Local 97 Ironworkers

Health and Welfare Plan

Plan Administrator:

convyta

501 - 4445 Lougheed Hwy
Burnaby BC V5C 0E4

For questions regarding your benefit eligibility
or self-payment
contact the Plan Administrator, Convyta, at:
Email: IW97@convyta.com
Toll Free: 1-844-7-IRON97 or 1-844-747-6697

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

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

*Including amendments to June 1, 2025

PRIVACY POLICY

We, the Trustees for the Local 97 Ironworkers Health and Welfare 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

The following is an outline of the Local 97 Ironworkers Health and Welfare Plan. The information in this benefits booklet is important to you. It provides the information you need about the group benefits available through the Local 97 Ironworkers Health and Welfare 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 Dental, Weekly Indemnity and 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.

SCHEDULE OF BENEFITS

Life Insurance	$100,000*
AD&D	Equal to Life Insurance
Weekly Indemnity	Equal to EI Weekly Maximum Integrated with EI
Long Term Disability	$1,400 per month
Employee and Family Assistance Plan	
Extended Health Benefits	90%, unless otherwise stated
Prescription Drugs	90%, Generic Substitution $9.50 Dispense Fee Cap Prior Authorization Program
Out of Province/Canada Emergency Medical Travel Insurance	Plan Members under Age 80: $5,000,000 Maximum Per Coverage Period (60 days per trip) Plan Members age 80 and over: $20,000 Included in EHB Lifetime Max 60 days per trip (should obtain private coverage)
Vision Care	as described herein
QuikCare Platinum Expedited Medical Services	as described herein
Dental Plan	90% Basic Services 50% Major Services 50% Orthodontia (Dep Child <19)
Transportation Assistance	as described herein

***NOTE:** All Active Members and Permit Members between the ages of 60 and 65 will be covered for $100,000 of Life Insurance. Members between the ages of 60 and 65, who are not active but are covered for benefits, will be covered for $50,000 of Life Insurance. Upon attaining age 65, all Members Life Insurance reduces to $10,000 and upon attaining age 70, the Life Insurance reduces to $5,000.

Any Member of Local 97 found to be working for a non-signatory Ironworker Contractor may have their coverage terminated and will forfeit any hours accumulated in their Hour Bank.

DETAILS of ELIGIBILITY

Who is eligible?

Any Member and Permit Member working under the Collective Agreement of Local Union 97 of the International Association of Bridge, Structural and Ornamental Ironworkers.

Do any Forms have to be completed?

YES. You must complete and an Enrolment and Beneficiary card.

If adding a Common-Law spouse after your initial eligibility date the notarized Common-Law Declaration is required.

It is most important that EACH Member and Permit Member complete an Enrolment and Beneficiary card. This completed form should be sent to the Administrators Office without delay.

How does a person qualify for coverage?

A Member in good standing and Permit Member must accumulate 220 hours of work within a 5 month period. Coverage will commence on the 1st day of the month following the month (lag) in which sufficient hours are reported and paid to the Plan by the employer(s).

A Member or Permit Member is eligible for all benefits except Weekly Indemnity and Long Term Disability after satisfying the normal qualifying conditions of the Plan. Coverage for Weekly Indemnity and Long Term Disability commences the first day of the second month after the Member or Permit Member has worked, and the Plan has received contributions for 1,000 hours of work from a participating employer.

Members who have previously retired and are in receipt of their union pension benefits, but return to work and qualify for coverage through an accumulation in their hourbank, are not covered for WI or LTD, nor are they permitted to collect WI or LTD benefits in addition to their union pension benefits.

Upon qualifying for coverage, the Member will receive two pay-direct cards from GreenShield - both will be in the Member's name.

EXAMPLE (all benefits except for Weekly Indemnity and Long Term Disability):

	HOURS REPORTED		
MONTH	**MEMBER A**	**MEMBER B**	**MEMBER C**
January	50 hours	150 hours	226 hours
February	70 hours	125 hours	lag
March	30 hours	lag	qualified
April	100 hours	qualified	–
May	lag	–	–
June	qualified	–	–

Once coverage starts, you will continue to be covered as long as your Hour Bank contains sufficient hours.

As a Member of Local 97, 110 hours will be withdrawn each month from the Hour Bank. A maximum of 8 months coverage (880 hours) can be accumulated in a Member's Hour Bank which will be drawn upon during a period of poor employment, lengthy illness or extended vacation.

A person who is not a Member of Local 97 but who is working under the Local 97 Collective Agreement will have a charge of 130 hours made against their Hour Bank. A maximum of 4 months coverage (520 hours) can be accumulated in a Permit Member's Hour Bank.

When does coverage end?

a) Coverage will terminate when there are insufficient hours in the Member's Hour Bank to allow for a deduction of 110 hours. Coverage for a Permit Member will terminate when there are insufficient hours in the Hour Bank to allow for a deduction of 130 hours.

b) Coverage for Members will be terminated immediately and the Hour Bank will be forfeited for any Member who is found to be working for a non-signatory Ironworker Contractor.

Disability Credits

When a Member is collecting benefits under the Weekly Indemnity Plan, EI Sick Benefits or under Workers' Compensation, Members can apply to receive assistance with their Hour Bank. For each day that the Member is disabled and on a claim that has been accepted for

payment, the Member's Hour Bank will be credited with contributions of 8 hours per day, subject to a maximum of 110 hours per month for up to 12 months. This is limited to a maximum of 6 months for Permit Members at a rate of 130 hours per month. The Member or Permit Member must request the appropriate form from the Administration Office and return the completed form to apply for Disability Credits. To qualify for these Disability Credits, the Member or Permit Member must be eligible for benefits when the disability commences.

Members in receipt of WCB/WorkSafe benefits may receive Disability Credits for the duration of their WCB/WorkSafe claim or up to a maximum of five consecutive years, whichever is the earliest. Such Member must provide evidence of continued receipt of such benefit payments from WCB/WorkSafe as requested by the Plan Administrator. Once Disability Credits are exhausted, the Member may run down their Hour Bank or continue their coverage under self-payment if eligible. Permit Members are not eligible to self-pay.

Self-Pay

A Member in good standing may continue coverage through self-payment for all benefits except Weekly Indemnity and Long Term Disability. Permit Members are not eligible to self-pay.

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

The maximum number of self-pays allowed is 6 consecutive months.

