufficient to render the necessary evaluation and treatment of mental illness.

Which hospitals are covered?

A hospital is covered if it is a lawfully operated institution under the supervision of a staff of Physicians. Such institution must provide twenty-four hour a day nursing service and primarily be engaged in providing inpatient medical care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities on its premises. An institution is **not** covered if it or any part of it is:

(a) used primarily as a convalescent, nursing or rest facility; a facility for the care of the aged, or of drug addicts or alcoholics; or

(b) operated primarily as a school, or whose primary function is to furnish domiciliary or custodial care.

An institution is covered if it is accredited as a hospital by the Canadian Council on Hospital Accreditation or approved for resident inpatient care under a provincial hospital services program.

To be recognized as a convalescent hospital for insurance purposes, an institution must have a transfer arrangement with one or more hospitals and regularly provide skilled nursing care during the convalescent stage of an injury or disease and its charges for ward care for the individual are reimbursed under a provincial hospital plan. Unless they fully meet this definition, institutions for rest, the aged, custodial care, drug addicts, or for the care of pulmonary tuberculosis, mental illness or mental retardation do not qualify as convalescent hospitals.

Are expenses incurred while outside Canada covered?

The Expense Insurance coverages described in this booklet are limited to the Province of Saskatchewan. This means that any medical expenses incurred by you or your eligible insured dependents for **any kind of** treatment while travelling outside Saskatchewan will not be eligible under this plan.

However, the plan does cover up to $250 per family per year of reimbursement for the purchase of separate travel

insurance. You are encouraged to purchase your own separate travel insurance while travelling outside of Saskatchewan.

How do I claim benefits?

Global Benefits have been authorized by the Trustees and the Insurer to pay claims. Claim forms are available from either the Administrator's office or from the Local Union.

When making a claim, complete the appropriate sectionof the claim form (and also have the doctor fill it out, if necessary), attach all bills and receipts and forward them directly to the Administrator:

Global Benefits
88 St. Regis Crescent South
Toronto, Ontario M3J 1Y8
Telephone: (416) 635-6000
Toll Free: (800) 810-2086
Fax: (416) 635-6464
Email: saskpipingbenefits@globalben.com

To be eligible for payment, all claims should be submitted for processing within ninety (90) days of the date incurred.

3. DESCRIPTION OF BENEFITS

LIFE INSURANCE

In the event of your death from any cause while insured, the amount of your Life Insurance is payable to your beneficiary. You may change your beneficiary at any time by written notice to the Administrator, subject to any provincial laws.

In the event of the death from any cause of an eligible dependent while insured, the amount of the Dependent Life Insurance is payable to you.

Waiver of Premium for Disability

If you become totally disabled while insured and before age 65, your Life Insurance will be continued free of charge while you remain a member of the United Association until you cease to be totally disabled (however, coverage will reduce in accordance with the Schedule of Benefits at retirement). To qualify, you must be unable to work for compensation or profit or to engage in any business or occupation, and you must submit proof of your continuing disability as may be required by the Insurer.

Note: The first proof must be filed with the Insurance Company within 12 months following the date you cease active work. Subsequent proofs of disability must be furnished each year thereafter.

Conversion Privilege

Your Life Insurance continues for 31 days following the termination of your active member coverage due to either insufficient hours in your Hour Bank or a change to pensioner coverage. During this 31 day period you may convert the amount to your Life Insurance without medical examination, to an Individual Policy on any one of the regular plans(term insurance excepted) issued by the insurer at the rates applicable on that date.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

This benefit is payable in addition to the Life Insurance benefit on either your life or that of your spouse. Payment is made either to you, if living, or otherwise to your beneficiary.

Coverage is provided on a 24 hour basis without geographical restriction and regardless of whether the loss results from an occupational or non-occupational basis. This benefit will be paid (subject to certain exclusions) for the following losses resulting solely from accidental bodily injuries which occur while insured, provided the loss occurs within 365 days after the date of the accident.

Schedule of Benefits

Loss of Life	$100,000
Loss of Both Hands	$100,000
Loss of Both Feet	$100,000
Loss of Entire Sight of Both Eyes	$100,000
Loss of One Hand and One Foot	$100,000
Loss of One Hand and Entire Sight of One Eye	$100,000
Loss of One Foot and Entire Sight of One Eye	$100,000
Loss of Speech and Hearing	$100,000
Loss of One Arm	$75,000
Loss of One Leg	$75,000
Loss of One Hand	$66,000
Loss of One Foot	$66,000
Loss of Entire Sight of One Eye	$66,000
Loss of Speech or Hearing	$50,000
Loss of Thumb and Index Finger of Either Hand	$33,334

"Loss" as used with reference to hand or foot means complete severance at or above the wrist or ankle joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance at or above the first phalange; as used with reference to eye means the irrecoverable loss of the entire sight thereof; and as used with reference to speech and hearing means the total and irrecoverable loss thereof.

