MACHINISTS, FITTERS & HELPERS INDUSTRIAL UNION LOCAL NO. 3 BENEFIT PLAN

ON BEHALF OF MEMBERS OF:

MACHINISTS, FITTERS & HELPERS INDUSTRIAL UNION LOCAL NO. 3
and
INTERNATIONAL ASSOCIATION OF BRIDGE, STRUCTURAL, ORNAMENTAL & REINFORCING IRONWORKERS LOCAL 643

Address inquiries to:

THE PLAN ADMINISTRATOR

convyta

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For Health & Dental Claims Inquiries:
1-888-525-7587
or visit **www.greenshield.ca** to email a question

Effective May 2007
*Including amendments to June 1, 2025

www.machinistslocal3benefits.org

PRIVACY POLICY

We, the Trustees of the Machinists, Fitters & Helpers Industrial Union Local No. 3 Benefit Plan 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 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.

The Trustees

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The following is an outline of the Machinists, Fitters & Helpers Industrial Union Local No. 3 Benefit Plan benefits. The information in this benefits booklet is important to you. It provides the information you need about the group benefits available through the Machinists, Fitters & Helpers Industrial Union Local No. 3 Benefit Plan.

Both British Columbia and Alberta have passed legislation affecting the use of self-insured funding for providing benefit plans. In each case, the legislation allows for the use of self-insured funding, subject to disclosing this information to the covered Members in writing.

The Trustees are constantly attempting to provide benefits under the Plan to the Members in the most cost-effective manner. For some benefits, such as Vision, Dental, Wage Indemnity, CPP Top Up, and some portions of the Extended Health Benefits, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act. In the event of Plan termination or your employer ceasing to participate in and remit contributions to the Plan, the Trustees, in their discretion, may terminate your benefit coverage and discontinue payments for any previously approved benefit claim.

BENEFIT SUMMARY

Life Insurance	$100,000
AD&D	$100,000
Wage Indemnity	Equal to EI Weekly Maximum Integrated with EI
CPP Top Up Benefit	$500 per month
Employee/Family Assistance Plan	
Extended Health Benefits	100%, No Deductible $1,000,000 Maximum
Prescription Drugs	80%, No Deductible Incl. in EHB Maximum Prior Authorization Program
Out of Province/ Canada Emergency Medical Travel Insurance	$5,000,000 Maximum Per 60-day Coverage Period Up to age 75
Vision Care	100%, $800/24 months
Dental	100% Basic Services 75% Major Services 75% Orthodontia
Health Care Spending Account	$500 per cal yr (pro-rated)

ELIGIBILITY DETAILS

Who is eligible?

Any Member in good standing of the Machinists, Fitters & Helpers Industrial Union Local No. 3 or the International Association of Bridge, Structural, Ornamental & Reinforcing Ironworkers Local 643, with sufficient hours in their Hour Bank to provide coverage. Some coverage terminates upon attaining a specific age, as specified in this booklet, according to each benefit's contractual terms.

Do any Forms have to be completed?

YES. Within one month of becoming eligible for coverage, you must complete an Enrolment and Beneficiary card in full and send it to the Plan Administrator.

How does a person qualify for coverage?

A Member in good standing must accumulate 300 hours of work within 6 consecutive months. Coverage will commence on the 1st day of the second month following the accumulation of 300 hours in your Hour Bank tracked by the Plan Administrator.

EXAMPLE:

Your employer(s) report that you have accumulated in excess of 300 hours during the last 6 months. March hours are reported and tabulated in April, which makes April the Lag Month; your coverage becomes effective May 1.

Month	**Hours Reported**
January	
February	160
March	160
April	Lag Month
May	Coverage Starts

Each month 150 hours will be deducted from your Hour Bank to provide coverage. Any excess hours will accumulate in your Hour Bank for future coverage.

A maximum of 6 months' coverage can be accumulated in a Member's Hour Bank.

Once coverage starts, you will continue to be covered as long as your Hour Bank contains sufficient hours. Upon qualifying for coverage for the very first time, you will be issued a pay-direct card. Two cards will be issued (both in the Member's name). You can use the pay-direct card when you visit your dentist, your ophthalmologist or optometrist, 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.

When does coverage end?

a) Coverage will terminate when there are insufficient hours in the Hour Bank to allow for a deduction of 150 hours.

b) Coverage will be terminated immediately and the Hour Bank will be forfeited for any Member who is suspended or issued a withdrawal card.

Disability Credits

When a Member is disabled and collecting benefits under the Wage Indemnity Plan, EI Sickness Benefits or under WCB/WorkSafe BC, the disabled Member can apply to receive assistance with their Hour Bank. For each day that the Member is disabled and on an approved claim, their Hour Bank will be credited with contributions of 5 hours per day, up to a maximum of 1200 hours (8 months of coverage). The Member must request the appropriate form from the Plan Administrator and return the completed form to apply for Disability Credits / Hour Bank Assistance. The Member must be eligible for coverage and full benefits when the disability commences.

Self-Pay:

A Member in good standing may continue full coverage through Self-Payment.

A self-pay notice will be sent to the Member's last known address.

The maximum number of self-pays allowable is 6 consecutive months. Disabled Members on a WCB/

WorkSafe BC claim, may self-pay for a maximum of 12 months while they remain disabled and on claim.

PLEASE NOTE: During the months that a Member is self-paying for coverage, the pay-direct card will not be activated/re-activated until payment is received by the 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, the Member or dependent will be required to pay for the expense and submit the claim to the Administrator for reimbursement.

Reminder: Once full coverage has lapsed, in order to be covered again with full benefits, you must re-qualify with 300 hours in a 6 consecutive month period.

Are there any reciprocity agreements with other Welfare Plans?

