# Your Benefits Handbook

**For Unifor Local 112 Employees of Bombardier Aerospace**

**Revised June 23, 2021**

## Why Should You Read This Handbook?

When you're young and looking for your first job, probably your only worry is that you won't find one.

But after you find work, you discover that the worries don't stop. You wonder what will happen if you need expensive health care. What if you get sick or injured and can't work? If you have a family, will they have enough money if something happens to you? And what about retirement? Will your pension be enough?

We all know worries are part of life. Fortunately, working for Bombardier as a member of Unifor Local 112 means you have benefit programs to ease some of those concerns. Of course, you can't have peace of mind if you don't know what those programs are or how they work. That's where this handbook can help.

There are four main parts to the handbook.

- **Part 1 is Health Care.** It tells you about the medical and dental expenses the Company will pay for. These are expenses *not* covered by your provincial health care plan.
- **Part 2 is Income Protection.** In it are five plans that continue to pay you all or part of your wages when you can't work because of sickness, accident, disability, or in some other situations.
- **Part 3 is Survivor Benefits.** The two plans in this section pay money to your survivors if you die. You can also receive benefits for specific severe injuries from the Accidental Death & Dismemberment (AD&D) Plan.
- **Part 4 is Pension.** This section describes the retirement income you can expect from the Company Pension Plan.

We encourage you to read the sections that interest you and share the information with your family. If you have questions that the handbook doesn't answer, please call your Employee Service Center. Ext 33333 or (416) 375-3333

***Contents***

**1 Health Care**....................7

***Medical Plan***....................7
What the Plan Does....................7
Who Is Covered....................7
Costs....................7
Benefit Details....................8
Special Situations....................12
Claims....................14
Claim Procedures for Green Shield Canada....................15
Claim Procedures for Industrial Alliance Financial....................17
***Travel Assistance Service***....................18
What the Plan Does....................18
Who Is Covered....................18
Costs....................18
Benefit Details....................18
Exceptions....................22
***Dental Plan***....................23
What the Plan Does....................23
Who Is Covered....................23
Costs....................23
Benefit Details....................23
Exceptions....................25
Special Situations....................26
Claims....................26
**2 Income Protection**....................29
***Sickness and Accident Plan (S&A Plan)***....................29
What the Plan Does....................29
Who Is Covered....................29
Costs & Taxes....................29
Benefit Details....................29
Special Situations....................30
Claims....................32
***Extended Disability Benefit Plan (EDB Plan)***....................33
What the Plan Does....................33
Who Is Covered....................33
Costs & Taxes....................33
Benefit Details....................33
Special Situations....................35
Claims....................35

***Supplemental Unemployment Benefit Plan (SUB Plan)*** ........ 37
What the Plan Does ........ 37
Who Is Covered ........ 37
Costs & Taxes ........ 37
Benefit Details ........ 37
Plan Administration ........ 41
Special Situations ........ 42
Application for Benefits ........ 42
***Separation Payment Plan (SPP)*** ........ 44
What the Plan Does ........ 44
Who Is Covered ........ 44
Costs & Taxes ........ 44
Benefit Details ........ 44
Plan Administration ........ 46
Special Situations ........ 47
Application for Benefits ........ 47
***Automatic Short Week Benefit Plan*** ........ 48
What the Plan Does ........ 48
Who Is Covered ........ 48
Costs & Taxes ........ 48
Benefit Details ........ 48
Plan Administration ........ 49
Special Situations ........ 49
Application for Benefits ........ 50
**3 Survivor Benefits** ........ **51**
***Basic Life Insurance*** Plan ........ 51
What the Plan Does ........ 51
Who Is Covered ........ 51
Costs & Taxes ........ 51
Benefit Details ........ 51
Special Situations ........ 51
Claims ........ 53
***Optional Life Insurance Plan*** ........ 54
What the Plan Does ........ 54
Who Is Covered ........ 54
Costs & Taxes ........ 54
Benefit Details ........ 54
Exceptions ........ 55
Special Situations ........ 55
Claims ........ 56
Optional Life Insurance Rates ........ 57
***Survivor Income Benefit Plan (SIB Plan)*** ........ 58
***Basic Accidental Death and Dismemberment (AD&D) Insurance Plan 58***
What the Plan Does ........ 58
Who Is Covered ........ 58
Costs & Taxes ........ 58

Benefit Details....58
Exclusions....60
Special Situations....61
Claims....61
**4 Pension Plan**....**62**
What the Plan Does....62
Who Is Included....62
Costs & Taxes....62
Details of Pension Benefits....63
**5 Appendix 1: Medical Plan** Details....71
**6 Appendix 2: SUB Plan** Administration....78
**7 Appendix 3:** Definitions....82

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Alternative Table of Contents


| I want to know… | Where to find it |
|---|---|
| …how to protect my family's income after my death | ▪ page 51, Basic Life Insurance<br>▪ page 54, Optional Life Insurance |
| …how to submit a claim for dental expenses | • page 27, Dental Plan – Claim Process |
| …how to submit a claim for medical expenses | • page 17, Medical Plan – Claim Process |
| ...if I get benefits if I resign while on lay-off | • page 44, Separation Payment Plan |
| …if I get benefits when I'm disabled for a short time | • page 29, Sickness & Accident Plan |
| …if I get benefits when I'm disabled for a long time | • page 33, Extended Disability Benefit Plan |
| …if I get paid when I'm available to work but can't get the hours | • page 48, Automatic Short Week Benefit Plan |
| …if I get paid when I'm on lay-off | • page 37, Supplemental Unemployment Benefit Plan |
| …if I get paid when I'm sick | • page 29, Sickness & Accident Plan |
| …if the Company will pay me a pension | • page 65, Pension Plan |
| …if the Company will pay my dental expenses | • page 23, Dental Plan – Benefit Details |
| …if the Company will pay my medical expenses | • page 7, Medical Plan – Benefit Details<br>• page 71, Appendix 1: Medical Plan Details |
| ...what happens to my Life Insurance coverage during maternity/parental leave | • page 51, Survivor Benefits |
| ...what happens to my Health coverage during long-term sick leave | • page 12, Health Care<br>• page 26, Dental Plan |
| ...what happens to my Life Insurance coverage during lay-off | • page 51, Survivor Benefits |
| ...what happens to my Health coverage when I retire | • page 13, Health Care<br>• page 25, Dental Plan |

# Health Care

## *Medical Plan*

### What the Plan Does

The Medical Plan pays for many medical expenses that the Ontario Health Insurance Plan (OHIP) does not cover. The expense must result from an accident, injury, or disease that is ***not*** work related.

If you are a retiree and reside outside of Canada, it is your responsibility to obtain medical coverage, if it is not provided by the local government. The Medical Plan will pay only eligible expenses which are over and above what would be payable by a provincial plan.

You may apply for care or compensation for workplace accidents or disease through the ***Workplace Safety and Insurance Board (WSIB)***.

### Who Is Covered

The Medical Plan covers you if you are a full-time employee of the Company. You may also choose to cover your ***dependents***, including your ***spouse***. (For a definition of *dependents* and *spouse*, see page 85).

You must complete an Enrollment Form to start your coverage. The Human Resources Department will give you this form on your first day of work.

Benefits under the Plan come into effect at different times. (See "Benefit Details," page 8.)

### Costs

The Company pays the costs of administration of the Medical Plan and also covers the costs of eligible, approved medical expenses for plan members.

In most cases, you must pay for your medical expenses first, and then the Medical Plan will pay you back after you complete a claim form. In other cases, your service provider may be able to submit the claim for you. (See "Claims," page 14.)

The Plan limits your coverage for some expenses to a maximum amount per calendar year or per lifetime. You may also need to pay a certain amount — a *deductible* — before you receive any reimbursement.

## Benefit Details

### *Qualification for Benefits*

The Plan covers you for the following benefits on the first of the month following 90 working days of active full-time service:

| Benefit | Administered by |
|---|---|
| • Drug Coverage<br>• Vision and Hearing Care<br>• Semi-Private Hospital Coverage<br>• Diabetic Supplies | Green Shield Canada |
| • Land Ambulance Services<br>• Paramedical Services<br>• Dental<br>• Other Medical Expenses e.g. Physiotherapy<br>• Emergency travel Insurance | Industrial Alliance |

### *Benefit Summary*

The following two tables show the main categories of coverage in the Medical Plan.

Some of the categories have maximum reimbursement levels or other restrictions. For a complete list of covered services, supplies and exclusions please see **Appendix 1: Medical Plan Details**, page 71

| **Green Shield** | |
|---|---|
| **Semi-Private Hospital Coverage (see page 72 for Limitations)** | • Charges for semi-private ***hospital*** room and board up to a maximum of $215.00 per day, not subject to overall $35K lifetime. |
| **Rehabilitation institution and convalescent home** | • Reimbursed at 100%, no deductibles and not subject to overall $35K lifetime. Semi-private room in a public general hospital, maximum $215 per day, no limit as to the number of days. |
| **Chronic care/Long Term care institutions** | • Please contact Green Shield Canada for coverage details. |

| | |
|---|---|
| **Nursing Home**<br><br>**Hospice Care** | • nursing home or home for the aged: reimbursed at 80%, semi-private room in a public general hospital, no limit as to the number of days.<br><br>• Up to 30 days: Lifetime maximum $7,500 |
| ***Drug Coverage (Please reference page 71)*** | • $5.00 deductible per prescription<br><br>• 1) Effective January 1, 2007: I) When a prescription drug order or refill for a covered person has a generic equivalent (regardless of interchange ability), the maximum benefit under our plan for such drug will be limited to the cost of the lowest price generic drug, less the co-pay.<br>• II) When the covered person chooses the more costly drug, in lieu of the lowest price generic, such person will be responsible for the difference in cost.<br>• Subsections I) and II) are subject to the "adverse Drug Reaction" Letter.<br>• Coverage for weight loss drugs will be limited to an one-time lifetime occurrence.<br>• The Conditional Drug Formulary date will be adjusted to January 1, 2009. All persons currently receiving, or who, within the 12 months prior to ratification, have received, medications that become subject to a change in status as a result of this change will continue to be eligible for such medication without exceptions.<br>• The Drug Plan will reimburse to a maximum of $9.00 for the drug-dispensing fee. Any excess dispensing fee will be separate from the $5.00 deductible.<br>• Effective June 23, 2022, mandatory use of GSC Preferred Pharmacy network for high-cost specialty drugs.<br>• Effective January 1, 2022, Bombardier's drug plan with Green Shield Canada (GSC) will limit the reimbursement of dispensing fees to 5 per year on maintenance drugs.<br>• *For retirees and spouses age 65 and over, if a provincial medical plan includes drug coverage, it will be the first payor before the Bombardier Plan.* |
| ***Over the counter drugs*** | • OTC drugs; will include only, non- sedating antihistamines, antacids, enteric coated ASA, NSAID preparations, calcium therapy and when medically necessary, laxatives. In addition, there will be a $300 |

| | |
|---|---|
| | per person per year maximum for OTC drugs. |
| ***Vision and Hearing Care***<br>***(see page 75 for limitations)*** | • prescription lenses and frames<br>• prescription contact lenses $195<br>• Glasses $230 (for single lenses) every 24 months for insured members over age 14, and every 12 months for insured dependents up to age 14; $250 for bifocals and $270 for trifocals |
| | • Laser eye surgery will be paid at the same level as the multifocal lenses, once per lifetime<br>• standard hearing aids: once every 24 months<br>• Ear molds for dependent children aged (14) years and under, up to a maximum of $400 per year |

| **Industrial Alliance** | |
|---|---|
| ***Land Ambulance Services*** | • up to $70 per trip; maximum $275 per person per year |
| ***Emergency Travel Insurance (page 18)*** | • Services covered out-of-province or out of country only if needed for emergency care |
| ***Paramedical Services***<br>***Therapist must be registered in the province of Ontario*** | • Acupuncture, Chiropractor, Osteopath, Speech Therapist, Podiatrist, Masseurs (RMT), Naturopath and Homeopath<br>• Combined maximum of $650 per calendar year<br>• *Registered Massage Therapist (RMT), limited to $500 per year, subject to the requirement of a medical prescription*<br>• No deductible applies<br>• *Podiatrist services will be paid concurrently with OHIP* |
| ***Other Medical Expenses***<br>*($35 single and $60 family deductible apply — see next page)* | • charges for surgical operations or other charges, unless prevented by law, for specific complications of pregnancy<br>• charges for cosmetic surgery if required because of an accident that is not work related (must commence within 12 months of the accident).<br>• services of a licensed registered nurse or registered nursing assistant provided he/she is qualified to administer drugs, if recommended by a doctor up to a $25,000 per person per calendar year maximum.<br>• services of a licensed psychologist- maximum 24 visits |

| | |
|---|---|
| | per year.<br>• services of a licensed physiotherapist- maximum 24 visits per year.<br>• dental care due to an accidental injury to natural teeth<br>• prosthetic appliances.<br>• durable medical equipment.<br>• prescribed support stockings maximum of 4 pairs per year, if ordered by a doctor and provided such charges are reasonable and customary, subject to pre-approval by the Insurance Company.<br>• Effective Jan 1, 2011, orthopedic shoes and custom-made orthotics one (1) pair every 18 months up to a maximum of $400.<br>• Orthopedic shoes and custom-made orthotics, must be prescribed by your physician and include the diagnosis.<br>• colostomy or ostomy supplies.<br>• medical services including anesthesia, oxygen, blood transfusions, diagnostic x-rays, laboratory and other diagnostic procedures, therapeutic radiology benefit will have a cumulative $1250 annual maximum per person.<br>• pediatric aero chamber.<br>• coverage for Wigs for patients undergoing treatment for cancer, lupus or alopecia, to a lifetime maximum of $600 per person. |

For expenses relating to Out of Province there will be a zero deductible and paid at 100%

"Other Medical Expenses" you must pay a deductible of **$35 single / $60 per family** covered by the Plan, per calendar year.

After you pay the deductible, the Plan will cover a **maximum of 80% of expenses** described. Land ambulance are exceptions — coverage is 100% of expenses.

CA 125 Ovarian cancer tests and PSA tests are covered at 100%, no deductibles apply.

Paramedical services are paid at 100% with no deductible for a combined $650 maximum.

Registered Massage Therapist (RMT), limited to $500 per year, subject to the requirement of a medical prescription.

Your lifetime maximum reimbursement for these expenses is $35,000 per family member. However, each year on January 1, the Plan "restores" up to $1,000 of your claim room based on your past expenses. As a result, the restored amount ($1,000 or less) no longer counts against the $35,000 maximum.

For those employees who have not retired yet, you may request to have the $35,000 maximum reinstated if you have expenses of more than $1,000 in the calendar year. You

must provide the insurance company with medical evidence of good health at your own expense. Your maximum may be reinstated after the insurance company approves your request.

Please note that once you **retire** your lifetime maximum is not eligible for yearly reinstatement amounts.

***Coverage Period***
Your coverage under this group Medical Plan ends if you end your employment with the Company or if you die.

## Special Situations

***When do I get my Green Shield Identification Card?***
Green Shield Canada will mail out your Identification Card approximately two weeks after you qualify for coverage. It is also your Drug Card.

If you have chosen to cover your dependents, you will automatically get a second Card.

You can receive a Card for a dependent child after your dependent information is up to date. You must provide proof of registration for your children who are ages 21–25 and in full-time post-secondary education. You must also provide **proof of disability on an annual basis** for any child that is over age 21. Please note that disabled children must be registered with Employee Service Center prior to their 21st birth date.

You should carry your Green Shield Card and your OHIP Health Card with you at all times, especially when traveling outside Ontario.

If you change your dependent coverage by completing an Enrollment/Change Form, or you change payrolls, you will receive a new Card. If you have a new baby or adopt a child, you will have to bring the documents to the Employee Service Center. You should keep any receipts from the date of the change until you receive your new Card, and then submit the expenses.

*For more information about using your Green Shield Card, see page 14.*

***How do I change my coverage?***
Visit Employee Service Center to change your dependent coverage and bring any relevant documents, such as a birth certificate (if you have a new baby). The change will **be effective the day you notify the Employee Service Center. However, it can take up to a week for the insurance company to update their records to reflect this change.**

***If my medical expenses for the current year do not add up to the deductible, can I apply that amount to the deductible in the following year?***
Yes. The Plan protects you from having to pay the deductible late in one year and again early in the next year. Any amount you pay toward the deductible in the last three months of a year will count toward the deductible for the next year.

***What happens to my coverage if I'm on disability leave?***
The Company will continue your Medical Plan coverage during your approved leave for as long as you are receiving Sickness and Accident or Extended Disability Benefits.

***What happens to my coverage if I'm on maternity/parental leave?***
The Company will continue your Medical Plan coverage during your approved leave.