Members who are on Maternity, Paternity or Parental Leave will be permitted to self-pay, once the hours in their Hour Bank are exhausted, for a maximum of 12 months if desired.

Members who are Totally Disabled and unable to work, or a regular or disabled Pensioner drawing from the Ironworkers Pension Plan, Local 97 may self-pay. The maximum duration of self-pay for Pensioners will be set at one year for every 3,000 hours recorded to the Pension Plan. Pensioners who retire after September 1, 2010 with 25 years or more of contributions to the Ironworkers Local 97 Pension Plan may self-pay indefinitely.

Members must arrange for their own Medical Services Plan (MSP) coverage.

To apply for individual MSP coverage contact:

MEDICAL SERVICES PLAN OF BC
P.O. BOX 9035 STN PROV GOVT
VICTORIA, BC V8W 9E3

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 220 hours in a 5 month period.

What happens if the Hour Bank falls short for coverage?

If the Hour Bank drops below 110 hours, the Administrator will send out a notice as to the balance in the Hour Bank and the amount required to maintain coverage. If payment of the amount requested is received by the deadline specified on the notice coverage will be continuous.

Those Members who have a balance of employer hours in their Hour Bank and, although working regularly, do not have sufficient work to maintain the Hour Bank charge, will qualify under "Shortage Hours" and will receive a billing showing the balance of hours required to make up the 110 hours needed each month to provide coverage. Shortage notices do not reduce the maximum months under self-payment.

Permit Members will not be notified when their Hour Bank drops below 130 hours.

Self-payment is only available to a Member who was covered under the Local 97 Ironworkers Health and Welfare Plan. The Fund is subsidizing the rate and a self-pay notice will be sent to each Member showing the amount to be paid.

The first month a Member falls below the 110 hours but has 90 or more employer hours in their Hour Bank, a self-pay notice will not be sent out and the Fund will absorb the difference out of general revenue.

Do Not Ignore the Self-Payment or Shortage Hours Notice

If you receive a Self-Payment or Shortage Hours Notice and you think it is incorrect, contact the Administrator – Convyta Partners:

Email: IW97@convyta.com

Toll Free: 1-844-7-IRON97 or 1-844-747-6697

The only sure way to provide yourself with coverage for a specified month is to pay the Self-Payment or Shortage Hours Notice by the date specified on the Notice.

In the event that late hours are reported or other adjustments are found later, the hours will be credited to your Hour Bank for future use.

Can hours be suspended while working for another Local?

No, hours cannot be "frozen" while you are covered with another employer.

Are there any reciprocity agreements with other Locals?

Local 97 Ironworkers Health & Welfare Plan has Reciprocal Agreements with the plans of other Locals of the International Association of Bridge, Structural and Ornamental Ironworkers and Members of a Local with a Reciprocal Agreement, will not receive coverage from the Local 97 Ironworkers Health and Welfare Plan. Contributions made on their behalf are remitted to their home Local's Welfare Plan.

Are Dependents Covered under the Plan?

YES. The Plan will provide Dental, Extended Health Benefits 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;

c) Any unmarried child of a covered Member to age 25 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.

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

For those wanting to add a common-law spouse, you must complete a Common-Law Declaration, have it notarized and sent to the Administrator. The co-habitation period for a common-law spouse is a continuous period of one year.

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

Upon the death of a covered Member, the surviving spouse (and eligible dependents) will be entitled to remain covered until the hourbank has been exhausted (where applicable) and then the covered spouse will be given the option to self-pay for six months. This does not apply to Permit Members. If the Member was already self-paying, the surviving covered spouse will be permitted to self-pay for six months following the Member's death.

APPRENTICES

Upon graduation from the 1st year course, Apprentices will be entitled to receive Health and Welfare coverage for 2 months following graduation and then will be entitled to self-pay until the hours worked are sufficient to provide coverage or you have made the maximum number of self-payments.

Individuals who Pre-Apprentice through Local 97 and then begin the Entry Level Trades Training (ELTT), will be entitled to full coverage under the Plan, excluding all disability benefits, for up to 6 months, once their Hour Bank runs out, providing they are in school attending the ELTT program.

Registered Apprentices (RA), who attend Ironwork upgrade classes, years 2 & 3, provided they have less than 4 months of banked hours in their Hour Bank, will be credited with 110 hours (one month of coverage) by the Trade Improvement Committee. The Registered Apprentices will be permitted to self-pay for a maximum of 6 months if no hours are remitted on their behalf.

B.C.I.T. INSTRUCTORS

B.C.I.T. Instructors will be given one month's coverage when they are finished teaching. When the instructor returns to teach at B.C.I.T. their Hour Bank will be frozen (if they had one) and will remain frozen until they are finished teaching.

LIFE INSURANCE

All Active Members and Permit Members to age 65 will be covered for $100,000 of Life Insurance. Members between the ages of 60 and 65, who are not active but are covered for benefits, will be covered for $50,000 of Life Insurance. Upon attaining age 65, all Member's Life Insurance reduces to $10,000 and upon attaining age 70, the Life Insurance reduces to $5,000.

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.

Continuation of Life Insurance on Termination of Coverage

When your coverage with the Plan terminates, you may convert up to $5,000 of your Life Insurance to an individual policy without a medical examination or health questionnaire but only if the Member had been insured under this Plan for at least three years. Contact the Administrator for details.

Your life would continue 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.

Only one such converted policy may be in force on a Member's life at any time.

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 60 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 a portion of the Basic Life Insurance to help meet the medical or other health and welfare expenses of terminally ill Members. Please contact the Administrator.

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. In the event your spouse is an eligible employee of your Benefit Trust Plan, you each may enroll. Only one of you may elect coverage for Dependent Children. If one spouse does not enroll, he will be the insured spouse by default.

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 Active Members under Age 65	$100,000
Self-Paying Members Aged 60-64	$50,000
All Eligible Members Aged 65-69	$10,000
All Eligible Members Aged 70+	$5,000
All spouses under age 70	$20,000
All eligible dependent children	$5,000

Schedule of Losses

The policy provides benefits for Injury resulting in Loss of, or permanent and total Loss of Use of, which occurs within 12 months after the date of the Accident as follows:

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

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 Coverage (Employees Only)

Your coverage under the policy may be continued during any approved leave of absence, temporary lay-off, 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 in-patient 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 in-patient, 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 non-fatal, 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 Insurance

Your 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 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 your 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.

