International Association of HEAT and FROST INSULATORS & ALLIED WORKERS, No. 118

Health and Wellness Trust Fund

Address all inquiries to:

THE ADMINISTRATOR
INTERNATIONAL ASSOCIATION OF HEAT AND FROST INSULATORS & ALLIED WORKERS, No. 118 HEALTH AND WELLNESS TRUST FUND

Suite 160 – 4400 Dominion Street
Burnaby, BC V5G 4G3
Phone (604) 299-7482
Facsimile (604) 299-8136
Toll Free 1-800-663-1356

May 2005

*Including amendments to March 2015

PRIVACY POLICY

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

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

The Trustees

TO ALL MEMBERS

This Plan is an Hour Bank system designed for Members of Local Union 118. Effective May 1, 2005 D.A. Townley has been appointed to arrange the benefits and administer the International Association of Heat and Frost Insulators & Allied Workers, No. 118 Health and Wellness Trust Fund.

This booklet outlines benefits to which eligible Members and their covered Dependents may be entitled and outlines the procedures to be followed when making claims.

The employers contribute for each hour worked under the Collective Agreement. The hours are accumulated in the Hour Bank to provide you with coverage when you meet the eligibility requirements as outlined further along in this booklet.

You are asked to read this booklet carefully so that you will have a clear understanding of how your Plan operates for the benefit of you and your family. It is your responsibility to maintain your coverage during periods of unemployment should your Hour Bank drop below the required amount of hours to provide monthly coverage.

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 the Administrator's Office.

FROM THE TRUSTEES,

INTERNATIONAL ASSOCIATION OF HEAT AND FROST
INSULATORS & ALLIED WORKERS, NO. 118
HEALTH AND WELLNESS TRUST FUND

The following is an outline of the International Association of Heat and Frost Insulators and Allied Workers, No. 118 Health and Wellness Trust Fund. The information in this benefits booklet is important to you. It provides the information you need about the group benefits available through the Heat and Frost Insulators and Allied Workers, No. 118 Health and Wellness Trust Fund.

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.

SUMMARY OF BENEFITS

Medical Plan (Medical Services Plan of British Columbia)	As provided by MSP Group No. 3131182
Life Insurance	$70,000
Basic Accident Insurance	$70,000
Weekly Indemnity	$535** per week – 1st day accident, 1st day hospitalization, 8th day sickness. Integrated with E.I. to a maximum of 52 weeks.
Long Term Disability	75% of monthly earnings to a maximum of $3,000. 365 day waiting period, 24 month own occupation definition of disability, taxable benefit. Payable to age 60.
Employee Family Assistance Program	Confidential counseling services for the Member and eligible dependents.
Extended Health Benefits	100% all eligible expenses, $50 calendar year deductible. Vision benefit of $300 every 12 months. At age 70 the overall calendar year maximum is $10,000.

Out of Canada Emergency Coverage	$5 Million maximum per coverage period to age 70.
Dental Plan	90% Basic, 50% Major reimbursement - combined annual maximum of $3,000, 50% Orthodontic reimbursement to a lifetime maximum of $3,000 for adults and children after 6 months of coverage.

PLAN SUMMARY TABLE

Active Members

	Active Members Classes 001 & 003	**Long-Term Disabled Classes 001 & 003**
Life	Yes	Yes
AD&D	Yes	Yes
Weekly Income	Yes	N/A
LTD	Yes	N/A
MSP BC	Yes	Yes
EAP	Yes	Yes
EHC	Yes	Yes
Dental	Yes	Yes
Eligible for Retirees Plan	Yes	Yes

	Honorary Retirees/ Exempt Class 002	**Associate Members Class 004**
Life	Yes	Yes
AD&D	No	Yes
Weekly Income	No	No
LTD	No	No
MSP BC	No	Yes
EAP	No	Yes
EHC	Yes	Yes
Dental	Yes	Yes
Eligible for Retirees Plan	N/A	No

PART 1

Details of Eligibility

Hour Bank System

Hours to qualify for coverage	250	hours
…worked within	10	months
Hour Bank maximum	1,125	hours
Self-Pay Limit	9	months
Hour Bank Charge	125	hours

How do I establish coverage?

1) You must be a Member in good standing of the Heat & Frost Insulators & Allied Workers, No. 118. (For H&W Plan purposes, Members working for non-union contractors who refuse to co-operate in Local 118 organizing efforts are not in good standing.)
2) You must be enrolled in the Plan by completing a Medical Services Plan application form and an Enrolment and Beneficiary card.
3) You must have earned, and your employer(s) must have reported and paid into the Plan, the number of hours required to qualify for coverage according to the Hour Bank table above. Hours worked but not reported or paid by your employer(s) do not qualify you for coverage.