Exclusions

No loss is covered which results from:

(a) intentionally self-inflicted injuries, suicide or any attempt thereat while sane or insane;
(b) sickness, disease or infection (except bacterial infection) occurring as a consequence of an accidental cut or wound;
(c) travel in any type of aircraft aboard which you have any duties;
(d) war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military power; or
(e) full-time service in any military, naval or air service of any country.

SURGICAL DISMEMBERMENT BENEFIT

In the event of a surgical dismemberment required because of sickness, disease or infection, a lump sum benefit may be payable to you.

This benefit will be paid (subject to certain exclusions) for the following surgical amputations resulting solely from sickness, disease or infection which occur while insured, provided the loss occurs within 365 days after the onset of sickness, disease or infection.

Schedule of Benefits

Loss of Both Hands	$100,000
Loss of Both Feet	$100,000
Loss of One Hand and One Foot	$100,000
Loss of One Arm	$75,000
Loss of One Leg	$75,000
Loss of One Hand	$66,000
Loss of One Foot	$66,000
Loss of Thumb and Index Finger of either Hand	$33,334

"Loss" as used with reference to:

- Hand or foot means complete severance at or above the wrist or ankle joint.
- Arm or leg means complete severance at or above the elbow or knee joint.
- Thumb and index finger means complete severance at or above the first phalange.

Exclusions

No loss is covered if it is payable under the Accidental Death and Dismemberment Insurance or which results from:

(a) intentionally self-inflicted injuries, suicide or any attempt while sane or insane;
(b) travel in any type of aircraft aboard which you have any duties;
(c) war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military power; or
(d) full-time service in any military, naval or air service of any country.

WEEKLY DISABILITY INCOME

In the event you become totally disabled while insured due to a sickness or an injury which did not occur at work, you will receive a disability benefit, provided you are under the

continual treatment of a qualified and licensed physician. You are considered to be totally disabled if you are unable to perform any and every duty of your occupation.

Benefits for any one period of disability are payable from the first day of disability for a disability resulting from an accident and the eighth continuous day of disability for sickness.

Employment Insurance (EI) Integration

The Plan's benefits are coordinated with the Employment Insurance Commission's accident and sickness benefits. This means that the Plan will pay benefits during the EI waiting period (which is 7 days), the EI will pay the next 15 weeks, and if you are still disabled, the Plan will resume its payments to you. A copy of the EI rejection notice must be submitted if your claim for EI disability benefits is denied.

Maximum Benefit

The maximum period of protection during any one period of disability provided by the Plan will total 41 weeks. If you qualify for EI benefits, you are entitled to 15 weeks of EI plus the 26 weeks of disability from the Plan.

If you do not qualify for EI benefits, the Plan will pay benefits as long as you are disabled up to 26 weeks after you became disabled.

Recurrent Disabilities

Successive periods of disability separated by less than two weeks of full-time work will be considered one period of disability (and the 26 week maximum benefit period from your initial date of disability will apply). However, there is an exception to this rule if the subsequent disability is due to a different cause which begins while you are back at work (after having recovered from the initial disability).

Exclusions

Benefits are not payable for disabilities resulting from the following:

1. any period of sickness during which you are not under the care of a duly qualified physician;
2. disability resulting from injuries sustained while performing any act relating to any occupation or employment for remuneration or profit;
3. sickness for which benefits are payable in accordance with the provisions of a Workers' Compensation law or similar law;
4. any period of disability for which you are eligible, qualified or entitled to receive a benefit under the Unemployment Insurance Act; or
5. any disability existing before the effective date of your coverage.

Notes: Non-UA members are not covered for LTD. LTD is effective after 26 weeks Weekly Indemnity and 15 weeks Employment Insurance.

LONG TERM DISABILITY

Active members of the United Association, in the event you become totally disabled while insured prior to age 65 (or your retirement under the Saskatchewan Piping PensionPlan if earlier) due to a sickness or an injury, you remain totally disabled for at least 26 consecutive weeks and you areunder the continual treatment of a legally qualified physician or specialist, you will be eligible to receive monthly income benefits of $2,000, subject to certain exclusions and limitations and subject to co-ordination with the expiry of the Weekly Disability and benefits.

The Long Term Disability plan guarantees you $2,000 per month if you are receiving no other income or disability income benefits. The benefits payable from this plan will be limited so that the total benefit from this plan plus all other income (rehabilitation program, etc.) or disability income benefits (Canada Pension Plan, Auto Insurance, Workers' Compensation, etc.) will not exceed 85% of your monthly rate of earnings at your date of disability.

