Local 67

Welfare Plan

Fall 2024

Your Health Your Family Your Life

A Guide to your UA Local 67 Group Benefits Plan

Local 67
Group Benefits Plan

YOUR HEALTH AT WORK

UA Local 67 is a pioneer of organized labour in Canada. Since 1899, we've fought to protect those working in the plumbing and pipefitting industry throughout Hamilton, Brantford and Niagara. Your UA Local 67 Group Benefits Plan is one way we help do that.

To make the most out of the plan, you need to know how it works. That's where this booklet comes in. It offers a detailed look at what's covered—and, equally important, what's not. It also explains what you need to do and when to make the most out of your benefits coverage. We encourage you to read the booklet carefully and to keep it handy for future reference.

WHO MANAGES THE GROUP BENEFITS PLAN?

The Board of Trustees oversees the Welfare, Pension and SUB plans. The Board is made up of eight independent Trustees who have a "fiduciary duty"—a legal responsibility to act in the best interests of all plan members. Seven Trustees are elected by the union membership and the Business Manager of the union is appointed as a Trustee by UA Canada.

The Trustees' job is to manage our plans in the best interests of all plan members. Because the Trustees are not group benefits plan experts, one of their key responsibilities is to choose professionals who can help them manage the plan effectively. Once they've chosen these professionals, the Trustees carefully monitor their performance.

To see a list of the current Board of Trustees, please visit www.reliableadmin.com.

WHO DO I CONTACT REGARDING THE GROUP BENEFITS PLAN?

Reliable Administrative Services Inc. (RASI) is the UA Local 67 Benefit Plans in-house administrator. Since December 1982, RASI has served the Local 67 membership by providing oversight on the Welfare, Pension and SUB benefits under the governance of the Board of Trustees. As professionals, the RASI team is focused on the administration and compliance to the terms of the Trust Agreements, Plan Texts and related legislation.

RASI is committed to providing quality service, and handling all plan inquiries with integrity to it the UA Local 67 Benefit Plans members and their beneficiaries. **Questions?** Contact RASI.

RASI
RELIABLE ADMINISTRATIVE SERVICES INC.

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HOW THE GROUP BENEFIT PLAN IS FUNDED

Employer contributions made on behalf of all plan members are held in each trust fund. The trust funds are managed by the Board of Trustees, who choose professional investment managers to invest the fund's assets based on the Board's guidelines. The investments in the Welfare Trust Fund are used to subsidize each member's benefit take out rate, which is below the actual cost of insurance and administration fees. The fund's assets are solely used to pay the cost of the UA Local 67 Benefit plan.

Claims for Health, Dental, Life and Short Term Disability are paid directly out of the Welfare fund, plus the insurer's administrative fees and taxes. The Welfare fund also pays the premium to insure your Long Term Disability, Travel Medical, and Hospital Cash. Your SUB claims are paid from the SUB fund and administered by RASI.

WHAT IS BENEFITS FRAUD AND HOW IT AFFECTS YOU

Benefits fraud refers to any abuse, misuse, or overutilization of the plan as well as inappropriate health provider billing practices—whether intentional or not. All beneficiaries of the Local 67 Benefit Plan are effected by fraud as fraudulent claims paid by the Trust Fund limit the plan's ability to provide benefits.

GREEN SHIELD CANADA (GSC)'s FRAUD PREVENTION PROGRAM

GSC's Fraud Prevention Program has a variety of different tools to prevent and detect fraudulent activity and it involves a team dedicated to analyzing claims data and watching for unusual claiming patterns or anything else that stands out as odd. To do this, GSC will periodically audit claims. If inappropriate claiming behavior is suspected, they may need to take extra steps when they adjudicate and pay claims.

Suspect fraud or the possible abuse of your benefits plan?
Your concerns can be reported anonymously by calling toll-free at **1.800.265.5615** ext. **6921** or calling GSC customer service at **1.888.711.1119** and asking for the Confidential TIPS Hotline.

BOOKLET DISCALIMER

This booklet describes your UA Local 67 Group Benefits Plan in simple terms, plus information on provincial sponsored benefits that you could be eligible for. It is not a legal document and does not cover every detail, but it does give you the basic facts. We have made every effort to ensure the information presented is accurate. However, should there be any differences between the information contained in this booklet and the legal plan documents, including insurance policies and group contracts, the plan documents will apply. Also, keep in mind that all plan rates, benefit maximums, provincial benefits, and other details presented are subject to change.

YOUR PRIVACY

It is impossible to administer your group benefits without using personal information. That said, the Trustees are committed to protecting your privacy and have strict safeguards in place to protect your information from unauthorized access or use. RASI uses your personal information to administer your benefits, which extends to but is not limited to insurance providers, information technology (IT) or software providers, auditors and legal. At no time is your personal information ever shared with marketing companies or disclosed to the Board of Trustees or the Union office. In addition, you have the right to see the information on file for you and to update or correct it as necessary. For more information, please contact RASI.

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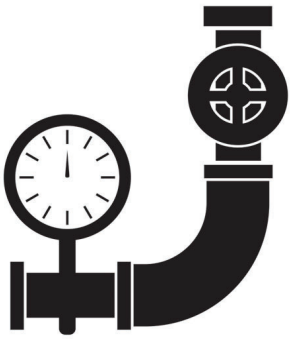
Benefits Summary
Your Plan Highlights

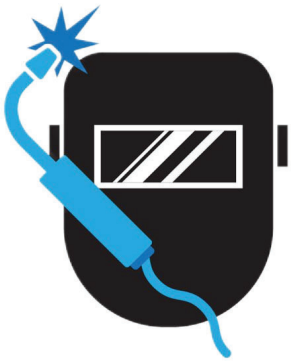
GROUP LIFE INSURANCE	
Member Life Insurance Canada Life Assurance Company	• **$50,000, reduced to $25,000 at retirement, and further reduced to $10,000 at age 71,** paid to your named beneficiary(ies) or estate.
INCOME BENEFITS	
Supplemental Unemployment Benefits (SUB) Reliable Administrative Services Inc.	• **$175 per week, up to 10 weeks;** Weeks are not deducted for periods you are attending Trade School related to your trade.
Short Term Disability (STD) Canada Life Assurance Company	• **A weekly benefit equal to the EI maximum, up to 26 weeks** • STD starts after Employment Insurance (EI) is exhausted or denied. • Benefit payments are taxable.
Long Term Disability (LTD) Canada Life Assurance Company	• **A maximum monthly benefit of $2,400,** until you reach age 62. • LTD starts after your 26 weeks of Short Term Disability (STD) ends. • Benefits payments are taxable.
HEALTH CARE BENEFITS	

Prescription Drugs
 	
Green Shield Canada
 	
This benefit is limited to a $15,000 overall annual maximum, per insured, including Extended Health Services.
	• **100% reimbursement of the drug cost for:**
	  • Level 1 Provincial Formulary NON-MAINTENANCE DRUGS purchased at any pharmacy
	  • Level 1 Provincial Formulary MAINTENANCE DRUGS if purchased through *TELUS Health Virtual Pharmacy*
	• **80% reimbursement of the drug cost for:**
	  • Level 1 Provincial Formulary MAINTENANCE DRUGS purchased at a local pharmacy
	  • Level 2 Other Formulary NON-MAINTENANCE DRUGS or MAINTENANCE DRUGS
	• **Mandatory Generic Substitution**
	• The Member pays the full cost of the pharmacy dispensing fee.

Extended Health Services (EHS)
 	
Green Shield Canada
 	
This benefit is limited to a $15,000 overall annual maximum, per insured, including Prescription Drugs.
	• **100% for eligible EHS expenses not covered by a Provincial Plan**
	• **$500 every 5 calendar years for hearing aids**
	• **$10,000 lifetime for preauthorized private duty nursing**
	• **$300 combined for vision (eyewear and eye exams)**
	  • Every calendar year for Active members
	  • Every 2 calendar years for Retirees and Dependents
	• **$300 for custom foot orthotics, every 2 calendar years**
	• **$55 per visit, up to 20 visits per calendar year for physiotherapy** ($85 is covered for the initial assessment)
	• **$400 combined maximum for eligible paramedical practitioners***
	• **$800 per calendar year for eligible mental health practitioners***
	**See pages 42 & 43 for the complete lists of eligible practitioners.*

HEALTH CARE BENEFITS (continued from the previous page)	
Group Travel Medical AIG Insurance Company of Canada	• **2 million maximum, per insured, per trip, for emergency medical benefits** outside of your province or outside of your country. • **90–Day trip duration for Active Members** • **60–Day trip duration for Retirees Members (under age 85)** • Spouses and eligible dependents are covered under the same terms as the insured member. • There is no coverage once the member turns age 85.
Health Care Spending Account (HCSA) Green Shield Canada	• **$750 credit per family, per calendar year, for eligible medical or dental expenses, or for self paid medical or dental premium under the Canada Revenue Agency (CRA) guidelines.** • Credits do not carryover. • Claim Deadline—Must be received by Green Shield, including all supporting documents within 31-days after the calendar years ends.
DENTAL CARE	
Dental Green Shield Canada	• **100% reimbursement for basic dental services** • **50% reimbursement for major dental services** • **100% reimbursement for orthodontics** • Claims are paid based on the current dental fee guide, minus 1 year • **$1,500 combined maximum, per calendar year, for ALL dental services,** orthodontic claims can only be reimbursed up to $750 in a month.





Welcome
UA Local 67 Plan Members

Welcome to the UA Local 67 Benefit Plan! The Board of Trustees strive to offer Local 67 plan members and their beneficiaries one of the most competitive and sustainable group benefit plans among the Plumbing and Pipefitters unions.

WHAT THE UA LOCAL 67 BENEFIT PLAN OFFERS

When you are considered eligible on the plan, you will have access to the following benefits as long as you remain eligible on the plan. Health Care and Dental Care benefits are extended to your eligible dependents.

Member Life Insurance, with an option to continue for your lifetime.

Supplemental Unemployment Benefits (SUB), up until you retire.

Short Term Disability (STD), up until you retire.

Long Term Disability (LTD), up until age 62.

Health Care, with options to continue for your lifetime, and the lifetime of your eligible surviving dependents, subject to the plan limitations.
The following benefits are included under Heath Care:

- **Prescription Drugs**
- **Paramedical Services**
- **Medical Services & Supplies**
- **Vision Care**
- **Group Medical Travel**, up until age 85
- **Health Care Spending Account,** for eligible medical & dental expenses.

Dental Care, with an option to continue for your lifetime, and the lifetime of your surviving dependents, subject to the plan limitations.
The following benefits are included under Dental Care:

- **Basic Dental**
- **Major Dental**

THE FIRST STEP

After the UA Local 67 Union office notifies RASI of your effective date to Local 67, RASI will mail you a Benefits Welcome Package. The welcome package will include a *Welfare Enrolment / Change Form*, which is required by RASI to enroll you and your dependents on the plan. Please complete and return the form to RASI at your earliest convenience. Provided RASI receives your form before you become eligible for benefits, RASI will automatically enroll you and your dependents on the benefits plan and mail your temporary Green Shield Canada (GSC) card to you.

Your claims will not be paid until RASI has received your completed *Welfare Plan Enrolment/ Change Form*.

JOINING THE PLAN

You will be automatically enrolled into the Welfare Plan once you have met the Eligibility, Contribution, and Enrolment requirements outlined in the chart below. After you meet the three requirements, your Welfare benefits will start on the 1st day of the month following the date you meet the requirements.

REQUIREMENTS TO JOIN THE UA LOCAL 67 BENEFIT PLAN	
1. ELIGIBILITY REQUIREMENTS—You must either:	
• Be a member in good standing with UA Local 67;	• Work full-time as a member of the administrative staff of either UA Local 67 or the UA Local 67 Benefit Plans.
2. CONTRIBUTION REQUIREMENTS—By plan:	
Welfare Plan • You must have enough employer contributions in your benefits account to pay for **3 months** of coverage under the plan.	**Supplementary Unemployment Benefit (SUB) Plan** • You must earn **1,800 SUB hours** within a period of 24 consecutive months.
3. ENROLMENT REQUIREMENTS—You MUST complete AND return the following documents to Reliable Administrative Services Inc. (RASI):	
• The *Welfare Enrolment / Change Form* • Supporting Documents for your dependents, if applicable.	

REJOINING THE PLAN

If you let your coverage stop when you do not have enough money in your benefits account—You are required to earn **2 months** of coverage in your benefits account to rejoin the Welfare Plan and **600 SUB hours** in the previous 12 months to requalify for SUB benefits.

There cannot be any break in your union membership to qualify as a member rejoining the plan.

COVERING YOUR DEPENDENTS

Once you are a member of the plan, your spouse and children will be covered under the Health and Dental benefits, provided they meet the requirements below. To add your dependents to the plan, you must list them on your enrolment form and provide any required supporting documentation.

Your dependents will be added to the plan, when you are enrolled on the plan, on the 1st of the following month when all of the required information is received by the plan administrator, RASI.

You can cover only one spouse at a time under the plan.

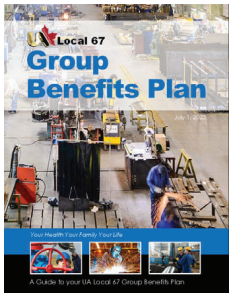
You cannot cover children from both a legal marriage and a common-law relationship at the same time unless they live with you, OR don't live with you, but are fully dependent on you for financial support.

DEPENDENT REQUIREMENTS FOR THE PURPOSE OF THE GROUP BENEFITS PLAN	
CRITERIA	
All dependents must: • reside in Canada; • be insured under a Provincial Healthcare Insurance Plan; and • be reported to the Canada Revenue Agency as an eligible dependent.	
SPOUSE DEFINITION	**CHILD DEFINITION**
Is a person of either sex who is living with you in a conjugal relationship, who is either: • legally married to you; or • your common-law partner of more than 12 months.	Is the natural, legally adopted, step or foster children of you or your approved spouse, who is: • unmarried and dependent on you or your spouse for financial support; AND • under age 21 (under age 25 if a full-time student at a recognized and accredited educational institution).
ENROLMENT REQUIREMENTS—You MUST complete AND return the following documents to Reliable Administrative Services Inc. (RASI):	
• They must appear on your *Welfare Enrolment / Change Form.* • Supporting Documents for your dependents, if applicable.	

The *Welfare Enrolment / Change Form* includes a list of acceptable supporting documentation for your dependents, if applicable. You will receive this form in your welcome package.

A new *Welfare Enrolment / Change Form* can be requested from RASI at any time and must be completed and returned to RASI if the information on your original enrolment form changes.

HOW TO GET STARTED WHEN YOU ARE ELIGIBLE FOR BENEFITS



Now that you are on the plan, this benefit booklet can help you to make the most of your benefits. Below are some of the basics you should know.

