HEALTH AND WELFARE PLAN

INFORMATION BOOKLET FOR MEMBERS OF

I.B.E.W. LOCAL 530

January 1, 2021

Why Group Benefits?

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance. Government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

Private health care and disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Group Benefit Program is provided by International Brotherhood of Electrical Workers Local 530, in partnership with The Manufacturers Life Insurance Company and Green Shield Canada.

Your Plan Administrator

Your Plan Administrator is responsible for ensuring that all Members are covered for the Benefits to which they are entitled by submitting all required premiums, reporting all new enrolments, terminations, changes, etc., and keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your Plan Administrator with the necessary information to perform such duties.

Plan Administrator: Shelby
Phone Number: *519-344-4154 ex. 2*

The statements in this booklet are a summary of some of the provisions of the master policy. They are not part of the master policy and are not terms of the insurance contract.

The information contained in this booklet is important to you and your family and should be kept in a safe place. You should familiarize yourself with the contents of the booklet and refer to it whenever you claim group insurance benefits.

Your Plan Administrator

Your plan administrator can give you more detailed information about your group benefits and will help you to:

1. enroll in the plan, and
2. provide you with the information and forms you need to claim benefits.

Please contact your plan administrator if at any time you require additional information about your benefits.

The following are a summary of the policies relating to Local 530 I.B.E.W. Health & Welfare Plan. These conditions may change from time to time and will be determined by the Health & Welfare Trustees. Trustees have the ability to make decisions regarding conditions on case-by-case basis.

Eligibility
You are eligible, and continue to be eligible; to be a member while you meet all of the following conditions:

1. You are a member in good standing of the Union, or an office employee.
2. You are actively working for an Employer, a Retired Member (or seeking employment through Local 530).
3. You have been continuously employed by an Employer at least as long as the waiting period.

Members must contribute to the plan for a period of 15 consecutive years immediately prior to retirement in order to be eligible for pensioner coverage.

Waiting Period – the period to accumulate 300 Bank Hours in the Welfare Trust Fund.

Pro-Rating – After a member has accumulated his 300 Bank hours, he will be eligible for Dental coverage on a prorated basis. For example, if the 300 hours have been accumulated after July 1, the member would be eligible for 50% of dental coverage until the year-end.

DEFINITIONS

Active Member – means a member who is working or seeking employment through Local 530 and is not collecting Local 530 Pension.

Contribution Hours – means the hours earned by a member of the Union for an Employer for which contributions are made to the Welfare Trust Fund.

Dependant

A. Means your spouse or a dependent child of you or your spouse.
B. Means an unmarried child who is entirely dependent on you for maintenance and support and who is:
    - under 21 years of age, or
    - under 25 years of age and attending a college or university full-time.

Employer – means any person, Company or business organization that is a party in a Collective Bargaining Agreement.

Spouse – means the person who is married to you, and/or a person who is living with you and is publicly represented as your wife or husband will be considered to be your spouse.

Union – means the International Brotherhood of Electrical Workers Local 530 Health and Welfare Trust Fund.

Enrolment – to enroll, you must submit a completed enrolment card. If you have a dependant, request dependant insurance when you enroll. If you have no dependant when you enroll and later acquire one, request dependant insurance, (e.g. birth of first child, marriage). If your new dependant

is a common-law spouse, see your Plan Administrator to find out how to enroll for dependant insurance.

Effective Date – your insurance is effective on the latest of:

- the date that you become eligible,
- the date that you enroll for insurance, or
- the date that Green Shield Canada / Manulife approves your evidence of insurability.

Minimum Contributions – All members must contribute a minimum of **1,400** hours each calendar year to maintain active membership in the plan.

The Health & Welfare Trustees review the contributions each year and those members that do not work the required number of hours will be billed for the difference. Depending on work availability, this bill may be adjusted. Failure to pay any amount owing will result in removal from the plan. To re-establish his membership the member must pay his bill in full and accumulate 300 hours. At this time the member will be deemed a "new member". This could adversely affect other benefits such as retirement or spousal coverage. Please make prompt arrangements to pay any amounts owing. Members may appeal in writing any amounts billed.

Termination of Insurance – your insurance could terminate for several reasons. For example:

- you are no longer eligible, (i.e., you are no longer actively working, or seeking work),
- the provision or the policy terminates.

Your drug card must be returned to your Plan Administrator.

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MANULIFE FINANCIAL BENEFIT SUMMARY

This Benefit Summary provides information about the specific benefits supplied by Manulife Financial.

Basic Life Insurance	Benefit Amount - $100,000 Termination Age – Benefits will be reduced to $10,000 upon attainment of age 65.
Dependent Life Insurance	Benefit Amount - $10,000 spouse. Termination Age – upon death of a member.
Basic Accidental Death and Dismemberment	Benefit Amount - $5,000 Termination Age - When you reach age 65.
Weekly Indemnity (Short Term Disability)	Benefit Amount - 75% of weekly earnings, to a maximum benefit of $500 Qualifying Period – 1 calendar day, if the disability is due to an accident; 8 calendar days, if the disability is due to a sickness Maximum Benefit Period - 26 weeks Termination Age – member's retirement.

