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

Including amendments to January 1, 2024

Active Member
Associate Member
and
Disabled Member Benefits

LOCAL 118
INSULATORS
UNION
TM

www.hfbenefits.org

privacy policy

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

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

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*does not apply to associate members

introduction

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

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

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

We welcome your interest and suggestions in the hope that the Plan will always reflect the desire of the majority of the people it serves. For additional information or assistance, feel free to contact D.A. Townley.

benefit overview

life insurance	$70,000
accidental death & dismemberment	$70,000
weekly indemnity*	$675 per week on the first day of accident, on the 8th day for illness EI Integration, 52 weeks maximum
long term disability*	75% of monthly earnings to a maximum of $3,000 per month 365 day waiting period, payable up to age 60, taxable
extended health benefits	as described within
Out of Province/ Canada Emergency Medical Travel Insurance	$5 Million maximum per coverage period up to age 70
dental benefits	as described within
member family assistance program	confidential counseling services for members and eligible dependents
medical services plan of british columbia	group no. 3131182

*not available to exempt or associate members

eligibility details

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

establishing coverage

To establish coverage, you must be a member in good standing of the Heat & Frost Insulators, Local 118 (the Union). For the purpose of the Plan, members working for non-union contractors who refuse to cooperate in Local 118 organizing efforts are not deemed to be in good standing.

You must complete an Enrolment and Beneficiary application, and, if you wish to have your MSP coverage administered by the Plan, you must complete a Medical Services Plan application form.

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

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

associate members

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

reporting

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

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

coverage begins

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

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

coverage continues

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

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

disability credits

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

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

when your hourbank drops below 125 hours

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

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

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

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

If you receive a Self-Payment or Shortage of Hours Notice and you think it is incorrect, contact the Plan Administrator, D.A. Townley, by telephone: (604) 299-7482 or toll-free: 1-800-663-1356.

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

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

self-pay limit

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

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

Associate members are not permitted to self-pay.

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

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

coverage ends

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

If you are suspended or issued a withdrawal card, your coverage will end immediately, and any balance in your hourbank will be forfeited.

hourbank freeze

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

reciprocity agreements

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

transferred back to this Plan to help you maintain your coverage.

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

if I retire

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

dependents

The Plan will provide the MSP, extended health and dental benefits for:

a) The spouse* of a covered member;
b) Any unmarried child of a covered member up to the age of 21, (age 19 for MSP) provided such person is mainly dependent on and living with the covered member; and
c) Any unmarried child of a covered member to any age if the child is in full-time attendance at a recognized school, college, or university; (age 25 for MSP); and
d) Any unmarried mentally or physically handicapped child of a covered member to any age, provided such person is mainly dependent on and living with the covered member or the spouse of the covered member.

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

When completing your application forms for coverage, please include all dependents to be covered. To

add, delete or change the dependents covered, complete an MSP Group Change form (if applicable) and Enrolment and Beneficiary card from the Plan Administrator or your Union Office, and forward it to the Plan Administrator's office.

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

dependents' coverage in the event of your death

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

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

life insurance

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

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

continuation of life insurance on termination of coverage

When your coverage with the Plan terminates, you may convert your Life Insurance to an individual

policy without a medical examination or health questionnaire. The individual policy would be for an amount not greater than the amount under the group policy and would be available at any time within 31 days after termination of the group insurance. Contact the Administrator for details.

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

waiver of premium for disability

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

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

For associate members who become disabled, Totally Disabled shall mean you are incapacitated by an injury or disease to the extent you are not able to perform any work for compensation or profit and are not able to engage in any business or occupation.

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

accidental death & dismemberment

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

principal sum

Your amount of Principal Sum is: $70,000

loss schedule

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

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of or Loss of Use of	
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand or foot and sight of one eye	100%
Speech and hearing in both ears	100%
One leg or one arm	75%
Either hand or foot	66 2/3%
Sight of one eye	66 2/3%
Speech or hearing in both ears	66 2/3%

Hearing in one ear	50%
Thumb and index finger of the same hand	33 1/3%
Four fingers of the same hand	33 1/3%
All toes of one foot	12 1/2%
Total and irreversible paralysis of	
All four limbs (quadriplegia)	200%
Both lower limbs (paraplegia)	200%
One arm and one leg on the same side of the body (hemiplegia)	200%