- **Benefits Booklet**—this booklet includes an Info & Tips section, to help inform you of benefit specific details, claim submission instructions, and how to complete a claim form. Plus some additional provincial resources that may be available to you.
- **GSC everywhere**—is the Green Shield's secure online account for plan members to submit their Health, Dental and HCSA claims online. It is a good idea to set up an account when you join the plan. You set your own password and provide your direct deposit information for GSC to deposit your funds. You can even indicate who GSC is allowed to speak to, such as a spouse. Simply sign up at **www.gseverywhere.ca** on your computer or download the app on your phone.
- **TELUS Health Virtual Pharmacy**—is the plan's preferred provider for prescription maintenance drugs. Your plan is designed to cover a higher reimbursement for your level-1 maintenance drugs, if you order them from TELUS Health Virtual Pharmacy, which is an online pharmacy that delivers to the address you provide. UA Local 67 plan members will also be charged a lower negotiated dispensing fee (see page 37 for more details). It is a good idea to sign up for your account when you join the plan, so your account is ready when you need it. Go to **www.teluspharmacy.com** or call **1-877-796-7979** to register.
- **innoviCares Card**—is provided to you when you and your eligible dependents join the plan. The FREE innoviCares card can help you save on select original brand name drugs. Show your card to your pharmacist to keep on file for when you require a brand name drug.
- **www.reliableadmin.com**—is the UA Local 67 Benefit Plans website. This site holds all of the benefit plan information; self-serve at your fingertips. Here you can find past benefit newsletters, claim forms, frequently asked questions, and benefit information, including an electronic copy of this booklet.
- **Reliable Administrative Services Inc. (RASI)**—is your plan administrator who is available to help you by phone, email, or in-person for all of your benefit plan needs. RASI manages all aspects of your group benefits plan, under the governance of the Board of trustees.

The RASI office is located in the same building as the Union Hall at:
195 Dartnall Road, Suite 102, Hamilton, Ontario L8W 3V9
Monday-Thursday from 9 am-5 pm and Friday 9 am-4pm
Phone: **905-387-5861** Email: **local67@reliableadmin.com**

Paying For Your Coverage

How It Works

CONTRIBUTIONS TO THE PLAN(S) ON YOUR BEHALF

Your employer contributes to both the group benefits plan and the Supplemental Unemployment Benefits (SUB) plan on your behalf. Contributions are made for each hour that you earn. The rates are set under the current collective agreement. Some collective agreements outside Local 67's jurisdiction do not include SUB.

The contribution rates are set under the current collective bargaining agreement (CBA). The Welfare rate is the group benefits plan rate per hour, and the SUB plan rate is the Supplemental Unemployment Benefit rate per hour. At the end of each month, your employer sends Reliable Administrative Services Inc. (RASI) a report of your hours earned and the contributions.

If you are a Travel Card Member working for another local, you may be able to transfer the group benefits plan contributions into the UA Local 67 Group Benefits Plan. Check with RASI to see if there is a reciprocal agreement between your old local and Local 67.

The following chart outlines the current monthly group benefit deduction rates for active members, retirees and surviving spouses. Keep in mind that rates are adjusted from time to time as the cost of benefits rise.

EMPLOYER CONTRIBUTION RATES PER HOUR*		
EFFECTIVE	**WELFARE**	**SUB**
May 2022	$2.67	$0.20
May 2023	$2.82	$0.35
May 2024	$2.97	$0.50

*Based on the Collective Bargaining Agreement.

GROUP BENEFIT DEDUCTION RATES*		
CATEGORY	**COVERAGE[1]**	**MONTHY RATE[2]**
Active	Full coverage	$410.00
Apprentice 1, 2, 3, 4, 5	Full coverage	$385.00
Extended (rate after 12 months of direct payment at the Active rate)	Full coverage	$470.00
Modified	Life, STD & LTD[3]	$195.00
Survivor	Dental & Health[3]	$250.00
Retiree Full	Life, Health & Dental[3]	$305.00
Retiree (over age 65)	Life & Health[3]	$205.00
Retiree (over age 65)	Life Only	$90.00
Retiree Survivor	Health Only[3]	$205.00
Local 666 Retiree	Life & Health[3]	$170.00
Local 666 Retiree	Life Only	$55.00

[1] Coverage is subject to individual plan age limitations.

[2] An additional 8% retail sales tax is added when you are paying direct.

[3] Eyewear is every 2 years.

*Effective June 1, 2024, and subject to change.

YOUR GROUP BENEFITS ACCOUNT (DOLLAR BANK)

Employer contributions made on your behalf are credited to your group benefits account. You use the funds in your benefits account to "pay" for your plan coverage. The regular monthly rate is deducted from your benefits account on the first of each month.

Group Benefit Deduction rates are subject to change in order to keep up with the rising cost of claims and expenses.

EXCESS CONTRIBUTIONS

You can save up to $17,000 for coverage payments in your group benefits account. On December 31st of each year, any funds in excess of this amount will be transferred to the plan's reserves. These reserves are used, as needed, by the Trust fund to pay for benefits and expenses on behalf of all members and their families.

DIRECT PAYMENTS

If you do not have enough money in your benefits account to cover the cost of your next monthly payment, RASI will send you a warning notice. At that point, you can either:

A Direct payment must be received by RASI by the 25th of the month after your benefits account falls below one month's payment.

- Keep your coverage by making a direct payment out of your own pocket; OR
- Let your coverage stop. If your coverage stops, it cannot be restarted until you return to work for a contributing employer and build up enough money in your benefit account to cover **2 months of payments**. Coverage will start again on the first day of the following month.

If you choose to make a direct payment, it must arrive at the RASI office before the 25th of the month in which coverage applies.

HOW TO MAKE A DIRECT PAYMENT

Contact RASI to confirm the amount you are required to pay to remain in benefit for another month, and follow one of the options below to make a payment.

CHEQUE or MONEY ORDER

Address it to **UA Local 67 Welfare Plan** and it should clearly show your **name**, **address** and **union number** or social insurance number (SIN).

ONLINE BANKING

Set up a "payee" in your online banking as "**Local 67 Welfare Plan**" and you must include your **SIN** as the account number.

DEBIT and CREDIT CARD

Go to www.reliableadmin.com to make a direct payment with your credit card or debit credit card or in-person at the RASI office. Alternatively, you can contact RASI to pay over the phone or to setup reoccurring payments by completing the required forms, if applicable.

FACTS ON TAX

You do not pay any tax on contributions made to the plan by your employer, except those contributions used to provide life insurance coverage. Each year, you will receive a T4A form showing the total employer contributions used to pay for life insurance coverage.

The benefits you receive from the plan are not taxable. The exception is income benefit payments, that includes short and long term disability. These payments, as well as SUB payments are also reported on your T4A.

Keep in mind that medical expenses already paid under the plan, including your Heath Care Spending Account cannot be claimed as a medical expense when filing your income tax plan.

BENEFITS RECEIPT FOR TAXES

If you made direct benefit premium payment out of your own pocket during the tax year, you can request RASI to prepare a receipt for the Health and Dental portion of the premium you paid. The Life and Disability portion of the premiums you self-paid is not an eligible medical expense according to CRA. The Health and Dental Premium Receipt can be claimed on your Income Tax or your Health Care Spending Account (HCSA) but not both.

IF YOUR BENEFITS ACCOUNT BALANCE FALLS BELOW 1 MONTH OF PREMIUM

Active members

If you are an Active Member with less than one month benefit payment in your benefits account and you can't afford the cost of regular (Full) coverage, but you want to maintain your Life, Short and Long Term Disability benefits at a reduced premium, you can:

- Buy modified (Life & Disability) coverage by making a direct payment out of your own pocket;

The current modified rate, plus 8% provincial sales tax is charged each month. Your full coverage can only be restored once you return to work and your employer has contributed enough to your benefits account to cover the cost of **two** monthly payments.

Retired Members

If you are a Retired Member, with less than one month benefit payment in your benefits account, your options will vary depending on your age. See pages 20 and 21 for details.

WHEN COVERAGE ENDS

Membership in the UA Local 67 Group Benefits Plan ends automatically on the first of the month after:

- Your membership in UA Local 67 ends; OR
- You no longer have enough money in your benefits account to pay the cost of one month of coverage and you do not make a direct payment.

You must submit any outstanding extended health and dental claims within **90-days** of your coverage ending.

Dental prosthetics (such as bridges or crowns) ordered while you were covered will be reimbursed if they are installed within 90 days of your coverage ending.

When your Membership in UA Local 67 Ends

If you'd like to continue your life insurance and are under age 65, you may arrange to buy individual life insurance directly from Canada Life. No medical exam is required within 31 days of the date your coverage ends.

If you are eligible, RASI will mail you a completed *Group Life Conversion Privilege Notification* form, which provides you the option to covert your life insurance group policy to an individually rated policy with Canada Life.

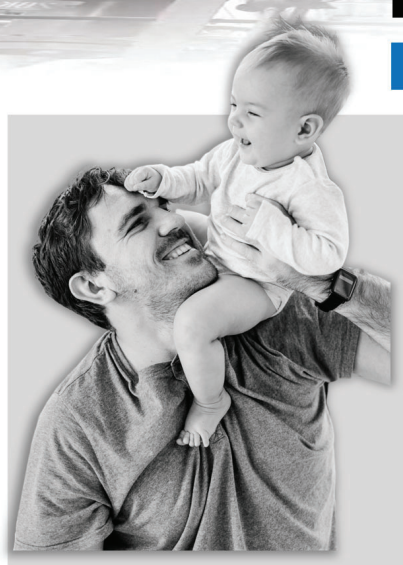
You must convert your life insurance within **31-days** of your coverage ending.

Why might a Member want to convert their group life insurance?

If you want to purchase individual life insurance but have been declined in the past or have a reason why your application may be declined, such as a medical condition or terminal illness.

By converting your life insurance within 31 days of your coverage ending, you do not need to submit medical evidence.

Keep Us Informed
Plan Member Responsibilities



CHANGES...

It is your responsibility to advise Reliable Administrative Services Inc. (RASI) when there is a change in your family status, beneficiary designation or contact information.

Below is a list of changes:

- Change in address
- Change in phone number or email
- Change in name
- Marriage or common-law
- Birth or adoption of a child
- Children aged 21 to 24 and a full-time student
- Disabled dependent
- Divorce or separation
- Loss of legal capacity of a beneficiary
- Illness or injury
- Death of a dependent
- Death of a beneficiary
- Retirement before age 65
- Retirement after age 65
- Death

It is important to know how changes can affect your benefits.

Provided below are the specifics of why it is critical to notify your plan administrator (RASI) of life events, such as a change in address, and to know your options during retirement. As well, how less common events could impact your benefits if your information is not up to date on your *Welfare Enrolment / Change Form*.

CHANGE IN ADDRESS, CONTACT INFORMATION OR NAME

It is your responsibility to provide RASI with your new address or contact information when you move, change your phone number or email address. Or if you or your dependents surname changes. As your plan administrator, RASI uses this information for the purpose of administering your benefits, including important communications regarding the status of your benefits and updating your information on your benefits card with Green Shield.

MARRIAGE OR COMMON-LAW / BIRTH OR ADOPTION OF A CHILD

When your family grows, you should notify RASI to request a new *Welfare Enrolment / Change Form*. Your new enrolment form must be completed in full and returned to RASI in order to add your new dependent(s) to your health and dental plan, or to change your life insurance beneficiary(ies).

If you name a minor child as your life insurance beneficiary, you should appoint a Trustee to look after your child's benefit in the event of your death. Simply indicate the person of your choosing to appoint as the Trustee on behalf of your child. If you don't appoint a Trustee, the plan will pay the benefit to a legal guardian who has been appointed by the court. If no Trustee is appointed, current Ontario law states that any amount above $10,000 must be paid to the Accountant of the Superior Court, who will hold the money until the minor reaches age 18.

CHILDREN AGE 21 TO 24 AND A FULL TIME STUDENT

Dependents aged 21 to 24 are eligible to remain on your group benefits plan until their 25th birthday if supporting documentation is provided to RASI to verify their full-time attendance at an accredited school. To avoid their termination from your plan, RASI must receive proof of schooling every year before September 30th.

DISABLED DEPENDENT CHILDREN

Dependents who are declared legally disabled while insured under your benefit plan are eligible to remain on your plan as a special needs dependent, if supporting documentation is provided to and approved by RASI.

DIVORCE OR SEPARATION

Notify RASI of Divorce or Separation and provide any applicable supporting documentation, as needed. You can request, complete and return a new *Welfare Enrolment / Change Form* to update your beneficiary(ies) or to remove your spouse from the plan. An ex-spouse can remain on your benefit plan if explicitly outlined in your separation agreement, however the onus to maintain benefits will remain on the member. Only one spouse can be on your benefit plan at any given time.

LOSS OF LEGAL CAPACITY—BENEFICIARY

If your life insurance beneficiary (such as a spouse) lacks legal capacity due to an injury or illness and can no longer make decisions, you can complete and return a new *Welfare Enrolment / Change Form* to appoint a Trustee to sign for and look after the life insurance benefit on their behalf, in the event of your death.

ILLNESS OR INJURY—WSIB

If you are collecting benefits from the Workplace Safety and Insurance Board (WSIB), in certain circumstances, your coverage under the UA Local 67 group benefits plan will continue up to a maximum of 12 months. The duration of your coverage depends on the hourly contributions your employer makes on your behalf, as required by Ontario Legislation. Contact RASI to confirm eligibility.

ILLNESS OR INJURY—NOT WORK RELATED

You are required to notify RASI if you cannot work due to a illness or injury that is expected to extend beyond the Short Term Disability (STD) waiting period. RASI is there to assist you with your short term disability application with Canada Life. Failure to notify RASI may cause your STD claim to be delayed or denied. Canada Life is not liable for STD claims submitted more than 6 months after your injury or 6 months plus 7 days for an illness.

DEATH OF A DEPENDENT

There is no Life Insurance for your eligible dependents. However, if your dependent is covered under your Health or Dental plan, you need to notify RASI in the event of your dependents death. Complete and return a new *Welfare Enrolment / Change Form* to RASI. You will have 90-days to submit their Health or Dental claims to Green Shield for reimbursement.

DEATH OF A BENEFICIARY

In the event your beneficiary predeceases you, you can return a new *Welfare Enrolment / Change Form* to appoint a new beneficiary(ies) to avoid your life insurance being paid to your estate, where it will be subject to probate fees, estate taxes, and creditors.

If you have already named a contingent beneficiary(ies) (back-up beneficiary), on your *Welfare Enrolment / Change Form*, your life insurance is paid to your named contingent beneficiary(ies), in the event your designated life insurance beneficiary has predeceased you.

If you have named more than one beneficiary, your life insurance is split equally between your remaining beneficiary(ies), If one of your beneficiaries predeceases you.

RETIREMENT BEFORE AGE 65

When you retire, your membership in the Retiree under age 65 benefits (Life, Health & Dental) will continue until you reach age 65. If your benefits account falls below the amount needed to cover the cost of one month of coverage, you must continue to pay the full cost by direct payment until you turn 65.

RETIREMENT AFTER AGE 65

When you reach age 65 and you still have enough funds in your benefits account to continue your coverage, you do not have to do anything.

RASI will call to notify you when your benefits account falls below one month's payment. You may choose to continue your Life, Health and Dental benefits by direct payment if:

- You are a member in good standing with UA Local 67;
- You are receiving a pension from the UA Local 67 Pension Plan; AND
- You were covered by the UA Local 67 Benefit Plan immediately before you retired.

Retirees over age 65 that have run out of funds in their benefits account and want to reduce their benefits have the following options available:

a) Pay the reduced Retiree over age 65 (Life & Health*) rate and stop your Dental benefits. *Member's vision frequency will extend to every 2 years; OR

b) Pay the reduced Retiree over age 65 (Life Only) rate to maintain your life insurance and stop your health and dental benefits.

The Retiree Full (Life, Health & Dental) rate and Retiree over age 65 (Life & Health) or (Life Only) monthly rates are found on page 14.