Explanation of Commonly Used Terms

The following is an explanation of the terms used in this Benefit Booklet.

Dependent
your Spouse who is insured under the Provincial Plan.

Spouse
your legal spouse, or a person continuously living with you in a role like that of a marriage partner.

Drug
a medication that has been approved for use by the Federal Government of Canada and has a Drug Identification Number.

Earnings
regular rate of pay from your employer (prior to deductions), excluding regular bonuses, regular overtime, and including regular commissions.

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the lesser of:

- the amount reported on your claim form, or
- the amount reported by your employer to Manulife Financial and for which premiums have been paid.

Immediate Family Member
you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

Medically Necessary
broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Non-Evidence Limit
you must submit satisfactory medical evidence to Manulife Financial for Benefit Amounts greater than this amount.

Provincial Plan
any plan which provides hospital, medical, or dental benefits established by the government in the province where the insured person lives.

Qualifying Period
a period of continuous total disability, starting with the first day of total disability, which you must complete in order to qualify for disability benefits.

Union
International Brotherhood of Electrical Workers Local 530.

Applying for Group Benefits
To apply for Group Benefits, you must submit a completed Enrolment or Re-enrolment Application form, available from your Plan Administrator. Your Plan Administrator then forwards the application to Manulife Financial.

Making Changes
To ensure that coverage is kept up to date for yourself and your dependents, it is vital that you report any changes to your Plan Administrator. Such changes could include:

- change in Beneficiary
- applying for coverage previously waived
- change in Name

To make such changes, you must complete the Application for Change Form available from your Plan Administrator.

The Claims Process

How to Submit a Claim

All claim forms, available from your Plan Administrator, must be correctly completed, dated and signed. Remember, always provide your Group Policy Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim.

Your Plan Administrator can assist you in properly completing the forms and answer any questions you may have about the claims process and your Group Benefit Program.

Who Qualifies for Coverage?

Eligibility

You are eligible for Group Benefits if you:

- are a Member in good standing with the International Brotherhood of Electrical Workers Local 530,
- are performing work within the jurisdiction of the Union,
- have sufficient hours earned,
- are a member of an eligible class,
- are residing in Canada.

Your dependents are eligible for coverage on the date you become eligible or the date you first acquire a dependent, whichever is later. You must apply for insurance for yourself in order for your dependents to be eligible.

Evidence of Insurability

Medical evidence is required when you apply for insurance in excess of the Non-Evidence Limit.

Effective Date of Coverage

- If Evidence of Insurability is not required, your Group Benefits will be effective on the date you are eligible.
- If Evidence of Insurability is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

You must be actively at work for insurance to become effective.

Your dependent's insurance becomes effective on the date the dependent becomes eligible, or the date any required medical evidence on the dependent is approved by Manulife Financial, whichever is later.

Termination of Insurance

Your Group Insurance will terminate on the earliest of:

- the date you cease to be an eligible Member

- the date you cease to be actively at work, unless the Group Policy allows for your coverage to be extended beyond this date
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy terminates or coverage on the class to which you belong terminates
- the date of your death

Your dependents' insurance terminates on the date your insurance terminates or the date the dependent ceases to be an eligible dependent, whichever is earlier.

Your Group Benefits

Member Life Insurance

If you die while insured, this benefit provides financial assistance to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit
Benefit Amount - $100,000
Non-Evidence Limit - $100,000
Qualifying Period for Waiver of Premium - 6 months
Termination Age - your benefit amount reduces to $10,000 on your 65th birthday.

Submitting a Claim
To submit a Member Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form. A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form which is available from your Plan Administrator. Your attending physician must also complete a portion of this form. A completed claim form must be submitted within 180 days from the end of the qualifying period.

Waiver of Premium
If you become Totally Disabled while insured and prior to age 65 and meet the Entitlement Criteria outlined below, your Life Insurance will continue without payment of premium.

Definition of Totally Disabled
Restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience.

The availability of work will not be considered by Manulife Financial in assessing your disability.
If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 2 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled

Your Group Benefits

- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience

- you must be receiving from a Physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial . At any time, Manulife Financial may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this booklet
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience
- the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial
- the date you do not attend an examination by an examiner selected by Manulife Financial
- the date of your death

Recurrent Disability

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived, and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, Manulife Financial will waive the Qualifying Period.

Your amount of insurance on which premiums were previously waived will be reinstated.
If the same disability recurs more than 6 months after cessation of your Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Member Life Insurance. If you die during this 31-day period, the amount of Member Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion. For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Dependent Life Insurance

If your dependent (spouse) dies while insured, the amount of this benefit is paid to you.

The Benefit

Benefit Amount - $10,000
Termination Age – upon death of a plan member.

Submitting a Claim

To submit a Dependent Life Insurance claim, you must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form. A completed claim form must be submitted within 90 days from the date of loss.