Such monthly income benefits for any one period of total disability will commence after the completion of the qualifying period of 26 weeks and will be payable until either the attainment of age 65 or your retirement date, if earlier, provided you remain continuously disabled.

Definition of Total Disability

You are considered totally disabled during the first 24 months in which you receive monthly income benefits if you are unable to perform any and every duty of your occupation. After this period you are considered totally disabled if you are unable to perform any and every duty of any occupation for which you are reasonably qualified by education, training or experience.

Recurrent Disability

If a disability recurs and it is due to the same or related causes, it will be considered as one continuous period of disability (and you will not be subject to the 26 week qualifying period) unless you have returned to active employment for a period of six consecutive months or longer.

If your new disability is due to causes unrelated to your prior disability, you may be eligible for a new disability period (and you will be subject to another 26 week qualifying period) if you have returned to active work for at least one full day.

Limitations and Exclusions

Benefits are not payable for disabilities resulting from the following causes:

(a) war (whether declared or not), insurrection, rebellion;
(b) chronic alcoholism or use of narcotics, barbiturates or hallucino-genic substances;
(c) your commission or, your attempt to commit, an assault or criminal offence;
(d) intentionally self-inflicted injuries; or
(e) in the case of disabilities resulting from pregnancy, benefits are not payable during the period beginning

with the tenth week prior to the week of the expected delivery and ending with the sixth week after the actual delivery date, or any longer period of maternity leave of absence that you have agreed to with your Employer.

If a period of total disability is due primarily to a mental, psychoneurotic or personality disorder, the period of total disability will terminate 24 months after it commences, unless you are confined as an in-patient in a hospital (subject to the normal age 65 or retirement termination of benefits).

Rehabilitative Employment

If you are disabled, you will be given every encouragement to undergo some suitable rehabilitative training program which would take into account the nature and limitations of your disability. Rehabilitative employment can include your regular occupation on a part-time basis, a formal vocational training program or any other training program deemed suitable by the Insurance Company.

With insurance company agreements, you can continue receiving LTD benefits for a limited time while performing some type of work. Thus you may get back into a gainful occupation with the assurance that for a specified period you will not lose your eligibility for benefits even though working. During this period, your monthly LTD benefitwill be your regular payment less 50% of your earnings from the rehabilitative job. Working under an Approved Rehabilitative Program is to your advantage as you will receive a greater total income than if you had not made the effort to rehabilitate yourself.

In addition, certain expenses of a vocational rehabilitation program may be paid. If the insurance company determines that a program that should make you self- supporting is within your ability, you will be notified of the type of expenses covered and the conditions for payment. If you agree to undertake the program, the charges for the covered expenses will be paid up to a maximum of $10,000.

MAJOR MEDICAL

The Plan pays toward the cost of reasonable and necessary medical expenses of you and your dependents which are prescribed by a doctor.

In the event that, while covered under the Plan, you incur any of the Eligible Expenses listed below, you will be paid 85% of such expenses, subject to the limitations and exclusions.

Maximum Benefit

The limitations imposed by the Plan for yourself and for each covered dependent are:

(a) up to $25,000 of Nursing Expenses;
(b) an annual maximum of $100,000 for all expenses.

On January 1st of each year, the amount which has been counted against the Maximum Nursing Benefit of each family member (and not previously reinstated) will be automatically reinstated up to $2,000. No evidence of good health is required for this automatic reinstatement but it is not available after the coverage has terminated. Reinstatement of the maximum may be requested by furnishing satisfactory proof that the individual is in good health.

Eligible Expenses

The following is a list of eligible expenses:

1. **Hospital Expenses in Canada**

   The difference between the charges made for ward and semi-private room and board in a licensed Canadian hospital. User fees are covered where not prohibited by Provincial Law.

2. **Prescription Drug Expenses**

   Any medically necessary drug or medicine which by law requires a physician's prescription for purchase including oral contraceptives and vaccinations and immunizations for preventive treatment of communicable diseases. Your administrator will

provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

Note: Eligible expenses do not include any charge for off-the-shelf preparations which may be purchased without a doctor's prescription (e.g. vitamins, minerals, foods and dietary supplements).

3. Professional Ambulance Service

Professional Ambulance Service when used to transport the individual from the place where he is injured by an accident or stricken by a disease to the first hospital where treatment is given, or from a hospital to a convalescent hospital. No other expenses in relation to travel are included.

4. Travel Insurance

Charges for the purchase of travel insurance will be reimbursed subject to a maximum benefit of $250 per calendar year per family.

5. Out-Patient Care

Charges made by a hospital while the insured person is an out-patient of a hospital for the following services and supplies:

(a) use of an examination or operating room;
(b) drugs, dressings or casts; and
(c) anesthesia in connection with the performance of a surgical procedure;

provided, however, that no benefit shall be payable with respect to charges made by a resident physician orintern of a hospital.

