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

Including amendments to January 1, 2026

Retired Member Benefits

Plan Administrator:

501 - 4445 Lougheed Hwy
Burnaby BC V5C 0E4

www.hfbenefits.org

privacy policy

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

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

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introduction

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

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

These benefits are provided on a self-payment basis, provided you qualify for such coverage at the time of your retirement.

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

benefit overview

life insurance	• retired before October 1, 2002: **$10,000** • retired October 1, 2002 - March 31, 2004: **$5,000** • retired April 1, 2004 - October 31, 2011: **no life insurance** • retired after November 1, 2011: **$10,000**
extended health benefits	as described within
out of Canada medical emergency coverage	$15,000 maximum (retired members and their depen-ents should pur-chase additional coverage)
dental benefits	as described within
member family assistance program	confidential counseling services for retired members and eligible dependents

eligibility requirements

- you must have at least 10 years of service as a member of the International Association of Heat and Frost Insulators and Allied Workers Union Local 118 and be designated an honorary or exempt member; and
- you must be receiving a pension from the Heat and Frost Local Union 118 Pension Plan; and
- you must be actively covered under the regular benefits provided through the International Association of Heat & Frost Insulators and Allied Workers Union Local 118 Health and Wellness Plan at the time you started collecting that pension; and
- you must enroll, with no break in coverage, within 30 days of termination of your regular benefits through the International Association of Heat & Frost Insulators and Allied Workers Union Local 118 Health and Wellness Plan.

establishing coverage

To establish coverage, you must contact the Plan Administrator, Convyta, at the time you wish to retire and confirm your eligibility for retired member benefit coverage.

Once the Plan Administrator confirms your eligibility to participate, you will be asked to select which coverage you'd like to be enrolled in and you will need to complete an authorization form to allow your self-payments for coverage to be deducted from your pension payments each month. You may opt out of dental coverage, however, you will not be permitted to opt in again at a later date.

CAUTION: If you are considering opting out of Dental coverage, which you are being offered and have access to, in order to join the federal Canadian Dental Care Plan (CDCP), please review the eligibility rules for the CDCP beforehand.

It's recommended you complete a new Enrolment and Beneficiary card to ensure your information with

the Plan Administrator is current and to ensure you have assigned your desired beneficiary. Please ask for an Enrolment and Beneficiary card from the Plan Administrator.

Upon establishing coverage, your pay-direct cards from your active Member coverage will be replaced by two new pay-direct cards (both in the Member's name). You will need to advise your providers of your new card information.

You can use the pay-direct card when you visit your dentist (if you have not opted out of Dental coverage), when you visit participating paramedical practitioners, and when you fill a prescription. Using your card eliminates the requirement to file a claim - your claim is paid directly at point of sale.

termination of coverage

Coverage will terminate on the earliest of the following:

- upon the Plan Administrator being advised by you that you wish to terminate your coverage and discontinue self-payments to the Plan;
- upon your death. Your spouse will be covered for the balance of the month that has been paid for.

dependents

The Plan will provide the extended health benefit and dental benefit (if dental was not opted out) for:

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

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

life insurance

Amount of life insurance for Members who retired:

Prior to October 1, 2002: $10,000
On or after October 1, 2002
but before April 1, 2004:.....$5,000
On or after April 1, 2004 but
before November 1, 2011: .....Nil
On or after November 1, 2011:.....$10,000

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

In the event of a Member's death, the Plan Administrator should be contacted as soon as possible.

extended health benefits

- $50 calendar year deductible per person per family (does not apply to prescription drugs)

- $50,000 lifetime maximum
- In-Canada eligible non-prescription drug expenses covered at 70%
- Out of Canada (emergency) eligible expenses reimbursed at 100% ($15,000 lifetime maximum)
- Pay-Direct Prescription Drugs
    - 100% coverage for all BC Fair PharmaCare-eligible drugs
      60% coverage for all other eligible drugs
    - $50,000 lifetime maximum on prescription drugs

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

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

prescription drugs

Provide your pay-direct card to your pharmacist to update their records with your most current card information.

Before your drug claim can be reimbursed, GreenShield may require prior authorization. You can find out if your drug requires prior authorization by using the online drug search tool available to you through the GreenShield+ member portal or by contacting GreenShield's Customer Service Centre at 1-888-525-7587. IMPORTANT: Do not fill/pay for a prescription before completing the prior authorization process (if prior authorization is required for the drug you have been prescribed) - authorization decisions will not be backdated.