Conversion Privilege

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by Manulife Financial, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Accidental Death and Dismemberment

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

The Benefit

Benefit Amount - $5,000
Non-Evidence Limit - $5,000

Qualifying Period for Waiver of Premium - 6 months
Termination Age - your benefit amount terminates at age 65 or retirement, whichever is earlier

Schedule of Losses
A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury
- occurs within 365 days from the date of the accidental injury
- is total and irreversible or irrecoverable

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 100%
- Loss of or Loss of Use of both Arms or both Legs - 100%
- Loss of or Loss of Use of One Arm and One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66 2/3%
- Loss of Sight of One Eye - 66 2/3%
- Loss of Speech or Hearing in Both Ears - 66 2/3%
- Loss of Thumb and Index Finger One Hand - 33 1/3%
- Loss of four fingers on the same hand - 25%
- Loss of Hearing in One Ear - 25%
- Loss of All Toes of One Foot – 12 1/2%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident. No more than 100% will be paid for all losses due to any one accidental injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while you are living).

Exposure and Disappearance
If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling, made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If you disappear after a conveyance in which you were travelling, made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Rehabilitation Expenses
If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Manulife Financial will pay incurred expenses, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- incurred within a period of 2 years from the date of the accidental injury

The amount payable is subject to a maximum of $10,000. No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Repatriation Expenses
If you die as a direct result of an accidental injury which occurs while travelling 100 kilometres or more from your place of residence, Manulife Financial will pay for expenses incurred for the preparation and transportation of your body to your place of residence. The amount payable is subject to a maximum of $10,000.

Family Transportation Expenses
If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and are confined to a hospital located 150 kilometres or more from your place of residence, Manulife Financial will pay the hotel and travel expenses incurred by an immediate family member, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- for hotel accommodations in the vicinity of the hospital
- for transportation by the most direct route to the hospital, including return fare

If transportation is by means other than a conveyance which is licensed to transport fare-paying passengers, expenses incurred will be reimbursed at a rate of $0.20 per kilometre travelled.
The amount payable is subject to a maximum of $1,500 per accident per accident.

Dependent Education Expenses
If you die as a direct result of an accidental injury, Manulife Financial will pay the tuition for each child who is enrolled as a full-time student:

- in a school for higher learning above the secondary school level, or
- at the secondary school level, but who enrols as a full-time student in a school for higher learning within 365 days after your death

A school for higher learning means any accredited university, private college, collèges d'enseignement général et professionel (CEGEP), community college or trade school.
The maximum payable each year for each child is the lesser of:

- 5% of your Accidental Death and Dismemberment benefit amount, or

- $5,000

The benefit is payable for up to a maximum of 5 years.
No payment will be made for:

- tuition expenses incurred prior to your death
- room and board expenses, or other living, travelling or clothing expenses

Spousal Occupational Training Expenses

If you die as a direct result of an accidental injury and your spouse must participate in a formal occupational training program to become qualified for employment for which he or she would not otherwise have sufficient qualifications, Manulife Financial will pay for expenses incurred by your spouse, provided the expenses are:

- reasonable and necessary, as determined by Manulife Financial
- incurred within a period of 3 years from the date of the accidental injury

The amount payable is subject to a maximum of $10,000. No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Seat Belt Benefit

If you die as a direct result of an accidental injury sustained while driving or riding in an automobile, Manulife Financial will pay an additional amount equal to 10% of the Benefit Amount of your Accidental Death and Dismemberment benefit, provided you were wearing your seat belt and it was properly fastened at the time of the accidental injury.

Permanent and Total Disability

If, as a direct result of an accidental injury, you become permanently and totally disabled while insured for this benefit, Manulife Financial will pay a lump sum benefit, provided:

- you become permanently and totally disabled within 365 days after the date of the accidental injury
- you have been permanently and totally disabled for a continuous period of 12 months and remain so disabled at the end of this period

The amount of benefit payable is equal to your Accidental Death and Dismemberment benefit amount.

Definition of Permanent and Total Disability

You are considered permanently and totally disabled if you are wholly and continuously disabled due to an accidental injury which is severe enough, in Manulife Financials' opinion, to permanently prevent you from working for remuneration or profit.

Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated

maximum. The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

Submitting a Claim

To submit an Accidental Death Claim, your beneficiary must complete a Life Claim form. To submit a Dismemberment Claim, you must complete an Accidental Dismemberment Claim form. Both forms are available from your Plan Administrator, and require a physician's statement. A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

If, while the Group Policy is in force, your Member Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Member Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the benefit terminates.

Exclusions

No Accidental Death & Dismemberment benefits are payable if the loss results from:

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol.

Weekly Income (Short Term Disability)

If you become disabled while covered and meet the Entitlement Criteria for this benefit, Manulife Financial will pay a disability benefit.