***What happens to my coverage during a lay-off?***
If you are subject to recall, the Company will continue your Medical Plan for up to three months. After that time, you may continue your coverage for up to 24 months by paying the required premiums.

If you have seniority and you are recalled your benefits will commence on your first day of work.

***What happens to my coverage if I'm on an approved non-disability leave?***
You can choose to continue your Medical Plan coverage for up to 12 months of your leave by paying the required premiums.

***What happens to my coverage if I leave the Company?***
Your coverage ends when you leave the Company, with some exceptions.

If you or your dependents are "totally disabled" when your employment ends, you may still receive benefits related to that disability for up to 12 months. In this case, the term "totally disabled" refers to an injury or disease that the Medical Plan would normally cover. It also means that the disability prevents you from performing your regular job, and you are not working at another job. A dependent is "totally disabled" if he or she cannot do most of the activities that a person in good health and of the same gender and age could normally do.

Also, if you or a dependent were pregnant before your coverage ended, you may still submit your covered expenses related to the pregnancy.

***What happens to my coverage if I retire?***
Once you retire, all benefits for the following will continue- major medical, drugs, semi-private, vision and audio coverage. Life Insurance will be **reduced** from $95,000 to $3,000 and Dental benefits will **cease**. You will also start to receive a pension from the Pension Plan.

***What happens to my coverage if I die?***
If you die prior to age 55 your spouse will continue to receive Health Care benefits (as defined in section 1.01.2 of the Benefits Agreement) based on your years of service with the Company. The minimum period will be (3) months and the maximum will be (9) months from your date of death. If you are over age 55 your spouse will receive Health Care benefits until she/he dies, remarries or enters into a common-law relationship.

## Claims

### *Co-ordination of Benefits*

The Medical Plan requires co-ordination of benefits (COB). This term means that if you or any of your dependents have group insurance for similar benefits, payments under Bombardier may be limited. The limit ensures that reimbursement from all the group plans is not more than 100% of your actual expenses.

Here is the procedure to follow:

- You submit your personal claims to the Bombardier Medical Plan.
- Your spouse submits his/her claims to his/her medical plan.
- The spouse whose month and day of birth come first in the year submits the claims for all dependent children.
- You can submit any amount not paid by the first plan to the second plan for reimbursement.

When you submit a claim to a second plan, you must include the Explanation of Benefits (EOB), which the first plan supplied to you, plus photocopies of any receipts.

If your spouse works at Bombardier, COB still applies to you. Please ensure that your clock number and your spouse's clock number are on the claim forms. The Plan will pay and co-ordinate your eligible expenses accordingly.

### *Claim Process*

*Green Shield Canada* administers claims for

- Drug coverage
- Vision and Hearing Care
- Semi-Private Hospital Coverage
- Diabetic Supplies

All claims submitted to Green Shield require the following information:

- Group number or identify your coverage as -- Bombardier
- Subscriber number/Patient number
- Patient's name and address

Please refer to your Green Shield Identification Card for the proper numbers. Your patient number will end in two zeros. Each dependent's patient number will end in a different digit.

You must submit a claim to Green Shield **within 12 months** of the date of an expense.

*Industrial Alliance* administers claims for

- Land Ambulance Services
- Paramedical Services
- Dental
- Other Medical Expenses

All claims submitted to Industrial Alliance require the following information:

- Plan Number for Health Claims (our Plan Number is 28202)
- Certificate Number (99 plus Clock Number)
- Patient's name and address

If you fill out a claim incorrectly, Industrial Alliance will return it.

You must submit a claim to Industrial Alliance **within 24 months** from the date of the expense.

## Claim Procedures for Green Shield Canada

### *Drug Claims*

Your Green Shield Card gives you the convenience of on-the-spot claims payment. Most pharmacies in Canada have access to a series of networks, which electronically submit claims.

Each time you purchase prescription drugs from a pharmacy in Canada, give your Card to the pharmacist. The pharmacist will enter your patient number from your Card into the on-line system, which submits your claim to Green Shield. The system stores all your dependent information. This ensures that Green Shield approves claims only for eligible individuals. If Green Shield approves your claim, the pharmacist receives a message indicating the amount the Plan will pay. You pay $5.00 per prescription.

Should you have a problem using the Card, you or the pharmacist can call Green Shield at 1-888-711-1119. If a pharmacist does not have an on-line terminal, you may submit a paper claim to Green Shield.

Your dependents may also be able to use a Green Shield Card. However, you must follow the same co-ordination of benefits (COB) process described on page 13. COB means that if you or any of your dependents have group insurance for similar benefits, payments under Bombardier may be limited. The limit ensures that reimbursement from all the group plans is not more than 100% of your actual expenses.

Here is the procedure to follow:

***If your spouse doesn't have a medical plan...***

- You use the Green Shield Card for any prescriptions for yourself, your spouse, and/or your eligible children. (If you wish, you can get separate cards for your eligible children who live away from home and for your spouse.)

***If your spouse has a medical plan…***

- You use the Green Shield Card for your own prescriptions only.
- Your spouse submits his/her claims to his/her medical plan first. You can use a Green Shield claim form to claim any amount that your spouse's plan did not pay.
- The spouse whose month and day of birth come first in the year submits the claims for all dependent children.
- If your birthday comes first in the year, you can use the Card to pay for prescriptions for your eligible children.
- If your spouse's birthday is first in the year, he/she must submit all your children's expenses to his/her plan first.
- In either case, you can submit to a second plan any amount that the first plan did not pay.

When you submit a claim to a second plan, you must include the Explanation of Benefits (EOB), which the first plan supplied to you, plus photocopies of any receipts.

If your spouse works at Bombardier, COB still applies to you. Please ensure that your clock number and your spouse's clock number are on the claim forms. The Plan will pay and co-ordinate your eligible expenses accordingly.

***Snapshot:***

First, the facts:

- Joe works at Bombardier. His spouse is Anna.
- Joe and Anna have three children. The oldest, Carter, is away at university.
- Anna has a medical plan at her company.
- Joe's birthday is in February and Anna's is in October.

Now, the process:

- Joe gets a Green Shield Card. He uses it for all his own prescriptions and pays $5.00 per prescription. Joe keeps all his receipts and submits the unpaid amounts to Anna's plan.
- Anna doesn't get a Card because she has her own plan. She submits her claims to her own plan first. (Of course, if her plan has a drug card, she can use that.) If her plan doesn't cover the whole expense, Joe can claim the rest. He needs the Explanation of Benefits (EOB), which Anna's plan sends with her reimbursement cheque, as well as copies of Anna's original receipts.
- Because Joe's birthday is first in the year, he's responsible for the children's claims. (It doesn't matter how old Joe is or how old Anna is, only the *month* and *day* matter.) So, Joe uses his Green Shield Card to buy all the children's prescriptions. He keeps the receipts for the $5.00 per prescription and submits them to Anna's plan.
- Since Carter is away from home, Joe gets a second Card and sends it to Carter. Carter buys his own prescriptions but keeps his receipts and sends them home to Anna (with his regular pleas for money) so she can submit them to her plan.

### *Vision Care Claims*

Vision care service providers can call Green Shield for prior approval. Most service providers have a supply of Green Shield Vision Claim Forms and will bill Green Shield directly.

If you have paid the service provider, submit a completed Vision Claim Form with an original itemized paid receipt. The receipt must show the following:

- the vision prescription
- a breakdown of the charges for lenses and frames
- the date of the service (**the date you picked up your glasses**)
- the patient's name and patient number

### *Hearing Aid Claims*

A medical specialist must prescribe hearing aids. Since the Plan includes detailed limitations and exclusions, call Green Shield before you purchase a hearing aid to find out what expenses will be eligible.

Many service providers have a supply of Green Shield Audio Claim Forms and will bill Green Shield directly. Otherwise, you will need to request a form from the Benefits Department.

***Hospital Claims***

For hospital expenses for yourself or an eligible dependent:

- You need to provide the hospital with your Green Shield plan number #2090 for active employees, #2091 for retirees, and #2093 for surviving spouses. The hospital will bill Green Shield directly.

- The hospital will bill you, when you leave, for any non-eligible expenses or expenses beyond individual plan maximums.

***Claim Submission Address***
All Green Shield Claims can be sent to
**Green Shield Canada**
**P.O. Box 1615**
**Windsor, Ontario N9A 7J3**

If you have any questions about your Green Shield coverage or the status of a claim, call Green Shield at **1-888-711-1119**

**Claim Procedures for Industrial Alliance**

In all cases, Industrial Alliance encourages you to consult with them at 416-585-5902 or 1-888-295-6555 **before** purchasing or renting expensive medical services or supplies. They will confirm if the expense is covered.

To claim an expense for yourself or an eligible dependent:

1. Pay the covered expenses and ask for a receipt.
2. Verify that the receipt includes full details about the expense. It should include the name of the doctor, pharmacist, or laboratory; a description of the service or product provided; the amount charged and the date of payment; and the patient's name (yours or your dependent's).
3. Obtain a *Medical Expenses Claim Request* form from the Benefits Department.
4. Follow the instructions on the form to complete it and sign it.
5. Mail the form, together with your receipts and claim documents, to Industrial Alliance at the appropriate regional address shown on the back of the claim form.

Upon receipt of your form and receipts, Industrial Alliance will prepare a claim summary called an Explanation of Benefits (EOB). They will send you the EOB and a benefit cheque, if applicable. Industrial Alliance reserves the right to request further details.

Submit original itemized receipts only. Industrial Alliance does not accept photocopies.

If you plan to submit a portion of the claim to your spouse's plan, be sure to keep photocopies of your receipts. (See "Co-ordination of Benefits," page 13)

***Claim Submission Address***
All Industrial Alliance Claims can be sent to
**Industrial Alliance**
**P.O. Box 4643, Station A**
**Toronto, Ontario M5W 5E3**

1-888-295-6555

Policy number 28202

Cert number 99+your clock number

## *Travel Assistance Service*

### What the Plan Does

The Travel Assistance Service gives you access to a worldwide communications and health care network that will help you deal with a medical emergency or other serious problem while traveling. The Service is available 24 hours a day, seven days a week.

In the event that the insured person fails to contact CanAssistance regarding a medical consultation or hospitalization, the insurer **reserves the right to reject the claim**.

### Who Is Covered

You must be a full-time employee or a retired employee of the Company to access the Travel Assistance Service.

The Service is available to you and your eligible ***dependents*** any time you leave your province of residence, whether the trip is for business or pleasure.

Your coverage is valid for 90 days from the date you leave your home province for active employees and **180 days for retired employees.**

### Costs

There is no employee cost for this Service. The Company pays the costs for you, up to your lifetime maximum of $35,000. Any expenses over the $35,000 is your responsibility.

**Benefit Details**

***Qualification for Benefits***

The Service covers you on the first of the calendar month following 90 working days of active full-time service with the Company. The full Service is available to your dependents if you have included them under your Medical Plan coverage.

***Access to Benefits***

If it is possible, you, or someone traveling with you, must contact CanAssistance before any services are provided. This is to ensure that you receive appropriate care. If contact cannot be made before services are provided, CanAssistance should be contacted as soon as possible afterwards.

Access to a fully staffed travel assistance centre is available 24 hours a day. As soon as you need assistance, contact CanAssistance, using the numbers that appear on your Industrial Alliance Identification Card.

**From the United States and Canada ................................ 1-800-203-9024**

**From other locations:**
**Collect........................................................................ 1 (514) 499-3747**

- ........................................................................ the policyholder's name Bombardier Aerospace
- ........................................................................ the group number 28202
- ........................................................................ the patient number 99 plus your badge number
- the patient's OHIP Health Card number
- your (or your eligible dependent's) full name, location, and telephone or telex number at the location
- an explanation of the problem

The Industrial Alliance call centre is staffed with multilingual professionals. One of them will speak with you or the service provider (such as a ***doctor***) to confirm your coverage and help you obtain access to any of the covered services.

**Summary of Services**

CanAssistance will reimburse you for the services, based on the usual, reasonable, and customary charges in the area you obtained the services, less any amount paid by OHIP.

The reimbursement will be in Canadian funds at the official rate of exchange on the date your claim is processed.

Emergency Assistance: If you need to see a doctor or require hospitalization as the result of an accident or sudden illness, it is extremely important that you contact CanAssistance (Industrial Alliance Travel Assistance Service) as soon as possible. In addition to confirming your eligibility, Can Assistance provides a variety of services, which include overseeing your file and advancing funds when necessary.

**Payment Advances or Guarantees**: If necessary for your care, Industrial Alliance may make guarantees of payment or advances of payment.

**24 Hour Assistance**: Industrial Alliance, will also provide the following services when they are appropriate and necessary.

- **Pre-departure assistance**

  CanAssistance provides information on passport, visa and vaccination requirements for your travel destination.

- **Assistance in the event of lost or stolen personal documents**

  In the event that your personal documents (eg. passport or credit cards) are lost or stolen, CanAssistance will contact local authorities to help you replace them.

- **Referrals for legal assistance**

  When needed, CanAssistance will provide contact information for local legal services and will help the insured person obtain cash advances from family, friends or through credit cards.

- **Transmission of urgent messages**

  When traveling, urgent messages from family, friends and associates are transmitted to the insured (you and your covered dependents) via the telephone messaging service. This service is also used to deliver messages from the insured person. Messages are saved for 15 days.

- **Information on local medical services**

  CanAssistance will recommend an appropriate local doctor, dentist, pharmacist or medical facility.

- **Medical care monitoring**

  CanAssistance's medical personnel will monitor the medical care that you receive and will, whenever necessary, communicate with you, the doctor who is treating you, your family doctor and your family.

**Transportation and Related Services**

- **Medical transportation**

  Appropriate steps will be taken to transport you to and from the closest local medical facility or medical facility in your province of residence. CanAssistance covers the cost of medical transportation.

  If medically necessary, CanAssistance will arrange for and cover the cost of a medical attendant's return trip. If necessary, CanAssistance will also arrange for and cover the cost of a return trip for a qualified children's escort.

- **Transportation of an immediate family member**

  If, while traveling alone, you or a dependent is hospitalized for more than 7 days, CanAssistance will cover the cost of round-trip economy class fare to the hospital for one family member.

- **Repatriation of the insured person's body**

  If the insured person dies during a trip, CanAssistance will obtain the necessary authorizations and make arrangements for the repatriation of the body to the province of residence. Costs incurred for the preparation and transportation of the body is covered up to a maximum of $7,500. Burial costs are not covered.

- **Meals and accommodations**

  In the event that the trip must be prolonged as the result of an injury or illness afflicting the insured person, an immediate family member traveling with the insured person or a traveling companion, meals and accommodations in a commercial establishment are covered up to a maximum of $3,000 per medical emergency.

- **Vehicle return**

  If, due to illness, injury or death, the insured is unable to return his/her vehicle home or to return a rented vehicle to a rental agency, CanAssistance will cover the cost up to a maximum of $1,000.

## Termination or Interruption of Insurance Coverage

The insured person's coverage ends on the first of the following dates:

- The date of termination of employment of the member
- The date on which the insured person ceases to be covered by the health insurance board in his/her province of residence.
- The date on which the insured person commits a fraudulent act against the insurer.

## Exceptions and Restrictions

Certain exclusions and restrictions to the travel insurance plan apply. For example, no benefit is payable in the event of:

- Pregnancy or related complications within eight weeks of the expected delivery date.
- Accident sustained while participating to a motor vehicle competition or speed contest, parachuting or skydiving, bungee jumping or mountain climbing (grade 4 or 5 routes).
- Over medication or drug abuse, driving while under the influence of drug or alcohol.
- Suicide or attempted suicide.
- Costs incurred for cosmetic purposes.
- Services which could have been incurred in the province of residence without endangering the life of the injured person.
- Nursing costs provided mainly for the patient's comfort.
- Expenses over the maximum coverage of $35,000 lifetime.

We strongly recommend that you read the detailed list of exclusions and restrictions, which you can find in the **Appendix 1.**

# Dental Plan

## What the Plan Does

The Dental Plan pays part or all of the cost of many of your dental expenses.

It does not cover the costs of dental care that you need because of an accident that is not work related. That coverage is available through your Medical Plan. Coverage for workplace accidents is available through the ***Workplace Safety and Insurance Board (WSIB)***.

## Who Is Covered

You must be a full-time employee of the Company to be covered under the Dental Plan. You may also choose to cover your ***dependents***, including your ***spouse***. (For a definition of *dependents* and *spouse*, see page 85.)

Your coverage comes into effect the first of the calendar month following 90 working days of active service with the Company.

## Costs

The Company pays the costs of administration of the Dental Plan and also covers the costs of eligible, approved dental expenses for plan members.

