Joint Electrical Industry's

WELFARE PLAN

Electrical Construction, Maintenance and Related Industries

Address all inquiries to:

THE ADMINISTRATOR

convyta

JOINT ELECTRICAL INDUSTRY'S WELFARE PLAN

501 - 4445 Lougheed Hwy
Burnaby BC V5C 0E4
Email: IBEW@convyta.com
1-844-551-4239 or 1-844-551-IBEW

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

*Including amendments to June 1, 2025

PRIVACY POLICY

The Joint Electrical Industry's Welfare Plan (the "**Plan**") provides a variety of benefits to its Members including Extended Health benefits, Vision benefits, Transportation Assistance, Employee and Family Assistance Plan, Dental benefits, Life Insurance, Accidental Death & Dismemberment Insurance, Long Term Disability and Weekly Indemnity benefits. The Plan is administered by a Board of Trustees (the "**Board**").

The administration of the Plan requires the collection, use and disclosure of Personal Information about Plan Members and their eligible dependents. The Board respects the privacy of our Members. We will only collect, use, and disclose Personal Information in accordance with the *Personal Information Protection Act* (British Columbia) ("**PIPA**") and the *Personal Information Protection and Electronic Documents Act* (Federal) ("**PIPEDA**")

Scope of this Policy

This Policy applies to the Plan, the Board and any agents and delegates retained by the Board. This Policy explains the Board's privacy practices including the steps the Board takes to comply with PIPA, PIPEDA and any other applicable legislation ("**Applicable Law**"). This Policy explains why Personal Information will be collected, used, and disclosed in respect of the Plan, the principles that govern such collection, use and disclosure and the steps that will be followed when Personal Information protection issues arise. The Board has the sole discretion to interpret and apply this Policy and may amend its terms at any time. In no event will this Policy affect or alter the interpretation of the Plan. If there is a conflict between this Policy and the text of the Plan or between this Policy and the Trust Agreement for the Plan, the text of the Plan or the Trust Agreement will prevail as applicable. Nothing in this Policy detracts from other applicable statutes including the *Income Tax Act* (Canada) which creates Personal Information collection, use and disclosure obligations for the Board.

What is Personal Information?

"**Personal Information**" is information about an identifiable individual. Personal Information does not include work contact information, statistical information or information in aggregate that does not identify a particular individual.

What Personal Information Do We Collect?

To administer the Plan the Board needs to collect, use, and disclose Personal Information including, but not limited to:

- name;
- home address and telephone number;
- gender;
- date of birth;
- Social Insurance Number;
- Plan Member ID Number;
- work history, including the number of hours worked;
- information relating to an individual's eligible dependents; and
- banking information.

The Board's need to collect, use, and disclose Personal Information continues during an individual's participation in the Plan and after termination of Membership.

Why Do We Collect Personal Information?

The Board collects, uses, and discloses Personal Information for a variety of purposes including:

- to establish a Member's identity and entitlement to participate in the Plan;
- to communicate with Members;
- to protect both the Plan and its Members from error and fraud;
- to determine an individual's entitlement to benefits under the Plan;
- to administer and pay Plan benefits; and
- to comply with Applicable Law including issuing tax-related forms arising from participation in the Plan.

The Board will endeavor to expressly identify the purposes for which that Personal Information is collected, used, and disclosed when that Personal Information is collected.

Consent

We rely upon your express and implied consent to collect, use, and disclose your Personal Information, except where we are authorized or required by Applicable Law to do so without consent. Upon request, we will inform you

about the purpose for which we are collecting, using or disclosing your Personal Information. If we want to use or disclose your Personal Information for a purpose other than for which it was collected and such other use or disclosure is not permitted by Applicable Law, we will first obtain your consent to do so.

We obtain consent either orally or in writing and your consent may be implied or expressed. Refusal to provide consent may influence your entitlement to participate in the Plan.

Withdrawing Consent

You can withdraw consent at any time, provided you give reasonable notice and there are no legal or contractual impediments to the withdrawal of consent. If you withdraw your consent, there may be consequences for you including your ability to obtain benefits from the Plan. If you are considering withdrawing your consent, please contact the Board's Privacy Officer.

Disclosure of Personal Information

We will disclose Personal Information when reasonably necessary to fulfill the purposes identified and when permitted by Applicable Law. For greater clarity Personal Information may be disclosed when an individual has provided express consent or where consent to disclose is deemed to have been given or is implied. Your Personal Information may be disclosed:

- to an insurer or health care provider involved in your claim for benefits;
- to your employer in respect of your employment history;
- to the administrative service provider retained by the Board to provide day to day administrative services in respect of the Plan.

Consent to disclose Personal Information will not be required if the disclosure is:

- to the Board's legal counsel;
- necessary to collect a debt owed to the Plan or to repay money owed to an individual;
- for the purpose of complying with a subpoena, warrant or order issue or made by an entity with jurisdiction to compel the disclosure;

- made to the administrator of another benefit plan if there is a reciprocity agreement in place and you are working in another jurisdiction; or

- made to a service provider retained by the Plan.

From time to time, we may share your Personal Information with the administrators of related industry pension and benefit plans, for example, we may provide your Personal Information to the administrator of such a plan to obtain information necessary to administer your benefits, update your contact information or enable the other plan to update your contact information, provide information about employer remittances paid to the Plan or respond to inquiries from the administrator about Membership issues.

Care of Personal Information

We are committed to ensuring the security of Personal Information to protect it from unauthorized access, collection, use, disclosure, copying, modification or disposal, and the Board takes special steps in its service provider agreements to ensure that its agents comply with this Policy and Applicable Law. We will keep your Personal Information for as long as necessary to fulfill the identified purposes, for as long as required for legal or business purposes, and/or for as long as necessary to allow you to exhaust any recourse that you may have under Applicable Law. When we no longer need to keep your Personal Information, it is disposed of in a way that maintains its confidentiality.

Access, Information and Correction

Subject to some exceptions, you have the following rights in respect of your Personal Information:

- to access your Personal Information;

- to information about how we have used or disclosed your Personal Information;

- to request that we correct your Personal Information under our control to ensure its accuracy and completeness.

