GROUP BENEFITS BOOKLET

Plumbers Local 170 Welfare Plan

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WWW.PLUMBERS.BC.CA

July 2019

To all insured members,
Plumbers Local 170 Welfare Plan

Insurance protection against the financial hardship that so often accompanies unforeseen events such as sickness, accident or death is important to all of us. In order to make this protection available to you, your Plumbers Local 170 welfare plan has been arranged to assist in protecting you and your family from these hardships.

This Welfare Plan exists for the sole purpose of providing Health & Welfare benefits to you and your covered dependents. This Welfare Plan is not an insurance company and the Member Life Insurance, Life Insurance and AD&D Disability Waiver Reserves, Extended Health Care, Vision Care, Dental Care, Medical Services Plan premium reimbursement, Weekly Wage Indemnity, Long Term Disability, Healthcare Spending Account, Jury Duty, and Drug and Alcohol treatment benefits provided through the Welfare Plan are not insured by an insurance company regulated under the Financial Institutions Act (BC). The Welfare Plan is exempt from the regulatory requirements of the Financial Institutions Act (BC).

The extended health care, vision care and dental care benefits are designed to assist you with the payment of these expenses. It does not pay the total cost of services and supplies. In effect, this welfare plan shares the payment of your medical, vision, and dental bills with you.

The life insurance and accidental death & dismemberment benefits are co-ordinated via Manulife, the emergency travel accident insurance is insured by Royal Sun Alliance (RSA), employee and family assistance program (EFAP) is insured by Shepell, while all other benefits (inclusive of extended health care, vision, dental, weekly wage indemnity, drug and alcohol treatment, and jury duty benefits) are self-insured and administered by the Plumbers Local 170 welfare plan administrator, with member/dependant claims adjudicated for extended health care and dental care by Coughlin & Associates Ltd. The welfare plan administrator adjudicates certain benefits including vision care, disability benefits, the provincial Medical Services Plan (MSP), the special senior member's extended health care, weekly wage indemnity, jury duty, and special rehabilitation and drug and alcohol treatment benefits.

We urge you to read your booklet carefully to thoroughly familiarize yourself with the benefits that are available to you and your dependants.

Please note that it is the intention of the trustees to maintain the current benefits available under the welfare plan. The trustees however, reserve the right to change the benefit portfolio at any time given legislative revisions and/or the utilization costs of the benefits. Members will be advised accordingly of any required plan revisions.

For further information on your coverage, contact the Plumbers Local 170 welfare plan administration office direct at (604) 526-3434 or toll-free 1-800-665-6808. A member of the staff will be pleased to provide you with the necessary information to explain how these provisions apply to your personal situation.

We are pleased to make these arrangements on your behalf and we are certain that your participation in the plan will bring greater security and peace of mind to you and your family.

Sincerely,

THE BOARD OF TRUSTEES
PLUMBERS LOCAL 170 WELFARE PLAN

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HIGHLIGHT OF BENEFITS

The highlight of benefits contains a brief summary of your benefits.

LIFE INSURANCE

All hour bank insured members, associates, insured retired members (under age 70)

Benefit	$85,000 reducing to $20,000 at retirement (i.e. receiving a monthly pension)
Termination	Age 65 or retirement (whichever occurs first) for associates. Age 70 for all other insured hour bank members, with exception of self-paying hour bank members whose coverage ceases following 24 consecutive months of self-payment.
Reinstatement	Coverage will reinstate to $85,000 for retired members upon return to work and satisfying the plan eligibility requirements but not beyond attainment of age 70.
Waiver of premium	On approved disability (refer to booklet for further details).

ACCIDENTAL DEATH & DISMEMBERMENT

All hour bank insured members, associates, insured retired members (under age 70)

Benefit	$85,000 reducing to $20,000 at retirement (i.e. receiving a monthly pension)
Termination	Age 65 or retirement (whichever occurs first) for associates. Age 70 for all other insured hour bank members, with exception of self-paying hour bank members whose coverage ceases following 24 consecutive months of self-payment.
Reinstatement	Coverage will reinstate to $85,000 for retired members upon return to work and satisfying the plan eligibility requirements but not beyond attainment of age 70.
Waiver of premium	On approved disability (refer to booklet for further details).

WEEKLY WAGE INDEMNITY

All hour bank insured members, apprentices, probationary apprentices, permit workers, and associates

Waiting period	Payable from the first date of non-occupational accident/injury or overnight hospitalization. Payable from the fourth day of illness or day surgery.
Benefit period	Four weeks, then EI sickness benefits (if applicable) up to an additional 11 weeks – maximum 15 weeks (total) payable from the plan
Benefit amount	Equivalent to EI maximum (or 1/7 of the weekly benefit for each day that a benefit is payable)
Tax status	Taxable
Termination age	Age 65

LONG-TERM DISABILITY

All hour bank insured members and apprentices (excludes associates)

Elimination period	Commencement of CPP benefits or alternate date determined by the trustees
Benefit period (max. disability age)	The last day of the month in which the member attains age 62, dies, ceases to receive CPP benefits, fails to participate in a rehabilitative program, or the last day of the month preceding the first day of the month in which retirement takes effect
Benefit amount	1/12 of 70 per cent of basic pre-disability hourly rate of earnings times 1,400 hours
Direct offsets	Disability payments under the pension plan or any other employer-sponsored pension plan; any employer-sponsored disability plan and any provincial or federal government program to which an employer directly contributes, including but not limited to EI, CPP and WCB disability benefits
Tax status	Taxable
Definition of disability	Upon approval of CPP disability benefits
All-source limitation	85 per cent of average of best three consecutive years of earnings
Rehabilitation	Yes. Reimbursement and offset determined by the trustees

MEDICAL SERVICES PLAN (MSP)

All hour bank insured members and eligible disabled members

Reimbursement	100 per cent of monthly rates noting if adjusted net income is $42,000 and over the full rate is $37.50 one adult and $75.00 family of two adults. If net income is below $42,000, subject to scale.
Termination age	Hour Bank members later of age 65 or expiry of Hour Bank.

EXTENDED HEALTHCARE

All hour bank insured members, insured retired members (under age 70), eligible disabled members, associates, survivors, special senior members (age 65 and over)

Calendar year deductible	No deductible
Reimbursement	100 per cent for certain benefits as noted. 95 per cent of eligible prescription drugs and diabetic supplies listed on the provincial BC Formulary up to $1,500 per family unless proof of a higher B.C. Fair Pharmacare Program deductible is provided. Fertility drugs and treatment up to $2,500 per person per Lifetime. 80 per cent of all other eligible expenses up to $1,000 and 100 per cent of other eligible expenses exceeding $1,000 per person or family in a calendar year Special senior members age 65 and over (associates excluded) are eligible for 100 per cent reimbursement of all eligible expenses subject to their plan maximum.
Plan maximum	Lifetime maximum to $1 million per person subject to applicable treatment and travel medical emergency maximums. **Special senior members (age 65+) are limited to $900 per family per calendar year (inclusive of dental treatment, and private health premiums, billed in the Member's name, that do not include life insurance) subject to a lifetime maximum of $25,000 per person, plus up to $35 per calendar year for special senior members for prostate testing.**

EXTENDED HEALTHCARE (CONTINUED)

100 per cent of eligible expenses	
- Ambulance Services	Reasonable and customary charges for emergency services and/or response
- Vaccines	Up to lifetime maximum of $500 per person for preventative vaccines dispensed by a licensed pharmacist or physician
- Foldable intraocular lens implants	Lifetime maximum of $1,000 per person in excess of the provincial health care plan
- Smoking cessation drugs/ products (Zyban, nicotine patches & gum, acupuncture)	Lifetime maximum of $500 per person subject to official receipt (detailing patient name, purchase date, and item)
- Diagnostic tests (inclusive of PSA, etc.)	Maximum of $100 per calendar year per active member. (Deductible not applicable)
- Medical bracelets	Subject to medical necessity maximum of $50 per person per calendar year (requires an official itemized receipt indicating patient's name and item description as well as date of purchase and amount (cash register receipts will not suffice.)