YES. From time to time the Trustees may enter into or terminate reciprocity agreements. The Administrator must be contacted to ensure there is reciprocity agreement in place with the Local you are working in and you must advise the Local in which you are working that you are a Member of the Machinists, Fitters & Helpers Industrial Union Local No. 3 Benefit Plan and wish your contributions be transferred to this Plan.

Are Dependents Covered under the Plan?

YES. The Plan will provide Dental, Extended Health Benefits, EFAP and Vision Care for:

a) The spouse* of a covered Member

b) Any unmarried child of a covered Member to age 21, provided such person is mainly dependent on and living with the covered Member. This child may be the Plan Member or their spouse's natural, legally adopted or stepchild. A legally adopted child cannot be added to the Plan until the adoption has been finalized and permanent custody awarded.

c) Any unmarried child of a covered Member to any age provided the child is in full-time attendance at a recognized school, college, or university;

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 and is considered a dependent, as defined under the Canada Revenue Agency's Disability Tax Credit. 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.

*Spouse means the Member's legal spouse, or a person who has been residing with the Member continuously for a period of at least one year and has been publicly represented as the Member's spouse in the community in which they reside. Only one person may qualify as the spouse at any one time.

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

LIFE INSURANCE

Each eligible Member is insured for $100,000 of Life Insurance. This amount reduces by 50% at age 65 and terminates at age 70.

This amount of insurance is payable to the beneficiary designated by you should your death occur from any cause while you are insured under the group policy.

If you do not designate a beneficiary, the insurance will be payable to your estate.

The Plan Administrator must be contacted and advised of the Member's death, to confirm eligibility and proceed in filing a claim for this benefit.

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.

If you Become Totally Disabled

Subject to satisfactory proof, submitted within 12 months from the date the insured person becomes totally disabled, an insured person who is under age 65 and who becomes totally disabled and continues to be disabled for 6 months, as a result of accident, injury or disease will, on written application, be eligible for the total amount of the Life Insurance to remain in force providing the person remains totally disabled, subject to termination at age 65. Proof of total disability will be required from time to time.

Living Assistance Benefit

The Living Assistance Benefit is available as an advance payment of your Basic Life Insurance to help meet the medical or other health and welfare expenses of terminally ill Members under age 65.

Application for this benefit must be approved by the Plan and the Co-operators will confirm that medical evidence meets the Plan's requirements before approving payment.

The amount of money available as a Living Assistance Benefit payment is 50% of your Basic Life Insurance Benefit subject to a maximum benefit of $50,000.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

The Basic Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed below in the Schedule of Losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is covered?	**Amount of Coverage**
All eligible members under age 70	Same as Life Insurance
All spouses under age 70	$ 20,000
All eligible dependent children	$ 5,000

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of Speech and Hearing in Both Ears	The Principal Sum
Loss of One Arm	Four-Fifths of The Principal Sum
Loss of One Leg	Four-Fifths of The Principal Sum
Loss of One Hand	Three-Quarters of The Principal Sum
Loss of One Foot	Three-Quarters of The Principal Sum
Loss of Entire Sight of One Eye	Three-Quarters of The Principal Sum
Loss of Speech or Hearing in Both Ears	Three-Quarters of The Principal Sum

Loss of Thumb and Index Finger
of Either Hand .....Two-Fifths of The Principal Sum

Loss of Four Fingers of
Either Hand .....Two-Fifths of The Principal Sum

Loss of Hearing in
One Ear .....Two-Fifths of The Principal Sum

Loss of All Toes of
One Foot .....One-Third of The Principal Sum

Paralysis Benefits

Quadriplegia (complete paralysis
of both upper and lower limbs) .....Two Times The Principal Sum

Paraplegia (complete paralysis
of both lower limbs) .....Two Times The Principal Sum

Hemiplegia (complete paralysis
of upper and lower limbs of
one side of body).....Two Times The Principal Sum

Indemnity provided under this part for all losses sustained by an Insured Person as the result of any one Accident will not exceed the following:

a) With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum;

b) With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum or the Principal Sum if loss of life occurs within 90 days after the date of the Accident.

In no event will indemnity payable for all losses under this part exceed, in the aggregate, two times the Principal Sum as the result of the same Accident.

"Accident" whenever used in the policy means a sudden, unforeseen and unexpected event which arises from a source external to an Insured Person and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease or treatment for the illness or disease. This event must occur while the policy is in force and be the basis of claim.

"Injury" whenever used in the policy means bodily injury caused by an Accident occurring while the policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease.

"Loss" whenever used in the policy with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

"Loss of Use" whenever used in the policy means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the Accident.

Bereavement Benefit (Employees Only)
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six sessions of grief counseling, by a professional counselor, subject to a maximum of $2,500.00.

Brain Damage Benefit
If you sustain an Injury which results in Brain Damage, the insurer will pay the Principal Sum, less any amount paid or payable under "Accidental Death, Dismemberment and Specific Loss Indemnity" of the policy as the result of the same Accident, provided that:

a) you incur Brain Damage within 120 days from the date of the Accident; and

b) you are hospitalized as a result of Brain Damage at least seven of the first 120 days of the Injury; and

c) a physician determines and the insurer is satisfied that you have evidence of Brain Damage for at least six consecutive months.

"Brain Damage" whenever used in the policy means irreversible physical damage to the brain causing complete incapacity of performing all the substantial and material functions and activities normal to everyday life.

Continuation of AD&D Coverage (Employees Only)
Your coverage under the policy may be continued during any approved leave of absence, temporary layoff, maternity or parental leave or disability leave, provided payment of premium is continued.

Conversion Option (Employees Only)
Upon termination of active employment with your Benefit Trust Plan, you may, if under age 70 and within 31 days following the date of such termination, make written application to convert to an individual Accident insurance plan with no evidence of insurability required, at the individual rates in force with the insurer at the time of your termination. You may elect an amount of Principal Sum equal to or lower than the amount of Principal Sum in force under all policies issued to your employer by the insurer to a maximum of $500,000.00. This benefit is restricted to Canadian residents only.