If you want to access your Personal Information, have a question about how your Personal Information is used or disclosed or request a correction, please write to the Privacy Officer. In your request, please provide the following information:

- your contact information (name, address, telephone number and Plan Member ID Number, if you know it);

- the nature of your request (whether you want to access your Personal Information, want information about our use or disclosure of it, or want to correct it);

- the specific Personal Information to which your request relates.

We will try to respond as promptly as reasonably possible and within the time limits set by Applicable Law, usually about 30 days. We will respond to your request as accurately and completely as reasonably possible. If we refuse your request, we will give you reasons for our refusal. We may charge a fee for access to your Personal Information, but before charging you, we will give you a written estimate of the fee. We may require a deposit or the whole fee before releasing the requested information to you.

Privacy-related Inquiries or Complaints

If you want to make a complaint about our collection, use or disclosure of your Personal Information, you must submit your complaint in writing and provide enough detail so that the Privacy Officer will be able to identify you and the Personal Information at issue, and to understand your complaint. Your complaint should also include your contact information (name, address, telephone number and Plan Member ID Number, if you know it) and the date you mailed it or dropped it off at our office. We will stamp your complaint with the date we receive it and will promptly acknowledge receipt. We may contact you to clarify your complaint or request. If you need help putting your complaint in writing or need any other assistance in relation to your complaint, you may telephone the Privacy Officer who will have someone contact you to assist you.

The Privacy Officer will investigate all complaints and the investigation will be fair, impartial, and confidential. The Privacy Officer will respond to your complaint in writing. If the Privacy Officer finds your complaint justified, they will advise you of the measures that will be taken to correct the problem. If the Privacy Officer does not find your complaint justified, they will tell you why in writing. If you are not satisfied with the response you receive from the Privacy Officer, you have a statutory right to file a

complaint with or ask for a review by the Information and Privacy Commissioner for British Columbia at:

Information and Privacy Commissioner for BC
Office of the Information and Privacy Commissioner for British Columbia
PO Box 9038, Stn. Prov. Govt.
Victoria, B.C. VSW 9A4
Phone: (250) 387-5629

Note that there are short time limits by which you must contact the Commissioner and information about the process may be found online (https://www.oipc.bc.ca/for-the-public/) or by calling Enquiry BC (Vancouver: 604-660-2421 and elsewhere in BC: 1-800-663-7867) and asking to be connected to the Information and Privacy Commissioner for BC.

Privacy Officer

The Privacy Officer is responsible for ensuring the Plan complies with this Policy and Applicable Law. If you have a question, you may call, email or write to the Privacy Officer. The Privacy Officer may be contacted at:

Privacy Officer
Plan Administration Office
Email: IBEW@convyta.com
Call: 1-844-551-4239 or 1-844-551-IBEW

Changes to Privacy Policy

We may change this Policy from time to time to ensure that it continues to provide for the protection of our Members' privacy and to ensure that it continues to comply with Applicable Law. You may obtain a copy of our current Policy by contacting our Privacy Officer. This Policy is subject to Applicable Law and if there are any inconsistencies between it and any Applicable Law, this Policy will be deemed to be amended as necessary to comply with Applicable Law.

The following is an outline of the Joint Electrical Industry's 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 Joint Electrical Industry's 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 some portions of the Extended Health Benefits, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act.

SCHEDULE OF BENEFITS

Life Insurance	$100,000 $70,000 (age 65+)
Optional Life	as described herein
AD&D	Same as Life Insurance
Weekly Indemnity	Equal to EI Weekly Max Integrated with EI
Long Term Disability	$1,750 per month
Employee and Family Assistance Plan	
Extended Health Benefits	80%, unless otherwise stated
Prescription Drugs	80%, Generic Substitution
Out of Province/Canada Emergency Medical Travel Insurance	$5,000,000 Maximum Per Coverage Period
Vision Care	100%, $750/24 months
TELUS Health Virtual Care	Online immediate medical support (does not apply to Members self-paying their coverage)
Dental	90% Basic Services 90% Major Services 90% Orthodontia
Transportation Assistance	as described herein

DETAILS OF ELIGIBILITY

Who is eligible?

Any Member of the International Brotherhood of Electrical Workers (IBEW) who is working under a Collective Agreement with Locals 230, 993 or 1003 and such Collective Agreement requires employer contribution to the Plan.

If owner/operators who are Members in good standing wish to participate in the Plan, they must remit a **minimum** of 115 hours each month. If such owner/operators decline to participate or drop out of the Plan, re-entry will not be permitted.

Do any Forms have to be completed?

YES. An Enrolment and Beneficiary card must be completed in full, including a witness signature, and returned to the Plan Administrator's office without delay.

How does a person qualify for coverage?

A Member in good standing must accumulate 150 hours or more of work within a 12 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).

HOURS REPORTED

MONTH	MEMBER A	MEMBER B	MEMBER C
January	50 hours	50 hours	150 hours
February	50 hours	125 hours	lag
March	30 hours	lag	qualified
April	50 hours	qualified	–
May	lag	–	–
June	qualified	–	

Once coverage starts, coverage will continue as long as the Member's Hour Bank contains sufficient hours. Upon qualifying for coverage for the very first time, the Member will be issued two cards (both in the Member's name) if there is dependent coverage. Use the pay-direct card when visiting the dentist, ophthalmologist or optometrist, participating para-medical practitioners, when filling a prescription or making a vision care purchase. Using this card

eliminates the requirement to file a claim – the claim is processed and, if eligible, paid directly at point of sale.

As a Member 100 hours will be withdrawn each month from the Hour Bank. As an Owner/Operator 115 hours will be withdrawn each month from the Hour Bank. A maximum of twelve hundred (1200) hours can be accumulated in a Member's or Owner/Operators Hour Bank which will be drawn upon during a period of poor employment, lengthy illness or extended vacation.

When does coverage end?

Coverage will terminate when there are insufficient hours in the Member's Hour Bank to allow for a deduction of 100 hours or 115 hours if an Owner/ Operator.

Any Member joining a union other than IBEW Locals 230, 993 or 1003, or performs non-union work, except as authorized by the Business Manager of any of the above Union Locals, may result in termination of the Member's eligibility for any and all benefits under the Plan, and any hours deposited to their Hour Bank may be forfeited to the Fund.