Associate Members

Associate Members are owners, estimators, office personnel and other employees of a participating employer, for which permission has been applied for and granted by the Union. The Union reserves the right to approve or reject a request for Associate Member coverage.

How do employer reports come in?

Your Collective Agreement requires that employers report, prior to the 15th day of each month, all hours worked by you up to the close of the employer's payroll ending closest to the last day of the preceding month. It is advisable that you keep your own pay slips as errors may occur in reporting or tabulating.

Reporting Month

The Administrator needs a reporting month to operate the Hour Bank system. Employers send their reports and contributions for the hours Members work each month to the Administrator in the following month. The Administrator posts the hours to your Hour Bank.

When does coverage begin?

If you have completed the application forms, your coverage will start on the first day of the month following the month in which enough hours are reported to the Plan by your employer(s).

EXAMPLE:

Your employer(s) report that you have accumulated in excess of 250 hours for the last 6 months. March hours are reported and tabulated in April, and your coverage becomes effective May 1.

Month	**Hours Reported**
January	
February	150
March	150
April	Lag Month
May	Coverage Starts

How does coverage continue?

Each month 125 hours will be deducted from your Hour Bank to provide coverage. Any excess hours will accumulate in your Hour Bank for future coverage.

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

A maximum of 9 months coverage can be accumulated in a Member's Hour Bank. Any hours in excess of the "Hour Bank maximum" go into the general fund of the Plan.

Disability Credits

When a Member is collecting benefits under the Weekly Indemnity Plan, EI Sick Benefits or under Worksafe BC/WCB, Members will receive assistance with their Hour Bank. For each day that the Member is disabled and on a claim that has been accepted for payment, the Member's Hour Bank will be credited with contributions of 7.5 hours per day, up to 125 hours per month to a maximum of 12 months. The Member must request the appropriate form from the Administration Office and return the completed form to apply for Disability Credits. To qualify for these Disability Credits, the Member must be eligible for benefits when the disability commences.

Members on Worksafe BC/WCB or receiving Long Term Disability benefits will receive Disability Credits for the duration of their claim.

Self-Pay limit

The "self-pay limit" is the number of consecutive months you may continue your coverage by self-payment, provided you remain a Member in good standing of the Heat & Frost Insulators & Allied Workers, No. 118. If you return to work for a participating employer then the count of your self-payments will reset to zero, if the employer remits enough hours to the Plan to provide a month of coverage.

While making full self-payments, you will have full benefits except for Weekly Indemnity and Long Term Disability benefits.

Associate Members are not permitted to self-pay.

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

What happens if the Hour Bank falls short for coverage?

If the Hour Bank drops below 125 hours, the Administrator will send out a notice as to the balance in the Hour Bank and the amount required to maintain coverage. If payment of the amount requested is received by the deadline specified on the notice, coverage will be continuous.

Those Members who have a balance of employer hours in their Hour Bank and, although working regularly, do not have sufficient work to maintain the Hour Bank charge, will qualify under "Shortage Hours" and will receive a billing showing the balance of hours required to make up the 125 hours needed each month to provide coverage. Shortage notices do not reduce the maximum months under self-payment.

Do Not Ignore the Self-Payment or Shortage Hours Notice

If you receive a Self-Payment or Shortage Hours Notice and you think it is incorrect, contact the Administrator – D.A. Townley:

by telephone: (604) 299-7482
or toll-free: 1-800-663-1356
or by email: hfhealth@datownley.com

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

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

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

When does coverage end?

a) Coverage will terminate when there are insufficient hours in the Hour Bank to allow for a deduction of 125 hours and you do not make your self-payment or pay your shortage notice by the date specified.

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

Hour Bank Freeze

The regulations of the Heat & Frost Insulators & Allied Workers, No. 118 Health and Wellness Trust Fund allow you to suspend or freeze hours if you are temporarily working out of any other Local in Canada. Please contact your Union office or Administrator for the rules regarding freezing your Hour Bank.

Are there any reciprocity agreements?

If you are working in the jurisdiction of another Local Union on a temporary basis for up to 12 consecutive months, and the other Local has a Welfare Plan which has entered into a Reciprocal Agreement with this Plan, then the hours remitted on your behalf may be transferred to this Plan to help you maintain coverage.

Before any hours can be transferred, a Benefits Transfer Form must be completed and returned to the Heat & Frost Local Union 118 Business Office.