"Loss" means, with regard to:

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

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

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

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

exposure and disappearance

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

If your body is not found within one year after the date of the disappearance, sinking or wrecking of the vehicle in which you are an occupant at the time of the accident and under such circumstances as would

otherwise be covered hereunder, it is presumed that you suffered loss of life resulting from bodily injury caused by an accident at the time of such disappearance, sinking or wrecking.

waiver of premium

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

repatriation

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

spousal retraining

If you receive benefits for a loss described in the Loss Schedule, RBC pays for the expenses actually incurred by your spouse within three years from the date of the accident, for an approved and mutually agreed upon formal occupational training program, specifically qualifying them to gain active employment in an occupation for which they would otherwise not have had sufficient qualifications. The maximum payable hereunder is **$10,000.**

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

- at least 18 years of age;
- competent to contract; and

- not related by blood closer than would legally bar marriage.

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

rehabilitation

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

family transportation

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

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

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

"Regular Care and Attendance" means observation and treatment to the extent necessary under existing

standards of medical practice for the condition causing the confinement.

continuation of coverage

Your coverage continues by the payment of premiums for a maximum period of 12 months while you are on an approved leave of absence, layoff, strike, maternity leave or compassionate care leave. This provision ends on the earlier of the date you return to active full-time employment, the policy is terminated or at the end of the 12-month period.

education

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

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

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

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

home alteration and vehicle modification

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

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

to whom are benefits paid?

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

exclusions

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

claim procedures

To make a claim under this plan, written notice of the accident must be given to RBC within 30 days of the date of the accident and written proof must be submitted within 90 days of the date of the accident. RBC provides the necessary claim forms as well as

instructions covering other requirements that may aid in a prompt handling of the claim.

If RBC does not receive the required notice and proof of loss, the claim may not be considered after the 90-day period has expired, unless there is good reason for the delay. In no event is a claim considered after one year from the date of the accident if RBC was not notified and the necessary forms not completed and submitted to RBC.

disclaimer

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

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

collecting your personal information

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

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

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

using your personal information

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

- to verify your identity and investigate your personal background;
- to issue and maintain insurance products and services you may request;
- to evaluate insurance risk and manage claims;
- to better understand your insurance situation;
- to determine your eligibility for insurance products and services we offer;
- to help us better understand the current and future needs of our clients;
- to communicate to you any benefit, feature and other information about products and services you have with us;
- to help us better manage our business and your relationship with us; and
- as required or permitted by law.

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

In the event our service provider is located outside of Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is

located. Third parties may include other insurance companies, the MIB, Inc. and financial institutions.

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

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

your right to access your personal information

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

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

continuation of coverage

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

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

exclusions

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

claim procedures

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

If RBC does not receive the required notice and proof of loss, the claim may not be considered after the 90-day period has expired, unless there is good reason for the delay. In no event is a claim considered after one year from the date of the accident if RBC was not notified and the necessary forms not completed and submitted to RBC.

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

weekly indemnity benefit

Provided you are eligible and provide sufficient medical evidence from your physician, a benefit of $675 weekly will be paid to you if you become disabled and are unable to work as the result of a non-occupational accident or sickness. Benefit payment commences on the 1st day of a non-occupational accident, and the 8th day of a non-occupational sickness. If you are hospitalized before the 8th day of sickness, benefits commence on the 1st day of hospitalization. If a surgical procedure is performed on an out-patient

basis in a general hospital, benefits will commence on the date the surgery was performed.

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

If your disability is incurred during the reporting period (lag month), you will be considered disabled from the date on which you qualify for full coverage under the Plan.

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

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

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

how to claim for weekly indemnity:

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

- Contact your doctor immediately upon becoming

disabled. You must be seen and treated during the time of your disability.

