The International Association of Heat and Frost Insulators & Allied Workers No. 118 Health and Wellness Trust Fund

Including amendments to January 1, 2026

Active Member
Associate Member
and
Disabled Member Benefits

Plan Administrator:

convyta

501 - 4445 Lougheed Hwy
Burnaby BC V5C 0E4

www.hfbenefits.org

privacy policy

We, the Trustees of the International Association of Heat and Frost Insulators & Allied Workers No. 118 Health and Wellness Trust Fund, have adopted the following Privacy Principles, which reflect our commitment to safeguarding our Members' personal information:

- Information about you and your communications with the Plan are kept confidential.
- Neither the Administrator, nor the Plan will sell your personal information.
- Information about you is gathered lawfully and fairly.
- Information about you is gathered, used, or disclosed only to provide you with benefits and services as outlined in your Plan documents.
- We maintain appropriate procedures to ensure that personal information in our possession is accurate and, where necessary, kept up to date. You are entitled to seek a correction of your personal information if you believe that the information held by the Plan is not accurate.
- You may access your personal information, subject to limited exceptions and conditions.
- Personal information is not disclosed without member's permission except in limited circumstances as permitted or required by law. However, the Administrator may share personal information with the Plan's actuaries, agents, consultants or service providers in connection with providing, administering, adjudicating, costing, financially managing and servicing members'plans and benefit programs.
- Where we choose to have certain services, such as an actuarial valuation, provided by third parties, we take all reasonable precautions regarding the practices employed by the service provider to protect your personal information. We ask that they, in turn, undertake to honour the Plan's privacy policy and applicable legislation.
- To protect your personal information against unauthorized access, disclosure, copying, use or modification, theft or accidental loss, the Plan will maintain appropriate security mechanisms.

contents

*does not apply to associate members

introduction

This pamphlet contains a summary of the benefits available to eligible active and associate members under the International Association of Heat and Frost Insulators & Allied Workers, Local 118 Health and Wellness Trust Fund (the Plan) and does not contain all the details found in the official plan documents and contracts. For example, there are many exclusions and limitations that are not contained in this pamphlet. You can obtain a more information on your benefits by contacting the Plan Administrator, Convtya.

Benefits are paid in accordance with the official plan documents and contracts. If there are any omissions in this pamphlet or a conflict between this pamphlet and the official plan documents and contracts, benefits will be paid according to the official plan documents and contracts.

The Plan is an hourbank program, wherein your employer(s) contribute to the Plan for each hour you have worked under the Collective Agreement. These hours are accumulated in your hourbank and provide you with coverage once you have met the Plan's eligibility criteria.

We welcome your interest and suggestions in the hope that the Plan will always reflect the desire of the majority of the people it serves. For additional information or assistance, feel free to contact Convyta.
Call Toll-Free: 1-866-432-8118 or 1-866-HEAT118
Email: heatandfrost@convyta.com

benefit overview

life insurance	$70,000
accidental death & dismemberment	$70,000
weekly indemnity*	a weekly benefit equal to the EI Sickness weekly max PLUS $25, on the 1st day of accident, 8th day for illness EI Integration, 52 weeks overall max
long term disability*	75% of monthly earnings to a maximum of $3,000 per month 365 day waiting period, payable up to age 60, taxable
extended health benefits	as described within
Out of Province/ Canada Emergency Medical Travel Insurance	$5 Million maximum per 90-day coverage period up to age 70
dental benefits	as described within
member family assistance program	confidential counseling services for members and eligible dependents

*not available to exempt or associate members

eligibility details

hours required to qualify for coverage	250 hours worked within 10 consecutive months
hourbank maximum	9 months / 1125 hours
monthly hourbank charge	125 hours
self-pay limit	9 months

establishing coverage

To establish coverage, you must be a member in good standing of the Heat & Frost Insulators, Local 118 (the Union). For the purpose of the Plan, members working for non-union contractors who refuse to cooperate in Local 118 organizing efforts are not deemed to be in good standing. You must complete an Enrolment and Beneficiary application and submit it to the Plan Administrator, Convyta.

You must have earned and your employer(s) reported and paid to the Plan, the required number of hours to qualify for coverage. Hours worked but not reported or paid by your employer(s) do not qualify you for coverage.

Upon qualifying for coverage for the very first time, you will be issued two pay-direct cards from GreenShield, regardless of whether you have single coverage or dependent coverage. Both cards will be in the Member's name. You can use the pay-direct card when you visit your dentist, participating paramedical practitioners, when you fill a prescription or make a vision care purchase. Using your card eliminates the requirement to file a claim - your claim is paid directly at point of sale.

associate / exempt members

These are owners, estimators, office personnel and other employees of participating employers for which permission has been applied for and granted by the Union. The Union reserves the right to approve or refuse a request for associate/ exempt member coverage.

reporting

Your Collective Agreement requires that your employer(s) report, prior to the 15th day of the month, all hours worked by you up to the close of the employer(s)' payroll ending closest to the last day of the preceding month. We recommend that you keep your own pay-slips because errors may occur in reporting or tabulating.

The Plan Administrator needs a reporting month (lag month) to operate the hourbank system. Employers send their reports and contributions for the hours members work each month, to the Plan Administrator in the following month. The Plan Administrator then posts those hours to your hourbank.

coverage begins

If you have completed the application form(s) and sent them to the Plan Administrator, your coverage will begin on the first day of the month following the month in which enough hours were reported and paid to the Plan by your employer(s).

In the example below, your employer(s) reported that you accumulated more than 250 hours within the last 10 months. March hours were reported and tabulated in April, which makes April the lag month and your coverage becomes effective May 1.

coverage continues

Each month, 125 hours will be deducted from your hourbank to pay for your coverage. Any excess hours reported that month will accumulate in your hourbank for future coverage. Once coverage starts, you will have continuous coverage as long as your hourbank has sufficient hours to pay for coverage.

A maximum of 9 months' equivalent hours (1125 hours) can accumulate in your hourbank. Any hours that are over this maximum, flow into the general fund of the Plan.

disability credits

If you are disabled and collecting Employment Insurance Sick benefits, WorkSafe BC benefits or weekly indemnity benefits under this Plan, you must contact the Plan Administrator to apply for disability credits. You must complete the application for disability credits and return it to the Plan Administrator. Disability credits are designed to provide you with assistance in maintaining your coverage that is supported by your hourbank.

For each day that you are disabled and on a claim that has been accepted for payment, and provided the Administrator has approved your application for disability credits, your hourbank will be credited with contributions of 7.5 hours per day, up to a maximum of 125 hours per month for a maximum of 12 months. You must be eligible for benefits when the disability commences in order to qualify for disability credits.

when your hourbank drops below 125 hours

If your hourbank balance drops below 125 hours, you will be sent a Shortage of Hours notice indicating the balance in your hourbank and the amount you are required to pay in order to maintain your coverage. If your payment of the amount requested is received by the deadline specified on the notice, your coverage will be continuous. If you are short 10 hours or less, the Plan will cover the shortage

automatically and coverage will continue and no Shortage of Hours notice will be created.

Important: Do not ignore the Self-Payment or Shortage of Hours Notice! The only way to provide you and your dependents with coverage for a specified month is to pay the Self-Payment or Shortage of Hours Notice by the date specified on the Notice.

If you have a balance of employer hours in your hourbank and, although you have been working regularly, do not have sufficient work to maintain the hourbank charge, you will qualify under "Shortage Hours" and you will receive a billing showing the balance of hours required to make up the 125 hours needed each month to provide you with coverage. Shortage of Hours notices do not reduce the maximum number of months you are permitted to self-pay.

If you receive a Self-Payment or Shortage of Hours Notice and you think it is incorrect, contact the Plan Administrator, Convyta, by telephone toll-free 1-866-432-8118 or 1-866-HEAT118 or email heatandfrost@convyta.com

If you prefer to receive your self-pay notice by email, please contact the Plan Administrator and make this request.

In the event that late hours are reported on your behalf, or other adjustments are found later, these hours will be credited back to your hourbank for future use.

If your coverage is terminated because you accidentally fail to pay a Shortage of Hours Notice, contact the Administrator immediately and you may be allowed to reinstate coverage by paying the actual number of hours you were short.

Withdrawal card members may run down the balance in their hourbank but are not permitted to self-pay.

self-pay limit

The "self-pay limit" is the number of consecutive months you may continue your coverage by self-payment, provided you remain a member in good standing of the Union. If you return to work for a participating employer then the count of your self-payments will reset to zero, if the employer remits enough hours to the Plan to provide a month of coverage.

While making full self-payments, you will have full benefits except for weekly indemnity and long term disability benefits.

Associate members and withdrawal card members are not permitted to self-pay.

PLEASE NOTE: During the months that you are self-paying for coverage, the pay-direct card will not be activated/re-activated until payment is received by the Plan Administrator and processed. If a prescription or other eligible benefit that would normally be claimed using the pay-direct card, is required prior to that, you will be required to pay for the expense and submit the claim for reimbursement.

Once full coverage has lapsed, in order to be covered again with full benefits, you must re-qualify with 250 hours in a 10-month period. You may not re-qualify with self-payment.

coverage ends

Coverage will end when there are insufficient hours in your hourbank to allow for a deduction of 125 hours and you do not make your Self-Payment or pay your Shortage of Hours Notice by the date specified.

