INTRODUCTION

This information booklet has been prepared to give you an informal summary of the main features of your Welfare program as of January 1, 2012.

This booklet is not an insurance contract, and does not grant or confer any contractual rights. All rights under this program shall be governed by the provisions of the Master Policies and by applicable law.

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

TABLE OF CONTENTS

Item Page

GENERAL INFORMATION

The Welfare Plan is administered by a Board of Trustees representing the Ironworkers and Rodmen Local 842 employers participating in the Plan. Such employers are called "Contributing Employers" in this booklet.

An account is kept by the Administrator of the Fund for each member which shows hours worked for a Contributing Employer for which contributions have been made for the purchase of coverage. This account is called an Hour Bank Account.

Each month, 120 hours will be deducted from your Hour Bank Account. The number of hours in your Hour Bank Account may never exceed 720 hours (enough to provide 6 months of coverage even though you acquire no hours during that period). Excess hours over this amount will be credited to the general reserves of the Fund.

ELIGIBILITY

Who May Be Covered

This Plan is for members of Ironworkers and Rodmen Local 842 who work for Contributing Employers.

In addition, retired members and their spouses may be covered for Supplementary Health Expense and Dental Expense Benefits on a Self-Pay basis provided the member:

- has 10 years of membership in Local 842 (does not apply to Rodmen Members who joined the plan between May 1, 2009 and December 31, 2010); and

- is age 55 or older at retirement and maintains full membership in Local 842, or is an honorary member, or has retired under the provisions of the International Pension Plan.

When You Become Covered Initially

For All benefits except for Accidental Death and Dismemberment Benefit: You and your eligible dependents will become covered on the first day of the second month following accumulation of 200 hours in your Hour Bank Account, provided you are actively at work or available for work on the day your coverage would ordinarily begin.

For Accidental Death and Dismemberment Benefit only: You will become covered on the first day of employment while you are accumulating hours in your Hour Bank Account to meet the initial eligibility requirement, provided you are actively at work or available for work on the day your coverage would ordinarily begin.

Should you not be working or available for work on the day your coverage would ordinarily start, the coverage for you and your dependents will be delayed until you return to work or are available for work.

Provision for Self-Pay by a Member

If at the end of any given month, a member covered under this Plan fails to meet the required monthly coverage cost as determined by the rules of the Trust Fund, such member will be notified by the Plan administrator before his coverage is terminated and given the opportunity of contributing the necessary amount of money so that he may continue to be covered.

Please contact your Union Office or the Plan Administrator (Benefit Plan Administrators (Atlantic) Limited for your self-payment options.

Please note that members working for a non-contributing employer will not be entitled to any of the self-payment options.

Reinstatement

If your coverage has previously terminated because of insufficient hours in your Hour Bank Account, you will again become covered on the first day of the month in which you have accumulated 200 hours in your Hour Bank Account.

Should you not be working or available for work on the day your coverage would ordinarily become reinstated, the coverage for you and your dependents will be delayed until you return to work or are available for work.

Termination of Coverage

Coverage for you and your eligible dependents will terminate the earlier of:

1. The last day of the month in which you have less than 120 hours in your Hour Bank Account. However, you may arrange to have your coverage continued on a self-pay basis as noted above.

2. If you cease to be a member of the Union.

3. If you enter Military Service.

4. If the Group Policy or Plan terminates.

5. If you discontinue any required contributions.

6. The date you become eligible (other than as a dependent) for other group insurance benefits similar to those for which he is covered under this Plan.

7. Attainment of age 70 for Active Members;

8. Upon retirement, unless you arrange to have your Supplementary Heath and Dental Expense Benefits continued on a self-pay basis.

Coverage for Outside Canada Expenses under Supplementary Health Expense is not available during a leave of absence.

A dependent's coverage will also terminate when he/she is no longer an eligible dependent.

Eligible Dependents

Eligible dependents under this plan shall include: the following persons who reside in Canada:

- Unmarried children who are under age 21, or under age 25 if attending an accredited school, college, or university as a full time student. Dependent children must be dependent on you for support and not employed at a regular full-time job. With respect to Dependent Life Insurance, dependent children must be over 14 days old.

- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was covered as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.