Even if an expense is covered, in most cases you must first pay the expense, and the Dental Plan will pay you back after you complete a claim form. In other cases, your dentist may be able to submit the claim for you. (See "Claim Process," page 27)

The Plan limits your coverage for some expenses to a maximum amount per person per year or per lifetime.

## Benefit Details

### *Qualification for Benefits*

You are covered for Dental Plan benefits on the first of the calendar month following 90 days of active service.

### *Benefit Summary*

The following table shows the main categories of coverage in the Dental Plan.

Some of these categories have individual maximum payment levels or other restrictions. There is an overall maximum of $2,500 per person per calendar year for all dental procedures except orthodontics.

Orthodontic services are limited to $2,500 per person per *lifetime*. Calendar year goes from January 1st to December 31st.

Industrial Alliance must pre-approve your expenses if your dentist expects your treatment will cost more than $300. If you do not receive this pre-approval, your expenses may not be covered.

| Category | Covered Services |
|---|---|
| **Diagnosis, Preventive Care, and Minor Restorative Care** ***(100% reimbursement)*** | • complete oral exam — once every 12 months<br>• recall oral exam — once every 6 months<br>• cleaning and scaling — once every 6 months, scaling is covered for up to 8 units of time reimbursed at 80%<br>• fluoride treatment — once every 6 months<br>• x-rays, tests, and laboratory examinations<br>• anesthesia<br>• basic restorative services (e.g., amalgam fillings)<br>• root canal therapy (maximum $750per tooth)<br>• surgical work (e.g., extraction of teeth)<br>• relining, rebasing, or repairing of dentures |
| **Periodontal Care (care of gums) and Major Restorative Care** ***(50% reimbursement)*** | • treatment of the gums<br>• root canal surgery<br>• major restorations:<br>• inlays, onlays, pins, etc.<br>• crowns, bridgework, dentures and implants<br>• other surgical services<br>• sealant coverage |
| **Orthodontic Care** ***(50% reimbursement)*** | • services of an orthodontist for insured members under 19*<br>• maximum coverage: $2,500 per *lifetime*<br>** services can continue past age 19 if they started before that age* |

***Dental Fee Guide***

All of the services above are described in the Ontario Dental Fee Guide. This is a pricing and service guide that all Ontario dentists use. It is updated every year. Dentists are not restricted to the fees in the guide — they may charge a higher or lower fee.

Maximum payments in the Dental Plan are based on the last year's Fee Guide. This means, in some cases, the Plan may not reimburse you for the full fee you have been charged.

These are the Dental Fee Guides used to calculate repayment:

| Effective Date | Dental Fee Guide Used |
|---|---|
| January 1, 2021 | 2020 Guide |
| January 1, 2022 | 2021 Guide |
| January 1, 2023 | 2022 Guide |

| January 1, 2024 | 2023 Guide |
| --- | --- |
| | |
| | |
| | |

***Coverage Period***
Your coverage under this group Dental Plan ends right away if you

- end your employment with the Company, or
- retire from the Company, or
- if you die.

**Exceptions**

The Dental Plan will not reimburse you for the following:

- Treatment or appliance related directly to full mouth reconstruction, to correct vertical dimension or any temporomandibular joint dysfunction.
- Services rendered by a dental hygienist and not administered under the supervision of a dentist.
- Dental services covered under the Medical Plan, if such benefit is part of this contract, or under any other group insurance contract.
- Services and supplies relating to any appliance worn in the practice of a sport.
- Expenses which are payable or reimbursable under a worker's compensation act or would normally have been if a claim had been submitted.
- Care or services necessary due to an attempted suicide or voluntary self-inflicted injury, while sane or insane.
- Care or services resulting from civil unrest, insurrection or war, whether war be declared or not, or participated in a riot.
- Services which are not medically required, which are given for cosmetic purposes or which exceed ordinary services given in accordance with current therapeutic practice.
- Care or services rendered free of charge or which would be free of charge were it not for coverage or which are not chargeable to the covered person.
- Orthodontic treatment that does not start before a patient reaches 19 years of age.
- Expenses incurred by any person who has entered the armed forces of any country on a full-time basis.
- Examinations required for use of a third party.
- Treatment which is not generally recognized by the dental profession as an effective appropriate and essential form of treatment for the dental condition.
- Replacement of an appliance which has been lost, mislaid or stolen.
- Personalization or characterization of dentures.
- Supplies, which were first, prescribed or recommended while the person was not a covered family member.

## Special Situations

***How do I change my coverage?***
To change your dependent coverage, you must complete an Enrollment/Change Form, available from Employee Service Center. Please bring copies of any necessary documents (such as a birth certificate if you have a new baby). The change will be effective the day you notify the Employee Service Center. However, it can take up to a week for the insurance company to update their records to reflect this change.

***What happens to my coverage if I'm on disability leave?***
The Company will continue your Dental Plan coverage during your approved leave for as long as you are receiving Sickness and Accident or Extended Disability Benefits.

***What happens to my coverage if I'm on maternity/parental leave?***
The Company will continue your Dental Plan coverage during your approved leave.

***What happens to my coverage during a lay-off?***
If you are subject to recall, the Company will continue your Dental Plan coverage for up to three months. After that time, your coverage will end if you are not recalled to the ***active payroll***.

If you have ***seniority*** and you are recalled your coverage will be effective on your first day of work. Please note it may take up to two weeks for this recall to be reflected in the Insurance Company's database.

***What happens to my coverage if I'm on an approved non-disability leave?***
You can choose to continue your Dental Plan coverage for up to 12 months of your leave by paying the required premiums.

***What happens to my coverage if I leave the Company?***
Your coverage ends.

***What happens to my coverage if I retire?***
Your coverage ends.

***What happens to my coverage if I die?***
Your coverage ends.

## Claims

***Co-ordination of Benefits***
The Dental Plan requires co-ordination of benefits (COB). This term means that if you, your spouse, or any of your dependents are insured for similar benefits under any other group plan, payments under Bombardier may be limited. The limit is designed to ensure that reimbursement from all the group plans does not exceed 100% of the current fee guide.

Here is the procedure to follow:

- You submit your personal claims to the Bombardier Dental Plan.
- Your spouse submits his/her claims to his/her dental plan.
- The spouse whose month and day of birth comes first in the year submits the claims for all dependent children.
- Any amount not paid by the first plan may be submitted to the second plan for reimbursement.

When you submit a claim to a second plan, you must include the Explanation of Benefits (EOB) form the first plan supplied to you and photocopies of any receipts.

If your spouse works at Bombardier, COB still applies to you. Please ensure that your clock number and your spouse's clock number are on the claim forms. All eligible expenses will be paid and coordinated under the plans accordingly.

***Claim Process***

It is your responsibility to submit claims to Industrial Alliance as soon as possible after the treatment has been rendered to ensure that the receipt are within the reimbursement period.

You must consult with Industrial Alliance at 416-585-5902 if your dentist expects that your recommended treatment will cost more than $300. Industrial Alliance will confirm if your expenses will be covered before you start treatment.

To claim dental expenses for yourself or a dependent, take these steps:

1. Obtain a Dental Claim Form from the Benefits Department.
2. Have your dentist complete Part 1 of the form.
3. Complete Part 2 of the form yourself. Make sure you include
   - your Plan Number for Dental Claims (which is #28202)
   - your Certificate Number (99 plus Clock Number)
   - the patient's name and address
4. Mail the form, together with your receipts and claim documents, to Industrial Alliance.

When Industrial Alliance receives your form and receipts, they will prepare a claim summary called an Explanation of Benefits (EOB). They will send the EOB to you along with a benefit cheque, if applicable. Industrial Alliance may ask you for further details before they can process your claim.

Submit original itemized receipts only; photocopies are not accepted.

If you plan to submit a portion of the claim to your spouse's plan, be sure to keep photocopies of your receipts. (See "Co-ordination of Benefits," page 26)

***Claim Submission Address***

All Industrial Alliance Claims can be sent to

**Industrial Alliance**

**P.O. Box 4643, Station A**
**Toronto, Ontario M5W 5E3**

If you have any questions about your Industrial Alliance coverage or the status of a claim, you may call Industrial Alliance at **416-585-5902**

***On-line Claims Submission***

Your dentist may have on-line access to Industrial Alliance. If so, your claim may be processed at your dentist's office without a claim form. You will pay only your portion of the cost.

# Sickness and Accident Plan (S&A Plan)

## What the Plan Does

The Sickness and Accident Plan (S&A Plan) pays you an income if you cannot work because of a disability that is *not* work related. The disability may be an illness or accidental injury. The Workplace Safety and Insurance Board (WSIB) covers work-related disabilities.

## Who Is Covered

The Plan covers you starting on the first of the calendar month following 90 working days of active service with the Company.

Your coverage ends if

- your employment with the Company ends (other than ***lay-off***) and you are not already receiving S&A benefits; or
- you retire from the Company; or
- you die.

## Costs & Taxes

The Company pays the costs of the S&A Plan.

The government counts S&A benefits as part of taxable income. The insurance company will withhold the appropriate taxes from any benefit payments you receive. They will send you a T4A slip each year before the income tax filing deadline.

## Benefit Details

### *Qualification for Benefits*

You must fill out an application form and show medical proof of your disability to qualify for benefits. (See "Claims," page 32.) The Carrier will reimburse up to $30 per completed medical form (Attending Physician Statement or APS) that you need to prove your claim. The Company also has a right to ask you to see a ***doctor*** of its choosing under certain circumstances.

Up to $30 will also be reimbursed if you have to secure an additional form if the wrong form was originally requested.

Effective December 31, 2006, employees aged 65 or older will be eligible for weekly benefits under the Sickness & Accident Plan for a maximum period of six (6) months and will not be eligible for coverage under the Extended Disability Plan.

### *Benefit Amount*

If you qualify, the Plan will pay you weekly benefits based on a seven-day week. The maximum weekly payment are as follows:
$805 and $830 for Skilled Trades.

You may also qualify for disability benefits from the ***Canada/Quebec Pension Plan (CPP/QPP)***. If you do, the Company will subtract an amount equal to your C/QPP benefit (benefit of the disabled contributor only) from your regular S&A payment. This happens because the S&A Plan is meant to protect you *only if you do not have other income*.

***Benefit Period***
The start date of your benefits depends on the type of disability you have.

- Your benefits will start on the **first day** of your disability if
  - you are disabled because of an accident; or,
  - you are hospital confined; or
  - you lose a full day's pay because of an outpatient surgical procedure for which a benefit of $25.00 or more is scheduled or payable, or
  - any treatment related absence to a patient undergoing cancer treatments, or

As of July 1, 2012, benefit is paid for up to 1 day for colonoscopy.

- Effective June 23, 2021, your benefits will start on the **third day** due to sickness, if hospital confinement is not necessary.

Payments may continue for up to 52 weeks, or up to the date you retire, whichever is first. Please note that once you turn 65, Short Term disability can only be paid for up to a 26-week period following your birth date. If a lay-off occurs or you end your employment during this time, your benefits will continue for as long as you meet the regular requirements of the S&A Plan.

**Special Situations**

***What happens if I'm not at work when my coverage should start?***
Your coverage will start on the day you return to work.

***What happens if I'm on lay-off when my coverage should start?***
Your coverage will start right away when you are back on the ***active payroll***.

### *What happens if I return to work and then become disabled again?*
The answer depends on the cause of your disability and the time period since you returned to work.

- The cause of your new absence is *different* from the first:
- the S&A Plan treats you as if you had not been disabled before.

- The cause of your new absence is the *same disability, or a related disability* and you become disabled *within two weeks* after you return to work:
- your benefits will start again where they left off, and
- the normal four-day waiting period will not apply.

- The cause of your new absence is the *same disability, or a related disability* and *more than two weeks* have passed since you returned to work:

- the S&A Plan treats you as if you had not been disabled before and the normal two days waiting period will apply.

***Can I return to work part time or do a different job?***
The Company's rehabilitation specialist will work with you to find a modified job that you are able to do. You may work at this job on a temporary basis until you can return to your regular job. You may not displace an employee with greater seniority.

***Can I get S&A benefits if I'm waiting for WSIB benefits?***
No.

In the event that WSIB is slow in reviewing your claim, you can apply for a WSIB Advance through Employee Health Services. They will require that you complete an authorization form which will allow payroll to deduct future wages or benefits, at the rate of $250 per week or 30% of your weekly wages, whichever is less.

In the event that WSIB declines your claim, you can then apply for S & A benefits. However, you will have to provide a copy of the denial letter to the Employee Service Center.

***What happens to my benefits if I'm on maternity leave?***

Complications due to pregnancy (before or during your leave) or an unrelated disability during your leave will be treated like any other disability under the S&A Plan. See "Claims," page 32, for the application process.

***What happens to my coverage during a lay-off?***
Your coverage will continue for up to 52 weeks if you have one or more years of seniority and you are not receiving Employment Insurance benefits. If you are disabled during the 52-week period, and meet the normal requirements of the S&A Plan, you may receive S&A benefits without a waiting period.

You may not receive S&A benefits if you are eligible for benefits from
- Employment Insurance or the Company SUB Plan (see page 37); or
- another employer's S&A Plan; or
- any federal or provincial plan other than the Canada or Quebec Pension Plan.

***What happens to my coverage if I'm on an approved non-disability leave?***
Your coverage will be suspended during your leave. It will start again when you return to work.

***What happens to my coverage if I leave the Company?***
If your employment with the Company ends (other than by lay-off) and you are not already receiving S&A benefits, your coverage ends.

***What happens to my coverage if I retire?***
Your coverage ends.

***What happens to my coverage if I die?***
Your coverage ends.

## Claims

Take the following steps as soon as possible after your disability begins:

1. Ask the Disability Department for an Attending Physician Statement (APS).
2. Ask your doctor to fill out the APS.
3. Return the completed APS to the Disability Department or the Health Center.

A delay in filling out the APS will delay your benefits. All claims must be reported to Industrial Alliance within 90 days of your last day worked.

You must be under a doctor's care to receive benefits. If you are not able to visit a doctor, the Company will accept proof that you have talked to your doctor by telephone. Your doctor must still fill out an APS to confirm the diagnosis and treatment he/she recommended by telephone.

From time to time, you may need to resubmit proof that you are still seeing a doctor and receiving appropriate care.

# *Extended Disability Benefit Plan (EDB Plan)*

## What the Plan Does

The Extended Disability Benefit Plan (EDB Plan) pays you a monthly benefit if you are ***totally and permanently disabled*** and your disability continues beyond the 52 weeks covered by the S&A Plan. (See below for a definition of *totally and permanently disabled*.)

## Who Is Covered

As soon as you are covered by the S&A Plan, you are eligible for coverage under the EDB Plan.

Your coverage ends if

- your employment with the Company ends (other than by lay-off) and you are not already receiving EDB benefits; or
- you reach age 65; or
- you retire from the Company; or
- you die.

## Costs & Taxes

The Company pays the costs of the EDB Plan.

The government counts EDB benefits as part of taxable income. The insurance company will withhold the appropriate taxes from any benefit payments you receive. They will send you a T4A slip each year before the income tax filing deadline.

## Benefit Details

### *Qualification for Benefits*

You must be "totally and permanently disabled" to qualify under the EDB Plan. That means the insurance company will only give benefits to a person who meets this definition:

> a person who cannot work at any gainful employment at Bombardier for which he/she is, or may reasonably become, qualified by education, training, or experience.

"Gainful employment" means work that you have at least minimum qualifications for and that you are physically able to do even if you are sick or injured. If you don't have minimum qualifications for a job, but could learn how to do it, the Company expects you to become qualified, if it's reasonable to expect you to go through the training.

You must fill out an application form and show medical proof of your disability to qualify for benefits. (See "Claims," page 35)

The Company has a right to ask you to see doctors or specialists of its choosing in order to get a second opinion on your condition.

### *Benefit Amount*

If you qualify, the Plan will pay you monthly benefits. The maximum monthly payment is $1,800

The EDB Plan is meant to pay you benefits *only if you do not have other income*.

### *Reduction of Benefits*

The monthly indemnity payable under this benefit will be reduced by any disability benefits which are payable or which would have been payable to the participant had a satisfactory application been made under:

- ***WSIB*** payments,
- *A provincial **automobile insurance law**, if applicable*
- *A provincial **crime victims compensation act**, if applicable*
- payment from the Company Pension Plan,
- Canada/Quebec Pension Plan (C/QPP) disability benefits,
- Any disability or old age benefit under any federal or provincial law*

  * *The last item does not include old age benefits paid on a "needs basis" or those paid in a reduced amount because of your age at the time you receive them. It also excludes federal or provincial lost-time disability benefits.*

Moreover, the amount of monthly disability income benefits payable by the insurer is adjusted so that the sum of all income, compensation, indemnity and benefits which the participant would or could receive, due to his disability, from a) the policyholder, b) government body, c) under any other insurance contract, may at no time exceed 80% of the gross monthly salary determined at the onset of disability.