If you are suspended your coverage will end immediately, and any balance in your hourbank will be forfeited.

hourbank freeze

The Plan rules allow you to suspend or freeze hours if you are temporarily working out of any other union local in Canada. Please contact the Union office or the

Plan Administrator for the rules regarding freezing your hourbank.

reciprocity agreements

If you are working in the jurisdiction of another union local on a temporary basis for up to 12 consecutive months, and the other local has a welfare plan which has entered into a Reciprocal Agreement with this Plan, then the hours remitted on your behalf may be transferred back to this Plan to help you maintain your coverage.

Before any hours can be transferred, you must complete a Benefits Transfer Form and return it to the Heat & Frost Insulators, Local 118 Business Office.

if I retire

If you are retiring with at least 10 years of Local 118 membership and are taking a pension from the Heat and Frost Local Union 118 Pension Plan, you may be eligible for coverage as a Retiree, under the Retiree benefits provided through the Plan. For further information, please contact the Plan Administrator.

dependents

The Plan will provide extended health and dental benefits for:

a) The spouse* of a covered member;
b) Any unmarried child of a covered member up to the age of 21, provided such person is mainly dependent on and living with the covered member; and
c) Any unmarried child of a covered member to any age if the child is in full-time attendance at a recognized school, college, or university; and
d) Any unmarried mentally or physically handicapped child of a covered member to any age, provided such person is mainly dependent on and living with the covered member or the spouse of the covered member. In advance of this covered dependent reaching the maximum age of 21, application must be made to the Plan Administrator to arrange for continued coverage

and the dependent must meet the criteria for such continuation of coverage.

*The legal spouse of the member, or in absence of a legal spouse, the common-law spouse of the member. The common-law spouse is a person whom the member has been living and that living arrangement must be recognized as a conjugal relationship in the community in which the couple resides. Only one person may qualify as the spouse at any one time. The co-habitation period for a common-law spouse is a continuous period of one year.

When completing your application form for coverage, please include all dependents to be covered. To add, delete or change the dependents covered, complete a new Enrolment and Beneficiary card from the Plan Administrator or your Union Office, and forward it to the Plan Administrator's office.

New dependents are not covered under the Plan until you enroll them – please contact the Plan Administrator or the Union Office for the necessary forms.

dependents' coverage in the event of your death

If at the time of your death you had full coverage, the Plan will continue your eligible dependents' coverage until the earliest of the following:

a) 10 months following the date of death;
b) the date the person ceases to be a dependent (other than because of your death);
c) the date the Plan is terminated; or
d) the date the dependent becomes eligible for coverage under a similar group plan.

life insurance

Each eligible active and associate member is insured for $70,000 of Life Insurance. This coverage terminates for an active member on the date you no longer have hours in your hourbank. This coverage terminates for an associate member at the end of the month in which employment terminates.

In the event of your death while insured, the amount of your Life Insurance is payable to your beneficiary should your death occur from any cause while you are insured under the group policy. You may change your beneficiary at any time by written notice to the Administrator. If you do not designate a beneficiary, the insurance will be payable to your estate.

continuation of life insurance on termination of coverage

When your coverage with the Plan terminates, you may convert your Life Insurance to an individual policy without a medical examination or health questionnaire. The individual policy would be for an amount not greater than the amount under the group policy and would be available at any time within 31 days after termination of the group insurance. Contact the Administrator for details.

Your life would be continued to be insured, at the conversion rate, under the group policy during the 31-day conversion period, whether or not you apply for an individual policy.

waiver of premium for life insurance

If while insured for this coverage you become totally disabled for 6 consecutive months before age 65, if approved, the Insurer will waive the payment of the Life Insurance premiums.

For active members who become disabled, Totally Disabled for the first 24 consecutive months of benefit payment, shall mean you are incapacitated to the extent that you are not able to perform any and every duty of your occupation or employment. After such 24 months, Totally Disabled shall mean you are incapacitated by an injury or disease to the extent you are not able to perform any work for compensation or profit and are not able to engage in any business or occupation.

For associate members who become disabled, Totally Disabled shall mean you are incapacitated by an injury or disease to the extent you are not able to perform

any work for compensation or profit and are not able to engage in any business or occupation.

Note: In order to qualify for the Waiver of Premium benefit you must notify Manulife Financial of your disability within 12 months of your last day of work and must furnish proof of your disability satisfactory to the Insurer within 18 months of that last active working day.

accidental death & dismemberment

You are insured against the losses described in the Loss Schedule. Your protection is world-wide, 24 hours a day, on or off the job. Benefits are payable regardless of any other benefits that you may receive from any insurance company other than the RBC Life Insurance Company (RBC), or any other organization. You are eligible if you are a member in good standing and are under the age of 80. Honorary members, exempt members and retirees do not have coverage for Accidental Death & Dismemberment.
Your Accidental Death benefit is paid to the designated beneficiary or to your estate if no beneficiary is designated. Any other benefits are paid to you (those described in the Loss Schedule are paid as a percentage of the Principal Sum).

principal sum

Your amount of Principal Sum is: $70,000

loss schedule

If an accident causes a loss payable under this schedule within one year from the date of the accident, RBC pays the amount set out as follows. No more than the total of the Principal Sum is paid for injuries resulting from the same accident.

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of or Loss of Use of	
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand or foot and sight of one eye	100%
Speech and hearing in both ears	100%
One leg or one arm	75%
Either hand or foot	66 2/3%
Sight of one eye	66 2/3%
Speech or hearing in both ears	66 2/3%
Hearing in one ear	50%
Thumb and index finger of the same hand	33 1/3%
Four fingers of the same hand	33 1/3%
All toes of one foot	12 1/2%
Total and irreversible paralysis of	
All four limbs (quadriplegia)	200%
Both lower limbs (paraplegia)	200%
One arm and one leg on the same side of the body (hemiplegia)	200%

"Loss" means, with regard to:

- Hands and Feet: Actual severance through or above the wrist or ankle joint;
- Eyes: Entire and irrecoverable loss of sight;
- Leg or Arm: Actual severance through or above the knee or elbow joint;
- Thumb and Fingers: Actual severance through or above the metacarpophalangeal joints
- Speech and Hearing: Entire and irrecoverable loss;
- Toes: Actual severance through or above the metatarsophalangeal joints;

Loss of Use of Any Limb(s): Must be total, irrecoverable and be continuous for 12 months after which the benefit is payable, provided the nerve damage is determined to be permanent.

Indemnity provided under this section for all losses you sustain as a result of any one accident does not exceed the following:

- With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum.
- With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum.

exposure and disappearance

If loss results from unavoidable exposure to the elements and indemnity is otherwise payable hereunder, such loss is payable under the terms of the policy.

If your body is not found within one year after the date of the disappearance, sinking or wrecking of the vehicle in which you are an occupant at the time of the accident and under such circumstances as would otherwise be covered hereunder, it is presumed that you suffered loss of life resulting from bodily injury caused by an accident at the time of such disappearance, sinking or wrecking.

waiver of premium for AD&D

If you become totally disabled from an accident or sickness and waiver of premium is approved under your applicable Group Life Insurance Plan, premiums for AD&D under this plan are waived while total disability continues, until the earlier of your attainment of age 65, your eligibility terminates, the AD&D policy is terminated or if you fail to provide RBC, upon request, proof of continued total disability.

repatriation

If you lose your life as a result of a covered accident occurring at least 100 kilometres from your principal residence, RBC pays up to **$10,000** for the preparation and transportation of your body back to your principal residence.

spousal retraining

If you receive benefits for a loss described in the Loss Schedule, RBC pays for the expenses actually incurred by your spouse within three years from the date of the accident, for an approved and mutually agreed upon formal occupational training program, specifi-

cally qualifying them to gain active employment in an occupation for which they would otherwise not have had sufficient qualifications. The maximum payable hereunder is **$10,000.**

"Spouse" means a person who is living with you and who is legally married to you; or if you are not married, is a person whom you have publicly represented as your spouse and with whom you have resided continuously for at least 12 months in a conjugal-like relationship, civil union, adult interdependent relationship, or any other formal union defined and recognized by law and who is:

- at least 18 years of age;
- competent to contract; and
- not related by blood closer than would legally bar marriage.

If more than one person meets this definition, RBC will only pay one benefit, which will be paid in equal shares to the persons meeting the definition.

rehabilitation

If you receive benefits for a loss described in the Loss Schedule and you require special training to allow you to work in an occupation that you would not have engaged in except for the injuries you sustained, RBC pays for that training, considering the expenses are reasonable and necessary (other than travelling, clothing and ordinary living expenses), up to **$10,000**, occurring within two years from the date of the accident.

family transportation

If while on a trip, you sustain an injury and as a result, are confined as an in-patient in a Hospital, are under the Regular Care and Attendance of a Physician and require the personal attendance of a Member of the Immediate Family as recommended by the attending Physician, RBC pays for the expense incurred by the family member for transportation to your bedside by the most direct route by a licensed common carrier, but not to exceed an amount of **$3,500** as the result of any one accident.

"Hospital" means an institution licensed as a hospital, which is open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with twenty-four (24) hour nursing service. Hospital will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home or convalescent hospital.

"Member of the Immediate Family" means your spouse or common-law spouse, parents, grandparents, children over age 18, brother or sister.