- Obtain a claim form from the Union office or the Plan Administrator's office and note instructions concerning an E.I. sick claim.
- Complete the form where indicated and have your doctor complete the physician's portion of the form.
- Send the completed form to the Plan Administrator without delay.
- Claim cheques will be sent directly to your home address.
- Claims for disability must be submitted no later than 30 days after your total disability begins.

right to recover

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

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

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

Receiving any funds loaned to you by the Plan is optional, but if received, must be repaid to the Plan in full.

third party liability

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

recurrence of former ailments

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

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

exclusions and limitations

No benefit will be paid for periods of disability:

- during which you are receiving or eligible to receive E.I. sick benefits;
- arising from occupational accident or illness, as these are covered by the WorkSafe BC Act or workers compensation legislation;
- arising from your commission of or attempt to commit an assault or criminal offense;
- arising from self-inflicted injuries or sickness;

- arising from substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician;
- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service;
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from E.I., or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence;
- if you become disabled during a strike or lockout at your place of employment, your rights to benefits will be reinstated when the strike or lockout ends;
- arising from an automobile accident except as a fully repayable loan.

termination of benefit payments

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

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

- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire; or
- you die.

long term disability

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

The qualifying disability period starts when you first become Totally Disabled and ends after 365 days provided your disability is continuous and you are under age 60. If the disability is not continuous, the days you are disabled will be accumulated to satisfy the qualifying disability period provided:
- no interruption is longer than 2 weeks; and
- the disabilities arise from the same or related dis ease or injury.

Coverage terminates on the date you attain age 60 or retirement, whichever is earlier.
LTD benefits are taxable.

LTD coverage is not provided for exempt or associate members.

how LTD benefits work

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

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

definition of total disability

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

recurrent disability

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

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

offsets

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

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

all source maximum

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

exclusions and limitations

LTD benefits are not payable for the following:

1. for any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of disability during which you are not participating in the treatment program recommended by said physician;
2. for any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;
3. for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addition, unless you are participating in a recognized substance withdrawal program;
4. disabilities resulting from self-inflicted injuries or attempted suicide;
5. disabilities as a result of participation in a war, riot, insurrection or criminal act;
6. disabilities resulting from an automobile accident except as a fully repayable loan;
7. for the portion of a period of disability during which you are
    - imprisoned in a penal institution; or
    - confined in a hospital, or similar institution, as a result of criminal proceedings;
8. any period of disability, or portion thereof, during any leave of absence (including maternity leave);
9. a disability which starts on or after the date a strike begins, except as outlined in the

Master Policy; however, an employee, may commence to fulfill their qualifying disability period from the date of disability;

10. to an insured individual who refuses to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending physician or on the advice of independent medical opinion;

subrogation

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

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

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

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

disability case management program

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

will work with you, your employer and your physician to assist you to recover and return to the work place.

rehabilitative employment

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

canadian residency requirement

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

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

extended health benefits

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

The extended health benefit is designed to help you pay for specified services and supplies incurred

by you and your eligible dependents, when not provided under a government health plan or by a tax supported agency.

Upon qualifying for coverage, you will receive a pay-direct card (one if you have single coverage or 2 cards if you have dependent coverage – both will be in the member's name).

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

prescription drugs

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

The Plan provides coverage for prescription drugs and medicines which require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits. Drugs and medicines are limited to a 34-day supply (100 days for long term therapy drugs). Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Drugs and medicines that can normally be purchased “over the counter” are excluded regardless of a prescription having been issued. Fertility drugs, smoking cessation drugs and products, vitamins, preventative drugs, dietary foods and supplements are excluded. Vitamin B12 for the treatment of pernicious anemia only, insulin preparations for diabetics and allergy extracts and serums with a DIN # and that are administered by a physician are covered.

There are a number of prescription drugs which are not eligible under PharmaCare’s standard drug formulary, but may be eligible under their Special Authority Program. You may be requested by the Plan to have your doctor apply for Special Authority for one or more of the drugs you have been prescribed.

Should PharmaCare approve the application for Special Authority, such drugs will be applied towards your annual PharmaCare deductible.

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

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

prescription drug prior authorization program

There are a number of prescription drugs which will now require prior authorization before they can be determined eligible under the Plan. A listing of these drugs can be found online at:
https://www.telus.com/en/health/prior-authorization-forms

If your doctor prescribes a drug for you or one of your eligible dependents, that is on the prior authorization listing, when you take your prescription to the pharmacy, your pharmacist will be advised that you must obtain prior authorization first. You will then need to download the applicable prior authorization (PA) form for that drug from:
https://www.telus.com/en/health/prior-authorization-forms
and complete the patient section, have the prescribing physician complete their section of the form, and then send the completed form to where indicated.