6. Convalescent Hospital Expenses

Charges for a licensed Convalescent Care Facility subject to a maximum expense of $10 per day and 120 days of confinement per disability.

7. Nursing Care

Charges for the services of a registered nurse (R.N.), licensed practical nurse, certified nursing assistant (C.N.A.) or a member of the Victorian Order of Nurses (V.O.N.) which are rendered in the patient's home, provided such nurse is not a resident in your home, or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and only if it is medically necessary.

Note: The lifetime maximum for nursing care is $25,000 with automatic reinstatement up to $2,000each calendar year.

8. Other Health Practitioners Services (for Active Members only)

(a) Charges for the services of a licensed chiropractor, osteopath, naturopath, massage therapist or podiatrist up to a maximum Eligible Expense of $50 per visit to a maximum of $500 per calendar year (per type of practitioner for these services). Also included are charges for diagnostic X-rays ordered by the practitioner up to a maximum of $25 per disability.

(b) Charges for the services of a licensed physiotherapist provided such services have been prescribed by a physician to a maximum of $50 per visit to a maximum of $500 per calendar year.

(c) Charges for the services of a licensed clinical psychologist provided such services have been prescribed by a physician up to a maximum of $600 per individual per calendar year.

9. Accidental Dental Treatment

Charges for necessary dental treatment required as the result of an accidental injury, while insured, tosound natural teeth. Only charges directly related tothe accidental injury are considered a covered medical expense and the dental work must be completed within 12 months of the accident.

10. Other Services and Supplies

The charges for the following medical services and supplies are covered:

(a) Rental (or, at the Administrator's option, purchase) of an iron lung, oxygen, hospital bed, wheel chair, electronic heart pacemaker, or other durable medical or surgical equipment required for therapeutic purposes and as approved by the Trustees.

(b) Rental (or, at the Administrator's option, purchase) of casts, splints, trusses, braces, crutches and prostheses (artificial limbs, eyes, larynx, etc.).

(c) Laboratory tests and X-rays not covered by any provincial government plan.

(d) Anesthesia, oxygen, blood and blood products.

(e) Diagnosis and assessment, but not treatment, by a psychologist.

(f) Medical reports up to a maximum of $200 per calendar year.

11. Hearing Aid Expenses

Charges for cost and installation including charges for replacement and repair subject to the recommendation of a physician certified as an otolaryngologist. Maximum allowable expenses are $1000 per person in any period of five consecutive years.

12. Orthopaedic Shoes

Charges for orthopedic shoes and special foot appliances which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment. Charges for orthopedic shoes are limited to a maximum benefit of $300 per calendar year and charges for orthotics are limited to a maximum benefit of $300 per calendar year. Both are for active members only.

13. Vision Care Expenses

Charges for vision care as follows:

(a) Single vision, bifocal or trifocal lenses (other than

contact lenses) or safety glasses prescribed by an ophthalmologist or optometrist, as required.

(b) Contact lenses, prescribed by an ophthalmologist or optometrist to a maximum eligible expense of $350 every 24 months.

(c) One set of frames for each person during any period of twenty four months (twelve months for a person under 18 years of age) up to a maximum eligible expense of $350.

(d) One set of safety glasses during any period of twenty four months up to a maximum eligible expense of $350.

(e) Eye examinations are covered up to a maximum of $100 every 24 months.

No benefits are payable for:

(a) Sunglasses (plain or prescription) or tinted glasses with a tint other than number one.

(b) Anti-reflective coatings.

14. Laser Eye Surgery

In the event that a member has laser eye surgery, the cost is covered up to a lifetime maximum of $1,000 without any reduction to the benefit for other vision care expenses.

15. Health Care Spending Account (HCSA)

Eligible active members may use their account to pay for medical expenses that qualify as a Medical Expense Tax Credit under the Income Tax Act of Canada. Note that this HCSA is not allowed to be used to cover any plan deductibles. The maximum amount allowed is $500 per calendar year. If the entire $500 amount is not used during the calendar year, then it may be carried over to the next calendar year but may not be carried over to a second calendar year. The medical expense may be for the active member or for one of his dependents and it must be a medical expense not otherwise covered by your provincial health insurance plan nor by your spouse's life & health plan, if any.