- A child of your spouse provided;
  i. he/she is also your biological child; or
  ii. your spouse is living with you and has custody of the child.

- Your spouse as the result of a valid civil or religious ceremony, or a person whose common-law relationship with you has existed for a minimum period of 12 consecutive months immediately prior to the date on which a claim arose. A common-law relationship must include continuous cohabitation and public representation of married status.

  Divorced or separated spouses (with or without a court order or separation agreement) are not eligible for coverage.

If a dependent is confined for medical care or treatment in any institution or at home when coverage would normally start, the dependent will not be covered until given a final release by the doctor from all such confinement.

No one will be eligible as a dependent while in military service.

SUMMARY OF BENEFITS

LIFE INSURANCE (For Active Members only)

Active Members under age 70 $30,000

ACCIDENTAL DEATH AND DISMEMBERMENT (For Active Members Only)

All Members are eligible for an amount of insurance equal to $10,000.

DEPENDENT LIFE INSURANCE (For Active Members only)

- Spouse ➢ $5,000
- Each Child ➢ $3,000

SUPPLEMENTARY HEALTH EXPENSE (For Active & Retired Members)

- Deductible ➢ NIL
- Coinsurance ➢ 50% for psychoanalysis treatment
  100% for all other eligible expenses
- Lifetime Maximum ➢ $100,000 (Active Members)
- Calendar Year Maximum ➢ $15,000 (Retired Members)

DENTAL (For Active and Retired Members)

- Deductible ➢ NIL
- Coinsurance ➢ 100% for Minor and Major Services

Dental Fee Guide - Benefits are paid in accordance with the Current Year Dental Fee Guide in effect in the province where the service is rendered on the date the charge is incurred. Please see the Dental Expense section for a list of eligible expenses.

Calendar Year Maximum Benefit per Individual - $2,000 for Minor and Major services combined.

MEMBER LIFE INSURANCE

In the event of your death 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 policy or legal limitations.

WAIVER OF PREMIUM FOR DISABILITY

If you become totally disabled for 9 consecutive months before age 65, your Life Insurance will be continued free of charge until you cease to be totally disabled or you reach age 65, whichever occurs first. 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: In order to qualify for the Waiver of Premium benefit you must notify the Administrator of your disability within one (1) year of your last active day at work, and must furnish proof of your disability satisfactory to the Insurer within 18 months of that last active working day.

CONVERSION PRIVILEGE

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Life Insurance coverage to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Member Life Insurance. If you die during this 31-day period, the amount of Member Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

DEPENDENT LIFE INSURANCE

In the event of the death of your spouse and/or dependent children while insured, the amount of Dependent Life Insurance is payable to you.

CONVERSION PRIVILEGE

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

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

ACCIDENTAL DEATH AND DISMEMBERMENT

When injury results in any of the following losses within 365 days after the date of the accident, Manulife Financial will pay:

Schedule of Benefits

For Loss of	Percentage of The Principal Sum
Life	100%
Entire Sight of One Eye	66 2/3%
Speech	66 2/3%
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%
For Loss or Loss of Use of	
One Arm	75%
One Leg	75%
One Hand	66 2/3%
One Foot	66 2/3%
Thumb and Index Finger or at Least Four Fingers of One Hand	33 1/3%
For Total Paralysis of	
Both upper and Lower Limbs (Quadriplegia)	200%
Both Lower Limbs (Paraplegia)	200%
Upper and Lower Limbs of One Side of Body (Hemiplegia)	200%

"Principal Sum" means the amount of insurance indicated in the Summary of Benefits.

"Loss" as used above with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and finger means the complete severance at or above the metacarpophalangeal joint; as used with reference to toe means the complete severance at or above the metatarsalphalangeal joint; and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

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

"Loss" as used above with reference to quadriplegia, paraplegia and hemiplegia means the complete and irreversible paralysis of such limbs.

"Loss" as used above with reference to loss of use means the total and irrecoverable loss of use provided the loss is continuous for twelve consecutive months and such loss of use is determined to be permanent at the end of the period.

Indemnity provided under this section for all losses sustained by any one insured individual as the result of one accident shall not exceed the following:

(a) The Principal Sum for all losses except quadriplegia, paraplegia and hemiplegia.