This information will be reviewed, and it will be determined whether the required eligibility criteria is met. The decision will be communicated directly with the patient or individual indicated by the patient on the form. If deemed to be eligible, an exception will be added to that patient's Plan record so that the pay-direct card will accept that drug going forward according to the terms of the approval.

It's recommended that you refer to the prior authorization listing while you are with your doctor, so that if a drug they intend to prescribe is on the Listing, the applicable prior authorization form can be downloaded, printed, and completed before you leave your doctor's office. If you need assistance accessing a prior authorization form, you can contact the claims customer service department at D.A. Townley.

If the prescribed drug is one that must be coordinated with Provincial Fair PharmaCare under Special Authority, you will also be advised to ask that your doctor apply for Provincial Special Authority for that drug on your behalf. This will not impact your ability to fill your prescriptions if it's approved under the Prior Authorization Program, but in order to ensure continued eligibility, the decision from Fair PharmaCare must be received by D.A. Townley within 90 days of the request.

ambulance services

Charges in excess of the amount payable under your Basic Medical Plan for professional licensed ambulance service in an emergency including transportation by railroad, boat or airplane, or in acute emergency by air ambulance, from the place where the injury or sickness occurs to the nearest acute general hospital and return fare, including round trip fare for one attending person (doctor, nurse, first aid attendant), where necessary.

hospital

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

out-of-hospital private duty nursing services

Charges up to a maximum of $25,000 per lifetime, when medically necessary and with a physician's

referral. Services must be for nursing care, and not for custodial care.

paramedical practitioners

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

other eligible expenses

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

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

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

Charges for surgical stockings to a maximum of 2 pair per calendar year.

Charges for stump socks.

Hearing aids up to a maximum of $500 per lifetime or $400 every 60 months for dependent children. Batteries and routine maintenance are not covered. (paid at 100% for disabled/associate members up to $500 per lifetime).

Charges for surgical brassieres up to two per calendar year.

One pair of custom fitted orthopedic shoes or one pair of custom orthotics per person per calendar year when prescribed by a physician or podiatrist up to a calendar year maximum of $350 per person.

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

Charges made by a dentist for the repair or replacement of sound, vital, natural teeth or the setting of a fractured or dislocated jaw under certain conditions. Wigs and hairpieces required as a result of medical treatment or injury, up to a lifetime maximum of $500 per person.

Non-emergency Eligible Expenses incurred while traveling outside your province of residence (subject to Plan limits).

standard durable medical equipment

(Preauthorization is required from the Plan Administrator for expenses in excess of $5,000)

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

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

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

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

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

vision care

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

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

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

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

d) prescription sunglasses;

e) laser eye surgery; and

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

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

medical examinations

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

medical referral benefit

The medical referral benefit provides coverage for eligible Members under the age of 70 and their eligible dependents for reasonable and customary charges for medical and transportation expenses in excess of those expenses covered by the insured person's government health insurance plan, Health Insurance Plan or EHC plan, for the insured person and an approved escort, up to a lifetime maximum of $75,000 per person, as a resulto f a pre-approved medical referral for treatment, subject to the following conditions:

a) the treatment must not be available within 500 kilometres from your residence; and

b) the medical referral service must be obtained in Canada, if available, regardless of any waiting lists; and

c) your attending Canadian physician and a qualified Canadian medical specialist from an appropriately related medical field must recommend the treatment; and

d) the referral service must be eligible for reimbursement and paid in whole or in part by

your government health insurance plan or Health Insurance Plan (a written pre-authorization from your government health insurance plan or Health Insurance Plan outlining their liability is required); and

e) if your government health insurance plan, Health Insurance Plan or EHC plan covers and reimburses the full medical referral expenses, no benefits are payable; and

f) the treatment must not be experimental or investigative in nature; and

g) medical services and travel must take place within 30 days of receiving approval from your government health insurance plan or Health Insurance Plan, unless the earliest possible treatment date exceeds 30 days from the date of approval; and

h) the medical referral must be pre-approved, following submission of a request for pre-approval in writing to Global Excel, along with supporting documentation.

out of province/canada emergency medical travel insurance

Emergency Medical Travel Insurance provides coverage for eligible Members under the age of 70 and their eligible dependents for certain expenses incurred as a result of an emergency while travelling outside your province. You and your eligible dependents must be covered under a Provincial Medical Plan. This travel insurance is underwritten by the Manufacturers Life Insurance Company (Manulife). Manulife has appointed Global Excel Management (Global Excel) as the provider of all assistance and claims services under this policy.

