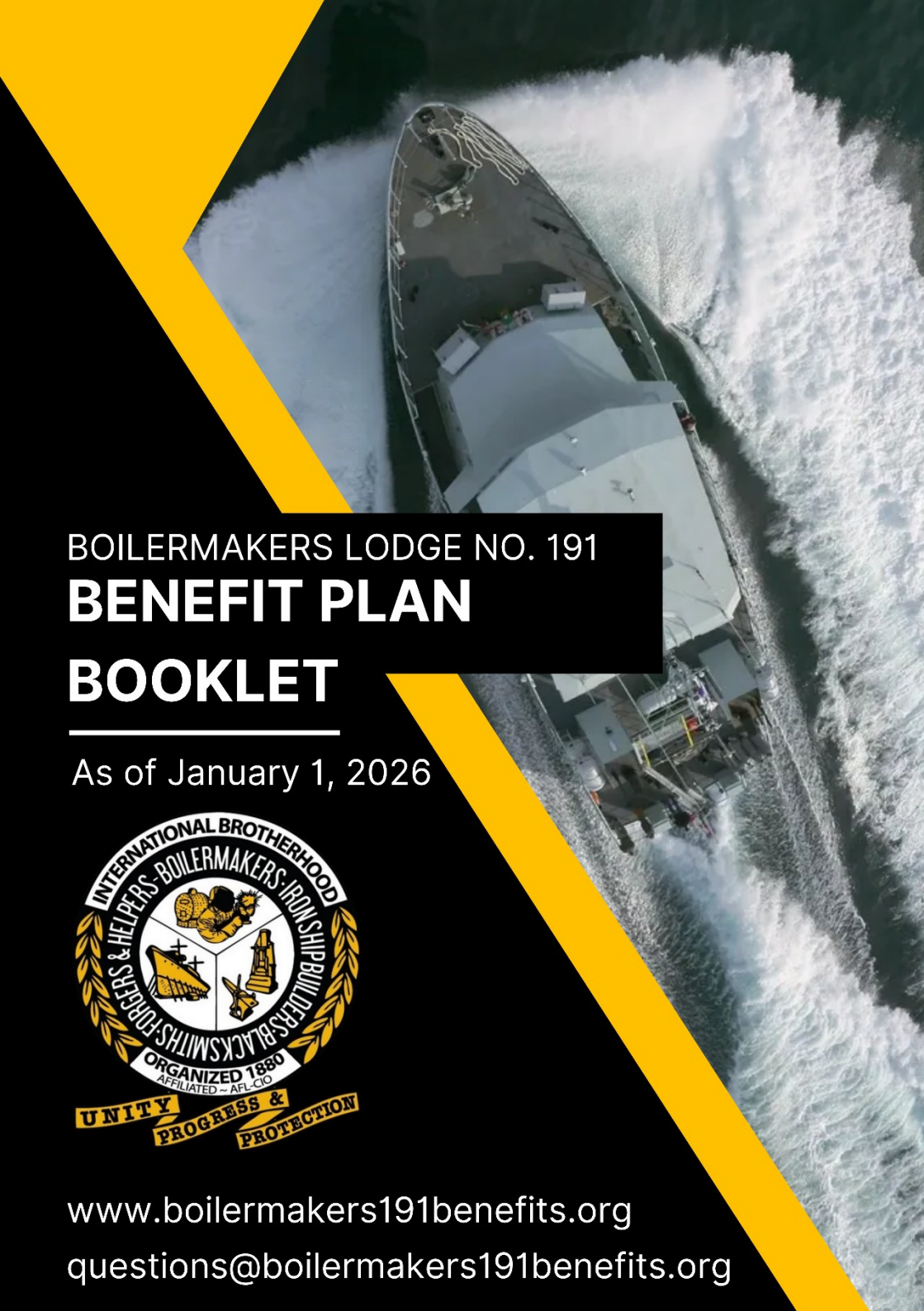

BOILERMAKERS LODGE NO. 191

BENEFIT PLAN BOOKLET

As of January 1, 2026

www.boilermakers191benefits.org

questions@boilermakers191benefits.org

TABLE OF CONTENTS

PRIVACY POLICY

We, the Trustees of The Boilermakers Lodge No. 191 Benefit Plan, 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 is 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 the 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' benefits.
- 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.