You should apply for disability benefits from C/QPP following four months of disability. C/QPP value will be deducted from your disability pay only after you were approved for C/QPP.

The current collective bargaining agreement limits the reduction for C/QPP benefits to a maximum of $414.13 per month.

### *Top Up*

As of June 23, 2009, during partial return to work, the amount of top up will be calculated using the same method as for S&A benefit.
This provision provides an incentive for a graduated return to work to reintegrate into the workplace after a total disability by permitting you to earn income for hours worked, in addition to your disability benefits which are adjusted according to your return to work schedule.

Here is how top up is calculated:

An employee works 40 hours/week and receives a monthly benefit for total disability in the amount of $1800. If he returns to work gradually on the basis of two eight hours day per week over the course of a month, his benefits will be adjusted as follows:

$1800 divided by 160 hours full time for a month = $11.25 per hour

2 days of 8 hours worked, over four weeks = 64 hours worked

64 hours worked at $11.25 per hour = $720

$1800 - $720 for hours worked as planned = $1,080 paid in benefits for that month.

***Benefit Period***
If you qualify, your EDB payments will continue for a period equal to the length of your ***seniority with the Company at the beginning of your disability*** minus 12 months.

Payments will end on the earliest of the following:
- the date you are no longer totally disabled, or
- the date you fail to provide required proof of disability, or
- the end of the month following your 65th birthday, or
- the date you qualify for benefits under the Old Age Security Act, or
- the date you die, or
- the end of a period that equals the length of your seniority with the Company at the beginning of your disability minus 12 months, or
- the date you cease to be under the care of a legally licensed physician.

## Special Situations

***Can I return to work part time or do a different job?***
Yes. You can work less than full-time hours for a specific period of time. You will be paid for the hours you work and will receive a top up. The amount of top up will be calculated using the same method as for S&A benefit. When you return to work full time, Industrial Alliance will close the file.

***What happens to my coverage during a lay-off?***
You are not covered by the EDB Plan during a ***lay-off***. If, however, you are already receiving EDB benefits when a lay-off starts, your EDB benefits will continue unless they would normally end for another reason other than lay-off.

***What happens to my coverage if I leave the Company?***
If your employment with the Company ends (other than by lay-off) and you are not already receiving EDB benefits, your coverage ends.

***What happens to my coverage if I retire?***
Your coverage ends.

***What happens to my coverage if I die?***
Your coverage ends.

## Claims

Industrial Alliance will review your claim prior to the expiry of your S & A benefits. If the medical on file supports that your claim will continue beyond the 52-week period, Industrial Alliance will correspond directly to you.

You will have to follow the same process as for S&A benefits:

1. Industrial Alliance will forward to you Attending Physician Statement (APS).
2. Ask your ***doctor*** to fill out the APS.
3. Return the completed APS to the Benefits Department or directly to Industrial Alliance.

A delay in filling out the APS will delay your benefits.

You must be under a doctor's care to receive benefits. Your doctor must fill out an APS to confirm the diagnosis and treatment he/she recommended.

From time to time, you will need to resubmit proof that you are still seeing a doctor and receiving appropriate care.

***Canada/Quebec Pension Plan Disability Benefits***

You should apply for disability benefits under the Canada Pension Plan or Quebec Pension Plan after you have been disabled for four months. Please contact Health and Welfare Canada for information about applying for these benefits.

# Supplemental Unemployment Benefit Plan (SUB Plan)

## What the Plan Does

The Supplemental Unemployment Benefit Plan (SUB Plan) pays you a weekly benefit if you are on a qualified **lay-off**. This benefit will replace part or all of your regular income if you have earned a Credit Unit or fraction of a Credit Unit. (See Appendix 3: Definitions for the definition of lay-off. Credit Unit is described on page 40.)

## Who Is Covered

You qualify for a benefit from the SUB Plan each week if you meet the conditions described in "Qualification for Benefits" (see below) during that week.

Only eligible employees may receive benefits, unless an employee dies or is unable to manage his/her affairs for any reason. Then benefits will be paid to an appointed legal representative, if there is one, or to a survivor or survivor(s). The latter may be the **spouse**, parents, children, or other relatives or dependents of the employee, according to the discretion of the Board of Administration of the SUB Plan. In the case of death, no benefit will be paid for any period following the last full week of lay-off immediately preceding the employee's death.

## Costs & Taxes

The Company is responsible for funding the SUB Plan. For details about the funding process, please see **Appendix 2: SUB Plan Administration**. Page 81

The government counts SUB Plan benefits as regular income, subject to income tax. The Company, on behalf of the Trustee of the Plan, will deduct the appropriate taxes from your benefits.

The Company, on behalf of the Trustee, will also deduct union dues from your SUB Plan payments. The amount will equal one hour of straight time pay per month. You only pay dues in a month that you apply for and receive a benefit.

## Benefit Details

If you qualify, the Plan will pay you weekly benefits starting after the second full week of a qualifying lay-off. The level and the duration of your SUB Plan benefits will vary. The variables that determine your benefits include the following:

- your ***seniority***,
- your ***base hourly rate***,
- your Credit Units (see "Benefit Period," below),
- your EI benefits and other compensation, and
- the level of funding.

All of these factors are described in the following sections.

***Qualification for Benefits***

You qualify for a benefit from the SUB Plan each week if you have a Credit Unit or a fraction of a Credit Unit and during that week you meet all of conditions 1 to 5, and *one* of either condition 6 or 7 as described below:

1. you were on a qualified lay-off for all or part of that week; and
2. you did not receive any pay from the Company for that week; and
3. you make a proper application to the Company; and
4. you qualify for a SUB Plan benefit of at least $2; and
5. you did not receive or qualify for an unemployment benefit under any contract or program of the Company (other than this Plan) or of another employer; and
6. you received Employment Insurance (EI) benefits for that week OR
7. you were disqualified from receiving EI benefits for any of these reasons:
   - you did not have prior to lay off a sufficient period of employment or earnings covered by Employment Insurance.
   - you exhausted your Employment Insurance Benefits rights.
   - the week was a week of an Employment Insurance “waiting period” immediately following a week for which you received an Employment Insurance Benefit, or occurring within less than 52 weeks since your last week of an Employment Insurance “waiting period” for which you received no benefit solely because the week was a week of an Employment Insurance “waiting period”;
   - you were denied an Employment Insurance benefit and it is determined, with the concurrence of Human Resources Development Canada, that under the circumstances it would be contrary to the intent of the Plan and HRDC policy to deny you a benefit.

***Benefit Amount:*** *The payment calculation is the following:*

**Step 1:**

**75% X Your Base Hourly Rate X (40 – Your Available Hours) = Basic Benefit**

**Step 2:**

**Basic Benefit – (EI benefits + other compensation for that week) = Final Benefit**

If you have exhausted your EI benefit rights and you do not refuse an offer to work at the Company, your maximum Final Benefit will be $75 per week.

**Step 3:**

Finally, the Credit Unit Cancellation Base level (CUCB — see Appendix 2-SUB Plan Administration), or the level of funding, affects the amount of Final Benefit paid. You may receive a portion of the Final Benefit or no payout depending on the CUCB level.

| ***If the CUCB level is:*** | ***The benefit paid is:*** |
|---|---|
| $58.50 or greater | the Final Benefit |
| between $18.00 and $58.49 | 80% of the Final Benefit |

| below $18.00 | no payout |
|---|---|

***Benefit Period***

The duration of your SUB Plan benefits depends on your Credit Units. You earn Credit Units after you have at least one year of seniority. You must also be on the ***active payroll*** when you reach that one-year mark, or on the active payroll in the 90 days before that point.

***Earning Credit Units***

You will earn one-half of a Credit Unit for each week that you work and receive pay from the Company while you are part of the Bargaining Unit.

The following maximums apply:

| Years of Seniority | Maximum Credit Units |
|---|---|
| Under 2 | 26 |
| 2 but less than 5 | 36 |
| 5 but less than 10 | 46 |
| 10 and over | 52 |

***Guaranteed Annual Income Credit Units***

Guaranteed Annual Income Credit Units (GAIC Units) are additional Credit Units (up to the maximums shown above) credited each year to eligible employees.

If you have at least one year of seniority, are on the active payroll, and in the Bargaining Unit on the annual guarantee date (see below), you may receive additional Credit Units as follows:

- subtract the number of Credit Units you have from the maximum that applies to you, and
- multiply the resulting number by the percentage in the following table:

| Your Years of Seniority on the Guarantee Date | Percentage |
|---|---|
| 1 but less than 1.5 | 12.5% |
| 1.5 but less than 2 | 25.0% |
| 2 but less than 4 | 50.0% |
| 4 but less than 7 | 75.0% |
| 7 and over | 100.0% |

Your Guarantee Date is the first day of any week after June 23, 2006, that you are on a qualifying lay-off, if

- the lay-off is scheduled to continue indefinitely,
- the week is the week the lay-off started or the first week that you are not entitled to any Company pay since the lay-off started,
- you have earned at least two Credit Units since any prior period of lay-off as of the start of the week,
- GAIC Units have not been credited to you in the last 12 months, and
- the CUCB rate for the month and for the last two months exceeds $350 or 17 times the Average Full Benefit used for the purpose of determining Maximum Funding. (See

  **Appendix 2: SUB Plan Administration**, for a discussion of Maximum Funding.)

### Using Credit Units

Each weekly benefit you receive from the SUB Plan "cancels" some of your Credit Units. Your benefits will continue until all your Credit Units are canceled.

The Company decides the rate of cancellation of Credit Units based partly on your seniority. It also uses a value called a Credit Unit Cancellation Base (CUCB), determined each month. The CUCB is a function of the total assets in the SUB Plan Fund and the number of active and laid-off employees who have Credit Units. It also takes into account the "current lay-off ratio" (CLR) — the number of laid-off employees divided by the number of active and other employees. For more information about this calculation, see **Appendix 2: SUB Plan Administration**.

The following table shows the rate of cancellation of Credit Units based on seniority and the CUCB.

| **CUCB** (for the week you receive SUB Plan benefits) | **Your years of seniority** (as of the last day of the week you receive a SUB Plan benefit) | | | | | |
|---|---|---|---|---|---|---|
| | **1-5 years** | **5-10 years** | **10-15 years** | **15–20 years** | **20–25 years** | **25 years and over** |
| | ***The Credit Units to be canceled will be:*** | | | | | |
| **$382.50 or more** | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| **$342.00 to $382.49** | 1.11 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| **$301.50 to $341.99** | 1.25 | 1.11 | 1.00 | 1.00 | 1.00 | 1.00 |
| **$261.00 to $301.49** | 1.43 | 1.25 | 1.11 | 1.00 | 1.00 | 1.00 |
| **$220.50 to $260.99** | 1.67 | 1.43 | 1.25 | 1.11 | 1.00 | 1.00 |
| **$180.00 to $220.49** | 2.00 | 1.67 | 1.43 | 1.25 | 1.11 | 1.00 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **$139.50 to $179.99** | 2.50 | 2.00 | 1.67 | 1.43 | 1.25 | 1.11 |
| **$99.00 to $139.49** | 3.33 | 2.50 | 2.00 | 1.67 | 1.43 | 1.25 |
| **$58.50 to $98.99** | 5.00 | 3.33 | 2.50 | 2.00 | 1.67 | 1.43 |
| **$18.00 to $58.49** | 10.00 | 5.00 | 3.33 | 2.50 | 2.00 | 1.67 |
| Under $18 | No Benefit Payable | | | | | |

The table shows that the more seniority you have, and the higher the CUCB is, the longer you will receive SUB Plan benefits.

***Snapshot:***

The Company declares a lay-off, and Mark, who has worked 15 years for Bombardier wants to calculate the SUB Plan benefit he will receive.

Seniority: 15 years

Credit Units: 52 (maximum)

Base hourly rate: $24.00

Available hours: 30 hours

Weekly EI benefit: $0 (disqualified)

Other compensation: $24.00 x 2 = $48

CUCB level: $58.49

**75% X $24 X (40.0 - 30) = $180**

**$180 – ($0 + $48) = $132**

**$132 X 80% =$105.60(because CUCB is below $58.50)**

Mark will start receiving this benefit after the second full week of the lay-off. Benefits will continue to Mark until he uses up all his Credit Units. Therefore, he could receive benefits for 20.8 weeks. If the CUCB was $80, he could receive SUB Plan benefits for 26 weeks.

## Plan Administration

A six-member Board of Administration runs the SUB Plan. Three members are from the Company and three are from the Union. The Board is responsible for the overall management of the Plan, approving the CUCB rate and determining ruling on appeals. A Trustee holds the actual funds of the plan and the Company makes payments on behalf of the Trustee upon approval of an application from an employee.

***For additional information on the administration of the SUB Plan, see Appendix 2: SUB Plan Administration.***

## Special Situations

***If I'm denied benefits, can I appeal?***
Yes. You may appeal the Company's decision within 30 days of the date of denial. You must appeal in writing. In some cases, an appeal by one employee can stand for a group of employees in the same situation. If so, the Board's decision will affect the whole group.

The Board's decision about an appeal is final. It is binding on all parties including the employee, the Union, the Trustee, and the Company. The Union will not encourage or help any of its members to further appeal any of the Board's decisions to any Court, Labor Board, or other agencies.

***If I don't have enough Credit Units for a full benefit, can I get a partial benefit?***
Once the CUCB reaches a level below $18.00, benefit payments are suspended until such time that the funding is adequate enough to cause the CUCB to exceed $18.00. At that point, benefit payout follows the sequence in which applications were received.

***Could I ever have to pay back all or part of my SUB Plan payments?***
Mistakes are made occasionally in the calculations. If your SUB Plan payment is too high, the Company will notify you in writing. If the overpayment is over $3.00, the Board will ask you to repay the amount. They must make the request in writing within 120 days of the overpayment. This time limitation does not apply if an employee has committed fraud or misrepresented information to the Board.

If you do not return an overpayment quickly, the Company can deduct the amount from your future benefit payment or your future compensation (including wages, vacation pay, and other compensation). The Company will deduct $10 from any benefit payment or $20 from anyone-pay cheque, until you have made the full repayment. This dollar limit does not apply if an employee has committed fraud or misrepresented information to the Board.

Once you repay the amount, you will be re-credited with the Credit Units that correspond to the overpayment.

***Is it possible to lose Credit Units?***
Yes. You can lose all your Credit Units permanently in these circumstances:

- you have a break in seniority other than one caused by Automatic Retirement and you are not entitled to a pension benefit under the Company Pension Plan; or
- you are on lay-off from the Bargaining Unit for a continuous period of 24 months (if you are still receiving benefits at that time, you will not lose your Credit Units until your benefits end); or
- you willfully misrepresent any material fact during any application for benefits under this Plan.

## Application for Benefits

You must file an application for benefits in person or by mail. The Company will issue the application procedures from time to time. You will be advised of the procedures to follow at the time of lay-off.

You must apply within 60 calendar days of the end of the week for which a benefit may be payable. The Company may make an exception if you are newly eligible because your EI benefits have been adjusted for a past time period.

After the Company receives your application, they will decide if you are eligible for a benefit. If you are, the Company on behalf of the Trustee will promptly pay the benefit.

If your application is denied, the Company will let you know right away in writing and give you the reason your claim was refused. The Company will also give a copy of all denied claims to a Union Member of the Board.

You may be denied a benefit if the Company determines your benefits have been overpaid in the past. The Board will inform you in writing if this occurs, and will give a copy of its decision to a Union Member of the Board.

# Separation Payment Plan (SPP)

## What the Plan Does

The Separation Payment Plan (SPP) pays you a lump sum of money if you decide to resign from the Company during a ***lay-off*** and if you meet certain conditions. If you resign and receive an SPP payment, you lose all of your ***seniority*** rights. Your SPP payment may be affected by any regular ***severance pay*** you may receive.

## Who Is Covered

All full-time employees who are members of the Bargaining Unit are covered by the SPP if they meet the qualifications explained in "Benefit Details," below.

## Costs & Taxes

The Company is responsible for funding the Separation Payment Plan. It is funded the same way as the SUB Plan. For details about the funding process, please see **Appendix 2: SUB Plan Administration**.

The government counts a Separation Payment as regular income, subject to income tax. The Trustee of the Plan will withhold the appropriate taxes from any payments you receive.

## Benefit Details

### *Qualification for Benefits*

You must meet certain conditions and make a proper application to qualify for a Separation Payment.