(b) Two Times the Principal Sum, or the Principal Sum if Loss of Life occurs within 90 days after the date of the accident with respect to quadriplegia, paraplegia and hemiplegia.

Exclusions

This plan does not cover a period of hospitalization which is less than five days with respect to the "HOSPITAL INDEMNITY" benefit nor any loss, fatal or non-fatal, caused or contributed to by:

1) self-destruction or self-inflicted injury, whether the insured individual be sane or insane; or;
2) declared or undeclared war or any act thereof;
3) riding as a passenger or otherwise in any vehicle or device for aerial navigation other than as provided in the part entitled "AIRCRAFT COVERAGE";
4) committing, attempting, or provoking, an assault or criminal offence; or
5) an accident which occurs while the insured individual is operating a motor vehicle or any other form of motorized transportation and the blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%).

YOUR ACCIDENTAL DEATH AND DISMEMBERMENT PLAN ALSO INCLUDES THE FOLLOWING BENEFITS WHICH ARE BRIEFLY DESCRIBED. PLEASE CONTACT YOUR PLAN ADMINISTRATOR FOR COMPLETE DETAILS AND LIMITATIONS

Aggregate Limit

$5,000,000 per accident for all insured individuals.

Waiver of Premium Benefit

If while insured for this coverage, you become disabled and qualify for the Waiver of Premium Benefit under your life insurance coverage, Manulife Financial will also waive the payment of your accidental death and dismemberment insurance premiums.

Your entitlement to Waiver of Premium Benefit ceases on the earlier of a) the date your Waiver of Premium for Life Insurance ceases, or b) the date the policy or this coverage terminates.

Aircraft Coverage

Coverage while riding as a passenger but not as a pilot or member of the crew.

Exposure and Disappearance

Loss due to unavoidable exposure to the elements. Loss of life resulting from bodily injury caused by an accident at the time of a disappearance, sinking or wrecking.

Repatriation Benefit

Manulife Financial will pay the reasonable and customary expenses incurred for the transportation of the body of the deceased insured individual to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased, subject to a maximum of $10,000.

Occupational Training Benefit (Applicable to Member coverage only)

In the event of your accidental death, Manulife Financial will pay the reasonable and customary expenses incurred within three years following the date of the member's accident for a spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, subject to a maximum of $10,000.

Rehabilitation Benefit (Applicable to Member coverage only)

In the event you sustain an accidental injury which results in a loss payable and such injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, Manulife Financial will pay the reasonable and customary expenses incurred for such training subject to a maximum of $10,000 for any one accident.

Family Transportation Benefit

In the event you sustain an accidental injury and are confined in a hospital located more than 150 kilometres from your normal place of residence, the Insurer will pay the reasonable expenses incurred by all members of your immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to the confined insured individual, subject to a maximum of $1,000.

"Immediate family" means a person at least eighteen years of age who is the spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the member.

Seat Belt Benefit

In the event you sustain an accidental injury payable under this benefit, the amount of Principal Sum will be increased by 10% if, at the time of the accident, you were:

(1) wearing a properly fastened seat belt; and
(2) driving or riding in a vehicle driven by a driver who was neither intoxicated nor under the influence of drugs, unless taken as prescribed by a physician, at the time of the accident. Intoxication and being under the influence of drugs is as defined by the local jurisdiction where the accident occurred.

Hospital Indemnity

A daily benefit (1/30th of 1% of your Principal Sum, maximum of $2,500 per month) will be payable if you are confined in a hospital for at least 5 days and under the care of a physician for an accidental injury payable under this benefit, subject to a maximum of 365 days per accident.

Education Benefit (Applicable to Member coverage only)

In the event of your accidental death, Manulife Financial will pay the Education Benefit stated below for each of your dependent children who are enrolled as full-time students in an institution for higher learning within 365 days following date of death of the member.

The Education Benefit is equal to the reasonable and customary expenses actually incurred, subject to the lesser of 5% of your Principal Sum or $5,000, for each school year the dependent child described above continues his education on a full-time basis in an institution for higher learning, but not to exceed 4 school years, which must run consecutively, with respect to any one dependent child.