SCHEDULE OF BENEFITS

Benefit	Amount
Employee & Family Assistance Program *See page 9 for details*	Available for all eligible members and dependants
Life Insurance *See page 9 for details*	Member - $60,000 Spouse - $25,000
Weekly Indemnity Benefit *See page 10 for details*	EI Maximum (integrated with EI)
Extended Health Benefits *See page 14 for details*	100% eligible expenses, no deductible, maximum $1,000,000 per covered person per lifetime
Drugs *See page 14 for details*	No Copay Included in the $1,000,000 lifetime maximum
Vision Care *See page 15 for details*	100% to a maximum of $750 Every 24 months (12 months for dependent children under age 19)
Dental Plan *See page 20 for details*	100% Basic, 75% Major – subject to the maximums as shown 50% Orthodontic to a maximum of $2,000 per lifetime
Out of Province/Canada Emergency Medical Travel Insurance *See page 25 for details*	$5 Million maximum per coverage period
Accidental Death & Dismemberment *See page 26 for details*	$60,000

ELIGIBILITY DETAILS

Who is eligible for Health Benefits?

Any Member in good standing who has sufficient hours for coverage and is working under a collective agreement requiring employer contributions to this Plan.

Do any forms have to be completed?

Yes. You must complete the Plan's enrolment and beneficiary designation form.

How does a person qualify for coverage?

Coverage under the Plan will commence on the 1st day of the month following the month (lag) in which 350 hours have been credited to the Member's hourbank. Permit Members or Lodge 191 Members who have been suspended or have taken a withdrawal card must become Members in good standing of Lodge 191.

In order for Travel Card Members to qualify for coverage, they must become a Member in good standing of Lodge 191, at which time, reciprocation to their previous union plan will stop, and the accumulation of 350 new hours to the Plan will begin. Coverage under the Plan would commence on the 1st day of the month following the month (lag) in which 350 hours have been credited to the Member's hourbank as a Lodge 191 Member in good standing. Hours paid prior to the Travel Card Member transferring to Lodge 191 are not credited to the hourbank.

Example

Your employer(s) report your hours on a monthly basis. In the example below, it is on the November report when you reach the 350-hour level. November hours are reported in December (the lag month), and coverage becomes effective on the 1st day of January.

Month	Hours Reported
September	75 hours
October	100 hours
November	200 hours
December	Lag month
January	Coverage starts

Each month, 125 hours will be deducted from the hourbank to provide coverage. Any excess hours will be accumulated in your hourbank for future coverage.

Once coverage starts, you will remain covered as long as your hourbank contains sufficient hours.

A maximum of 8 months' coverage can be accumulated in a Member's hourbank.

The Trustees may change the number of hours deducted from your hourbank in the future, and/or may change the maximum number of months coverage that can be accumulated in the hourbank.

Enrollment under the Provincial Plan

Any individual covered for medical benefits under this Plan is required to be enrolled under the provincial health plan in their province of residence or its proxy, whether or not the individual is enrolled in a provincial plan or the required proxy. **The Plan will not pay any benefits for any services or supplies that are eligible for reimbursement under a provincial health or government plan.**

Are Dependants covered under the Plan?

Yes. The Plan will provide health coverage for:

- The spouse of a covered Member;
    - Spouse means the Member's legal spouse, or a person who has been residing with the Member continuously for a period of at least one year and has been publicly represented as the Member's spouse in the community in which they reside.
- Any unmarried child of a covered Member to age 21, provided such person is mainly dependent on and living with the covered Member;
- 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;
- 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.

To add, delete or change the dependants covered, obtain an enrolment and beneficiary designation form from the Administrator or your Union Office, and forward it to the Plan Administration Office.

When does coverage end?

Coverage will terminate when there are insufficient hours in the hourbank to allow for a deduction of 125 hours.

For any member who is suspended or issued a withdrawal card, coverage will be terminated immediately, and the hourbank will be forfeited.

Coverage will terminate once the Member has reached their maximum number of self-payments allowed by the Plan, or a self-payment notice sent to the Member is not returned with payment.

Self-Pay: Active Members

A Member in good standing of Lodge 191 may continue full coverage through self-payment. A self-pay notice will be sent by email, if there is no email on file, it will be sent to the last known address. The maximum number of consecutive self-pay months allowed is 12.