The application rules are the following:

1) The earliest you can make an application is after 12 complete months of lay-off. This is the **First Separation Application Date (FSAD)**. *(The Company may sometimes set an earlier date.)*
2) The latest you can make an application is 36 months after a lay-off starts or 36 months after the Company terminates your employment. This is the **Last Separation Application Date (LSAD)**.
3) If you are disabled, your LSAD may not be more than 30 days after the last month that you received Extended Disability Benefits.
4) You must submit your application during a pay period when the Credit Unit Cancellation Base (CUCB) is $58.50 or more. * (See Appendix 2-SUB Plan Administration, for more information about the CUCB.)

* Applications received during a pay period when the CUCB is less than $58.50 will be paid as soon as the CUCB is equal to or higher than $58.50. At that time, the Separation Payments will be paid in the order that the applications were received, and will have priority over other Separation Payments.

To qualify for a Separation Payment, you must meet one of the conditions described in A through F below:

A) You are on lay-off for a continuous period of 12 months. (*Two periods of lay-off count as one if you are back at work for five days or less before the second lay-off starts.*)

B) You are age 60 or over when the Company terminates your employment, but you do not qualify to receive a pension or retirement benefit from the Company.

C) You become disabled but do not have enough ***credited service*** to qualify for a disability pension from the Company Pension Plan.

D) You have one or more years of seniority on the last day you were on the ***active payroll*** and that seniority is unbroken on or before the FSAD.

E) You are not eligible to receive a pension or retirement benefit other than a deferred vested pension under any Company Pension Plan.

F) You have not refused an offer of work on or after the last day you worked in the Bargaining Unit and before the FSAD.

***Benefit Amount***

A Separation Payment is a lump sum amount linked to your seniority and base pay.

To calculate your payment:
1. Find your seniority in the left-hand column of the table below.
2. Multiply the corresponding number in the right-hand column to your ***base hourly rate***.

| **Years of Seniority on Last Day on Active Employment Roll** | **Number of Hours of Pay** (multiply by base pay rate = Separation Payment) |
|---|---|
| 1 *but less than* 2 | 50 |
| 2 *but less than* 3 | 70 |
| 3 *but less than* 4 | 100 |
| 4 *but less than* 5 | 135 |
| 5 *but less than* 6 | 170 |
| 6 *but less than* 7 | 210 |
| 7 *but less than* 8 | 255 |
| 8 *but less than* 9 | 300 |
| 9 *but less than* 10 | 350 |
| 10 *but less than* 11 | 400 |
| 11 *but less than* 12 | 455 |
| 12 *but less than* 13 | 510 |
| 13 *but less than* 14 | 570 |
| 14 *but less than* 15 | 630 |

| | |
|---|---|
| 15 *but less than* 16 | 700 |
| 16 *but less than* 17 | 770 |
| 17 *but less than* 18 | 840 |
| 18 *but less than* 19 | 920 |
| 19 *but less than* 20 | 1000 |
| 20 *but less than* 21 | 1085 |
| 21 *but less than* 22 | 1170 |
| 22 *but less than* 23 | 1260 |
| 23 *but less than* 24 | 1355 |
| 24 *but less than* 25 | 1455 |
| 25 *but less than* 26 | 1560 |
| 26 *but less than* 27 | 1665 |
| 27 *but less than* 28 | 1770 |
| 28 *but less than* 29 | 1875 |
| 29 *but less than* 30 | 1980 |
| 30 and over | 2080 |

Your payment may be reduced if the CUCB is below $225 on the date the Company receives your application. The reduction will be 1% for each full $2.25 that the CUCB is less than $225, except for Separation Payments deferred under (F) above. In the latter case, Separation Payment will be based on the CUCB in effect on the date the cheque is issued by the Company.

If you receive SUB Plan benefits or other benefits from the Company after your last day worked in the Bargaining Unit, these payments will reduce your Separation Payment.

The Separation Payment will be further reduced by Separation Pay received from the Ministry of Labor under the Employment Standards Act.

Please note: If you are of retirement age, and you resign and take an SPP payment, you will not be entitled to Retiree Life and Medical benefits.

***Benefit Period***
A Separation Payment is a one-time payment. If you accept an SPP payment, you are no longer an employee of the Company and you lose all of your seniority rights.

## Plan Administration

The same Board of Administration that runs the SUB Plan also runs the SPP.

***For information on the administration of the SPP, see Appendix 2: SUB Plan Administration.***

## Special Situations

***If I'm denied benefits, can I appeal?***
Yes. You can use the same appeal process described on page 42, under the SUB Plan.

***If the Company re-hires me, can I get back my seniority if I repay my Separation Payment?***
No. Once you accept a Separation Payment, you lose your seniority. The choice is *not* reversible.

***Could I ever have to pay back all or part of my Separation Payment?***
Mistakes are made occasionally in the calculations. If your Separation Payment is too high, the Company will notify you in writing. If the overpayment is over $3.00, the Board will ask you to repay the amount. The repayment schedule will be the same one as described on page 37, under the SUB Plan.

## Application for Benefits

The Company will notify all eligible employees in writing about the time limits for applications. They will send the notices at least 30 days before the FSAD and LSAD. Be sure to keep your address up to date with Employee Records so the notices can reach you.

# *Automatic Short Week Benefit Plan*

## What the Plan Does

The Automatic Short Week Benefit Plan (Short Week Plan) may pay benefits to you during a short workweek. A short week may occur when the Company cannot find work for you for reasons beyond its control other than during a ***lay-off***.

## Who Is Covered

All full-time employees who are members of the Bargaining Unit are covered by the Short Week Plan if they meet the qualifications explained in "Benefit Details," below.

## Costs & Taxes

The Company is responsible for funding the Short Week Plan. Benefits are paid by the Company and funds paid will be deducted from future SUB funding payments.

The government counts payments from the Short Week Plan as regular income, subject to income tax. The Company will withhold the appropriate taxes from any payments you receive.

## Benefit Details

### *Qualification for Benefits*

You qualify for a benefit for all or part of a week if you worked for less than 40 *compensated hours* or *available hours* and these conditions were true:

- the Company was unable to provide work to you for all or part of the week;
- you were available for work;
- a lay-off did not apply to the full week; and
- you had at least one year of ***seniority*** as of the last day of the week.

"Compensated hours" are all hours for which you receive pay from the Company. The definition includes call-in pay, holiday pay, bereavement pay, jury duty pay, and vacation pay if the vacation is scheduled for that week. It does not include either vacation pay that does not apply to a vacation taken that week or sick-leave pay. Each hour paid at a premium rate is counted as one hour.

"Available hours" for a week equal all the hours described below:

- hours the Company schedules for you or makes available* to you but that you do not work (including a leave of absence), if the Company gives you reasonable notice; and
- hours not worked for reasons that might disqualify you from receiving SUB Plan benefits through a lay-off; and

- hours not worked because other employees are absent (according to a written agreement between the Company and the Union); and
- hours not worked that equal the difference between part-time scheduled hours in a normal workweek and regular full-time hours.

Compensated hours or available hours are counted to the nearest one-tenth of an hour.

*(* The total excludes any hours you have the option to refuse without disqualification, according to the Collective Bargaining Agreement.)*

***Benefit Amount***
The benefit amount for the week results from this calculation:

**80% X base hourly rate X (40 - (compensated hours + available hours))**

Your ***base hourly rate*** is your highest straight-time hourly pay rate during the week. It includes cost-of-living allowance but excludes all other premiums or bonuses. (It may be a higher rate if you meet certain conditions: see the definition of "base hourly rate" on page 85

If you receive EI benefits and a benefit from the Short Week Plan for the same time period, your benefit from this Plan will be reduced by the amount of the EI benefits.

The Company will always try to pay you your Short Week Plan benefit on your regular pay cheque for the week.

***Benefit Period***
You will receive a Short Week Plan benefit for each week that you meet the qualifications.

## Plan Administration

The same Board of Administration that runs the SUB Plan also runs the Short Week Plan.

***For information on the administration of the Short Week Plan, see Appendix 2: SUB Plan Administration.***

## Special Situations

***If I'm denied benefits, can I appeal?***
Yes. You can use the same appeal process described on page 40 under the SUB Plan.

***Could I ever have to pay back all or part of my Short Week Plan payment?***
Mistakes are made occasionally in the calculations. If your Short Week Plan payment is too high, the Company will notify you in writing. If the overpayment is over $3.00, the Board will ask you to repay the amount. The repayment schedule will be the same one as described on page 42 under the SUB Plan.

## Application for Benefits

Normally, you will not have to file an application; the Company will pay your benefits automatically.

If you did not receive a benefit but think you should have, you have 60 days to state your claim from the day you claim that the benefit should have been paid.

# Survivor Benefits

## *Basic Life Insurance Plan*

### What the Plan Does

The Basic Life Insurance Plan pays money to your ***beneficiary*** if you die while working for the Company.

### Who Is Covered

The plan covers you for this benefit on the first of the calendar month following 90 working days of active service.

### Costs & Taxes

There is no employee cost for this insurance. The Company pays the premiums for you.

The government counts the premiums for Basic Life Insurance as part of your taxable income. The value of the premiums will appear on your T4 slip. The Basic Life amount payable to your beneficiary is not taxable.

### Benefit Details

Should you die, the Plan will pay your beneficiary $95,000.

Your beneficiary can choose to receive the money as one payment or as a series of payments.

In addition to Basic Life Insurance, the Company provides $100,000 of Flight Life Insurance coverage for each employee during experimental and production test flights and during off-site work parties.

### Special Situations

***What happens if I'm not at work when my coverage should start?***
Your coverage will start on the day you return to work.

***What happens if I'm on lay-off when my coverage should start?***
Your coverage will usually start right away when you are back on the ***active payroll***.

***What happens to my coverage if I'm sick, injured, or disabled?***

Your coverage may continue. It will depend on how long you are sick, injured, or disabled.

- ***Up to 52 weeks***
  If you are getting payments from the Sickness & Accident Plan or the ***WSIB***, your coverage will continue for up to 52 weeks. After that, you may qualify for Extended Disability Benefits.
- ***After 52 weeks***
  Your insurance may continue at no cost to you if the following statements are true:
  (a) you are receiving benefits from the Extended Disability Benefits Plan.
  (b) your disability occurred while you were insured for life insurance and at least one month before you turned age 65.
  (c) you have not retired.

  If one of the conditions is not true, your insurance coverage ends. As well, you must provide proof of disability to continue your coverage. The first proof is due within three months after you have been ***totally and permanently disabled*** for six months. After that, you must provide proof once each year.

  ***Installment Payment Option***
  You may be able to receive your life insurance like a pension, in installments. To have this option, you must meet the conditions (a), (b) or (c) above and have 10 or more years of ***credited service*** in the Company Pension Plan (see Appendix 3: Definitions for the definition of Credited Service).

  The installment payments continue for 50 consecutive months. Each monthly payment is equal to $20 for every $1,000 of life insurance. The payments will start after you have received all available benefits from the Sickness and Accident Insurance Plan and the Extended Disability Benefits Plan. If you die after receiving all payments, your beneficiary will qualify for a $3,000 death benefit. If you die *before* the payments are finished, your beneficiary will receive the remaining payments, or $3,000, whichever is greater.

***Snapshot:***

Mary becomes disabled at age 40. At that time, she has over 10 years of credited service in the pension plan and her life insurance is in force.

While on leave, she uses up her Sickness and Accident insurance benefits, and then qualifies for Extended Disability Benefits. When her EDB payments stop, she starts to receive a monthly installment amount from the Life Insurance Plan. Since she was covered for $95,000 of life insurance, her monthly installments are $1,900 per month, ($20 X 95 = $1,900).

Mary dies after she has received 49 payments. Her beneficiary receives $3,000. (Her remaining payments equaled $1,900, but her beneficiary will receive at *least* $3,000.)

***What happens to my coverage if I'm on maternity/parental leave?***
Your coverage will continue at no cost to you as long as you are on leave.

***What happens to my coverage during a lay-off?***
If you are subject to recall, the Company will continue your Life Insurance coverage for up to three months at no cost to you. After that time, you must pay the current premium for life insurance if you want to keep your coverage. You may continue your coverage for the next 24 months of your leave.

***What happens to my coverage if I'm on an approved non-disability leave?***
Your coverage will continue at no cost to you for one month of your leave. After that, you must pay the current premium of life insurance if you want to keep your coverage. This payment will keep your coverage up to date for the next 11 months of your leave.

***What happens to my coverage if I leave the Company?***
If you wish, you can convert your group life insurance to an individual policy if you are under 55 years of age. You have 31 days after you end your employment to choose this option. The premium payments then become your responsibility.

The insurance amount may not be more than $95,000 or less than $5,000. You will not need to fill out a medical questionnaire. The policy will continue for as long as you pay the premiums.

***What happens to my coverage when I retire?***
When you retire, your coverage reduces to $5,000 less the C/QPP death benefit, to a minimum of $3,000 of coverage. ***Retired employees are not able to convert their policy into an individual plan.***

## Claims

You should discuss your life insurance coverage with your family and the ***executor*** of your ***estate***. They should also know where to find the Employee Service Center address and phone number so they can call if you should die. They will need to provide a proof of death and other details to the Department before they can receive your life insurance benefits.

If your family is in financial difficulties at the time of your death, they may be able to get an advance payment of up to $5,000. They will need to sign a request form for the advance and also promise in writing to pay it back before the money is released to them.

# *Optional Life Insurance Plan*

## What the Plan Does

The Optional Life Insurance Plan pays money to your ***beneficiary*** if you die while working for the Company.

## Who Is Covered

You must apply for coverage and the insurance company must approve your application before your insurance is in force.

You may choose to insure your life and the lives of your ***dependents***, including your ***spouse***. For this Plan only, your dependent children who are age 21 or younger may qualify.

Deductions from your pay will start on the first of the month after the insurance company approves your application.

Your coverage will continue as long as you are actively at work or on ***lay-off*** subject to recall. Your coverage ends on the earliest of the following:

- the date you stop paying premiums for your insurance,
- the date you end your employment,
- the date you retire from the Company,
- the date you die, or
- the date when you have exhausted your 24 months of lay-off benefits

## Costs & Taxes

You will pay the premiums for the insurance coverage you choose to buy. The rates appear at the end of this section, Rates depend on the amount of coverage selected, the age and sex of the person insured, and whether he/she smokes or not.

Since you pay for Optional Life Insurance, the value of your premium does not appear on your T4 slip. You will, however, have to pay applicable taxes on the premiums. Any Optional Life benefit payable to the beneficiary is not taxable.

## Benefit Details

### *Qualification for Benefits*

You qualify for benefits if the insurance company approves your application. As part of the application process, you must complete a short medical questionnaire. Both forms are available from the Employee Service Center.

Your spouse must make a separate application and complete a medical questionnaire.

***Benefit Amount***
You can buy insurance in units of $10,000 up to the maximums on the table below:

| | **Maximum** |
|---|---|
| *For you* | $400,000 |
| *For your spouse* | $400,000 |
| *For each child* | $50,000 |

## Exceptions

The insurance company will not pay a benefit for death resulting from suicide or attempted suicide (while sane or insane) if the death occurs within 24 months of starting or amending coverage under this Plan.

## Special Situations

***What happens if I'm not at work when my coverage should start?***
Your coverage will start on the day you return to work; you must pre-pay any outstanding optional life premiums.

***What happens if I'm on lay-off when my coverage should start?***
Your coverage will usually start right away when you are back on the ***active payroll***.

***What is the definition of "smoker" and "non-smoker"?***
To qualify as a non-smoker, you or your spouse must not have used any "smoking materials" for at least 12 months before you apply for insurance. Smoking materials include cigarettes, cigars, pipes and other tobacco products.

If you are a smoker now and later stop smoking, you can apply to change your coverage. You must complete a Non-Smoker's Declaration form and submit it to the Benefits Department. Your coverage will change on the first of the month after the insurance company receives your declaration.

If you make a false declaration, your insurance will be invalid. The insurance company will refund to you any "non-smoker" premiums you have paid since the date of the false declaration.

***What happens to my coverage if I'm sick, injured, or disabled?***
If you are disabled and you are receiving payments from the Sickness and Accident Plan or the ***WSIB***, you should arrange to prepay your premiums in order to continue your coverage. The Benefits Department can help you make the arrangements.

If you think you or your spouse's absence due to disability will last four months or more, contact the Benefits Department to discuss a Waiver of Premium application. This form lets you apply to stop paying premiums if you have been ***totally and permanently disabled*** for at least six months. If the insurance company accepts your application, your insurance will continue without premiums for as long as you remain totally and permanently disabled.

You can also apply to have the premiums waived for your spouse's insurance if he/she is totally and permanently disabled. Your spouse must complete a medical questionnaire in this situation.

If the disabled person (you or your spouse) recovers or reaches age 65, the insurance company will no longer waive your premiums.