Exclusions

The foregoing list of eligible expenses shall exclude all of the following:

1. Charges which are considered an insured service of any federal, provincial or municipal government plan.
2. Charges not specified in the list of eligible expenses.
3. Charges which would not normally have been incurred but for the presence of this Plan, or for which the member or dependent is not legally obligated to pay.
4. Charges for services and supplies which are not necessary for treatment of the injury or disease orare not recommended and approved by the attending physician, or charges which are unreasonable.
5. Charges for dental work where a third party is responsible for payment of such charges.
6. Charges for benefits if payment of such charges if prohibited by law.
7. Charges for erectile dysfunction drugs.
8. Charges for weight loss drugs.
9. Charges for smoking cessation drugs.
10. Charges for vitamins (including B6 and B12 injections), minerals and food supplements.
11. Charges for fertility drugs.
12. Charges for surgical hose.

There may be other exclusions for other less common expenses.

DENTAL

The Plan pays toward the cost of reasonable and necessary dental expenses for you and your dependents which are outlined below.

You are strongly urged to show this booklet to your dentist. The technical terms used to identify the covered dental services may be unfamiliar to you, but your dentist will be able to answer your questions about them. He will also be interested in knowing what benefits this Plan covers. In addition, some dentists may charge higher amounts for their services than this Plan allows.

In the event that, while insured, you incur any of the Eligible Expenses listed below, you will be paid 60% of Orthodontics (for dependent children ony)and 85% of all other eligible expenses, subject to the limitations and exclusions.

Maximum Benefit

The total benefits payable are subject to the maximums specified in the Summary of Benefits. The maximums apply separately to each insured person.

Alternate Services

Many dental conditions can properly be treated in more than one way. This Plan is designed to help pay your dental expenses, but not on the basis of treatment that is more expensive than necessary for good dental care. Thus if a condition is being treated for which two or more services included in the list of Eligible Expenses are suitable under customary dental practices, the benefit under the Plan will be based on the least expensive of the services.

If a dental service not on the list of Eligible Expenses is performed, but the list contains one or more other services which under customary dental practices are suitable for the condition being treated, a charge for the least expensive of all such suitable services will be considered to have been incurred.

Dental Claim Form Required

No payment will be made unless a Dental Claim Form, satisfactory to the Administrator is submitted.

Pre-Determination of Benefits

Whenever you are uncertain whether a proposed course of dental treatment is covered under the Plan, it is strongly recommended that a Treatment Plan be submitted to and reviewed by the Administrator before any work is started. A Treatment Plan is normally not necessary for routine dental services (examinations, X-rays, fillings, etc.) or for emergency care, but prior submission is recommended for other major services and for Orthodontic expenses.

A Treatment Plan is the dentist's report that (i) itemizes the recommended services; (ii) shows the charge for each service; and (iii) when requested by the Administrator, is accompanied by supporting pre-operative X-rays.

Pre-determination of benefits 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 you and the dentist will know in advance what is covered and payable under the Plan. The pre-determination will remain valid for 90 days from the date of issue.

Eligible Expenses

Eligible Expenses included under the Plan are charges for the following supplies and services up to the amount specified in the current Saskatchewan Dental Association Fee Guide.

1. **Diagnostics:** Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:
   a) **Oral Examinations:** Recall oral examinations limited to once every 6 consecutive months;
   b) **X-rays:** Complete series or equivalent once each year.

2. **Preventative Therapy:** Procedures intended to eliminate or reduce the need for future dental treatment subject to the scaling and polishing (prophylaxis) and topical applications of sodium or stannous fluorideonce every 6 months.

3. **Basic Restorative Dentistry:** The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, or synthetic restorations (including white fillings on molars). Also in this category are space maintainers, including stainless steel crowns, but only if placed on a deciduous tooth which is non-restorable.

4. **Extractions:** Uncomplicated removal of teeth.

5. **Endodontics:** Emergency endodontic procedures and conservative root canal therapy.

6. **Periodontics:** Treatment of periodontal and other diseases of the gums and tissues of the mouth.

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

8. **Anesthesia:** Anesthesia where reasonably and customarily required in connection with other covered procedures.

9. **Injections:** Injections of antibiotic drugs by the attending dentist.

10. **Repairs, and Relining of Dentures:** Repair or recementing of crowns, inlays, bridgework or dentures; or relining of dentures.

11. **Removable Prosthetic Devices:** The initial installation of partial or full dentures including adjustments during or relining of dentures.

12. **Extensive Restorative Dentistry:** Those procedures, including gold inlays and crowns (including inlays and crowns to form abutments), used to restore the natural teeth to their normal functions where the tooth, as a result of extensive decay or fracture, cannot be restored with a filling (otherwise benefits will be based on the cost of a normal filling).

13. **Fixed Prosthetic Devices:** The initial installation of fixed prosthetic devices (bridges etc.).
The replacement of existing fixed prosthetic devices is covered if:

a) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth while insured; or

b) The existing fixed prosthetic device is at least 5 years old and no longer serviceable.

The replacement of a temporary denture by a permanent denture within 12 months from the date of installation of the temporary denture.