Day Care Benefit (Employees Only)
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $5,000.00, for each of your dependent children under 13 years of age who (a) are enrolled in a legally licensed day care centre on the date of your death; or (b) enroll in a legally licensed day care centre within 12 months after the date of your death.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled in a legally licensed day care centre, but not to exceed four consecutive annual payments with respect to any one dependent child.

Education Benefit (Employees Only)
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $10,000.00, for each of your dependent children who (a) are enrolled as full-time students in a school for higher learning above the secondary school level; or (b) were enrolled as full-time students at the secondary school level but enroll as full-time students in a school for higher learning within 12 months after the date of your death.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in a school for higher learning, but not to exceed four consecutive annual payments with respect to any one dependent child.

If, at the time of loss, none of your dependent children are eligible for the Education Benefit, the insurer shall pay an additional amount of $2,500.00 to your designated beneficiary.

Family Transportation Benefit
If, following an Injury which results in a Loss covered by the policy, you are confined as an inpatient in a hospital located from a point of not less than 150 kilometers from your normal place of residence, the insurer will pay the reasonable and necessary expenses actually incurred by any one member of your immediate family for hotel accommodation and transportation by the most direct route to you, subject to a maximum of $210,000.00 for all such expenses.

Funeral Expense Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred for your funeral, subject to a maximum of $5,000.00.

Home Alteration and Vehicle Modification Benefit
If, following an Injury which results in a Loss covered by the policy, you are required to use a wheelchair to be ambulatory, the insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the Accident causing such Loss for (a) the cost of alterations to your principal residence; and/or (b) the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by the provincial vehicle licensing authorities where required for the purpose of making them wheelchair accessible, subject to a maximum of $50,000.00 as the result of any one Accident.

Hospital Indemnity Expense
A daily benefit of one-thirtieth of one percent of your Principal Sum, to a maximum monthly benefit of $2,500.00 will be payable when you are in a hospital and under the regular care and attendance of a physician, but only if such period of hospitalization is necessary for the treatment of an Injury which results in a Loss covered by the policy.

Such daily benefit will be paid from the first day of a necessary period of hospitalization as an inpatient, for which a full day's room and board is charged, but in no event for more than 12 months per Accident. A period of hospitalization which becomes necessary for the treatment of any Injury other than for a Loss covered by the policy will be covered in accordance with the above terms, and the daily benefit will be paid from the first day of hospitalization of at least a four day period of hospitalization. If a particular condition causes more than one period of hospitalization due to the same or related causes, then the maximum benefit (12 months in a hospital) will be reinstated, provided a period of six months has elapsed between periods of hospitalization.

Identification Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, and provided identification of your body is required by the police or similar law enforcement agency, the insurer will pay the reasonable and necessary expenses actually

incurred by a member of your immediate family for lodging and board (not to exceed a maximum duration of three consecutive nights) and transportation by the most direct route to and from the location of your body, subject to a maximum of $20,000.00. The body's location must not be less than 150 kilometers from the family member's normal place of residence.

Permanent Total Disability (Employees Only)
If, following an Injury and within 12 months of the date of the Accident, you are totally and permanently disabled while under age 65 and prevented from engaging in any and every occupation or employment for compensation or profit, the insurer will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any amount paid or payable under "Accidental Death, Dismemberment and Specific Loss Indemnity" as the result of the same Accident.

Psychological Therapy Benefit
If Injury results in a Loss covered by the policy and you require psychological therapy as prescribed by a physician, the insurer will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $5,000.00, until the full maximum has been paid, two years have elapsed from the date of Injury, or you die, whichever occurs first.

Rehabilitation Benefit (Employees Only)
If, following an Injury which results in a Loss covered by the policy, you require special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such Injury, the insurer will pay the reasonable and necessary expense incurred for such training within two years of the date of the Accident, subject to a maximum of $20,000.00 as the result of any one Accident.

Repatriation Benefit
If Injury results in loss of life for you, your insured spouse or insured dependent child and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred for preparation and transport of the body to

the city of residence, subject to a maximum of $20,000.00.

Seat Belt Benefit
If, due to a vehicular Accident, Injury results in a loss covered by the policy, the Principal Sum applicable to you, your insured spouse or insured dependent child will be increased by 10% if, at the time of the Accident, you, your insured spouse or insured dependent child were driving or riding in a vehicle and wearing a properly fastened seat belt. The driver of the vehicle must hold a current and valid driver's license authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs at the time of the Accident. Due proof of seat belt use must be provided as part of the written proof of loss.

Spousal Retraining Benefit (Employees Only)
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such Accident by your spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications, subject to a maximum of $20,000.00 for all such expenses.

Waiver of Premium (Employees Only)
In the event you become totally disabled and your waiver of premium claim is accepted and approved under your Benefit Trust Plan's current Group Life policy, premiums payable under the Basic A.D.&D. policy will be waived as of the same date the claim is accepted and approved by the Group Life policy Underwriter.

Workplace Modification and Accommodation Benefit (Employees Only)
If, following an Injury which results in a Loss covered by the policy, you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active full-time employment with the Benefit Trust Plan providing this benefit, the insurer will pay the reasonable and necessary expenses actually incurred by your Benefit

Trust Plan subject to a maximum of $5,000.00 as the result of any one Accident, provided your Benefit Trust Plan (a) agrees to provide the required equipment and/or make modifications to your workplace; and (b) acknowledges performance of the essential duties of your occupation may be altered. All required equipment and/or workplace modification must have prior approval by the insurer.

Aggregate Limit of Indemnity
The policy is subject to an Aggregate Limit of Indemnity of $2,500,000.00 for all losses resulting from any one Accident. This means that in the event of an Accident that results in an accumulation of losses exceeding $2,500,000.00, the amount payable with respect to each Insured Person will be reduced proportionately.