***What happens to my coverage if I'm on maternity/parental leave?***
You can continue your coverage if you arrange to prepay your premiums. Contact the Employee Service Center to make arrangements before you start your leave.

***What happens to my coverage during a lay-off?***
You can continue your optional life coverage if you arrange to prepay your premiums.

***What happens to my coverage if I'm on an approved non-disability leave?***
You can continue your coverage if you arrange to prepay your premiums. Contact the The Employee Service Center to make arrangements before you start your leave.

***What happens to my coverage if I leave the Company?***
If you wish, you can convert your group optional life insurance, and insurance for your dependents, to individual policies. You have 31 days after you end your employment to choose this option. Making timely premium payments becomes your responsibility from that date forward.

***What happens to my coverage if I retire?***
Your coverage ends. ***Retired employees are not able to convert their policy into an individual plan.***

## Claims

You should discuss your optional life insurance coverage with your family and the ***executor*** of your ***Estate***. They should also know where to find The Employee Service Department address and phone number so they can call if you should die. They will need to provide proof of death and other details to the Department before they can receive your optional life insurance benefits.

**Optional Life Insurance**

**Monthly Rates per $1,000 of coverage (excluding sales tax)**

| | MALE | | FEMALE | |
|---|---|---|---|---|
| | NON-SMOKER | SMOKER | NON-SMOKER | SMOKER |
| **Insured Person's Age** | | | | |
| Under Age 30 | 0.028 | 0.055 | 0.021 | 0.037 |
| Age 30 to 34 | 0.028 | 0.055 | 0.021 | 0.037 |
| Age 35 to 39 | 0.036 | 0.070 | 0.029 | 0.049 |
| Age 40 to 44 | 0.054 | 0.108 | 0.044 | 0.072 |
| Age 45 to 49 | 0.095 | 0.192 | 0.081 | 0.134 |
| Age 50 to 54 | 0.166 | 0.333 | 0.148 | 0.248 |
| Age 55 to 59 | 0.268 | 0.534 | 0.216 | 0.362 |
| Age 60 to 64 | 0.408 | 0.817 | 0.369 | 0.615 |
| Age 65 to 69 | 0.551 | 1.104 | 0.468 | 0.779 |

| Optional Life Insurance - Children | 0.074 | Per $1,000 of coverage, regardless of the number of children |
|---|---|---|

**Maximum Optional Life Insurance amounts**

**Employee:**

Maximum of $400,000 with Evidence of Insurability.

An employee may obtain $40,000 of insurance without evidence of insurability within the first 31 days of his eligibility date.

**Spouse**

Maximum of $400,000 with Evidence of Insurability.

An employee may obtain $40,000 of insurance for his spouse without evidence of insurability within the first 31 days:

- of his eligibility date
- of his marriage
- following one year of cohabitation with a common-law spouse

**Dependent Child/Children:**

Maximum of $50,000 with Evidence of Insurability.

An employee may obtain $20,000 of insurance for his children without evidence of insurability within the first 31 days:

- of his eligibility date
- of his marriage
- following one year of cohabitation with a common-law spouse
- birth of his child

This benefit terminates on the participants 70th birthday or retirement, if earlier.

## *Survivor Income Benefit Plan (SIB Plan)*

Effective June 23, 2021, the Survivor Income Benefit Plan was removed, and the basic life insurance has been increased from $85,000 to $95,000.

## *Basic Accidental Death & Dismemberment*

### What the Plan Does

The Accidental Death and Dismemberment Insurance Plan (AD&D Plan) pays money to your ***beneficiary*** if you die because of an accident. It will also pay money to you if you suffer certain severe injuries.

### Who Is Covered

Your coverage comes into effect on the first of the calendar month, following 90 working days of active service with the Company.

### Costs & Taxes

There is no employee cost for this insurance. The Company pays the premiums for you. You will have to pay income tax on the value of the AD&D premiums. Any AD&D amount payable is taxable.

### Benefit Details

***Qualification for Benefits***
The Plan will pay a lump sum to your beneficiary if you die because of an accident. This death benefit is called the Principal Sum.

Effective June 23, 2021, the Principal Sum is $42,500.

If you are injured in an accident, the Plan may pay you all or part of the Principal Sum, depending on the severity of the injury.

***Benefit Amount***
This table shows the amounts the Plan will pay for specific losses:

| FOR LOSS OF | AMOUNT PAYABLE |
|---|---|
| Life | $42,500 |

| | |
|---|---|
| Loss or loss of use of both hands | $42,500 |
| Loss or loss of use of both feet | $42,500 |
| Entire sight of both eyes | $42,500 |
| Loss or loss of use of one arm | 3/4 of the sum |
| Loss or loss of use of one leg | 3/4 of the sum |
| Loss or loss of use of one hand | 2/3 of the sum |
| Loss or loss of use of one foot | 2/3 of the sum |
| Loss of thumb and index finger on the same hand | 1/3 of the sum |
| Loss of four fingers of one hand | 1/3 of the sum |
| **FOR LOSS OR LOSS OF USE OF** | |
| Loss of all toes of one foot | 1/4 of the sum |
| Loss of Speech and Hearing | $42,500 |
| Loss of Speech or Hearing | 2/3 of the sum |
| Loss of Hearing in One Ear | 1/3 of the sum |
| Loss of entire sight of one eye | 2/3 of the sum |
| **FOR TOTAL PARALYSIS OF** | |
| Both upper and lower limbs (quadriplegia) | $95,000 |
| Both lower limbs (paraplegia) | $95,000 |
| Upper and lower limbs of one side of body (hemiplegia) | $95,000 |

The maximum benefit for all losses caused by the same accident is $42,500 with the exception of Total Paralysis where payment is $95,000

The maximum benefit would be paid for hearing impaired employees (both ears) who lose a hand, finger or arm.

***Benefit Period***
The Plan will pay for losses that occur up to one year after the accident if the loss is a direct result of injuries suffered in the accident.

<u>Ancillary Benefits</u>

While Accidental Death and Dismemberment insurance is in force, the carrier will provide the following Ancillary Accidental Death and Dismemberment benefits, the terms and conditions of which shall be equivalent to those applicable on June 23, 2006

Rehabilitation Benefit, Repatriation Benefit, Family Transportation Benefit, Education Benefit, Day Care Benefit, Home Alteration and Vehicle Modification Benefit, Seat Belt Rider, In-Hospital Indemnity Benefit and Identification Benefit.

In no case will more than the full Principal Amount be paid for all losses resulting from one accident while insurance is in force. Benefits are payable only if the loss results directly from bodily injuries sustained **solely** through accidental means and occurs within one (1) year after the date of the accident causing the loss.

Since this is coverage for losses due to accidents, no benefits are paid on account of a loss caused or contributed to by bodily or mental infirmity, ptomaine's, bacterial infections, disease, medical or surgical treatment not made necessary by injuries covered under the plan, war, active full-time services in the armed forces of any country, or suicide.

**Aircraft Coverage**

Your coverage under this Plan is effective if you are injured while

- riding as a passenger, pilot, operator, or member of the crew in or on any aircraft having a current and valid certificate of airworthiness and piloted by a person who holds a current and valid pilot's license.
- riding as a passenger, and not as a pilot, operator or member of the crew in or on any aircraft operated by the armed forces of any recognized country; or
- boarding or alighting from or being struck by any aircraft.

**Exclusions**

Benefits apply to accidental death or injury only. No benefit will be paid for a loss caused by or contributed to by

- Suicide or any attempt threat by the Insured Person while sane or self-destruction or any attempt threat by the Insured Person while insane.
- Injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the "Aircraft Coverage" section above.
- Declared or undeclared war or any act thereof.

- Active full-time service in the armed forces of any country

## Special Situations

***What happens if I'm not at work when my coverage should start?***
Your coverage will start on the day you return to work.

***What happens if I'm on lay-off when my coverage should start?***
Your coverage will usually start right away when you are back on the ***active payroll***.

***What happens to my coverage if I'm on disability leave?***
The Company will continue your AD&D coverage for as long as you are receiving benefits from the S&A Plan or the EDB Plan.

***What happens to my coverage if I'm on maternity/parental leave?***
Your AD&D coverage will continue at no cost to you as long as you are on leave.

***What happens to my coverage during a lay-off?***
If you are subject to recall, the Company will continue your AD&D coverage for up to three months at no cost to you. After that time, you must pay the full premium if you want to keep your coverage. You may continue this coverage for up to 24 months.

***What happens to my coverage if I'm on an approved non-disability leave?***
Your coverage will continue at no cost to you for one month of your leave. After that, you must pay the full premium if you want to keep your coverage for the next 11 months.

***What happens to my coverage if I leave the Company?***
Your coverage ends.

***What happens to my coverage if I retire?***
Your coverage ends.

## Claims

You should discuss your AD&D coverage with your family and the ***executor*** of your ***Estate***. They should also know where to find the Employee Service Center address and phone number so they can call if you should die. They will need to provide proof of accidental death and other details to the Center before they can receive your insurance benefits.

For a claim for severe injury, contact the Employee Service Center. They will provide the necessary forms and information to you.

# Pension Plan

## What the Plan Does

The Company Pension Plan is one of several sources of retirement income for Bombardier employees.

When you retire, your income will likely come from three main sources:
- the Company Pension Plan (or, more formally, the Bombardier Inc. Unifor Local 112 Non-Contributory Pension Plan);
- government pensions, such as the ***Canada/Quebec Pension Plan (CPP/QPP)*** and Old Age Security; and
- whatever you set aside on your own, through personal RRSPs, or other investments outside your RRSPs.

The quality of your retirement lifestyle will depend, in large part, on how well you plan and prepare for it. Building your future is an important, shared responsibility.

Although the Company Pension Plan is a valuable component in your retirement planning, your personal savings are a very important aspect as well. You should stay informed about financial planning matters and make decisions that will help build the future you desire.

## Who Is Included

All employees who are members of Unifor Local 112 and who have ***seniority*** with the Company become members of the Pension Plan.

## Costs & Taxes

The Company pays the full cost of the Plan. Its contributions vary from year to year because investment returns on the Pension Funds vary. In years when investment returns are good, the Company will contribute less. If returns are lower, the Company will contribute more. Other factors, such as how long pensioners live and the level of benefits, also determine how much the Company needs to contribute.

It is possible for the Pension Fund to grow to more than is needed. If it does, the Company may not need or be allowed to contribute due in part to Revenue Canada rules.

The Pension Plan affects your taxable income indirectly. Each year you "earn" a certain amount of pension under the Plan. The Company uses this amount to calculate a figure called a Pension Adjustment (PA). The government uses the PA amount to determine your RRSP contribution room and sends you a notice each year telling you how much you can contribute to your RRSP.

## Details of Pension Benefits

### *Qualification for Benefits*

You earn the rights to your Plan benefits — the benefits are "vested" immediately. If you leave the Company, you are entitled to your benefits. In each calendar year that you receive pay from the Company, you receive credited service in the Pension Plan according to the following table:

| Hours for which you receive pay in the year | Credited Service (years) |
|---|---|
| 1,710 or more | 1.0 |
| 1,530 but less than 1,710 | 0.90 |
| 1,350 but less than 1,530 | 0.80 |
| 1,170 but less than 1,350 | 0.70 |
| 990 but less than 1,170 | 0.60 |
| 810 but less than 990 | 0.50 |
| 630 but less than 810 | 0.40 |
| 450 but less than 630 | 0.30 |
| 270 but less than 450 | 0.20 |
| 90 but less than 270 | 0.10 |
| Less than 90 | 0.00 |

Your hours will count toward calculating credited service if you are absent from work in the following situations:

- an approved leave of absence for union business requested by Local 112 or the National Office of Unifor.
- any injury arising out of your work at Bombardier, for which you are receiving Workers' Compensation benefits.
- an approved Sickness and Accident disability leave of up to 52 weeks.
- absent on Company approved sick leave beyond fifty-two (52) weeks, provided

  a) the Employee is in receipt of Extended Disability Benefits payable under the Company Insurance Program,
  b) the Employee was not in receipt of such Extended Disability Benefits as of June 22, 2000, and
  c) the Employee is not in receipt of a monthly disability pension under the pension plan (Article V).
- a lay-off for up to 13 weeks*; or
- an approved maternity leave of up to 17 weeks, or parental leave of up to 35 weeks.

* *During lay-off, you remain an active member of the Plan. If you are not recalled before your seniority rights to a recall expire, the same conditions will then apply as if you had terminated employment.*

Your credited service for periods while you are absent from work will include a maximum of 40 hours per week of absence, or a total of 1,710 hours for any one year.

### *Amount of Pension Benefits*

Effective July 1, 2021, the pension increased as follows:

Regular non-skilled trades employees - from $80.00 to $86.00.

Skilled trades employees - from $87.00 to 94.00

The Plan provides a pension calculated by multiplying a flat benefit rate (negotiated at each union contract) by your credited service. The pension is paid per month for your lifetime.

The pension calculation includes

- your years and fractions of years of credited service, and
- the monthly benefit rate in effect at the time you retire (as negotiated in the collective bargaining agreement). This amount increased to $86.00, effective July 1, 2021, for any non-skilled trades employee who retires on or after June 23, 2021 and $94.00 for any skilled trades employee who retires on or after June 23, 2021.

***Snapshot:***

Let's assume you retire at age 65. If the monthly benefit rate at the time you retire is $86.00, and you retire with 30 years of credited service, your monthly pension starting at age 65 would be the following:

**$86 X 30 years = $2,580 per month**

If you retire early, your pension may be lower because it is expected to be paid over a longer period of time (see below). Also, if you choose or are required to take an alternative form of pension such as one that pays a survivor pension to your ***spouse*** (see Appendix 3: Definitions for a definition of spouse), your pension will be lower because it will be spread out over two lifetimes (yours and your spouse's) instead of one.

### *Timing of Pension Benefits*

#### Normal Retirement

Normal retirement is at age 65. However, you can retire as early as age 55.

Your normal retirement date under the Pension Plan is the first day of the month following the month in which you reach age 65.

If you retire at normal retirement, the pension formula shown above will be used to calculate your pension.

**Early Retirement**

You can retire as early as age 55.

Your pension will be *unreduced* when you retire, if you are:

- at least age 62, with 10 years' credited service; or
- at least age 55, with 30 years' credited service.

If you retire earlier than age 62 and have more than 10 years of credited service, your earned pension will be reduced. The reduction will be 6% for each year (0.5% per month) that the start of your pension precedes the first day of the month after your 62nd birthday.

If you retire earlier than age 65 and have less than 10 years of credited service, your pension will be reduced. The reduction will be 6% for each year (0.5% per month) that the start of your pension precedes the first day of the month after your 65th birthday.

If you retire early, you do not have to start your pension right away. If you start your pension at a later date, any reductions will only be calculated to that start date.

***Snapshots:***
**Employee #1: Maria**
- Age: 57, 6 months
- Credited Service: 15 years
- Monthly Benefit Rate: $86.00
- Reduction:
  - ∑ age 62* subtract age 57, 6 months = 54 months
  - ∑ therefore, pension reduced by 0.5% X 54 months = 27%
  - ∑ *or*, pension reduced to 100% – 27% = 73%

BASIC PENSION CALCULATION: **$86 X 15 years = $1,290 per month**

EARLY RETIREMENT PENSION AFTER REDUCTION: **$1,290.00 X 73% = $947.10 per month**

** Reduction only applies from age 62 because Maria has at least 10 years of credited service.*

**Employee #2: Joe**
- Age: 58
- Credited Service: 32 years
- Monthly Benefit Rate: $86.00
- Reduction: there is no reduction because Joe has over 30 years of credited service

BASIC PENSION CALCULATION: **$86 X 32 = $2,752 per month**

**Employee #3: Peter**
- Age: 63
- Credited Service: 8 years
- Monthly Benefit Rate: $86.00
- Reduction:
  - ∑ age 65* subtract age 63 = 24 months
  - ∑ therefore, pension reduced by 0.5% X 24 months = 12%
  - ∑ *or*, pension reduced to 100% – 12% = 88%

BASIC PENSION CALCULATION: **$86 X 8 years = $688.00 per month**

EARLY RETIREMENT PENSION AFTER REDUCTION: **$688.00 X 88% = $605.44 per month**

** Reduction applies from age 65 because Peter has less than 10 years of credited service.*

**Supplementary Benefit or Early Retirement**
You are eligible for full Canada/Quebec Pension Plan benefits at age 65. If you retire before then and have at least 10 years' credited service, the Company will pay you a monthly supplementary pension from the Pension Plan.

The calculation for the monthly supplement is $19.00 multiplied by your years of credited service (up to 30 years). You continue to receive the supplement until your death or the date you reach age 65, whichever is earlier. If your pension is reduced, your supplement will also be reduced.