Reminder: If full coverage lapses for a Member who has continually been a Member in good standing, that Member will be required to accumulate 250 new hours reported to the Plan in order to re-qualify for full benefits.

Self-Pay: Retired Members

Members in good standing, who have registered for retired members cards through the Union, on or after January 1, 2021, who are covered by the Plan on the date they retire, **may continue to be covered by the Plan until the hours in their hourbank are exhausted, at which point, they will be given the opportunity to continue their coverage by self-paying for a further 24 consecutive months.** If a retired Member returns to work for a signatory employer, those hours reported and paid to the Plan on behalf of that Member will be permitted to accumulate in their hourbank until sufficient hours permit requalification of coverage under the Plan.

Benefits provided under the Plan coverage are subject to the maximum age permitted by each benefit. The maximum age for Life Insurance, AD&D and Emergency Medical Insurance and Travel Assistance is age 80.

Disability Credits

For disabilities incurred on or after January 1, 2024, when a Member is collecting benefits under the Weekly Indemnity Plan, EI Sickness Benefits, or under WorkSafeBC, Members can apply to the Plan Administrator to receive assistance with their hourbank.

Once approved for Disability Credits, the Member's hourbank balance will be 'frozen', and for each day that the Member is disabled and on a claim that has been accepted for payment, the Member's hourbank will be credited with contributions of 8 hours per day, subject to a maximum of 125 hours per month for up to 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. If the Member is disabled for longer than the maximum Weekly Indemnity claim of 26 weeks, the Member must contact the Administration Office to inquire about further disability credits. Evidence of continued disability must be provided.

If the Member remains disabled after receiving 12 consecutive months of Disability Credits, coverage will continue if there are sufficient hours in their hourbank to allow for a deduction of 125 hours, or if they opt to self-pay for their coverage up to the maximum of 12 consecutive months permitted.

During the months that a Member is self-paying for coverage, the benefit card will not be activated/reactivated until payment is received by the Administrator and processed. If a prescription or other eligible benefit that would normally be claimed using the benefit card is required prior to that, the Member or dependant will be required to pay for the expense and submit the claim to the Administrator for reimbursement or submit the claim via the Plan's Green Shield app (see page 13).

Can hours be frozen while working for another Lodge 191 employer who does not contribute to this Plan?

Yes. On notification from the Union office, hours can be "frozen" while you are covered with another employer under Lodge 191's jurisdiction, who does not contribute to this Plan. Hours can be frozen for up to 12 months, after which they will be forfeited.

Are there any reciprocity agreements with other Boilermaker Locals?

Yes. If a Member is working under another local of the International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers, they may be entitled to have their contributions remitted to The Boilermakers Lodge 191 Benefit Plan. The Union office must be contacted to ensure there is a reciprocity agreement in place with the local you are working in, and you must advise the local in which you are working that you are a Member of Lodge 191 and wish your contributions transferred to this Plan.

SURVIVOR BENEFITS

When a covered Member becomes deceased, if there is a balance in their hourbank sufficient to provide coverage, the surviving eligible dependants may continue to be covered under the Plan until there are insufficient hours in the hourbank to allow for a deduction of 125 hours. At that point, the surviving eligible dependants will be provided the option to self-pay for their coverage for up to 12 additional months.

If the Member is self-paying for coverage during the month of their death, the surviving eligible dependants will be permitted to continue to self-pay for up to a maximum of 12 months, inclusive of the months which were already self-paid up to and including the month of death of the Member.

EMPLOYEE & FAMILY ASSISTANCE PROGRAM (EFAP)

The EFAP is a voluntary, confidential, short-term counselling and advisory service that connects you and your eligible family members to a network of dedicated professionals available 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.

For additional information, please refer to the brochure available from the Administrator. Access the Employee and Family Assistance Program (EFAP) 24/7 by phone, web or mobile app.

This service is provided by Telus Health.

Visit: one.telushealth.com or call 1-844-880-9137

username: boilermakers191

password: eap

LIFE INSURANCE

Each eligible Member is insured for a Life Insurance benefit of $60,000.

The maximum age for Life Insurance coverage is age 80.

This amount of insurance is payable to the beneficiary designated by you should your death occur from any cause while you are insured under the Plan's group insurance policy.