Coverage Period: 90 days per trip

Policy Number: DAT00013345

Emergency Out of Country coverage has a maximum of $5 Million per coverage period.

IF YOU HAVE AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY BEFORE SEEKING TREATMENT. THEY ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK AND CAN BE CONTACTED BY CALLING:

From Canada and the United States,
call TOLL FREE 1-833-685-2790

From anywhere else in the world,
call COLLECT + 519-735-9448

You must notify Global Excel before obtaining emergency treatment, so that they may:

- confirm coverage
- provide pre-approval of treatment

If it is medically impossible for you to call prior to obtaining emergency treatment, call or have someone call on your behalf as soon as possible.

If you fail to notify Global Excel, the Insurer reserves the right to limit your benefits as follows:

- The Insurer will not pay expenses for benefits that are not approved by Global Excel, if pre-approval is required; and
- In the event of hospitalization, 80% of eligible expenses, based on reasonable and customary charges, to a maximum of $25,000; and
- In the event of an outpatient medical consultation, a maximum of one visit per sickness or injury.

You will be responsible for payment of any remaining charges.

Some treatments require pre-approval in order to be covered (for more details refer to full Emergency Medical Travel Insurance Booklet, available from the Plan Administrator).

If you do not contact Global Excel prior to seeking treatment, the medical treatment you receive may not be covered by this insurance.

Global Excel can direct you to a medical facility or doctor in your area of travel. If you contact Global

Excel at the time of your emergency, they will ensure that your covered expenses are paid directly to the hospital or medical facility, where possible.

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your coverage before you travel, as your coverage is subject to certain limitations and exclusions.

Pre-existing medical condition exclusions may apply to medical conditions and/or symptoms that existed before your trip. Refer to your Schedule of Benefits outlined above your Manulife/Global Excel Assistance Wallet Card to determine how these exclusions affect your coverage and how they relate to your departure date. In the event of a claim, your medical history will be reviewed after a claim has been reported.

Your insurance provides travel assistance. You are required to contact Global Excel prior to treatment. Failure to do so limits benefits.

Coverage is for an unlimited number of trips up to the coverage period for each trip (90 days per trip); however, each trip must be separated by a return to your province.

Coverage must be in effect before you leave your province. You do not need to provide advance notice of your departure date and return date for each trip. However, you will be required to provide evidence of these dates when filing a claim, for example, an airline ticket or boarding pass.

A Manulife/Global Excel Assistance Wallet Card, with worldwide contact numbers, for the Emergency Medical Travel Insurance coverage should be carried by the Insured when travelling. These cards, along with the Schedule of Benefits and the full Emergency Medical Travel Insurance booklet can be obtained from the Plan Administrator.

Members working outside of Canada must independently arrange for additional coverage.

claims procedures - emergency out of province/canada expenses

You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim:

If in Canada or the United States,
call toll free at: 1-833-685-2790

From anywhere else in the world,
call collect to: + 519-735-9448

During your call, you will be given all the information required to file a claim.

You will be asked to substantiate your claim by providing all required documents. Failure to do so may result in non−payment of your claim. The Insurer is not responsible for fees charged in relation to any such documents. Incomplete documentation will be returned to you for completion.

When making a claim, you may be required to complete a Claim & Authorization Form along with providing supporting documentation such as:

- Complete original unused Transportation or Return of Travel Companion benefit is used.
- All original itemized bills from the medical provider(s) stating the patient's name, diagnosis,all relevant dates and type of treatment, and the name of the hospital or medical facility and/or physician.
- All original prescription drug receipts (not cash receipts) from the pharmacist, physician, hospital or medical facility showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.
- Proof of your departure date and return date. While boarding passes are preferred, airline tickets or other proof of departure date from your province, may be accepted, provided it contains your name and the location and date of your purchase.
- Any other additional documents pertinent to your claim, as may be required by Global Excel.