**Snapshots**

**Employee #1, Maria**, would receive a supplement from age 57 years & 6 months to age 65 determined as:

$19.00 X 15 years = $285 per month reduced to 73%, the same reduction that was applied to calculate her early retirement pension.

So, her supplement is $285 X 73% = $208.05 per month.

**Employee #2, Joe**, receives a supplement from age 58 to 65 as follows:

$19.00 X 30 years* = $570 per month.

There is no adjustment since there was no adjustment in determining his pension.

**A maximum of 30 years is counted for the supplement.*

**Employee #3, Peter**, is not entitled to a supplement because he has less than 10 years of credited service.

**Postponed Retirement**
If you continue working with the Company past age 65, you must commence your Company Pension no later than December 31st of the year in which you turn age 71.

If you automatically retire at age 65 after January 1, 1998, with more than 5 but less than 10 years' credited service, you will receive a guaranteed minimum monthly pension of $740.

**Forms of Pension Benefits**
The Pension Plan sets standard or "normal" forms of pension for employees and also provides several "optional" forms of pension. The differences between options usually relate to the type of survivor benefits the pension includes.

### Normal Forms of Pension

*If you have no spouse when you retire,* you will receive a monthly pension for the rest of your life, with payments ending upon your death. You may, instead, choose an optional form of pension (see below).

*If you have a spouse when you retire,* you will receive a monthly pension for your life, equal to 95% of the pension you would receive if you had no spouse. Then, 60% of that reduced pension will continue to your spouse for life upon your death. This is known as a "joint-and-survivor" pension. Your pension will be reduced to less than 95% if you are more than 5 years older than your spouse. Your pension will be reduced to more than 95% if your spouse is more than 5 years older than you.

If your spouse dies before you or is no longer your spouse (according to the master Plan document), you may choose to have your pension revert to the full 100% pension in accordance with the terms of the master Plan document.

If you wish to choose an optional form of pension (see below) with no guaranteed payment after your death, both you and your spouse must sign a waiver form approved by the Company.

### Optional Forms of Pension

The normal forms of pension may not be the best fit for everyone. The Plan allows for three optional forms of pension payment. The pension you will receive will be reduced, depending on the option you choose and your age at retirement.

The options include:
1. Pension for your life, with five-year guarantee (60 payments)
2. Pension for your life, with 10-year guarantee (120 payments)
3. Pension for your life, with 15-year guarantee (180 payments)

Under each option, you still receive a monthly pension until your death. However, if you die before you have received the number of guaranteed payments, the remaining payments will be paid to your beneficiary or estate. If you die after the guaranteed period has ended, payments will end upon your death. For each option, a different adjustment is made to your basic pension to allow for the guaranteed payments.

Your beneficiary is the person or persons elected by you, and need not be your spouse.

**Special Situations**

***What if I'm disabled before retirement?***

If you become ***totally and permanently disabled*** as defined in the master Plan document before retirement, you may apply to receive your pension. You must submit appropriate medical documentation to the Company doctor through the Benefits Department. After medical approval has been granted, the Pension Plan Board can approve payment of the pension.

To calculate your monthly disability pension, the Company will multiply the monthly benefit rate in effect on the approval date by your years of credited service. That figure is then reduced by any Extended Disability Benefit you receive.

If you recover from your disability, your pension will stop. Your credited service on record will return to its former level before your disability pension began. If you are then re-employed by the Company, your seniority at the time your disability pension began will also be reinstated.

Your pension when you next retire will be based on your total credited service, which will include your credited service before you retired due to disability and after your return.

***What if I transfer into or out of the bargaining unit?***

You will not lose credited service by transferring into or out of the bargaining unit.

If you transfer into the bargaining unit, you will keep your credited service in this Plan earned up to your date of transfer. You will receive separate pensions from each of the plans you have participated in.

Any service you earned in the other Company pension plans will count toward vesting or for eligibility for early retirement or supplemental pensions under this Plan.

***What if I leave the Company before retirement age?***

You will receive a benefit from the Plan if you have at least two years' continuous service when you leave the Company. Your benefit can be in one of two forms:

A) an immediate *lump sum transfer* of the value of your future pension (the "commuted value"), or
B) a *deferred pension*, which means you receive your pension at a later date.

If you choose option A your benefits under the Plan are "locked in." This means that you cannot receive the lump sum as cash, but must invest it to provide retirement income. You can do this in several ways:

- transfer the lump sum to another locked-in vehicle, called a Locked-In Retirement Account (LIRA), also called a locked-in RRSP.
- transfer the lump sum to another employer's pension plan, if that plan allows the transfer or
- purchase an annuity from an insurance company, to pay you a pension at retirement.

If you choose option B, you keep your benefits in the Plan, and the Plan pays you a pension when you retire. Your deferred pension, payable from age 65, is calculated as $86.00 multiplied by your credited service.

If you resign or lose your seniority and elect to leave your benefits in the Plan, you can apply to receive your pension as early as age 55. If you start your pension early, it will be reduced by 0.5% for each month that the start date precedes your 65th birthday.

You must apply for your deferred pension at least 90 days before you intend to receive it.

***What if I leave and then rejoin the Company?***

If you leave and then rejoin Bombardier, your service after re-hire will be calculated as follows:

- If you transferred the commuted valued of your pension benefits out of the Company Pension Plan, you will earn credited service as if you were a new employee who had not worked for the Company before.
- If you kept your benefits within the Pension Plan, your credited service from your re-hire date will be combined with your previous credited service when calculating your future pension.
- If you are receiving a pension from Bombardier, your pension will be suspended immediately when you are rehired. Your future service will be combined with your prior service when calculating your pension when you next retire, based on your age at that time. If you are receiving a normal or early retirement pension, your service at your previous retirement date will be reinstated when you rejoin the Company. If you are receiving a deferred pension, your accrued service at the time you lost your seniority or retired will be reinstated.

***What if I die before retirement?***

If you die before retirement — either as a current or a former employee with a deferred pension— your spouse will receive the lump-sum value of your pension benefits. . Alternatively, your spouse may take the benefit in the form of an immediate or deferred pension starting no later than your spouse's 65th birthday.

If you were over age 55 and have more than 10 years' credited service, or if you have over 2 years' continuous service and were at least age 55, your spouse will have another option — to receive a survivor pension calculated as if you had retired on the date of your death.

When notified of your death, the Employee Service Center will inform your surviving spouse of available options, so that he or she can make an informed decision.

## Arranging Your Pension

If you hope to retire in the near future, please send a request for pension estimate to the Employee Service Center, so you can arrange that your pension be paid when you need it, without delay.

You will need to provide legal evidence of your date of birth, your marital status, your spouse's age, and social insurance numbers for both you and your spouse. You should also supply a void cheque from your bank account,  for direct deposit of your pension.

Your pension will begin on the first day of the month after you retire or on a subsequent date if you elect to defer your pension. Each month, you will receive your

payment for that month on the first day. For example, if you retire on September 15, you will receive your October payment on October 1.

If you have a spouse and are receiving a joint-and-survivor pension, and your spouse dies before you or is no longer your spouse, you should inform the Company so that you can have the opportunity to elect that your pension be restored to its full amount.

**This handbook provides a brief description of your pension benefits under the Pension Plan. It is not intended to provide all details of Pension Plan entitlements. Full details of your entitlements can be found in the master Plan document. If there is any difference between this handbook description and the master Plan document, the master Plan document will always govern.**

# Appendix 1: Medical Plan Details

## Medical Plan Coverage

The following items are covered under the categories below, with the exclusions and maximums shown:

***Drug Coverage***

- all medication which requires a prescription by law and are on Green Shield Canada's approved list, including contraceptives
- some medications may require the completion of a questionnaire and are subject to approval by Green Shield Canada
- The plan covers the following over-the-counter (OTC) medications: non-sedating antihistamines, antacids, enteric coated ASA, NSAID preparations, calcium therapy and, when medically necessary, laxatives. There is a $300 per person yearly maximum applied for OTC drugs.
- When the covered person chooses the more costly drug, in lieu of the lowest price generic, such person will be responsible for the difference in cost.
- drugs for erectile dysfunctions are subject to an annual limit of $1,000
- maximum coverage: prescriptions or other drugs must be limited to a 3-month supply at any one time
- Coverage for weight loss drugs will be limited to one occurrence per life- time.
- $9.00 drug dispensing fee cap will now apply. Any excess-dispensing fee will be separate from the $5.00 deductible and will be your responsibility.

***Vision Care***

- contact lenses and associated dispensing fee if the lenses are medically necessary when visual acuity cannot otherwise be corrected to at least 20/70 level in the better eye, or because of keratoconus, irregular astigmatism, irregular corneal curvature, or physical deformity resulting in an inability to wear normal frames.
- maximum coverage: you may be eligible for vision care coverage once every 24 months; dependent children under age 14 are eligible for vision benefits once every 12 months.
- Maximum reimbursement is $230 for single lenses, $250 for bifocal lenses, $270 for multifocal lenses and $195 for contact lenses.
- Green Shield starts counting the 12-month or 24-month period based on the date that you make your first claim for vision care coverage.
- The multifocal lenses benefit may be applied towards the cost of laser eye surgery.

***Hearing Care***

- expenses for standard hearing aids and associated dispensing fee if the hearing aids are recommended by a doctor specializing in medical examinations of the ear or treatments of the ear (i.e., an otologist or an otolaryngologist) who has determined the patient has a loss of hearing acuity which can be compensated for by a hearing aid.
- maximum coverage: once every 24 months
- expenses for ear molds for dependent children aged fourteen (14) years and under, up to a maximum of $400 per year.

***Hospital Coverage***

- charges made by a hospital, in its own behalf, for necessary services furnished by the hospital, including room and board
- maximum coverage:
- charges for semi-private room and board (in excess of ward accommodation — OHIP pays for ward accommodation) up to a maximum of $215 per day
- Reimbursement up to a maximum of $3.00 per day for 120 days per calendar year for the difference in cost between standard ward charges and semi-private accommodation in a public chronic hospital or chronic wing facility of a public general hospital when eligible subscriber or dependent has occupied a chronic treatment bed.
- Reimbursement for the difference in cost between standard ward charges and semi-private accommodation in a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital when eligible subscriber or dependent has occupied an active convalescent or rehabilitation bed.

***Land Ambulance Services***

- a professional land ambulance required as the result of an non-occupational accident or non-occupational disease that does not duplicate services covered by OHIP

- maximum coverage: $70 per trip for up to $275 per calendar year per covered person

***Osteopathic Services***

- Services of a licensed osteopath
- no benefit paid for treatments connected to pregnancy, childbirth, or miscarriage, dental work or treatment, or for diagnostic x-rays, drugs, or medicines

***Other Medical Expenses ($35 single and $60 family deductibles apply).***

- charges by a licensed doctor which are in excess of the Ontario Medical Association Schedule of Fees (in effect when services rendered), unless prevented by law
- charges due to pregnancy complications:
- charges, unless prevented by law, for surgical operations for either extra-uterine pregnancy or complications requiring intra-abdominal surgery after termination of pregnancy
- charges, unless prevented by law, resulting from pernicious vomiting due to pregnancy, or toxemia with convulsions due to pregnancy
- no other expenses in connection with pregnancy are covered
- charges in connection with cosmetic surgery required because of a non-occupational accident (within 12 months of the accident)
- nursing home care:
- A patient certified as eligible to receive Extended Care benefits pursuant to the Health Insurance Act of Ontario, and residing in and receiving daily care in an approved Nursing Home defined in and licensed under the Nursing Homes Act of Ontario, or in a Home for the Aged licensed by the Ministry of Community and Social Services under the Homes for the Aged and Rest Homes Act of Ontario, may receive benefits.
- The benefit payment shall be the difference between the daily allowance paid by the Nursing Home or licensed Home for the Aged's daily charge in a standard ward and the Nursing Home or licensed Home for the Aged's daily charge up to the semi-private rate, if such accommodation is occupied, as approved by the Ministry of Health.
- No benefit is payable if the patient is eligible for or receiving the same or similar benefits from the Ontario Ministry of Health, the Workplace Safety and Insurance Board or any other Agency or Department of the Government of Canada or any Province thereof or Municipal Corporation therein, regardless of whether or not the benefit was applied for or contributed to.
- hospice care– paid at 100%, deductibles do not apply:
- reasonable charges made by a hospice for service at home or in a facility, received by a covered family member who is terminally ill and whose life expectancy is 6 months or less.
- maximum coverage: $7,500 per person for his/her lifetime or 30 days.
- care by a registered nurse: subject to a $25,000 limit per person per calendar year

- the professional services of a Registered Graduate Nurse (RN) or of a Registered Nursing Assistant (RNA) provided that he/she is qualified to administer drugs, if ordered by a doctor as medically necessary.
- the patient must not be confined to a hospital and the nurse must not ordinarily live in the patient's home or be a member of the family.
- services of a licensed psychologist requires a physician's note.
- services of a licensed physiotherapist requires a physician's note.
- care after dental accident:
- dental work performed by a dentist for the prompt repair of *natural* non-diseased teeth and required as a result of a non-occupational, accidental injury, external to the mouth (The dental work under this clause is covered under the Medical Plan, not the Dental Plan. These expenses will not be included in your yearly dental maximum).
- Industrial Alliance may require a dental accident report and related dental x-rays prior to payment for prosthetic appliances.
- provision of anesthesia, oxygen, blood and blood products, if ordered by a doctor
- rental of an iron lung or other durable medical or surgical equipment, if ordered by a doctor.
- artificial limbs and eyes, crutches, splints, casts, trusses, and braces, including replacement, but only if replacement is required because of a change in the covered patient's physical condition.
- Wigs for patients undergoing treatment for cancer, lupus or alopecia, to a lifetime maximum of $600 per person.
- diagnostic laboratory and x-ray expenses and other diagnostic procedures, therapeutic radiology benefit will have a cumulative $1250 annual maximum per person.
- CA 125 Ovarian cancer tests and PSA tests are covered at 100%, deductibles do not apply.
- prescribed support stockings maximum of 4 pairs per year, if ordered by a doctor and provided such charges are reasonable and customary, subject to pre-approval by the Insurance Company.
- orthopedic shoes, including arch supports and custom-made orthotics, up to a maximum of $400 per person per calendar year. The orthopedic shoes, arch supports, and orthotics benefit will require a medical prescription. As of Jan 1, 2011, maximum for the above benefit is one (1) pair every 18 months.
- Podiatrist services will be paid concurrently with OHIP.
- drugs and supplies required as a result of a colostomy or ostomy
- supplies required for the treatment of diabetes.
- syringes and needles, diabetic testing agents (insulin and all other approved injections are covered under Green Shield's Drug Plan)

Note: Some medical supplies may be covered by the ***Assistive Devices Program (A.D.P.)*** in Ontario. The Ontario Ministry of Health makes this program available to

Ontario residents who have long-term physical disabilities. A.D.P. will contribute a portion toward the cost of eligible devices to qualified residents.

The A.D.P. covers several items, some of which are prosthetic devices, wheelchairs, respiratory devices, orthotic devices, and hearing and visual aids. For specific benefit information, contact the A.D.P. at 1-800-268-6021.

Both Green Shield and Industrial Alliance co-ordinate their coverage with the A.D.P. Eligible A.D.P. claims must be submitted first to the A.D.P., which will pay its portion of the approved cost, and then to Green Shield/Industrial Alliance for consideration of the unpaid portion.

***Out-of-Province Emergency Care***
*all charges described below are eligible only if they result because of a medical emergency when you or your eligible dependents are traveling outside your home province. The reimbursement level is 100%.*

- charges for a professional land ambulance service to transport you to the nearest hospital that provides the required treatment.
- in-patient hospital charges for the **difference** between the room and board benefit payable by the provincial hospital plan and the actual cost of **ward accommodation**
- charges by a doctor or surgeon that exceed those set out in the current Ontario Medical Association Schedule of Fees. The charges must be reasonable and customary for the area where the service is performed.
- other covered expenses described in the Industrial Alliance Insurance contract with Bombardier Inc.

## Medical Plan Exceptions

The following services and supplies are not included under the Medical Plan. Reimbursement will ***not*** be made for the following:

*General exceptions*:

- expenses in connection with accidents or illness that are work-related.
- expenses normally paid through any provincial government health plan, Workers' Compensation Board, the Assistive Devices Program (see page 78), or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made.
- charges for eligible expenses that are higher than what is normal, reasonable, and customary based on current medical practice.
- charges for services or supplies that require pre-authorization, if that pre-authorization has not been requested and approved.
- expenses resulting from intentional self-inflicted injuries or illness while sane or self-inflicted injuries or illness while insane.