WEEKLY INDEMNITY BENEFIT

Weekly Indemnity Benefits will be paid to each eligible Member or Permit 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 8th day of a non-occupational sickness. If the Member is hospitalized, 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: Benefit will not commence prior to the day the Member is seen and treated by a physician. Members or Permit Members whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Plan Member or Permit Member qualifies for coverage under the Plan.

Members who have previously retired and are in receipt of their union pension benefits, but return to work and qualify for coverage through an accumulation in their hourbank, are not covered for WI, nor are they permitted to collect WI benefits in addition to their union pension benefits.

The Weekly Indemnity benefit provides, from the first claim submitted, a maximum of 26 weeks of benefit. Once the 26 week maximum has been reached, either through one claim or a series of shorter claims, the entitlement to benefits thereafter will be limited to a total of 20 weeks. Once the 20 week maximum has been reached, either through one claim or a series of shorter claims, the entitlement to benefits will be limited to a total of 13 weeks. Once a Member or Permit Member has claimed the final 13 weeks (59 weeks in total) they are no longer eligible for Weekly Indemnity benefits.

The maximum number of weeks includes weeks the Member or Permit Member is receiving EI medical payments.

How to claim for Weekly Indemnity:

The following steps must be taken as soon as possible after a Member has become disabled:

a) The Member must contact their doctor immediately upon becoming disabled. They must be seen and treated at the time of their disability.

b) Obtain an EI Claims Kit from the Employment Office.** The physician's report must be completed and a copy sent to the Administration Office in order that they may provide the Member with Disability Credits.

c) If the Member is not eligible for EI sick benefits, they must obtain a claim form from the Administration Office as they are entitled to submit a claim to the Ironworkers Weekly Indemnity Plan, provided a copy of the EI rejection letter accompanies the claim. **Claimants must be under the care of a physician and be treated in person during the period claimed for.**

d) The Member must complete the front of the claim form.

e) The attending physician must complete the Physician's Statement on the back of the same form. If there is any charge for completing this form, it is the claimant's responsibility.

f) Claim for disability must be submitted no later than 30 days after total disability begins unless special circumstances prevent such.

**A Member claiming for a non-occupational accident may commence benefits from the 1st day of the accident through to recovery or to the maximum weeks of the claim, whichever occurs first. The Member must make an application to EI at the time of the accident in order that benefits would commence on the 8th day.

On what basis are the Weekly Indemnity Benefits paid?

Claim payments are made to the Member at the end of each 7-day period, provided that the Member is not eligible for EI sick benefits, including Saturdays and Sundays. Benefit payments commence on the 1st day of a non-occupational accident or the 8th day of a sickness. If hospitalized prior to the 8th day of a disability, benefits commence on the 1st day of hospitalization provided the Member is not eligible for EI sick benefits.

All substance abuse claims will be paid a maximum Weekly Indemnity benefit of 6 weeks provided that the Member is in a rehabilitation centre and remains there for the full course of treatment.

Is it necessary to consult a physician in person before making a claim for Weekly Indemnity Benefits?

Yes. The physician's report is required to establish the record of the Member's inability to work and regular medical attendance will be required for the duration of the claim.

Will further medical reports be required?

Yes, depending on the nature of the illness and in addition, the Member may be required to have an independent medical examination.

Please note: Members and Permit Members returning to work, must be cleared in writing to do so by their physician.

Third Party Liability

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

a) a third party may be, directly or indirectly, either in whole or in part, liable to the Member, such as in the case of a motor vehicle-related accident or injury; or

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

the Plan will not pay benefits to the Member.

EXCLUSIONS and LIMITATIONS:

No benefit will be paid for periods of disability:

- arising from a motor vehicle-related accident or injury, as these are covered by ICBC or similar Insurance (Vehicle) Act;
- arising from occupational accident or illness, as these are covered by the WorkSafe BC/WCB Act;
- arising from the Member's 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 the Member is receiving continuing treatment for substance abuse from their physician;
- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service;
- during which the insured is receiving or eligible to receive EI benefits;
- if the Member becomes disabled during a strike or lockout at their place of employment; however, their rights to benefits will be reinstated when the strike or lockout ends.

TERMINATION OF BENEFIT

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

- the Member is no longer disabled;
- the Member is no longer receiving continuing medical care or treatment from their physician;
- the Member fails to submit satisfactory proof of continuing disability as required by the Plan;
- the Member refuses a medical examination by a physician chosen by the Plan;
- the Member is no longer following the treatment recommended for their disability;

- the Member leaves the province, state or country where they 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 the Member normally resides outside Canada, such treatment must be approved by the Plan;
- the Member performs any work for compensation or profit;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- the Member retires; or
- the Member dies.

LONG TERM DISABILITY

If a Member or Permit Member becomes Totally Disabled while covered under the Long Term Disability Benefit, the Plan will pay the benefits for which that Member is eligible in accordance with the following:

All eligible Members under age 65*:	Flat $1,400
Benefit Waiting Period:	26 weeks of total disability
Duration Period:	5 years or to age 65* whichever occurs first
Definition of Disability:	2 year own occupation
All Source Maximum:	85% for all sources
Taxable Status:	Taxable

*age 60 for LTD claims incurred prior to January 1, 2011

Please note: The all source maximum benefit entitlement will be determined in accordance with the following formula:

> 1,000 hours times the basic hourly rate exclusive of overtime or any additional allowances as outlined in the Collective Agreement in force at the onset of disability times 85% divided by 12.

Members who have previously retired and are in receipt of their union pension benefits, but return to work and qualify for coverage through an accumulation in their hourbank, are not covered for WI or LTD, nor are they permitted to

collect WI or LTD benefits in addition to their union pension benefits.

Benefit Payment Waiting Period

A Member must be Totally Disabled for a period of 26 weeks or for the duration of the Weekly Indemnity Benefit period, whichever is greater.

If a Member, who has satisfied some but not all of the Benefit Waiting Period, returns to work for a continuous period of 30 days or less and again becomes disabled as a result of the same sickness or injury, such later Period of Disability will be deemed by the Plan to be a continuation of the previous Period of Disability, however the Benefit Waiting Period will be extended by the number of days worked by the Member during that period.

Calculation of Monthly Integrated Benefit

The Monthly Integrated Benefit shall be the Monthly Benefit reduced by an amount equal to the sum of any disability or retirement benefits for which the Member is eligible under:

a) i) the Canada Pension Plan or Quebec Pension Plan; and

   ii) any Worker's Compensation legislation in Canada; and

b) any government disability or retirement benefit plans in any other jurisdiction.