Exclusions
Coverage does not apply to any loss, fatal or nonfatal, caused by or contributed to, directly or indirectly resulting from:

- declared or undeclared war or any act of war;
- active full-time service in the armed forces of any country;
- suicide or self-destruction, regardless of any impairment, illness or state of mind;
- flying as a pilot or crew member in any aircraft;
- flying in owned, operated, leased or chartered aircraft of your Benefit Trust Plan;
- physical or mental illness or disease or treatment for the illness or disease;
- Injury sustained while operating a motor vehicle while either under the influence of any intoxicant, or with blood alcohol content in excess of the lower of: the then-current legal limit for operating a motor vehicle in the jurisdiction in which the Accident took place, or 80 milligrams of alcohol per 100 millilitres of blood;
- the commission or the attempt to commit a criminal act by the Insured Person;
- an act, attempted act or omission taken or made by the Insured Person, or an act, attempted act or omission taken or made with the Insured

Person's consent, for the purposes of interrupting the blood flow to the Insured Person's brain or to cause asphyxiation to the Insured Person whether with intent to cause harm or not;
- taking any drug other than as prescribed by a licensed Physician.

Exposure and Disappearance
If due to Accident you are unavoidably exposed to the elements and such exposure, within 12 months of the date of the Accident, results in a Loss for which indemnity would otherwise have been payable under the policy, such Loss will be deemed to be the result of Injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and if your body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you suffered loss of life as a result of Injury.

Beneficiary
The beneficiary or beneficiaries of an employee shall be that person or persons designated in writing by the employee and on file with your Benefit Trust Plan. If no such beneficiary designation has been filed, the beneficiary in respect of loss of life of an employee shall be the estate of the employee. All other indemnities payable, including those payable for the insured spouse and/or insured dependent children, are payable to the employee, with the exception of indemnities payable under "Bereavement Benefit", "Day Care Benefit", "Education Benefit", "Family Transportation Benefit", "Identification Benefit", "Spousal Retraining Benefit" and "Workplace Modification and Accommodation Benefit".

Termination of AD&D Insurance
Your AD&D insurance will immediately terminate on the earliest of the following dates:

a) the date the policy is terminated;

b) the premium due date if your Benefit Trust Plan fails to remit your premium to the insurer, except as the result of an inadvertent error;

c) the date you reach 65 years of age with respect to the "Permanent Total Disability" benefit, and with respect to other benefits, the premium due date coinciding with or immediately following the date you reach 80 years of age;

d) the premium due date coinciding with or immediately following the date you cease to be associated with your Benefit Trust Plan in a capacity making you eligible for insurance, except as provided under the part titled "Continuation of Coverage".

Your insured spouse's and/or insured dependent children's AD&D insurance will terminate on the earliest of the following dates:

a) the date such person ceases to be an eligible person;

b) the date your insurance is terminated.

A.D.&D. Claims Procedures
Written notice of claim is to be given to the insurer within a period of 30 days from the date of the Accident. Claim forms are available from Convyta, the Plan Administrator. The insurer reserves the right to request additional information when processing the claim. Completed claim forms must be filed with the insurer within 90 days after the date of the Injury and no later than one year regardless of whether the full extent of loss is known.

WAGE INDEMNITY BENEFIT

A benefit equal to the Employment Insurance (EI) weekly maximum benefit rate will be paid to each eligible Member who is disabled and 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 4th day of a non-occupational sickness. If you are hospitalized prior to the 4th 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.

Members whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Plan Member qualifies for full coverage under the Plan.

You must make application to Employment Insurance for EI Sickness Benefits and if you are eligible, benefits from the Plan will cease during the period you are eligible to collect EI Sickness Benefits. If you are still disabled after reaching the maximum duration of EI Sickness Benefit payments, or if you are not eligible for EI Sickness Benefits, or only partially eligible, the Plan will continue benefits for up to a maximum of 34 weeks including the EI Sickness Benefit payments.

How to claim for Wage Indemnity:

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

a) Contact your doctor immediately upon becoming disabled. You must be seen and treated during the time of your disability.

b) Contact Service Canada immediately and apply for EI Sickness Benefits.

c) Contact the Plan Administrator and advise that you have become disabled and wish to apply for Wage

Indemnity benefits. The Plan Administrator will determine whether you are eligible to apply for Wage Indemnity and, if so, will provide you with forms to complete. You must complete the Plan Member Statement in full and your doctor must complete the Attending Physician Statement in full. Both completed forms must be sent directly to Cooperators.

d) The Plan Administrator will ask you and/or the Union some questions in relation to your claim and will then complete the Plan Sponsor Statement and send it to Cooperators to establish your application for Wage Indemnity benefits.

e) Once all documentation is received by Cooperators in full, if there is no outstanding information, a disability case manager will be assigned to the claim and a decision will be communicated to you within approximately five business days.

f) Wage Indemnity benefits will be considered for the eligible portion of the 7-day waiting period for EI Sickness Benefits. Then EI Sickness benefits will commence for a maximum of 26 weeks. If you remain disabled at the 26-week mark of your claim, you must contact the Plan Administrator and Cooperators to advise and, subject to meeting disability criteria, the Wage Indemnity benefits will recommence up to an overall maximum of 34 weeks of EI Sickness and Wage Indemnity benefits combined.

Claims for Wage Indemnity must be submitted no later than 30 days after your total disability begins.

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, you will be required to complete a Reimbursement Agreement. This will entitle the Plan to be reimbursed for any benefits paid, which have been recovered from a third party.