EXTENDED HEALTHCARE (CONTINUED)

100 per cent of eligible expenses (continued)	
- Vision Care	Subject to a maximum of $500 every 24 months for prescriptive corrective lenses, no deductible. Laser eye surgery reimbursed $3,000 per person per lifetime. (Adjudication handled by welfare office).
- Eye exams (Vision Care)	Subject to a maximum of $100 every calendar year when performed by a physician or optometrist for covered members and their eligible dependents to the later of age 65 or expiry of his hour bank account; charges in excess of Insured's Provincial Plan
- Paramedical Services	$700 per person per calendar year, per practitioner maximum including chiropractor (inclusive of X-rays), massage, naturopath, physiotherapist (including athletic therapy), podiatrist, acupuncturist, and speech language pathologist.
-Psychologists (family and marriage counsellors, etc.)	up to $1,500 per person per calendar year.
- Hearing Aids & Repairs	$2,000 every five years, as prescribed by a physician.
- Custom Ear Plugs	$500 every 5 years, as prescribed by a physician.

EXTENDED HEALTHCARE (CONTINUED)

95 per cent of eligible expenses – up to a calendar year maximum out of pocket dispensing fee cost of $200 per family	
- Drugs	Prescribed drugs (excluding oral contraceptives and nicotine patch) and diabetic supplies. Drug coverage is restricted to those listed on the provincial (BC) formulary being reimbursed up to $1,500 per family, unless proof of a higher B.C. Fair Pharmacare Program deductible is provided. EHC deductible is not applicable. Special seniors and dependants remain at 100 per cent subject to applicable maximum. Fertility drugs and treatment up to $3,000 per person per Lifetime.
80 per cent of eligible expenses	
- In-province expenses	Once $1,000 has been paid in a calendar year, further eligible expenses will be reimbursed at 100 per cent, subject to maximums in contract
- Hospital room and board	Semi-private or private
- Private nursing	Provided for acute care
- Surgical brassieres	$500 per person per calendar year
- Termination	Hour bank insured members and insured retired members later of age 70, self-pay period or expiry of hour bank. All others earlier of age 65 or expiry of hour bank/self-pay period/defined eligibility (i.e. associates no later than age 65. However, no later than age 62, disabled members may then self-pay to age 70). Retired members may transition to special senior member category following attainment of age 65.

TRAVEL MEDICAL EMERGENCY INSURANCE

All hour bank insured members, associates, insured retired members (under age 70), eligible disabled members, and survivors (special senior members excluded)

Active hour bank insured members (working)	
Overall maximum	$5 million per coverage period
Coverage period	60 days per trip
Termination age	Earlier of age 70 or expiry of hour bank account/self-pay) Not applicable
Pre-existing condition	
Survivors	
Overall maximum	$5 million per coverage period
Coverage period	60 days per trip
Termination age	Earlier of age 65 or 24 months from member's date of death
Pre-existing condition	$25,000 lifetime maximum for pre-existing condition
Associates	
Overall maximum	$5 million per coverage period
Coverage period	60 days per trip
Termination age	Earlier of age 65 or three months following last contribution received
Pre-existing condition	Not applicable

Insured retired members (under age 70)	
Overall maximum	$5 million
Coverage period	60 days per trip
Termination age	Earlier of age 70 or expiry of hour bank/self-pay.
Pre-existing condition	$25,000 lifetime maximum for pre-existing condition

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM (EFAP)

All hour bank insured members, associates, insured retired members (under age 70), survivors, eligible disabled members, and special senior members (age 65 and over)

Benefits	Provides short-term, confidential professional counselling and work life services to Members and their eligible dependants to assist with resolving work and life problems and issues. *EFAP brochure available on request.* For immediate, confidential help 24/7/365, call 1-844-880-9142 or go online at www.workhealthlife.com. Click on "*register*" and enter "*Plumber Local 170 Welfare Plan"* to get started.
Termination Age	Age 65 for Associates Later of age 70, self-pay period or expiry of hour bank for Hour bank insured Members, insured Retired members and eligible Disabled members. Age 75 for Special Senior Members

HEALTHCARE SPENDING ACCOUNT (H.S.A)

Insured retired members (under age 65)	
Reimbursement	100% of eligible expenses limited to H.S.A. account balance
Eligibility	Local Union 170 Insured Members at July 1, 2019. Refer to H.S.A. section for additional details
Termination	Termination of membership or any break in active insured coverage, or up until June 30, 2020.

DENTAL CARE

All hour bank insured members, associates, insured retired members (under age 70), eligible disabled members, survivors, and special senior members (age 65 and over noting subject to EHC $900 per family per calendar year max.)

Deductible	No deductible		
Provincial fee schedule	Current basis, on the date services performed and subject to your province of residence		
	Plan A	**Plan B**	**Plan C**
	Basic services	Major restorative services	Orthodontics
Reimbursement	90%	80%	50%
Dependant children only	100%	80%	50%
Frequency plan limits	Each calendar year	Each calendar year	Lifetime
Financial limit per dependant child	$3,000 combined with Plan B	$3,000 combined with Plan A	$5,000
Financial limit per member or spouse	$3,000 combined with Plan B	$3,000 combined with Plan A	$5,000

HOW TO MAKE A CLAIM

The following benefits are co-ordinated and/or adjudicated by the **Plumbers Local 170 welfare office:**

- member life insurance and accidental death and dismemberment;
- weekly wage indemnity;
- MSP reimbursements;
- jury duty fund;
- special rehabilitation fund drug and alcohol treatment;
- special senior members (age 65 and over) extended health benefit claims;
- vision care claims including eye examinations;
- long-term disability benefits.

Please contact the welfare office at 604-526-3434 or 1-800-665-6808. Claim forms (including Coughlin & Associates Ltd.) can be obtained from our website: www.plumbers.bc.ca

CLAIM NUMBERS
IDENTIFICATION NUMBER = member's Social Insurance Number
POLICY NUMBER = 271029
TELUS CARRIER IDENTIFICATION NUMBER = 610105 (the number your dental office will need to submit your dental claim electronically)

Coughlin & Associates Ltd. will adjudicate all other extended health and/or dental benefits with exception of drug card claims (refer to Page 24). In the event of a claim, you or a member of your family should **obtain the proper claim form from the plan administrator (Plumbers Local 170 welfare plan office) or alternatively, an applicable generic claim form from the claim adjudicator's (Coughlin & Associates Ltd.) website www.coughlin.ca.**

The completed claim form can be mailed to:

The claims department
Coughlin & Associates Ltd.
Box 764
Winnipeg, MB R3C 2L4
Toll-free: 1-888-204-1234
Local: (204) 942-4438
Fax: (204) 943-5998

Please note that the original receipts submitted with your claim will not be returned to you as a detailed claims summary provided by the claim adjudicator (Coughlin & Associates Ltd.) on finalization of your claim is sufficient for the purposes of tax reporting and co-ordination of benefits. Alternatively, you can access your claims history from the claim adjudicator's (Coughlin & Associates Ltd.) website at www.coughlin.ca by clicking on "Log On" and entering a temporary password and your identification number detailed on your claims summary.

The claim forms must be signed by the **insured member** and should include your personal identification number, which is your Social Insurance Number.

Dental care

There are two options available to submit your dental claim:

1. Electronic data interchange (EDI)

With ***EDI, your dental claim is sent directly from the member's dental office*** to Coughlin & Associates Ltd. for claims adjudication. ***Coughlin & Associates Ltd. EDI*** service uses the secure data networks of **Telus**, the dedicated claims processing network sponsored by the Canadian Dental Association.

To take advantage of Coughlin's **EDI** service, just tell the dentist that Coughlin & Associates Ltd. is your claims adjudicator and present him/her with the following security codes:

- the Coughlin & Associates Ltd. Telus carrier identification number (also known as the BIN number), which is **610105 on the Telus network**;

- your identification number which is your PIN (Social Insurance Number);
- the policy number of your welfare plan, which is 271029.

Not all dental offices are participants of Telus. So, be sure to first ask your dentist or his/her office administrator about Telus access.

2. In case an insured member's dentist is not set up for EDI:

- Obtain a claim form from the plan administrator or Coughlin & Associates Ltd., claims adjudicator, (directly or via the website at **www.coughlin.ca)**
- Have the dentist/denturist complete Part 1 of the form. You must sign at the appropriate place in Part 1 if you want the dentist/denturist to be paid directly by the welfare plan.
- Complete and sign Part 2 of the form.
- Date and sign the form in member *Authorization and declaration* section.
- Return the completed form promptly to the claims adjudicator.