"Institution for higher learning" includes any university, college, CEGEP or trade school.

SUPPLEMENTARY HEALTH EXPENSE

MEMBER AND DEPENDENT COVERAGE

In the event you incur in a calendar year any of the Eligible Expenses listed below, you will be paid a percentage (coinsurance) of such expenses, provided you are resident in Canada. The percentage (coinsurance) are specified in the Summary of Benefits.

MAXIMUM BENEFIT

The maximum benefit payable in respect of you or your dependents is as noted in the Eligible Expenses section.

EXTENSION OF BENEFITS

No benefits for Eligible Expenses will be paid for claims incurred after the termination of the Plan or after your coverage under this benefit ceases.

ELIGIBLE EXPENSES

The following is a list of eligible expenses.

Hospital Expenses In Canada

Charges for hospital confinement ordered by a doctor as a result of a non-occupational accident or sickness, up to a daily limit equal to the hospital's rate for a standard semi-private room. Benefits are provided for the entire confinement.

Drug Expenses

Reasonable and customary charges incurred for medically necessary drugs and medicines which:

1) are dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines subject to the note below; and

2) are prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of an illness or injury and are either;

   a) drugs requiring the prescription of a physician in accordance with the Food and Drugs Act, Canada; or

   b) other specified drugs and medicines which have been identified by the Administrator as covered expenses and are by convention usually not dispensed without a physician's prescription; or

   c) injectable preparations identified by the Administrator, insulin preparations and supplies, and allergy serums.

Smoking cessation aids which require a physician's prescription are covered as follows:

1) For the first course of treatment, the maximum expense is $400; and
2) For the second course of treatment, 50% of the incurred cost to a maximum expense of $200.

   Charges which exceed these limitations and charges for subsequent courses of treatment are not covered.

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase

.

Outside Canada Expenses

Note: Only insured individuals under age 65 are eligible for coverage. Coverage is limited to a period of 60 days from the date the insured leaves the province of residence. Coverage is not available during a leave of absence.

If, while travelling outside Canada, hospitalization or medical treatment is required due to emergency and nonelective reasons the following expenses are covered:

1) reasonable and customary hospital charges, in excess of any provincial government plan allowance, up to a maximum eligible expense of $35.00 for each day of such hospital confinement;

2) reasonable and customary charges in the area where the service is provided, in excess of any government plan allowance, for the services of a physician;

3) reasonable and customary charges, in excess of any provincial government allowance, for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

Extended Health Expenses

- Charges for licensed Convalescent Care Facility immediately following 3 consecutive days of hospital confinement, subject to a maximum benefit of $10 per day and 100 days of confinement per disability. Confinement must be for the continued care of the same condition for which the insured was hospitalized and must begin prior to the insured's 65th birthday;

- Charges for an artificial larynx or for the services of a licensed speech therapist, up to a maximum eligible benefit of $500, in excess of the provincial plan, for any calendar year;

- Charges for the services of a licensed osteopath or chiropractor, up to a maximum eligible benefit of $500 per calendar year per practitioner. Charges for x-rays ordered by such practitioner are payable subject to a maximum eligible benefit of $25 per disability. No benefit shall be payable for charges incurred while the member is entitled to similar benefits under any provincial health plan regardless of whether the provincial plan pays for all or only part of such charge;

- Charges for the services of a licensed psychologist up to a maximum eligible benefit of $500 per calendar year;

- Charges for the services of a licensed podiatrist for surgery, or care prescribed by a physician for treatment of metabolic or peripheral vascular disease;

- Charges for the services of a physiotherapist, when not covered by a provincial government plan;

- Charges for the services of a massage therapist up to a maximum eligible benefit of $500 per calendar year when treatment is prescribed by a Physician, as to duration and type;

- 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 if medically necessary;

- Charges for rental (or, at the Insurer's option, purchase) of a wheelchair, hospital bed, iron lung, oxygen tent or similar durable medical equipment required for therapeutic purposes and as approved by the Insurer;

- Charges for rental (or, at the Insurer's option, purchase) of splints, casts, trusses, braces, crutches, electronic heart pacemaker and prostheses, including replacement if required due to a change in physical condition, including but not limited to breast prosthesis once every 2 calendar years;