- charges for failure to keep a scheduled appointment.
- any cosmetic surgery or procedures which are not required because of an accident
- charges for completion of any claim forms and/or insurance reports (except Group Insurance Forms — maximum $30.00 per form).
- services which do not meet accepted standards of medical practice, including charges for services or supplies which are experimental in nature.
- services that are not recommended or approved by the attending doctor.
- replacement of lost, missing, or stolen items, or items which are damaged due to negligence.

*Industrial Alliance - medical plan exceptions:*
- charges by a registered nurse, who is related to you by birth or marriage, and/or who normally resides in your home.
- charges by a registered nursing assistant unless such professional is qualified to administer drugs through the appropriate provincial courses, a practical nurse, or any person who is not a registered nurse.

*Green Shield - audio plan exceptions:*
- batteries for hearing aids
- replacement of lost or broken hearing aids
- audiometric examinations, or hearing aid evaluations

*Green Shield - drug plan exceptions*:
- vitamin products, patent medicines, blood and blood plasma, contraceptive devices, foams, or gels, atomizers, vaporizers, and first aid supplies.
- ingredients or products which have not been approved for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage.
- After you have reached the maximum of five dispensing fees in a given year for a DIN that qualifies as a maintenance drug, the dispensing fee portion of the prescription cost will no longer be covered by your drug plan
- cosmetic products.
- mixtures, compounded by a pharmacist, which do not contain one or more ingredient(s) under your prescription plan or which do not conform to the current extemporaneous compound policy.
- food and nutritional systems.
- delivery and transportation charges.
- video instructional kits, informational manuals, or pamphlets.

*Green Shield - vision care exceptions*:
- vision care services or supplies listed below:
- plano sunglasses.
- vision examinations.

- medical or surgical eye treatment.
- special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses.
- replacement of lenses or frames which are lost, broken, or stolen unless at the time of such replacement, you are otherwise eligible under your regular vision care coverage.
- vision benefits which are not dispensed by a licensed optometrist, optician, or ophthalmologist.
- repairs to eye-glasses, lenses, and/or frames.
- anti-reflective, photosensitive, invisible, or progressive bifocal or trifocal lenses to the extent the charge for such lenses exceeds the benefit amount established for regular lenses.
- charges for sunglass tints, scratch-resistant coating, or ultraviolet filters to the extent the charge for such expenses exceeds the benefit amount established for regular lenses.
- follow-up visits associated with the dispensing and fitting of contact lenses
- charges for eye glass cases.
- charges for industrial safety eyeglasses (covered through Health & Safety).

- Appendix 2: SUB Plan Administration

### *Composition of the Board*

A six-member Board of Administration manages the SUB Plan. Three members are from the Company and three are from the Union. The members are volunteers and do not receive pay to sit on the Board.

Each member has an alternate. If a member will be absent from a Board meeting, his/her alternate can attend instead. In that case, the alternate will have the same powers and duties as the absent member.

Both the Company and the Union are responsible for appointing or replacing their own board members. Appointments or removals have to be announced in writing before the effective date of the change.

### *Voting Procedure*

At least two members from the Company and two members from the Union have to be present to make decisions. Each member or alternate has only one vote. All decisions are based on the majority of votes cast.

In the case of a tie vote, the Board members can choose an Impartial Chairman to break the tie. If the members cannot agree on a Chairman, they will select one using the process described in the Collective Agreement for selecting an arbitrator.

### *Powers and Authority of the Board*

The Board is responsible for deciding any disputes under the Plan, subject to these restrictions:

- The Board cannot remove any provision of this Plan or change it in any way.
- The Board does not have the power to decide issues arising under the Collective Agreement even if they are relevant to the issues before the Board.
- The Board does not have the power to decide any internal procedures or operations of the Company or of the Union.

### *Funding of the SUB Plan*

#### Company Contributions

The Company will make a contribution to the SUB Plan Fund of a maximum of $0.05 for each hour that each employee receives pay from the Company, excluding vacation pay. The Company may contribute a smaller amount if it will bring the total assets of the Fund up to Maximum Funding (see below).

When calculating its contribution, the Company may deduct any amounts it pays under the Separation Payment Plan (SPP) and the Automatic Short Week Benefit Plan (Short Week Plan). Contributions to the Fund will start again after all the SPP and Short Week Plan payments have been accounted for. Any amount outstanding will be deducted

from the assets of the Fund in calculating the CUCB or relationship of the Fund with the Maximum Funding.

A contribution calculation will be made each week. However, the actual contribution will be paid in the second week following the calculation date, on the first scheduled work day of that week.

The Company has the right to deduct from the contribution any amount required by federal, provincial, or municipal regulations.

### Maximum Funding

The Board calculates the maximum funding of the SUB Plan Fund each month. The calculation is shown below:

**Average Full Benefit Rate X 20 X the Average Number of Employees**

Interpretation notes:

- The *averages* in the formula use the previous 12 months ending with the second month before the calculation date.
- *Employees* in this case includes
  1) those in active service, and
  2) those on a qualifying lay-off who have Credit Units (but not included in (1) above).
- The calculation for the *Average Full Benefit Rate (AFBR)* divides the total number of Full Benefits since the first pay period after June 23, 2006, by the number of Full Benefits paid in the month the maximum funding calculation is made. If the AFBR is zero using that formula, the figure 50 will be used instead.
- A *Full Benefit* is the amount paid to a laid-off employee under the SUB Plan for a week in which he does not have any Available Hours and no other compensation as defined in the SUB Plan description in this document.

### Administrative Costs

The following administrative costs are paid out of the SUB Plan Fund:

- the Trustee's costs and expenses.
- reasonable and necessary expenses of the Board (the members are not paid to serve on the Board);
- Trustee fees, bank fees, and audit fees; and
- other expenses required to prepare and distribute material explaining the Plan.

### Vested Interest

No employee has any right, title, or interest in any of the assets held in the Fund or to any Company contribution.

### *Calculation of the Credit Unit Cancellation Base (CUCB)*

The CUCB is determined for each calendar month by dividing the current market value of total assets in the Fund by the sum of the number of active employees and laid-off employees who have Credit Units. The current market value of assets is the value on the Friday, preceding the first Monday of such month.

The CUCB for any month will be applied to each pay period beginning in that month except if the CUCB is less than $200.00 or the Current Layoff Ratio (CLR) is 15.0% or higher (see below for an explanation of "CLR"). In that case, the CUCB is applied to the first pay period beginning in that month until such time that the CUCB for any pay period exceeds $200.00 or the CLR is 15.0% or less for the same pay period.

The market value of assets for any pay period is based on the close of business on the Friday preceding such pay period.

If the CLR equals or exceeds 5%, the CUCB, as calculated above, will be adjusted by dividing it by the factor related to the range of CLR below:

| CURRENT LAYOFF RATIO | CUCB ADJUSTMENT FACTOR |
|---|---|
| Under 5% | Not Applicable |
| 5% but less than 10% | 1.2 |
| 10% but less than 15% | 1.4 |
| 15% but less than 20% | 1.6 |
| 20% but less than 25% | 1.8 |
| 25% but less than 30% | 2.0 |
| 30% but less than 35% | 2.2 |
| 35% and over | 2.4 |

**Current Layoff Ratio (CLR)**

At the same time the Company calculates the CUCB, it will calculate the CLR by dividing the total number of laid-off employees who have Credit Units by

a) the total number of active employees; and

b) the number of laid-off employees with Credit Units excluded from (a).

### *Finality of Determinations*

Normally, the Board will not retroactively adjust the Maximum Funding or the CUCB due to error(s) later discovered in the figures or calculations, unless it is practical to do so and the Company determines that the adjustment is substantial.

The above does not excuse the Company from making up any shortage in its contributions to the Fund.

### *Liability*

The Company's contribution is its only obligation under the Plan. The Company is not responsible for making up any depreciation or loss of value in the securities held in the Fund.

As well, the Board, the Company, the Trustee, and the Union each are not responsible or liable for any act or failure to act by one of the other parties. Each party is authorized to rely on the correctness of the information provided by someone representing any of the other parties.

# Appendix 3: Definitions

**active payroll:** You are on the *active payroll* in any week you perform work and/or draw pay from the Company.

**Assistive Devices Program (A.D.P.):** The Ontario Ministry of Health makes this program available to Ontario residents who have long term physical disabilities. A.D.P. will pay part of the cost of eligible medical devices (e.g., wheelchairs) to residents who qualify. See page 78 for more information.

**base hourly rate:** In the description of the *SUB Plan*, this term means your highest straight-time hourly rate during the week that a SUB Plan benefit is payable to you. The rate will include applicable cost-of-living allowances but exclude all other premiums or bonuses.

In the description of the Separation Payment Plan, and the Automatic Short Week Benefit Plan, this term means your straight-time hourly rate on your last day of work in the Bargaining Unit. If you had a higher rate for a regular classification in the last 13 consecutive pay periods, you can claim this rate. In either case, the rate will include applicable cost-of-living allowances but excludes all other premiums or bonuses.

**beneficiary:** Your *beneficiary* is a person who can legally receive money from a benefit plan when you die. You must fill out a form to record your choice of beneficiary. The last form on file controls who gets the money, so it's very important to keep your records up to date. If you don't fill out a form at all, your estate will receive the benefits, if any. In some cases, the beneficiary appointed under your will may take precedence.

**Canada/Quebec Pension Plan (CPP/QPP):** The Canada Pension Plan or Quebec Pension Plan (C/QPP) pays retirement benefits to those people who have contributed through time spent in the work force. Currently, full benefits are payable at 65, with reduced benefits, in certain cases, available from age 60.

**children:** *See* dependents

**credited service:** Service with the Company, measured in years that is used to calculate your benefits from the Company Pension Plan. For details about the calculation of credited service, see page 66.

**dependents:** Under the Medical Plan and Dental Plan, your dependents include your spouse and/or dependent children, according to these definitions and who is also a resident of the same Country in which the employee resides. Please note that all dependents ***must at all times be covered under a government health plan and live in Canada permanently.***

Your *spouse* is either

- your legal spouse — the person who is legally married to you through a religious or civil marriage ceremony, or

- your common-law spouse — the person who you live with and have publicly represented as your spouse for at least the previous 12 months. (This definition does not apply if either you or your partner are legally married to someone else.)

Only one person may be insured as your spouse at any time.

You must provide the Company with proof of a common-law relationship at the beginning of the 12-month period. Satisfactory proof is an affidavit signed by both of you, which attests to your relationship. The affidavit must be completed by a Notary Public licensed under the laws of the province of Ontario. Costs to obtain the affidavit are your responsibility.

Coverage for your spouse will end if you become divorced, your marriage is annulled, or you become <u>legally separated.</u>

<u>The spouse enrolled on the Health Care benefits program at time of retirement will be the only spouse entitled to Health Care benefits after retirement.</u>

<u>Special consideration will be given in the event of a true reconciliation between the employee and his/her spouse who was previously enrolled in the Health Care benefits program as the spouse of that employee.</u>

- Your *dependent children* include your or your spouse's unmarried, natural or legally adopted children.
- To be eligible, you must be able to claim for dependent coverage under the *Income Tax Act*. A dependent child must be under age 21 and depend on you for support. However, if your child is covered before age 21, he/she will still be covered up to age 25 if he/she is a full-time student at a university or other accredited institution. You must provide evidence each year of your child's registration at that institution.
- Children who are permanently disabled and dependent on you for support before reaching age 21 remain covered beyond the age limit, if they were insured before their 21st birthday and continue to reside with you.

**doctor:** In the sections describing the Medical Plan, Sickness and Accident Plan, and Extended Disability Benefit Plan, the term *doctor* means a legally qualified physician who is licensed and authorized by law to practice medicine in the area where treatment is given.

**estate:** The total property and possessions owned by a person.

**executor:** A person who is given the responsibility of carrying out the terms of another person's will.

**hospital:** In the description of the Medical Plan, a *hospital* is an institution that

- is legally operating as a hospital,
- is open at all times,
- is operated primarily for the care and treatment of sick and injured persons as inpatients,
- has a staff of one or more licensed doctors available at all times,

- continually provides 24-hour nursing services by graduate registered nurses,
- provides organized facilities for diagnosis and major surgery, and
- is not primarily a clinic, nursing home, rest home, or convalescent hospital/home or similar establishment, nor other than incidentally a place for the treatment of alcoholics or drug addicts.

**lay-off:** The Company considers you to be on lay-off if you are not scheduled to work for one of the following reasons:

- the plant, department, or operation is operating with a reduced work force because of a lack of work or is shut-down;
- you are unable to do the work the Company offers you, although you would be able to perform other work if you had enough seniority; or
- you are not totally disabled but are medically disqualified to perform the work that is available.

The lay-off must be from the Bargaining Unit. It must not result from disciplinary reasons or as the consequence of a strike, work stoppage, or any type of concerted action, involving employees or other persons employed by the Company and represented by the Union at the Company or elsewhere.

(Other conditions may apply but are typically rare or unusual. For more specific information, please refer to the Benefit Agreement signed between the Company and the Union.)

**seniority:** This term is defined in the Collective Bargaining Agreement as "seniority status." After completing a probationary period, an employee will be credited with seniority from the date on which he/she started his/her present employment with the Company and his/her name will be added to the appropriate Seniority List. A probationary period is equal to 90; working days during one period of employment. A full day, a part day, or a Plant Holiday each count as a working day when calculating a probationary period.

**severance pay:** This is a payment some employees are entitled to when they lose their jobs. It is compensation for the years and effort they have put into the employer's business. Severance pay is determined by provincial law and is not the same thing as termination pay.

**spouse:** For the purposes of the pension benefits described in this handbook, this term means the legal spouse or common law spouse of an employee. In the case of a common law spouse of the opposite sex, the relationship will be recognized under this definition if

a) the couple have been living in a conjugal relationship for a period of at least one (1) year or more immediately preceding the date of such notice to the Company; or

b) the couple have a conjugal relationship of some permanence and are the natural or adoptive parents of a child (as defined in the Family Law Act of Ontario).

In order for the Company to act on either (a) or (b) above, the employee and his/her spouse must submit proof of their relationship to the Company. Satisfactory proof is an affidavit, obtained at the employee's expense. It must be signed by the couple attesting to their relationship as described in (a) or (b) above, and completed by a Notary Public licensed in Ontario.

**taxable benefit:** Sometimes the Company pays for benefits for you. If the government counts the payment as part of your income, it is called a taxable benefit. For example, if the Company pays premiums for life insurance, the premiums are a taxable benefit. Your T4 slip will show the value of your combined taxable benefits.

**totally and permanently disabled:** This is a term the insurance company uses to describe a person who qualifies for Extended Disability Benefits. The insurance company will only give benefits to a person who meets this definition: *a person who cannot work at any gainful employment at the Company for which he/she is, or may reasonably become, qualified by education, training, or experience.* "Gainful employment" means work that you have at least minimum qualifications for and that you are physically able to do even if you are sick or injured. If you don't have minimum qualifications for a job, but could learn how to do it, the Company expects you to become qualified, if it's reasonable to expect you to go through the training. The Pension Plan also uses this definition to determine eligibility for a disability pension.

For purposes of the Pension Plan, you are permanently and totally disabled if the Pension Board of the Plan finds that, on the basis of medical evidence, your disability will presumably prevent you for life from engaging in regular employment or occupation for compensation or profit based on jobs available at the Company.

**Workplace Safety and Insurance Board (WSIB):** This Board was called the Workers' Compensation Board until January 1, 1998, when the Workplace Safety and Insurance Act, 1997 took effect. The four purposes of the WSIB are

- promoting health and safety in workplaces, and preventing and reducing the occurrence of workplace injuries and occupational diseases;
- facilitating the return to work and the recovery of workers;
- facilitating the re-entry into the labor market for spouses of deceased workers; and
- providing compensation and other benefits to workers and their survivors.

**WSIB:** *See* Workplace Safety and Insurance Board

**This handbook is a summary of the Bombardier benefits available to you. All the provisions applicable to your coverage are described by the official collective bargaining agreements between Bombardier Aerospace and the Unifor Local 112 (or the Union), the group insurance contracts, administrative services agreements, and pension plan texts filed with the Financial Services Commission of Ontario -FSCO. If you wish to know more about the terms and conditions of the plans described in this handbook, or if you need to find out how they apply in a specific situation not described here, please contact your Employee Service Center.**

**Bombardier Aerospace is providing this benefit coverage in conjunction with government-sponsored programs. Bombardier's commitment to provide coverage is based on the presumption that the services and products, which are currently covered under government programs, will continue to be covered. In the event that coverage is modified in any way, suspended, or discontinued, Bombardier will not automatically assume responsibility for any services or products previously covered under the government programs.**

**In the event of any discrepancy between the information provided in the booklet and the union contract, the terms of the union contract will always apply.**