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

Spousal Life Insurance

If your spouse should die while insured for this benefit, the $25,000 Spousal Life Insurance will be paid to you, if living, otherwise 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 Plan's group insurance policy and would be available at any time within 31 days after termination of your Life Insurance benefit, provided you have not reached the maximum age under the Plan's policy. Your life would continue to be insured under the group policy during the 31-day conversion period, whether or not you apply for an individual policy.

Contact Sun Life – 1-877-893-9893 – without delay for more information. Your policy number is #G56709.

If you Become Totally Disabled

Subject to satisfactory proof, submitted within 12 months from the date the Member becomes totally disabled, a Member who is under age 65 and who becomes totally disabled and continues to be disabled for 6 months, as a result of accident, injury or disease will, on written application, be eligible for the total amount of the Life Insurance to remain in force providing the person remains totally disabled, subject to termination at age 65. Proof of total disability will be required from time to time.

WEEKLY INDEMNITY BENEFIT

A benefit of the Employment Insurance (EI) weekly maximum benefit rate will be paid to each eligible Member who is disabled and unable to work as a result of a non-occupational accident or sickness. Benefit payment commences on the 1st day of a non-occupational accident and on the 4th day of a non-occupational sickness. If you are hospitalized prior to the 4th day of sickness, benefits commence on the 1st day of hospitalization. If a surgical procedure is performed on an outpatient basis, in a general hospital, benefits will commence on the date the surgery was performed.

If you are eligible for EI Sickness benefits, benefits from the Plan will cease during the period you are eligible to collect EI. If you are still disabled after reaching the maximum duration of EI sick benefit payments, or if you are not eligible for EI, or only partially eligible, the Plan will continue benefits for up to a maximum of 26 weeks, including the period paid for by EI Sickness benefits.

Plan members must apply for EI Sickness Benefits as soon as they become disabled.

A Member who makes a claim for Weekly Indemnity benefits must be seen and treated by a physician within 3 days (excluding weekends) of disability, unless there are extenuating circumstances. Otherwise, the determination of

eligibility for benefit commencement date will be as of the first day of treatment.

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 Boilermakers Lodge No. 191 Benefit Plan.

How to claim for Weekly Indemnity:

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

1. Obtain a claim form from the Plan Administration Office and note instructions concerning an EI Sickness claim.
2. Contact your doctor immediately upon becoming disabled. You must be seen and treated during the time of your disability.
3. Complete the form where indicated and have your doctor complete the physician's portion of the form.
4. Your Union must complete the authorization at the bottom of the form.
5. Send the completed form to the Plan Administration Office without delay.

Any claim for the weekly disability income benefit must be received by the Plan Administration Office within 30 days of the date of Total Disability. Late filed claims will not be accepted or considered.

Claim payments will be deposited into your bank account. Be sure to include this with your application.

Third Party Liability

The Plan will not pay benefits to the Member where a Member becomes Totally Disabled as a result of an injury or sickness in respect of which

- a third party may be, directly or indirectly, either in whole or in part, liable to the Member or
- the Member has a claim for benefits under workers compensation legislation.

Recurrence of Former Ailments

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

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

unrelated cause.

Weekly Indemnity (WI) Exclusions and Limitations

No benefit will be paid for periods of disability:

- arising from a motor vehicle accident.
- arising from an occupational accident or illness, as these are covered by WorkSafe BC / Workers compensation legislation; except as a fully repayable loan upon receipt of a signed Loan & Replacement Agreement between the Member and the Plan.
- arising from self-inflicted injuries or disease.
- Arising from the use of drugs or alcohol unless the person is being actively supervised by and receiving continuous treatment for that disability from a rehabilitation centre, a physician or an institution provincially designated for that treatment.
- arising from injuries or disease resulting from war or participation in a riot or arising while serving as a member of any armed service.
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from EI, or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence.
- during which the insured is receiving or eligible to receive EI benefits.
- any day you perform any form of work for wages or profit.
- arising from your commission of or attempt to commit an assault or criminal offence.
- 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.

Termination of Benefit

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

- you are no longer disabled;
- you are no longer receiving continuing medical care or treatment from your physician;
- you fail to submit satisfactory proof of continuing disability as required by the Plan;

- you refuse a medical examination by a physician chosen by the Plan;
- you are no longer following the treatment recommended for your disability;
- you leave the province, state or country where you normally work and live, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by the Plan.
- you perform any work for compensation or profit;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire;
- you reach age 65; or
- you die.