Disability Credits

When a Member is collecting benefits under the Weekly Indemnity Plan, EI Sick Benefits, Long Term Disability 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 if approved, the Member's Hour Bank will be credited with contributions of 8 hours, 7 days per week, subject to a maximum of 100 hours per month for Members and 115 hours for Owner/Operators for up to 12 months. The Member or Owner/Operator must request the appropriate form from the Plan Administrator and return the completed form to apply for Disability Credits. To qualify for these Disability Credits, the Member or Owner/Operator must be eligible for benefits when the disability commences.

Maternity Leave

Effective January 1, 2024, Members with active coverage under the Plan, who are birthing parents, can

apply for a freeze of their Hour Bank balance for up to six consecutive months, during the period while such Member is specifically in receipt of EI Maternity Benefits. This provision is intended to provide support while they undergo health and other stresses of late pregnancy, birth and recovering from birth. Such Members will be required to make application with the Plan Administrator for this Hour Bank freeze and continuation of coverage and provide evidence that they are in receipt of EI Maternity Benefits. If approved, while collecting EI Maternity Benefits, the Member's Hour Bank balance will be frozen for up to six months maximum, at which point coverage would be continued based on the availability of sufficient hours in their Hour Bank and, once depleted, the Member would be offered the opportunity to self-pay to continue coverage, according to the existing Plan rules.

Self-Pay

Members in good standing will be entitled to the following coverage on a self-pay basis

i) Those Members who have a residue of employer hours in their Hour Bank or who, 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 100 hours needed each month to give a Member coverage under **"Plan A" or "Plan G" if the Member is 65 years of age or older. Shortage notices do not reduce the maximum months under self-payment.**

ii) If there are no employer hours, a Member has the option of self-paying under,

Plan A **(up to Age 65)**	**Plan B** **(up to Age 65)**
Life Insurance	Life Insurance
AD&D	AD&D
Weekly Indemnity*	Weekly Indemnity*
Extended Health Benefits	Extended Health Benefits
Supplemental Travel	Supplemental Travel
Vision	
Dental	

Plan G **(Age 65+)**	**Plan H** **(Age 65+)**
Life Insurance (reduced)	Life Insurance (reduced)
AD&D (reduced)	AD&D (reduced)
Weekly Indemnity*	Weekly Indemnity*
Extended Health Benefits	Extended Health Benefits
Supplemental Travel	Supplemental Travel
Vision	
Dental	

*Weekly Indemnity claims **must** commence within 3 months of **ceasing to work under the Collective Agreement.**

The first month in which a Member's Hour Bank falls below 100 employer hours, the Fund will absorb the difference out of general revenue. The following month, a Self-Payment or Shortage Hours Notice will be sent to the Member's last known address and self-payment must be returned to the Plan Administrator within one month of the Member's Hour Bank falling below 100 hours. Members are not permitted to self-pay while working within the Trade, except as authorized in advance by their IBEW Business Manager. If it is preferred that the Self-Payment Notice be sent out by email, the Member must contact the Plan Administrator and make this request.

The first 24 months of self-payments are subsidized by the Plan at 50% of the cost of such benefits. After 24 months of self-payments, the Plan will subsidize 30% of the cost of such benefits. As such, the self-pay rates will be adjusted from time to time as deemed appropriate by the Board of Trustees. **Owner/Operators, whose company is active in the Electrical Contracting business, are not permitted to self-pay.**

The coverage available under self-payment is determined based on the Member's age and the cost is determined by the length of time since self-payments commenced.

In order to re-qualify for full benefits under the regular Plan, a Member must return to work and accumulate a minimum of 150 hours in their Hour Bank within a 12-month period.

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 for reimbursement.

Do Not Ignore the Self-Payment or Shortage Hours Notice

If a Self-Payment or Shortage Hours Notice is received and it is believed to be incorrect, contact the Administrator – Convyta Partners:

Email: IBEW@convyta.com
Call: 1-844-551-4239 or 1-844-551-IBEW

The only sure way to provide 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 the Member's Hour Bank for future use.

Can hours be suspended while working for another Local?

Hours can be “frozen” while a Member is covered with another IBEW Local.

Are there any reciprocity agreements with other Locals?

Joint Electrical Industry’s Welfare Plan has Reciprocal Agreements with other IBEW Locals across Canada and the USA. If a Member is working in another Local with whom there is a Reciprocal Agreement in place, the contribution made on their behalf will be transferred to Joint Electrical Industry’s Welfare Plan.

In addition, Reciprocal Agreements have been signed with certain other trades who are members of the BC Building Trades Council. This enables a Member to receive credit while temporarily working out of another jurisdiction.

It should be noted that any contributions submitted on a Member's behalf from another health and welfare plan would be subject to an adjustment in accordance with the hourly contribution rate.

Before leaving BC to work in another IBEW jurisdiction, we suggest that the Member be in contact with the Administrator's office to determine the status of their Health and Welfare coverage.

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 can be covered 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. In advance of this covered dependent reaching the maximum age of 21, application must be made to the Plan Administrator to arrange for continued coverage and the dependent must meet the criteria for such continuation of coverage.

* The legal spouse of the Employee, or in absence of a legal spouse, the common-law spouse of the Employee. The common-law spouse is a person with 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.

"Employee" means an individual who meets the eligibility requirements of the Plan.

When completing application forms 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 the Union Office, complete the form in full, reflecting the changes, and forward it to the Administrator's Office.

If I die do my Dependents remain covered?

If at the time of a Member's death, they were an active Member covered under the Plan, their surviving spouse and dependent children will be permitted to continue their coverage for twelve months on a self-paying basis once the Member's Hour Bank has been exhausted.

If the Member was self-paying, coverage will be continued for the Member's covered surviving spouse and dependent children up to twelve months, on a self-paying basis.

Bereavement

In the event of a death in their immediate family, an employee may apply to receive up to three (3) days bereavement leave at no cost to their Employer. Immediate family will be recognized as the employee's spouse (including common-law spouse), mother, father, mothers-in-law*, fathers-in-law*, step-parents*, sister, brother, son, daughter (including adopted son or daughter), step-children*, grandfather, or grandmother. Additional unpaid bereavement leave may be granted upon request. The employee must have been scheduled to work the time in which they are applying for paid time off. NOTE: The Member must contact their IBEW Local union office for Bereavement Leave (lost wages) reimbursement forms.