Right to Recover

a) Where a Member becomes Totally Disabled as a result of an injury or sickness in respect of which

   i) a third party may be, directly or indirectly, either in whole or in part, liable to the Member or

   ii) the Member has a claim for benefits under workers compensation legislation;

   the Plan will not pay benefits to the Member.

b) In the circumstances described in (a) 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 the Member is fully repayable to the Plan on terms to be settled between the Member and the Plan and incorporated into a written Loan Agreement.

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) A period of 2 weeks before you again become disabled because of the same or related cause, or

b) 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:

- arising from occupational accident or illness, as these are covered by the WorkSafe BC Act;
- arising from your commission of or attempt to commit an assault or criminal offense;
- arising from self-inflicted injuries or sickness;
- 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 EI, 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;
- during which the insured is receiving or eligible to receive EI Sickness Benefits;
- if you become disabled during a strike or lockout at your place of employment; however, your rights to benefits will be reinstated when the strike or lockout ends.

TERMINATION OF BENEFIT

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

- you reach age 65;
- 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;
- you have reached the maximum of 34 weeks of benefit including any EI Sickness Benefits collected;

- you retire; or
- you die.

CPP TOP UP BENEFIT

The Plan will provide a top-up benefit of $500 for those eligible Members in Good Standing who are covered for full benefit coverage under the Plan at the date of their disability and who apply for and receive CPP Disability Benefits for disabilities incurred on or after November 1, 2009. This top-up benefit will be paid until the end of the month in which the Member turns age 65, recovers or dies (whichever occurs first). The top-up benefit will not be paid for any occupational illnesses or injuries.

EMPLOYEE/FAMILY ASSISTANCE PLAN (EFAP)

The EFAP is a voluntary, 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 give you assistance 24 hours a day.

This benefit provides professional assistance for 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.

For additional information, please refer to the brochure available from the Administrator. Access the Employee and Family Assistance Program (EFAP) 24/7 by phone, web or mobile app.

Visit: **one.telushealth.com**

login username: **mfhi3**
password: **eap**

or call **1-844-880-9137**

EXTENDED HEALTH BENEFITS

Calendar Year Deductible:	Nil
Eligible Prescription Drugs:	80%
All Other Eligible Expenses:	100% (unless otherwise noted)

$1,000,000 maximum per person per calendar year. Coverage reduces to $25,000 maximum per person per calendar year for Members age 75 or older (maximum applies to eligible dependents also).

Out of Province/Canada Emergency Medical Travel Insurance coverage is provided to eligible Members and their dependents up to a maximum of $5,000,000 per trip. There is no Out of Province/Canada Emergency Medical Travel Insurance coverage for Members (or their dependents) once the Member reaches the age of 75.

Medical Referral Services - 100%, $75,000 maximum per calendar year to age 75.

Benefits:

The Extended Health Benefit is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax supported agency.

The following are classed as eligible expenses when incurred as the result of necessary treatment of illness or injury and where applicable when ordered by a physician. Reimbursement will be limited to reasonable and customary charges in addition to any specific limitations and maximums stated.

a) 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 to send in your prescription receipt and wait for reimbursement. Your Plan provides coverage for prescription drugs and medicines (including oral contraceptives)

which are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law, and legally require a prescription and have a Drug Identification Number (DIN).

If approved, benefits include drugs with a Drug Identification Number (DIN) that do not legally require a prescription, including, but not limited to nitroglycerin, insulin and all other approved injectables, as well as related supplies such as diabetic syringes, needles, lancets, and testing agents.

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 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. If your pharmacist advises you that the drug you are trying to fill requires prior authorization, do not purchase the drug in advance. Prior authorizations that are approved, are not retroactive.

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.

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.

PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial 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 BC Fair PharmaCare website: **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.

b) Charges in excess of the amount payable under the Insured Person's 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. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation arranged at the patient's convenience are not eligible expenses.

c) Private Duty Nursing in the Home: 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 $10,000 every calendar year, and subject 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.

d) You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, kinesiologist, osteopath, speech therapist, acupuncturist, psychologist (including clinical counsellor), podiatrist, chiropractor, naturopath or physiotherapist, who is registered and legally practicing within the scope of their license. These charges will be covered at 100% up to a calendar year maximum of $1,500 per insured person for all practitioners combined.

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

Aids for daily living such as:

- hospital style beds including rails and mattresses;
- bedpans, standard commodes, and urinals;
- decubitus (bedridden) supplies, portable patient lifts (including batteries), trapezes/transfer poles, and I.V. stands;

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

- Custom-made foot orthotics or repairs to custom-made foot orthotics - One pair per calendar year. 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, modifications and repairs to orthopedic shoes, or footwear as an integral part of a brace, (subject to a

medical pre-authorization) - One pair per person per calendar year. 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. Orthopedic shoes means off-the-shelf, ready-made footwear prescribed for covered persons diagnosed with a specific medical condition that affects their feet and who require specialized footwear to treat their condition and assist with mobility. The footwear may be modified or adjusted to fit the covered person's feet.

Diabetic equipment and supplies, such as:

- blood glucose meters;
- insulin infusion pump, limited to one every 5 calendar years;
- insulin infusion pump supplies;
- glucose monitoring systems (GMS) such as continuous and flash type monitors including sensors and transmitters;

Medical items such as:

- braces and casts;
- transcutaneous electrical nerve stimulators (TENS machine), limited to one every 5 calendar years;
- incontinence/ostomy equipment, such as catheters and ostomy supplies;

Mobility aids, such as:

- canes, crutches, and walkers;
- wheelchairs and scooters (including batteries);

Standard Prosthetics, such as:

- myo-electric arm limited to the cost of a standard arm;
- arm, hand, leg, foot, eye, larynx;

- external breast prosthesis;

post-mastectomy bra, limited to 2 every calendar year;

Respiratory/Cardiology equipment, such as:

- compressors and inhalant devices;
- oxygen and equipment for its administration;
- tracheotomy supplies;
- CPAP, BiPAP, APAP machine, limited to one every 5 calendar years;

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

Wigs for temporary or permanent hair loss as a result of a medical condition limited to $500 per lifetime.