Pre-authorization

For treatment where the estimated cost is $500 or more, pre-determination of costs should be obtained from the claims adjudicator.

Have your dentist/denturist or orthodontist complete the appropriate form or section. Mail the form to the claims adjudicator.

For major dental services, please ask your dentist to send the applicable X-rays with the form.

A letter will be sent to the dentist/denturist with a copy to you, showing how much the plan will pay.

Most dentists/denturists will submit claims for payment directly to the claims adjudicator's office. Some dentists/denturists may insist that you pay immediately.

Please note that the portion of your dental claim not covered by the plan is payable immediately to your dentist/denturist.

Extended health care

- Obtain a claim form from the plan administrator or Coughlin & Associates Ltd., claims adjudicator, (directly or via the website **www.coughlin.ca** or alternatively, **www.plumbers.bc.ca.**
- Obtain a receipt from the selected specialist, pharmacist, ophthalmologist, optometrist or optician.
- Complete the form and sign at the bottom of the form.
- Return the completed form with original receipts to Coughlin & Associates Ltd.

Note: For prescription drug claims, we will provide you with an Express Scripts prescription drug identification card. Present card when purchasing drugs to cover the cost up to the plan maximum and percentage of coverage.

Submit your Claims Electronically

Paramedical (Chiropractor, Massage Therapist, Physiotherapist) services claims can be submitted directly through the Coughlin Plan Member Portal. Your claim will be adjudicated within two business days.

Some important points to remember:

- The maximum amount that can be claimed is $500 for paramedical services per claim transaction per covered person. You may not submit a claim for yourself and another person, such as a dependant, at the same time.

- You must be registered with Coughlin's Pre-authorized Deposit plan before the service will be activated.

- Claims are audited randomly. Be sure to keep your claim receipts for one year. If you receive an audit notice, please submit the requested original claim receipts within the timeframe indicated.

Coughlin Plan Member Portal

You can log in to the Coughlin Plan Member Portal at www.coughlin.ca and view your personal benefits and claims account. You can:

- Manage your profile, including updating your mailing address, telephone number, email address, updating your language of preference and viewing your dependant information.

- Auto-enroll in Pre-Authorized Deposit by entering your banking information directly on the portal. You also have the ability to change your banking information directly on the portal. Your changes will be live immediately – no processing delay. Members will also receive an e-mail notification if any changes are made to their banking information.

- View your claims history and the status of claims, print explanation of benefits statements, view your benefit accumulations/maximums and view your booklet (where applicable).

- Download and print claim submission and administrative forms.

If you are interested in registering, please contact the Claims Department at Coughlin & Associates Ltd. (Telephone: 1-888-204-1234 or E-Mail: winnclaim@coughlin.ca) for assistance.

Pre-Authorized Deposit (PAD)

Eligible reimbursements for extended health and dental care claims can be deposited directly into your bank account within two to five days following their approval. In order to enrol in Coughlin & Associates Ltd.'s PAD program:

- Auto-enroll in PAD by entering your banking information directly on the portal. You also have the ability to change your banking information directly on the portal. Your changes will be live immediately – no processing delay. Members will also receive an e-mail notification if any changes are made to their banking information; **or**

- Print the PAD form from the Coughlin Plan Member Portal or at www.coughlin.ca. Complete and return the form with a void cheque to Coughlin.

To be eligible for PAD, deposits must be made to an accredited Canadian financial institution. Please note that lines of credit are not accepted.

Travel medical emergency

- I.D. cards and travel medical emergency booklets are available from your plan administrator or Coughlin & Associates Ltd.
- In case of emergency, please immediately call
  Canada or US → 1-866-870-1898
  or
  Collect → 1-819-566-1898
  Noting:
  Policyholder → Plumbers Local 170 welfare plan
  Policy number → 1059144
- Claims should be submitted to Global Excel within 90 days from the date a claim arises and in no event later than one year from the date of injury.

Employee and Family Assistance Program (EFAP)

- Shepell EFAP brochure available from Plan Administrator or Coughlin & Associates Ltd.
- To access Shepell confidential help 24/7/365 call 1-844-880-9142 or online via www.workhealthlife.com. Click on "Register" and enter "Plumbers Local 170 Welfare Plan" to get started.

Time limitations

- **MSP, health care, dental care, vision care, and H.S.A.**

  Claims for these benefits must be submitted within 90 days from the date the expense was incurred. However, we must receive your claim by June 30th of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstance. For example, we must receive your receipts for 2019 before June 30, 2020.

- **Travel medical emergency**

  Claims must be submitted to Global Excel within 12 months of the date incurred.

- **Life insurance and AD&D**

  Claims must be submitted within 12 months of the day of loss.

- **Weekly wage indemnity**

  A claim for disability income benefits must be submitted within six months of the end of the qualifying disability period.

- **Long-term disability**

  A claim for the waiver of premium benefit and long-term disability benefits must be submitted within 12 months of the date disabled.

- **Jury duty fund**

  Applications must be made within 14 days of jury duty.

PAY DIRECT DRUG CARD

Insured members of Plumbers Local 170 welfare plan can pay for their prescription drugs at any retail pharmacy in Canada directly through their drug plan using the pay direct card from Express Scripts and Coughlin & Associates Ltd.

With the pay direct drug card, your prescription drug claims will be processed on-the-spot. There are no forms to complete, no payment required outside of the five per cent co-insurance and no waiting for a reimbursement cheque to arrive. Simply present the card to your pharmacist when you purchase prescription drugs. Your claim payment will be processed immediately. It's that simple.

The card can by used by you as well as your spouse and eligible dependants. Remember, the Plumbers Local 170 welfare plan **pay direct drug card is designed to cover only prescription drug costs. It cannot be used for dental, vision, or other health care claims.** (Submit claims for vision or MSP directly to Local Union 170 welfare office and all other claim services to Coughlin & Associates Ltd., in the normal fashion.)

You must present the new Express Scripts card to your pharmacist in order to take advantage of this fast and convenient service.

How it works

When you purchase prescription drugs, simply present the Plumbers Local 170 welfare plan pay direct card to your pharmacist. The prescription data will be submitted electronically to Express Scripts and your drug claim will be assessed in seconds while you wait. When your claim is approved, the pharmacist will return the card to you.

The card can be used at any pharmacy in Canada.

Note: the drug benefit coverage is subject to five per cent co-insurance, whereby you are responsible for five per cent of the eligible drug cost at the point of sale.

Number of cards to be issued

You will receive two pay direct drug cards; one for you and one for your spouse, if applicable. Upon request, an additional card will be issued in your name for eligible dependants 19-25 and in full-time attendance at college or university.

If your card is lost or stolen, please contact Coughlin & Associates Ltd., toll-free, **1-888-204-1234.**

Only in Canada

The pay direct card cannot be used outside of Canada.

If you forget your card

You can fill your drug prescription without the Plumbers Local 170 welfare plan pay direct drug card. However, your paper drug claim, also subject to a five per cent co-insurance, will have to be submitted to Coughlin & Associates Ltd. for manual processing.

If it doesn't work

Occasionally, there are cases when the drug card is not accepted by a pharmacist's system. This is usually a result of either input error or incorrect data being on file. If you encounter difficulties, ask your pharmacist to confirm or correct key data such as the spelling of your name, birth date, address, etc. Most errors can be corrected on-the-spot.

Otherwise, ask your pharmacist to contact the Express Scripts Pharmacy Help Desk at **1-800-563-3274.** If you continue to run in difficulties, please contact Coughlin & Associates Ltd., at toll free, **1-888-204-1234.**

You can submit your claim to Coughlin & Associates Ltd. at the following address:

Coughlin & Associates Ltd.
Claims department
PO Box 764
Winnipeg, MB R3C 2L4
Phone: (204) 942-4438
Toll-free: 1-888-204-1234

Most claims are processed within 48 hours of receipt by mail.

Co-ordination of benefits with your spouse

If the member's spouse has drug coverage under his/her own group benefit plan, the drug card will not accept prescription drugs purchased for the spouse, as their own plan is the first payer. Likewise, for eligible dependant children, if the spouse's birthdate appears first in the calendar year, the spouse's group benefit plan is considered first payer for the children. The drug claims must first be considered under the spouse's plan and then, if any amount is not covered, the balance may be submitted via a manual paper claim via Coughlin, to the Plumbers Local 170 welfare plan.