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

customer service department at GreenShield at 1-888-525-7587. If the prescribed drug is one that must be coordinated with Provincial Fair PharmaCare under Special Authority, you will also be advised to ask that your doctor apply for Provincial Special Authority for that drug on your behalf.

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.

If the drug you are filling is one which is covered under the BC Fair PharmaCare Plan, this Plan will cover the drug at 100% of the reasonable and customary cost. If the eligible drug is not covered by Fair PharmaCare, the cost of the drug will be covered at 60% and you will be asked to pay the 40% balance of the cost directly to your pharmacy.

Using your pay-direct card eliminates the requirement for you to pay for your prescription and wait for reimbursement from the Plan. In order to reduce your out of pocket costs, advise your doctor that your Plan will cover 100% of the cost of drugs that are recognized by Fair PharmaCare and to wherever possible prescribe the Fair PharmaCare eligible drug to treat your condition. Most doctors are familiar with the first-line therapies on Fair PharmaCare's drug formulary, but if there is any uncertainty, they can contact GreenShield or your pharmacist or look up the drug here: https://pharmacareformularysearch.gov.bc.ca/

In cases where your doctor has applied under Special Authority for coverage of a drug that is not on Fair PharmaCare's drug formulary and it is approved, please provide a copy of such approval to GreenShield and an exception can be made to cover that drug at 100% by the Plan under the same terms of approval

granted by PharmaCare. If your spouse has his/her own coverage, his/her prescriptions must be paid first by their Plan, with any balance unpaid submitted to your Plan.

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

- drugs for the treatment of erectile dysfunction and infertility;
- vitamins that do not legally require a prescription;
- smoking cessation oral drugs;
- products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required, unless specifically identified and included as eligible;
- ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage;
- mixtures, compounded by a pharmacist, that do not conform to GreenShield's current Compound Policy.

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

ambulance services

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

hospital

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

out-of-hospital private duty nursing services

Reimbursement for the services of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) in the home on a visit or shift basis, up to a lifetime maximum of $25,000 (not to exceed the Plan's $50,000 overall extended health benefit lifetime maximum. No amount will be paid for services which are custodial and/or services that do not require the skill level of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.). A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GreenShield.

paramedical practitioners

You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a Speech Language Pathologist, Acupuncturist, Registered Psychologist*, Podiatrist, Chiropractor, and Naturopath, who is registered and legally practicing within the scope of their license. These charges will be covered up to a calendar year maximum of $400 per insured person per practitioner type. Charges for a Registered Massage Therapist and Physiotherapist will be covered up to a calendar year maximum of $3,250 per insured person per practitioner type, not to exceed the Plan's $50,000 overall extended health benefit lifetime maximum.

*Effective January 1, 2026 the services of a Registered Clinical Counsellor, Registered Therapeutic Counsellor, Licensed Psychotherapist, Licensed Social Worker or Master of Social Work are included with Registered Psychologist with a combined calendar year maximum of $400 per insured person.

other eligible expenses

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

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

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

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

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

Charges for stump socks.

Charges for surgical brassieres up to two per calendar year.

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

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

- Custom-made foot orthotics or repairs to custom-made foot orthotics. Custom-made foot orthotics means devices made from a 3-dimensional model

of an individual's foot and made from raw materials. These devices are used to relieve foot pain related to biomechanical misalignment to the feet and lower limbs;

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

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

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

standard durable medical equipment

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

Usually, the Plan covers standard durable medical equipment when rented from a medical supplier and will be reimbursed monthly. Standard durable equipment includes a variety of items but are not limited to

- manual wheelchairs, manual type hospital beds,
- medical monitors including heart and cardiac screeners
- breathing machines and appliances
- transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain - one every 60 months

- transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

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

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

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

out-of-province/Canada emergency expenses

Coverage period is 90 days per trip and overall maximum per insured person is $15,000 per lifetime. **It is STRONGLY recommended that you purchase private emergency travel insurance before travelling outside of your province of residence.**

exclusions and limitations

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

- Expenses for benefits, care or services payable by or under the Basic Medical Plan, PharmaCare, any Hospital Program or the WorkSafe BC Act, whether or not a claim is made thereunder or provided without cost or at nominal cost by any public or tax-supported authority or agency or for which you or your dependent can recover from another party;