To qualify, you must satisfy ALL of the following conditions:

1. Be over 65 years old;
2. Be covered under the Active or Retiree group insurance premium;
3. Remain a member in good standing with UA Local 67;
4. Have a monthly premium payment for the Retiree over age 65 a) Life & Health or b) Life Only, plus 8% retail sales tax deducted directly from your monthly pension benefits or by preauthorized debit or credit; AND
5. Sign RASI's form declaring in writing your request to reduce your coverage.

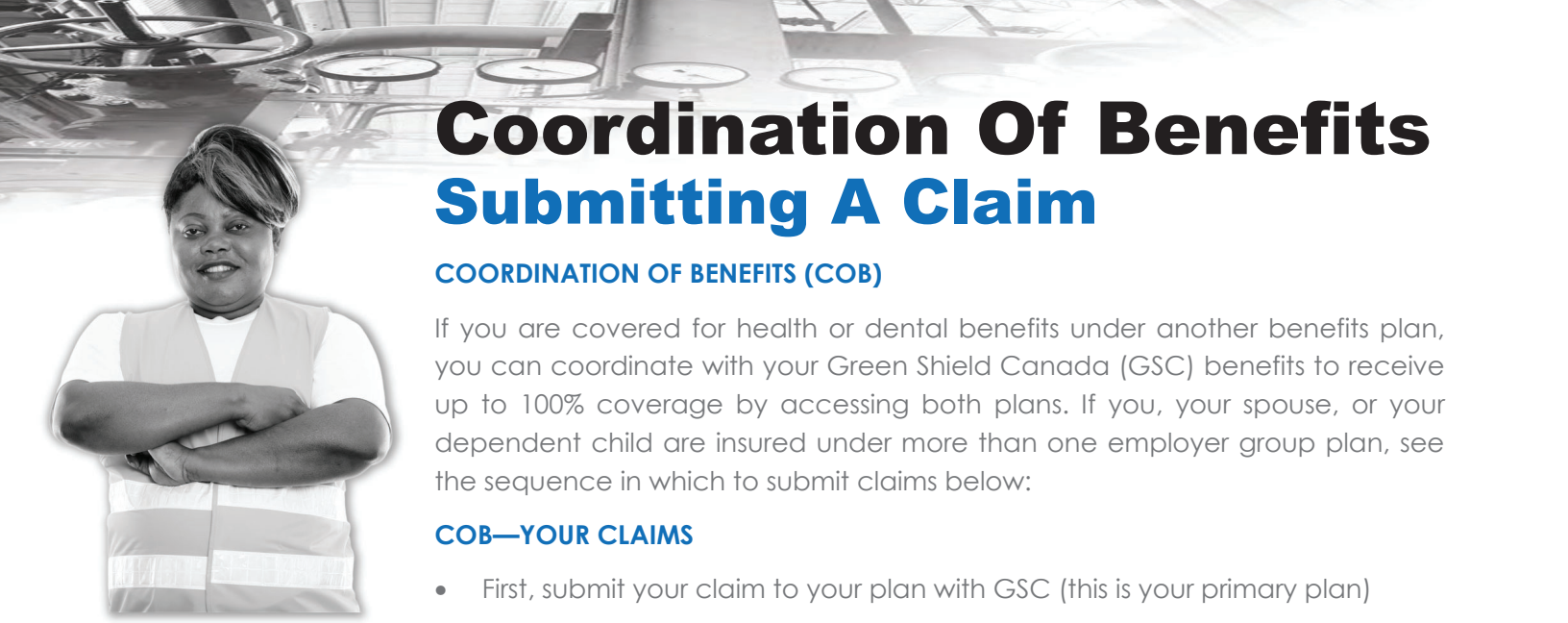
You may contact RASI at anytime to stop your benefits and payments. Once you reduce or stop your coverage, you cannot restart the benefits you stopped unless you return to work and earn the required contributions.

DEATH

If you die with full benefits, your spouse and children on your health & dental plan will remain covered until your benefits account falls below one month's payment. Your spouse then has the option to continue coverage by paying the group benefit deduction rate for *Survivors* each month by the 25th of the month after your benefits account falls below one month's payment. Your surviving family members' coverage will end if your spouse stops paying the premium. If you die with the *Retiree over age 65* (no dental) plan, your spouse can continue the health benefits at the same group benefit deduction rate.

If you die, your spouse has the option to continue coverage through direct payments.

See page 14 for the monthly *Survivor* and *Retiree over age 65 (no dental)* rates.



Coordination Of Benefits
Submitting A Claim

COORDINATION OF BENEFITS (COB)

If you are covered for health or dental benefits under another benefits plan, you can coordinate with your Green Shield Canada (GSC) benefits to receive up to 100% coverage by accessing both plans. If you, your spouse, or your dependent child are insured under more than one employer group plan, see the sequence in which to submit claims below:

COB—YOUR CLAIMS

- First, submit your claim to your plan with GSC (this is your primary plan)
- Second, submit the unpaid portion to your spouse's benefits plan (this is your secondary plan)
- Third option, you can submit any remaining unpaid portion to your Health Care Spending Account (HCSA) (this is your primary HCSA) if you have HCSA credits available.
- Fourth option (if available), you can submit any remaining unpaid portion to your spouse's Health Care Spending Account (HCSA) (this is your secondary HCSA, if applicable) provided a HCSA balance is available.

If you are covered under another employers group plan as a part-time employee, your Local 67 plan is the first payer, and the other employer plan is the secondary payor before a spouse's plan.

If you are covered under another employers group plan as a full-time employee AND you are insured under the other employer plan longer. Your other employer plan is the first payor, before the local 67 plan, followed by your spouse's plan, the other employers HCSA (if available), the Local 67 HCSA, and lastly your spouse's HCSA (if available).

If you are covered under an employer plan where you are a retiree, the plan where you are a retiree pays after the plan you are an active employee. If you are insured under two employer plans as a retiree, the plan where your coverage as a retiree has been in effect the longest is the first payor.

COB—YOUR SPOUSE'S CLAIMS

- First, your spouse must submit their claims to their benefits plan (this is their primary benefits plan).
- Second, submit the unpaid portion to your GSC plan with Local 67 (this is their secondary plan.
- Third option (if available), your spouse can submit any remaining unpaid portion to their (HCSA) (this is their primary HCSA).
- Fourth option, submit any remaining unpaid portion to your (HCSA) (this their secondary HCSA.

Your provincial health care plan pays for many health services, like a visit to your doctor. Your GSC plan covers many Health and Dental services not paid for by the province.

GSC will never pay for benefits paid by your provincial plan.

When applicable, GSC will direct you to first apply to the Assistive Devices Program (ADP) or the Home and Community Care Services, as they may pay for certain benefits through your provincial plan.

COB—YOUR CHILDREN'S CLAIMS

Below applies to applies to all joint custody arrangements:

- First, submit your children's claims to the plan of the parent whose birthday falls earliest in the calendar year (month/day), regardless of the year of birth (this is your child's primary plan).

  If both parents have the same birthdate (month/year), the parent with the earliest alphabetical order in their first name is your child's primary plan.

- Second, submit the unpaid portion to the other parent's plan (this is your child's secondary plan).
- Third option (if available), submit any remaining unpaid portion to your child's primary plan's HCSA.
- Fourth option (if available), submit any remaining unpaid portion to your child's secondary plan's HCSA.

Below applies to single custody arrangements :

- First, submit your children's claims to the plan of the parent with custody (this is your child's primary plan).
- Second, submit the unpaid portion to the spouse of the parent who has custody (this is your child's secondary plan).
- Third, submit any unpaid portion to the parent who does not have custody.
- Fourth, submit any unpaid portion to the spouse of the parent who does not have custody of the child.
- If any unpaid portion of your child's claim is remaining, the unpaid portion can be submitted to the HCSA of each parent and spouse's HCSA, following the same order.

MOTOR VEHICLE ACCIDENT OR WORK RELATED INJURY

Injuries or illnesses resulting from a car accident that results in medical or dental claims should be directed to the auto insurance company involved (the auto insurance company is the first payor, before any employer plan).

Injuries or illnesses from a work related injury that results in medical or dental claims should be directed to the Workplace Safety and Insurance Board (WSIB), who is the first payor before any employer plan.

Member Life Insurance

Group Basic Life

Life insurance can help to protect those closest to you in the event of your death.

Under current tax law, premiums paid for your life insurance are taxed as income. The exact amount is shown on your T4A form that you receive each year.

RASI will mail you a conversion package if you are covered by the plan and under age 65 when your membership with the union ends.

You must be covered by the plan at the time of your death for your Life Benefit to be paid.

Member Life Insurance Plan Provider	The Canada Life Assurance Company
Member Life Insurance Policy Number	179357
Life Insurance Benefit	$50,000 for Active Members, then reduced to $25,000 at retirement, and further reduced to $10,000 at age 71 Or $10,000 for former Local 666 Retirees, if you did not accept the one-time opt–in to the UA Local 67 benefit.
Living Life Benefit Amount You can make the request if: • You provide a written medical report from your physician attesting to the terminal illness (death expected within 24-months); and • Your beneficiary is not Irrevocable; and • You acknowledge the Living Life benefit amount, plus interest will reduce your final Life Insurance amount paid to your beneficiary.	Equal to 50% advance of your Member Life Insurance to a maximum of $25,000 or up to $5,000 for members with the $10,000 Local 666 Retiree Life benefit. If you are terminally ill with less than 24 months to live, you can request an advance Life Insurance payment. Your request is subject to approval from both your benefits administrator Reliable Administrative Services Inc. (RASI) and you group life insurance carrier Canada Life.
Group Life Conversion Privilege Your privilege is available if: • Your group life insurance benefits are terminated/end; and • You are under the age of 65. • You apply within 31 days.	Yes, if you are under the age of 65 Life conversion is the option to purchase an individual life insurance policy for the same or lower benefit amount without providing medical evidence of insurability. Canada life must receive you application within 31 days after your group coverage terminates/ends. This includes paying your first premium.
Termination Age	Death

Info & Tips
Member Life Insurance

As the administrator of UA Local 67 Benefit Plans, RASI holds the record of your Life Insurance beneficiary.

How do you select or change a beneficiary(ies) for your life insurance?

Complete and sign a *Welfare Enrolment / Change Form* and return it to Reliable Administrative Services Inc. (RASI).

What happens to your life insurance in the event of your death?

Your Life insurance benefit is paid tax-free to the beneficiary you designated on your last *Welfare Enrolment / Change Form*. If you designated multiple beneficiaries, the benefit is divided as you indicated on the form. If you did not indicate the percentage for each beneficiary, the benefit is split in equal shares.

What happens if you do not complete/return your enrollment form?

Your Estate automatically becomes your beneficiary. When Life Insurance is paid to an Estate, the benefit is subject to probate taxes.

How to designate your Beneficiary on the Enrolment/Change Form?

You can select anyone as your beneficiary by filling out their name and indicating the percentage of your life insurance benefit you want them to receive. You can choose as many beneficiaries as you wish as long as the total of the percentage is equal to 100%.

5A. Beneficiary Designation

This section is to be completed by the plan Member and must be completed to designate a beneficiary for your life insurance, if applicable.

I hereby revoke all previous beneficiary designations and designate the following beneficiary(ies).

Primary Beneficiary

Last name	First name	Middle Initial	Relationship to the plan member:	Percent Allocated (Must = 100%)

In the event of your death, your beneficiary(ies) should contact RASI. At that time, RASI will assist your beneficiary(ies) through a simple life insurance claim process.

Why does the form have an option to designate a Contingent Beneficiary?

Having a contingent (back-up) beneficiary prevents your life insurance from being paid to your estate in the event that your sole beneficiary(ies) predecease you before you have time to complete a new *Welfare Enrolment / Change Form*. Complete this section to designate a backup beneficiary(ies).

5B. Contingent Beneficiary Designation

If you wish to appoint a contingent beneficiary in the event that there are no surviving primary beneficiaries at the time of your death, please complete this section.

If there are no surviving beneficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Contingent Beneficiary

Last name	First name	Middle Initial	Relationship to the plan member:	Percent Allocated (Must = 100%)

If you don't appoint a Trustee for a beneficiary under the age of 18, the Life Benefit can be paid to a legal guardian appointed by the court. If no guardian is appointed, current Ontario law states that any amount above $10,000 must be paid to the Accountant of the Superior Court, who will hold the money until the child turns age 18.

When should you complete the Appointment of a Trustee section?

If any of your beneficiaries or contingent beneficiaries are under the age of 18, you should consider appointing a Trustee to look after the minor child's Life Insurance benefit monies.

5C. Trustee Appointment

This section only applies if you have designated a beneficiary that is a minor (under age 18 in Ontario) or a person that lacks legal capacity.

If you have named more than one minor as a beneficiary and want to appoint different trustees, attach a separate page naming the Trustees appointed to each minor.

DO NOT COMPLETE THIS SECTION IF YOU ARE A QUEBEC RESIDENT

If you have designated a beneficiary who is a minor or who lacks the legal capacity, you may wish to appoint a trustee/administrator by completing this section. This appointment may not be suitable for all purposes. If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

I hereby appoint the following trustee to receive and hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group benefits plan where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks the legal capacity. Any such payment, to its extent, will release the insurance carrier from further liability. The trustee shall act prudently and may use the money, including any returns on it or investments made, for the education and/or maintenance of the beneficiary. The trust will terminate once the beneficiary is of the age of majority and has legal capacity. At that time, the trustee shall deliver to the beneficiary all assets held in account.

Trustee Appointment (for any minor beneficiary or beneficiary that lacks legal capacity)

Last name	First name	Middle Initial	Relationship to the plan member:

For Quebec Applicants Only – Benefits payable under his pan to a beneficiary who, payment is made to a minor or lacks legal capacity, will be paid to their tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and the carrier has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section.

Supplemental Unemployment Benefits (SUB)

Income Benefit

The Supplemental Unemployment Benefits (SUB) tops up the income of members who are receiving Employment Insurance (EI) benefits due to an illness or injury or shortage of work, attendance at trade school, or a maternity/ parental leave.

The SUB plan is funded through employer contributions. Employers contribute for each SUB hour earned.

You must report any SUB payments on your income tax return.

RASI will mail your T4A slip each year you receive SUB payments.

Benefits are not paid for weeks of unemployment when the Local indicates there is work available.

SUB Plan Administrator	Reliable Administrative Services Inc. (RASI)
SUB Plan Registration, with the Government of Canada	File: **S00472-000** Name: **The Plumbing & Pipefitters Worker's Benefit Plan Local 67**
SUB Plan Eligibility	Active Members* *You are not eligible for weeks you are: • Unable to work due to a work-related illness or injury. Please apply to WSIB. • In receipt of or previously received a UA Sponsored pension plan.
Weekly Income Benefit Amount	$175 per week, up to the Annual Maximum
SUB Plan Benefit	Taxable
Annual Maximum	10-weeks per calendar year *Weeks where you attended Trade School are not counted towards the maximum.*
To Qualify for SUB you must earn*: **Not required if you are in Trade School relating to your trade.*	• 1,800 SUB hours in the previous 24 months for the first SUB claim. Or • 600 SUB hours in the previous 12 months for subsequent SUB claims.
SUB Plan Requirements	You MUST be in receipt of the following Employment Insurance (EI) benefits: • EI Regular benefits; or • EI Maternity/Paternity leave benefits; or • EI Sickness benefits AND if you are not on approved EI Sickness benefits you must: • Have signed the out-of-work list at the local Union office AND if not on EI Maternity/Parental leave: • Be available for work; or • Be attending Trade School related to your trade and recognized by JATC.