If your personal information changes

If you have any changes to your personal information, such as the adding or removal of a dependant, new address, etc., please contact your Local Union 170 welfare plan office for assistance. Phone: 604-526-3434 or
toll-free at 1-800-665-6808)

DEFINITIONS

Allowable enrolment period - means within four months from the date the covered member is eligible for coverage.

Coverage effective date – means the date coverage becomes effective as determined by the Plumbers Local 170 welfare plan.

Covered member – means an hour bank member, an associate (max. age 65), a retired member (under age 70), survivors (spouse and eligible dependants), or a special senior member (age 65 and over), as defined in the plan document, who is entitled to benefits in accordance with the plan document.

Deductible – means the initial portion of the eligible expenses, which you must pay before we will reimburse charges for any eligible expense.

Dentist – means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided and is acting within the scope of that license. For the purpose of this booklet, dentist may also mean dental specialist, or denturist.

Dependant – means any of the following persons for whom coverage is provided under this plan:

- one spouse;
- any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 19 and financially dependent on you or your spouse;
- under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute;
- any unmarried handicapped child to any age, who is living with you or your spouse, is financially dependent and is incapable of self-sustaining employment.

Disabled members – means a covered member who is disabled, under the regular care of a physician and in receipt of CPP disability benefits. Such disabled members are extended health and dental benefits to a maximum of age 70 or recovery, whichever occurs first. Note: LTD benefits cease at age 62.

Duplicate coverage – means that you (and your dependants) are eligible to claim certain benefits under more than one plan.

Fee guide – means the Canadian provincial/territorial dental fee guide that contains dental services and fees in effect on the date the dental service is performed.

Pre-existing condition – means a condition for which medical treatment or advice is required, or for which symptoms were present which would have caused a covered member or covered dependant to seek medical diagnosis or treatment.

Retiree – means a union member who is receiving pension benefits from the union pension plan.

Spouse – means at the relevant time:

- an individual who is married to a covered member and has not been living separate or apart from the covered member for the preceding 12-month period; or only if there is no such person;

- an individual who has lived and co-habited with the covered member in a marriage-like relationship, including a marriage-like relationship between persons of the same gender, for the preceding 12-month period.

Only one spouse is eligible for coverage under the contract at any one time.

GENERAL INFORMATION

Eligibility

This plan is for members of the Plumbers Local 170 welfare plan who work for contributing employers and includes the following:

1) Union members

Are members of Local Union 170 participating in the Plumbers Local 170 welfare plan and for whom an employer is obligated to make contributions to the fund.

2) Associate employees*

"Associate" means either

i) an individual employed with a participating employer where that individual does not work in the same capacity as union members; or

ii) an individual who:

a) is partner of a participating employer that is a legal partnership, or is a major shareholder company as defined in the union's collective agreement of a participating employer which is a limited liability company; and

b) who does not work in the same capacity as union members,

and for whom the administrator has received the initial associate contribution and for whom the administration continues to receive contributions;

3) Special senior members

Are eligible for EFAP, extended health care, and dental only (refer to page 8 pertaining to maximum coverage) and means an individual age 65 or older who at any time prior to attaining the age of 65:

i) was an active member, a retired member, or apprentice;

ii) was covered for benefits;

iii) has submitted to the administrator the enrolment documentation required on attaining age 65; and

iv) opted not to self-pay for full or mini retired member coverage

v) continues to remain a union member.

4) Retired (Senior) members

Means a union member who is receiving pension benefits from the pension plan.

5) Returning retired (Senior member)

Means a retired member, under age 70, who, after becoming a retired member:

i) ceased to be an hour bank member; and
ii) re-accumulates the eligibility hours in the hour bank associated with that retired member.

6) Disabled member

Means a covered member who is disabled, under the regular care of a physician and in receipt of CPP disability benefits. Such disabled members are extended EFAP, TME, extended health, and dental benefits to a maximum of age 70 or recovery, whichever occurs first. Note: LTD benefits cease at age 62.

When you become insured initially

1) Union member

For each participant, an account is kept by the plan administrator that shows hours worked with a contributing employer for which contributions have been made on your behalf for the purpose of group benefits. This account is called an hour bank account.

You and your eligible dependants will become insured on the first day of the second month following accumulation of 220 earned hours in your hour bank account and the

first day of the second month following receipt in the administrator's office of the duly completed signed enrolment documentation, provided you are actively at work or available for work on the day you would ordinarily become insured. Should you not be working or available for work on the same day your insurance would ordinarily start, the insurance for you and your dependants will be delayed until you return to work or are available for work.

Each month, 110 hours (monthly maintenance) will be deducted from your hour bank account to cover costs associated with the benefit coverage. The number of hours in the union member's hour bank account may not exceed 1,980 hours (enough to provide 18 months of coverage). Excess hours accumulated over 1,980 hours will be credited to the general reserves of the trust fund.

A permit worker or apprentice can accumulate hours worked in excess of the monthly maintenance, however, upon the end of the month following the date of termination of employment or lay-off, the balance in the hour bank account is forfeited to the general reserves of the trust fund unless the permit worker or apprentice becomes a union member in good standing.

2) Associate employee

For associates and eligible dependants for whom the administrator has received in full, the required contribution as determined by the fund administrator's office, and thereafter ongoing monthly contributions to fund the benefits, is eligible for coverage on the first day of the second month following the month in which the administrator also receives duly completed and signed enrolment documentation for the associate.

3) Special senior member

Special senior members (age 65 and over) are eligible for benefits on the first day of the second month following the month in which the administrator receives duly completed and signed enrolment documentation for the special senior member. The member has opted not to self-pay for full or mini retired member coverage.

Provision for self-pay by a union member

If at the end of any given month, a union member insured under the policy fails to meet the required monthly coverage cost as determined by the rules of the trust fund, such member will be given the opportunity of contributing the necessary amount of monthly coverage cost so that he may continue to be insured. Contact the administrator's office for complete details.

Provided the member continues to be in good standing with the union, *self-payments* means payments of money to the fund in lieu of contributions and is limited to a maximum period of 24 consecutive months for hour bank members; age 70 for retired members with reduced life insurance/AD&D; and for special senior members (age 65 and over), EHC/Dental is extended until the earlier of the member being deceased or no longer a union member in good standing.

Survivor benefit coverage

If you die, the following benefits will be extended to your eligible dependants (spouse and children) as follows:

Actively working hour bank insured or insured disabled members/ associates, insured retirees (under age 65) and insured self-paying members (under age 65)

- Extended health, travel medical emergency, EFAP, vision and dental benefits up to 24 consecutive months.

- Medical Services Plan (MSP) and travel medical emergency (TME subject to a $25,000 pre-existing maximum) extended to the earlier of 24 months or until the spouse attains age 65. Coverage for these benefits cannot go beyond age 65. Furthermore, for dependants of deceased retired members (under age 65), MSP is excluded.

- If your surviving children cease to qualify as eligible dependants (as defined earlier in this booklet), the health benefits being continued after your death will terminate on the date they no longer qualify.

- If a dependant is disabled on the date insurance under this continuation terminates, insurance payments for that

dependant will be continued until the earlier of the following:

- the date the disability ends;
- the date your dependant has received maximum benefits;
- 90 days from the date the insurance terminated.

Please note: If your dependant is in the hospital on the last day of this 90-day period, insurance payments for that dependant will be continued until the hospital confinement ends or until maximum benefits have been paid.

Special senior members (age 65 and over) and inactive non-insured self-paying members (i.e. if not insured for EHC, vision, dental, TME, EFAP, MSP) are not eligible for the survivor benefit coverage.

Integration with government plans

Extended health care benefits are intended to supplement and not overlap benefits under government plans such as the Medical Services Plan and Fair PharmaCare Program of British Columbia. As a condition of coverage, you are required to take all reasonable steps to qualify and obtain the fullest extent of coverage, benefits, contribution, or reimbursement available under all applicable government plans. We will also make payment only where permitted by provincial legislation or other applicable law.

Effective date of coverage and enrolment

Coverage effective as determined by the Plumbers Local Union 170 welfare plan.

Change in amounts of insurance

Please note a change in the amount of your insurance shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are actively at work.