Dental implants are a covered expense up to an annual maximum of $2,000. The tooth must be extracted while covered for benefits under this plan and covered under (4) above.

14. **Orthodontics:** Coverage includes the diagnosis and correction of teeth irregularities and malocclusion of jaws, by wire appliance, braces or other mechanical aids, commonly known as "straightening of the teeth." This includes active space retainers, or orthodontic appliances, for the purpose of repositioning or moving the teeth. Only dependent children are covered for orthodontic benefits. The member and their spouse are not covered for orthodontic benefits.

Benefits are only payable if the treatment is required for an overbite of at least four millimeters, a cross bite or a protrusive or retrusive relationship of at least one cusp. An Orthodontic Treatment Plan must be submitted to the Administrator and returned to the dentist showing estimated benefits prior to treatment commencing.

An Orthodontic Treatment Plan is a report on a form satisfactory to the Administrator that among other things describes the recommended treatment, gives the estimated charge, when required, and is accompanied by cephalometric X-rays, study models and other supporting evidence.

The claim will be paid in equal instalments beginning when the active orthodontic appliances are first inserted, and quarterly thereafter for the estimated duration of the active treatment plan, as long as the patient remains covered.

In any event, the following charges are not eligible:

a) Charges for a procedure for which an active appliance was installed before the patient was covered.

b) A charge incurred while the patient's coverage is not in effect. However, if benefits are being paid at termination of coverage for any orthodontic procedure which was started while insured, they will be continued for charges incurred during the 30 days following the date the insurance terminated. Oral examinations, dental prophylaxis or diagnostic X-rays are not considered to be the start of a procedure or a series of treatments.

Exclusions

The foregoing list of Eligible Expenses shall exclude all of the following:

1. Services or supplies that are primarily for cosmetic dentistry unless made necessary by an accident occurring while insured (facings on crowns, or pontics, posterior to the second bicuspid shall always be considered cosmetic, as shall be plastic, porcelainor other materials fused to gold on molar crowns or pontics).
2. Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license (except X-rays ordered by a dentist or dental hygienist's work under a dentist's supervision).
3. Any charge for an injury resulting from war, riot, insurrection or participation in a criminal act.
4. Any miscellaneous charges such as counselling, travel, broken appointments, communication costs or filling in of forms.
5. Any charge resulting from any intentionally self-inflicted injury.
6. Any services covered in whole or in part by any government plan, services for which no charge is made, or services which the insurer is not permitted by law to cover.

7. Any charge for services which would not normally have been incurred, but for the presence of this insurance, or for which the member or dependent is not required to pay.
8. Any hospital charges for room and board and related services and supplies.
9. Any dental examinations required by a third party.
10. Diagnostic procedures in connection with any benefit categories excluded as Eligible Expenses.
11. Services or supplies for equilibration, personalization or characterization of dentures.
12. Replacement of lost or stolen prosthetic devices.
13. Charges for oral hygiene instruction.
14. Protective athletic appliances.

4. RETIRED MEMBERS' HEALTH & WELFARE PLAN

Qualification

Prior to September 1, 2021, upon retirement, members were automatically eligible for $20,000 of life insurance coverage providing:

- they were receiving a pension under a United Association Plan;
- they were a member in good standing in UA Local 179 when they retired; and
- they had maintained union membership continuously since retirement.

Members retiring after September 1, 2021 will also need to be enrolled in the Optional Health and Welfare Benefits described below in order to qualify for the life insurance coverage.

Taxation of Benefits

The premiums paid by the Health & Welfare Plan for Life Insurance for each month you are eligible during a calendar year will be added to the total pension benefits paid to you in the calendar year and that total will be reported on the T4 Supplementary issued to you for income tax purposes.

Optional Health and Welfare Benefits

You may apply for optional Major Medical and Dental benefits for which there is a monthly charge. The following conditions must be met to be eligible for this coverage:

- you must be retired and receiving a pension from a United Association Plan;
- you must be a member in good standing in UA Local 179;
- you were covered for Health & Welfare benefits under the Saskatchewan Piping Industry Health & Welfare plan at the time of retirement and for at least 12 months in the 24 months preceding retirement; and

you must submit an application *(available from the Administrator – see address on inside front cover)* with the appropriate fee within two months after receiving your first pension cheque.

The cost of this benefit on March 1, 2022 is $150 per month and will change in the future to reflect at least 50% of the actual cost of thesebenefits.

Note: that you will also have the option of deducting the per month cost of your benefits from your monthly pension payments.

Summary of Optional Benefits

The optional Health & Welfare benefits include Major Medical and Dental.