- Charges for professional ambulance service, other than airline or railroad to the nearest hospital qualified to provide the necessary treatment, or for transportation from a hospital to a convalescent hospital;

- Charges for necessary dental treatment required as the result of an accidental injury by external means to sound natural teeth provided the accident occurred while insured under this coverage. As determined by the Insurer, only such charges directly related to such an accidental injury are considered a covered medical expense;

- Charges for orthopedic shoes and orthotics which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

    1) a diagnosis, including a list of symptoms and the primary complaint;

2) a description of the physical findings from the clinical examination;
3) a brief description of the abnormal walking pattern associated with the diagnosis; and
4) confirmation that the product has been custom-made.

Your orthopedic shoes and orthotics must be prescribed on an annual basis. For information on eligible prescribing and dispensing providers, please contact your Benefits Administrator.

Charges for orthopedic shoes are limited to one pair every 12 consecutive months and orthotics (including arch supports, lifts, wedges, Dennis Browne splints) are limited to $300 per 24 consecutive months.

- Charges for hearing aids provided by a certified, clinical audiologist, subject to a maximum eligible benefit of $3,000 every 60 consecutive months. This limitation shall not apply in the event of an accidental injury to the ear. Repairs for hearing aids are not covered;

- Charges for services in connection with psychoanalysis treatment, but only if the covered family member is a resident of the province of Quebec and in a hospital or similar institution. Charges for services in other provinces are paid by Medicare;

- Charges for laboratory tests and x-rays not covered by any provincial government plan, subject to a maximum eligible benefit of $500 in any calendar year;

- Charges for anaesthesia, oxygen, blood and blood products ordered by a physician;

- Charges for treatment by x-ray or radioactive substance.

Vision Care Expenses

Charges for vision care as follows:

- One eye examination performed by a qualified optometrist or ophthalmologist in any period of 24 consecutive months (every 12 consecutive months for dependent children under 18 years of age); however, no benefits shall be payable for charges incurred for which you are entitled to benefits under any provincial health plan regardless of whether the provincial plan pays for all or only part of such charges;

- lenses for eye glasses (or for safety glasses in lieu of regular eye glasses) when required by a change in prescription once in any period of 24 consecutive months (12 consecutive months for dependents under 18 years of age);

- frames for regular or safety eyeglasses, subject to a maximum eligible benefit of $125 per person in any period of 24 consecutive months (12 consecutive months for dependents under 18 years of age);

- contact lenses (not covered below) in lieu of eyeglasses, subject to a maximum eligible expense of $200 per person in any period of 24 consecutive months (12 consecutive months for dependents under 18 years of age);

- contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, provided visual acuity can be improved to at least the 20/70 level by contact lenses but cannot be improved to that level by spectacle lenses, or if acquired after cataract surgery;

- laser eye surgery, subject to a maximum of $1,000 per lifetime.

EXCLUSIONS

The foregoing list of eligible expenses shall not include any of the following:

- charges which are considered an insured service of any provincial government plan;

- charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;

- charges for general health examinations, and examinations required for use of third party;

- charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;

- charges for medical treatment or surgical procedure by a physician other than as provided under outside of Canada Expenses;

- charges for transport or travel, other than as specifically provided under eligible expenses;

- charges not specified in the foregoing list of eligible medical expenses;

- charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his license;

- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;

- charges which are from an occupational injury or disease covered by any Workers' Compensation law or similar legislation;

- charges which would not normally have been incurred but for the presence of this coverage or for which you are not legally obligated to pay;

- charges which the Plan is not permitted, by any law or regulation, to cover;

- charges for dental work where a third party is responsible for payment for such charges;

- charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;

- charges for services or supplies resulting from any intentionally self-inflicted wound;

- charges for drugs, sera, injectable drugs or supplies which are not approved by Health and Welfare - Canada or are experimental or limited in use whether or not so approved;

- charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;

- charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies; and

- charges for drugs, sera, injectable drugs or supplies when administered in a hospital setting, whether administered on an inpatient or outpatient basis, except as provided under the Outside Canada Expenses or Outside Canada Referral sections, where provided under the Supplementary Health Expense.