Late applicants

If you did not apply during the allowable enrolment period but request coverage later (for yourself and/or your dependants), ask your plan administrator to explain the requirements for late enrolment in your group plan. **Note:** Different benefits may have different requirements – health evidence or retroactive premium payment. In some instances, coverage may be denied.

Identification (ID) cards

RSA will issue, travel medical emergency, identification (ID) cards for distribution by your plan administrator or claims adjudicator, Coughlin & Associates Ltd.

Only you and your enrolled dependants are entitled to use this card. Should you (or your dependant) allow an ineligible person to use this card, your coverage may be suspended without notice.

You may be asked to substantiate that an individual you claim as a dependant meets the definition of *dependant* for your group.

Duplicate coverage

If you and your spouse have coverage under the Plumbers Local Union 170 welfare plan, please check with your plan administrator to see if duplicate coverage is allowed for dental and extended health benefits.

If you and your spouse have coverage through different employers and you are both enrolled for similar benefits, duplicate coverage is allowed.

If you are eligible for duplicate coverage, you and your family should discuss both plans (and what portion of the benefits you pay) to determine whether it is to your advantage to enrol under more than one plan.

Your plan administrator will advise you if you are eligible to waive certain benefits under this group plan.

Co-ordination of benefits

If duplicate coverage is allowed, the claims adjudicator will pay claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

1) Dependant 00 is always the primary claimant. Dependant 01 (or 90 to 99) is always the second claimant.

2) Dependant children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).

3) In situations of separation or divorce, the following order applies:

    a) the plan of the parent with custody of the child;
    b) the plan of the spouse of the parent with custody of the child;
    c) the plan of the parent not having custody of the child;
    d) the plan of the spouse of the parent in c) above.

4) Total reimbursement shall never exceed 100 per cent of the eligible expenses.

General exclusions

1) The Plumbers Local 170 welfare plan, claims adjudicator, plan administrator, or RSA Travel will not be liable for any portion of an expense for which you or your dependant is entitled to reimbursement:

    a) under any other group or individual benefit plan or insurance policy; or
    b) due to legal liability of any other party.

2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:

    a) intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion;

b) active duty in the military forces or any nation or international organization, or in any civilian non-combatant unit which serves with such forces in combat;
c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country;
d) false pretences or fraudulent misrepresentation;
e) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventative treatment and services applicable under any Workers' Compensation Act or similar plan.

Termination of coverage

Not withstanding the applicable benefit age and/or period limitations, please note the following:

Termination of coverage for hour bank members

Coverage for benefits for an hour bank member will cease on the earliest of the following dates:

1) the last day of the month in which he ceases to be:

   a) a union member;

   b) a permit worker or probationary apprentice, as the case may be, for reason other than becoming an active member; or

   c) an individual to whom a reciprocal agreement applies and for whom the administrator establishes and maintains an hour bank;

2) the last day of the month following the month at the end of which all of the following conditions apply:

   a) his/her hour bank has less than 110 hours per month (the monthly maintenance hours required to maintain coverage);

   b) he/she has not been approved for plan paid coverage. Please refer direct to the administrator's office.

c) he/she does not qualify for self-payment.

3) the deemed date of termination of his/her eligibility for benefits in accordance with the self-payment provisions. Please refer direct to the administrator's office.

4) the last day of a month if on that day all of the following conditions apply:

   a) the hour bank maintained on his behalf has less than the maintenance hours (110 hours per month); and

   b) he/she is not a special senior member;

5) the last day of the month in which his death occurs;

6) the date the trust agreement is terminated; and

7) the date the member obtains the benefit age limitation.

Termination of coverage for associates

An associate will cease to be eligible for benefits on the earliest of the following dates:

1) the first day of the third month after the month in respect of which the administrator does not receive a contribution for the associate;

2) the last day of a month in which he attains age 65;

3) the last day of the month in which his death occurs;

4) the date the trust agreement is terminated;

5) the date the associate obtains the benefit age limitation; and

6) the date the associate ceases to be an employee of a contributing employer.

Termination of coverage for special senior members

A special senior member will cease to be eligible for benefits on the earliest of the following dates:

1) the last day of the month in which he ceases to be a special senior member;

2) the last day of the month in which his death occurs; and

3) the date the trust agreement is terminated.

4) age 75 for EFAP benefit

Termination of coverage for retired members

A retired member will cease to be eligible for benefits on the earliest of the following dates:

1) the last day of the month in which he ceases to be a retired member;

2) the last day of the month in which his death occurs; and

3) the date the trust agreement is terminated; and

4) benefit coverage cease as follows:

    a) Dental, EHC, Vision and EFAP on the later of age 70 or expiry of his hour bank account. MSP will cease earlier of age 65 or expiry of his hour bank account. Travel medical emergency will cease earlier of age 70 or expiry of hour bank account/self-pay. In effect, a retired member who has returned to work and met/continues to meet the eligibly requirements will be covered for dental, EHC, MSP, and vision indefinitely. (Note: other benefits cease at specific ages, LTD age 62, travel medical emergency, EFAP, and Life/AD&D cease at age 70, etc. regardless of hour bank status);

    c) Life and AD&D coverage cease on the earlier of attainment of age 70 or cessation of hour bank/self-pay.

A retired member will transfer to the special senior member classification the day he has attained age 65 provided depleted his hour bank account and opted not to self-pay for full or mini retired member coverage.

Termination of coverage for disabled union members

A disabled insured individual will cease to be eligible for applicable benefits on the earliest of the following dates:

1) the last day of the month he/she is no longer deemed totally disabled and receiving disability benefits (i.e. LTD, WCB, etc.);

2) the last day of the month in which his death occurs;

3) the last day of the month in which he attains age 70 (for early retired members, must self-pay following conclusion of LTD benefit at early retirement age, currently age 62);

4) the date the trust agreement is terminated.

REINSTATEMENT OF COVERAGE:

An individual who has ceased to be eligible for benefits may again become eligible for benefits only upon re-qualifying in accordance with the terms of this document. If an individual re-qualifies within six months of ceasing to be eligible for benefits, completion of the enrolment documentation for the basic Life insurance and basic AD&D insurance benefits is required. However, completion of the enrolment documentation for the other benefits is not required, provided the individual confirms in writing that all of the information contained within the former enrolment documentation remains accurate.

DISABILITY CLAIMS:

All disability claims should be recorded with the plan administrator and Manulife Financial, regardless of whether or not you are eligible to receive Workers' Compensation, CPP disability, auto insurance, or E.I. disability benefits. This recording will assist you should your claims with these agencies be declined either immediately or at a future date. In addition, proper application will be made relative to a waiver of life insurance and AD&D premium which is required within 12 months of the date of initial disability.

DISABILITY PROVISION:

Disabled union member

If a union member is disabled and approved for LTD benefits (or similar coverage), the trust fund will extend coverage for extended health, travel medical emergency, EFAP, vision, and dental up to age 62 with the appropriate premium payments paid by the trust fund noting life, LTD, AD&D, premiums are subject to waiver of premium if submitted within 12 months of the date of disability and subject to assessment/approval. After this period, the union member may be extended coverage, subject to receipt of applicable self payments to age 70 as a retired member. This provision is subject to review from time to time and it may change at the discretion of the board of trustees due to the financial stability of the plan.

The union member is eligible for this extension of coverage only as long as he/she remains a member in good standing with Plumbers Local 170.

Disabled associate employee

If an associate employee is deemed to be disabled of a long-term nature, extended health, travel medical emergency, EFAP, vision, and dental care can be extended to age 65 subject to receipt of ongoing required monthly contributions. The life, LTD, and AD&D premiums are subject to waiver of premium, if submitted within 12 months of the date of disability and subject to assessment/approval. Coverage will cease at the earlier of the date of recovery, the date appropriate monthly contribution remittances is not received within the allowable time, or the disabled participant reaches age 65.

RECIPROCAL AGREEMENTS:

Plumbers Local 170 members – union members working in a jurisdiction other than Plumbers Local 170 and on whose behalf contributions are being made to a welfare plan should complete a *Transfer Authority Form* and advise the local union or plan administrator to reciprocate contributions to their *"Home fund"*. This will maintain coverage under the Plumbers Local 170 welfare plan.

TRAVEL CARD MEMBERS:

Employees of employers on whose behalf contributions are made but who are members of other local unions or funds and whose funds have entered into a reciprocal agreement with the Plumbers Local 170 welfare plan will not be eligible for benefits but will have all contributions made on their behalf reciprocated to their *"Home fund"* after they complete the *Transfer Authority Form* available at the Local Union 170 office or from the plan administrator.