"Regular Care and Attendance" means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

education

RBC pays for tuition fees in the event of your accidental death. To qualify, eligible dependent children must be enrolled as full-time students in a post- secondary "institution of education" at the time of your death or must enroll within one year following your death.

The amount paid for tuition fees and textbook expenses is equal to the lesser of **3%** of your Principal Sum or **$5,000**, per year per child, for a maximum of four consecutive years. RBC must receive proof of enrollment and attendance for each year that a payment is to be made for each child. If there are no dependent children eligible for this benefit, your Principal Sum is increased by **$2,500**.

For the purpose of this benefit, "dependent child" means your unmarried legally adopted child, stepchild or any child dependent upon you in a "parent-child" relationship as defined under the Income Tax Act for support and maintenance where such child is under 21 years of age inclusive or unemployed and under age 25 years of age and is a full-time student. In addition, a child incapable of self-support by reason of mental or physical infirmity is covered beyond the maximum age.

"Institution of education" includes any University, CEGEP, Trade School or College, as defined where you live.

home alteration and vehicle modification

If you receive benefits for a loss described in the Loss Schedule and are subsequently required (due to the cause for which payment under the Loss Schedule is made) to use a wheelchair to be ambulatory, RBC pays, upon presentation of proof of payment, the one-time cost of (a) alterations to your residence to make it wheelchair accessible and habitable and (b) modifications necessary to your motor vehicle to make the vehicle accessible or driveable for you.
Benefits herein are not paid unless: (a) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization providing support and assistance to wheelchair users and (b) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the provincial vehicle licensing authorities.

The maximum payable under this benefit is **$10,000**.

to whom are benefits paid?

Your accidental death benefit is paid to the beneficiary designated and in effect at the time of payment, or to your estate if no such designation is made. Any other benefits are paid to you (those described in the Loss Schedule are paid as a percentage of the Principal Sum).

disclaimer

This booklet is a summary of the principal features of the AD&D plan and is presented as a matter of general information only. The contents are not to be accepted or construed as a substitute for the provisions of the Master Policy GSR 16853, underwritten by RBC Life Insurance Company.

Underwritten by:
RBC Life Insurance Company
PO Box 1800 Stn B
Mississauga, Ontario L4Y 3W6

collecting your personal information

RBC Life Insurance Company (RBC) may from time to time collect information about you such as:

- information establishing your identity for example, name, address, phone number, date of birth, etc.) and your personal background;
- information related to or arising from your relationship with and through us;
- information you provide through the application and claim process for any of our insurance products and services; and
- information for the provision of products and services.

We may collect information from you, either directly or through representatives. We may collect and confirm this information during the course of our relationship. We may also obtain this information from a variety of sources including hospitals, doctors and other health care providers, the MIB, Inc., the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your employer.

using your personal information

This information may be used from time to time for the following purposes:

- to verify your identity and investigate your personal background;
- to issue and maintain insurance products and services you may request;
- to evaluate insurance risk and manage claims;
- to better understand your insurance situation;
- to determine your eligibility for insurance products and services we offer;
- to help us better understand the current and future needs of our clients;

- to communicate to you any benefit, feature and other information about products and services you have with us;
- to help us better manage our business and your relationship with us; and
- as required or permitted by law.

For these purposes, we may make this information available to our employees, our agents and service providers, and third parties, who are required to maintain the confidentiality of this information. If you are insured under a group insurance policy obtained through your employer, we may also share your information with your employer when necessary for the services we provide to you. Your health information will not be shared with your employer without your consent.

In the event our service provider is located outside of Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is located. Third parties may include other insurance companies, the MIB, Inc. and financial institutions.

We may also use this information and share it with RBC® companies (i) to manage our risks and operations and those of RBC companies and (ii) to comply with valid requests for information about you from regulators, government agencies, public bodies or other entities who have a right to issue such requests.

If we have your social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.

your right to access your personal information

You may obtain access to the information we hold about you at any time and review its content and accuracy, and have it amended as appropriate; however, access may be restricted as permitted or required by law. To request access to such information or to ask questions about our privacy policies, you may do so now or at any time in the future by contacting us at:

RBC Life Insurance Company
P.O. Box 515, Station A,
Mississauga, Ontario
L5A 4M3
Telephone: 1-800-663-0417
Facsimile: 905-813-4816

continuation of coverage

Your AD&D coverage continues by the payment of premiums for a maximum period of 12 months while you are on an approved leave of absence, layoff, strike, maternity leave or compassionate care leave.

This provision ends on the earlier of the date you return to active full-time employment, the AD&D policy is terminated or at the end of the 12-month period.

exclusions

The AD&D insurance does not cover losses caused in any way from suicide or any suicide attempt; self-inflicted injuries; war, declared or undeclared; full-time active service in the armed forces of any country; travelling as a pilot or crew member of any aircraft or travel in the Policyholder's owned or leased aircraft.

claim procedures

To make a claim for AD&D under this plan, contact the Plan Administrator, Convyta Partners. Written notice of the accident must be given to RBC within 30 days of the date of the accident and written proof must be submitted within 90 days of the date of the accident. The Plan Administrator will provide the necessary claim forms as well as instructions covering other requirements that may aid in a prompt handling of the claim.

If RBC does not receive the required notice and proof of loss, the claim may not be considered after the 90-day period has expired, unless there is good reason for the delay. In no event is a claim considered after

one year from the date of the accident if RBC was not notified and the necessary forms not completed and submitted to RBC.

This section is a summary of the principal features of the Accidental Death & Dismemberment benefit. The contents are not to be accepted or construed as a substitute for the provisions of the Master Policy GSR 16853, underwritten by RBC Life Insurance Company.

weekly indemnity benefit

Provided you are eligible and provide sufficient medical evidence from your physician, a weekly benefit, equal to the EI Sickness weekly benefit maximum PLUS $25, will be paid to you if you become disabled and are unable to work as the result of a non-occupational accident or sickness. Benefit payment commences on the 1st day of a non-occupational accident, and the 8th day of a non-occupational sickness. If you are hospitalized before the 8th day of sickness, benefits commence on the 1st day of hospitalization. If a surgical procedure is performed on an out-patient basis in a general hospital, benefits will commence on the date the surgery was performed.

Note: The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a physician or a licensed chiropractor – whichever is later – and will be paid only during periods of disability when you are under their regular care and following the treatment prescribed. When certification of disability is made by a chiropractor, any periods beyond 6 weeks must be made by a physician.

Note: Benefits will not commence prior to the day you are seen and treated by a physician. If your disability is incurred during the reporting period (lag month), you will be considered disabled from the date on which you qualify for full coverage under the Plan.

If eligible and approved, the weekly indemnity benefit will be responsible for the first 8 weeks of your disability, then you must apply for Employment Insurance (E.I.) sick benefits, which will provide benefits for up to an additional 26 weeks of disability benefit payments. If you remain disabled after reaching the maximum duration of your E.I. sick benefit payments, the weekly indemnity benefit may continue benefits, while you remain eligible, up to an overall maximum of 52 weeks, including the E.I. sick benefit payments.

Please note: you can only collect disability payments from one source at a time. Your application should be made to weekly indemnity first, then to E.I. sick benefits to start on the date your 1st 8 weeks of weekly indemnity are exhausted.

Weekly indemnity coverage is not provided for exempt or associate members.

how to claim for weekly indemnity:

Take the following steps as soon as possible after you have become disabled:

- Contact your doctor immediately upon becoming disabled. You must be seen and treated during the time of your disability.
- You must contact the Plan Administrator and advise that you wish to make an application for WI benefits and ask for the required claim forms. You must complete the Plan Member Statement and your physician must complete the Attending Physician's Statement in full.
- Once completed in full, these forms must be sent directly to Cooperators, no later than 30 days after total disability begins.
- If your disability is expected to last beyond 8 weeks, shortly before the 8 week mark of your WI claim, you will need to apply for EI Sickness benefits to start at the end of the 8th week of WI benefits.
- Claims for disability must be submitted no later than 30 days after your total disability begins.

right to recover

1. If you become Totally Disabled as a result of an injury or sickness in respect of which
    - a third party may be, directly or indirectly, either in whole or in part, liable to you, the member, or
    - you have a claim for benefits under workers compensation legislation;

    the Plan will not pay benefits to you for this disability.