Long-service retirees from the Active Plan – Local 118 Retirees Benefit Plan

If you are retiring from the Active Plan with at least 10 years of Local 118 Membership, and are taking a pension from the Heat and Frost Local Union 118 Pension Plan, you may be eligible for the Local 118 Retirees Benefit Plan.

For further information, please contact the Administrator.

Are Dependents Covered under the Plan?

YES. The Plan will provide MSP, Dental and Extended Health Benefits for:

a) The spouse* of a covered Member

b) Any unmarried child of a covered Member to age 21, (age 19 for MSP) provided such person is mainly dependent on and living with the covered Member;

c) Any unmarried child of a covered Member to any age provided the child is in full-time attendance at a recognized school, college, or university; (age 25 for MSP)

d) Any unmarried mentally or physically handicapped child of a covered Member to any age, provided such person is mainly dependent on and living with the covered Member or the spouse of the covered Member.

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

The co-habitation period for a common-law spouse is a continuous period of one year.

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

When completing your application forms for coverage, please include all dependents to be covered. To add, delete or change the dependents covered, obtain a MSP Group Change Form and an Enrolment and Beneficiary card from the Administrator or your Union Office, and forward it to the Administrator’s office.

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

If I die do my Dependents remain covered?

Yes, if at the time of your death you had full coverage, the Plan will continue their coverage until the earliest of the following:

a) 10 months from the date of death

b) the date the person ceases to be a Dependent other than as a result of the Member's death

c) the date the Plan is terminated

d) the date the Dependent becomes eligible for coverage under a similar group plan.

PART II

Details of Coverage Provided by the Plan

BASIC MEDICAL (MSP)

When you qualify for coverage, you will be covered by the Medical Services Plan of B.C., provided you have completed the required MSP application form. If you do not apply for MSP coverage through the Plan at the time you become eligible to do so, the Plan will only make retroactive payments on your behalf back 6 months for MSP coverage. MSP Premiums paid by the employer are a taxable benefit to you.

Members who need to obtain their own Medical Services Plan (MSP) coverage need to make arrangements for 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

Classes 001, 003 and 004

Each eligible person is insured for $35,000 of Life Insurance. Increases to $70,000 for all Members who are active and/or available for work March 1, 2013.

Coverage terminates on the date you no longer have hours in your Hour Bank if you are in Classes 001 or 003.

Coverage terminates at the end of the month in which employment ceases if you are in Class 004.

Class 002

- retired after November 1, 2011 - $10,000
- retired between April 1, 2004 but before November 1, 2011 – no coverage
- retired between September 30, 2002 but before April 1, 2004 - $5,000
- retired before October 1, 2002 - $10,000

Coverage terminates on the date you cease to be an Exempt Honorary Member.

All Classes

In the event of your death while insured, the amount of your Life Insurance is payable to your beneficiary should your death occur from any cause while you are insured under the group policy.

You may change your beneficiary at any time by written notice to the Administrator.

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

Continuation of Life Insurance on Termination of Coverage

When your coverage with the Plan terminates, you may convert your Life Insurance to an individual policy without a medical examination or health questionnaire. The individual policy would be for an amount not greater than the amount under the group policy and would be available at any time within 31 days after termination of the group insurance. Contact the Administrator for details.

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

Waiver of Premium for disability

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

For Classes 001 and 003, Totally Disabled for the first 24 consecutive months of benefit payment, shall mean you are incapacitated to the extent that you are not able to perform any and every duty of your occupation or employment. After such 24 months, Totally Disabled shall mean you are incapacitated by an injury or disease to the extent you are not able to perform any work for compensation or profit and are not able to engage in any business or occupation.

For Class 002, Totally Disabled shall mean you are incapacitated by an injury or disease to the extent you are not able to perform any work for compensation or profit and are not able to engage in any business or occupation.

For Class 004, Totally Disabled shall mean you are incapacitated by an injury or disease to the extent you are not able to perform any work for compensation or profit and are not able to engage in any business or occupation.

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

BASIC ACCIDENT INSURANCE

THE PLAN

You are insured against the perils described in the Loss Schedule. Your protection is world-wide, 24 hours a day, on or off the job. Benefits are payable regardless of any other benefits that you may receive from any insurance company other than the Company, or any other

DEFINITION

"The Company" means RBC Life Insurance Company.

WHO IS ELIGIBLE

You are eligible if you are a member of the Policyholder in good standing and are under age 80.

PRINCIPAL SUM

Your amount of Principal Sum is: $70,000 if you are a Member who is active and/or available for work on March 1, 2013.

TERMINATION

All benefits terminate on the earlier of the day you reach age 80 or the day you retire.