The Major Medical benefits are similar to the ones covered for active members except that LTD is not included for retirees and the overall maximum for prescription drugs is $5,000 per calendar year for each individual. Medical expenses should be submitted to the Saskatchewan government plan first. The benefits covered include:

- Prescription drugs.
- Hospital expenses at the semi-private room level.
- Ambulance service.
- Nursing care.
- Health practitioners. Charges for service of a licensed chiropractor, osteopath, naturopath, physiotherapist, or podiatrist are covered to a maximum eligible expense of $50 per visit to a maximum of $500 per calendar year. Charges for service of a licensed psychologist are covered to a maximum of $600 per calendar year.
- Hearing aids. Charges up to maximum of $1,000 per person every 5 years.
- Vision care and eye examinations are covered up to a combined maximum of $350 every 24 months.
- Other benefits as described in this booklet.

Note: Prescription drug claims must be submitted to the Saskatchewan government first.

The Dental plans reimburses up to 85% of the expenses incurred. The basic Dental benefits covered include the following:

- X-rays, exams and cleaning.
- Fillings and extractions.
- Root canals and gum surgery.
- Repairs to existing dentures.

In addition, the major Dental benefits covered include bridgework, dentures (initial and replacement) and crowns are covered up to 85%. The combined overall maximum for basic and major Dental benefits is $2,500 per calendar year for each individual. Orthodontics are not covered.

UA CANADA NATIONAL WELLNESS PROGRAM

Your UA Canada National Wellness Program offers three distinct benefits:

1. Member Assistance Plan (MAP)
2. Pregnancy Benefit
3. Maternity / Parental Supplementary Unemployment Benefit

1. MEMBER ASSISTANCE PLAN (MAP)

UA Canada
National Wellness Program
Member Assistance Program

Your Member Assistance Program (MAP) offered through the UA Canada National Wellness Program provides you with immediate and confidential help for any work, health or life concern. Access your MAP 24/7 by phone, web or mobile app.

1.833.778.2627 (UAMAP)
workhealthlife.com
TTY: 1.877.338.0275

The UA Canada National Wellness Program has a Member Assistance Program designed to help members and their families deal with personal or work-related issues which may impact health, well-being and/or job performance.

UA Members can contact advisers to discuss work and life issues such as financial, legal, childcare and eldercare. Additionally, your MAP offers services such as future planning, debt support, retirement planning and many more.

Your MAP is a confidential and voluntary support service which provides you and your family with immediate and confidential support for any work, health or life concern to help you with the supports you and your eligible family members need to live healthy, happy, and productive lives.

The MAP services are provided at no cost to you and your family members. However, if a member accepts a referral to services outside the MAP, you as the member may be responsible for any associated costs. The MAP consultant will work with you to find the most appropriate and cost-effective help to address your needs.

What issues can the MAP help with?

Mental Health and Safety Concerns

✓ stress, depression
✓ anxiety
✓ substance abuse
✓ concern about another person's substance abuse
✓ gambling or other addictions
✓ domestic abuse
✓ grief and loss
✓ crisis and trauma

Financial and Legal Topics

✓ budgeting, financial worries, and reducing debt
✓ legal matters

Work-Related Issues

✓ work-related problems and job stress
✓ conflict at work
✓ job burnout
✓ workplace change

Relationship and Family Matters

✓ adoption issues
✓ relationship issues
✓ separation and divorce
✓ child care and parenting issues
✓ elder care/caregiving issues
✓ education issues

Is the MAP confidential?

MAP services are completely confidential. Neither your union, employer, nor anyone else will know that you have

contacted MAP unless your consent and written permission have been expressly provided. No business manager, supervisor, not even a partner or spouse is notified.

The **only exception** to this rule of confidentiality is if the MAP consultant learns that someone is at risk of self-harm or of harming others. In this case, the consultant may be required to report the situation to the appropriate authorities.

Who provides the services in the MAP?
Your MAP services allow you access to 24/7, best-in-class and specialist counselling in all communities across Canada. You have access to our network of master's level counselors, who are specialized professionals in counseling, social work, human services and psychology.

Additionally, your MAP services provide members with support from specialists in financial and legal, child care and elder care, future planning and debt support, retirement planning and many more.

Service Options
Your MAP services allow you the flexibility to choose the method of receiving service from the MAP team. You can choose immediate access to an MAP counselor through live chat, text and email. Confidential and secure counseling sessions with members of our professional network include phone counselling as well as online counselling via live chat and/or video conference.

How does the MAP work?
We start very simply, by helping members to deal with problems that could be affecting them both inside and outside of the workplace. The MAP initially works by providing a professional assessment of which kind of support the individual concerned would most benefit from.

Following this assessment, the member may be referred to a counseling service, referred to another professional affiliate, and continue receiving the ongoing specialists support that they need to work through their difficulties.