All sums under this Plan are in Canadian currency unless otherwise indicated. If you paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Any information not provided may result in a delay in processing your claim. All pertinent documents should be sent to:
Global Excel Management Inc.
73 Queen St.
Sherbrooke, Quebec J1M 0C9

Online Claim Submission:
Visit **https://manulife.acmtravel.ca** to submit your claim online. For faster and easier submissions, have all your documents available in electronic format, such as a PDF or a JPEG.

exclusions and limitations

There are items that are not covered under the extended health benefits for members and their dependents, including but not limited to:

- Expenses for benefits, care or services payable by or under the Basic Medical Plan, PharmaCare, any Hospital Program or the WorkSafe BC Act, whether or not a claim is made thereunder or provided without cost or at nominal cost by any public or tax-supported authority or agency or for which you or your dependent can recover from another party;
- Expenses of dental services or care or dentures except as specifically provided in this booklet;
- Any portion of fees in excess of the usual or recognized fees for the service performed;
- Expenses incurred outside the Province of British Columbia unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out-of-Province/Canada Emergency Expenses;
- Expenses for services and/or supplies for cosmetic purposes;
- Medical Cannabis in any and all of its forms;

- Expenses caused, contributed to or necessitated as a result of:
    - war or any act of war or participation in a riot or civil insurrection;
    - injury or sickness which was intentionally self-inflicted, whether sustained or suffered while sane or insane;
    - occupational illness or injury; or
    - the commission by the person of any unlawful act including an offense under the Criminal Code of Canada
- Any expenses that a covered person may obtain as a benefit under any government plan or law;
- Any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging which represents an amount in excess of the schedule of costs prescribed by the Medical Services Plan.

dental benefits

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

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

basic services

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

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

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

preventative services – all necessary procedures to prevent the occurrence of oral disease, including:
- Cleaning (limited to twice in any calendar year)
- Scaling and root planning
- Topical application of fluoride (limited to two applications in any calendar year)
- Pit and fissure adhesive sealants (limited to once per tooth every 24 months)
- Fixed space maintainers on primary teeth for dependent children under 18.

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

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

prosthetic repairs and maintenance
- Repair if a 6-month period has elapsed since the last date on which the dentures were provided.

- Denture maintenance, after the 3-month post insertion care period, including:
    - relines and rebase – a combined limit of 1 per upper and 1 per lower prosthesis in a 2-year period
    - tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5-year period

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

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

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

anesthesia – general anesthesia required in relation to oral surgery.

major services

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

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

- Initial installation of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Partials may only be provided by a dentist
- Initial placement of a crown or veneers and their replacement if at least 5 years has lapsed
- Replacement of an existing full or partial denture, or fixed bridgework, if the existing denture or fixed bridgework was installed 5 years before its replacement and cannot be made serviceable (no benefit is payable for the replacement of dentures that are misplaced, lost or stolen)

- Bruxing guards – 2 appliances in a 5-year period (no benefit is payable for the replacement of lost, broken or stolen bruxing guards).

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

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

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

orthodontia (dependent children under 21 and adults)

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

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

pre-treatment estimate of major restorative & orthodontic charges

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

alternative services

If alternative services may be performed for the treatment of a dental condition, the maximum amount

shown in the Suggested Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

emergency dental care anywhere in the world

In an **emergency** only, 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 your 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;
- Services or items which would not normally be provided, or for which no charge would be made, in the absence of dental coverage;
- Stainless steel crowns on permanent teeth;
- Protective athletic appliances;
- Anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- Full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- Replacement of a lost or stolen prosthesis;
- Incomplete and temporary procedures;
- Implants;
- Grafts;
- Any dental charge for services which were started prior to the date of coverage;
- Dental treatment which was ordered while covered, (which included lab work and impres-

sions), but was not installed or delivered until more than 31 days after the dental benefit terminated; and
- Travel expenses incurred to obtain dental treatment.

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

how to file a claim
claims for extended health and dental

Use your pay-direct card when you fill a prescription, visit your dentist, visit participating paramedical practitioners, and make vision care purchases. If you do not use your pay-direct card, these expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the **D.A. Townley *My Claims*** portal or mobile app (see page 53 for details).

Alternatively, claim forms for dental and extended health benefits can be printed off the Plan Administrator's website: **https://www.datownley.com/health-benefits/filing-a-claim/** or obtained from the Administrator's office or your Union Office.