However, no Benefit reduction shall be applied until income for all disability related sources exceeds 85% of the Member's gross pre-disability earnings at onset of disability and then only to the extent that the total income exceeds the 85% threshold.

For the purpose of the calculation of the Monthly Integrated Benefits, any lump sum payment received for any source specified in the definition of "Income from All Sources" shall be converted to equivalent monthly amounts for the period to which such payments relate.

Government Source Income Integration Freeze

During any one Period of Disability, any Cost-of-Living increase in disability benefits under a Government Plan will not reduce the amount of the Monthly Integrated Benefit otherwise payable under this policy if the increase is effective after the due date of the first payment to a Member under this benefit.

Time of Payment

Subject to the terms and conditions of the policy, the Long Term Disability Benefit shall be payable one month following the expiration of the Benefit Payment Waiting Period and at the end of each monthly period thereafter.

Taxability Status

The Plan will administer any payments made under this benefit on the basis of the Taxability Status. The Plan shall not be responsible for any taxes or penalties levied by any government in connection with such benefit payments and shall not be liable to Policyholder or any Member or Employer for any such taxes or penalties.

Termination of Monthly Disability Benefit Payments

Monthly Disability benefit payments payable to a Disabled Member shall terminate on the earliest of the date the Member:

1. engages in any occupation for wage or profit, except as allowed by the provisions of this policy;
2. fails to provide written proof satisfactory to the Plan of continuance of Disability;
3. fails to submit to any medical examination by physicians of the Plan's choice;
4. refuses to follow the treatment recommended for their disabling condition by a physician whose specialty encompasses such disabling condition;
5. is no longer receiving regular and ongoing care of a physician;
6. refuses to enter into any Rehabilitation Program that is considered to be appropriate by the Plan;
7. fails to agree in writing to reimburse the Plan, following written request to do so, for any amounts owed to the Plan;
8. ceases to be Disabled;
9. dies;
10. starts to draw a Union Pension; or
11. has received benefits for the Maximum Benefit Payment Period as shown in the Policy.

Recurrent Disability

If a Member who has received benefits under the Long Term Disability Benefit of this policy returns to work for a period of 180 days or less and again becomes Disabled as a result of the same sickness or injury, such later Period of Disability will be deemed by the Plan to be a continuation of the previous Period of Disability. No new Benefit Payment Waiting Period will be required, however, no benefits are payable for any period of such employment.

Extension of Benefit Payments

If a Member's coverage terminates while Disabled, the Plan will continue to pay benefits, provided:

1. the Member is receiving benefits under the Long Term Disability Benefit of this policy, or is completing the Benefit Payment Waiting Period on the date the coverage terminated;

2. the Member was Disabled on the date the coverage terminated;

3. the Member has remained Disabled since the date the coverage terminated; and

4. notice of Disability is given by the Member to the Plan within six months from:

    a) the commencement date of Disability with respect to a Member who resides in the province of Quebec,

    b) the termination date of coverage with respect to a Member who resides in a province other than Quebec.

In no event will benefit payments continue beyond any date specified for the termination of benefits payments.

LIMITATIONS

1. The Plan will not pay benefits for any Period of Disability which directly or indirectly result from or is contributed to by a disability due to:

    a. a self-inflicted sickness or injury caused while sane or insane,

    b. any act related to insurrection or war or participation in a riot, or

c. the Member's commission or attempted commission of any criminal offense (including an offense related to driving a vehicle while under the influence of alcohol).

d. an automobile accident.

2. No amount will be paid for any period:

   a. during which the Member is imprisoned; or

   b. on formal leave of absence taken by the Member; or

   c. a Member collects Union Pension benefits.

3. The Plan will not pay disability benefits for a Period of Disability due to:

   a. the chronic use of alcohol or drugs (prescribed or otherwise), or

   b. the use of any hallucinogen,

   unless the Member is under active treatment and is participating in a medically supervised rehabilitation program. All substance abuse claims will be paid a maximum Weekly Indemnity benefit of 6 weeks, provided they are in a rehabilitation centre and remain there for the full course of treatment.

4. No amount will be payable for any Period of Disability which results from or is caused by a condition for which the Member was treated or attended by a physician, or for which prescription drugs were taken, during the 3 month period prior to the effective date of insurance, until the Member has performed all the duties of their regular occupation (on a full-time basis) for a 12 month period after the effective date of their insurance.

Eligibility for Total Disability Benefits

A Disabled Member will be eligible for Total Disability Benefit payments if:

1. the Member became Total Disabled while insured for the Total Disability Benefit,

2. the Member's Total Disability has continued for a period in excess of the Benefit Plan Waiting Period, and

3. as a result of the Disability, the Member

   a. is absent from work,

   b. incurs a loss of Earnings, and

c. is not engaged in any occupation for wage or profit, except as specified under the subsection "Rehabilitation Program".

The Member must submit proof of loss satisfactory to the Plan.

Please note: Members returning to work, must be cleared in writing to do so by their physician.

Rehabilitation Program

If a Member is receiving Total Disability Benefits under this policy, participates in a Rehabilitation Program approved by the Plan, they shall be eligible for Disability benefits while participating in the program for a period of up to 24 months, or a longer period if deemed advisable by the Plan. The Rehabilitation Program must be supervised by a physician, and is subject to the continued approval of the Plan.

Amount of Benefit

For purposes of the calculation of the Monthly Integrated Benefit, the Monthly Benefit shall be the Insured Amount shown in the Policy.

The Total Disability Benefit shall be the Monthly Integrated Benefit reduced by:

1. 50% of the Member's monthly Net (after-tax) Earnings under an approved Rehabilitation Program; and

2. an amount equal to the amount by which the Member's

   a. Income from All Sources; plus

   b. 100% of the Member's monthly Net (after-tax) Earnings under the Rehabilitation Program

   exceeds 100% of the Member's monthly Inflation Indexed, Pre-Disability Net (after-tax) Earnings.

DEFINITIONS

When used in the provisions of the Long Term Disability Benefit, each of the following terms is limited in meaning to the definition shown.

Claims Anniversary Date

The date 12 months after the first day for which benefits are payable, and each date 12 months thereafter during the same Period of Disability.