- Expenses of dental services or care or dentures except as specifically provided in this booklet;
- Any portion of fees in excess of the usual or recognized fees for the service performed;
- Expenses incurred outside the Province of British Columbia unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out-of-Province/Canada Emergency Expenses;
- Expenses for services and/or supplies for cosmetic purposes;
- Medical Cannabis in any and all of its forms;
- Expenses caused, contributed to or necessitated as a result of:
  - war or any act of war or participation in a riot or civil insurrection;
  - injury or sickness which was intentionally self-inflicted, whether sustained or suffered while sane or insane;
  - occupational illness or injury; or
  - the commission by the person of any unlawful act including an offense under the Criminal Code of Canada
- Expenses incurred for orthoptic treatment, eyeglasses, contact lenses, hearing aids, or prescriptions for any of them;
- Any expenses that a covered person may obtain as a benefit under any government plan or law;
- Any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging which represents an amount in excess of the schedule of costs prescribed by the Medical Services Plan.

dental benefits

(If dental coverage was opted for)

- Pay-direct claims processing using your pay-direct card – present your card at your dentist's office
- No calendar year deductible
- 70% reimbursement for Basic Services, 50% for Major Services (covers full or partial dentures only)

- $1,000 per calendar year maximum per person for Basic & Major Services combined

basic services

The following services are eligible for payment. The amount payable will be calculated using the lesser of the amount charged or the fee shown in the Dental Association Fee Guide (General Practitioner) in the Province of residence paid at the indicated reimbursement level.

Basic Diagnostic and Preventive Services:

- complete oral examinations once every 3 years;
- emergency and specific oral examinations;
- complete series of X-rays;
- panoramic X-rays once every 24 months;
- bitewing X-rays once per recall period
- recall examinations twice per calendar year;
- cleaning of teeth, up to 1 unit of polishing plus up to 1 unit of scaling once per recall period;
- topical application of fluoride once per recall period;
- denture cleaning once per recall period;
- pit and fissure sealants once every 24 months
- space maintainers eligible for dependent children age 17 and under;

Basic Restorative Services:

- amalgam, tooth coloured filling restorations and temporary sedative fillings;
- inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam.

Basic Oral Surgery:

- extractions of teeth and/or residual roots.

General anaesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery only.

comprehensive basic services

Standard Denture Services:

- denture adjustments and remount and equilibration procedures, only after 3 months have

elapsed from the installation of a denture;
- denture repairs and/or tooth/teeth additions only after 6 months have elapsed from the installation of a denture;
- standard relining and rebasing of dentures, limited to one upper and one lower every 24 months combined, only after 3 months have elapsed from the installation of a denture;
- soft tissue conditioning linings for the gums to promote healing two upper and two lower every 60 months, only after 3 months have elapsed from the installation of a denture;
- remake of a partial denture using existing framework, once every 5 years;

Comprehensive Oral Surgery:
- surgical exposure, repositioning, transplantation or enucleation of teeth;
- remodeling and recontouring – shaping or restructuring of bone or gum;
- excision – removal of cysts and tumors;
- incision – drainage and/or exploration of soft or hard tissue;
- fractures including the treatment of the dislocation and/or fracture of the lower or upper jaw and repair of soft tissue lacerations;
- maxillofacial deformities – frenectomy – surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth.

Endodontic Treatment
- root canal therapy – retreatments of a previously treated tooth will be eligible only if the original treatment fails after the first 18 months;
- pulpotomy (removal of the pulp from the crown portion of the tooth);
- pulpectomy (removal of the pulp from the crown and root portion of the tooth);
- apexification (assistance of root tip closure);
- apical curettage, root resections and retrograde fillings (cleaning and removing diseased tissue of the root tip);
- root amputation and hemisection;
- bleaching of non-vital tooth/teeth;
- emergency procedures including opening or draining of the gum/tooth.

Periodontal Treatment

- treatment of diseased bone and gums;
- periodontal scaling and/or root planing 8 time units every 12 months;
- occlusal equilibration – selective grinding of tooth surfaces to adjust a bite 8 time units every calendar year;
- gingival curettage once per sextant every 60 months

The fees for periodontal treatment are based on units of time (15 minutes per unit) and/or number of teeth in a surgical site in accordance with the General Practitioners Fee Guide.