The Benefit

Benefit Amount - 75% of weekly earnings, to a maximum of $500
Qualifying Period – 1 calendar day, if the disability is due to an accident; 8 calendar days, if the disability is due to a sickness
Maximum Benefit Period - 26 weeks
Termination Age – member's retirement

Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- you must be continuously disabled throughout the Qualifying Period
- Manulife Financial must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation
- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial

At any time, Manulife Financial may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Periods for Which You are Not Entitled to Benefits

You are not entitled to benefit payments for any period that you are:

- not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Manulife Financial
- receiving Employment Insurance, maternity or parental benefits
- on lay-off during which you become Totally Disabled
- on leave of absence during which you become disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law
- receiving benefits under an employer-sponsored salary continuance or wage loss replacement plan, or receiving temporary disability benefits from Workers' Compensation
- receiving earnings or payments from any employer, including severance payments and vacation pay
- incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

- Canada or Quebec Pension Plans, including dependent benefits
- any government motor vehicle automobile insurance plan or policy which is considered an allowable exclusion under the Employment Insurance Premium Reduction Regulations, unless prohibited by law

Subrogation

If your disability is caused by another person and you have a legal right to recover damages, Manulife Financial will request that you complete a subrogation reimbursement agreement when you submit your Weekly Income claim.

On settlement or judgement of your legal action, you will be required to reimburse Manulife Financial those amounts you recover which, when added to the disability benefits that Manulife Financial paid to you, exceed 100% of your lost income.

Payment of Disability Benefits
Disability benefit payments will be made weekly in arrears. Any payment for a period of less than one week will be made at a daily rate of one-seventh of your weekly benefit amount.

Termination of Benefit Payments
Your disability benefit payments will cease on the earliest of:

- the date you cease to be disabled, as defined under this benefit;
- the date you work in any occupation for wage or profit;
- the date you do not supply Manulife Financial with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation;
- the date you do not attend an examination by an examiner selected by Manulife Financial;
- the date on which benefits have been paid up to the Maximum Benefit Period for this benefit;
- the date you retire; or
- the date of your death

Recurrent Disability
If you become disabled again from the same or related causes within 2 weeks from the end of the period for which Weekly Income benefits were paid, Manulife Financial will treat the disability as a continuation of your previous disability.

You will not be required to satisfy any applicable Qualifying Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

If the same disability recurs more than 2 weeks after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Submitting a Claim
To submit a claim, you must complete the Weekly Income Claim form which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.
A completed claim form must be submitted within 180 days from the end of the Qualifying Period.

Exclusions
No benefits are payable for any disability related to:

- any illness or injury which arises out of or in the course of employment, unless Workers' Compensation denies your claim
- any illness or injury for which benefits are payable under the Quebec Automobile Insurance Act

- self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- medical or surgical care which is not medically necessary
- the committing of or the attempt to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- abuse of addictive substances, including drugs and alcohol, unless you are actively participating and cooperating in a medical treatment program for substance abuse which has been approved by Manulife Financial

GREEN SHIELD CANADA BENEFITS SUMMARY

Services shown below will be eligible if they are usual, reasonable, and customary, and are medically necessary for the treatment of an illness or injury. Please contact your benefits administrator or Green Shield Canada (GSC) Customer Service Centre at 1.888.711.1119 to determine benefit eligibility and coverage details. All claims must be received by GSC no later than 12 months from the date the eligible service was incurred.

For Prescription Drugs
Co-pay is the rendered amount that must be paid by you or your dependent before reimbursement of an expense will be made.

For other Health Benefits
Co-pay is the eligible allowed amount that must be paid by you or your dependent before reimbursement of an expense will be made.

TERMINATION
Your coverage will end on the earliest of the following dates:

a) the date you cease to be a member of IBEW Local 530 Health and Welfare Plan;
b) the end of the period for which rates have been paid to GSC for your coverage; or
c) the date the group contract terminates.

Prescription Drugs

- Maximum plan pays: Unlimited
- A co-pay equal to dispensing/compounding fee in excess of $5 applies to each prescription
- Ontario residents only: The Ontario Drug Benefit co-pay/deductible for seniors **is** a benefit
- Enhanced generic substitution (EGS) - If a medical practitioner or dentist prescribes a drug for which a less costly alternative medication is available, your plan will cover no more than the cost of the lowest priced equivalent drug, regardless of interchangeability, even if the medical practitioner or dentist indicates “no substitution” on the prescription. If a medical practitioner or dentist indicates a brand name drug is medically required, GSC must be provided with a

copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (that can be obtained from the Health Canada website) completed by the medical practitioner or dentist that has been submitted to Health Canada, to determine eligibility for payment of the cost of the prescribed drug.

- Smoking cessation program, one course of treatment in any 12-month period.

Erectile Dysfunction (ED) Drugs: will now be covered. The following guidelines apply:
Please note that for the ED drugs, documented medical evidence indicating that erectile dysfunction has existed for a period of at least 6 months, must accompany the first reimbursement request. To be eligible for coverage, patients must have one or more predisposing risk factors, such as diabetes, hypertension, peripheral vascular disease, neurological or endocrine disease, or medication-induced erectile dysfunction. If necessary, claimants may also be required to provide other information requested by Green Shield's Medical or Pharmacy Consultant.
Up to 24 tablets every 3 months will be allowed, to a maximum cost of $1,550 in a 12-month period, such 12-month period commencing from the date of the first eligible claim.

Claims must be submitted using a special authorization form, which is available from Green Shield's Customer Service Centre, along with supporting documentation from a medical doctor and the paid receipts. The initial claim will be reimbursed directly to the patient (unless pre-approved); subsequent claims can be submitted through Green Shield's pay direct drug system.