WHEN IS THIS PLAN EFFECTIVE

You are insured from the first of the month following completion of your applicable waiting period. If there is no waiting period, your coverage is effective immediately.

LOSS SCHEDULE

If an accident causes a loss payable under this schedule within one year from the date of the accident, the Company pays the sum set opposite such loss, and not more than the aggregate of the Principal Sum is paid for injuries resulting from the same accident.

For Loss of:	Percentage of Principal Sum
Life	100%
For Loss of or Loss of Use of:	
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand or Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Leg or One Arm	75%
Either Hand or Foot	$66^{2}/_{3}$%
Sight of One Eye	$66^{2}/_{3}$%
Speech or Hearing in Both Ears	$66^{2}/_{3}$%
Hearing in One Ear	50%
Thumb and Index Finger of the Same Hand	$33^{1}/_{3}$%
Four Fingers of the Same Hand	$33^{1}/_{3}$%
All Toes of One Foot	$12^{1}/_{2}$%
For Total and Irreversible Paralysis of:	
All four limbs (Quadriplegia)	200%
Both lower limbs (Paraplegia)	200%
One arm and one leg on the same side of the body (Hemiplegia)	200%

"Loss" means, with regard to:

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

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

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

(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.

EXPOSURE AND DISAPPEARANCE

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

If your body is not found within one year after the date of the disappearance, sinking or wrecking of the vehicle in which you are an occupant at the time of the accident and under such circumstances as would otherwise be covered hereunder, it is presumed that you suffered loss of life resulting from bodily injury caused by an accident at the time of such disappearance, sinking or wrecking.

WAIVER OF PREMIUM

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

REPATRIATION

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

SPOUSAL RETRAINING

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

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

- at least 18 years of age;
- competent to contract; and
- not related by blood closer than would legally bar marriage.

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

REHABILITATION

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

FAMILY TRANSPORTATION

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

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

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

"Regular Care and Attendance" means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

CONTINUATION OF COVERAGE

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

EDUCATION

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

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

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

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

HOME ALTERATION AND VEHICLE MODIFICATION

If you receive benefits for a loss described in the Loss Schedule and are subsequently required (due to the cause for which payment under the Loss Schedule is made) to use a wheelchair to be ambulatory, the Company pays, upon presentation of proof of payment, the one-time cost of (a) alterations to your residence to make it wheelchair accessible and habitable and (b) modifications necessary to your motor vehicle to make the vehicle accessible or driveable for you.

Benefits herein are not paid unless: (a) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization providing support and assistance to wheelchair users and (b) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the provincial vehicle licensing authorities.

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

TO WHOM ARE BENEFITS PAID?

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

EXCLUSIONS

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

CLAIM PROCEDURES

To make a claim under this plan, written notice of the accident must be given to the Company within 30 days of the date of the accident and written proof must be submitted within 90 days of the date of the accident. The Company provides the necessary claim forms as well as instructions covering other requirements that may aid in a prompt handling of the claim.

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

DISCLAIMER

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

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

Collection and use of personal information

Collecting your personal information

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

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

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

Using your personal information

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

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

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

In the event our service provider is located outside of Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is located. Third parties may include other insurance companies, the MIB, Inc. and financial institutions.

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

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

Your right to access your personal information

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

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

Our privacy policies

You may obtain more information about our privacy policies by asking for a copy of our “Financial fraud prevention and privacy protection” brochure, by calling us at the toll-free number shown above or by visiting our website at www.rbc.com/privacysecurity.

WEEKLY INDEMNITY BENEFIT

903118 Active Members
903120 Active Members

A benefit of $535 weekly will be paid to each eligible Member who is disabled and unable to work as the result of a non-occupational accident or sickness which occurs on or after January 1, 2013. Benefit payment commences on the 1st day of a non-occupational accident, and the 8th day of a non-occupational sickness. If you are hospitalized prior to the 8th day of sickness, benefits commence on the 1st day of hospitalization. If a surgical procedure is performed on an out-patient basis, in a general hospital, benefits will commence on the date the surgery was performed.

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

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

If you are eligible for E.I. sick benefits, benefits from the Plan will be paid for the first 8 weeks of disability. EI will provide benefits from the 9th week to the 23rd week of disability and then the plan will provide an additional 29 weeks of benefits.

If you are still disabled after reaching the maximum duration of E.I. sick benefit payments, or if you are not eligible for E.I., or only partially eligible, the Plan will continue benefits for up to a maximum of 52 weeks including the E.I. sick benefit payments.

How to claim for Weekly Indemnity:

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

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

b) Obtain a claim form from the Union office or the Administrator's office and note instructions concerning an E.I. sick claim.

c) Complete the form where indicated and have your doctor complete the physician's portion of the form.

d) Send the completed form to the Administrator without delay.

e) Claim cheques will be sent directly to your home address.