- bruxism appliance, limited to one every 24 months;

alternate benefit clause

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

predetermination

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

Failure to submit an estimate before treatment begins will delay the assessment of your claim.

limitations

1. Laboratory services that are in excess of 67% of the dentist's fee in the applicable Fee Guide shown in the Summary of Benefits will be reduced

accordingly. Laboratory services must be completed in conjunction with other services and reimbursement is limited to the same percentage as the service for which the laboratory service was received.

2. Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standard and/or basic services, supplies or treatment will remain your responsibility.

3. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Summary of Benefits.

4. If this plan includes endodontic services, reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy, calcified canals, and retreatments occurring within the first 18 months of the original treatment are not included. The total fee for root canal therapy includes all pulpotomies and pulpectomies performed on the same tooth.

5. Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36-month period.

6. When more than one surgical procedure, including multiple periodontal surgical procedures if this plan covers periodontics, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor.

7. The multiple services factor occurs when a

minimum of 6 or more restorations (fillings) or multiple periodontal services, if this plan covers periodontics, are performed at the same appointment and the full fee guide price is charged for each restoration or periodontal service, the first service will be paid in full and all remaining services will be reduced by 20%.

8. If this plan includes coverage for major services (crowns), core build-ups are eligible only for the purpose of retention and preservation of a tooth when performed with crown treatment. Necessity must be evident on mounted pre-treatment X-rays. Core build-ups to facilitate impression taking and/or block out undercuts are considered included in the cost of a crown.

9. If this plan includes periodontics, root planing is not eligible if done at the same time as gingival curettage.

10. In the event of a dental accident, claims should be submitted under the health benefit plan before submitting them under the dental plan.

dental exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) attempting to commit or committing a criminal offence or illegal act.

2. Services or supplies provided while serving in the armed forces of any country;

3. Failure to keep a scheduled appointment with a legally qualified dental practitioner;

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

5. Charges for the translation or completion of any claim forms and/or insurance reports;

6. Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;

7. Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion;

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

9. Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces;

10. Service and charges for sleep dentistry;

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

12. Any specific treatment or drug which:
    a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
    b) is not considered to be effective (either medically or from a cost perspective) as determined by GreenShield's drug review process regardless if Health Canada has approved the drug;
    c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
    e) is not dispensed by the pharmacist in accordance with the payment method shown

under the Health Benefit Plan Prescription Drugs benefit;

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

13. Services or supplies that:
    a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GreenShield) medical practitioner or dental practitioner as permitted by law;
    b) are legally prohibited by the government from coverage;
    c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage; or for which payment is made on your behalf by a not-for-profit pre payment association, insurance carrier, third party administrator, like agency or a party other than GreenShield, your plan sponsor or you;
    d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
    e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
    f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
    g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
    h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
    i) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;

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

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

l) are delivery and transportation charges;

m) are a duplicate prosthetic device or appliance;

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

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

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

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

i) the service or supplies being claimed is not eligible; or

ii) the financial commitment is complete;

A letter from your automobile insurance carrier will be required.

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

claims for extended health and dental

inquiries

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

submitting claims

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

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

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

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

claims submission period

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

reimbursement

Reimbursement will be made by one of the following methods:

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

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

overpayments

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

limitation on legal action

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

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

subrogation

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

co-ordination of benefits (COB)

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

Claims must be submitted to the primary payer first. Any unpaid balances should then be submitted to the secondary plan(s). When GreenShield is identified as a

secondary carrier, submit the original Explanation of Benefits statement from the primary carrier and a copy of the claim form in order to receive any balances owing.

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

heat and frost retired plan member

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

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

spouse

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

children

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

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

If the parents have joint custody and both have the children listed as dependents under their plans,

claims should first be submitted to the plan of the parent whose birth date (month and day) occurs earliest in the calendar year. Balances can then be submitted to the other parent's plan.

access to information

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

a) any enrollment form you completed for coverage under this plan that was submitted to GreenShield;
b) any written statements or other record about your health that you submitted to GreenShield during the course of applying for coverage under this plan;
c) one copy of the group contract.

GreenShield may charge you to provide any additional copies.

member / family assistance program

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

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

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

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

benefits provided by:

Manulife Financial
policy #961442
life insurance

Int'l Assoc. of Heat and Frost Insulators & Allied Workers, Local 118 Health and Wellness Trust Fund
policy #903119
extended health
dental

Homewood Health
policy #1500
member / family assistance plan

Contact us:

convyta

501 - 4445 Lougheed Hwy
Burnaby BC V5C 0E4

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

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

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

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