Prescription drug benefits are eligible if they:

a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law; and
b) legally require a prescription and have a Drug Identification Number (DIN); and
c) are approved under GSC's drug review process; and
d) are paid on a Pay Direct basis.

GSC reserves the right to manage its drug formularies through an evidence-based review process in which drugs are evaluated based on overall value taking into account clinical efficacy, safety, unmet need and plan affordability. Formulary management includes the right to:

- add a drug to GSC's formularies;
- exclude or remove a drug from GSC's formularies regardless of Health Canada approval and/or the existence of provincial coverage;
- place restrictions on a formulary drug as determined by GSC. Restrictions may include, but are not limited to, GSC's pre-approval of the drug before the claim can be reimbursed, requirement to obtain the drug through an approved provider, and requirement to obtain a lower cost alternative of the same treatment such as a generic or a biosimilar drug.

If approved by GSC, this plan includes drugs with a Drug Identification Number (DIN) that do not legally require a prescription, including but not limited to nitroglycerin, insulin, and all other approved injectables, as well as related supplies such as diabetic syringes, needles, testing agents, limited access drugs and some over-the-counter drugs. In addition, this plan includes all vaccines.

Certain drugs require prior approval from GSC before your drug claim can be reimbursed. Further, certain drugs defined by GSC as specialty, high cost drugs may be required to be purchased from an approved pharmacy that is a member of GSC's Specialty Drug Preferred Provider Network (PPN) before your claim can be reimbursed. You can find out if your drug requires prior approval or is included in the PPN either by using the online drug search tool available to you through GSC's Plan Member Online Services, or by contacting GSC's Customer Service Centre.

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.

Benefits do not include drugs for the treatment of obesity, infertility and nicotine replacement products (such as patches, gum, lozenges, and inhalers), reference biologic drugs that have an approved biosimilar.

Conditional Drug Formulary™ - Effective January 1, 2007
New drugs introduced to the Canadian marketplace and approved by Health Canada after **January 1, 2007** (conditional/controlled date) will be subject to an evaluation process by GSC to determine the Need, Safety, Effectiveness and Cost.

Upon filling a prescription, your Pharmacist will know whether the drug is covered, covered with conditions, or not covered. If the drug is covered with conditions, you must contact our Customer Service Centre to obtain a Special Authorization Form and a Criteria Sheet for your physician to complete. Once these forms are completed, they must be returned to GSC for review. We will advise you if the drug is covered or not covered. Once the drug has been approved for your use, all future claims can be submitted electronically.

Extended Health Services

- Deductible: $25 Single or $25 Family per calendar year. This is waved for members enrolled on GreenShield online.
- Overall Maximum: Unlimited
- All dollar maximums are expressed in Canadian dollars
- Your co-pay for all other Extended Health Services is 0%
- Deductible applies to Emergency Transportation, Accidental Dental, Medical Items, Private Duty Nursing in the Home and Professional Services

Emergency Transportation
Ambulance Transportation, for land or air ambulance to the nearest hospital equipped to provide the required treatment.

Accidental Dental

Accidental Dental benefits for treatment by a dentist. A dental accident report form must be submitted immediately following the accident.

Hearing Care
Reimbursement will be made for standard hearing aids, repairs or replacement parts up to a maximum of $500 every 5 years. No amount will be paid for batteries.

Medical Items

Standard Prosthetic Appliances and Durable Medical Equipment as well as replacements, repairs, fittings, and adjustments of such devices. Contact the Customer Service Centre to verify eligibility of a particular benefit.

- Orthotics: $400.00 maximum every 3 years.
- Prosthetic Eyewear (1/Lifetime) at 50% reimbursement.

Private Duty Nursing in the Home
Private duty nursing benefits carry a maximum of $25,000 per calendar year for the services of a Registered Nurse (R.N.) to supplement the Provincial Home Care Program with additional nursing hours. If the Provincial Home Care Program is not involved with ongoing registered nursing care in the home, then the request for services will be ineligible. The plan does not cover services of a Personal Support Worker (PSW).
Please note - all in home care requires prior approval.

Professional Services

- Physiotherapist, *Chiropractor and *Registered Massage Therapist (medical referral required): up to a maximum of $800 per calendar year combined.
  *Registered Massage Therapist: subject to a $40 per visit maximum
  *Your co-pay for Chiropractor is 50%
- Osteopath, Podiatrist/Chiropodist, Naturopath or Speech Therapist: up to a maximum of $250 per one practitioner per calendar year.
- Psychologist: up to a maximum of $500 per calendar year

NOTE:

- Podiatry services are not eligible until your Ontario health insurance plan annual maximums have been exhausted
- Professional Services are only eligible when the practitioner rendering the service is a member in good standing with their provincial regulatory agency or an active member of a professional association, either of which must be recognized by GSC. Please contact the GSC Customer Service Centre to confirm eligibility when in doubt

Vision

- Your Vision benefit carries a maximum of $400 for member and spouse every 2 calendar years ($250 every 2 calendar years for dependent children) inclusive for prescription eyeglasses or

contact lenses, or laser eye surgery, or optometric eye examinations, or medically necessary contact lenses, provided they are dispensed by an Optometrist, an Optician or an Ophthalmologist
- Laser eye surgery (plan member and spouse only) up to a maximum $2,000 (less any paid claims in previous 2 calendar years) every 10 years

Commencement of your benefit period is based on the initial date you receive vision benefits. The date of service for vision benefits is the date **payment is made in full** for the eyewear.