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

Third Party Liability

If you receive benefit payments under this Plan for loss of income for which there may be a cause of action against a third party, you will be required to complete a Loan Agreement. This will entitle the Plan to be reimbursed for any benefits paid, which have been recovered from a third party.

Right to Recover

(a) When 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.

(b) In the circumstances described in (a) above, the Plan may, not must, provide financial relief on a periodic (usually bi-weekly) basis to alleviate income loss. The total of all advances made to the member is fully repayable to the Plan on terms to be settled between the member and the Plan and incorporated into a written Loan Agreement.

Recurrence of Former Ailments

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

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

b) One full day before you again become disabled because of a different or unrelated cause.

EXCLUSIONS and LIMITATIONS:

No benefit will be paid for periods of disability:

- arising from occupational accident or illness, as these are covered by the WorkSafe BC/WCB Act;
- arising from your commission of or attempt to commit an assault or criminal offense;
- arising from self-inflicted injuries or sickness;
- substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician;
- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service;
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from E.I., or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of

leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence;

- during which the insured is receiving or eligible to receive E.I. benefits;
- if you become disabled during a strike or lockout at your place of employment, your rights to benefits will be reinstated when the strike or lockout ends;
- arising from an automobile accident except as a fully repayable loan.

TERMINATION OF BENEFIT

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

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

LONG TERM DISABILITY SUMMARY OF BENEFITS

Classes 001 and 003

This benefit is equal to 75% of monthly earnings, subject to the 85% All Source Maximum described under Offsets in the Long Term Disability section. The maximum benefit payable is $3,000 per month for disabilities which occurred on or after January 1, 2013.

The qualifying disability period starts when you first become totally disabled and ends after 365 days, provided your disability is continuous and you are under age 60. If the disability is not continuous, the days you are disabled will be accumulated to satisfy the qualifying disability period provided:

1) no interruption is longer than 2 weeks;
2) the disabilities arise from the same or related disease or injury.

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

Long Term Disability benefits are taxable.

Classes 002 and 004

No Long Term Disability coverage.

LONG TERM DISABILITY BENEFITS

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

Qualifying Disability Period	>	As described in the Summary of Benefits
Monthly Benefit	>	As described in the Summary of Benefits
Maximum Disability Period	>	To age 60

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

Total Disability

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

Recurrent Disability

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

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

Offsets

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

1) wages or retirement benefits payable from your employer or employer's pension or retirement plans;
2) any payments on account of your disability from any Workers' Compensation law or similar law;

3) payments received from the Canada or Quebec Pension Plan, excluding payments made in respect of dependent children;

4) any income or benefit payable under any other plan or program of any government or of any subdivision or agency of the government, including any plan or program established pursuant to a provincial automobile insurance act.

All Source Maximum

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

EXCLUSIONS AND LIMITATIONS

Benefits are not payable for the following:

1) any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of disability during which you are not participating in the treatment program recommended by said physician;

2) any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;

3) any portion of a period of disability resulting from substance abuse, including alcoholism and drug addition, unless you are participating in a recognized substance withdrawal program;

4) disabilities resulting from self-inflicted injuries or attempted suicide;

5) disabilities as a result of participation in a war, riot, insurrection or criminal act;

6) an automobile accident except as a fully repayable loan.

7) the portion of a period of disability during which you are

   a) imprisoned in a penal institution; or

   b) confined in a hospital, or similar institution, as a result of criminal proceedings;

8) any period of disability, or portion thereof, during any leave of absence (including maternity leave) as defined in the General Provisions section of this booklet;

9) a disability which commences on or after the date a strike begins, except as outlined in the Master Policy; however, an employee, may commence to fulfill his/her qualifying disability period from the date of disability;

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

11) to employees of Class 003 unless they have been actively working for a participating employer for a minimum of 24 hours per week at the date of disability.

Subrogation

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

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

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

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

Disability Case Management Program

Manulife Financial has developed a disability case management program. The purpose of this program is to assist you, in the event you become totally disabled and qualify for benefits, to return to productive employment. Manulife Financial's disability case management team includes medical consultants, claim adjudicators and a field coordinator. This team will work with you, your employer and your physician to assist you to recover and return to the work place.

Rehabilitative Employment

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

Canadian Residency Requirement

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

a) the Member has previously notified and received approval in writing from the Insured, and;

b) the Member remains under the regular care of a licensed physician deemed appropriate by the Insurer, and;

c) proof of ongoing disability can be determined on evidence satisfactory to the Insurer in English or French.