*Effective March 1, 2024

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

LIFE INSURANCE

All eligible Active Members and Owner/Operators will be covered for $100,000 of Life Insurance. This coverage will reduce to $70,000 at age 65.

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

If a Member does not designate a beneficiary, the insurance will be payable to their estate.

Continuation of Life Insurance on Termination of Coverage

A Member's life would continue to be insured, at the conversion rate, under the group policy during the 31 day conversion period, whether or not they apply for an individual policy.

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

Life Waiver Benefits

Subject to satisfactory proof, submitted within 12 months from the date the insured person becomes Totally Disabled, an insured person who is under age 65 and who becomes Totally Disabled and continues to be disabled for 6 months, as a result of accident, injury or disease may, 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.

Application must be made within 6 months of the disability date. Members in receipt of WorkSafe Benefits must contact the Plan Administrator to make application within 5 months of the start of their WorkSafe claim.

Living Assistance Benefit

The Living Assistance Benefit is available as an advance payment of a portion of the Life Insurance to help meet the medical or other health and welfare expenses of terminally ill Members. Please contact the Administrator.

OPTIONAL LIFE INSURANCE

Personal Life Insurance through Manulife Financial is available to the Member and their spouse. They can choose the amount of coverage that is right for them.

- Units of $25,000 are available for the Member and their spouse, up to a maximum of $500,000 each*
- A flat $20,000 is available for each child

*for amounts over $100,000 for the Member and $50,000 for the spouse answers to medical questions will be required on their application.

Paying for Personal Life Insurance is handled directly to Manulife Financial through pre-authorized monthly banking or credit card payments.

Members can contact the Plan Administrator for a brochure, application and rates.

Applying is easy. Members simply decide how much insurance they would like to purchase, check the cost, complete the application form and send it directly to Manulife.

Optional Life coverage will continue, provided premium payments are made, and does not terminate if the Member's benefits under Joint Electrical Industry's Welfare Plan end. For questions, call 1-800-268-6195 and provide policy number 888889.

ACCIDENTAL DEATH & DISMEMBERMENT

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

Who is Covered?	Amount of Coverage
All eligible Members under age 65	$100,000
All eligible Members age 65+	$ 70,000
All spouses under age 70	$ 20,000
All eligible dependent children	$ 5,000

Schedule of Losses

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, they will be the insured spouse by default.

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 Sum

Paralysis Benefits

Quadriplegia (complete paralysis of both upper and lower limbs)	Two Times the Principal Sum
Paraplegia (complete paralysis of both lower limbs)	Two Times the Principal Sum
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	Two Times the Principal Sum

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

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

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

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

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

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

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

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

Bereavement Benefit (Employees Only)

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

Brain Damage Benefit

If you sustain an Injury which results in Brain Damage, the insurer will pay the Principal Sum, less any amount paid or payable under "Accidental Death, Dismemberment and Specific Loss Indemnity" of the

policy as the result of the same Accident, provided that:

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

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

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

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

Continuation of 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

If a Member or Owner/Operator becomes disabled and unable to work as a result of an non-occupational accident or illness, they must make application for EI Sickness Benefits, or for WorkSafe benefits, if the accident or illness is work-related.

If the Member or Owner/Operator's application for EI Sickness Benefits is rejected, they may apply for Weekly Indemnity Benefits. Contact the Plan Administrator as soon as possible to apply. A copy of the rejection from EI Sickness Benefits must be provided. If the Weekly Indemnity claim is approved, benefits will commence on the 15th day of a non-occupational accident or illness for up to a maximum of 26 weeks. If the Member or Owner/Operator was approved and in receipt of EI Sickness benefits, but was not eligible for the full 26 weeks of benefits and remains totally disabled and unable to work, the Member may apply for Weekly Indemnity Benefits for the balance of the 26 weeks. A copy of the termination notice from EI Sickness Benefits must be provided.

If the Member or Owner Operator is unable to work due to substance abuse, and they are in a substance abuse rehabilitation centre, and remain there for the full course of treatment, the Member may apply for Weekly Indemnity Benefits without the requirement to apply for EI Sickness Benefits, provided they had full coverage including Weekly Indemnity at the date of entering the treatment facility. If their Weekly Indemnity claim is approved, benefit payments would commence on the 15th day and would be paid a maximum benefit of 5 weeks, provided they remain in the rehabilitation treatment centre for the full course of treatment.

Note: Benefits will not commence prior to the day the Member is seen and treated by a physician. Members or Owner/Operators whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Member or Owner/Operator qualifies for coverage under the Plan.

The maximum number of weeks includes weeks the Member or Owner/Operator is receiving EI Sickness Benefit payments.

* Weekly Indemnity claims must commence within 3 months of **ceasing to work under the Collective Agreement.**

How to claim for Weekly Indemnity:

The Member must take the following steps as soon as possible after becoming disabled:

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

b) Apply for EI Sickness Benefits and provide a copy of the confirmation of eligibility for EI Sickness to the Plan Administrator and request Disability Credits.

c) If the Member is not eligible for EI Sickness Benefits or is not eligible for the full 26 weeks of EI Sickness Benefits, they must contact the Plan Administrator to apply for Weekly Indemnity Benefits and provide a copy of the EI rejection or termination letter. **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 Plan Member Statement and their physician must complete the Attending Physician's Statement. Once completed in full, these must be sent directly to Cooperators, no later than 30 days after total disability begins, unless special circumstances prevent such. Any charge from the physician for completing this form, is the claimant's responsibility.

On what basis are the Weekly Indemnity Benefits paid?

Claim payments are made at the end of each 7 day period on the basis of a 7 day work week up to a maximum of the current EI maximum provided that the Member is not eligible for EI Sickness Benefits, including Saturdays and Sundays.

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.

Benefits will not commence prior to the day the Member is seen and treated by a physician.

Will further medical reports be required?

Yes, depending on the nature of the illness and in addition, the Member may be required to provide additional medical evidence.

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 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 occupational accident or illness, as these are covered by the WorkSafe BC/WBC 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;

- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from EI, or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence;

- during which the insured is receiving or eligible to receive EI 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;

- arising from an automobile accident where a third party may be, directly or indirectly, either in whole or in part, liable to the Member.