2. In the circumstances described in (1) above, the Plan may, not must, provide financial relief on a periodic (usually bi-weekly) basis to alleviate income loss. The total of all advances made to you is fully repayable to the Plan on terms to be settled between you and the Plan and incorporated into a written Loan and Replacement Agreement. It must be understood that if your disability is the result of a motor vehicle-related incident, ICBC will consider any payments for wage loss loaned to you by the Plan as being made by a first payer and these payments will not be factored into your settlement with ICBC despite your requirement to repay these funds to the Plan once your claim is settled. If you choose not to be loaned these funds, they can be included as part of your settlement from ICBC. Receiving any funds loaned to you by the Plan is optional, but if received, must be repaid to the Plan in full.

third party liability

If you receive benefit payments under this Plan for loss of income for which there may be a cause of action against a third party such as described in (1) above, you will be required to complete a Loan and Replacement Agreement. Before entering into this Agreement, it is important to understand that you will be required to reimburse the Plan for any benefits paid to you, once you have completed your settlement with the third party, regardless of what losses the settlement represented. As ICBC considers any payment from the Plan to have been made as a first

payer, repayment to the Plan may reduce the amount of your settlement for other losses. Receiving any funds loaned to you by the Plan is optional, but if received, must be repaid to the Plan in full.

recurrence of former ailments

You will not receive benefits for more than 34 weeks as a result of disability due to any one ailment. However, a new waiting period and benefit duration period will start if you return to active full-time work for:

- A period of 2 weeks before you again become disabled because of the same or related cause, or
- One full day before you again become disabled because of a different or unrelated cause.

exclusions and limitations

No benefit will be paid for periods of disability:

- during which you are receiving E.I. sick benefits;
- arising from occupational accident or illness, as these are covered by the WorkSafe BC Act or workers compensation legislation;
- arising from your commission of or attempt to commit an assault or criminal offense;
- arising from self-inflicted injuries or sickness;
- arising from substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician;
- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service;
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from E.I., or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence;
- if you become disabled during a strike or lockout at your place of employment, your rights to benefits will be reinstated when the strike or lockout ends;

- arising from an automobile accident except as a fully repayable loan.

termination of benefit payments

Your benefit payments will stop on the earliest date one or more of the following occurs:

- you are no longer disabled;
- you are no longer receiving continuing medical care or treatment from your physician;
- you fail to submit satisfactory proof of continuing disability as required by the Plan;
- you refuse a medical examination by a physician chosen by the Plan;
- you are no longer following the treatment recommended for your disability;
- you leave the province, state or country where you normally work and live, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by the Plan.
- you perform any work for compensation or profit;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire; or
- you die.

long term disability

The long term disability (LTD) benefit is equal to 75% of monthly earnings, subject to the 85% All Source Maximum described under Offsets in the 'how LTD benefits work' section. The maximum benefit payable is $3,000 per month.

The qualifying disability period starts when you first become Totally Disabled and ends after 365 days provided your disability is continuous and you are under age 60. If the disability is not continuous, the days you are disabled will be accumulated to satisfy the qualifying disability period provided:

- no interruption is longer than 2 weeks; and
- the disabilities arise from the same or related dis ease or injury.

Your coverage for LTD under the Plan will end on your 59th birthday or your retirement date, whichever is earlier.

LTD benefits are taxable.

LTD coverage is not provided for exempt or associate members.

how LTD benefits work

In the event you become Totally Disabled for the required period of time known as the Qualifying Disability Period (as described above) and you are under the continual treatment of a legally qualified physician deemed appropriate by the Insurer, you will receive a monthly income benefit.

Benefits will not be paid beyond age 60, unless you satisfy the Qualifying Disability Period while age 59, in which case benefits will be payable for a maximum of 12 months.

definition of total disability

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

recurrent disability

If a disability recurs and it is due to the same or related causes, it will be considered as one continuous disability and will not be subject to the Qualifying Disability Period unless you have returned to active, full-time employment for a period of 6 consecutive months or longer.

If your new disability is due to causes unrelated to your prior disability you may be eligible for a new disability period, subject to the Qualifying Disability Period, if you have returned to active work for at least one full day.

offsets

The amount payable under this benefit for Total Disability is calculated by deducting from your benefit any other sources of income. These are specified in the Master Policy and include the following:

1. wages or retirement benefits payable from your employer or employer's pension or retirement plans;
2. any payments on account of your disability from any Workers' Compensation law or similar law;
3. payments received from the Canada or Quebec Pension Plan, excluding payments made in respect of dependent children;
4. any income or benefit payable under any other plan or program of any government or of any subdivision or agency of the government, including any plan or program established pursuant to a provincial automobile insurance act.

all source maximum

The total monthly income while disabled (LTD benefit plus any income listed above and Canada or Quebec Pension family benefits) cannot exceed 85% of your gross monthly earnings as of the date your disability started. If your income exceeds 85%, your LTD benefit will be reduced accordingly.

exclusions and limitations

LTD benefits are not payable for the following:

1. for any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of disability during which you are

not participating in the treatment program recommended by said physician;

2. for any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;
3. for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addition, unless you are participating in a recognized substance withdrawal program;
4. disabilities resulting from self-inflicted injuries or attempted suicide;
5. disabilities as a result of participation in a war, riot, insurrection or criminal act;
6. disabilities resulting from an automobile accident except as a fully repayable loan;
7. for the portion of a period of disability during which you are
    - imprisoned in a penal institution; or
    - confined in a hospital, or similar institution, as a result of criminal proceedings;
8. any period of disability, or portion thereof, during any leave of absence (including maternity leave);
9. a disability which starts on or after the date a strike begins, except as outlined in the Master Policy; however, an employee, may commence to fulfill their qualifying disability period from the date of disability;
10. to an insured individual who refuses to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending physician or on the advice of independent medical opinion;

subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will subrogate to all the rights of recovery for loss of income, to the extent of the sum of benefits paid or

payable by the Insurer. You must execute such documents as required by the Insurer.

In the event you provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the Insurer's right of subrogation will apply.

The term compensation will include any lump sum or periodic payment which you receive or are entitled to receive on account of past, present or future loss of income.

disability case management program

Manulife Financial has developed a disability case management program. The purpose of this program is to assist you, in the event you become Totally Disabled and qualify for benefits, to return to productive employment. Manulife Financial's disability case management team includes medical consultants, claim adjudicators and a field coordinator. This team will work with you, your employer and your physician to assist you to recover and return to the work place.

rehabilitative employment

If you are disabled, the Insurer may recommend that you undergo some suitable rehabilitative training program which would consider the nature and limitations of your disability. Further details on this aspect will be provided in the event you become disabled.

canadian residency requirement

No benefits are payable if you reside outside Canada for any period exceeding 90 consecutive days or a total of 180 days in any 365-day period unless:

- you have previously notified and received approval in writing from the Insurer;
- you remain under the regular care of a licensed physician deemed appropriate by the Insurer; and
- proof of ongoing disability can be determined on evidence satisfactory to the Insurer in English or French.

extended health benefits

- $50 calendar year deductible per person per family
- Unlimited overall maximum
- Out of Province/Canada Emergency Medical Travel Insurance eligible expenses reimbursed at 100% ($5,000,000 incident maximum)
- Medical Referral Benefit - 100% of pre-approved expenses, $75,000 calendar year maximum
- Active members: In-Canada eligible expenses covered at 100%, unless otherwise noted
- Associate members/members on LTD: In-Canada eligible expenses covered at 80% of the first $1,000 per family then 100%, unless otherwise noted
- Vision active members 100% to $300 every 12 months / associate & disabled members 100% to $150 every 12 months

The extended health benefit is designed to help you pay for specified services and supplies incurred by you and your eligible dependents, when not provided under a government health plan or by a tax supported agency.

The following are eligible expenses when incurred as the result of necessary treatment of illness or injury and where applicable when ordered by a physician.

prescription drugs

Present your pay-direct card, along with your prescription, to your pharmacist and your prescription drug claim will be adjudicated right at the pharmacy. Using your pay-direct card eliminates the need for

you to pay for your prescription and submit a claim to the Plan for reimbursement.

The Plan provides coverage for prescription drugs and medicines which require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits.

Before your drug claim can be reimbursed, GreenShield, on behalf of the Plan, may require prior authorization. You can find out if your drug requires prior authorization by using the online drug search tool available to you through the GreenShield+ member portal or by contacting GreenShield's Customer Service Centre. Further, reimbursement of reference drugs (including biologics) that have an approved biosimilar may not be reimbursed or may be limited to the lower cost drug unless medical evidence is provided. IMPORTANT: Do not fill/pay for a prescription before completing the prior authorization process - authorization decisions will not be backdated.

It's recommended that you refer to the prior authorization listing while you are with your doctor, so that if a drug they intend to prescribe is on the listing, the applicable prior authorization form can be downloaded, printed, and completed before you leave your doctor's office. If you need assistance accessing a prior authorization form, you can contact the claims customer service department at GreenShield at 1-888-525-7587. If the prescribed drug is one that must be coordinated with Provincial Fair PharmaCare under Special Authority, you will also be advised to ask that your doctor apply for Provincial Special Authority for that drug on your behalf.

Maintenance drugs required to treat lifelong chronic conditions may be required to be purchased in a 90-day supply of a prescription at any one time. Non-maintenance drugs may be purchased in a supply not exceeding 3-months (90-day) supply of a prescription at any one time. However, for all drugs, 6 months for a vacation supply may be purchased and not more than a 13-month supply in any 12 consecutive months.

The following are excluded and no amount will be paid for:

- drugs for the treatment of erectile dysfunction and infertility;
- vitamins that do not legally require a prescription;
- smoking cessation oral drugs;
- products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required, unless specifically identified and included as eligible in "Prescription Drugs";
- ingredients or products which have not been approved by Health Canada 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.

There are a number of prescription drugs which are not eligible under PharmaCare's standard drug formulary, but may be eligible under their Special Authority Program. You may be requested by the Plan to have your doctor apply for Special Authority for one or more of the drugs you have been prescribed. Should PharmaCare approve the application for Special Authority, such drugs will be applied towards your annual PharmaCare deductible.