EMPLOYEE FAMILY ASSISTANCE PROGRAM

The EFAP is a voluntary, confidential, short-term counseling and advisory service that connects you and your eligible family members to a network of dedicated professionals who are available to give you assistance 24 hours a day.

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

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

Please refer to the brochure or contact the Administrator to request that one be sent to you.

EXTENDED HEALTH BENEFITS

903118 Active Members
903119 Retirees
903211 Members on Long Term Disability and Associates
903120 Active Members

Deductible – All Groups

$50 per person or family each calendar year.

Reimbursement

903118 Active Members

903120 Active Members

In-Canada Eligible Expenses	100%
Out-of-Province/Canada Emergency Eligible Expenses	100%

903119 Retirees

In-Canada Eligible Expenses	70%
Out-of-Province/Canada Emergency Eligible Expenses	100%

903211 Members on Long Term Disability and Associates

In-Canada Eligible Expenses	
• Hearing Aids and Vision Care	100%
• Other Eligible Expenses	80%
Out-of-Province/Canada Emergency Eligible Expenses	100%

Note for 903119 and 903211: After $1,000 has been paid for a person or family in a calendar year, further Eligible Expenses for that person or family will be reimbursed at 100%, subject to any maximums under this benefit.

Plan Maximums

903118 Active Members
903211 Members on Long Term Disability and Associates
903120 Active Members

The lifetime maximum amount of benefits payable for a Member or Dependent is unlimited, however there may be maximums for certain benefits as shown.

903119 Retirees
The lifetime maximum amount of benefits payable for a Member or Dependent is $25,000.

Benefits:

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

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

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

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

   PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for the Fair PharmaCare Program call 604-683-7151 from Vancouver and toll-free1-800-663-7100 from the rest of BC. If you prefer to go on-line to the Fair PharmaCare website the address is http://www.health.gov.bc.ca/pharmacare/plani/planiindex.html

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) Charges for out-of-hospital private duty nursing services up to a maximum of $25,000 per policy period, when medically necessary and with a physician's referral. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties.

4) Charges for the following practitioners (excluding appliances, tray fees and x-rays)

903118 Active Members
903211 Members on Long Term Disability and Associates
903120 Active Members

a) acupuncturist $400
b) chiropractor $400
c) massage practitioner .....no calendar year maximum
d) naturopath $400
e) physiotherapist .....no calendar year maximum
f) podiatrist $400
g) speech language pathologist $400

903119 Retirees

a) acupuncturist $100
b) chiropractor $200
c) massage practitioner $250
d) naturopath $200
e) physiotherapist $250
f) podiatrist $200
g) speech language pathologist $100

5) Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies

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

7) Charges for testing supplies, needles and syringes for diabetics.

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

9) Charges for stump socks.

10) Charges for surgical brassieres up to two per calendar year.

11) One pair of custom fitted orthopaedic shoes or orthotics when prescribed by a physician or podiatrist and replacements when necessitated by normal wear and tear.

12) 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

13) 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 mouth and not as a result of an object placed in the mouth;
- the accident occurred while the person is covered under this benefit; and
- the charges are incurred within 90 days of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 90 day period and the work is completed within 52 weeks.

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

15) Costs of hearing aids and repairs to a lifetime maximum of $500. Dependent children are covered for an additional benefit of $400 per 60 month period. Hearing Aids must be prescribed by a certified Ear, Nose and Throat Specialist. Maintenance, batteries or other accessories will be covered.

Hearing aids are not a covered expense for 903119.

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

17) Standard durable medical equipment

a) Preauthorization is required from us for expenses in excess of $5,000

b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.

c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.

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

e) Standard durable equipment includes:

i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent

ii) medical monitors including heart and blood glucose monitors and cardiac screeners

iii) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems

iv) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks and regulators

v) insulin infusion pumps for diabetics when basic methods are not feasible

vi) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain

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

18) Vision Care

Charges for non-prescription eyewear are not covered. Eye exams are not covered.

a) Groups 903118 and 903120: Charges for the purchase and/or repair of eyewear when prescribed by a Physician or optometrist to a maximum of $300 in a 12 month period.

b) Group 903211: Charges for the purchase and/or repair of eyewear when prescribed by a Physician or optometrist to a maximum of $150 in a 12 month period.

c) Group 903119: Vision Care expenses are not covered under this plan.

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

Out-of-Province Non-Emergency Eligible Expenses

We will reimburse you (and your Dependents) for non-emergency Eligible Expenses incurred while traveling outside your province of residence subject to the Deductible, in-province reimbursement percentage and maximums. We will not reimburse any expenses payable or provided under a government plan.