Claim Submission Deadline *You must include the required supporting documents with your claim submission.*	90-days from the date you were paid your weekly EI benefit. If you submit a claim or the supporting documents past the deadline you will not be paid for that week.
Required Supporting Documents* **Not required if you are in Trade School relating to your trade.*	Your Employment Insurance (EI) Benefit Statement (The ***My Payments*** page in your ***My Service Canada Account***) The screenshot must include the following: • Your full name • ***Report Covering Period*** including the dates of each claim week • ***Date Report Processed*** • ***Net Amount Paid*** indicating the dollar amount for each claim week PLUS, the EI Benefit Statement details page for EACH week of EI, including weeks where the Net Amount Paid is $0. (The ***My Payment Details*** in your ***My Service Canada Account)*** Each screenshot must include the following: • Your Full Name • ***Type of Benefit*** • ***Net Amount Paid*** Any week that you do not provide the ***My Payment Details*** page may result in your SUB claim being denied for that week.
Trade School Supporting Documents *Only required if you are attending a trade school related to your trade.*	Your ***Verification of Attendance*** issued by your College or a Local other than Local 67. The letter must include the following: • Your Full Name • The Program Name • The Type of Program • The Academic Level • The Start and End Date of the Semester.
Termination Age	Retirement

Your EI Stub's ***Date Report Processed*** section indicates the date(s) EI paid your week(s) of EI benefit. RASI will use these dates to confirm your SUB claim(s) are submitted within the 90-days submission deadline.

If you provide all of the correct supporting documentation and qualify for SUB, you are eligible to receive a SUB payment for the week of the EI waiting period.

You are not eligible for SUB after you retire.

Info & Tips

Supplemental Unemployment Benefits (SUB)

How do I find the Required EI Supporting Documentation to Submit my SUB Claim?

Below outlines where you can find the required supporting EI documentation.

1. Your Main Employment Insurance (EI) Benefit Statement Page: Sign into your ***My Service Canada Account*** and go to ***My Payments***—Take a screenshot of the page or multiple screenshots to capture all of the required information shown below.

The **Dates for Each EI week** under the ***Report Covering Period*** section.

The **Date Each Week of EI Benefit was Paid** under the ***Date Report Processed*** section.

The **Dollar Amount for Each Claim Week** under ***Net Amount Paid***

Your Full Name

My Payments - Canada.ca — 2020-01-14, 12:37 PM

Government of Canada / Gouvernement du Canada

RECEIVED JAN 14 2020

Home > My Service Canada Account > My Payments

Featured Services | Help | Logout

My Payments

JOHN DOE

...m information is available in your My Service Canada ... from the left-hand menu to register now!
...d correspondence page.

We have processed your report for the period ...
Additional payments have been issued on the ...
Your next report for the 2 week period beginni...
file your next report within 3 weeks of this date

Please note that if you have changed your mailing address or your banking information for Direct Deposit since the last time you completed a report, you must update this information before proceeding to the Internet Reporting Service. From the My Service Canada Account Home page click on the **"Change"** tab and then click on either the **"View/Change my mailing address and telephone number"** or **"View / change my Direct Deposit"** links to provide us with your new information.

Report Covering Period	Date Report Processed	Net Amount Paid	Amended report
January 05, 2020 to January 11, 2020	January 12, 2020	$493	No
December 29, 2019 to January 04, 2020	January 12, 2020	$493	No
December 22, 2019 to December 28, 2019	December 29, 2019	$492	No
Decem... 2019 to December 21, 2019	December 29, 2019	$492	No
...er 08, 2019 to December 14, 2019	December 15, 2019	$492	No
...mber 01, 2019 to December 07, 2019	December 08, 2019	$492	No
November 24, 2019 to November 30, 2019	December 08, 2019	$0	No

Please note that this is the most up-to-date information available in our system. Our Call Centre agents have access to the same information presented here. Any information processed on your claim today can be viewed online on the next business day.

Return to My Service Canada Account home page

Date modified: 2019-12-07

2. Your EI Stub Details Page for EACH week of EI: Sign into your in your ***My Service Canada Account*** and go to ***My Payment Details***.

My Payment Details

Did you know... JOHN DOE

- if you do not receive email alerts when new important Employment Insurance (EI) claim information is available in your My Service Canada Account, go to View my status and correspondence and select "Register for Alert Me" from the left-hand menu to register now!
- additional inf... le on the View my status and correspond...
- you must alwa... before deduction) in the week in which they are earned.

Your Full Name

These details are a result of the initial processing of this report period.

Week 1 of reporting period (December 22, 2019 to December 28, 2019)

Benefit Rate:	$562
Type of Benefit:	Regular benefits
Gross Amount:	$562

Totals for reporting period:

Tax:	$69
Net Amount Paid:	$493

—Find ***My Payment Details*** by clicking on the **underlined** dates for Each week of EI under ***Report Covering Period.*** Take a screenshot with all of the required information.

Remember to take a screenshot for every week even if the *Net Amount Paid* is $0.

Type of Benefit

Net Amount Paid

Where do I submit my SUB claim?

Submit your SUB claim by email to **local67@reliableadmin.com**, by Canada Post, or by dropping off your required supporting documents in person to Reliable Administrative Services Inc. (RASI). Remember to include your UNION NUMBER.

If you send your SUB claim by email, please ensure that you receive a confirmation of receipt from RASI.

When should I submit my SUB claim?

You can provide your supporting documents after each week you receive EI benefits. Remember if you wait to send in your weeks together, earlier weeks will not get paid if they are older than 90 days.

When are SUB payments made?

SUB payments are based on the schedule below. If your SUB claim is submitted before the 3:00 pm submission cutoff on Thursday, your SUB benefit will be issued on Friday. If your claim is submitted after the cutoff period, your SUB benefit will be issued the following Friday.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
WEEK 1				3:00 pm is the submission cutoff for SUB claims. 4:00 pm SUB cheques are processed .	12:00 pm-4:00 pm Cheques are ready at RASI for in-person pickup. .
WEEK 2	Canada Post picks up the remaining cheques for regular mail delivery.				

RASI makes your SUB payments a priority.

RASI's process is to issue SUB cheques the day before a statutory holiday.

During the holidays, please call ahead to ensure your cheque is ready for pick up.

When I apply for EI benefits, do I indicate I have a SUB Plan?

Yes, always disclose your Supplemental Unemployment Benefit (SUB) plan when prompted. If space permits, add your SUB Plan's registered name when you apply for EI benefits. Your SUB plan is registered with the Government of Canada as: Name: **The Plumbing & Pipefitters Worker's Benefit Plan Local 67** File: **S00472-000**
If there is an issue with EI locating your SUB plan, contact RASI for Assistance.

Payments received under the Local 67 SUB Plan will not be considered earnings for the purposes of determining your entitlement to Employment Insurance (EI) benefits.

Short Term Disability (STD)
Income Benefit

You must notify your plan administrator, RASI as soon as you become sick/disabled and are able to do so.

If your Illness or injury is related to work, you must advise your employer.

STD benefit income is taxable as your employer contributes to some or all of the premium.

Your medical information is always kept confidential and is **not** shared with your Employer or Union.

Canada Life provides status updates to RASI regarding your restrictions and limitations, and potential return to work plan without sharing the medical details.

You must be covered by the plan as Regular member at the time of your disability .

Short Term Disability Plan Provider	The Canada Life Assurance Company
Short Term Disability Policy Number	179357
STD Weekly Income Benefit Amount	Equal to the maximum weekly payment under the Employment Insurance Act on the date of your disability. If disabled less than a full week, the STD benefit is pro-rated 1/5 of the weekly benefit.
STD Benefit	Taxable
Waiting Period Injury Disease You must see a doctor within 7 days	 0 calendar days 7 calendar days If you are hospitalized or have day surgery before the last day of the waiting period for disease, benefits will begin on the day you are hospitalized or the surgery is performed.
EI Integration	Yes
STD Benefits Commence (If approved by Canada Life)	After the STD waiting period is satisfied, your benefit commences after: • EI Sickness benefits are exhausted; or • EI Sickness benefits are denied.
Maximum Benefit Period	26 weeks
Termination Age	Retirement

Info & Tips

Short Term Disability (STD)

What do I do if I am disabled due to a non-work related injury, illness, or surgery?

1. You need to be under the care of a physician. If you are disabled due to an illness, injury or surgery, you MUST see a doctor within seven days, or your benefits will be delayed until you do.
2. You should apply for Employment Insurance (EI) Sickness benefits, even if you think you do not qualify. If you are already on EI Regular due to unemployment, you must change your claim to EI sickness retro to the date you became disabled.
3. You should notify Reliable Administrative Services Inc. (RASI) immediately following your disability and obtain a ***U.A. Local 67 Benefit Plan Disability Guide.***

Where do I apply for Employment Insurance (EI) Sickness benefits?

Apply for the EI sickness benefit with the government of Ontario on their website www.canada.ca. Remember to apply as soon as possible after you stop working. If you apply more than 4 weeks after your last day of work, you may lose benefits.

What if I already know I don't have enough hours to qualify for EI Sick?

You still have to apply for EI Sickness benefits even if you know you do not have enough hours to qualify. Your EI Sick denial letter is required by Canada Life in order to review your claim or start your Short Term Disability benefits.

What if my EI Sick claim is denied because I do not have enough hours to qualify?

You are not penalized if your EI Sick claim is denied due to lack of hours worked. Your STD plan is designed to provide coverage as early as the first day you were injured or in hospital as long as you were seen by a doctor, or after 7 days due to disease if you visited a doctor.

When do my Short Term Disability benefits start?

If your disability claim is approved by Canada Life, your STD benefits will begin after your EI Sickness benefits are exhausted. If you were denied EI Sick due to lack of hours, your STD benefits begin after you have completed the STD waiting period.

How to make a Short Term Disability claim?

Contact RASI to obtain the Canada Life claim forms for completion by you and your attending physician. Return your completed claim forms to RASI, who will finalize and submit your STD application to Canada Life. As soon as it becomes available, you are required to provide proof that your EI Sickness benefits are exhausted or that your EI Sickness claim was denied because you did not have enough hours to qualify.

When will my STD disability benefits end?

Your disability benefit payments will end; a) when your medical condition no longer meets the plan's definition of disability; b) if you do not meet all requirements of the STD plan; or c) when you retire.

If you become disabled do not delay contacting Reliable Administrative Services Inc. (RASI).

RASI is there to guide you through the short term disability process and assist you with your application to Canada Life.

Late claims may cause your payment to be delayed or **denied.**

Canada Life is not liable for claims submitted more than **6 month**s after the end of your waiting period.

Canada Life will keep you informed of any changes to the status of your claim.

Long Term Disability (LTD)
Income Benefit

Your Long Term Disability (LTD) plan provides you with regular income because of a lengthy disability due to disease or injury.

LTD benefit income is taxable as your employer contributes to some or all of the premium.

During your LTD period, you will be asked to apply for the *Canadian Pension Plan (CPP) Disability Pension*.

The amount of your CPP benefit will reduce your LTD benefit.

You earn pension credits for each completed month you receive LTD benefits, up until age of 62.

The amount of pension credits will be determined by the Board of Trustees based on advice from the pension plan actuary.

Long Term Disability Plan Provider	The Canada Life Assurance Company
Long Term Disability Policy	179357
LTD Monthly Income Benefit Amount	$2,400 If disabled less than a full month, the LTD benefit is pro-rated 1/30 of the monthly benefit for each day disabled.
LTD Benefit	Taxable
Waiting Period	The later of: • 26 weeks of uninterrupted disability; or • The last day benefits are payable under your UA Local 67 Short Term Disability plan; or • The last day benefits are payable under any Short Term Disability loss of income or other salary continuation plan.
CPP/QPP Offsets	Yes Your monthly CPP/QPP benefit will directly offset your Long Term Disability Benefit. Child CPP/QPP benefits does not offset your monthly Long Term Disability Benefit.
All Source Maximum (Applies to indirect offsets)	85% of pre-disability gross monthly earnings
Own Occupation Period	The first 24 months of LTD
Any Occupation Period	After 24 months of LTD If you have 35 years of service with Local 67, your disability will continue to be assessed based on your own occupation.
Pre-Existing Conditions Limitation	1 year / 90 days
Maximum Benefit Period	The last day of the month in which you reach age 62
Termination Age	Age 62, less the waiting period

Info & Tips

Long Term Disability (LTD)

If I remain disabled, when do my Long Term Disability (LTD) benefits start?

Your LTD benefits are designed to begin when your Short Term disability (STD) benefits end, as long as you remain disabled. If approved, you will receive your LTD benefit on the last day of the month in which you were approved.

How to make a Long Term Disability Claim?

No application form is required. Your only responsibility is to continue to work with your previously assigned STD Case Coordinator at Canada Life.

What does own occupation period mean?

Your plan includes a 24 months own occupation period (unless you have 35 years of service with UA Local 67). During this period, Canada Life will assess if your disease or injury prevents you from preforming the essential duties of your regular occupation at Local 67, such as a Plumber, Pipefitter or Welder.

What does any occupation period mean?

After 24 months of LTD, your plan changes to an any occupation period. Meaning Canada Life will only continue your benefits if your disability prevents you from being gainfully employed in any job. They will assess if you are medically able to perform the duties at a different type of job for which you have at least the minimum qualifications and which provides you with an income of at least 66.67% of your indexed monthly earnings before you became disabled.

What if I receive income from another source? How will that impact my benefit?

Your LTD benefits may be reduced by payments you receive from other sources for the same or any subsequent disability. Such as Canada Pension Plan (CPP), Quebec Pension Plan (QPP) Disability benefits, Workers' Compensation benefits, or benefits from a provincial automobile insurance plan, etc.

What is involved to support my recovery and safe return-to-work?

Canada Life is committed to help you in your recovery, to monitor your progress, and to identify safe return to work opportunities when appropriate. Through Canada Life's Disability Intervention Services, you may have access to other medical and rehabilitation services to facilitate medical recovery, functional restoration, and help you achieve your return to work goals. If you are unable to return to your own occupation based on your medical restrictions and limitations, you are expected to consider any reasonable offer of alternative work.

What are my responsibilities when I am in receipt of LTD benefits?

You must be under the regular care of a licensed medical physician or healthcare provider. You are to participate in discussions with and to advise your Case Manager of changes in your condition, treatment and return to work plans. You are expected to actively participate in treatment and rehabilitation plans as required by Canada Life and failure to do so could impact your benefits.

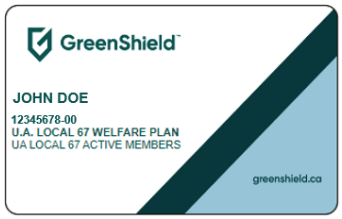
You do not need to reapply to Canada Life for your LTD benefits. Canada Life will start reviewing your eligibility before your STD benefits end.

To ensure benefits are managed effectively, you should notify your Case Manager of other disability benefit payments or any other reportable income.

Reportable income or other disability benefit payments may result in an overpayment that you will be required to pay back to Canada Life.

Health Care
Prescription Drugs

For many Canadians, prescription drug coverage is one of the most important benefits under their group benefit plan. It is also one of the most expensive benefits to provide to our members.



You should use your Green Shield card for all medications regardless of where you buy them. Including those from TELUS Health Virtual Pharmacy.

Present your innoviCares card at your pharmacy with your Green Shield card, when you are asking for a brand name prescription.