THIRD PARTY LIABILITY:

If you or your dependant have the right to recover damages from any person or organization with respect to which benefits are payable by the plan or, if applicable, the insurer, you will be required to reimburse the plan or, if applicable, the insurer, in the amount of any benefits paid out of the damages recovered.

The term *"damages"* will include any lump sum or periodic payments received with respect to: (1) past, present, or future loss of income; and (2) any other benefits, otherwise payable by the plan or, if applicable, the insurer.

If you or your dependant receives a lump sum payment under judgment or settlement for benefits which would otherwise be payable by the plan or, if applicable, the insurer, no further benefits will be paid by the plan, or if applicable, the insurer, until the benefits that would otherwise be payable equal the amount of the lump sum.

If a claim for damages is settled before trial, you will be required to reimburse the plan, or if applicable, the insurer the amount that reasonably reflects the loss of benefits that would otherwise by payable by the plan, or if applicable, the insurer.

You or your dependant must notify the plan administrator of any action commenced against a third party and of any judgment or settlement in the circumstances described above.

MEMBER LIFE INSURANCE BENEFIT

Eligibility

All eligible hour bank insured members, associates, and insured retired members (under age 70) are entitled to the basic life insurance benefits noting self-paying insured members are limited to 24 consecutive months.

Amount of benefit

On the date of death of a covered member, his designated beneficiary is entitled to a lump sum payment as follows:

1) $85,000 if the deceased was an hour bank member at the date of death, subject to a reduction to $20,000 for self-paying retired member classification, terminating at age 70. Life insurance will reinstate to $85,000 for retired members who have returned to active employment and satisfied eligibility requirements;

2) $85,000 if the deceased was an associate at the date of death, terminating at age 65; or

3) the lump sum amount that would have been payable at the date he became disabled, if the deceased was disabled at the date of death,

and if the deceased was a special senior member, the designated beneficiary will not be entitled to any lump sum payment.

Conversion privilege

If the basic life insurance benefit is not maintained for any reason other than death of a covered member, a covered member may elect to convert all or a portion of his basic life insurance benefit to an individually-owned life insurance policy. Covered members over age 65 are entitled to convert up to the terminated coverage amount.

To exercise the conversion privilege, the covered member must submit to the claims payer for the basic life insurance benefit a completed application within 31 days of the date of such termination. The covered member shall not be required to provide any medical evidence of insurability to the claims

payer and the regular premium rates of the claims payer for the individually owned policy of life insurance will apply.

If a covered member dies within the 31 days following termination of coverage for the basic life insurance benefit, then his/her designated beneficiary will be entitled to the basic life insurance benefit as if it had not been terminated.

Exclusions and limitations

The payment of the basic life insurance benefit to the designated beneficiary shall be subject to any exclusion or limitation stated in the contract with the claims payer for the basic life insurance benefit.

Waiver of premium benefit

For covered member's approved for long-term disability (LTD) benefits, the plan will waive the payment of life insurance premiums for such a covered member and the plan will self-insure the applicable insurance coverage.

To qualify for the waiver of premium benefit, the covered member must furnish due proof of disability, satisfactory to the plan.

Premiums will be waived starting with the date the required proof is approved by the plan. Premiums shall not be waived beyond the earlier of the date the member ceases to be totally disabled, or upon attainment of age 62 for members on LTD via the welfare plan, and age 65 for members on LTD via the pension plan.

From time to time, the plan shall have the right to require proof of continuance of the member's totally disability. The member may be required to be examined by a medical examiner designated by the plan, at the plan's expense.

No benefits shall be provided for a member under this benefit if the member fails to submit proof of disability when required.

The amount of life insurance for which premiums shall first be waived shall be the amount in force on the covered member's date of disability. If the amount of insurance would have reduced at a later date based on the *Schedule of insurance* in force on the member's date of disability then the amount of insurance for which premiums are being waived will be reduced in a like manner.

If the member dies while insurance is being continued in accordance with this provision, the amount of insurance that the plan will pay will be the amount of insurance for which premiums are being waived at the time of death.

If the covered member dies within one year after the date he became totally disabled and unable to work, due to such disability but before due proof of his total disability was furnished to the plan, the plan will pay to his beneficiary the amount of life insurance to which the member was entitled on the date he became so disabled. The plan must receive proof of his death and that he was totally disabled during this period not later than one year after his death.

No further benefit shall be provided for the member under this provision if:

1) the covered member ceases to be approved for long-term disability benefits;

2) the covered member fails to submit proof of continuance of disability when required;

3) the covered member fails to be examined by a qualified physician when required.

If the covered member does not return to active work within 31 days after this benefit ceases, he may apply with the basic life benefit claims payer, to convert the amount of insurance that was subject to this provision as though insurance had ceased on that date due to termination of employment.

If this contract or waiver of premium provision terminates, the plan remains liable to provide waiver of premium benefits for continuous disability caused by an accident or sickness that occurred prior to termination provided a claim is submitted within 12 months of the covered member's last active day at work and due proof of disability, satisfactory to the plan, is furnished within 18 months of the last active working day.

At the end of any 90-day period during which the member was not disabled the plan ceases to be liable for any future waiver of premium benefit for disability caused by an accident or sickness that occurred prior to termination.

However, the plan shall not be liable for waiver of premium benefits after the termination of the contract or waiver of premium provision if a replacing policy is bound contractually or as a matter of law.

BASIC AD&D INSURANCE BENEFIT

Eligibility

All hour bank insured members, associates, and insured retired members (under age 70), noting self-paying insured members are limited to 24 consecutive months, will be entitled to the basic AD&D insurance benefits in accordance with the contract issued by the appointed insurer (i.e. claims payer).

Amount of benefit

If a covered member suffers any loss as a direct result of bodily injury caused by an accident and such loss occurs within 365 days after the date of the accident and is listed in the contract with the claims payer for this benefit, there shall be paid to the covered member, or if the accident results in death of the covered member, to his designated beneficiary, a lump sum payment determined as follows:

1) if he/she suffers only one loss, by multiplying the "principal amount" referred to in this section by the percentage for that loss listed in *Schedule of losses* in the contract with the claims payer for this benefit;

2) if he/she suffers multiple losses, by multiplying the principal amount referred to in this section and the insurer contracts by the percentage that is the highest of all his multiple losses suffered as listed in the *Schedule of losses* in the contract with the claims payer for this benefit.

Principal amount

The principal amount of basic AD&D insurance benefits, as referred to in the *Schedule of benefits*, is determined as follows:

1) $85,000 if the covered member was an hour bank member at the date of loss, subject to a reduction to $20,000, for retired member classification, terminating at age 70. AD&D will reinstate to $85,000 for retired members who have returned to active employment, and satisfied eligibility requirements;

2) $85,000 if the covered member was an associate at the date of loss, terminating at age 65; or

3) the lump sum amount that would have been payable at the date he became disabled, if the covered member was disabled at the time of loss;

and if the covered member was a special senior member, he/she or his/her designated beneficiary will not be entitled to any lump sum payment.

SCHEDULE OF BENEFITS

For loss of	**Percentage of the principal sum**
Life	100%
Entire sight of one eye	66 2/3%
Speech	66 2/3%
Hearing in one ear	33 1/3%
All toes of one foot	25%
For loss or loss of use of	
One arm	75%
One leg	75%
One hand	66 2/3%
One foot	66 2/3%
Thumb and index finger or at least four fingers of one hand	33 1/3%
For total paralysis of	
Both upper and lower limbs (Quadriplegia)	200%
Both lower limbs (Paraplegia)	200%
Upper and lower limbs of one side of body (Hemiplegia)	200%

Principal sum means the amount of insurance indicated in the *Summary of benefits*.

"Loss" as used above with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to

arm or leg, means complete severance through or above the elbow or knee joint; as used with reference to thumb and finger means the complete severance at or above the metacarpophalangeal joint; as used with reference to toe, means the complete severance at or above the metatarsophalangeal joint; and as used with reference to eye, means the irrecoverable loss of the entire sight thereof.

"Loss" as used above with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing.

"Loss" as used above with reference to quadriplegia, paraplegia and hemiplegia means the complete and irreversible paralysis of such limbs.