Note: 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.

f) Charges made by a dentist for the repair or replacement of sound, vital, natural teeth or the setting of a fractured or dislocated jaw if:

- those services are required as a result of a direct accidental blow to the month and not as a result of an object placed in the mouth;

- the accident occurred while the person is covered under this benefit; and
- the charges are incurred within 90 days of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 90 day period.

g) Hospital charges made by an approved acute general hospital in B.C. 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.).

h) Costs of hearing aids and repairs to a maximum of $600 in a 60-month period for adults and $800 in a 60-month period for dependent children under the age of 21 when prescribed by a certified Ear, Nose and Throat Specialist. Maintenance, batteries or other accessories will be covered.

i) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician limited to once every 24 months, subject to a maximum of $85.

EXCLUSIONS and LIMITATIONS:

Eligible benefits do not include and reimbursement will not be made for:

a) Services or supplies received as a result of disease, illness or injury due to:

- an act of war, declared or undeclared;
- participation in a riot or civil commotion; or
- attempting to commit or committing a criminal offence or illegal act;

b) Services or supplies provided while serving in the armed forces of any country;

c) Failure to keep a scheduled appointment with a legally qualified medical or dental practitioner;

d) Any treatment, drug, service, or supply received outside of Canada on a non-emergency basis;

e) Charges for the translation or completion of any claim forms and/or insurance reports;

f) Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document or prescription from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis;

g) Any specific treatment or drug which:
- does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
- is not considered to be effective (either medically or from a cost perspective) as determined by GreenShield's drug review process regardless if Health Canada has approved the drug;
- is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
- is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
- is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
- is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e. off-label use).

h) Services or supplies that:
- are not recommended, provided by or approved by the attending legally qualified (in the opinion of GreenShield) medical practitioner or dental practitioner as permitted by law;
- are legally prohibited by the government from coverage;
- you are not obligated to pay for or for which no charge would be made in the absence of

benefit coverage or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than the Plan or you;

- are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
- are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
- are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
- are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
- are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
- are provided by your employer and/or a practitioner employed by your employer, other than as part of an employee assistance plan;
- are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
- are video instructional kits, informational manuals or pamphlets;
- are for medical or surgical visual treatment (unless specifically identified and included as eligible under the Plan) or medical or surgical audio treatment;
- are special or unusual procedures such as, but not limited to, visual training (unless specifically identified and included as eligible

under the plan), orthoptics, subnormal vision aids and aniseikonic lenses;

- are tips or delivery and transportation charges;
- are for Insulin pumps and supplies (unless specifically identified and included as eligible under the Plan);
- are for audiometric examinations or hearing aid evaluation tests (unless specifically identified and included as eligible under the plan), or medical examinations;
- are batteries, unless specifically included as an eligible benefit;
- are a duplicate prosthetic device or appliance;
- are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
- would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
- were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as a result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;
- may include but are not limited to, drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
- are provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan

would have otherwise paid for such eligible service;

- relates to treatment of injuries arising from a motor vehicle accident;
  Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if the service or supplies being claimed is not eligible or the financial commitment is complete. A letter from your automobile insurance carrier will be required.
- are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

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: 60 days per trip

Maximum Age for Coverage: under age 75

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 further 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 prepaid 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 60 days per trip commencing with the date of departure from your province/territory of residence. If you are hospitalized on the 60th 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.
- GreenShield Travel Assistance or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for:
  i) 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
  ii) the cost incurred for a one-way economy airfare for a Travelling Companion.

This Coming Home benefit assumes that you are not holding a valid open-return air ticket. Charges for

upgrading, departure taxes, or cancellation penalties are not included.

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:
  i) the return of unaccompanied travel companions;
  ii) travel to the bedside of a stranded person;
  iii) rearrangement of ticketing due to accident or illness and other travel related emergencies;

iv) 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

a) 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.

b) 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.

c) 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.

d) 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.

e) 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.

f) 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.

g) 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:

a) 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:

   i) was not completely Stable in the professional opinion of GreenShield Travel Assistance Team;

   ii) where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling; or

   iii) 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.

b) 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.

c) Any expenses incurred for any services received that:

   i) were not required to treat an Emergency;

   ii) were not recommended by a legally qualified physician or surgeon;

   iii) are not covered under your provincial/territorial health insurance plan;

   iv) 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

   v) are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined c) i), ii), iii), or iv)

d) Any expenses incurred for services received after GreenShield Travel Assistance determined:

   i) 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;

   ii) the services could be reasonably delayed until the covered person returned to the province/territory of residence;

   iii) the emergency had ended; or

iv) the services are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined d) i), ii), or iii) above.

e) 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.

f) Any expenses incurred for services to treat:

i) 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;

ii) 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

iii) any medical condition resulting from not following Treatment as prescribed, including prescribed or over-the-counter medication.

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

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

i) 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 healthcare provider or facility recommended by GreenShield Travel Assistance.

VISION CARE

(eyeglasses/contact lenses/laser eye surgery)

The Vision Care Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

Covered Expenses

You can use your pay-direct card for the purchase 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 at 100%, up to a combined maximum of $800 per covered person during any period of 24 consecutive months.

DENTAL

The Dental Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

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.