Note to members residing in BC: You must register for the BC Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for Fair PharmaCare call 1-800-663-7100 or visit the PharmaCare website at
https://my.gov.bc.ca/ahdc/msp-eligibility

For members who are self-paying their benefits, please refer to the Self-Payment section of this booklet for information regarding the continued use of the pay-direct card benefit.

ambulance services

Charges in excess of the amount payable under your Basic Medical Plan for professional licensed ambulance service in an emergency including transportation by railroad, boat or airplane, or in acute emergency by air ambulance, from the place where the injury or sickness occurs to the nearest acute

general hospital and return fare, including round trip fare for one attending person (doctor, nurse, first aid attendant), where necessary.

hospital

Hospital charges made by an approved acute general hospital in BC for private or semi-private room if ward is not available or if required as medically necessary by a physician (not including rental of telephone, T.V. etc.).

out-of-hospital private duty nursing services

Reimbursement for the services of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) in the home on a visit or shift basis, up to a lifetime maximum of $25,000. No amount will be paid for services which are custodial and/or services that do not require the skill level of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.). A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GreenShield.

paramedical practitioners

You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a Speech Language Pathologist, Acupuncturist, Registered Psychologist*, Podiatrist, Chiropractor, and Naturopath, who is registered and legally practicing within the scope of their license. These charges will be covered up to a calendar year maximum of $400 per insured person per practitioner type. Charges from a Registered Massage Therapist and Physiotherapist will be covered up to a calendar year maximum of $3,250 per insured person per practitioner type.

*Effective January 1, 2026 the services of a Registered Clinical Counsellor, Registered Therapeutic Counsellor, Licensed Psychotherapist, Licensed Social Worker or Master of Social Work are included with

Registered Psychologist with a combined calendar year maximum of $400 per insured person.

other eligible expenses

Unless otherwise specified, the following must be prescribed by a legally qualified medical practitioner. Reimbursement is limited to the reasonable and customary charges. **Some items may require pre-authorization. To confirm eligibility prior to purchasing or renting equipment, submit a Pre-Authorization Form to GreenShield.**

Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies.

Charges for walkers, canes and cane tips, crutches, splints, casts, collars and trusses but not elastic or foam supports.

Charges for testing supplies, needles and syringes for diabetics. External insulin pumps when basic methods are not feasible, up to the reasonable and customary cost and not within five years of the purchase of the previous insulin pump, where applicable. Continuous glucose monitoring (CGM) and flash glucose monitoring (FGM) devices, sensors and transmitters for adults aged 18 years or older and have at least two years experience in self-managing their diabetes.

Compression stockings with a pressure measurement of 15 mmhg or higher, limited to 2 pairs per calendar year.

Charges for stump socks.

Hearing aids, when prescribed by an Audiologist, ENT Specialist (Otolaryngologist) or doctor, are covered by the Plan at 50% for Members and their eligible dependents, up to a maximum of $3,000 per person, every five years. WorkSafe is the first payer for Member claims and any claims for Members will require a copy of the rejection or partial payment letter from WorkSafe unless hearing loss is not work-related in which case a note is required from the prescriber (Audiologist, Ear Nose and Throat Specialist

(Otolaryngologist), or doctor) for any amount to be paid under this Plan for Members.

Charges for surgical brassieres up to two per calendar year.

Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist, or chiropodist, and dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist:

One pair of custom-made boots or shoes or custom-made orthotics per calendar year up to a combined maximum of $350.

- Custom-made foot orthotics or repairs to custom-made foot orthotics. Custom-made foot orthotics means devices made from a 3-dimensional model of an individual's foot and made from raw materials. These devices are used to relieve foot pain related to biomechanical misalignment to the feet and lower limbs;

- Custom-made boots or shoes or modifications and repairs to orthopedic footwear as an integral part of a brace, (subject to a medical pre-authorization). Custom-made boots or shoes means footwear used by an individual whose condition cannot be accommodated by existing footwear products. The fabrication of the footwear involves making a unique cast of the covered person's feet and the use of 100% raw materials. This footwear is used to accommodate the bony and structural abnormalities of the feet and lower legs resulting from trauma, disease or congenital deformities.

Charges for rigid support braces and permanent prosthesis (artificial eyes, limbs, larynxes and mastectomy forms). Myoelectrical limbs are excluded but the Plan will pay the equivalent of a standard prosthesis.

Wigs and hairpieces required as a result of medical treatment or injury, up to a lifetime maximum of $500 per person.

standard durable medical equipment

Some items may require pre-authorization. To confirm eligibility prior to purchasing or renting equipment, submit a Pre-Authorization Form to GreenShield.

Usually, the Plan covers standard durable medical equipment when rented from a medical supplier and will be reimbursed monthly. If unavailable on a rental basis, or required for a long term disability, purchase of these items from a provider may be considered.

Repairs to purchased items: The Plan will replace the item when it can no longer be made functional. The Administrator may request trade-in or return of replaced equipment.

Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.

Standard durable equipment includes a variety of items but are not limited to

- manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent
- medical monitors including heart and cardiac screeners
- bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems
- breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks and regulators
- insulin infusion pumps for diabetics when basic methods are not feasible - one every 60 months
- transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain - one every 60 months
- transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

The rental price of durable medical equipment will not exceed the purchase price. The Plan's decision to purchase or rent will be based on the legally qualified medical practitioner's estimate of the duration of need as established by the original prescription. Rental authorization may be granted for the prescribed duration. Equipment that has been refurbished by the supplier for resale is not an eligible benefit;

Durable medical equipment must be appropriate for use in the home, able to withstand repeated use and generally not useful in the absence of illness or injury;

When deluxe medical equipment is a covered benefit, reimbursement will be made only when deluxe features are required in order for the covered person to effectively operate the equipment. Items that are not primarily medical in nature or that are for comfort and convenience are not eligible.

accidental dental

Reimbursement for the services of a licensed dental practitioner for dental care to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. When natural teeth have been damaged eligible services are limited to one set of artificial teeth. You must notify GreenShield immediately following the accident and the treatment must commence within 24 months of the accident, and be completed within 180 days of the initial treatment date. The Plan will not be liable for any services performed after the date you or your dependent cease to be covered under the Plan. No amount will be paid for periodontia or orthodontia treatments or the repair or replacement of artificial teeth. Charges will be based on the current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered. Approval will be based on the current status and/or benefit level of the covered person at the time that the Plan is notified of the accident. Any change in coverage will alter the Plan's liability. In the event of a dental accident, claims should be submitted under

the extended health benefit before submitting them under the dental plan.

exclusions and limitations

There are items that are not covered under the extended health benefits, including but not limited to:

- Expenses for benefits, care or services payable by or under the Basic Medical Plan, PharmaCare, any Hospital Program or the WorkSafe BC Act, whether or not a claim is made thereunder or provided without cost or at nominal cost by any public or tax-supported authority or agency or for which you or your dependent can recover from another party;
- Expenses of dental services or care or dentures except as specifically provided in this booklet;
- Any portion of fees in excess of the usual or recognized fees for the service performed;
- Expenses incurred outside the Province of British Columbia unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out-of-Province/Canada Emergency Expenses;
- Expenses for services and/or supplies for cosmetic purposes;
- Medical Cannabis in any and all of its forms;
- Expenses caused, contributed to or necessitated as a result of:
    - war or any act of war or participation in a riot or civil insurrection;
    - injury or sickness which was intentionally self-inflicted, whether sustained or suffered while sane or insane;
    - occupational illness or injury; or
    - the commission by the person of any unlawful act including an offense under the Criminal Code of Canada
- Any expenses that a covered person may obtain as a benefit under any government plan or law;
- Any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging which represents an amount in excess of the schedule of costs prescribed by the Medical Services Plan.

vision care

You can use your pay-direct card for the purchase and/or repair of the following eligible expenses:

a) single vision, bifocal or trifocal lenses, prescribed by a person legally qualified to make such a prescription;

b) frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable;

c) contact lenses prescribed by a person legally qualified to make such a prescription;

d) prescription sunglasses;

e) laser eye surgery; and

f) prescription safety lenses and frames for members where their employer does not cover the full cost of such. The Plan shall be the final payer on these expenses.

The covered expenses described above will be paid for active members and their eligible dependents up to a combined maximum of $300 per person during any period of 12 consecutive months and for associate members, those members on LTD and their eligible dependents up to a maximum of $150 during any period of 12 consecutive months. Charges for non-prescription eye wear and eye examinations are not covered.

medical examinations

Charges of a physician for medical examinations required by government statute or regulation for employment purposes provided such charges are not payable by your employer under a collective agreement.

travel

Important: This Travel benefit includes requirements, limitations, and exclusions that can affect eligibility

and/or reimbursement of incurred expenses. You must be accurate and complete in your dealings with GreenShield at all times. Please take the time to read through this benefit before you travel to ensure you are aware of the terms and conditions, making note of the following:

- With the exception of the **"Referral Services"**, this Travel benefit is an **emergency** medical benefit only and provides coverage while you are temporarily outside of your regular province/ territory of residence for vacation, education, or business reasons. It does not cover any non-emergency, elective, cosmetic, or experimental treatment, surgery, procedure, or any other service a covered person chooses to have performed outside of their home province/ territory – whether pre-planned or not.
- GreenShield reserves the right to review your medical information at the time of claim. Any invasive or investigative procedures must be pre-approved by GreenShield Travel Assistance. If the covered person is the patient and it is medically impossible for the covered person to call prior to obtaining emergency treatment, it is extremely important to have someone call GreenShield Travel Assistance on the covered person's behalf within 48 hours. If GreenShield Travel Assistance is not notified within the first 48 hours, reimbursement of incurred expenses may be limited to the lesser of the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum. This means the covered person will be responsible for all expenses thereafter.