Drug Plan Provider	Green Shield Canada (GSC)
Policy Number	UAPP
Drug Plan Maximum	$15,000 maximum every calendar year, combined with Extended Health Services.
Drug Deductible	Equal to the dispensing / compound fee
Ontario Drug Benefit (ODB) co-pay deductible for seniors	Covered for seniors residing in Ontario
Oral Smoking Cessation Treatment Includes items such as: • Zyban® and Champix® where a prescription is required.	168 tablets, per participant, per calendar year
Drug Card	Yes
Prescription Drug Type Includes items such as: • Based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will only be made up to the cost of the lowest priced equivalent drug. • If a medical practitioner indicates a brand name drug is medically required due to a serious medical reaction to at least two generic equivalent drugs, 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, to determine eligibility for payment of the cost of the prescribed drug	Mandatory generic drug substitution
Innovicares Card A free prescription savings card funded by participating pharmaceutical manufacturers.	Yes—Available to all Members of the UA Local 67 Benefit Plan, separate from your Green Shield Canada (GSC) Plan.

Prescription Drugs Are eligible if they: • are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law; and • legally require a prescription and have a Drug Identification Number (DIN); and • are approved under GSC's drug review process; and • are paid on a Pay Direct basis.	Covered
Drug Supplies If approved by Green Shield, includes Items such as: • diabetic syringes • needles • testing agents	Covered
Vaccines	Covered
Preferred Provider Network (PPN) Maintenance Drugs	 TELUS Health Virtual Pharmacy
<u>Non-Maintenance Drugs</u> Level 1 – Provincial Formulary Level 2 – Other Formulary	 100% reimbursement of the drug cost 80% reimbursement of the drug cost
<u>Maintenance Drugs</u> Level 1 – Provincial Formulary <u>if</u> purchased through **TELUS Health Virtual Pharmacy** Level 1 – Provincial Formulary <u>if</u> purchased at a local pharmacy Level 2 – Other Formulary	 100% reimbursement of the drug cost 80% reimbursement of the drug cost 80% reimbursement of the drug cost
Drugs Not Covered: Drugs for the treatment of obesity, erectile dysfunction, infertility, nicotine replacement products (such as patches, gum, lozenges, and inhalers), reference biologic drugs that have an approved biosimilar, and over the counter drugs, whether prescribed or not.	

You cannot typically buy more than a three-month supply of a prescription at one time without the use of a special pharmacist code (such as a vacation supply code) or approval from Green Shield.

See page 39 for Diabetic Appliances.

TELUS Health Virtual Pharmacy

TELUS Health is a virtual pharmacy that will deliver maintenance drugs to your home, your requested address, or your local post office for pick-up, all for a low dispensing fee. Learn more on page 37.

Erectile dysfunction drugs may be covered under certain medical circumstances if you have a contributing condition, disease or medication. Have your doctor complete GSC's special authorization form.

Info & Tips

Prescription Drugs

When a UA Local 67 Benefit Plan member approaches the $15,000 plan maximum, Green Shield automatically mails out a confidential letter advising of the Trillium Drug Program.

Reliable Administrative Services is available to assist with a Trillium Drug Program application, upon the plan member's request.

An innoviCares card will be sent to you and your eligible dependents. When you become eligible for benefits. The card will always belong to you and won't expire.

Specialty and High Cost Drugs—Green Shield's Requirements

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 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.

Trillium Drug Program

The Trillium Drug Program is intended to help Ontario residents who have high prescription drug costs in relation to their net household income. If you or your family member have a serious illness and higher than normal drug costs, you can combine benefits from your Local 67 Benefits Plan to cover up to 100% of the cost.

The Trillium Drug Program year is from August 1 to July 31. Make sure you apply by September 30th, to be reimbursed for any eligible drug you received in the previous program year (August 1-July 31). Deductibles and co-pays apply to this program. Your deductible is applied quarterly and is based on your family size and the combined net income of your of your family members (in most cases it ranges from 3% - 5% of your household income).

You may qualify for the Trillium Drug Program if you meet all of this criteria:

- Your private insurance does not cover 100% of your prescription drugs;
- You have valid coverage through the Ontario Health Insurance Plan (OHIP) and are an Ontario resident;
- You do not qualify for drug coverage under the Ontario Drug Benefit (ODB) Program.

Ontario Drug Benefit (ODB) for members over age 65

For covered members over the age of 65, the plan will pay 100% of the ODB deductible, less the dispensing fees. You should not submit a claim to the plan for the annual ODB deductible before the end of the ODB program year (currently July 31), unless the full deductible has already been reached.

innoviCares

The innoviCares card is a free prescription savings card available to all Members of the UA Local 67 Benefit Plan, and is funded by participation pharmaceutical manufacturers. **Present your innoviCares card at your pharmacy when you want to ask for an original brand-name medication.** Your card will automatically cover a portion of the cost of the original brand. Your innovicares card will coordinate with our existing UA Local 67 Group Benefit Plan or if you don't have insurance, it can be used on it's own.

Dispensing Fees—Remember to shop around

You are responsible for paying the dispensing fee for your drugs. The amount each pharmacy charges to dispense your prescription drug varies depending on where you go. Be in the know of what your pharmacy charges. See the chart for some average fees, noting some local or compound drug pharmacies can charge more. You do not require a membership to fill your prescription at Costco Pharmacy. Learn more about TELUS Health Virtual Pharmacy below.

Who is TELUS Health Virtual Pharmacy?

TELUS Health Virtual Pharmacy is a reliable Canadian online pharmacy complete with pharmacy consultations, medication delivery, and online prescription and is your plan's preferred provider network (PPN) for maintenance drugs. These are medications that you take regularly.

Why is TELUS Health Virtual Pharmacy used as the plan's PPN?

As an online pharmacy, TELUS pharmacy can offer lower markups on the ingredients in your prescription drugs. The Welfare plan passes on these savings to members by reimbursing maintenance drugs on the level 1 provincial formulary purchased through TELUS Health Virtual Pharmacy at 100%, instead of 80% if purchased at another pharmacy. In addition, plan members will pay a lower-than-average **dispensing fee of $7.49 or $4.11 for seniors (subject to change).**

Do I have to use TELUS Health Virtual Pharmacy?

No. Plan members can use any pharmacy. The purpose of TELUS pharmacy is for you to pay less for your regular maintenance drugs and dispensing fees. Even if you use TELUS pharmacy, there may be times when it is more appropriate for you to use another pharmacy. Such as when you are sick and require an non-maintenance drug on the spot. Or if you take a compound drug, a biologic or other specialty drug that require a specialized pharmacy to administer. Please note that TELUS Health Virtual Pharmacy does not fill prescriptions for drug substances classified as narcotic, controlled or targeted.

How does TELUS Health Virtual Pharmacy work?

It works very similar to a regular pharmacy. Instead of walking into a pharmacy, you simply contact TELUS pharmacy via their website or call to get started. Once you are set up, your existing medications can be transferred over and your doctor can fax your new prescriptions. Debit and Credit card is accepted.

How do I get my prescription drugs from TELUS Health Virtual Pharmacy?

You can call, go online, or use the app to request your prescription. Request your prescription a week before you need it to avoid running out. Always call if you need your medication right away. TELUS pharmacy uses Canada Post Xpresspost™ for delivery in 1-3 business days or FedEx Express for priority overnight. A signature is required when your medication is delivered to your home or work. Or have your prescription delivered to a post office near you.

Average Pharmacy Dispensing Fees*	
Pharmacy	**Dispensing Fee**
Costco	$4.49
TELUS Health Virtual Pharmacy	$7.49 or $0-$4.11 for seniors
Walmart	$9.96
Shoppers	$11.99
Rexall	$12.73

**Dispensing fees as of 2023 are subject to change and can vary by location.*

TELUS Health Virtual Pharmacy

Get started with TELUS Health Virtual Pharmacy!

New members simply call TELUS Health or visit their website to register.

telusphamacy.com
1-877-796-7979
Hours Mon-Fri 9am-5pm

Are you working on a jobsite and no one is home to sign for your medication?

Ask TELUS Pharmacy to deliver your prescription to your local post office.

When your prescription is ready, simply pick it up on your way home by presenting a valid photo ID at the Post Office™.

Health Care

Extended Health Services (EHS)

Medical Alert Bracelet—is covered with Trustee Approval to a maximum of $150.00.

Please email your receipt to RASI.

ADP

Ministry of Health and Long-Term Care's **Assistive Devices Program**

Hearing aids and **other devices** may be eligible to claim under ADP.

Home and Community Care Support Services

Some **Private Duty Nursing** may be available through Home and Community Care Support Services.

Extended Health Services Plan Provider	Green Shield Canada (GSC)
Extended Health Services Policy Number	UAPP
Extended Health Services Plan Maximum	$15,000 maximum every calendar year, combined with Prescription Drugs.
Extended Health Services & Supplies Limited by and subject to: • Stated benefit maximums • Reasonable and customary limits • The overall Health Care maximum • Approval requirements • Services listed with a lower reimbursement • Portions reimbursed by a provincial plan or another group benefit plan	100% reimbursement
Hearing Aids or Replacement Parts Does not include: • Repairs • Batteries • Hearing/ear tests Requirements are but not limited to a doctor's prescription and an audiogram.	$500 maximum every 5 calendar years
Private Duty Nursing in the Home on a visit or shift basis Includes the services of a: • Registered Nurse (R.N.) • Registered Practical Nurse (R.P.N.) • Licensed Practical Nurse (L.P.N.) Does not include charges: • By a nurse related to you by birth or marriage or lives with you • For services which could be provided by someone who is not a registered nurse • Agency fees • Commissions • Overtime Preapproval from Green Shield is required and each month after 30 days.	$10,000 per lifetime* *Pre-authorization is required from GSC prior to commencement of services. Please call GSC Customer Service Centre at 1.888.711.1119 for detailed instructions.

Diabetic Appliances If approved by Green Shield, includes Items such as: • Insulin infusion pump* • Blood glucose meter • Auto injector See page 35 for diabetic Drug Supplies.	Covered *$500 maximum, per calendar year
Compression Stockings Items such as: • Knee length, 15-mmHg and over • Thigh/Full, 15 mmHg and over • Custom, any length Does not include: • Footless, any length • Stocking aid	6 pairs every calendar year
Wigs Only after radiation or chemotherapy	$500 lifetime maximum
Mastectomy Bra	6 every calendar year
Vision Care Includes items such as: • Prescription Glasses (Frames & Lenses) • Prescription Contacts • Industrial safety glasses • Eye examination* *For persons not covered under the provincial plan.	$300 combined maximum; Every calendar year for: • Active Members • Retirees paying the full rate by direct payment Every 2 calendar years for: • Retirees • Dependents
Cataract Eyewear Includes items such as: • Frames • Lenses • Contact lenses	Once per lifetime
Vision Care and Cataract Eyewear services not covered: Contact lens fitting or exam, visual training, laser eye surgery, shipping and handling, cataract eyewear repair, or cataract implant.	

ADP

Ministry of Health and Long-Term Care's **Assistive Devices Program**

Insulin pumps and other **diabetic supplies** may be eligible to claim under ADP.

Compression garments may be eligible under *ADP*.

Visual aids such as **specialized glasses**, **magnifiers** and other **optical aids** may be eligible under *ADP* for those that qualify.

Remember that glasses are an eligible expense that you can claim through your HCSA, if you require more than the combined Vision Care maximum.

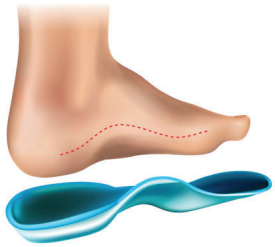
You must go to one of the following health care professionals to get your diagnosis and a prescription for custom orthotics, or orthopedic shoes:

- Physician
- Podiatrist
- Chiropodist
- Nurse Practitioner

You must also go to one of the following authorized providers for the making and fitting of your prescribed orthotics or orthopedic shoes:

- Podiatrist
- Chiropodist
- Pedorthist
- Orthotist
- Chiropractor

Don't buy orthotics from a provider that Green Shield has DELISTED. If you do, that item or service will NOT be reimbursed.



A GSC **Custom Foot Orthotics Claim Form** is available to print out if you want to submit a paper claim.

Orthopedic Shoes, without a brace	$15 per pair, per calendar year
Orthopedic Shoes, as integral part of brace Are eligible with the following, but not limited to: • A prescription from an eligible medical professional showing the medical diagnosis that requires the orthopedic shoe; and • An itemized receipt showing the date of pick up and that the payment was made in full; the receipt must include the make and model of the orthopedic shoe.	1 pair, per calendar year *Your claim reimbursement date is the date you pickup your orthopedic shoes .*

Custom Foot Orthotics
 	
Are eligible with the following, but not limited to:
 	
• A prescription from an authorized health care professional–it must include the medical diagnosis for which you were prescribed the custom orthotic; and
• An itemized receipt showing the date the orthotic was picked up and that payment was in full; and
• A copy of the biomechanical examination or gait analysis; and
• An identified casting technique (must create 3D volumetric model of patient's foot); and
• A detailed lab invoice* showing:
  • Patient's name
  • Date of invoice or shipping date
  • Materials used to construct the orthotic (for onsite labs)
  • Invoice number
  • From (lab name) and To (clinic name/dispensing provider name)
 	
*A lab invoice or proof of manufacturing, not the manufacturing process document
	$300 every 2 calendar years
	
	Your claim reimbursement date is the date you pickup your orthotics.

The following are not considered custom-made and are not covered: Stock items, off-the-shelf orthotics, and prefabricated devices such as cushioned heel cups or insoles; shoes purchased for comfort only (e.g. comfort/walking/ running shoes); shoes purchased for sports or recreational activities; orthotics made from walking over a pressure pad or plate, making a footprint on an inkpad, or using your shoe size to provide a prefabricated sole or insert.	

Hospital Room	Ward Semi-private or Private hospital rooms are **not covered**.
Ground Ambulance from site of incident to hospital	Covered
Aids For Daily Living A prior authorization form completed by the member and the Member's Physician and/or a prescription is required. Includes Items such as: • Hospital Bed, manual or electric; or rails, non–decubitus mattress, repair or rental	Covered* **GSC must grant pre-approval prior to purchase*. Please call GSC Customer Service Centre at 1.888.711.1119 for detailed instructions.
Miscellaneous Aids For Daily Living A prior authorization form completed by the member and the Member's Physician and/or a prescription is required. Includes Items such as: • Bandages • Bedpan • Commode, standard/portable toilet, shower, stationary; or rental • Commode, wheeled; or rental • Decubitus supplies • IV stand; or rental • Mattress, alternating pressure, decubitus; or rental • Patient lift, portable, standard, crank, electric; or rental • Patient lift, sling replacement • Sitz bath • Trapeze/Transfer Pole; or rental • Urinal; or rental Not covered: • Toilet seat, raised • Versa frame • Toilet seat, raised, rental • Miscellaneous aids for daily living, repair • Versa frame, rental • Stairlift	Covered* **GSC must grant pre-approval prior to purchase*. Please call GSC Customer Service Centre at 1.888.711.1119 for detailed instructions.

The cost of a Private or Semi-private hospital room is **not covered** under your plan. However, hospital rooms are an eligible expense that you can submit to your HCSA.

If you or you or one of your loved ones are in Hospital long term or need full time care, see page 51 to learn how to access Ontario's **Home and Community Care Support Services**

Local 67's plan includes every mental health practitioner allowed by Green Shield because the mental health of you and your family is as important as your physical health.