Copies of receipts and the completed claim forms should be sent to the Administrator. All receipts must be received by the Administrator within 12 months of the date of service to be considered for payment.

When submitting eligible claims, please be sure to include your full name, address and your certificate number/Client ID. All claims for reimbursement should be forwarded, along with applicable receipts, to the Administrator via:

* the **D.A. Townley *My Claims*** portal or mobile app
* by email to health@datownley.com
* by fax to (604) 299-8136
* mail to **D.A. Townley**
  4250 Canada Way
  Burnaby BC V5G 4W6

coordination of benefits:

1. D.A. Townley complies with the Canadian Life and Health Insurance Association (CLHIA) guidelines for coordination of benefits in effect on the date the eligible expense was incurred.
2. If the you or your dependent is also covered under your spouse's plan or under any other group plan which provides similar benefits, payment will be coordinated and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the eligible expense (for dental, the fee guide applies).
3. The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.
4. The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:
    - the amount that would have been payable had it been the primary carrier, or
    - 100% of all Eligible expenses reduced by all other benefits payable for the same expenses by the primary carrier.
5. If the other plan does not contain a co-ordination of benefits clause, payment under that plan must be made before this Plan will pay under this provision.
6. Extended health plans with dental accident coverage determine benefits before dental plans.
7. If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.
8. You must provide the information required to implement this provision.

It is your responsibility to present a copy of the original claim form and the remittance statement or cheque stub when making further claim under this provision.

member / family assistance program

The member / family assistance program (MFAP) is a voluntary, 100% confidential, short-term counseling and advisory service that connects you and your

eligible family members to a network of dedicated professionals who are available to help 24 hours a day, 7 days a week.

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

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

If you need help, call 1-800-663-1142.

You can also obtain services online by signing up at **www.homeweb.ca**

D.A. Townley *My Claims* portal and mobile app

Go to: **www.datownley.com/myclaims/** and look for *Online Registration* in the resources section on the right side of the page. Click on the link. Complete all the required fields and acknowledge that you have read the terms and conditions. Click on the *Submit* button and it will automatically direct you to the *My Claims* portal. Set up your account on the *My Claims* portal by clicking on *Register Account.* Enter your group number and your Client ID number from your member ID card, along with your postal code and date of birth. Then click *Next.* Set up your username and password. Please note: you can only create one username and password for the same coverage. Then click *Sign Up* and accept the terms and conditions. Now you can download the free **D.A. Townley *My Claims*** app by visting the App Store for IOS devices or Google Play for Android devices. Once downloaded, register your account on the portal and app, then you are ready to sign in using your username and password that you assigned.

direct deposit

If you have not already done so, you can sign up for Direct Deposit for your claims reimbursements. Get your reimbursement faster and have the funds

deposited directly into your bank account rather than waiting for a physical cheque. On the **D.A. Townley *My Claims*** website or app, click on the Person icon on the top navigation. Go to *Update Direct Deposit* and enter your banking information (this can be found on the bottom of a personal cheque, from your online banking app or by calling your financial institution directly.)

rights to copies of documents

Effective July 1, 2012, if an employee/member lives in British Columbia or Alberta, they have the right to request, with reasonable notice, copies of documents that relate to the plan. Legislation allows for them to obtain copies of the following documents:

- Their enrollment form or application for insurance
- Any written statement or other record, not otherwise part of the application, provided to the insurer as evidence of insurability
- A copy of the contract/policy

The first copy will be provided at no cost to the employee/member and a fee may be charged for subsequent copies. All requests for copies of documents should be directed in writing to D.A. Townley.

legal action

Every action or proceeding against the plan for the recovery of benefits payable under the Contract is absolutely barred unless commenced within the time set out in the Insurance Act.

benefits provided by:

Manulife Financial
policy#961442
life insurance
long term disability
policy #DAT00013345
out of province/canada emergency medical travel insurance

RBC
policy #16853
accidental death & dismemberment

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

Homewood Health
policy #1500
member/family assistance plan

Contact us:

D.A. Townley, Plan Administrator
4250 Canada Way
Burnaby BC V5G 4W6

Telephone **604-299-7482**
Toll-Free **1-800-663-1356**
Facsimile **604-299-8136**
Email: **heatandfrostadmin@datownley.com**
(Administration Inquiries)

health@datownley.com
(Claims Inquiries)

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