SUBMITTING CLAIMS

All eligible claims must be submitted electronically, preferably by the service provider. Prescription drug claims must be submitted by the pharmacy. Please show your benefit card to your pharmacist and any other healthcare practitioners so that they can submit your claims directly to the Plan.

Members can submit health claims through GreenShield+.

Register for GreenShield+ by going to app.greenshieldplus.ca/signin or clicking the claims payment service link on the plan's website. Electronic payments will be made to your bank account.

You may also download the free "GreenShield+" app to submit claims through your mobile device if your provider did not submit your claim for you. Search "GreenShield+" in the App Store or Google Play.

In the event that eligible prescription drugs are prescribed and dispensed outside of Canada, the receipts can be submitted to the Plan Administration Office. Claim forms are available on the Plan website. Your fully completed claim form and receipts can be emailed to questions@boilermakers191benefits.ca or faxed to 1-

905-946-2535, or mailed to:

Boilermakers Lodge No. 191 Benefit Office

45 McIntosh Drive

Markham, ON L3R 8C7

All claims must be received by the Administrator within 12 months of the service date to be considered for payment.

EXTENDED HEALTH BENEFITS

The Extended Health Benefit is designed to help you pay for specified services and supplies incurred by you and your dependants, when not provided under a provincial health or government plan. The names of your eligible dependants are listed on your benefit card.

Any individual covered for medical benefits under this Plan is required to be enrolled under the provincial health plan in their province of residence or its proxy, whether or not the individual is enrolled in a provincial plan or the required proxy. **The Plan will not pay any benefits for any services or supplies that are eligible for reimbursement under a provincial health or government plan.**

The services mentioned in this section are eligible expenses when incurred as a result of the necessary treatment of illness or injury, and where applicable, when ordered by a physician.

Reasonable and customary (R&C) charges apply to all benefits.

There is no annual deductible, and 100% of eligible expenses will be reimbursed up to a maximum of $1,000,000 per lifetime.

Prescription Drugs

Your Plan provides coverage for prescription drugs and medicines that require, and can only be obtained with, a written prescription from a licensed physician or dentist, if provincial law permits.

Drugs and medicines are limited to a 100-day supply. Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Vacation supplies of your medications that exceed the regular supply limit must be pre-authorized by the Plan and paid for in full by the Member, who then submits them to the Plan for reimbursement. If a member requires more than a 100-day supply of medication, they must contact the Plan Administration Office.

Drugs and medicines that are normally available “over the counter” are excluded, even if a prescription is provided. Fertility drugs, vitamins, preventative

medications, dietary foods and supplements are also excluded.

Smoking cessation products will be covered up to a lifetime maximum of $500 per person.

All prescription drug claims are subject to the Plan's $1,000,000 per covered person lifetime maximum benefit.

Health Care Paramedical Practitioners

The Plan will provide coverage for the services of the following medical paramedical practitioners, subject to the specified reimbursement levels and specific benefit maximums. Providers must be registered with their professional association and practising within the scope of their license.

- Accupuncturist
- Chiropractor (including x-rays)
- Physiotherapist
- Registered Massage Therapist
- Registered Psychologists
- Registered Clinical Counsellor
- Licensed Social Worker
- Licensed Dietitian
- Naturopath (including x-rays)
- Osteopath (including x-rays)
- Podiatrist (including x-rays)
- Speech Therapist

These charges will be covered at 100% up to a maximum of $1,500 per eligible person per calendar year, for all eligible paramedical practitioner types combined. Benefits are paid based on reasonable and customary charges for the practitioner in the Plan Member's province of residence. These services may not be provided by a family member or relative, whether or not a resident of the same household.

Vision Care

Eye exams, performed by a licensed optometrist or ophthalmologist, **are covered for a maximum of $85 every 24 months and are included in the $1,000,000 lifetime maximum benefit.**

Laser eye surgery is covered for a $1,000 lifetime maximum per eligible person.

The following are covered for a maximum of $750 per 24 consecutive months per eligible person (12 consecutive months for dependant children under age 19).

- One set of glasses, bifocal or trifocal lenses, prescribed by a person legally qualified to make such a prescription;
- One set of frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable. One frame is limited to $700.
- Contact lenses prescribed by a person legally qualified to make such a prescription.