Trip Duration Maximum: 90 days per trip

Maximum Age for Coverage: under age 70

Pre-Existing Condition Stability Period: 90 days immediately preceding trip departure date

Emergency means a sudden and unforeseen Medical Condition that requires Treatment. An emergency no longer exists when the evidence reviewed by GreenShield Travel Assistance indicates that no fur-

ther Treatment is required at your destination, or you are able to return to your province/territory of residence for further Treatment. If GreenShield Travel Assistance determines that you transfer to another facility or return to your home province/territory of residence, and you choose not to, the benefits will not be paid for further medical treatment and coverage will be limited for unrelated events.

Emergency excludes Treatment of a **Pre-existing Condition** that was not completely **Stable** for the 90-day period immediately preceding the covered person's departure.

Pre-existing Condition means any Medical Condition that exists prior to the date of the covered person's departure.

Medical Condition means any disease, illness or injury (including symptoms of undiagnosed conditions).

A Medical Condition is considered Stable when all of the following statements are true during the 90-day period immediately preceding the date of the covered person's departure.

a) There has not been any new Treatment prescribed or recommended, or change(s) to existing Treatment (including stoppage in Treatment), and

b) The Medical Condition has not become worse, and

c) There has not been any new, more frequent, or more severe symptoms, and

d) There has been no hospitalization or referral to a specialist, and

e) There have not been any tests, investigation or Treatment recommended, but not yet complete, nor any outstanding test results, and

f) There is no planned or pending treatment, and

g) There has not been any change to an existing prescribed drug (including an increase, decrease, or stoppage to prescribed dosage), or any

recommendation or starting of a new prescription drug. The following are not considered changes to existing prescribed drug Treatment.

i. Routine dosage adjustments of Coumadin, Warfarin, or insulin, as long as these medications have not been newly prescribed or stopped;

ii. A change from a brand name to a generic equivalent product as long as the dosage is the same – including a transition from a biologic to a biosimilar product;

iii. A decrease in the dosage of a medication due to the improvement of a condition.

All of the above conditions must be met during the 90-day period prior to the covered person's departure in order for a Medical Condition to be considered Stable.

Travelling Companion means any person who has pre-paid accommodation and/or transportation with the Covered Person for the same covered trip.

Treat, Treated, Treatment means a procedure prescribed, performed, or recommended by a Physician for a Medical Condition. This includes but is not limited to prescribed medication, investigative testing, and surgery.

- To qualify for benefits, the claimants must be covered by their respective provincial/territorial government health plan or equivalent at the time the expenses are incurred; otherwise, there is no coverage under this benefit.
- Eligible travel benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial/territorial health insurance plan, if your province/territory provides such coverage.
- All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, based on the country of the

payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.
- Eligible benefits are limited to a maximum of 90 days per trip commencing with the date of departure from your province/territory of residence. If you are hospitalized on the 90th day, your benefits will be extended until the date of discharge.

Eligible travel expenses include the following:

Hospital services and accommodation
- up to a standard ward rate in a public general hospital;
- up to $350 for out-of-pocket expenses such as telephone, television rental, and parking.

Medical/surgical services rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;

Emergency Transportation
- **Land ambulance** to the nearest qualified medical facility;
- **Air ambulance** – the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial/territorial health insurance plan or to the nearest qualified medical facility.

Referral services – Reasonable and customary hospital, medical, surgical, and transportation expenses in excess of those expenses covered by your provincial/territorial health insurance plan for you and an approved escort;

- **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial/territorial health insurance plan and GreenShield must be obtained. Your provincial/territorial health insurance plan may cover this referral benefit entirely. You must provide GreenShield with a letter from your attending physician stating the reason for the referral, and a letter from your provincial/territorial health insurance plan outlining their

liability. **Failure to obtain pre-authorization will result in non-payment.**

Services of a registered private nurse up to a maximum of $10,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse registered and licensed in the jurisdiction in which treatment is provided. You must contact GreenShield Travel Assistance for pre-approval;

Diagnostic laboratory tests and X-rays when prescribed by the attending physician. Except in emergency situations, GreenShield Travel Assistance must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery);

Reimbursement of prescriptions for drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded). Submit to GreenShield Travel Assistance the original paid receipt from the pharmacist, physician or hospital outside your province/territory of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

Medical appliances including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province/territory of residence;

Treatment by a dentist only when required on an emergency basis for:

- Services and treatment of a direct accidental blow to the mouth up to a maximum of $2,500. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GreenShield Travel Assistance along with dental X-rays;
- Treatment to relieve dental pain up to a maximum of $500 per trip.

Coming Home – when your emergency illness or injury is such that:

- GreenShield Travel Assistance specifies in writing that you should immediately return to your province/territory of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one-way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you and a Travelling Companion by the most direct route to the major air terminal nearest the departure point in your province/territory of residence.
- This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, or cancellation penalties are not included.

GreenShield Travel Assistance or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant.

Cost of returning your personal use motor vehicle to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $10,000 per trip. GreenShield Travel Assistance requires original receipts for costs incurred, i.e. gasoline, accommodation and airfares;

Meals and accommodation up to a maximum of $250 per day to a maximum of $5,000 per family per trip will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you or a covered dependent when the trip is delayed or interrupted due to an illness, accidental injury to or death of a Travelling Companion and the covered person remains until they or their Travelling Companion is fit to travel. This must be verified in writing by the attending legally qualified physician or surgeon and

supported with original receipts from commercial organization;

Transportation to the bedside including round trip economy airfare by the most direct route from your province/territory of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of 5 days for meals and accommodation at a commercial establishment will be paid for that family member to:

- be with you or your covered dependent when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least 7 days outside your province/territory of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit;
- identify a deceased prior to release of the body.

Return airfare if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you and your covered dependents travelling with you, or a Travelling Companion by the most direct route to the major airport nearest your departure point in your province/territory of residence. An official report of the loss or accident is required;

Return of deceased up to a maximum of $15,000 toward the cost of preparation and transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province/territory of residence. In the case of cremation and/or burial at the place of death, this benefit is limited to $5,000. The benefit excludes the cost of a burial coffin, urn, or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc.;

Paramedical Practitioners up to a maximum of $500 per practitioner per Emergency (including x-rays) for the services of a licensed chiropractor, physiotherapist, podiatrist/chiropodist, or osteopath in conjunction with treatment for an Emergency;

Child Care when pre-approved by GreenShield Travel Assistance, up to $5,000 for one of the following benefits for dependent children under the age of 16 in the event of an Emergency involving you or your spouse while travelling:

- Additional cost of one-way economy airfare for the return home of accompanying dependent children when you or your spouse are hospitalized, plus the cost of an escort if required;
- The cost of services of a caregiver (who is not a relative) in the location where you or your spouse is hospitalized;
- The cost of services of a caregiver (who is not a relative) in your home province/territory when the children are left unattended due to the delayed return of you or your spouse.

Pet Return up to a maximum of $500 for the return of your accompanying pet(s) in the event you are hospitalized or repatriated during an Emergency.

greenshield travel assistance service

The following services are available 24 hours per day, 7 days per week through GreenShield's international medical service organization.

these services include:

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination;
- Multilingual assistance;
- Assistance in locating the nearest, most appropriate medical care;
- International preferred provider networks;
- Medical consultation and monitoring to review appropriateness and quality of medical care;
- Assistance in establishing contact with family, personal physician and employer as appropriate;
- Monitoring of progress during treatment and recovery and confirming when the patient is medically fit for transportation when a transfer or repatriation is necessary;

- Emergency message transmittal services;
- Translation services and referrals to local interpreters as necessary, pertaining to the medical emergency;
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers;
- Special assistance regarding the co-ordination of direct claims payment;
- Co-ordination of embassy and consular services;
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary;
- Management, arrangement and co-ordination of repatriation of remains;
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
  - the return of unaccompanied travel companions;
  - travel to the bedside of a stranded person;
  - rearrangement of ticketing due to accident or illness and other travel related emergencies;
  - the return of a stranded personal use motor vehicle and related personal items.
- Knowledgeable legal referral assistance;
- Co-ordination of securing bail bonds and other legal instruments;
- Guidance in replacing lost or stolen travel documents including passports;
- Courtesy assistance in securing incidental aid and other travel related services.

how travel assistance service works

For assistance dial **1.800.936.6226** within Canada and the United States or call collect **519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GreenShield Identification Card.

Quote your GreenShield Identification Number, found on your GreenShield Identification Card, and explain your medical emergency. **You must always be able to provide your GreenShield Identification Number and your provincial/territorial health insurance plan number.**

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, GreenShield Travel Assistance will guarantee the provider (hospital, clinic or physician), that you have the required provincial/territorial health insurance plan coverage and GreenShield travel benefits as detailed above.

GreenShield Travel Assistance will follow your progress to ensure that you are receiving the best available medical treatment. GreenShield Travel Assistance also keeps in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GreenShield Travel Assistance and submit them for reimbursement upon your return to Canada.

travel limitations

1. Coverage becomes effective at the time you or your dependent crosses the provincial/territorial border departing from their province/territory of residence and terminates upon crossing the border returning to their province/territory of residence on the return home. If traveling by air, coverage becomes effective at the time the aircraft takes off in the province/territory of residence and terminates when the aircraft lands in the province/territory of residence on the return home.