TERMINATION OF BENEFIT

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

- the Member is are 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 Owner/Operator 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 Benefit Schedule:

All eligible Members under age 65:	Flat $1,750*
Benefit Waiting Period:	180 days of total disability
Duration Period:	to age 65
Definition of Disability:	2 year own occupation, any occupation thereafter
All Source Maximum:	85% of inflation-indexed, pre-disability earnings.
Taxable Status:	Taxable

*The benefit amount cannot exceed 85% of the Eligible Member's average gross monthly earnings. If the benefit exceeds 85% the benefit will be reduced by the amount that the benefit exceeds the 85% threshold. Benefit increased from $1,500 to $1,750 for claims incurred on or after June 1, 2021.

Benefit Payment Waiting Period

A Member must be Totally Disabled for a period of 28 weeks or for the duration of the Weekly Indemnity benefit period, whichever is greater.

Total Disability Benefit

If a Member becomes Totally Disabled while insured for this benefits, incurs a loss of time from work and a loss of earnings, and remain disabled for longer than the Benefit Payment Waiting Period, the Member will be eligible to apply for the monthly disability income payments described below.

The Member's disability, due to sickness or bodily injury, must require the regular and ongoing care of a legally qualified physician appropriate to the sickness or injury and must prevent them:

- for the first 24 months of benefit payments, from performing the substantial duties of their own occupation, and
- thereafter, from performing any gainful occupation for which they are or may reasonably become qualified by training, education, or experience.

The benefit provider will monitor the quality and appropriateness of medical care and also reserves the right to refer the Member to a specialist for proper ongoing treatment.

Integration of Benefits

The Member's Monthly Integrated Benefit will be their Monthly Benefit reduced by an amount equal to the amount by which their Income from All Sources exceeds the All Source Maximum shown in the Benefit Schedule.

Rehabilitation Programme

While a Member is receiving Long Term Disability benefits, if they participate in an approved rehabilitation programme which is supervised by a physician, they may still be considered Totally Disabled, subject to the continued approval of the benefit provider.

Benefit payments under the plan will be reduced by 50% of their monthly net (after tax) earnings from the rehabilitation programme.

A Member's total amount of income from "all sources" including remuneration from the rehabilitation programme, must not exceed 100% of their inflation-indexed, pre-disability earnings.

Benefit Payment Termination

A Member will stop receiving benefits on the earliest of:

1. attainment of the maximum age as specified under Age Termination in the Benefit Schedule;
2. failure to satisfy any of the following:
    a. furnish written proof satisfactory to the Insurer of their disability,
    b. submit to a medical examination by an independent physician of the Insurer's choice,
    c. accept medical treatment by a specialist covering their disability when requested by the Insurer,
    d. receive medical supervision and treatment,
    e. enter into a rehabilitation programme considered appropriate by the Insurer and its medical advisors,
    f. agree in writing to reimburse the Insurer, following written request to do so, for any amounts paid by the Insurer that are recoverable from a third party;
3. end of disability as outlined in the group policy;
4. death; or
5. commencement of any occupation for wage or profit other than as specifically described in the group policy.

Extension

If a Member's insurance terminates while they are Totally Disabled, the Insurer will pay the same amount as if insurance had not terminated if:

1. the Member is receiving monthly benefits or is completing the Benefit Payment Waiting Period,

2. a physician certifies that the Member was Totally Disabled when insurance terminated, and

3. the Member continues to be Totally Disabled.

However, there is no extension if the Insurer receives "late notice" of disability. "Late notice" means more than 6 months from either: termination of insurance (provinces other than Quebec) or commencement of disability (Quebec).

Recurrent Disability

1. If a Member has satisfied some but not all of the Benefit Payment Waiting Period, returns to work for up to a maximum of 2 weeks, and subsequently becomes disabled as a result of the same or related disability, then the Insurer shall consider the subsequent period of disability as a continuation for the purpose of satisfying the Waiting Period. Only one period of continuation will be allowed per disability.

2. If a Member hase satisfied the Benefit Payment Waiting Period and received Monthly Integrated Benefits, returns to work for up to a maximum period of 6 months, and subsequently becomes disabled as a result of the same or related disability, then the Insurer shall consider the subsequent period of disability as a continuation, and no new waiting period shall be required.

Benefit Offsets

Benefits will be reduced by any amount necessary to limit the income payable (or would have been payable had the Member applied for it):

- as a Long Term Disability Benefit;

- from any job for pay or profit (except under an approved rehabilitation or partial disability program); or

- because the Member is disabled or retired under any plan required or provided by a government or pursuant to a statute, such as, but not limited to, Workers' Compensation and any Automobile Insurance Act; and

- because the Member is disabled or retired under any other group insurance, benefit, or other arrangement for members of a group (whether on an insured basis or not.

to 85% if pre-disability earnings.

Should income be received from any of the above sources payable:

- as a retroactive award, benefit payments will be adjusted to reflect any overpayment that may have been made
- other than monthly, such income will be converted to a monthly basis; or
- in a lump sum payment for loss of future income, no further benefits will be paid until such time as the sum of the benefit payments otherwise payable equals the amount of each sum.

This benefit will not be reduced by income payable from:

a) the Canada or Quebec Pension Plan (CPP/QPP);

b) disability or retirement benefits at the level that the Member was receiving them prior to the date of becoming Totally Disabled under this Benefit; or

c) any individual disability insurance, exclusive of accident benefits payable under an automotive policy;

unless the total amount of disability related income, including benefits described in a) (CPP/QPP) exceeds 85% of the disabled employees pre-disability gross monthly income.

Limitations

1. No benefit will be paid for any disability which directly or indirectly results from:
    a. intentionally self-inflicted sickness or injury;
    b. any act of insurrection or war, or participation in a riot;

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

2. No amount will be payable for any period:

   a. during which the Member is in prison;

   b. during a leave of absence for any reason if they had arranged the leave with their Employer prior to commencement of disability; or

   c. during which the Member is absent from Canada.

3. For a period of disability due to the chronic use of alcohol or drugs (prescribed or otherwise) or the use of any hallucinogen, benefits will be payable for a maximum of 12 months and only if the Member is actively participating in a medically supervised rehabilitation programme approved by the Insurer. The Insurer will also pay their cost for such a programme.