EXTENDED SUPPLEMENTARY HEALTH EXPENSE COVERAGE AFTER THE MEMBER'S DEATH

Your dependents who are covered under this Plan at the time of the your death will continue to be covered for the Supplementary Health Expense without premium payment until the earlier of:

- the date the dependent ceases to be a Dependent as defined;
- the end of the 12-month period* after the date of the member's death; or
- the date the coverage terminates for any reason.

* After this 12 consecutive month period, coverage may be continued on a self-pay basis until the date of your spouse's death or until your spouse is eligible for coverage under another plan.

DENTAL EXPENSE BENEFIT

MEMBER AND DEPENDENT COVERAGE

As the wording of this dental coverage is technically oriented we suggest you take this booklet with you when you visit your dentist.

In the event you incur in a calendar year any of the eligible expenses listed below, you will be paid a percentage of such expenses as specified in the Summary of Benefits.

MAXIMUM BENEFIT

The total benefits payable are subject to the maximums specified in the Summary of Benefits.

EXTENSION OF BENEFITS

No benefits for Eligible Expenses will be paid for claims incurred after the termination of the Plan or after your coverage under this benefit ceases.

DENTAL CLAIM FORMS

Paper claims will not be processed unless a Dental Claim Form is submitted to the Plan Administrator (Benefit Plan Administrators (Atlantic) Limited).

ALTERNATE BENEFITS AND SUBMISSION OF TREATMENT PLAN

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, the Plan reserves the right to determine eligible expenses on the basis of an alternate benefit.

As a service to you, we will advise you in advance of the amount payable when a proposed course of treatment includes major restorative dentistry. To use this service, simply have your dentist complete a treatment plan on forms available from the Plan Administrator (Benefit Plan Administrators (Atlantic) Limited), including pretreatment x-rays if the proposed treatment involves crowns or bridgework.

ELIGIBLE EXPENSES

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the Fee Guide for General Practitioners of the Dental Association as outlined in the Summary of Benefits.

MINOR PROCEDURES

Diagnostics: Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

- oral examinations limited to once every 9 consecutive months;
- complete oral exam and diagnosis;
- x-rays; and
- study casts.

Preventive Therapy: Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

- scaling and polishing (prophylaxis);
- topical fluoride; and
- passive space maintainers, those that do not move the teeth.

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 (fillings). In addition, sedative dressings are covered.

Extractions: Uncomplicated removal of teeth.

Emergency Palliative Treatment: The lessening of pain without curing or resolving the problem.

Endodontics: The treatment of diseases of the pulp and periapical tissues.

Periodontics: The treatment of diseases of the tissues and bones surrounding and supporting the teeth.

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

Anaesthesia: Anaesthesia where reasonably and customarily required in connection with other covered procedures.

MAJOR PROCEDURES

Removable Prosthetic Devices: The initial installation of partial or full dentures, or the addition of teeth to an existing partial denture, when the installation or addition is necessary to replace one or more sound natural teeth which were lost, extracted, or fractured and the re-basing and repair of broken full or partial dentures. Replacement of dentures, full or partial is limited to once every 5 years.

Fixed Prosthetic Devices: The initial installation of fixed prosthetic devices (bridgework) to replace one or more sound natural teeth lost, extracted or fractured. Also included is recementing and replacement of the facing of the bridgework.

EXCLUSIONS AND LIMITATIONS

No benefit is payable for the following:

- Services or supplies that are primarily for cosmetic dentistry;
- Charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;

- Services or supplies which are not furnished by a legally qualified dentist, hygienist or denturist acting within the scope of his or her license;

- Any charge for an injury resulting from war, riot, insurrection or participation in a criminal act;

- Any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or filling in of forms;

- Any charge resulting from any intentionally self-inflicted injury;

- Any services covered in whole or in part by any government plan, services for which no charge is made, or services which the Plan is not permitted by law to cover;

- Any charge for services which would not normally have been incurred, but for the presence of this Plan, or for which you are not required to pay;

- Any hospital charges for board and room and related services and supplies;

- Any dental examinations required by a third party;

- Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease;

- Services or supplies for equilibration of dentures;

- Any services or supplies in connection with any procedures excluded as eligible expenses;

- Services or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants;

- Any services or supplies in connection with Orthodontics procedure;

- Any services or supplies for any of the following:

  Inlays and Gold Fillings: Gold foil fillings and all cast gold and/or porcelain inlays or onlays including the re-cementing of an inlay or onlay; and

  Crowns: All gold, acrylic, porcelain or stainless steel crowns including the re-cementing of crowns.