Consumer Price Index

The Consumer Price Index published by Statistics Canada.

If the Consumer Price Index is:

a. no longer available,

b. no longer published, or

c. changed so that it no longer reasonably reflects the rate of change in the cost of living,

then the Plan will determine some other appropriate index to use in these calculations and the CPI Factor will be based on such index.

CPI Factor

A ratio calculated annually at the Claim Anniversary Date by dividing the Consumer Price Index at Claim Anniversary Date* of the Consumer Price Index at commencement date* of Disability, but in no event will the CPI Factor be less than 1.

*The Consumer Price Index is published monthly for a period several months in the past. For calculations based on the Consumer Price Index, the index will be that published for the month four months prior to the date used for calculation. For example, for any date in January, the index used will be that published for the preceding September.

Disability or Disabled

Respectively, Total Disability or Totally Disabled.

Income from All Sources

The sum of any amounts for which the Member is eligible as:

a. disability or retirement benefits provided under the Canada Pension Plan or Quebec Pension Plan (Primary and Secondary Income Benefits);

b. any salary continuance from the Employer;

c. any indemnity for loss of time provided under any other group disability plan, including any professional association plan;

d. any retirement income provided under any retirement or pension plan of any other employer is the income commenced after the date of Disability;

e. any indemnity for which the Member is eligible under any Employment Insurance Act, Workers' Compensation Law or similar legislation;

f. any amount paid or payable under any no-fault automobile insurance policy for disability, loss of income or wage replacement, if permitted by law;

g. disability benefits paid by the Plan under this policy.

Inflation-Indexed,

Pre-Disability Net (after-tax) Earnings

Net (after-tax) Earnings at commencement of Disability times CPI Factor.

Net (after-tax) Earnings

A Member's Earnings, excluding any Federal and Provincial Income Taxes deducted, and non-voluntary pension plan contributions.

Period of Disability

The period of time from and including the date on which the Member becomes Disabled until the Member ceases to be Disabled due to the same sickness or injury.

Primary Income Benefits

Disability income benefits for which a Member is eligible under the Canada Pension Plan or Quebec Plan, whether or not the Member has dependent children.

Rehabilitation Program

A program of job training or work-related activity approved by the Plan designed to facilitate a Disabled Member's return to employment or any other gainful employment for which the Member is or may become qualified.

Secondary Income Benefits

Disability income benefits for which a Member is eligible under the Canada Pension Plan or Quebec Plan, which are in addition to Primary Income Benefits and are provided in respect of the Member's dependent children.

Total Disability or Totally Disabled

A condition, due to sickness or accidental bodily injury, which required the regular and ongoing care of a legally qualified Physician appropriate to the sickness or injury and as a result of which the Member is not engaged in any occupation for wage or profit and

1. during the Own Occupation Disability Period, is prevented from performing the substantial duties of their own occupation;

2. after the Own Occupation Disability Period, is prevented from performing any gainful occupation

    a. for which the Member is or may become reasonably qualified by training, education, or experience, and

    b. which will enable the Member to earn at least 67% of their inflation-indexed, Pre Disability Earnings.

EMPLOYEE AND 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 a wide range of issues such as:

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

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: **97ironworkers**
password: **eap**
or call **1-844-880-9137**

EXTENDED HEALTH BENEFITS

There is no annual deductible. In-Canada expenses are reimbursed at 90% unless otherwise indicated and all In-Canada eligible expenses will be reimbursed up to a

lifetime maximum of $1,000,000 if under age 80 and to a lifetime maximum of $20,000 if age 80 or older.

Out of Province/Canada Emergency Medical Travel Insurance coverage is provided to eligible Members and their dependents under age 80 up to a maximum of $5,000,000 per coverage period. **Those 80 years and older do not have Out of Province/Canada Emergency Medical Travel Insurance coverage but may use what is remaining of their $20,000 lifetime maximum towards such expenses. It is recommended that if you or a dependent is 80 years or older that you purchase Travel Insurance.**

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

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.

Upon qualifying for coverage, the Member will receive two pay-direct cards from GreenShield - both will be in the Member's name.

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.

1) Prescription Drugs – (Generic Substitution Always) – present your pay-direct card, along with your prescription, to your pharmacist and your prescription drug claim will be adjudicated right at the pharmacy. Reimbursement of prescription drugs is based on the cost of the lowest priced generic equivalent drug. 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 require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits. Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Smoking cessation products will be covered up to a combined lifetime maximum of $500 per person. Dispensing fees over $9.50 per prescription are not covered by this Plan.

   There are a number of prescription drugs which are not eligible under BC's Fair PharmaCare 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 Fair PharmaCare approve the application for Special Authority, such drugs will be applied towards your annual Fair PharmCare 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 the Fair PharmaCare Program call 604-683-7151 from Vancouver and toll-free 1-800-663-7100 from the rest of BC. If you prefer to go on-line to the Fair PharmaCare website, the address is:

https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/who-we-cover/fair-pharmacare-plan/register-for-fair-pharmacare

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.

Before your drug claim can be reimbursed, GreenShield, the Plan's claims processor, 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.

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.

Mandatory Generic Drug Substitution

Based on specific provincial health insurance plan regulations, where a generic equivalent drug exists,

reimbursement will only be made up to the cost of the lowest priced equivalent drug. If a medical practitioner indicates a brand name drug is medically required due to a serious medical reaction to at least two generic equivalent drugs, GreenShield must be provided with a copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (that can be obtained from the Health Canada website) completed by the medical practitioner, to determine eligibility for payment of the cost of the prescribed drug.

Prescription Drug Exclusions

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

- drugs for the treatment of infertility;
- vitamins that do not legally require a prescription;
- vaccines, with the exception of vaccines to prevent Shingles;
- nicotine replacement products, such as patches, gum, lozenges, and inhalers;
- products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required, unless specifically identified and included as eligible in "Prescription Drugs";
- ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage.

2) 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, firs 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.

3) 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 $25,000 per illness/injury. 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-Authoriz-ation Form for Private Duty Nursing must be completed by the attending physician and submitted to GreenShield.

4) Convalescent Home or Physical Rehabilitation Facility room and board charges, excluding charges for chronic care, if the Insured Person's residence in the institution:

   1. is certified as medically necessary by a Physician,

   2. occurs within 48 hours after a Hospital stay of at least 5 consecutive days, and

   3. is due to the same sickness or accidental bodily injury which was the reason for the Hospital stay.