The following items are excluded:

- Duplicate or spare eyeglasses or any lenses or frames thereof;
- Safety goggles, sunglasses (plain or prescription);
- Replacement or lost, stolen or broken lenses or frames.

Orthotics and Footwear

One pair of custom-fitted orthopedic shoes when prescribed by a physician or podiatrist, and replacements when necessitated by normal wear and tear.

One pair of custom-made orthotics (including moulds and arch supports), when prescribed by a physician or podiatrist, to a maximum of $200 per eligible person per calendar year.

2 modifications every 6 months to custom orthotics and footwear are covered.

Ambulance Benefit

The Plan will pay the charges in excess of the amount payable under your provincial 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.

Private Duty Nursing Care Benefit

The Plan will pay up to $25,000 per covered person during any 3 consecutive benefit years for the charges for the services of an out-of-hospital private duty nurse. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or a 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 These charges are subject to reasonable and customary limitations and will be considered eligible only if medically necessary and recommended by a physician.

Medical Services, Supplies, and Durable Medical Equipment

The Plan provides 100% coverage on a reasonable and customary basis (unless stated otherwise below) for the following medical services and supplies. Your provincial plan is the first payer for all eligible expenses. The following items are included in the $1,000,000 lifetime maximum:

- Charges for walkers, canes and cane tips, crutches, splints, casts, collars and trusses, but not elastic or foam supports.
- Charges for surgical stockings to a maximum of 2 pairs per calendar year.
- Charges for stump socks.
- Charges for surgical brassieres to a maximum of 2 per calendar year as a result of a mastectomy.
- 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.
- Cost of rental or, where more economical, purchase of durable equipment for therapeutic treatment, including wheelchairs and hospital beds.
- Manual wheelchairs, the Plan covers 1 every 60 months to a maximum of $800. Rentals are covered for 3 months in a 12-month period.
- Electric wheelchairs, the Plan covers 1 every 60 months, only when a doctor certifies the patient is incapable of operating a manual wheelchair (e.g. Paraplegic).
- Wigs and hairpieces required as a result of chemotherapy up to a maximum of $300 per eligible person per year.
- Charges for CPAP, BIPAP, APAP. Eligible supplies include hose/tubing (1 per year), filters 2 packages per year), water chamber (1 per year). 2 masks are covered per calendar year.
- Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies.
- Charges for testing supplies, needles, syringes, and glucose monitoring systems and supplies for diabetics. Insulin pen injector covered for 1

purchase every 3 years. Blood glucose meter covered for 1 purchase every 3 years. Freestyle Libre/Dexcom/Medtronic sensors are covered for 7 sensors every 100 days.

Accidental Dental Benefit

The Plan covers the 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 was covered under this benefit; and
- The charges are incurred within 6 months of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 6-month period.

Hospital Benefit

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

Convalescent Hospital Benefit

The Plan will cover the charges for a convalescent hospital, up to a maximum of $20 per day for a maximum of 180 days, for treatment of an illness resulting from the same or related causes.

Hearing Aid Benefit

The Plan covers hearing aids at 50% of the cost of purchase and fitting of hearing aids for all eligible Members and dependants, up to a maximum of $2,500 in a 5-year period.

WorkSafe BC is the first payer on behalf of Members.

Extended Health Services and Prescription Drug Exclusions and Limitations

The Plan's Extended Health and Prescription Drug Benefits do not cover:

- Expenses for benefits, care or services that result from a motor vehicle accident incurred on or after November 9, 2018, or which are payable by or under the Basic Medical Program, PharmaCare, any Hospital Program or the Workers Compensation Act, whether or not a claim is made thereunder or provided without cost or at a nominal cost by any public

or tax-supported authority or agency or for which the Member or dependent can recover from a third party.