Travel

- Travel benefits are eligible for the first **60** days per trip
- Maximum plan pays: $1,000,000 per covered person per calendar year for Emergency Services and $50,000 per calendar year for Referral Services
- If you live in a province that offers coverage for hospital and medical services while you are out-of-Canada, expenses for these services are eligible only if your provincial health insurance plan provides payment toward the cost of incurred services. This restriction does not apply if your province does not offer out-of-Canada coverage
- Deductible and co-pay do not apply to Travel

Expenses arising as a result of a medical emergency while you or an eligible dependent are temporarily outside of your regular province of residence for vacation, business, or education will be considered eligible under the Travel benefit.

To qualify for benefits, the claimants must be covered by their respective provincial government health plan or equivalent at the time the expenses are incurred.

Eligible travel benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial health insurance plan.

All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, based on the country of the payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.

Upon notification of the necessity for treatment of an accidental injury or medical emergency, **the patient must contact GSC Travel Assistance within 48 hours of commencement of treatment.**

- **Emergency means** a sudden, unexpected injury, illness or acute episode of disease that requires immediate medical attention **and could not have been reasonably anticipated based upon the patient's prior medical condition**. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence.

- Any invasive or investigative procedures must be pre-approved by GSC Assistance Medical Team.

Eligible benefits are limited to the maximum days per trip as shown above commencing with the date of departure from your province of residence. If you are hospitalized on the last day shown above, your benefits will be extended until the date of discharge.

1. **Hospital services and accommodation** up to a standard ward rate in a public general hospital;

2. **Medical/surgical services** rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;

3. **Emergency Transportation**

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

4. **Referral services** – (a) hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or (b) medical surgical services rendered by a legally qualified physician or surgeon;
   - **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial health insurance plan and GSC **must be obtained**. Your provincial health insurance plan may cover this referral benefit entirely. You must provide GSC with a letter from your attending physician stating the reason for the referral, and a letter from your provincial health insurance plan outlining their liability. **Failure to comply in obtaining pre-authorization will result in non-payment**
5. **Services of a registered private nurse** up to a maximum of $5,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse (R.N.) registered in the jurisdiction in which treatment is provided. You must contact GSC Travel Assistance for pre-approval;

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

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

8. **Medical appliances** including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs,

and when the devices are obtained outside your province of residence;

9. **Treatment by a dentist** only when required due to a direct accidental blow to the mouth up to a maximum of $2,000. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GSC Travel Assistance along with dental X-rays;

10. **Coming Home** - when your emergency illness or injury is such that:
    - GSC Assistance Medical Team specifies in writing that you should immediately return to your province of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major air terminal nearest the departure point in your province of residence
      This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, cancellation penalties or airfares for accompanying family members or friends are not included;

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

11. **Cost of returning your personal use motor vehicle** to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $1,000 per trip. We require original receipts for costs incurred, i.e. gasoline, accommodation and airfares;
12. **Meals and accommodation** up to $1,500 (maximum of $150 per day for up to 10 days) will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you when you remain with a travelling companion or a person included in the "family" coverage, when the trip is delayed or interrupted due to an illness, accidental injury to or death of a travelling companion. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from commercial organization;

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

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

- identify a deceased prior to release of the body

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

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

GSC Travel Assistance Service

The following services are available 24 hours per day, 7 days per week through GSC's international medical service organization.

These services include:

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination
- Multilingual assistance
- Assistance in locating the nearest, most appropriate medical care
- International preferred provider networks
- GSC Assistance Medical Team consultative and advisory services, including second opinion and review of appropriateness and analysis of the quality of medical care
- Assistance in establishing contact with family, personal physician and employer as appropriate
- Monitoring of progress during treatment and recovery
- Emergency message transmittal services
- Translation services and referrals to local interpreters as necessary
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers
- Special assistance regarding the co-ordination of direct claims payment
- Co-ordination of embassy and consular services
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary
- Management, arrangement and co-ordination of repatriation of remains
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
    1. the return of unaccompanied travel companions
    2. travel to the bedside of a stranded person
    3. rearrangement of ticketing due to accident or illness and other travel related emergencies
    4. the return of a stranded personal use motor vehicle and related personal items

- Knowledgeable legal referral assistance
- Co-ordination of securing bail bonds and other legal instruments
- Special assistance in replacing lost or stolen travel documents including passports
- Courtesy assistance in securing incidental aid and other travel related services

How Travel Assistance Service Works
For assistance dial **1.800.936.6226** within Canada and the United States or call collect **0.519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GSC Identification card.

Quote your GSC Identification Number, found on your GSC Identification card, and explain your medical emergency. **You must always be able to provide your GSC Identification Number and your provincial health insurance plan number.**

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, we will guarantee the provider (hospital, clinic or physician), that you have the required provincial health insurance plan coverage and GSC travel benefits as detailed above.