   Charges are limited to the difference between the Provincial Medical Allowance for Room and Board charges, and the institution's charge, up to $8.50 per day for a maximum of 30 days per disability.

5) You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, speech therapist, acupuncturist, psychologist*, podiatrist, chiropractor, naturopath or physiotherapist, who is registered and legally practicing within the scope of their license. These charges will be covered at 50% up to a calendar year maximum of $400 per insured person per practitioner type.

   *The Plan will recognize the services of a licensed social worker, registered clinical counsellor or a registered therapeutic counsellor under the combined category of registered psychologist.

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

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

8) Diabetic equipment and supplies, such as blood glucose meters, insulin infusion pumps (limited to one every 5 calendar years), glucose monitoring systems

(GMS) such as continuous and flash type monitors including sensors and transmitters.

9) Compression stockings with a pressure measurement of 15 mmhg or higher, limited to 3 pairs per calendar year.

10) Charges for stump socks.

11) Standard Prosthetics, such as:

    - myo-electric arm limited to the cost of a standard prosthetic arm, hand, leg, foot, eye, larynx;
    - external breast prosthesis;
    - post-mastectomy bra, limited to 4 per calendar year;

12) Cataract surgery foldable lens.

13) Two pair of custom built orthopaedic shoes when prescribed by a physician, chiropractor, physiotherapist, or podiatrist and replacements when necessary due to normal wear and tear to a maximum of $400 per calendar year. Modifications to stock items are not a covered expense.

14) Two pair of custom fitted orthotics when prescribed by a physician, chiropractor, physiotherapist, or podiatrist and replacements when necessary due to normal wear and tear to a maximum of $400 per calendar year.

15) 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). Electric wheelchairs are covered only when a doctor certifies the patient is incapable of operating a manual wheelchair (e.g. Paraplegic).

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

Plan through GreenShield. 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;

16) Respiratory/Cardiology equipment, such as:

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

17) 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 24 months of the date of the accident.

18) Hospital charges made by an approved acute general hospital in B.C. for the difference between ward cost and semi-private room , or if required as medically necessary by a physician, private accommodation (not including rental of telephone, T.V. etc.).

19) Hearing aids, when prescribed by a doctor, including repairs will be reimbursed at 50% up to a maximum of $2,000 per person every 5 years for adults and children. Does not require the prescription to be made by an Ear, Nose and Throat Specialist. Maintenance, batteries or other accessories will not be covered.

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

21) You can use your pay-direct card when you visit a Licensed Optometrist or Ophthalmologist for an eye examination, up to a maximum of $75 every 24 months.

EXCLUSIONS and LIMITATIONS:

The Plan's Extended Health Benefits does not cover:

a) expenses for benefits, care or services payable by or under the Basic Medical Plan, PharmaCare, any Hospital Program or the Worker's Compensation Act, whether or not a claim is made thereunder or provided without cost or at nominal cost by any public or tax-supported authority or agency or for which the Member or dependent can recover from another party.

b) expenses of dental services or care or dentures except as specifically provided in Item 17.

c) any amount of fees in excess of the usual or recognized fees for the service performed.

d) expenses incurred outside the province of residence unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out of Province/Canada Emergency Medical Travel Insurance or if pre-approved under the Medical Referral Benefit as described herein.

e) expenses of services and supplies for cosmetic purposes.

f) expenses caused, contributed to or necessitated as a result of:

- war or any act of war or participation in a riot or civil insurrection;
- injury or sickness which was intentionally self-inflected, whether sustained or suffered while sane or insane;
- occupational illness or injury; or
- the commission by the person of any unlawful act including an offense under the Criminal Code of Canada.

g) any expenses that a covered person may obtain as a benefit under any government plan or law.

h) any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging which represents an amount in excess of the schedule of costs prescribed by the Medical Services Plan.

i) medical cannabis in any and all of its forms.

Out of Province/Canada Emergency Travel Medical

This Travel benefit applies to Members and their dependents under the age of 80, and 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.

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 pay.

- 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 last 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 service rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;

Emergency Transportation

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

Referral services – Reasonable and customary hospital, medical, surgical, and transportation expenses in excess of those expenses covered by your provincial/territorial health insurance plan for you and an approved escort. Prior to the commencement of any referral treatment, written pre-authorization from your provincial/territorial health insurance plan and GreenShield must be obtained. Your provincial/territorial health insurance plan may cover this referral benefit entirely. You must provide GreenShield with a letter from your attending physician stating the reason for the referral, and a letter from your provincial/territorial health insurance plan outlining their liability. Failure to obtain pre-authorization will result in non-payment.

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

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

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

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

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

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

- Treatment to relieve dental pain up to a maximum of $500 per trip.

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

- GreenShield Travel Assistance specifies in writing that you should immediately return to your province/territory of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one-way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you and a Travelling Companion by the most direct route to the major air terminal nearest the departure point in your province/territory of residence.

  This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, or cancellation penalties are not included.

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

Cost of returning your personal use motor vehicle to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $10,000 per trip. GreenShield

Travel Assistance requires original receipts for costs incurred, i.e. gasoline, accommodation and airfares;

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

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

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

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

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

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

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

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

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

How Travel Assistance Service Works

For assistance dial **1.800.936.6226** within Canada and the United States or call collect **519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GreenShield Identification Card. Quote your GreenShield Identification Number, found on your GreenShield Identification Card, and explain your medical emergency. You must always be able to provide your GreenShield Identification Number and your provincial/territorial health insurance plan number.

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care. Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, GreenShield Travel Assistance will guarantee the provider (hospital, clinic or physician), that you have the required provincial/territorial health insurance plan coverage and GreenShield travel benefits as detailed above.

GreenShield Travel Assistance will follow your progress to ensure that you are receiving the best available medical treatment. GreenShield Travel Assistance also keeps in

constant communication with your family physician and your family, depending on the severity of your condition.

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

Travel Limitations

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

2. GreenShield Travel Assistance must be notified **before** obtaining Emergency Treatment in order for GreenShield Travel Assistance to:

   - confirm coverage; and

   - provide pre-approval of treatment.

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

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

3. After your medical emergency treatment has started, GreenShield Travel Assistance must assess and pre-approve additional medical treatment. If you undergo tests as part of a medical investigation, treatment or surgery, obtain treatment or undergo surgery that is not pre-approved, your

claim will not be paid. This includes invasive testing, surgery, cardiac catheterization, other cardiac procedures, transplants, MRI.