- Expenses for dental services except as specifically provided above.
- Any amount of fees in excess of the usual or recognized fees for the service performed.
- Expenses incurred outside the province of residence unless resulting from an unexpected injury or sickness occurring while temporarily travelling outside the province and then only to the extent provided under the section Out of Province/Canada Emergency Medical Travel Insurance or if pre-approved under the Medical Referral Benefit as described herein.
- Expenses of services and supplies for cosmetic purposes.
- 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 offence under the Criminal Code of Canada.
- Expenses incurred for orthoptic treatment, eyeglasses, contact lenses, hearing aids, or prescriptions for any of them except as specifically provided; (see Vision Care Plan).
- Any expenses that a covered person may obtain as a benefit under any government plan or law.
- Any payment to a medical practitioner, whether or not a participant in the Basic Medical Plan, 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 a provincial plan.
- Medical Marijuana, in any and all of its forms, regardless of whether or not it has been prescribed by an attending physician.
- Drugs that have not been issued a compliance certificate and/or a Drug Identification Number (DIN) by Health Canada whether or not they have been approved under a provincial formulary.
- Charges for drugs, sera, injectable drugs or supplies that are not approved by Health Canada with a compliance certification or that do not have a Drug Identification Number (DIN) or are experimental or limited in use, whether or not so approved;

- expenses that exceed the Plan's $1,000,000 lifetime maximum benefit per covered person.

PRIOR AUTHORIZATION

Some prescription drugs, prescription drug treatment therapies and certain medical devices require prior review and approval for reimbursement through a Prior Authorization process. Your physician or pharmacist will advise you of a drug that needs prior authorization, and will be able to submit the prescribed drug electronically

To submit a Prior Authorization request:

- Log in to GreenShield+ and click the "Coverage" tab.
- Select Prior Medication Authorization and click "Request Prior Authorization."
- Search for your drug, and complete the form.

You can track your submission on the "Prior Medication Authorization" page. Submissions typically receive a response in 3-5 days, up to 10 days in some circumstances.

Prior authorization is not required for emergency drugs, such as antibiotics.

These steps and the tracking of your submission are available on the GreenShield+ mobile app.

DENTAL PLAN

The Plan will pay the eligible, reasonable, and customary costs of medically necessary dental expenses incurred by active Plan members and their eligible Dependants, as outlined below.

Electronic Claims Submission

Claims, including coordination of benefits and pre-determination of benefits, must be filed electronically by your dental provider. Please show your all-in-one benefit card to your dental office.

Maximum Annual Benefit

Maximums for basic and major dental services are listed by service below. Orthodontic services have a lifetime maximum of $2,000 per person, as shown below.

Basic Services

The following services are eligible for reimbursement of the lesser of 100% of the

amount charged or 100% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment.

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.
    - Dental x-rays: bite-wing x-rays are limited to one set in any 6-month period, 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 36-month period.
2. **Preventive Services.** All necessary procedures to prevent the occurrence of oral disease, including:
    - Cleaning: limited to twice in any calendar year.
    - Scaling and root planing: combined maximum of 15 units per calendar year.
    - 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 for children under 18.
    - Fixed space maintainers on primary teeth for dependent children under 18
    - Oral hygiene instruction: allowed once in any 36-month period.
3. **Surgical Services.** All necessary procedures for extractions and other routine oral surgical procedures normally preformed by a dentist.
4. **Restorative Services.** All necessary procedures for:
    - Filling teeth with amalgam, silicate, acrylic or composite restorations
    - Replacement restorations if at least 12 months have elapsed since initial placement.
    - Stainless steel crowns on primary teeth.
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:
        - denture relines for dentures at least 6 months old, once every 36

months

- denture rebases for dentures at least 2 years old, once every 36 months
- resilient liner in relined or rebased dentures, once every 36 months.

6. **Endodontia (Root Canals).** All necessary procedures required for pulpal therapy and root canal filling. Repeat treatment is covered only if the original treatment fails after the first 18 months.
7. **Periodontia.** All necessary procedures for the treatment of tissues supporting the teeth including grafts.
8. **Major Restorative Services**
   - Inlays, onlays and gold foils 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.
9. **Anesthesia.** General anesthesia required in relation to oral surgery.

Major Services

Prosthetic Appliances, Veneers, Crowns and Bridge Procedures.

The following services are eligible for reimbursement of the lesser of 75% of the amount charged, or 75% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment:

- Initial installations of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Partials may only be provided by a dentist.
- Initial placement of a crown or veneers and their replacement 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.

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

Orthodontia

Dependant children under 21 and adults are eligible for orthodontic services performed by an orthodontist.

Payment will be made at 50% to a maximum lifetime limit of $2,000 per person.

Payment of claims will be based on eligibility and the work completed. Appliances that are 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.