"Loss" as used above with reference to loss of use means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of the period.

Indemnity provided under this section for all losses sustained by any one insured individual, as the result of one accident shall not exceed the following:

1) The principal sum for all losses except quadriplegia, paraplegia and hemiplegia.

2) Two times the principal sum, or the principal sum if loss of life occurs within 90 days after the date of the accident with respect to quadriplegia, paraplegia and hemiplegia.

EXCLUSIONS

This plan does not cover a period of hospitalization which is less than five days with respect to the *Hospital indemnity benefit* nor any loss, fatal or non-fatal, caused or contributed to by:

1) self-destruction or self-inflicted injury, whether the insured individual be sane or insane;

2) declared or undeclared war or any act thereof;

3) riding as a passenger or otherwise in any vehicle or device for aerial navigation other than as provided in the part entitled *Aircraft coverage*;

4) committing, attempting, or provoking, an assault or criminal offence (except for an accident which occurs while the member is operating a motor vehicle and the blood contains more than 80 milligrams of alcohol in 100 millilitres of blood [.08 per cent]).

Your accidental death and dismemberment plan also includes the following benefits, which are briefly described. Please contact your plan administrator for complete details and limitations.

Aggregate limit

$5 million per accident for all insured individuals.

Waiver of premium benefit

If a covered member becomes disabled and qualifies for the waiver of premium benefit under his/her life insurance coverage, the plan will also waive the payment of accidental death and dismemberment insurance premiums for that covered member and the plan will self-insure the applicable insurance coverage.

The amount of accidental death and dismemberment insurance for which premiums shall first be waived shall be the amount in force on the member's date of disability. If the amount of insurance would have reduced at a later date based upon the *Schedule of insurance* in force on the member's date of disability, then the amount of accidental death and dismemberment insurance for which premiums are being waived will be reduced in a like manner.

A member's entitlement to waiver of premium benefits cease on the earlier of:

1) the date the waiver of premium for life insurance ceases;

2) the date the coverage terminates.

Aircraft coverage

Coverage while riding as a passenger but not as a pilot or member of the crew.

Exposure and disappearance

Loss due to unavoidable exposure to the elements. Loss of life resulting from bodily injury caused by an accident at the time of a disappearance, sinking or wrecking.

Repatriation benefit

The insurer will pay the reasonable and customary expenses incurred for the transportation of the body of the deceased insured individual to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased, subject to a maximum of $10,000.

Occupational training benefit
(Applicable to member coverage only)

In the event of your accidental death, the insurer will pay the reasonable and customary expenses incurred within three years following the date of the member's accident for a spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, subject to a maximum of $10,000.

Rehabilitation benefit
(Applicable to member coverage only)

In the event that you sustain an accidental injury which results in a loss payable and such injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, the insurer will pay the reasonable and customary

expenses incurred for such training subject to a maximum of $10,000 for any one accident.

Family transportation benefit

In the event that you sustain an accidental injury and are confined in a hospital located more than 150 kilometres from your normal place of residence, the insurer will pay the reasonable expenses incurred by all members of your immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to the confined insured individual, subject to a maximum of $1,000.

Immediate family means a person at least 18 years of age who is the spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the member.

Seat belt benefit

In the event that you sustain an accidental injury payable under this benefit, the amount of principal sum will be increased by 10 per cent if, at the time of the accident, you were:

1) wearing a properly fastened seat belt;

2) driving or riding in a vehicle driven by a driver who was neither intoxicated nor under the influence of drugs, unless taken as prescribed by a physician, at the time of the accident. Intoxication and being under the influence of drugs is as defined by the local jurisdiction where the accident occurred.

Hospital indemnity

A daily benefit (1/30th of one per cent of your principal sum, maximum of $2,500 per month) will be payable if you are confined in a hospital for at least five days and under the care of a physician for an accidental injury payable under this benefit, subject to a maximum of 365 days per accident.

Education benefit
(Applicable to member coverage only)

In the event of your accidental death, the insurer will pay the *Education benefit* stated below for each of your dependant

children who are enrolled as full-time students in an institution for higher learning within 365 days following date of death of the member.

The *Education benefit* is equal to the reasonable and customary expenses actually incurred, subject to the lesser of five per cent of your principal sum, or $5,000, for each year the dependant child described above continues his education on a full-time basis in an institution for higher learning, but not to exceed four years, which must run consecutively, with respect to any one dependant child.

Institution for higher learning includes any university, college, CEGEP or trade school.

WEEKLY WAGE INDEMNITY BENEFITS

Eligibility

- Active hour bank insured members, apprentices, probationary apprentices, permit members and associates are eligible if they are covered under the welfare plan in the month of disability.

- Members making self-payments, if making full subsidized payments and registered on the out-of-work board in the month of disability. The member must be covered for the duration of the WWI claim at least on mini benefits.

- Member must have worked within the last 90 days for a contributing employer.

- Members must be unable to perform work of any kind and suffered loss of wages.

- Member must be under a physician's care for the disability.

- Member cannot receive WWI benefits for more than two claims in a two-year period, without trustee approval.

- Member must make written application to the welfare plan office.

Benefits payable

- Equivalent to the EI maximum per week based on a seven-day week.

- Benefits begin on the first day of an accident/injury (including assault) or overnight hospital stay or on the fourth day of an illness or day surgery (providing you have been seen by a doctor).

- Maximum duration 15 weeks, but not beyond age 65.

- If the member is already on an Employment Insurance (EI) claim, the claim should be changed to a disability claim. If still disabled after claim runs out, the member should contact the office for further benefits.

- If not already on claim, the member must apply for EI disability benefits, if he/she is to be off longer than four weeks.

- The welfare plan will pay for four weeks; then EI will become the payer. If the member is still disabled after EI claims is finished, the member should apply to the welfare office for the balance of weeks up to 15 weeks maximum, but not beyond age 65.

- If the member does not qualify for EI nor WCB, a letter of rejection must be submitted to the office to start a claim.

- WWI benefits are taxable.

Successive claims

Absences from work due to disability are considered to be the same period of disability unless separated by:

- two complete consecutive weeks of active, full-time work; or

- one full day of work if the disability is due to a different cause.

How to make a claim

- Contact the administrator's office and a claim form will be sent to you for completion.

- When this has been returned to the office, a *Physician's Statement* will be sent to your doctor for information regarding your claim.

- A claim cannot be started until this has been returned.

- If required, further information may be required from your doctor to continue your claim.

- Weekly wage indemnity cheques are issued on Wednesday of each week.

- Maximum claim is 15 weeks, based on medical information.

A covered member is not eligible for weekly wage indemnity if:

- 65 years of age or over;
- receiving pension benefits from the Plumbers Local 170 pension plan;
- receiving Workers Compensation wage loss benefits;
- disabled due to an ICBC accident, unless unable to work due to the accident for a period under eight days;
- works more than half his/her shift he/she cannot claim for that day;
- any new illness or injury occurs during an established claim. Then, it is considered to be in the same period of disability and will not result in additional benefits.
- on strike or lock-out.
- While enrolled and attending school.

No benefits will be paid for periods of disability arising from:

- disability existing prior to commencement of coverage;
- occupational accident or illness covered by the WCB Act;
- self-inflicted injuries;
- injuries or illnesses resulting from war, participating in a riot or arising while serving as a member of an armed service;
- substance abuse unless participating in an approved rehabilitation program;
- an accident while operating a vehicle, vessel or aircraft while impaired;
- disability resulting from cosmetic surgery or treatment.

LONG-TERM DISABILITY BENEFITS

Eligibility

- A member in good standing with the union.
- A covered member of the Plumbers Local 170 welfare plan at the time of disability.
- If making self-payments, you must be paying at either full or mini subsidized rate in month of disability.
- Must be under age 62.
- Not retired.
- Must be *totally and permanently* disabled as defined in the welfare plan document and under the care of a physician.

Definition of "Totally and permanently" disabled

- Disability can be either physical or mental. To be considered disabled, the condition must be *severe* and *prolonged*. *Severe* means the condition prevents regular employment working at any job even part-time. *Prolonged* means the condition is long-term and has an indefinite duration.
- Must be in receipt of Canada Pension Plan disability benefits.
- Long-term disability benefits commence on the date CPP benefits take effect.