Lean more about free crisis support for all Canadians or the cost of Green Shield's digital mental health services: *Tranquility by Inkblot* and *MindBeacon Therapist Guided Program* *on page 46.*

A GSC **Health Professional Services Claim Form** is available to print out if you want to submit a paper claim.

Mental Health Practitioners Includes the services of the following licensed Health Professionals: • Behaviour Analyst/Therapist • Counsellor, Social Worker • Master of Social Work (MSW) • Psychoanalyst • Psychologist • Psychotherapist A Marriage/Family Counsellor is eligible if they have a designation of one of the above licensed Mental Health Practitioners. Includes Green Shield's digital mental health services: • *Tranquility by Inkblot,* self-guided program or coach assisted program • *MindBeacon Therapist Guided Program* Does not include the services of a: • Psychoeducator • Psychological assessment • Psychiatrist • Employee Assistance Program (EAP)Counsellor • Wellness Education Program	$800 combined maximum, per calendar year Subject to the reasonable and customary (R&C) hourly limit.
Physiotherapy Includes the services of the following registered Health Professional: • Physiotherapist Does not include the services of a: • Athletic Therapist • Ergotherapist • Kinesiologist • Kinesitherapist • Muscle Physiologist • Occupational Therapist • Orthotherapist	$55 per visit ($85 for a first assessment) up to: 20 Visits per calendar year

Paramedical Services (Select) Includes the services of the following licensed Health Professionals: • Acupuncturist • Chiropractor • Chiropractor, x-rays • Chiropodist • Chiropodist surgery • Christian Science Practitioner • Naturopath • Osteopath • Podiatrist • Registered Massage Therapist is covered for the member only. • Speech Therapist Does not include the services of a: • Audiologist • Cardiac rehab care • Dietitian • Foot care, Clinic Nurse • Homeopath • Hypnotist • Midwife • Natural remedies/medicines, • Nutritionist • Physician Services • Reflexologist • Resource Teacher • Shiatsu therapist • Tutorial expense • Wellness Education Program	80% Reimbursement up to; $400 combined maximum, per person, per calendar year Subject to the reasonable and customary (R&C) hourly limit.
Naturopathic Laboratory Tests	$20 per visit maximum
Osteopath x-rays.	$25 additional maximum per calendar year
Podiatrist x-rays	$25 additional maximum per calendar year

The $400 combined maximum for the listed professional services will reset every calendar year for you and each of your dependents on your benefit plan.

A GSC **Health Professional Services Claim Form** is available to print out if you want to submit a paper claim.

Most professional services are an eligible expense that you can claim through your HCSA, for the portion you pay out of pocket.

This includes massage therapy claims for your spouse or dependent child that are not covered under your traditional plan.

ADP

Ministry of Health and Long-Term Care's **Assistive Devices Program**

Custom braces may be eligible to claim under ADP.

An **Authorization Form For Custom Braces Form** is available to print out.

Custom Brace A prior authorization form completed by the member and the Member's Physician and/or a prescription is required. Includes Items such as: • Brace or splint, footwear attachable or modification/repair • Brace, custom, other or rental • Cast, fiberglass or plaster • Brace, helmet • Brace, knee, custom • Brace, AFO/KAFO, custom Not Covered: • Brace, modification/repair • Brace, AFO/KAFO, non-custom • Brace or splint, footwear attachable • Brace, below the knee, non-custom • Brace, knee, non-custom • Brace, hip, non-custom • Brace, below the elbow, non-custom • Brace, elbow, non-custom • Brace, shoulder, non-custom • Brace, slings • Brace, helmet/cranial • Brace, cervical, custom or non-custom • Brace, spinal/torso, custom or non-custom • Cast • Serial Casting • Powered parallel-limb exoskeleton or orthosis, custom	Covered* **If required, GSC must grant pre-approval prior to purchase.* Please call GSC Customer Service Centre at 1.888.711.1119 for detailed instructions.
Incontinence / Ostomy A prior authorization form completed by the member and the Member's Physician and/or a prescription is required. Includes Items such as: • Catheterization supplies • Ostomy supplies, excludes gloves • Urethral/urinary control device and supplies Not Covered: • Briefs—cloth (washable) • Incontinence supplies	Covered* **If required, GSC must grant pre-approval prior to purchase.* Please call GSC Customer Service Centre at 1.888.711.1119 for detailed instructions.

Mobility Aids A prior authorization form completed by the member and the Member's Physician and/or a prescription is required. Includes Items such as: • Scooter, electric, or modification or repair • Wheelchair, electric, or modification, repair, or rental • Wheelchair, standard manual, or modification, transport, or repair • Wheelchair accessories, manual; or cushion, cushion rental, postural seating insert, or postural seating insert modification or repair Not covered: • Geriatric chair, or modification/repair • Electric wheelchair/scooter replacement batteries* *batteries are only eligible with initial purchase	Covered* **If required, GSC must grant pre-approval prior to purchase.* Please call GSC Customer Service Centre at 1.888.711.1119 for detailed instructions.
Miscellaneous Mobility Aids A prior authorization form completed by the member and the Member's Physician and/or a prescription is required. Includes Items such as: • Cane, standard adjustable or quad, or accessories, or rental • Crutch, forearm, or accessories (grip, tip, underarm pad, platform trough, attachment), or rental • Crutches, pair • Walker, standard, adjustable, folding, or accessories or rental • Walker, wheeled, class 1 (indoor); or modification, repair, or rental • Walker, pediatric • Stand, upright positioner Not covered: Walking frame/gait trainer; or repair or accessories	Covered* **If required, GSC must grant pre-approval prior to purchase.* Please call GSC Customer Service Centre at 1.888.711.1119 for detailed instructions.
Accidental Dental	Covered

ADP

Ministry of Health and Long-Term Care's **Assistive Devices Program**

Mobility aids such as **wheel chairs** and **walkers** may be eligible to claim under ADP.

If you are eligible for the Assisted Devices program, Green Shield will require you to submit your claim there first.

An GSC **Authorization Form For Prosthetic Appliances and Durable Medical Equipment** is available to print out.

A dental accident may be covered under your Health plan up to 100%. Your dentist will need to complete GSC's Dental Accident Report form to confirm if your dental accident claim is approved by GSC.

Info & Tips

Extended Health Services (EHS)

Paramedical Practitioner claims—What is a *Reasonable & Customary* limit?

A Reasonable & Customary (R&C) limit is a set maximum dollar amount that an insurance carrier will reimburse for a specific product or service.

GSC regularly keeps up with the going rate of the professional services (chiropractor, physiotherapist, psychologist, etc.) in your province. GSC uses this information to create and update their R&C list as a guide when they pay claims.

If your claim is above GSC's R&C limit, GSC will limit your reimbursement to their listed reasonable & customary maximum for that service.

At any time, you can call GSC to ask about the reasonable and customary limit for a specific professional service. Knowing the R&C limit can help you determine if a provider's price for service is fair and avoid surprises when you submit your claim.

What is the cost of Green Shield's Digital Mental Health Services?

Tranquility by Inkblot fees:*

$75 for the Self-guided program, *which* is an Internet-based Cognitive Behavioural Therapy (iCBT) platform is backed by science, to help you to manage anxiety and depression, so you can take control of your mental health. With interactive learning modules, tools, to help you develop positive coping strategies and reduce life-disrupting symptoms without the wait, you can start building skills to feel better today.

$325 for the Coach assisted program, that delivers live, personalized mental health support, from the comfort of home. Each qualified therapist is matched as the best fit for you. Advanced technologies drive intelligent matching between patients and therapists, monitor effectiveness of care, and eliminate geographical barriers.

MindBeacon Therapist Guided Program fees:*

$500 for the Therapist Guided Program, which is a 6 to 12 week online program to tackle a wide range of issues that impact your wellbeing, including depression, anxiety, panic, PTSD and stress. Your therapist will guide you through online readings and activities that you complete on your own. Plus, you have access to the resources for up to 1 year.

+$300 to add plus insights to the above program, should you opt to speak to a clinical psychologist to discuss your assessment results over a one-on-one phone call. Plus, you will receive a psychologist diagnosis report you can share with your healthcare provider.

The services of *Tranquility by Inkblot* and *MindBeacon Therapist Guided Program* are eligible to claim under your plan's *Mental Health Practitioners* benefit.

*Fees are before tax and are subject to change.

GreenShield™

Both of GSC's online Mental Health services are similar in how they help individuals deal with their anxiety and/or depression.

To start or to learn more details simply visit:

www.tranquility.app

www.mindbeacon.com

www.tranquility.app/gsc

How to check if I am covered?

You can find the majority of what you want to know by signing into your GSC everywhere account, and clicking on **Check Your Coverage,** then enter or select the type of service you want to check. Complete the requested details to and select **Continue.** The tool will display an overview of what your plan will cover.

Click on **View details below** to find out the details on the amount GSC will pay, your out of pocket amount, plan details or restrictions, such as, how close you are to the benefit's maximum or frequency limitation.

Remember, not every item is available to search in the tool. So, call GSC if you don't find what you are looking for because it may be covered.

Learn how to avoid an unpaid claim—don't use the service of a delisted provider!

If a store that sells medical items or a medical professional is delisted, it means they are no longer in good standing with the insurance company, and your claim will NOT be reimbursed for that specific delisted location or service provider.

GSC regularly updates its Delisted Health Service Providers list to protect against potential fraud. A few examples of the type of businesses or professionals who may fall on the GSCs delisted providers list are orthotic and glasses retailers or massage therapists, physiotherapists, naturopaths, psychologists, and dentists.

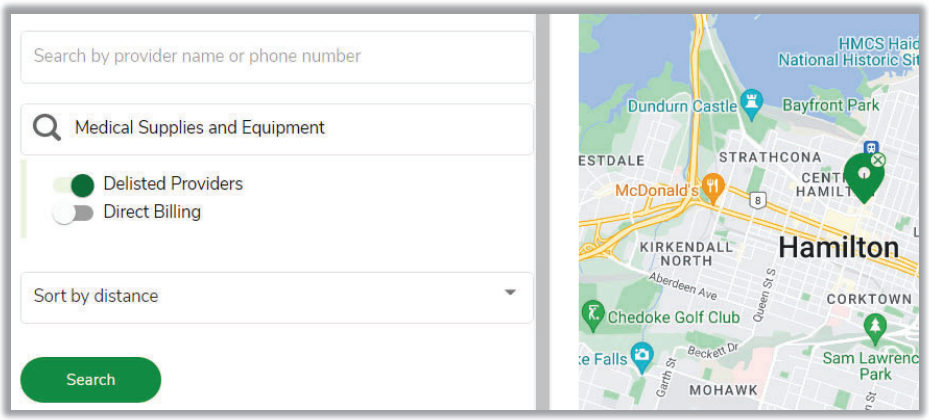
It is your responsibility—to ensure a provider is eligible before you purchase an item or pay for a service. You can search for delisted providers by signing into your GSC the Plan Member Online Services via gsceverywhere.ca or the *GSC on the Go™* app or by calling the Customer Service Centre.

Once you are signed into your GSC Plan Member Online—click on **Find Provider**. In the Find a Health Provider tool—choose the applicable **service or item** in the drop-down, then—indicate you are searching **Delisted Providers**, then—select your location or scroll to your city on the **map**, when ready—press the **Search** button.

Below is an example of a search to find the delisted Orthotic providers in Hamilton.

—*Medical Supplies and Equipment* is chosen

—*Delisted providers* is selected, and



—*Hamilton* is indicated in the Map.

GreenShield™

Sign up for GSC online!

Set up your GSC everywhere account to easily submit your claims and receive reimbursement directly to your bank account.

To register your GSC account visit:

gsceverywhere.ca

Submitting your claims online and mobile claim is the fastest* way to get your claims reimbursed!

**Remember to add your Direct Deposit details to your GSC everywhere online account.*

Where to get a paper form from GSC?

Sign into your *GSC everywhere* account and on the right click on "*View Personalized Claim Form*" and get the form you need personalized.

Or visit support.greenshield.ca select "Forms"and find the form you want to print.

Need more help? Call GSC or RASI.

How to Submit your Health Care Claim with Green Shield?

Green Shield has three ways that claims can be submitted.

1. Submitting Green Shield Online and Mobile Claims

To file a Green Shield claim online, you'll need to register for Plan Member Online Services at **gsceverywhere.ca** or using **GSC on the Go™** app, After that:

- Click on "Submit a Claim" in the menu.
- Find and select the claim type you need.
- Enter all your details and submit your claim—that's it!

Note: You should always hang on to any receipts or supporting documents for 13 months, in the event that you are randomly audited.

What are the benefits of submitting your claim online?

- Your claim will be processed by the GSC team quickly.
- You can easily submit supporting documents for new or previous claims.
- You can easily check the status of your claim and remaining balances online.
- You don't have to worry about mail delays or lost letters.
- You are reimbursed directly to your bank account, if you added your direct deposit detail to your account.
- This is the most secure way to submit your claims.

2. Provider-Submitted claims. Is when your provider submits your claim to GSC and you do nothing, though not all providers are willing to do so. Your provider may still require you to pay the full amount or a portion of your service.

3. Submitting Green Shield Paper Claims

Your third option is to submit your claim by mail. To do so, you will need to print and fill out a the appropriate claim form by signing into your **gsceverywhere.ca** account and clicking on **View Personalized Claim Forms,** then select the kind of claim form and the participant who the claim is for to get your personalized claim form. Alternatively you can pick up a form in-person at the benefit administrator office or you can request RASI to email or mail a form to you.

- Be sure write in your GSC ID number, and the dependent number (-00,-01,-02) both of which can be found on the front of your GSC card.
- Each form must be completed in full and signed by the plan member. GSC requires you to complete a separate form for each dependent, if applicable.
- Include any supporting documents and receipts alongside your form.
- Mail the form to Green Shield. There is a corresponding mailing address for each claim type listed at the bottom of every claim form.

How to upload a Supporting Document to my GSC account?

Additional supporting documentation can be uploaded via your online account by following the simple steps below:

- Signed in to your GSC online account at **gsceverywhere.ca**.
- On the top menu select 'Your Claims' then "Claims History".
- You can use the filters on the left side to sort your claims or simply scroll through the list of claims to locate the claim you want to add supporting documentation to.

  Once your claim has been located, you can click anywhere on the claim itself to open it up.
- Scroll to the bottom of the claim and you will see a button called 'Upload'. Here you can add any notes you want to add and then click 'Upload' to search for the file on your computer. Acceptable file types (extensions) are: bmp, pdf, gif, jpeg, jpg, png, tif, tiff and txt. When you find the file, double click the file name, or click the file name to highlight it and click "Open".
- Once you have attached all the necessary files, click "Attach to claim".

You can upload a missing supporting document to a claim that was previously denied by Green Shield due to missing information.

GreenShield™

Have a question for Green Shield?

Contact the GSC Customer Service Centre

Mon-Fri 8:30am-8:30pm

1-888-711-1119

FREE Crisis Support Lines for Canadians—Available 24 Hours / 7 Days a Week

9-8-8 Suicide Crisis Helpline

If you are thinking about suicide or you're worried about someone else, call or text 9-8-8. The support responders will provide a safe space for you to talk.

KIDS HELP PHONE™

Kids Help Phone is for young people to get immediate help in a crisis from a responder or support from a professional counsellor for issues young people face. Call 1-888-668-6810 or text WELLNESS to 686868 to chat.