What does your MAP offer?
The MAP provides users with free counselling. Whetherthe participant's mental health issue has resulted from a personal, family or workplace problem, the counselor can talk through the issue and refer them to other counselling professionals if necessary. If a member has become affected by a critical incident, such as a relationship, marital or parent/child conflict resulting in trauma or violence, the MAP allows for a quick response.

What does your MAP cover?
The objective of an MAP is to ensure that issues inside or outside of the workplace do not adversely affect a member's productivity. Therefore, professionals from various fields, including social work, human services, and psychology,are available. Through the counselling service, users may also be referred to their family physician, a specialist orto a community based resource to support their ongoing wellbeing.

Is the MAP easy to use?
Contacting the MAP is easy – simply call the toll-free telephone number or use the mobile app.

When members, or their families, call the MAP, they must be prepared to identify themselves as a member covered by the UA Canada National Wellness Program. The individual's name and any other identifying information will be kept confidential.

Your program name (the UA Canada National Wellness Program) is important because it allows the MAP consultant to identify the specific type of services MAP can provide to you, along with other important benefit-related information.

Return calls can be arranged at the discretion of the member.

The MAP consultant will discuss your needs and concerns, listening to and professionally assessing the situation.

Depending on your situation, the MAP consultant will:

- set you up to meet (virtually or live) with a local counselor for ongoing counseling
- work with you to make a plan to resolve your issues or concerns
- refer you to a community based support group
- refer you to helpful resources in your community
- help you navigate the MAP website for informative online content

The MAP services are provided at no cost to you and your family members. However, if a member accepts a referral to services outside the MAP, you as the member may be responsible for any associated costs. The MAP consultant will work with you to find the most appropriate and cost-effective help to address your needs.

Your Member Assistance Program (MAP) offered through the UA Canada National Wellness Program provides you with immediate and confidential help for any work, health or life concern. Access your MAP 24/7 by phone, web or mobile app.

1.833.778.2627 (UAMAP)
workhealthlife.com
TTY: 1.877.338.0275

UA Canada
National Wellness Program
Member Assistance Program

2. PREGNANCY BENEFIT

This benefit will provide financial assistance to expecting members who would otherwise need to continue working in the trades in an environment that could pose a risk to both the mother and unborn child. This program will instead allow these members to take paid time off prior to the birth of their child without having to exhaust their Federal Government Employment Insurance Maternity/ Parental Benefits. UA Canada Pregnancy Benefit will pay qualifying members the equivalent of the current Federal Employment Insurance rate for up to 24 weeks during pregnancy.

3. MATERNITY/PARENTAL SUPPLEMENTARY EI BENEFIT

The Maternity & Parental SUB provides a weekly financial top up od $100 / week to members who are eligible and receiving Federal EI Maternity or Parental benefits.

The Maternity Benefit is available for eligible pregnant members and birth mothers for up to 15 weeks. This benefit can begin up to 12 weeks prior to the child's due date if utilizing EI Maternity benefits.

The Parental Benefit is available for up to 35 weeks to any eligible UA Member who is receiving EI Parental benefits. This includes mothers, fathers and adoptive parents.

For additional information on eligibility and to apply, visit:

UA CANADA
NATIONAL WELLNESS PROGRAM
www.uacanada.ca/wellness
1 866-238-3013
PREGNANCY BENEFIT

MATERNITY & PARENTAL
SUPPLEMENTARY UNEMPLOYMENT BENEFIT

MEMBER ASSISTANCE PROGRAM

6. SUBMITTING CLAIMS

Life Insurance Claims

Phone or write to the Administrator within six months following the death and the forms will be sent to you with instructions.

Major Medical Claims

Complete the Saskatchewan Piping Industry Health & Welfare Plan Supplementary Medical claim form and mail it to the Administrator. Be sure to attach all original receipts.

Dental Claims

Complete the Saskatchewan Piping Industry Health & Welfare Plan Supplementary Dental claim form, have your dentist sign it and mail it to the Administrator.

Administrator

Global Benefits
88 St. Regis Crescent South
Toronto, Ontario
M3J 1Y8
Telephone: (416) 635-6000
Toll Free: (800) 810-2086
Fax: (416) 635-6464
Email: saskpipingbenefits@globalben.com

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ADMINISTRATOR

Global Benefits

88 St. Regis Crescent South
Toronto, Ontario M3J 1Y8

Telephone: (416) 635-6000
Toll Free: (800) 810-2086 Fax: (416) 635-6464
Email: saskpipingbenefits@globalben.com

Did you know?

UA Canada offers our members and their families free, confidential support to help with work, health and life challenges? Visit **www.workhealthlife.com** or call **1.833.778.2627** 24/7 for assistance.

UA Canada
National Wellness Program
Member Assistance Program