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 or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- Dental care that is cosmetic;
- Dental care provided under a medical plan provided by an employer or government.
- Which, in the absence of coverage, there would be no charge;
- Stainless steel crowns on permanent teeth;
- Protective athletic appliances;
- Anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- A full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;

- Replacement of a lost or stolen prosthesis;
- Incomplete and temporary procedures;
- Implants;
- Any dental charge for services which were started prior to the date of coverage; or
- Dental treatment which was ordered while covered (which included lab work and impressions), but was not installed or delivered until more than 31 days after the dental benefit terminated.

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

COORDINATION OF BENEFITS

When coordinating benefit payments, the Plan will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the eligible expense was incurred.

If the Member or Dependant is also covered under the Spouse's plan or under any other group plan which provides similar benefits, payment will be coordinated and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the eligible expense (for dental, the fee guide applies).

The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.

The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:

- the amount that would have been payable had it been the primary carrier, or
- 100% of all Eligible expenses reduced by all other benefits payable for the same expenses by the primary carrier.

If the other plan does not contain a coordination of benefits clause, payment under that plan must be made before this Plan will pay under this provision.

Extended health care plans with dental accident coverage determine benefits before dental plans.

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.

When the Plan has paid benefits to the Member to the limit of the Fair PharmaCare

deductible, the Plan will pay their portion of the eligible expenses based on the Plan's reimbursement percentage. 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 a further claim under this provision.

When submitting eligible claims, please be sure to include:

- Your Name (please print)
- Your Address
- Your Certificate Number/Client ID
- Your Local Union

OUT OF PROVINCE / CANADA EMERGENCY MEDICAL TRAVEL ASSISTANCE

Out of Province/Canada Emergency Medical Travel Assistance Benefit is provided to eligible members and their Dependants up to a maximum of $5,000,000 per coverage period.

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

Coverage Period: 180 days per trip

Policy Number: DAT00013344

Out of Province/Canada Emergency Medical Travel Assistance Benefit has a maximum of $5 Million per coverage period. The maximum age for coverage is age 80.

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

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

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

You must notify Global Excel before obtaining emergency treatment, so that they may confirm coverage and provide pre-approval of treatment.

ETA Benefit Details

For full details on your ETA benefit, please visit the Plan website at boilermakers191benefits.org/benefits and view the Emergency Travel Assistance booklet.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Your Accidental Death and Dismemberment (AD&D) benefit is provided by AIG Insurance Company of Canada (the "Company").

If you suffer any of the losses listed below in the Schedule of Losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is covered?	Benefit Amount
Member	$60,000
Spouse under age 70	$20,000
All eligible dependant children	$5,000

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm or One Leg	80% of the Principal Sum
Loss of One Hand or One Foot	75% of the Principal Sum
Loss of The Entire Sight of One Eye	75% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	33% of the Principal Sum
Loss of Speech or Hearing	75% of the Principal Sum
Loss of Speech and Hearing	The Principal Sum

Loss of Hearing in One Ear	66.7% of the Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	Two Times The Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two Times The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two Times The Principal Sum

How to Make a Claim

In the event of a claim, claim forms can be obtained from the Plan Administration Office.

Written notice of claim to the Company must be given no later than 30 days from the date of the accident. Within 90 days from the date of the accident, proof of claim must be submitted to the Company. Proof may include a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from a legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed above will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and in no event later than one year from the date of the accident or the Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

More Details

For more details on your AD&D benefit, please visit the Plan website at boilermakers191benefits.org/benefits.

PLAN SERVICE PROVIDERS

Plan Administration Office

45 McIntosh Drive
Markham, ON
L3R 8C7

Toll-Free: 1-800-263-3564
Email: questions@boilermakers191benefits.org

Insurers

Life Insurance and Spousal Life Insurance	Sun Life Financial Canada
	Policy # G56709 Phone: 1-877-893-9893
Accidental Death and Dismemberment	AIG Insurance Company of Canada
	Policy # GPA 9430300
Employee and Family Assistance Program	TELUS Health
	Website: one.telushealth.com
	Username: boilermakers191 Password: eap
	Call: 1-844-880-9137
Out of Province / Canada Emergency Travel Assistance	Manulife Financial / Global Excel Management Inc.
	Policy # DAT00013344

Self-Funded Benefits

Extended Health Care, Vision, Dental, Weekly Indemnity	The Boilermakers' Lodge No. 191 Benefit Plan (Hosted by The Boilermakers' National Health Plan (Canada)