4. No amount is payable for a total disability due to a condition for which the Member was treated or attended by a physician, or for which prescription drugs were taken, within 3 months prior to the effective date of their insurance. This limitation will not apply after the Member has performed all the duties of their regular occupation on a full-time basis for 3 months after the applicable effective date.

Right to Recover

If the Insurer makes any payment of benefits to the Member which they have the right to recover from any other person, the Insurer reserves the right to recover the amount of such payments. The Member will be expected to do everything necessary within their power to secure such rights of recovery.

For a **Long Term Disability claim,** the Member must submit written proof of loss (completed claim form) 6 weeks before the end of the LTD Benefit Payment Waiting Period.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM (EFAP)

The EFAP is a voluntary, confidential, short-term counseling and advisory service that connects Members and their eligible family members to a network of dedicated professionals who are available to give assistance 24 hours a day, 7 days a week, 365 days a year.

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: **jeiwp**
password: **eap**

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

EXTENDED HEALTH BENEFITS

There is a $100 annual deductible per Member or family per calendar year applied to eligible prescription drugs only. In-Canada expenses are reimbursed at 80% unless otherwise indicated and all In-Canada eligible expenses will be reimbursed up to a lifetime maximum of $1,000,000 if under age 65, to a lifetime maximum of $100,000 if aged 65 to 79 inclusive and from age 80 to a lifetime maximum of

$20,000. Benefits in excess of $25,000 provided by Joint Electrical Industry's Welfare Plan self-insured Extended Health Care program will be limited to those expenses incurred within 52 weeks of the date of the covered injury or sickness

Out of Province/Canada Emergency Medical Travel Insurance coverage is provided to eligible Members and their dependents up to a maximum of $5,000,000 per coverage period. For those who are the age of 80 through to 98, there is a pre-existing condition limitation wherein any such condition must be stable for a minimum of 90 days prior to travel.

The Extended Health Plan will cover Members and their eligible dependents. The Member must be prepared to prove that persons claimed as dependents are actually dependent upon them.

Benefits:

The Extended Health Benefit is designed to help pay for specified services and supplies incurred by the Member and their eligible dependents, when not provided under a government health plan or by a tax supported agency.

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

1) Prescription Drugs – present the pay-direct card and prescription to the pharmacist and the prescription drug claim will be adjudicated right at the pharmacy. Using the pay-direct card eliminates the need to send in the prescription receipt and wait for reimbursement. The 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.

   The Plan provides coverage for vaccines (effective August 1, 2024). Vitamins and dietary foods and supplements are not covered. Smoking cessation products will be covered up to a lifetime maximum of $500 per person. Fertility drugs are covered up to a lifetime maximum of $5,000.

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

PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for Fair PharmaCare call 1-800-663-7100 or from the Lower Mainland call 604-683-7151 or visit the BC Fair PharmaCare website:
https://my.gov.bc.ca/fpcare/registration/requirements
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.

Before a drug claim can be reimbursed, GreenShield, the Plan's claims processor, may require prior authorization. Claimants can find out if their drug requires prior authorization by using the online drug search tool available 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.

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, first aid attendant), where necessary. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation arranged at the patient's convenience are not eligible expenses.

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 52-week period. No amount will be paid for services which are custodial and/or services that do not require the skill level of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.). A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GreenShield.

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 after a Hospital stay, and

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

Charges are limited to reasonable and customary Room and Board charges, and the institution's charge, up to a maximum of 120 days. All confinements in a convalescent hospital will be considered as one period of disability unless confinements are separated by at least 90 days.

5) Use the pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, speech therapist, acupuncturist, podiatrist, chiropractor, naturopath or physiotherapist, who is registered and legally practicing within the scope of their license. These charges will be covered at 100% up to a calendar year combined maximum of $1,500 per insured person.

6) Use the pay-direct card for the charges of a registered psychologist. Coverage is provided at 100% up to a maximum of ten (10) visits per calendar year per person. Charges for the services of a registered clinical counsellor or a licensed social worker or a psychotherapist or an addiction therapy counsellor (including those registered with the Canadian Addiction Counsellors Certification Federation) or Valentus Clinics are included in this combined practitioner calendar year maximum.

   Coverage for 100% confidential counseling is also available under the Plan's EFAP benefit provided by TELUS Health at no charge to Members and their eligible dependents.
   one.telushealth.com or 1-844-880-9137.

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

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

9) 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.

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

11) Charges for stump socks.

12) 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;

13) Cataract surgery foldable lens.

14) Custom built orthopedic shoes will be reimbursed at 50% to a maximum of $250 per calendar year when prescribed by a physician or podiatrist and replacements when necessary due to normal wear and tear. Modifications to stock items are not a covered expense.

15) Custom fitted orthotics when prescribed by a physician or podiatrist and replacements when necessary due to normal wear and tear to a maximum of $400 per calendar year. Reimbursed at 50%.

16) 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;

17) 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.

18) 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 60 days of the date of the accident.

19) 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.).

20) Costs of hearing aids to a maximum of $700 in a 5 year period for adults and dependent children. In addition to traditional hearing aids, wireless Bluetooth hearing aids are also eligible. Maintenance, batteries or other accessories will not be covered.

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

22) Use the pay-direct card when visiting a Licensed Optometrist or Ophthalmologist for an eye examination, once every 24 months, with no maximum per examination.

23) Prostate Screening Assessments (PSA Tests)

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 18.

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

d) 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 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 MEDICAL TRAVEL

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. A claimant must be accurate and complete in their dealings with GreenShield at all times. Please take the time to read through this benefit before traveling to be 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 the covered person is temporarily outside of their 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 the covered person's medical information at the time of claim. Any invasive or investigative procedures must be preapproved 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 the covered person's destination or they are able to return to their province/territory of residence for further Treatment. If GreenShield Travel Assistance determines that the covered person transfer to another facility or return to their home province/territory of residence, and they 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 the covered person's province/territory of residence. If hospitalized on the last day, 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 the 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 the provincial/territorial health insurance plan for the covered person and an approved escort. Prior to the commencement of any referral treatment, written preauthorization from the provincial/territorial health insurance plan and GreenShield must be obtained. The provincial/territorial health insurance plan may cover this referral benefit entirely. The covered person must provide GreenShield with a letter from their attending physician stating the reason for the referral, and a letter from their 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.