2. GreenShield Travel Assistance must be notified before obtaining Emergency Treatment in order for GreenShield Travel Assistance to:
   - confirm coverage; and
   - provide pre-approval of treatment.

If it is medically impossible for the covered person to call prior to obtaining Emergency Treatment, GreenShield Travel Assistance requires either the covered person or someone on behalf of the covered person to call GreenShield Travel assistance within 48 hours of commencement of treatment.

If GreenShield Travel Assistance is not notified before the Emergency Treatment was received, benefits will be limited to the lesser of the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum. This mean you will be responsible for all expenses thereafter.

3. After your medical emergency treatment has started, GreenShield Travel Assistance must assess and pre-approve additional medical treatment. If you undergo tests as part of a medical investigation, treatment or surgery, obtain treatment or undergo surgery that is not pre-approved, your claim will not be paid. This includes invasive testing, surgery, cardiac catheterization, other cardiac procedures, transplants, MRI.

4. Repatriation is mandatory when GreenShield Travel Assistance determines that the covered person should transfer to another facility or return to the home province/territory of residence for treatment, or at the end of the emergency. If you choose not to return:
   - no benefits will be paid for any further medical treatment;
   - no benefits will be paid for any recurrence or complications related directly or indirectly to the Medical Condition that caused the emergency; and
   - for the remainder of the trip, coverage will be limited to Medical Conditions completely unrelated to the Medical Condition that caused the emergency.

5. Air ambulance services will only be eligible if:
   - they are pre-approved by GreenShield Travel Assistance;
   - there is a medical need for you or your

dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey;
- you or your dependent are admitted directly to a hospital in your province/territory of residence, and;
- medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GreenShield Travel Assistance;
- proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GreenShield Travel Assistance.

6. If planning to travel in areas of political or civil unrest, or in areas where the Canadian government has issued a formal travel warning regarding non-essential travel, contact GreenShield Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services.

7. GreenShield Travel Assistance reserves the right, without notice, to suspend, curtail or limit its services in any area if any of the following occur:
   - political or civil unrest, rebellion, riot, or military uprising;
   - labour disturbance or strike;
   - act of God; or
   - refusal of authorities in a foreign country to permit GreenShield Travel Assistance to provide service.

   This includes travel if when you booked your trip (including delay of travel), or before your departure date, the Canadian government issued a formal travel warning advising Canadians to avoid either all travel or all non-essential travel regarding the country, region, city, or other key components of your travel arrangements (e.g., cruise ship) due to a likely or actual epidemic or pandemic.

In this limitation, non-essential travel means anything other than a significant medical or family emergency, such as the death of a family member.

travel exclusions

In addition to the Health Exclusions, Travel claims will not be paid for the following.

1. Any expenses incurred for the treatment related directly or indirectly to a Pre-existing Medical Condition that, at the time of your departure from your province/territory of residence and the 90-day period immediately preceding your departure from your province/territory of residence:
   a) was not completely Stable in the professional opinion of GreenShield Travel Assistance Team;
   b) where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling; or
   c) a physician advised the covered person not to travel.

   GreenShield Travel Assistance reserves the right to review the covered person's medical information at the time of claim. A physician's opinion that the covered person was fit to travel does not override or eliminate the requirement for the covered person to satisfy all the conditions of stable.

2. Any expenses submitted if the covered person or anyone acting on behalf of a covered person attempts to deceive GreenShield Travel Assistance, or makes a fraudulent, false, or exaggerated statement or claim.

3. Any expenses incurred for any services received that:
   a) were not required to treat an emergency;
   b) were not recommended by a legally qualified physician or surgeon;
   c) are not covered under your provincial/territorial health insurance plan;
   d) are normally covered under the out-of-Canada benefits of your provincial/territorial health insurance plan's out-of-Canada coverage (where applicable), when the provincial/territorial plan has declined payment; or

e) are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined 3.a), b), c), or d) above.

4. Any expenses incurred for services received after GreenShield Travel Assistance determined:
   a) the covered person was to return to the province/territory of residence for treatment, but the covered person chose not to return to the province/territory of residence;
   b) the services could be reasonably delayed until the covered person returned to the province/territory of residence;
   c) the emergency had ended; or
   d) the services are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined 4.a), b), or c) above.

5. Any expenses incurred for services to treat a medical condition or complications of a medical condition directly or indirectly related to an epidemic or pandemic if, when the trip was booked, or before the departure date, an official travel advisory was issued by the Canadian government advising Canadians to avoid either all travel or all non-essential travel regarding any country, region, city, or other key components of your travel arrangements (e.g., cruise ship). To view the travel advisories, visit the Government of Canada Travel site.

6. Any expenses incurred for services to treat:
   a) any medical condition, including symptoms of withdrawal, arising from or in any way related to the chronic use of alcohol, drugs, or other intoxicants whether prior or during the trip;
   b) any medical condition arising during the trip resulting from, or in any way related to, the abuse of alcohol that results in a blood alcohol level of more than 80 milligrams in 100 millilitres of blood, drugs or other intoxicants; or
   c) any medical condition resulting from not following Treatment as prescribed, including prescribed or over-the-counter medication.

7. Any expenses related to pregnancy, delivery, or complications of either, arising during the 8-week period before and after the expected date of delivery.

8. Any expenses incurred for a child born during the trip within the 8-week period before and after the expected date of delivery.

9. Any expenses incurred during any trip made for the purpose of obtaining a diagnosis, Treatment, surgery, palliative care, or any alternative therapy, as well as any directly or indirectly related complication.

GreenShield does not assume responsibility for, nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other health-care provider or facility recommended by GreenShield Travel Assistance.

dental benefits

The Plan provides pay-direct claims processing using your pay-direct card. Present your pay-direct card to the receptionist when you arrive at your dentist's office for your appointment.

- No calendar year deductible
- 90% coverage for Basic Services, 50% for Major Services
- $3,000 per calendar year maximum per person for Basic & Major Services combined
- 50% Orthodontia, $3,000 lifetime max (adults and children after 6 months of coverage under the Plan)

basic services

diagnostic services – all necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:

- Oral examinations: limited to two in any calendar year; however, complete oral examinations are limited to one in any 36-month period

- Specific examinations provided the Plan has not paid for any other exam by the same dentist in the past 60 days
- Consultations (as a separate appointment) limited to two per calendar year
- Dental x-rays: bite-wing x-rays are limited to two sets per calendar year, full mouth x-rays are limited to one set in any 36-month period, and panoramic film is limited to one x-ray in any 24-month period, diagnostic models are limited to 1 set per calendar year.

preventative services – all necessary procedures to prevent the occurrence of oral disease, including:

- Cleaning (limited to twice in any calendar year)
- scaling and root planing - 16 units every 12 months combined
- Topical application of fluoride (limited to two applications in any calendar year)
- Pit and fissure adhesive sealants (limited to once per tooth every 24 months)
- Fixed space maintainers on primary teeth for dependent children under 18.

surgical services – all necessary procedures or extractions and other routine oral surgical procedures normally performed by a dentist.

restorative services – all necessary procedures for:

- Filling teeth with amalgam, silicate, acrylic or composite restorations (composite restorations on primary or molar teeth are not covered)
- Replacement restorations if at least 24 months has elapsed since initial placement
- Stainless steel crowns on primary teeth once per tooth in a 2-year period
- Inlays and onlays will be covered only when other material cannot be used satisfactorily
    - Patients choosing gold where other materials would suffice will be responsible for the cost difference
    - A pre-authorization is suggested
    - Covered once in a 5-year period
- Gold Foil only when used to repair existing gold restorations.

prosthetic repairs and maintenance

- Repair if a 6-month period has elapsed since the last date on which the dentures were provided.
- Denture maintenance, after the 3-month post insertion care period, including:
    - relines and rebase – a combined limit of 1 per upper and 1 per lower prosthesis in a 2-year period
    - tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5-year period

endodontic services (root canals) – all necessary procedures required for pulpal therapy and root canal filling. Repeat treatment is covered only if the original treatment fails after the first 18 months.

periodontic services – all necessary procedures for the treatment of tissues supporting the teeth including grafts:

- Occlusal equilibrations 8 units per calendar year
- Gingival curettage once per sextant in a 5-year period
- Osseous surgery once per sextant in a 5-year period.

anesthesia – general anesthesia required in relation to oral surgery.

major services

Major services include: prosthetic appliances, veneers, crowns and bridge procedures.

The following services are eligible for coverage at the lesser of 50% of the amount charged, or 50% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment:

- Initial installation of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Partials may only be provided by a dentist
- Initial placement of a crown or veneers and their replacement if at least 5 years has lapsed
- Replacement of an existing full or partial denture, or fixed bridgework, if the existing denture or fixed bridgework was installed 5 years before its

replacement and cannot be made serviceable (no benefit is payable for the replacement of dentures that are misplaced, lost or stolen)
- Bruxism Appliances - one every 24 months (no benefit is payable for the replacement of lost, broken or stolen bruxing guards).

Charges made by a licensed Denturist will be recognized for payment, in accordance with a separate Schedule of Allowances.

Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.

orthodontia (dependent children under 21 and adults)

Benefits are payable for Orthodontic Services performed after you have been enrolled under this dental plan for a 6 consecutive month period. This benefit is designed to cover Orthodontic Services provided to maintain, restore or establish a functional alignment of the upper and lower teeth. If your coverage lapses and you re-qualify for benefits, you will need to be covered for 6 consecutive months before the Orthodontic coverage become effective.

Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen are not be covered.

pre-treatment estimate of major restorative & orthodontic charges

Before starting treatment, the dentist should provide a summary of charges for the proposed course of dental care. The Plan will then provide a written estimate of the maximum amount for which payment will be made.

alternative services

If alternative services may be performed for the treatment of a dental condition, the maximum amount shown in the Suggested Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

exclusions and limitations

The Plan's dental benefits do not cover payment for:

- Items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- Charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- Dental care which is cosmetic;
- Dental care provided under a medical plan provided by an employer or government;
- Services or items which would not normally be provided, or for which no charge would be made, in the absence of dental coverage;
- Stainless steel crowns on permanent teeth;
- Protective athletic appliances;
- Anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- Full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- Replacement of a lost or stolen prosthesis;
- Incomplete and temporary procedures;
- Implants;
- Grafts;
- Any dental charge for services which were started prior to the date of coverage;
- Dental treatment which was ordered while covered, (which included lab work and impressions), but was not installed or delivered until more than 31 days after the dental benefit terminated; and
- Travel expenses incurred to obtain dental treatment.

Expenses recoverable under any other Plan will be coordinated with payments from this Plan, so that total payment received will not exceed the expenses actually incurred.

claim information
for extended health and dental

inquiries

For detailed inquiries, contact GreenShield's Customer Service Centre at 1-888-525-7587 to determine eligibility for a specific item or service and GreenShield's pre-authorization requirements, or Visit their website at greenshield.ca to e-mail your question.

submitting claims

Claim forms, including Pre-Authorization forms, and valuable claims submission information, is available at greenshield.ca.

Please note that in addition to a completed claim form, claims reimbursement requires the original itemized paid receipt **(cash receipts or credit card receipts alone are not acceptable)**.

GreenShield, on behalf of the Plan, reserves the right to request supplementary claims information. Failure to respond to such requests may result in the denial of the claim.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud. Submission of a fraudulent claim is a criminal offence and will be reported to the applicable law enforcement and/or regulatory agencies and your plan sponsor. This could result in termination of your coverage under this benefit plan.

emergency travel

GreenShield Travel Assistance must be contacted by phone within 48 hours of commencement of treatment.

For assistance and to obtain the proper claim form, dial **1.800.936.6226** within Canada and the United States or call collect **519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GreenShield Identification Card.

If you have incurred out of pocket expenses, make sure you tell GreenShield Travel Assistance about all the travel coverage you have when submitting claims. Claims must be submitted together with supporting original receipts to GreenShield Travel Assistance who will then co-ordinate reimbursement of those approved, eligible expenses from all sources (e.g., provincial plans that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.).

When submitting your Emergency Medical claim, please include:

- Completed and signed claim form provided to you by GreenShield Travel Assistance when notice of claim has been given, which you must complete and sign for the purpose of allowing GreenShield Travel Assistance to recover payment from any other insurance contract or health plan (group, individual or government).
- A fully completed and signed claim form with all original bills and receipts from commercial organizations for any claims you paid out of pocket.
- Medical records including an emergency room report and diagnosis from the medical facility, or a Medical Certificate completed by the treating physician. Any fee for completion of the certificate is not a benefit under this insurance.
- Completed appropriate Government Health Insurance Plan forms; see claim form for details.
- Proof of date of departure from your province or territory of residence.

- Any other documentation that may be required and/or requested by GreenShield Travel Assistance.

claims submission period

All Health, Travel and Dental claims must be received by GreenShield no later than 12 months from the date the eligible benefit was incurred.

reimbursement

Reimbursement will be made by one of the following methods:

- Direct deposit to your personal bank account, when requested;
- A reimbursement cheque, or
- Direct payment to the provider of services, where applicable.

All dollar maximums and limitations stated are expressed in Canadian dollars. Reimbursement will be made in Canadian or U.S. funds for both providers and plan members, based on the country of the payee.

overpayments

GreenShield reserves the right to recover all amounts resulting from overpaid or unsupported claims for benefits by deducting such amounts from future claims and/or by any other legal means.

limitation on legal action

In Ontario, every action or proceeding against GreenShield for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002.*

In British Columbia, Alberta and Manitoba, every action or proceeding against GreenShield for recovery of benefit payment under the plan is absolutely

barred unless commenced within the time set out in the *Insurance Act.*

subrogation

GreenShield retains the right of subrogation of benefits. This means if GreenShield paid benefits on behalf of you or your dependent, but the benefits either should have been paid or are subsequently paid or provided, in whole or in part, by a third party liability or other coverage(s), GreenShield has the right to recover such payment or reimbursement. In cases of third party liability, you must advise your lawyer of our subrogation rights.

co-ordination of benefits (COB)

If you are covered for extended health and dental benefits under more than one plan, your benefits under this plan will be coordinated with the other plan so that you may be reimbursed up to 100% of the eligible expense incurred.

Claims must be submitted to the primary payer first. Any unpaid balances should then be submitted to the secondary plan(s). When GreenShield is identified as a secondary carrier, submit the original Explanation of Benefits statement from the primary carrier and a copy of the claim form in order to receive any balances owing.

Use the following guidelines to identify the primary and secondary plans:

heat & frost local 118 plan member

GreenShield coverage for you is always primary. If you are the plan member under two group plans, priority goes in the following order:

- The plan where you are a full-time plan member;
- The plan where you are a part-time plan member;
- The plan where you are a retiree.

spouse

If your spouse is a plan member under another benefit plan, this GreenShield coverage is always secondary. Your spouse must first submit claims to his/her benefit plan.

children

When dependent children are covered under both your GreenShield plan and your spouse's benefit plan, use the following order to determine where to submit the claims:

- The plan of the parent whose birth date (month and day) occurs earliest in the calendar year;
- The plan of the parent whose first name begins with the earlier letter of the alphabet, if the parents have the same birth date;
- In cases of separation or divorce with multiple benefit plans for the children, the following order applies:
  - The benefit plan of the parent who has custody of the dependent child;
  - The plan of the spouse of the parent who has custody of the dependent child;
  - The plan of the parent who does not have custody of the dependent child;
  - The plan of the spouse of the parent who does not have custody of the dependent child.

If the parents have joint custody and both have the children listed as dependents under their plans, claims should first be submitted to the plan of the parent whose birth date (month and day) occurs earliest in the calendar year. Balances can then be submitted to the other parent's plan.

travel benefits

In the event of a travel claim, all plans equally share the cost of the claim.

access to information

If you live in a province where the law permits you to request copies of your records, GreenShield will provide one copy of the following at no charge:

a) any enrollment form you completed for coverage under this plan that was submitted to GreenShield;

b) any written statements or other record about your health that you submitted to GreenShield during the course of applying for coverage under this plan;

c) one copy of the group contract.

GreenShield may charge you to provide any additional copies.

member / family assistance program

The member / family assistance program (MFAP) is a voluntary, 100% confidential, short-term counseling and advisory service that connects you and your eligible family members to a network of dedicated professionals who are available to help 24 hours a day, 7 days a week.

This benefit provides professional assistance for a wide range of issues such as:

- Personal and work-related stress;
- Couple and marital relationships;
- Childcare and parenting issues
- Family matters;
- Eldercare concerns;
- Depression and anxiety;
- Alcohol and drug abuse;
- Legal matters and financial concerns.

If you need help, call 1-800-663-1142.
You can also obtain services online by signing up at **www.homeweb.ca**

conflict

To the extent that there is any conflict between the content of this Booklet and a provision of the Trust Agreement, an applicable insurance policy or benefit contract, or applicable legislation, the provision of the Trust Agreement, insurance policy, benefit contract or applicable legislation (as the case may be) will prevail.

not a contract of insurance

This booklet is not to be considered a contract or policy of insurance. The complete terms of any insured benefit are set forth in the group policies of insurance issued to the Trustees.

benefits provided by:

Manulife Financial
policy#961442
life insurance
long term disability

GreenShield
out of province/canada emergency medical
travel insurance

RBC
policy #16853
accidental death & dismemberment

Int'l Assoc. of Heat and Frost Insulators & Allied Workers, Local 118 Health and Wellness Trust Fund
policy #903118 (active members)
policy #903211 (associate and disabled members)

extended health and vision
dental
weekly indemnity (903118 only)

Homewood Health
policy #1500
member/family assistance plan

Contact us:

convyta

501 - 4445 Lougheed Hwy
Burnaby BC V5C 0E4

Toll-Free 1-866-432-8118 or 1-866-HEAT 118
Email: heatandfrost@convyta.com

For questions regarding your Health and Dental Claims contact **GreenShield at: 1-888-525-7587**

For on-line claims submission, or for information about your benefit utilization register for **GreenShield+ at www.greenshield.ca**

If you leave us a voice message or send an email, please include your full name, the name of the Int'l Assoc. of Heat and Frost Insulators & Allied Workers, Local 118 Health and Wellness Trust Fund and your telephone number including area code.