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 13.

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 Emergency Eligible Expenses.

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-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.

g) expenses incurred for orthoptic treatment, eyeglasses, contact lenses, hearing aids, or prescriptions for any of them except as specifically provided; (see Vision Care Plan).

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

i) 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.

Out-of-Province/Canada Emergency Eligible Expenses

Charges for services and supplies required as a result of a medical emergency occurring while travelling if:

- you or your Dependent is covered under a provincial medical plan; and
- treatment could not have been delayed until return to Canada.

Emergency Medical Insurance & Travel Assistance

While you are travelling outside your Province of residence carry the wallet card that has been provided to you.

Travel insurance is designed to cover losses arising from sudden or unforeseeable circumstances occurring while you are temporarily travelling outside your province or territory of residence. It is important that you read and understand your Plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provisions of the Policy shall govern. The Plan has contracted Viator/Global Excel Management Inc. (called Global Excel) to provide medical assistance and claims services under the Policy. This is a summary of benefits. A complete booklet is available from the Plan Administrator.

Coverage Period: 90 days per trip.

IN THE EVENT OF AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY

The emergency telephone numbers are listed on the back of the Medical Assistance Card provided.

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the policy expressly requires the prior approval or authorization of Global Excel, on the basis of the reasonable and customary costs that would have been payable for such expenses by the insurer in accordance with the terms and conditions of the policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the reasonable and customary costs reimbursed by the insurer.

In an emergency the policy covers expenses that are:

- incurred outside the province or territory of residence of the insured person;
- medically necessary;
- reasonable and customary costs;
- incurred as a result of an emergency due to sudden and unforeseen sickness and/or injury occurring during the coverage period;
- in excess of those covered by the Government Health Insurance Plan or other insurance under which you may have coverage; and
- legally insurable;
- subject to the overall maximum per insured person of $5,000,000 per coverage period.

Claims Procedures

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

a) include the policy number, the patient's name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);

b) submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or physician;

c) provide the original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

d) provide proof of the departure date(s) and return date(s);

e) provide written proof of claim within ninety (90) days of the date of receipt of services covered under the policy;

f) provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;

g) sign and return the authorization form, provided by Global Excel, allowing the insurer to recover payment from the Canadian provincial or territorial Government Health Insurance Plan. The insurer will coordinate and pay your claim to the participating medical providers and where permitted, coordinate claims directly with the Canadian provincial or territorial Government Health Insurance Plan on your behalf; and

h) return the unused portion of your air ticket to Global Excel if the Emergency Air Transportation benefit is used.

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

Any information not provided may result in a delay in processing your claim.

All pertinent documents should be sent to:

Global Excel Management Inc.
73 Queen St., Sherbrooke, Quebec J1M 0C9
Tel.: 1-866-870-1898 (toll free) or
(819) 566-1898 (collect) during business hours (EST)

Policy Number: 1059730

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

DENTAL PLAN

903118 Active Members
903119 Retirees
903211 Members on Long Term Disability and Associates
903120 Active Members

Calendar Year Deductible: Nil

Reimbursement:

Groups 903118, 903211 and 903120
Basic Services: 90%
Major Services: 50%
Orthodontia: 50% - Member, Spouse and dependent children to age 21

Groups 903119
Basic Services: 70%
Major Services: 50% (covers dentures only)

Maximum payable:

Groups 903118, 903211 and 903120
Basic & Major Combined: $3,000 per calendar year
Orthodontia: $3,000 lifetime

Group 903119
Basic & Major Combined: $1,000 per calendar year

Part I – 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.

1) Diagnostic Services
All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:
   - Oral examinations: limited to two in any calendar year; however, complete oral examinations are limited to one in any 36 month period
   - Specific examinations provided the Plan has not paid for any other exam by the same dentist in the past 60 days
   - Consultations (as a separate appointment) limited to two per calendar year.
   - Dental x-rays: bite-wing x-rays are limited to two sets per calendar year, full mouth x-rays are limited to one set in any 36 month period, and panoramic film is limited to one x-ray in any 24 month period Diagnostic models: limited to 1 set per calendar year.

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

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

5) Prosthetic Repairs and Maintenance
Repair if a 6-month period has elapsed since the last date on which the dentures were provided.

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

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.
- occlusal equilibrations 8 units per calendar year
- gingival curettage once per sextant in a 5 year period
- osseous surgery once per sextant in a 5 year period.

8) Anesthesia
General anesthesia required in relation to oral surgery.