Part I – Basic Services

The following services are eligible for coverage at the lesser of 100% of the amount charged or 100% of the current Dental Association Fee Guide (General Practitioner) in the Province of treatment.

a) 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 one set in any 6 month period, 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 36 month period
- Diagnostic models: limited to 1 set per calendar year.

b) Preventative Services

All necessary procedures to prevent the occurrence of oral disease, including:

- Cleaning (limited to twice in any calendar year)

- replace second bullet with: "Scaling and root planing (combined maximum of 16 units per calendar year.
- 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.

c) Surgical Services

All necessary procedures for extractions and other routine oral surgical procedures normally preformed by a dentist.

d) Restorative Services

All necessary procedures for:

- Filling teeth with amalgam, silicate, acrylic or composite restorations
- Replacement restorations if at least 12 months has elapsed since initial placement.
- Stainless steel crowns on primary teeth
- Gold Foil only when used to repair existing gold restorations.

e) 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:

- denture relines for dentures at least 6 months old, once every 36 months
- denture rebases for dentures at least 2 years old, once every 36 months
- resilient liner in relined or rebased dentures, once every 36 months.

f) Endodontia (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.

g) Periodontia

All necessary procedures for the treatment of tissues supporting the teeth including grafts.

h) Anaesthesia

General anaesthesia required in relation to oral surgery to a maximum of $175 per calendar year.

Part II – Major Services

Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for coverage at the lesser of 75% of the amount charged, or 75% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment:.

- Inlays, onlays and gold foils 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.
- Initial installations 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 (including porcelain crowns) 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 prior to its replacement and cannot be made serviceable. Dentures misplaced, lost or stolen will not be replaced at the Plan's expense. If the teeth/tooth was missing before being eligible under the Plan, you must be covered under the plan for 2 years before this would be considered an eligible expense.

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

Part III – Orthodontia (dependent children under 21 and adults)

Reimbursement for orthodontic treatment to straighten teeth and/or correct the bite, performed by an orthodontist. Payment will be made at 75% to a maximum lifetime limit of $2,500.00. Receipts for payment must be received no later than 12 months from the date the service is incurred while treatment is in progress, not at the end of the treatment.

If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefit for the remaining services, will be resumed. The benefit payment for orthodontic services will be only for the months that coverage is in force.

Pre-Treatment Estimate of Major Restorative & Orthodontic Charges

Before your treatment begins, your dental practitioner must submit an estimate, including supporting materials, such as digital photos and x-rays, for any proposed treatment for which the total cost is expected to exceed $500. The assessment of the proposed treatment may result in a lesser benefit being payable or in benefits being denied. Failure to submit an estimate before treatment begins will delay the assessment of your claim.

Alternative Services:

The Plan will reimburse the amount shown in the Fee Guide for the least expensive service or supply where two or more professionally accepted courses of treatment are a benefit under the Plan. The covered person can choose to have a more expensive treatment performed, however reimbursement will be limited to the cost of the least expensive alternative.

Emergency Dental Care Anywhere in the World

In an EMERGENCY, while you are travelling or on vacation outside of your Province of residence, you

are entitled to the services of a duly qualified dentist and will be reimbursed at the lower of the actual cost or the amount that would have been paid had the service been rendered in Province of residence.

LIMITATIONS

- Laboratory services that are in excess of 67% of the dentist's fee in the applicable Fee Guide will be reduced accordingly. Laboratory services must be completed in conjunction with other services and reimbursement is limited to the same percentage as the service for which the laboratory service was received.
- Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standard and/or basic services, supplies or treatment will remain your responsibility.
- Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide.
- Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy, calcified canals, and retreatments occurring within the first 18 months of the original treatment are not included. The total fee for root canal therapy includes all pulpotomies and pulpectomies performed on the same tooth.
- Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36-month period.
- When more than one surgical procedure, including multiple periodontal surgical procedures, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor.

- The multiple services factor occurs when a minimum of 6 or more restorations (fillings) or multiple periodontal services are performed at the same appointment and the full fee guide price is charged for each restoration or periodontal service, the first service will be paid in full and all remaining services will be reduced by 20%.
- Core build-ups are eligible only for the purpose of retention and preservation of a tooth when performed with crown treatment. Necessity must be evident on mounted pre-treatment X-rays. Core build-ups to facilitate impression taking and/or block out undercuts are considered included in the cost of a crown.
- Root planing is not eligible if done at the same time as gingival curettage.
- In the event of a dental accident, claims should be submitted under the Extended Health benefit before submitting them under the Dental benefit.

Dental Exclusions

Eligible benefits do not include and reimbursement will not be made for:

a) Services or supplies received as a result of disease, illness or injury due to:

   i) an act of war, declared or undeclared;

   ii) participation in a riot or civil commotion; or

   iii) attempting to commit or committing a criminal offence or illegal act.

b) Services or supplies provided while serving in the armed forces of any country;

c) Failure to keep a scheduled appointment with a legally qualified dental practitioner;

d) Any treatment, drug, service, or supply received outside of Canada on a non-emergency basis;

e) Charges for the translation or completion of any claim forms and/or insurance reports;

f) Any dental service that is not contained in the p rocedure codes developed and maintained by the

Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;

g) Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion;

h) Appliances related to treatment of myofascial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines;

i) Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces;

j) Service and charges for sleep dentistry;

k) Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction;

l) Any specific treatment or drug which:

   i) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;

   ii) is not considered to be effective (either medically or from a cost perspective) as determined by GreenShield's drug review process, regardless if Health Canada has approved the drug;

   iii) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;

   iv) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;

   v) is not dispensed by the pharmacist in accordance with the payment method shown

under the Extended Health Benefit Plan Prescription Drugs benefit;

vi) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e. off-label use).

m) Services or supplies that:

i) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GreenShield) medical practitioner or dental practitioner as permitted by law;

ii) are legally prohibited by the government from coverage;

iii) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage; or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than the Plan or you;

iv) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;

v) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;

vi) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;

vii) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;

viii) are provided by an immediate family member related to you by birth, adoption, or by

marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;

ix) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;

x) are video instructional kits, informational manuals or pamphlets;

xi) are delivery and transportation charges;

xii) are a duplicate prosthetic device or appliance;

xiii) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;

xiv) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;

xv) relates to treatment of injuries arising from a motor vehicle accident;

Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if –

- the service or supplies being claimed is not eligible; or
- the financial commitment is complete;

A letter from your automobile insurance carrier will be required.

xvi) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

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

What is the maximum amount that will be paid for any one person?