GSC Assistance Medical Team will follow your progress to ensure that you are receiving the best available medical treatment. These physicians also keep in constant communication with your family physician and your family, depending on the severity of your condition.

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

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

2. Upon notification of the necessity for treatment of an accidental injury or medical emergency, GSC's Assistance Medical Team reserves the right to determine whether repatriation is appropriate if the patient's medical condition will require immediate or scheduled care. Such repatriation is mandatory, where the Assistance Medical Team determines that the patient is medically fit to travel and appropriate arrangements have been made to admit the patient into the provincial government health care system of their province of residence. Repatriation will ensure continued coverage under the plan. Should the patient opt not to be repatriated or elects to have such treatment or surgery outside their province of residence, the expense of such

continuing treatment will not be an eligible benefit;

The patient must contact GSC Travel Assistance within 48 hours of commencement of treatment. Failure to notify us within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum, whichever is the lesser of the two;

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

4. If planning to travel in areas of political or civil unrest, or in areas where Global Affairs Canada (GAC) has issued a formal travel warning regarding non-essential travel, contact GSC Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services;

5. GSC reserves the right, without notice, to suspend, curtail or limit its services in any area in the event of political or civil unrest, including rebellion, riot, military uprising, labour disturbance or strike, act of God, or refusal of authorities in a foreign country to permit GSC to provide service. This includes travel in any area if at the time of booking the trip (including delay of travel), or before your departure date, Global Affairs Canada (GAC) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city due to a likely or actual epidemic or pandemic, (non-essential travel will be deemed as anything other than a significant medical or family emergency, such as the death of a family member);

Travel Exclusions

In addition to the General Overall Exclusions, eligible benefits do not include and reimbursement will not be made for:

1. Any expenses incurred for the treatment related directly or indirectly to a pre-existing or pre-diagnosed medical condition that, at the time of your departure from your province of residence, was not completely stable in the professional opinion of GSC Assistance Medical Team and where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling. GSC reserves the right to review your medical information at the time of claim.

   Stable means that during the 90 days immediately preceding your departure:
   a) your pre-existing/pre-diagnosed medical condition:
      i) has been controlled by the consistent use of the same medications and dosages (excluding

changes in medication that regularly occur as part of your ongoing treatment, or decreases in dosage resulting from an improvement in your pre-existing or pre-diagnosed medical condition) prescribed by a legally qualified medical professional;

ii) has not, in the reasonable opinion of a legally qualified medical professional, required additional treatment for a recurrence, complications or any other reason related either directly or indirectly to your pre-existing or pre-diagnosed medical condition;

b) you have not consulted a legally qualified medical professional for, or had investigated or diagnosed, a new medical condition for which you have not received medical treatment;

c) you have not scheduled/are not awaiting any future appointments for non-routine examinations, consultations, tests or investigations (including results) for an undiagnosed medical condition;

d) you have not scheduled/are not awaiting any exploratory surgical procedures for an undiagnosed medical condition or surgical procedures for a diagnosed medical condition;

2. Any expenses incurred for services that are not required as a result of an Emergency. Eligible benefits will not be reimbursed for treatment or surgery that could reasonably be delayed until you return to your province of residence;

3. Any expenses incurred for services received that:
   a) are not covered under your provincial health insurance plan; or
   b) are normally covered under your provincial government health insurance plans' out-of-Canada coverage (where applicable), when the provincial health insurance plan declined payment;

4. Any expenses incurred for services, treatment or surgery received once the patient has opted to not be repatriated or elects to have such treatment or surgery outside their province of residence;

5. Any claims arising directly or indirectly from any medical condition you suffer or contract in a specific country, region or city due to an epidemic or pandemic, if at the time of booking the trip (including delay of travel), or before your departure date, Global Affairs Canada (GAC) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city. In this exclusion a medical condition is limited to the reason for which the formal travel warning was issued and includes complications arising from such medical condition;

6. Treatment or services required for ongoing care, rest cures, health spas, elective surgery, check-ups or travel for health purposes, even if the trip is on the referral of a physician;

7. Treatment or service that you elect to have performed outside Canada when the medical condition would not prevent your return to Canada for such treatment;

8. Any expenses for injuries caused by, arising from, or directly or indirectly contributed to by the abuse or excessive consumption or use of medications, drugs, alcohol or other toxic substances or for injuries caused by, arising from, or directly or indirectly contributed to as a result of the consequences of such abuse or excessive consumption. Use of alcohol which gives rise to a blood

alcohol level of more than 80 milligrams in 100 milliliters of blood will be deemed to be excessive consumption or use and this exclusion will apply.

9. Any expenses relating directly or indirectly to an injury sustained as a result of the covered person's operation of a motorized vehicle while legally impaired or intoxicated as a result of the excessive use of a medication, drugs, alcohol or other toxic substances. Use of alcohol which gives rise to a blood alcohol level of more than 80 milligrams in 100 millilitres of blood will be deemed to be intoxication as a result of excessive use and this exclusion will apply. A motorized vehicle means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to an automobile, truck, motorcycle, moped, snowmobile, or boat).