Part II – Major Services
Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for reimbursement of the lesser of 50% of the amount charged, or 50% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment. Group 903119 has coverage for only full or partial dentures

- Initial installation of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Partials may only be provided by a dentist.
- Initial placement of a crown or veneers and their replacement if at least 5 years has lapsed.
- Replacement of an existing full or partial denture, or fixed bridgework, if the existing denture or fixed bridgework was installed 5 years prior to its replacement and cannot be made serviceable. Dentures misplaced, lost or stolen will not be replaced at the Plan's expense.
- Bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken or stolen bruxing guards).

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

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

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

Part III – Orthodontia (Member, Spouse and dependent children to age 21)

Groups 903118, 903211 and 903120 only

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

Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced at the Plan's expense.

Pre-Treatment Estimate of Major Restorative & Orthodontic 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.

Alternative Services:

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

Emergency Dental Care Anywhere in the World

In an EMERGENCY, while you are travelling or on vacation outside of your Province of residence, you are entitled to the services of a duly qualified dentist and will be reimbursed at the lower of the actual cost or the amount that would have been paid had the service been rendered in your Province of residence.

EXCLUSIONS and LIMITATIONS

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

- items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- dental care which is cosmetic;
- dental care provided under a medical plan provided by an employer or government;
- services or items which would not normally be provided, or for which no charge would be made, in the absence of dental coverage;
- stainless steel crowns on permanent teeth;
- protective athletic appliances;
- anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- 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;
- grafts;
- 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;
- travel expenses incurred to obtain Dental treatment.

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.

TO MAKE A CLAIM

Extended Health Benefits and Dental Plan:

Claim forms for Extended Health Benefits can be obtained from the Administrator's office or your Union Office. Standard B.C. Dental claim forms are usually provided by your dentist, but if required, Dental claim forms can also be provided by the Administrator's office or your Union office.

Both the original receipts and the forms should be sent to the Administrator. Although claims for Extended Health Benefits and Vision Care can be made at any time, it would be preferable if they were sent every two or three months. All receipts must be received by the Administrator within 12 months of the date of service to be considered for payment.

COORDINATION OF BENEFITS:

1) When co-ordinating benefit payments, D.A. Townley will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the Eligible expense was incurred.
2) If the Member or Dependent is also covered under the Spouse's plan or under any other group plan which provides similar benefits, payment will be co-ordinated and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the Eligible Expense (for dental, the fee guide applies).
3) The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.
4) The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:
   a) the amount that would have been payable had it been the primary carrier, or
   b) 100% of all Eligible expenses reduced by all other benefits payable for the same expenses by the primary carrier.
5) If the other plan does not contain a co-ordination of benefits clause, payment under that plan must be made before the Plan will pay under this provision.
6) Extended health care plans with dental accident coverage determine benefits before dental plans.
7) If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.
8) When the Plan has paid benefits to the Member to the limit of the Pharmacare deductible, the Plan will pay their portion of the Eligible expenses based on the plan's reimbursement percentage.
9) The Member will provide the information required to implement this provision. It is the Member's responsibility to present a copy of the original claim form and the remittance statement or cheque stub when making further claim under this provision.

When submitting eligible claims, please be sure to include::

– Your Name (please print)
– Your Address
– Your Certificate Number/ID Number (SIN)
– Your Local Union

All claims should be forwarded to the Administrator's office

INTERNATIONAL ASSOCIATION OF HEAT AND FROST INSULATORS & ALLIED WORKERS, LOCAL 118 HEALTH AND WELLNESS TRUST FUNDS

Suite 160 – 4400 Dominion Street
Burnaby, BC V5G 4G3

MEMBER WEBSITE & DIRECT DEPOSIT

For Extended Health and Dental you can now view and print your claim history by using D.A. Townley's Member Website at www.hfbenefits.org. You can also arrange to have your claim reimbursements directly deposited into your bank account by completing the Direct Deposit Registration form, also available on the D.A. Townley website at www.hfbenefits.org.

RIGHTS TO COPIES OF DOCUMENTS

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

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

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

LEGAL ACTION

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

Benefits Provided by:

Manulife Financial #961442
Life Insurance
Long Term Disability

RBC Life Insurance Company #16853
Accidental Death & Dismemberment

International Association of Heat and Frost Insulators and Allied Workers, No. 118 Health and Wellness Trust Fund #'s 903118, 903119, 903211 and 903120
Weekly Indemnity
Extended Health Care
Dental

Human Solutions #1500
Employee Family Assistance Plan

Medical Services Plan of BC #3131182

Royal Sun Alliance Insurance Company #1059730
VIATOR Out of Province Emergency Excess Medical and Hospital Travel Insurance

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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