There is no limit for Part I and II coverage. The maximum amount that will be paid for Part III (Orthodontia) is $2,500.00 per lifetime per covered Member or dependent.

HEALTH CARE SPENDING ACCOUNT (HCSA) (effective July 1, 2023)

This benefit provides an entitlement of $500 per year per Member, regardless of whether the Member has single or dependent coverage under the Plan. The Member's initial entitlement will be prorated to the month they qualify for coverage. For example, if the Member qualifies for coverage July 1st, the initial entitlement will be $250 for the balance of that calendar year. These funds are available to claim any unpaid portion of eligible benefits that are not reimbursed in full under the Plan and after coordinating benefits with a spouse's benefit plan, where applicable. Provided the Member remains eligible for coverage under the Plan, an additional $500 will be contributed to their HCSA account on January 1st of each subsequent year.

Funds are available in the HCSA for 12 months from the end of the calendar year in which they were contributed. If the Member does not fully claim a current year's HCSA entitlement, the balance of the entitlement contributed that year will be carried forward into the next calendar year to be used for expenses incurred in that new calendar year and will

be forfeited at the end of the carry-forward year. For example, any unclaimed entitlement earned in 2023 will be carried forward into 2024 and will be forfeited (expire) December 31, 2024 if any portion remains unclaimed. The funds contributed in 2024 will be available until December 31, 2025. Members can view their available balance in the GreenShield+ App and Member Portal or contact GreenShield's Customer Service Centre at 1-888-525-7587 to inquire.

Expenses incurred during a calendar year must be reimbursed using that same calendar year's entitlement (or the previous year's entitlement if the funds were carried forward, where applicable). No unpaid portion of a HCSA claim may be carried into the next year for further reimbursement. For example, if a $400 expense were incurred in November 2023, any available 2023 entitlement would be applied to this claim and the 2024 entitlement could not be used to pay the balance. This claim would be considered closed.

Upon termination of coverage, the Member has 30 days to submit any eligible expenses to the Plan, provided they were incurred while the Member was eligible for HCSA coverage. Any unclaimed entitlements following termination will be forfeited. If the Member requalifies for coverage later that same year, any forfeited entitlement from that same year will be reinstated but can only be used to reimburse eligible expenses that were incurred while the Member was eligible for coverage. If the Member already claimed their HCSA entitlement prior to coverage terminating, the Member must wait until the next new calendar year for a new entitlement, provided they remain eligible for benefits.

Members have 60 days at the beginning of a new calendar year to submit eligible expenses that were incurred in the previous year. These expenses will be paid from any entitlement balance that was available at the end of the previous year. Claims incurred during the previous year, which are received after February 28th, will be returned unpaid.

Eligible Expenses

Eligible expenses include but are not limited to those that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) Income Tax guidelines. It also includes the amount of the deductible and the percentage not covered by the group benefit plan or the amount in excess of group benefit plan maximums. For a list of eligible medical expenses, visit greenshield.ca, or for more information about eligible expenses you can consult a CRA office or visit the CRA website.

Exclusions

Expenses not eligible for reimbursement are at all times governed by the non-eligible expenses, restrictions and limitations outlined in the Canadian Income Tax Act. An example of expenses would be:

- premiums paid to provincial medical or hospitalization plans, and
- medical costs for which you or your dependent are reimbursed or entitled to be reimbursed under a provincial health insurance plan, your group benefit plan or your spouse's group benefit plan.

CLAIMS

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 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.

Health Care Spending Account (HCSA) Claims

Your HCSA does not have automatic coordination with your health and dental benefits. If you would like to enable this functionality, you may do so through the member portal (the GreenShield Customer Service Centre is unable to arrange set up of this function).

Auto–Coordination with HCSA - Once you have accessed the member portal and have set up your HCSA Auto–Coordination, your health and dental claims will automatically be coordinated with your HCSA. You must pay the provider of service the HCSA portion of the claim and you will be automatically reimbursed from your HCSA without having to submit a paper claim. The unpaid balance of your health and dental claims will not be re-directed to a secondary plan (COB) before paying out of the HCSA.

Manual Coordination with HCSA - If you choose not to have all your traditional health and dental claims automatically coordinated with your HCSA, you must pay the provider of service the HCSA portion of the claim, then complete a HCSA Claim Submission Form and attach proof of payment. You can indicate on this claim form if you want your eligible expenses paid from your GreenShield health and/or dental plan first, and any unpaid portion of your eligible expenses paid from your HCSA.

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. All HCSA claims must be received by GreenShield no later than 60 days after the end of the benefit year in which the expense was incurred, or, no later than 30 days after your

termination date, your retirement date or, your date of death.

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:

Machinists, Fitters & Helpers Industrial Union Local No. 3 Benefit 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 their 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:
  i) The benefit plan of the parent who has custody of the dependent child;
  ii) The plan of the spouse of the parent who has custody of the dependent child;
  iii) The plan of the parent who does not have custody of the dependent child;
  iv) 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.

Benefits Provided by:

The Co-operators
#G419
Life Insurance

Machinists, Fitters & Helpers
Industrial Union Local No. 3
Benefit Plan
#11244
Wage Indemnity
CPP Top-Up
Extended Health Benefits
Vision Care
Dental
Health Care Spending Account

Industrial Alliance
#100013339
Accidental Death & Dismemberment

GreenShield
Out of Province/Canada Emergency
Medical Travel Insurance

TELUS Health
#7023
Employee/Family Assistance
Plan (EFAP)

This booklet explains in general terms the Plan of benefits and coverage in effect. It is not to be considered a contract of insurance. The complete terms of the Plan are set forth in the group policies issued to the Trustees.

JUN 2025

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