Not a crisis? Visit the Canadian government's website: Canada.ca/mental-health to search by your province or territory for mental health support, such as:

MyGrief.ca *—Free modules to help you understand and move through your grief.*

BounceBackOnline.ca *—Access free workbooks, interactive worksheets, and videos to work through independently at your own pace to overcome low mood and worry and help you turn the corner.*

ConnexOntario.ca *—Free access to Healthcare Services Information for people experiencing problems with alcohol and drugs, mental illness or gambling. You can also call 1-866-531-2600 or Text CONNEX to 247247.*

In need of immediate crisis support?

Call or text with a Crisis Responder anytime at:

Suicide Crisis Support

Call or Text: **988**

Kids Help Phone

Call: **1-888-668-6810**
Text: **WELLNESS** to **686868**

All services and support lines are private and confidential.

ADP

Ministry of Health and Long-Term Care's **Assistive Devices Program**

The ADP program is the first payor for eligible assisted devices and Green Shield is the second payor.

If ADP denies your claim, Green Shield will also deny your claim under your plan. However, your denied claim may be an eligible HCSA expense.

Green Shield will require you to apply for ADP for eligible claims.

ADP

Ministry of Health and Long-Term Care's
Assistive Devices Program

If you need a medical device, you may qualify for benefits from the Ontario Ministry of Health's Assistive Devices Program (ADP).

Types of Equipment & Supplies covered under the ADP program:

- Artificial eyes and facial prosthetics
- Communication aids
- Custom orthotic braces, compression garments and lymphedema pumps
- Diabetic equipment and supplies
- Enteral-feeding pumps and ostomy supplies.
- Hearing aids and other devices
- Home oxygen therapy
- Mobility aids
- Visual aids

To qualify for ADP, you must:

- be an Ontario resident
- have a valid Ontario health card
- have a disability requiring the equipment or supplies for **six months or longer**

Your income is not considered.

ADP and Ontarians with type 1 diabetes

Ontarians with type 1 diabetes who are at risk of severe hypoglycemia or who are unable to recognize, or communicate about, symptoms of hypoglycemia can receive ADP funding for a continuous glucose monitor and the related supplies.

How much is covered?

The ADP program covers 75% of the cost for most equipment and supplies. For these items, ADP bills directly by the supplier and you pay 25% when you buy the item. In some cases, you will receive a series of payments throughout the year to help cover the cost of supplies.

How to apply?

Find out more about how to qualify, apply and find a vendor for these types of equipment and supplies:
www.ontario.ca/page/assistive-devices-program#mobility

Home and Community Care Support Services

The services of Home and Community Care Support Services organizations are available to eligible Ontario residents of any age and are fully funded by the Ministry of Health.

The Home and Community Support Services' Care Coordinators are connected to every part of the health-care system and can serve as your single-point of contact in obtaining services and information.

Their Care Coordinators will work hand in hand with you and your family to find out what care you need, and then work with you to develop a care plan that is right for you – whether it's nursing care, meal delivery, a day program, or help finding a family doctor.

The Home and Community Care organizations offer a point of access to Ontario's home and community care system by assessing need, determining eligibility, and providing or arranging for:

- Visiting health and professional services in people's homes;
- The provision of school health services for children;
- Managing admissions to long-term care homes; and
- Providing information and referrals to the public about other community agencies and services available to them.

The Home and Community Support Services' Care Coordinators are connected to every part of the health-care system and can serve as your single-point of contact in obtaining services and information.

Their Care Coordinators will work hand in hand with you and your family to find out what care you need, and then work with you to develop a care plan that is right for you–whether it's nursing care, meal delivery, a day program, or help finding a family doctor.

Some Home and Community Care Support Services organizations will manage admissions to adult day programs, supportive housing and assisted living programs, and to chronic care or rehabilitation beds in hospitals.

Home and Community Care Support Services
Available 7 days/week 8:30am – 8:30pm
Phone: 1-800-810-0000
www.healthcareathome.ca

Home and Community Care Support Services

The *Home and Community Care Support Services* is the first payor for eligible **Private Duty Nursing** and GSC is the second payor.

If *Home and Community Care Support Services* denies your claim, GSC will also deny your claim under your plan. However, your denied claim may be an eligible HCSA expense.

Green Shield (GSC) will require you to first go through *Home and Community Care Support Services* and be approved if you need Private Duty Nursing.

Health Care
Group Travel Medical

AIG's *Assistance Company* is available 24/7 when you travel.

You MUST call the *Assistance Company* if you or your eligible dependents have a medical emergency while travelling.

All questions prior to your trip or for a copy of your brochure/policy and travel card, contact RASI.

Questions while travelling—contact the *Assistance company*.

Travel Medical Insurance Provider	AIG Insurance Company of Canada, with Travel Guard as the Assistance Company
Travel Medical Insurance Policy	9429604
Travel Medical Insurance Eligibility	Members and their eligible dependents are covered provided that they are: • Under age 85, • Insured under the Health Care Benefit, • A Canadian Resident, and; • Covered under a Government Health Insurance Plan (GHIP).
Travel Medical Insurance Covers	Eligible Emergency Hospital & Medical Services Out-of-Province and Out-of-Country
Coverage for each trip begins	On the date and time the insured person departs his/her province or territory of residence.
Trip Duration The Trip Duration resets after you return to your province of residence for 24 hours.	• **90-Days for Active Members** • **60-Days for Retired Members UNDER the age of 85** • Eligible spouses and dependent children are covered under the same terms as the insured member. • There is no coverage once the member turns age 85.
Maximum	$2 million per trip*, per insured **Emergency Hospital & Medical Services are reimbursed subject to reasonable and customary costs for eligible expenses* ***subject to all policy limitations, exclusions and provisions.***
Termination Age	Age 85

Review your Travel Medical Insurance brochure/policy for full details on what is included in your coverage and what is excluded from your policy.

Info & Tips

Group Travel Medical

Do I need to notify the insurance company of my trip?

No. The AIG does not require notification before your trip.

Can I call the insurance company with questions before my trip?

No. The number on your Emergency Assistance Card is for medical emergencies or questions during your trip.

Where do I direct my questions before my trip?

Reliable Administrative Services Inc. (RASI) will help you with questions regarding:

- Your Travel policy with AIG.
- Your status with the UA Local 67 benefit plan.
- Your dependent's eligibility on the benefit plan.

In addition, RASI will provide you with:

- a copy of your Travel Medical Insurance Policy and Medical Assistance Card.

What should I do before my Trip?

- Remember to bring your Emergency Assistance Card insured by AIG.
- Review your Travel brochure/policy's Coverage & Exclusions to ensure you know what you are covered for and what you are not.
- Review Travel brochure/policy to ensure you meet the eligibility of the plan.
- Make sure you are covered under the Health Care plan and will remain in benefit in the month(s) you plan to travel. If required, make any payments.

Do I need to purchase additional insurance?

Consider if your Travel Medical Insurance meets your needs based on what the policy will and will not cover. If the coverage does not meet your family's needs, you are responsible for purchasing additional insurance at your own expense.

Your plan covers emergency medical expenses, subject to the terms of the policy. Understand that your policy has exclusions and does include insurance for lost baggage, trip interruption, or trip cancellation.

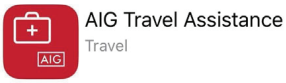
Review if any of the policy's **Exclusions** apply to you, thus limiting your coverage. Do you meet the pre-existing condition stability period? If not, a medical emergency related to your unstable condition will not be covered.

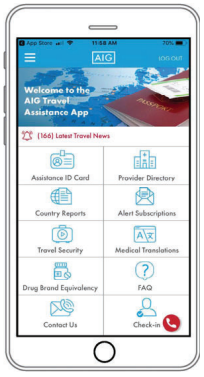
What should I do if I have a Medical Emergency when I am Travelling?

Contact the AIG's *Emergency Assistance Company* when you or your eligible dependent has a medical emergency while you are travelling or as soon as you are medically able to do so. The *Assistance Company* is there to help you, such as locating an appropriate hospital. Failure to notify the *Assistance Company* prior to treatment could affect your coverage.

Remember to take your **Emergency Assistance Card** with you when you travel!

You also have the option to download the *AIG Travel Assistance* app on your mobile device.





To access the *AIG Travel Assistance* app —register using the AIG Policy Number 942604.

Health Care

Health Care Spending Account (HCSA)

Your Health Care Spending Account is like a bank account that you can use to pay for eligible health and dental expenses not paid or partially paid by your group benefits plan or your provincial health plan.

Your HCSA covers a wide range of health and dental expenses such as medications, medical equipment, eyeglasses, paramedical practitioners and orthodontic expenses, as well as co-payments or deductibles.

Check if your expense is eligible under your HCSA. A list of eligible HCSA expenses is available in your GSC Plan Member online account. Or, you can view eligible medical expenses on CRA's website, contact GSC's customer service, or contact RASI.

Health Care Spending Account (HCSA) Provider	Green Shield Canada (GSC)
HCSA Eligibility	You are insured under UA Local 67's Health Care benefit plan or; You were issued a HCSA as a qualified Apprentice or Member out-of-benefit of Local 67
Annual HCSA Credit Deposited annually on the earlier of January 1st or when you become eligible for benefits	$750 per family, per calendar year Future Health Care Spending Account credits (if any) are subject to change at the beginning of each year based on the financial status of the Welfare Trust Fund.
Carry Forward Provision	There is no carry over of unused Credits. Credits cannot be carried over into the new year and do not accumulate.
HCSA Claim Submission Deadline	31 days after the following year ends. The claim must be received by GSC with all supporting documents, by the deadline or the claim will be denied.
Eligible HCSA Expenses	Health or Dental expenses that qualify for Canada Revenue Agency (CRA) eligible medical expenses you can claim on your tax return. Any portion of your eligible expense for which you paid by a gift card, or you were reimbursed by your plan, a spouses plan or a government plan is not eligible.

Info & Tips

Health Care Spending Account (HCSA)

What kind of eligible expenses can I submit to my HCSA?

Any health or dental expense that the Canada Revenue Agency (CRA) lists as an eligible medical expense to claim on your tax return—is an eligible HCSA claim. You cannot submit the portion of a claim for which you were already reimbursed.

Expenses, but not limited to the following (subject to change by the CRA):

- **Authorized medical practitioners in Ontario**: Acupuncturist; Audiologist; Chiropodist; Chiropractor; Dietician; Homeopath; Kinesiologist; Licensed/ Registered/Practical Nurse; Midwife; Naturopath; Occupational Therapist; Physician; Physiotherapist; Podiatrist; Psychologist; Registered Massage Therapist; Registered Psychotherapist; Social Worker; Speech-Language Pathologist; Traditional Chinese Medicine practitioner.
- **Dentures** and dental implants .
- **Dental services and orthodontics**—paid to a medical practitioner. Expenses for purely cosmetic procedures are not eligible.
- **Dispensing fees**, or the out-of-pocket portion of your prescription drugs.
- **Fertility drugs**, In vitro fertility program—the amount paid to a medical practitioner or a public or licensed private hospital.
- **Hospitals** – public or private, all room types .
- **Premiums paid to private health services plans including medical, dental, travel and hospitalization plans**. As long as 90% or more of the premiums paid under the plan are for eligible medical expenses.
- **Vision devices:** eyeglasses, contact lenses, and swimming goggles to correct eyesight. A prescription is required.

If self-paying for my benefits, how can I claim the premium to my HCSA?

Contact RASI and request a receipt for the and Health and Dental premium you paid. Life and Disability premium is not eligible.

Things to remember:

- **Submit your claim to your traditional health or dental plan first,** then claim the balance to your secondary/spouse's plan (if applicable)—then submit the remaining unpaid portion to your HCSA.
- **Avoid Duplicate claims**—claims reimbursed by another plan are not eligible.
- **Part of your claim may not be eligible**—for example, sales tax or shipping and handling fees. Expenses paid by a gift card are not eligible.
- **Submit all of your HCSA claims to GSC before the claim submission deadline!** Your HCSA Credit is available from January to December, and you have 31-days after the year ends to get any remaining HCSA expenses in the hands of Green Shield. If you mail in your claims, remember to account for delays with the post. GSC recommends that if you incur claims in December or have unsubmitted HCSA claims at year-end, then you should submit your claims online to avoid missing the deadline.
  Claims GSC receives after the submission deadline will go unpaid.

Each year, you decide what medical or dental claims you will submit to your HCSA on behalf of your family.

How do I submit an HCSA claim?

Your HCSA claims can be submitted via **online** by signing into your GSC Everywhere account or using **your phone** with the GSC on the Go™ app. Or you can submit a **paper claim**.

Paper claims require:
An original itemized paid receipt, with the health provider's name and address, date, and charges for each service or supply; and
An HCSA claim form, complete with the Patient's name and address, GSC ID number and dependent code (00, 01, 02), and signed by the plan member.

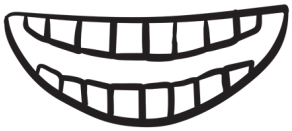
Dental Care
Basic, Major & Orthodontic Services

Your UA Local 67 Benefit Plan pays for a wide range of dental services and procedures intended to keep you and your family smiling.

Your calendar year combined $1,500 maximum will reset every year on the first of January.

Dental treatment from an accident may be covered at 100% under your Health Care plan. See page 45.

Applicable lab, drug and other expenses are eligible to a maximum of 40% of the allowable professional fee. Any applicable co-pay is then applied



Dental Plan Provider	Green Shield Canada (GSC)
Policy Number	UAPP
Deductible	None
Dental Fee Guide	Current fee guide minus 1 year
Combined Dental Maximum Applies to: • Basic Services • Comprehensive Basic Services • Major Services • Orthodontic Services	$1,500 per calendar year, per covered person
Dentures Maximum Applies to: • Prosthodontics removable (dentures)	$300 maximum every five calendar years This is in separate from the calendar maximum of $1,500.
Basic Services Includes items such as: • Recalls visits, limited to: – 1 per calendar year, or – 2 per calendar year for children age 15 and under. Includes items such as: • Recall exam; • Preventative scaling • Fluoride treatments • Polishing, limited to: – 2 time units per calendar year • Bitewing X-rays, limited to: – 2 per calendar year • Complete, general or comprehensive oral exams, full mouth X-rays and panoramic X-rays, limited to: – 1 every 3 calendar years • Basic Restorations, fillings and inlays • Extractions and surgical services • General anaesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery only	100% reimbursement up to the combined maximum, subject to the dental fee guide and plan limitations.

Comprehensive Basic Services Includes items such as: • Endodontic treatment including standard root canal therapy, excluding retreatments • Periodontal treatment including scaling and/or root planing, limited to: – 7 time units every calendar year covered persons age 16 and over, or – 6 time units every calendar year for covered persons age 15 and under • Standard denture services including: • Relining and rebasing of dentures only after 6 months have elapsed from the installation of a denture, once every 2 years • Denture adjustments only after 3 months have elapsed from the installation of a denture	100% reimbursement up to the combined maximum
Major Services Includes items such as: • Standard dentures, complete, immediate and partial, once every 5 years • Standard crown restorations or onlays on natural teeth, once every 5 years • Repair or recementing of crowns, onlays and bridgework on natural teeth • Standard bridges, including pontics, abutment retainers/crowns on natural teeth, once every 5 years	50% reimbursement up to the combined maximum
Orthodontics Includes items such as: • Orthodontic treatment • Orthodontic appliance	100% reimbursement up to the combined maximum $750 monthly installment maximum
Does not include: Oral hygiene instruction, gingival curettage, splinting/ligation, medical travel for dental, cancelled appointment, treatment of muscular dysfunctions such as TMJ, bleaching or teeth whitening for cosmetic purposes, or any dental procedure solely for cosmetic purposes.	