4. Repatriation is mandatory when GreenShield Travel Assistance determines that the covered person should transfer to another facility or return to the home province/territory of residence for treatment, or at the end of the emergency. If you choose not to return:

    - no benefits will be paid for any further medical treatment;
    - no benefits will be paid for any recurrence or complications related directly or indirectly to the Medical Condition that caused the emergency; and
    - for the remainder of the trip, coverage will be limited to Medical Conditions completely unrelated to the Medical Condition that caused the emergency.

5. Air ambulance services will only be eligible if:

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

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

7. GreenShield Travel Assistance reserves the right, without notice, to suspend, curtail or limit its services in any area if any of the following occur:

    - political or civil unrest, rebellion, riot, or military uprising;
    - labour disturbance or strike;
    - act of God; or
    - refusal of authorities in a foreign country to permit GreenShield Travel Assistance to provide service.

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

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

Travel Exclusions

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

1. Any expenses incurred for the treatment related directly or indirectly to a Pre-existing Medical Condition that, at the time of your departure from your province/territory of residence and the 90-day period immediately preceding your departure from your province/territory of residence:

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

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

    c) a physician advised the covered person not to travel.

    GreenShield Travel Assistance reserves the right to review the covered person's medical information at the time of claim. A physician's opinion that the covered person was fit to travel does not override

or eliminate the requirement for the covered person to satisfy all the conditions of Stable.

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

3. Any expenses incurred for any services received that:

   a) were not required to treat an Emergency;

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

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

   d) are normally covered under the out-of-Canada benefits of your provincial/territorial health insurance plan's out-of-Canada coverage (where applicable), when the provincial/territorial plan has declined payment; or

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

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

   a) the covered person was to return to the province/territory of residence for treatment, but the covered person chose not to return to the province/territory of residence;

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

   c) the emergency had ended; or

   d the services are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined 4.a), b), or c) above.

5. Any expenses incurred for services to treat a medical condition or complications of a medical condition directly or indirectly related to an epidemic or pandemic if, when the trip was booked, or before the departure date, an official travel advisory was issued by the Canadian government

advising Canadians to avoid either all travel or all non-essential travel regarding any country, region, city, or other key components of your travel arrangements (e.g., cruise ship). To view the travel advisories, visit the Government of Canada Travel site.

6. Any expenses incurred for services to treat:

   a) any medical condition, including symptoms of withdrawal, arising from or in any way related to the chronic use of alcohol, drugs, or other intoxicants whether prior or during the trip;

   b) any medical condition arising during the trip resulting from, or in any way related to, the abuse of alcohol that results in a blood alcohol level of more than 80 milligrams in 100 millilitres of blood, drugs or other intoxicants; or

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

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

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

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

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

QUIKCARE PLATINUM EXPEDITED MEDICAL SERVICES

(Eligible Active Members Only)

Extensive wait times to see a specialist or receive diagnostic imaging can lead to deteriorating conditions, and stress and worry, as well as the inability to work and participate in planned recreational activities.

If your attending physician places you on a waitlist greater than 21 days for either a diagnostic scan (CT, MRI or

Ultrasound) or an appointment to see one of the covered specialists (Orthopedic, Cardiologist, Neurologist, Gastroenterologist, General Surgeon, Ear Nose and Throat (ENT), Ophthalmologist, Urologist, Rheumatologist, or Neurosurgeon), then the Plan may be able to arrange Expedited Medical Services on your behalf through QuikCare Platinum by TeksMed Services Inc., for non-work-related medical conditions.

If you are deemed to be eligible for this service, you will need to provide TeksMed Services Inc. with any necessary documentation, such as a referral letter or requisition form from your doctor, and TeksMed will utilize their exclusive network of specialists and diagnostic imaging services to arrange an appointment on your behalf. They will coordinate and pay for the required service, so that you are not faced with any complications that typically occur when seeking private healthcare assistance, and following such appointment, the results will be shared with your attending physician. Treatment for some serious conditions cannot be accommodated as the public system is already providing the highest treatment priority. Any travel costs incurred are not covered by this benefit but may be eligible under the Plan's Transportation Assistance Benefit - learn more in the applicable section of this booklet.

This service is limited to a maximum of one diagnostic scan and specialist consultation per year; diagnostic imaging to multiple body parts/areas can typically necessitate multiple scans and therefore could exceed the annual entitlement of a Member, and may not be accommodated. Diagnostic or specialist services obtained without prior authorization of TeksMed Services Inc. are not eligible for reimbursement.

To access this benefit, call the QuikCare Platinum Expedited Medical Services hotline at: **1-866-593-2919**.

This benefit is not available to Permit Members. Retired Members, those who are self-paying for coverage or for spouses or dependents and you must be a Member in Good Standing of Ironworkers Local 97.

If you are disabled and are collecting WI or LTD or are in receipt of EI Sickness Benefits and your doctor has placed you on a waitlist as described above, please contact your disability case manager at Co-operators to discuss the possibility of arranging your appointment through QuikCare Platinum.

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, prescribe 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) laser eye surgery for Members and Permit Members only (no coverage for dependents) (pay-direct card cannot be used)

Payment of Expenses

The maximum amount payable during any period of 24 consecutive months shall be 100% of the actual expense incurred or $750*, whichever is the lesser for an eligible adult. A maximum amount of $300 is payable during any period of 12 consecutive months for dependent children to age 19.

For Members and Permit Members only, Laser Eye Surgery will be reimbursed in installments of up to $750* every 24 consecutive months, up to a lifetime maximum of $2,000. There is no Laser Eye Surgery coverage for dependents.

*Effective August 1, 2024

EXCLUSIONS and LIMITATIONS

The cost of the following items are excluded from this Plan:

a) duplicate or spare eye glasses or any lenses or frames thereof;

b) safety goggles, sun glasses (plain or prescription);

c) replacement or lost, stolen or broken lenses or frames.

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.

Basic and Major Services combined have an annual maximum of $2,700.

Part I – Basic Services

The following services are eligible for reimbursement of the lesser of 100%* of the amount charged or 100%* of the Dental Association Fee Guide (General Practitioner) in the Province of residence.