10. Amounts paid or payable under any Workplace Safety and Insurance Board or similar plan;

11. Hospital and medical care for childbirth occurring within 8 weeks of the expected delivery date from the date of departure, or deliberate termination of pregnancy;

12. Treatment or service provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, Long-Term Care (LTC) Facility, health spa, or nursing home;

13. Services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation;

14. Cataract surgery or the purchase of eyeglasses or hearing aids;

15. Any expenses incurred during any trip taken for the purpose of seeking medical treatment or advice that have not been previously authorized as outlined in referral services.

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

GENERAL INFORMATION

GENERAL OVERALL EXCLUSIONS

Eligible Services 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) committing a criminal offence;

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 medical or dental practitioner;

4. the completion of any claim forms and/or insurance reports;

5. Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document or prescription from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis;

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

7. service and charges for sleep dentistry;

8. services or supplies that:
   a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) 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 prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, 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 primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
   g) 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;
   h) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence.
   i) 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;

j) would normally be paid through any provincial health insurance plan, worker's compensation board or tribunal, the Assistive Devices Program 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;
k) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as result of changes in provincial health plan legislation or delisting of any provincial health plan services or supplies;
l) may include but are not limited to, drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
m) are provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such eligible service;
n) relates to treatment of injuries arising out of a motor vehicle accident;
o) 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.

Claim Information

Pre-authorization
For **pre-authorization** forward a pre-authorization form OR a physician's prescription indicating the diagnosis and what is prescribed.

Submitting Claims
When submitting a claim to GSC, you must show the GSC Identification Number for the person who has received the benefit. You can find the applicable GSC Identification Number for yourself and each of your dependents listed on your GSC Identification Card.

Original itemized paid receipts are required for claims reimbursement **(cash receipts or credit card receipts alone are not acceptable as proof of payment)**.

GSC reserves the right to request supplementary claims information. Failure to respond to requests for supplementary information 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 could result in termination of coverage under this benefit plan.

Overpayments
GSC 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 GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the Limitations Act, 2002.

In all other provinces, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the Insurance Act, or other legislation applicable in your province or territory of residence.

Coordination of Benefits (COB)
Where you or your dependents have coverage with more than one carrier, claims will be coordinated so that reimbursement from all coverage will not exceed 100% of the actual claim. Visit our web site at greenshield.ca or call our Customer Service Centre at 1.888.711.1119 for information on COB.

Subrogation
GSC retains the right to subrogation if benefits have or should have been paid or provided by a third party. In cases of third-party liability, you must advise your lawyer of these rights.

Plan Member Online Services
In addition to this booklet and our Customer Service Centre, we also provide you with access to our secure website. Self-service through the GSC website makes things quick, convenient and easy. Register today to:

- View your Benefit Plan Booklet
- Access your personal claims information, including a breakdown of how your claims were processed
- Simulate a claim to instantly find out what portion of a claim will be covered
- Submit certain claims online
- Search for a drug to get information specific to your own coverage (or coverage for your family)
- Search for eligible dental, paramedical, and vision care providers in a particular location (within Canada)
- Search for vision and hearing care providers who offer discounts to GSC plan members through our Preferred Provider Network
- Arrange for claim payments to be deposited directly into your bank account
- Print personalized claim forms and replacement Identification Cards
- Print personal Explanation of Benefits statements for when you need to co-ordinate benefits

Register online at greenshield.ca .

UNION SELF INSURED BENEFITS

Dental Coverage Provisions

We DO NOT have a dental plan with any insurance carrier, therefore, when you or any member of your family goes to a dentist and are asked if you have insurance the answer is no.

However, we do have a pay direct coverage in which we reimburse the members from our Health & Welfare plan upon receipt of any bills issued by a registered dentist. All you have to do is bring your receipt to our office and you will be reimbursed to the current rate of payment in each calendar year. The only exception for claims is the loss of dentures.

The current rate of coverage for the year 2021 is as follows:

Active Union Members: $3000.00 per year, per family.
Retired Union Members: $750.00 per year. per family.

Employee Assistance Program (EAP)

The Employee Assistance Program is a voluntary, confidential counselling and information service for you and your family. The program is designed for you and your family members with personal problems, pressures and stress before your problems reach a crisis point, and before they affect your health, family life or job performance.

For further information please read the EAP brochure and/or contact your plan administrator.

Family Counselling Center

IBEW Local 530 has a contract with Family Counselling Center, all members and family members are eligible to use their services. To access Family Counselling Centre please call 519-366-0120, for after hours emergencies please call 1-844-864-8343. Identify yourself as an IBEW Local 530 member or family member. Please call Local 530 for more information or to pick up an information brochure.

Coverage for Local 530 Widows/Widowers

Health care coverage for the spouses of Local 530 members ceases two years following the death of the plan member. After this time the Health & Welfare Plan will pay up to $500.00 yearly towards Health Insurance Premiums or Miscellaneous Medical Expenses (Not to exceed the limits set out in the Local 530 Welfare plan). Receipts are to be turned into the Union office once per year. This coverage is available to the spouses of members who have maintained a continuous membership in the Health and Welfare Plan for 20 years.