Predetermination—before your treatment begins:

For all proposed treatment for crowns, onlays and bridges, an estimate completed by your dental practitioner, **must** be submitted for GSC to assess.

GSC's assessment of the proposed treatment, may result in a lesser benefit being payable or may result in benefits being denied. Failure to submit an estimate prior to beginning your treatment will result in the delay of the assessment.

Info & Tips
Dental Care

Are you expecting a high cost dental procedure?

Remember one dentist may charge higher than another, so you can shop around for a competitive price or ask your existing dentist for a discount.

GreenShield™

Want to know how much of your dental maximum you have used to date?

Simply log into your online account, go to Your Health Benefits, select Dental, select a dental service and click on continue to see your claim history. Or, call Green Shield Canada at 1-888-711-119

About the Dental Fee Guide

Every year the Dental Association for each Province or Territory publishes a suggested Fee Guide for each dental procedure.

How the Dental Fee Guide affects your claims

Your plan pays claims based on the dental fee released one year before the current fee guide. If your dentist charges fees listed in the current fee guide, your plan will pay the amount published in the guide the prior year and you are responsible for the difference.

Alternative treatments and how they affect your claims

There are often different ways to treat a particular dental problem or condition, and the cost can vary widely. The plan will reimburse claims based on the least expensive service or supply that provides satisfactory results. You must pay the difference between this amount and the actual cost of your treatment.

When to get a treatment plan estimate from your dentist

It is important to get a treatment plan from your dentist before starting any treatment above $300. That way you will know in advance how much the plan will cover, and how much you will have to pay out of you own pocket.

For dental predeterminations, forward the following to Green Shield:

- Treatment plan estimate completed by your dentist
- X-rays (your dentist can submit these online via – providerconnect.ca)

Send in your treatment plan at least one month before treatment begins. After approval is granted, you have one month to start your treatment.

Do you or your dependents require Orthodontics?

Find out the expected cost an number of years the treatment is required for. Where possible, use the tips below to plan effectively and have the most reimbursed from your benefits.

- Plan to use the $1,500 per person dental maximum solely for orthodontics. By the person requiring the orthodontics completing any required basic or major dental services in the year before they start their orthodontics.
- Review if you can utilize one additional annual dental maximum over the orthodontic treatment period by simply starting the braces partway in the year vs. the beginning of the year.
- Understand that the plan has a monthly installment maximum of $750, the full $1,500 maximum cannot be reimbursed all one month.
- In the years the orthodontic treatment is required, you can plan to use your $750 family HCSA credit towards the expected orthodontic expense.

Where do I submit my Dental claim?

The majority of dental claims are **Provider-Submitted claims.** This is when your provider submits your dental claim to GSC and you do nothing, though not all providers are willing to do so. Your provider may still require you to pay the full amount or a portion of your service. If your provider does not submit your claim to GSC, you have the following two options:

Do you need further help with a help with a dental claim?

Contact RASI for assistance.

1. Submitting Green Shield Online and Mobile Claims

To file a Green Shield claim online, you'll need to register for Plan Member Online Services at **gsceverywhere.ca** or using **GSC on the Go™** app, After that:

- Click on "Submit a Claim" in the menu.
- Find and select the claim type you need.
- Enter all your details and submit your claim—that's it!

Always hang on to any receipts or supporting documents for 13 months, in the event that you are randomly audited

2. Submitting Green Shield Paper Claims

To submit your claim by mail you will need to print out the appropriate claim form by signing into your **gsceverywhere.ca** account and clicking on **View Personalized Claim Forms,** then select the kind of claim form and which participant to get your personalized claim form. Alternatively can request RASI to email or mail you the form or you can pick up a form in-person at the RASI office.

Your GSC ID nUmber and dependent code are found on your GSC card.

- Write your GSC ID number and the applicable dependent number (-00,-1,-02).
- Each form must be completed in full and signed by the member. GSC requires you to complete a separate form for each dependent, if applicable.
- Include any supporting documents and receipts alongside your form.
- Mail the form to the GSC address listed at the bottom of every claim form.

Info & Tips for Seniors

Ontario Seniors Dental Care Program (OSDCP)

OSDCP is a government-funded dental care program. It provides free, routine dental services for low-income seniors who are **65 years of age or older**. Visit their website to apply online or print a form to apply by mail. ODSCP is through your province, and does not affect your application to the federal **Canadian Dental Care Program (CDCP)** launched December 2023.

Ontario Seniors Dental Care Program (OSDCP)

Toll-free: 1-833-207-4435
Website:
www.ontario.ca/page/dental-care-low-income-seniors

Canadian Dental Care Program (CDCP)

Toll-free: 1-833-537-4342
Website:
Canada.ca/dental

Reminders if you are over 65 with Life & Health coverage (no Dental)

- Accidental Dental is part of the Local 67 Health Care benefit
- You can always ask your dentist if they are able to charge you less.
- Dental expenses may be claimed under your HCSA, see page 54 for details.
- Any portion of a dental claim not reimbursed by an insurance company might be eligible to claim on your income tax, discuss with your accountant.

Additional Benefits
Available To Local 67 Members

workhealthlife
For assistance, call or visit: 1.833.778.2627 (UAMAP)
worklifehealth.com

Applications for the **Pregnancy Benefit & Maternity/Paternity SUB** are submitted directly to UA Canada at: **uacanada.ca/wellness**—To confirm your eligibility, contact the Local 67 Union Office at 905-385-0034.

All inquiries regarding the **Benevolent Fund** benefits should be directed to the Local 67 Union Office at 905-385-0043.

The family of the deceased member should contact the Local 67 Union Office regarding the **Burial Benefit** at 905-385-0043.

Speak about **De Novo** confidentially with a Business Agent at the Local 67 Union Office at 905-385-0043.

UA NATIONAL WELLNESS PROGRAM BENEFITS

Member Assistance Program (MAP)

MAP is to provide members and their families with **immediate, confidential,** and **free** help for any work, health, or life concern. **Open 24/7** by phone, web, or mobile app.

Pregnancy Benefit

The Pregnancy Benefit will pay qualifying members the equivalent of Employment Insurance (EI)'s weekly rate for up to 24 weeks. The benefit allows pregnant members paid time off from a work environment that could pose a risk to themselves and their unborn child without having to exhaust their EI benefit.

Maternity and Parental Supplemental Unemployment Benefit (SUB)

Maternity and Parental SUB provides $100/week for up to 50 weeks combined for eligible members who are receiving maternity or parental EI benefits. Maternity SUB is available for 15 weeks for eligible pregnant members. The benefit can begin up to 12 weeks before the child's due date if the member is in receipt of EI maternity benefits. Parental SUB is available for up to 35 weeks for eligible mothers, fathers, or adoptive parents receiving EI paternity benefits.

UA LOCAL 67 BENEVOLENT FUND BENEFITS

Members in times of need

Eligible members off sick are entitled to $750 per week, up to 3 weeks, for a total of $2,250 from the Benevolent Fund. One occurrence every 12 months. To qualify, the member must not be in receipt of EI, WSIB, disability, or any other monetary benefit.

Bereavement Benefit

The fund pays $750 for each bereavement claim to eligible members working a job obtained through Local 67 or an affiliated union at the time of the leave. Members must provide the required claim documentation and have taken at least one day off work to attend the funeral of a family member, defined as a:

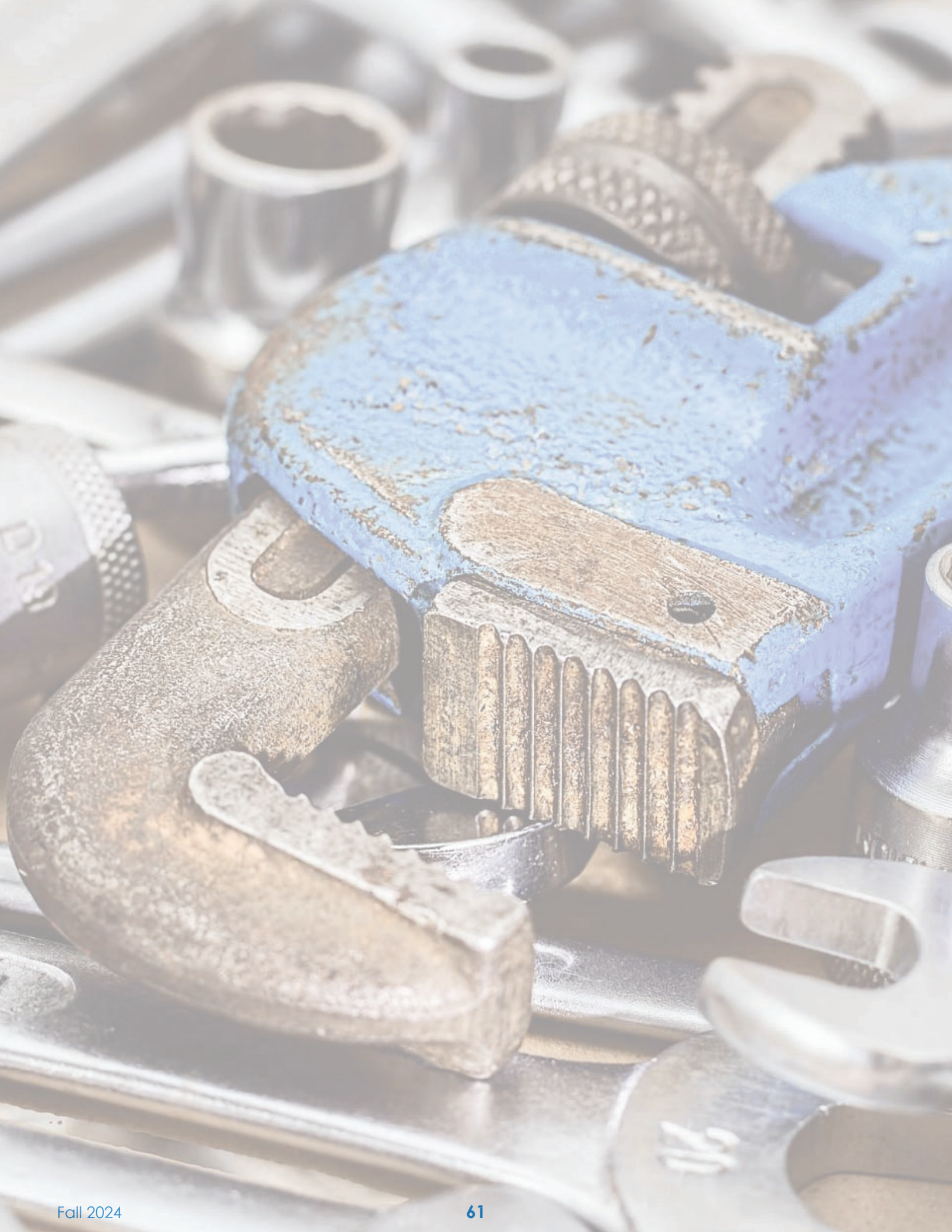
- Spouse or Common Law Spouse as defined in the Family Law Act of Ontario
- Parent or Adoptive Parent
- Child or Adopted Child
- A Brother or Sister
- Active Member's Grandparent
- Current Mother/Father in law

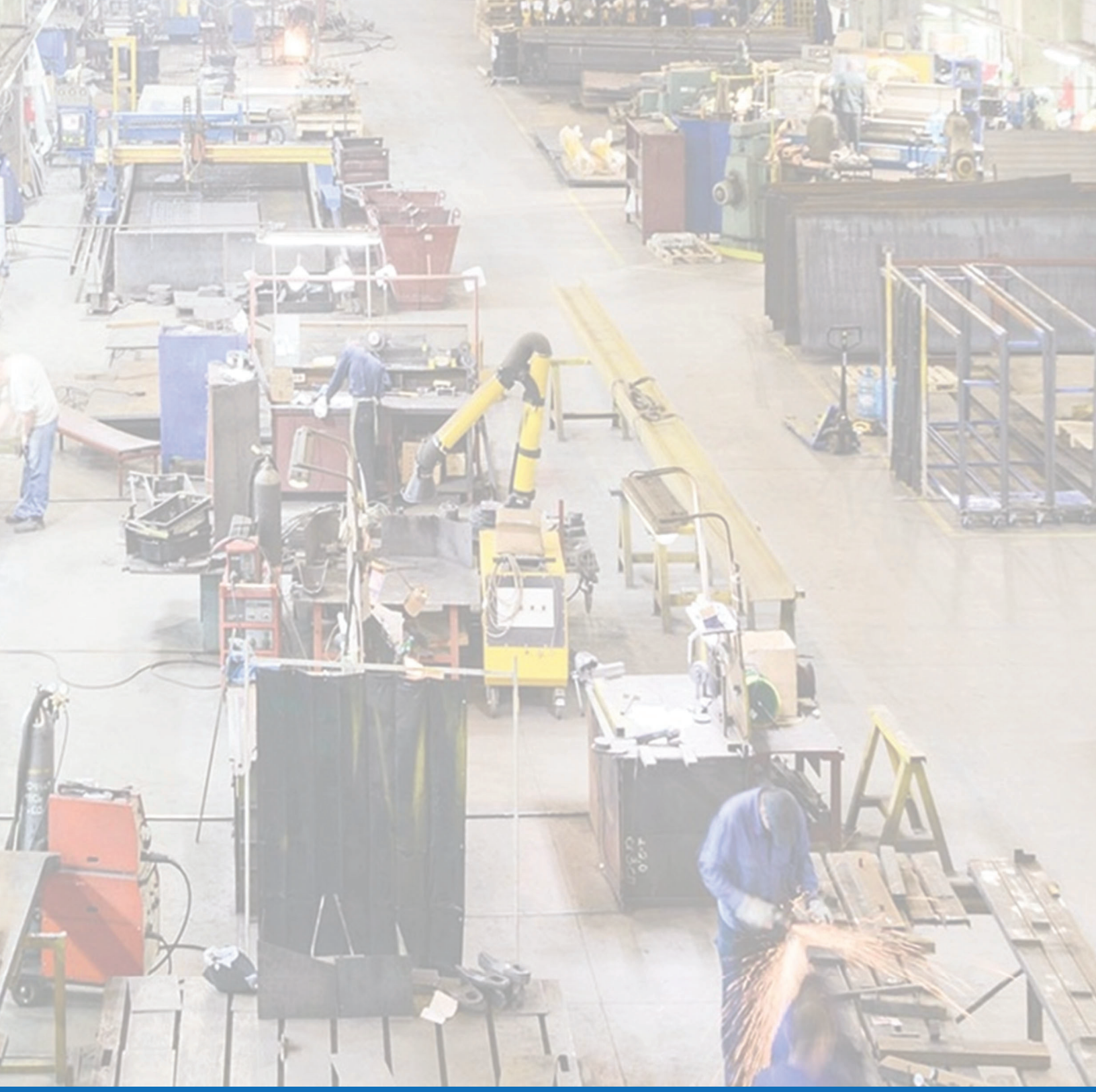
Burial Benefit

The Burial Benefit provides aid in the final expenses of a member who has passed away—$2,500 is paid by UA International, and $1,000 is paid by UA Local 67.

DE NOVO

De Novo is an alcohol and drug treatment program available to UA Members. De Novo offers a Residential Addiction Treatment Program, Aftercare Program, Youth Addiction Treatment and Family Program.





Hamilton-Niagara

Canadian Piping Trades®
LOCAL 67

Trustees of the Plumbing and Pipefitting Workers' Benefit Plans