*Effective August 1, 2024

1) 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 one in any 6 consecutive month period for dependent children under the age of 19 and once in any 9 consecutive month period for adults and dependent children 19 years of age and older; however, complete oral examinations are limited to one in any 36 month period
   - Specific examinations
   - Consultations (as a separate appointment)
   - 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 24 month period, and panoramic film is limited to one x-ray in any 36 month period
   - Diagnostic models: limited to reasonable and customary.

2) Preventative Services

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

   - Cleaning and the topical application of fluoride (limited to once in any 6 consecutive month period

for dependent children under the age of 19 and once in any 9 consecutive month period for adults and dependent children 19 years of age or older year)

- Scaling and root planing (combined maximum of 16 units per calendar year)
- Pit and fissure adhesive sealants limited to once per tooth every 24 months for dependent children under the age of 19
- Fixed space maintainers on primary teeth for dependent children under 18.

3) Surgical Services

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

4) 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.

5) 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.

6) 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.

7) Periodontia

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

8) Anesthesia

General anesthesia required in relation to oral surgery.

Part II - Major Services

Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for reimbursement of the lesser of 50% of the amount charged, or 50% of the Dental Association Fee Guide (General Practitioner) in the Province of residence.

- 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 or veneers and their replacement if at least 5 years has lapsed.
- Replacement of an existing full or partial denture if at least 2 years has lapsed
- Fixed bridgework, if the existing 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.

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 19 years of age)

For orthodontia services performed by an orthodontist payment will be made at 50% to a maximum lifetime limit of $4,000.00. Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced at the Plan's expense.

Predetermination

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. Our 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:

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

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.

EXCLUSIONS and LIMITATIONS

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

- items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- dental care which is cosmetic;
- dental care provided under a medical plan provided by an employer or government.

- which, in the absence of coverage, there would be no charge;
- stainless steel crowns on permanent teeth;
- protective athletic appliances;
- anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- replacement of a lost or stolen prosthesis;
- incomplete and temporary procedures;
- implants;
- any dental charge for services which were started prior to the date of coverage; or
- dental treatment which was ordered while covered, (which included lab work and impressions), but was not installed or delivered until more than 31 days after the dental benefit terminated.

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.

TRANSPORTATION ASSISTANCE

Eligibility

Any person who is covered under the Local 97 Ironworkers Health and Welfare Plan will be entitled to submit transportation expenses for him/herself or for an eligible dependent.

Covered Expenses

The following expenses shall be eligible for reimbursement:

The actual cost of transportation, up to a maximum of 75% of the amount equal to the round trip commercial economy class airfare for transportation within British Columbia or Alberta or the Yukon Territory from the commercial airport nearest to the Member's residence in British Columbia where regularly scheduled airlines depart from to the commercial airport located nearest to the facility recommended by the patient's physician where treatment, diagnostic tests or examination takes place.

Within each calendar year no more than six (6) trips will be eligible for reimbursement. If, on the physician's recommendation, the patient requires an accompanying person, payment shall be made on the basis of 50% of the airfare subject to the conditions as outlined, but only if air transportation is involved.

Lodging

In conjunction with transportation charges, lodging expenses up to a maximum of 30 days in a calendar year at a rate not to exceed $30.00 per day, for a patient receiving treatment outside their area of residence, on presentation of the appropriate medical documentation and receipts, will be recovered.

EXCLUSIONS

The following are excluded from payments:

a) The cost of transportation from the patient's home to the nearest airport from which regular scheduled airlines depart.

b) The cost of transportation from the airport at the city of destination to the place where treatment, examination or tests take place.

c) Any accident or sickness which is the responsibility of WCB/WorkSafe BC, Insurance Corporation of British Columbia or any other third party.

d) Any journey where the round trip is less than 250 kilometers.

e) Treatment for services not medically required.

How a Claim is Made

1) The attending physician must complete a form confirming the diagnosis, the facility or name of the physician who will see the patient and the date and time of the appointment, also if the patient required an accompanying person.

2) The physician who renders the treatment, examination or test will complete a form confirming the visit(s).

3) Payment of expenses will be made directly to the Member, subject to receipt of the applicable forms.

4) Should the patient be transported by car or bus, reimbursement will be 75% of the actual cost.

CLAIM INFORMATION

Inquiries

For detailed inquiries, contact your Plan Administrator (Convyta Partners) or contact GreenShield:

- Call 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 GreenShield's 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.

Claims Submission Period

All Health, Travel and Dental claims must be received by GreenShield no later than 24 months from the date the eligible benefit was incurred.

Reimbursement

Reimbursement will be made by one of the following methods:

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

All dollar maximums and limitations stated are expressed in Canadian dollars. Reimbursement will be made in Canadian

or U.S. funds for both providers and plan members, based on the country of the payee.

Overpayments

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

Limitation on Legal Action

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

Subrogation

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

Co-ordination of Benefits (COB)

If you are covered for extended health and dental benefits under more than one plan, your benefits under this Plan will be coordinated with the other plan so that you may be reimbursed up to 100% of the eligible expense incurred. Claims must be submitted to the primary payer first. Any unpaid balances should then be submitted to the secondary plan(s). When Local 97 Ironworkers Health and Welfare Plan is identified as a secondary plan, 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:

Local 97 Ironworkers Health and Welfare 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 Plan's coverage is always secondary. Your spouse must first submit claims to his/her benefit plan.

Children

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

- The plan of the parent whose birth date (month and day) occurs earliest in the calendar year;
- The plan of the parent whose first name begins with the earlier letter of the alphabet, if the parents have the same birth date;

In cases of separation or divorce with multiple benefit plans for the children, the following order applies:

- The benefit plan of the parent who has custody of the dependent child;
- The plan of the spouse of the parent who has custody of the dependent child;
- The plan of the parent who does not have custody of the dependent child;
- The plan of the spouse of the parent who does not have custody of the dependent child.

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

Travel Benefits

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

ACCESS TO INFORMATION

If you live in a province where the law permits you to request copies of your records, the Plan 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 the Plan Administrator;

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.

CONFLICT

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

NOT A CONTRACT OF INSURANCE

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

Benefits Provided by:

Manulife Financial
#115358
Life Insurance

Local 97 Ironworkers Health and Welfare
Weekly Indemnity
Long Term Disability
Extended Health Care
Vision
Dental
Transportation Assistance

Industrial Alliance
#100013339
Accidental Death & Dismemberment

GreenShield Canada
Out of Province/Canada Emergency
Medical Travel Insurance

TELUS Health
#7018
Employee and Family Assistance Plan

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

2000 210