DENTAL EXPENSE COVERAGE AFTER THE MEMBER'S DEATH

Your dependents who are covered under this Plan at the time of your death will continue to be covered for the Dental Expense without premium payment until the earlier of:

- the date the dependent ceases to be a Dependent as defined;
- the end of the 12-month period* after the date of the member's death; or
- the date the coverage terminates for any reason.

* After this 12 consecutive month period, coverage may be continued on a self-pay basis until the date of your spouse's death or until your spouse is eligible for coverage under another plan.

GENERAL PROVISIONS

COORDINATION OF BENEFITS

Payment of Supplementary Health and Dental benefits shall be coordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, the Plan has a right to receive and release information on benefits and if necessary, collect any overpayments made by it.

CHANGE IN GOVERNMENT SPONSORED PROGRAMS

The medical, dental and hospital benefits under this Plan are provided in conjunction with government sponsored provincial programs. In the event coverage under any provincial program is modified, suspended or discontinued, the Plan will not automatically assume responsibility for any services or products previously covered under the provincial programs.

DEFINITIONS

Earnings shall mean that amount of money, based on the number of hours in the regular work week, as per the Collective Agreement multiplied by the hourly wage rate for each particular member in the wage rate classification to which he belongs.

Member shall mean a person who conforms to the definition of member as defined in the Trust Agreement of the Ironworkers and Rodmen Local 842 Benefit Plan, meets the eligibility requirements as set out in this Plan, and is resident in Canada.

Leave of Absence shall mean a period of time away from work mutually agreed to by you and your employer. In the case of maternity leave of absence, the leave shall begin and finish on dates agreed to by you and your employer or as required by Provincial or Federal law.

Hospital shall mean 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 licensed physicians and registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term hospital, as used in this policy, 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 or drug addiction, tuberculosis or mental illness.

Convalescent care facility shall mean 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 as used in this policy shall not include a home for the aged, health spa or hotel, an establishment providing custodial care or an institution for the care and treatment of alcoholism or drug addiction, tuberculosis or mental illness.

Physician shall mean only a person who is duly licensed to prescribe and administer any drugs or to perform surgical procedures.

HOW TO CLAIM

When you have a claim you should contact your Plan Administrator who will supply you with the proper forms with instructions for completion.

In order to quickly process your claim, all claim forms should clearly indicate the following:

- **your full name and address**
- **the name of your Employer**
- **your Certificate (Identification) Number**
- **your Group Policy Number:**
  -#903409 for Supplementary Health Expense and Dental Expense Benefits;
  -#901409 for Life Insurance, Dependent Life Insurance, Accidental Death and Dismemberment Benefits

All claims should be forwarded to the Plan Administrator:

Benefit Plan Administrators (Atlantic) Limited

7001 Mumford Road, Tower 1, Ste. 216
Halifax, N.S. B3L 4N9

Phone: 902-455-7277
Toll Free: 1-888-426-4433

TIME LIMITATIONS

A claim for a waiver of premium benefit must be submitted within 12 months of the date disabled.

A claim for any other loss must be submitted within 15 months following the date the loss is incurred. However, in the event of termination of coverage:

- a claim for Member Life, Dependent Life and Accidental Death and Dismemberment must be submitted within 90 days following the date of termination of your coverage or the date following termination of the Plan; and

- a claim for Supplementary Health Expense and Dental Expense Benefits must be submitted no later than the date of termination of coverage or the contract.

PLAN ADMINISTRATOR:

BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED
7001 MUMFORD ROAD, TOWER 1, SUITE 216
HALIFAX, NOVA SCOTIA
B3L 4N9

SUPPLEMENTARY HEALTH AND DENTAL BENEFITS
ASO PLAN #903409

All other benefits are underwritten by:

MANULIFE FINANCIAL

POLICY #901409