The covered person must contact GreenShield Travel Assistance for preapproval;

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 the 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 the covered person's 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 the covered person's emergency illness or injury is such that:

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

person is 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 the covered person 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 their 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 personal use motor vehicle to the covered person's residence or nearest appropriate vehicle rental agency when they 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 the covered person 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 the covered person's 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 the covered person or their covered dependent when confined in hospital. This

benefit requires that the covered person must eventually be an inpatient for at least 7 days outside their 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 the covered person or their covered dependent is stolen or rendered inoperabledue to an accident, reimbursement will be made for the cost of a one-way economy airfare to return the covered person and their covered dependents travelling with them, or a Travelling Companion by the most direct route to the major airport nearest their departure point in their 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 the covered person or their 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 their 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, physio-therapist, 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 the covered person or their spouse while travelling:

- Additional cost of one-way economy airfare for the return home of accompanying dependent children when the covered person or their 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 the covered person or their spouse is hospitalized;
- The cost of services of a caregiver (who is not a relative) in their home province/territory when the children are left unattended due to the delayed return of the covered person or their spouse.

Pet Return up to a maximum of $500 for the return of the covered person's accompanying pet(s) in the event the covered person is 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 the Member's GreenShield Identification Card. Quote the GreenShield Identification Number, found on the Member's GreenShield Identification Card, and explain the medical emergency. The GreenShield Identification Number and the covered person's provincial/ territorial health insurance plan number must be provided.

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 the covered person has the required provincial/territorial health insurance plan coverage and GreenShield travel benefits as detailed above.

GreenShield Travel Assistance will follow the progress to ensure that the covered person is receiving the best available medical treatment. GreenShield Travel Assistance also keeps in constant communication with the claimant's family physician

and their family, depending on the severity of their condition.

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

Travel Limitations

1. Coverage becomes effective at the time the covered person or their covered 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 means the covered person will be responsible for all expenses thereafter.

3. After the covered person's medical emergency treatment has started, GreenShield Travel Assistance must assess and pre-approve additional medical treatment. If the covered person undergoes tests as part of a medical investigation, treatment or surgery, obtains treatment or undergoes surgery that is not pre-approved, their 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 they 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 the covered person or their dependent to be confined to a stretcher or for a medical attendant to accompany them during the journey;

    - the covered person or their dependent are admitted directly to a hospital in their 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 nonessential 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 the trip was booked (including delay of travel), or before their 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 the 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 the covered person's departure from their province/territory of residence and the 90-day period immediately preceding their departure from their 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 the provincial/ territorial health insurance plan;

   d) are normally covered under the out-of-Canada benefits of the covered person's 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 the covered person's 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 milliitres 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 physician, pharmacist or other healthcare provider or facility recommended by GreenShield Travel Assistance.

VISION CARE

(eyeglasses/contact lenses)

The Vision Care Plan will cover Members and their eligible dependents. The Member must be prepared to prove that persons claimed as dependents are actually dependent upon them.

Covered Expenses

Use the pay-direct card for the purchase of the following eligible expenses:

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

b) one set of 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 safety glasses.

Payment of Expenses

The maximum amount payable during any period of 24 consecutive months shall be 100% of the actual expense incurred or $750.00, whichever is the lesser for an eligible adult and for dependent children.

For Members only, the Plan will allow a Member to submit and resubmit a receipt for Laser Eye Surgery or Intraocular Lens Implant Surgery which occurred while the Member is covered under the Plan, and while they remain covered under the Plan, a maximum of five Vision Care cycles or until the cost of the procedure is paid in full, if sooner.

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) non-prescription safety glasses;

c) safety goggles (plain or prescription);

d) sun glasses (plain or prescription);

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

TELUS HEALTH VIRTUAL CARE

Provides eligible Members and their families with confidential online virtual access to doctors, medical practitioners and other health care professionals without having to leave home or the workplace, avoiding travel and wait times that come with traditional medical appointments.

TELUS Health Virtual Care provides immediate, professional support from a desktop/laptop computer, tablet or smart phone. Once registered and logged in to TELUS Health Virtual Care, enter your name and the reason for the consult, and a TELUS Health Virtual Care Manager will be accessed to gather the information necessary to connect with the appropriate medical practitioner. The assigned practitioner can address basic physical and mental

medical needs, issue referrals to specialists, issue and renew prescriptions and lab or other diagnostic tests ordered, as appropriate.

To set up an account, visit **virtualcare.telushealth.com/welcome** and have the **Client ID number** from the Member's pay-direct card and use **Group number 4239**. Have government-issued ID handy (Provincial Health Insurance Card, Drivers License or Passport). When prompted enter the email address preferred to use to set up the account, along with province. Select eligibility type and select the option to enter the group number (4239) and personal coverage identifier (the Member's Client ID Number). An activation link will be provided. Follow the link in the email to activate the account. Then sign in with your email address and choose a password.

Now download the TELUS Health Virtual Care app from the App Store or Google Play. Use the account credentials to sign in to the app and enable notifications. Set up a profile under the Profile tab and add any family members. For help, contact **help@vc.telushealth.com**

Everything is now ready to start a consult from the home screen as soon as care is needed.

This benefit is not available to Members who are self-paying for their coverage.

DENTAL PLAN

The Dental Plan will cover Members and their eligible dependents. The Member must be prepared to prove that persons claimed as dependents are actually dependent upon them. The Plan provides pay-direct claims processing using the Member's pay-direct card. Present the pay-direct card to the receptionist when arriving at the dentist's office appointment.

Basic and Major Services have an annual combined maximum of $2,500 per person.

Part I – Basic Services

The following services are eligible for coverage at the lesser of 90% of the amount charged or 90% of the Dental Association Fee Guide (General Practitioner) in the Province of residence.

1) Diagnostic Services

All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:

- Complete oral examinations are limited to one in any three-year period
- Recall oral examinations are limited to two in any calendar year
- Specific examinations
- Consultations (as a separate appointment)
- Dental X-Rays: bite-wing x-rays are limited to one set in any six-month period, full mouth x-rays are limited to one set in any three-year period and panoramic film is limited to one x-ray in any three-year period
- Diagnostic models are limited to reasonable and customary

2) Preventative Services

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

- Cleaning, prophy and topical application of fluoride – two per calendar year
- Scaling and root planing – 16 units per calendar year
- Pit and fissure adhesive sealants
- Fixed space maintainers on primary teeth

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

   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 coverage at the lesser of 90% of the amount charged, or 90% of the Dental Association Fee Guide (General Practitioner) in the Province of residence.

- Inlays, onlays and gold. 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 every 5 years
- Replacement of an existing full or partial denture, once every 5 years
- Fixed bridgework and its replacement if the existing bridgework was installed 5 years prior 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 (adults and dependent children under 21 years of age or 25 if a student)

For orthodontia services performed by an orthodontist payment will be made at 90% to a maximum lifetime limit of $3,000.00. 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.

Part IV – Implants

Effective June 1, 2021, implants (including implant surgery and implant crowns) will be reimbursed at 50% up to a maximum of $3,000 per person every five years. The implant procedure must be performed in Canada and if the implant fails, the Plan will not allow a second procedure earlier than five years from placement.

Pre-Treatment Estimate of Major Restorative & Orthodontic and Implant Charges

Prior to the commencement of 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.

Emergency Dental Care Anywhere in the World

In an EMERGENCY, while the covered person is travelling or on vacation outside of their Province of residence, the covered person is 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 their 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;
- 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

This benefit is available to the Member or an eligible dependent covered under the Plan where transportation exceeding 500 km round-trip* from the patient's residence in BC is medically necessary to obtain medical treatment, diagnostic testing or attend medical appointments. Contact GreenShield and request the Transportation Assistance Claim Form and have the referring physician complete Section 3 in full.

*Except for those eligible claimants who meet all other eligibility criteria but must travel from or through Vancouver Island to the mainland for their medical treatment or medical appointment.

Airfare expense will be reimbursed at 75% and ground transportation by car or bus (or ferry) will be reimbursed at 100%. Transportation expenses will be reimbursed up to a maximum not to exceed 75% of the cost of the round trip commercial economy airfare for transportation within BC or Alberta or the Yukon Territory from the commercial airport nearest to the covered person's residence in BC, 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. Lodging expenses will be reimbursed up to a maximum of three days per trip at a rate not to exceed $75.00 per day.

Covered Expenses

The following expenses shall be eligible for reimbursement:

Transportation Expenses - Actual mileage from the covered person's residence in BC to the location where treatment, diagnostic tests or examinations take place, and the return trip back to the covered person's residence, at the mileage rate posted by Canada Revenue Agency for the calendar year in which transportation expenses are incurred.

OR

Receipts for up to a full tank of fuel on date of departure from the covered person's residence, AND up to a full tank of fuel on the date returning to the covered person's residence AND up to a full tank of fuel upon arrival at the covered person's residence. Dates on receipts must coincide accordingly.

Receipts for Ferry expense, where required, for one passenger vehicle and driver.

Receipts for round trip transportation by bus from the covered person's residence in BC to the location where treatment, diagnostic tests or examinations take place.

A receipt for round trip commercial economy class airfare for transportation within BC or Alberta or the Yukon Territory from the commercial airport nearest to the covered person's residence in BC, 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.

Lodging - In conjunction with transportation charges, lodging expenses up to a maximum of 3 days per trip at a rate not to exceed $75.00 per day, for a patient receiving treatment outside their area of residence, on presentation of the appropriate medical documentation and receipts, will be reimbursed.

Within each calendar year no more than eight (8) 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 75% of the airfare subject to the conditions as outlined, but only if air transportation is involved.

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 WorkSafe BC, Insurance Corporation of British Columbia or any other third party.

d) Any journey where the round trip is less than 500 km, except for those eligible claimants who meet all other eligibility criteria but must travel from or through Vancouver Island to the mainland for their medical treatment or medical appointment.

e) Treatment for services not medically required.

f) Meals and parking.

g) The cost of transportation such as taxi etc., while at the location where treatment is being provided.

How a Claim is Made

1) Contact GreenShield and request the Transportation Assistance Claim Form.

2) Complete Section 1, Section 2 and Section 4 of the form. The referring physician must complete Section 3 in full. Any charge associated with completion of the form is the responsibility of the Member.

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 100% of the actual cost.

CLAIM INFORMATION

Inquiries

For detailed inquiries, contact the 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 a 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 the plan sponsor. This could result in termination of 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 the Member's GreenShield Identification Card.

If a covered person incurs out of pocket expenses, GreenShield Travel Assistance must be advised about all the travel coverage in place 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 a credit card, etc.).

When submitting an Emergency Medical claim, please include:

- Completed and signed claim form provided by GreenShield Travel Assistance when notice of claim has been given, 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 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 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 the Member's 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 setout 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 a Member or their 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, the covered person must advise their lawyer of our subrogation rights.

COORDINATION OF BENEFITS:

If covered for extended health and dental benefits under more than one plan, benefits under this Plan will be coordinated with the other plan so that the claimant 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 Joint Electrical Industry's 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:

Joint Electrical Industry's Welfare Plan Member

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

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

Spouse

If the spouse is a plan member under another benefit plan, this Plan's coverage is always secondary. The spouse must first submit claims to his/her benefit plan.

Children

When dependent children are covered under both this plan and the 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 a Member lives in a province where the law permits them to request copies of their records, the Plan will provide one copy of the following at no charge:

a) any enrollment form the Member has completed for coverage under this plan that was submitted to the Plan Administrator;

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

c) one copy of the group contract.

GreenShield may charge 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 Administered by:

convyta

MANULIFE FINANCIAL #31317
Life Insurance
Long Term Disability
Optional Life #888889

JOINT ELECTRICAL INDUSTRY'S WELFARE PLAN #2600
Weekly Indemnity
Extended Health Care
Vision
Dental
Transportation Assistance

TELUS HEALTH VIRTUAL CARE #4239
Virtual Health Care/Telemedicine

INDUSTRIAL ALLIANCE #100013339
Accidental Death & Dismemberment

GREENSHIELD
Out of Province/Canada Emergency Medical Travel Insurance

TELUS HEALTH #7017
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.

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