How long-term disability benefits calculated

- The monthly benefit is equal to 70 per cent of your last regular basic hourly rate of earnings multiplied by 1,400 and divided by 12.
- Total annual disability income from all sources is limited to 85 per cent of the average of a disabled member's best

three consecutive years of earnings in covered employment.

- There is an offset for disability income from CPP (excluding benefits for dependant children) and WCB.

- There is also an offset for any income received from weekly wage indemnity for the same period of LTD benefits. And any other pension plan or long term disability plan to which the participating employers directly contribute, including Employment Insurance Act benefits.

- All-source test is applied if there is a disability income from ICBC.

- LTD benefits are taxable.

When long-term disability benefits end

- Last day of month in which you die.

- Date you cease to be totally and permanently disabled.

- Date you cease to be entitled to Canada Pension Plan disability benefits.

- Date you refuse or fail to participate in a rehabilitation program.

- Last day of the month in which you attain age 62.

- Last day of the month preceding the month you retire.

- If a member is not under the care of a legally qualified physician recognized by the trustees.

- For eligible members who become disabled, and after a full and thorough investigation, the trustees may at any time decide that such a member is or is not totally and permanently disabled.

No LTD benefits shall be payable for any disability resulting from:

- a criminal offense;
- an intentionally self-inflicted injury or sickness;
- an injury or illness sustained in military service;
- substance abuse, unless participating in an approved rehabilitation program;
- operating a vehicle, vessel or aircraft while impaired by drugs or alcohol.

Other benefits available to members receiving long-term disability benefits

- Accrual is credited each year, at the industry average, to members who are active in the pension plan and have at least five years of credited service.
- The member can apply for plan paid coverage for all plan benefits for which the member and his dependants qualify. This benefit is effective on the same effective date as LTD and ceases when LTD benefits cease.
- Members awaiting qualification for LTD benefits can apply for plan paid coverage for a 12 month period. Must be applying to CPP and provide medical information regarding disability.

How To Make A claim

- A claim for waiver of premium and long-term disability benefits must be submitted within 12 months of the date disabled.
- A claim cannot be assessed until this has been returned.
- If required, further information may be required from your doctor to continue your claim.

Note: If the LTD benefits of a covered member cease before his/her retirement, due to either return to gainful employment or to being determined not to be totally and permanently disabled, and if he/she is again determined to be totally and permanently disabled within five months of cessation of his/her LTD benefits, by a cause related to the original disability, then the covered member shall have the LTD benefits originally granted to him/her reinstated from the date the trustees determine him/her to be disabled again.

MEDICAL SERVICES PLAN (MSP)

Reimbursement of premiums – The plan does not pay MSP premiums for or on behalf of covered members but will reimburse, in accordance with this section, a portion of the MSP premiums actually paid by ***covered individuals*** **(hour bank insured members and eligible disabled members) excluding:**

- special senior members;
- associates;
- covered members making self-payment;
- members who are eligible for MSP through a spouse's plan;
- retired members.

The plan will not reimburse a covered individual more than once for each month that a covered individual has paid MSP premiums.

If the covered individual participates in a provincial health care (PHC) plan outside of BC, then he/she is entitled to have the plan reimburse any premiums required under that program but only up to the amount that would be reimbursed in accordance with this section based on the MSP premium structure in BC.

Qualification for reimbursement

A covered individual will not receive reimbursement from the plan in respect of MSP premiums, until the administrator is satisfied that the covered individual actually paid the MSP premiums and the covered individual completes and delivers to the administrator such forms and documents as the administrator may require from time to time.

Amount reimbursed

Subject to any requirements or limitations outlined in this section, the amount that a covered individual will be eligible to be reimbursed will be based on the MSP premium rates in effect at January 1, 2018, or as determined by the trustees, and will depend on the circumstances of the covered individual, as set out in the following table (i.e. if net income $42,000 or over, otherwise subject to scale):

Covered individual who is:	Reimbursement percentage	Maximum monthly rates (by status) as at January 1, 2018	
		1 Adult	Family of 2 Adults
Not disabled	100% of	$37.50	$75.00
Disabled	100% of	$37.50	$75.00

[1] Only applicable for the months that a covered individual is disabled under the plan, qualifies for plan paid coverage. See the administrator for clarification.

Residents outside of BC

If a covered individual resides outside of BC, is not covered by any provincial health care (PHC) plan, and submits to the administrator the required documentation, the administrator will reimburse him/her on a monthly basis from the plan the cost to purchase individual health insurance providing similar coverage to a PHC plan, to a maximum monthly amount equal to the cost that BC MSP premiums would be required for that covered individual if he/she were eligible for MSP coverage.

MSP reimbursement guidelines

For a covered hour-bank member to be reimbursed MSP premiums, the administrator requires **along with proof of payment,** the following:

- a copy of the whole (top and bottom) MSP billing in the **member's name** clearly indicating the month and dependants they are claiming.

- If the member has MSP automatic withdrawal, the bank statement must clearly provide the member's name.

Acceptable proof of payment
The following are acceptable proof of payment:

- bank statement;
- bank stamped MSP billing notice; and/or
- copy of online payment confirmation.

All MSP reimbursements submitted must be accompanied by proof of payment.

The Plumbers Local 170 Welfare Office must receive your claim by **June 30th** of the calendar year following the year. For example, 2019 MSP premiums must be in by **June 30, 2020** for reimbursement.

EXTENDED HEALTHCARE

The extended health care (EHC) plan is designed to help you pay for specified services and supplies incurred by you and your dependants, when not provided under a government health plan or by a tax supported agency.

All dollar limits included in the benefit descriptions are **claimable** unless specifically shown as **payable**.

To determine the benefit amount **claimable,** Coughlin & Associates Ltd., the claims adjudicator, assesses the claim as follows:

- calculates the total eligible expense;
- applies the claimable limits;
- subtracts the deductible, when applicable;
- applies the reimbursement percentage;
- applies the EHC plan maximum.

To determine the benefit amount **payable,** Coughlin & Associates Ltd., assesses the claim as follows:

- calculates the total eligible expense;
- subtracts the deductible, when applicable;
- applies the reimbursement percentage;
- applies the payment limits;
- applies the EHC plan maximum.

Deductible

No deductible applicable.

Definitions

Eligible expense – means a charge for any service and/or supply included in this booklet as a benefit that:

1) in our assessment, is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth;

2) was ordered or referred by a physician or dentist, unless otherwise specified in the benefit description;

3) is not a cost normally paid (in whole or part) or provided by a government plan or any other provider of health coverage;

4) is incurred while your coverage is valid. An expense is incurred on the date the service is provided or the supply is received.

It does not include any payment to a pharmacy or a practitioner (demanded or received by balanced billing, extra billing, or extra charging) that represents an amount in excess of the schedule of costs prescribed by the government plan. PharmaCare's low cost alternative and reference based pricing will not be applied unless specified in this booklet.

Physician – means only a doctor or surgeon who is a doctor of medicine (MD) duly licensed to practice medicine in Canada or any state of the United States of America and who is recognized by the College of Physicians and Surgeons in the province or state in which treatment is rendered.

Practitioner – means an individual who is currently licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided or, where no such authority exists, has a certificate of competency from the professional body that establishes standards of competence and conduct for the profession, and is acting within the scope of that license.

In-province eligible expenses

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a physician. Unless otherwise indicated, the maximums included here are on a per person basis.

Reimbursement at 100 per cent of eligible expenses

1) Vaccines

Vaccines dispensed by a licensed pharmacist or physician for preventative purposes covered up to $500 per person per lifetime on a reasonable and customary basis. No benefit shall be payable for any charges incurred for the administration of a vaccine.

2) Diagnostic tests

Covers diagnostic testing that is not covered by provincial health care (inclusive of prostate blood testing, etc.)

a) for covered individuals, excluding special senior members and their covered dependants, maximum of $100 per calendar year per person;

b) for special senior members and their covered dependants, $900 maximum combined per calendar year (inclusive of dental treatment) with exception that special senior members are eligible for up to an additional $35 per calendar year for prostate blood testing, not subject to the $900 calendar year maximum.

3) Smoking cessation products

Covered up to $500 per person per lifetime subject to official receipt (detailing patient name, purchase, date, item). Includes nicotine patches and gum, Zyban, acupuncture.

4) Foldable intraocular lens implants

Coverage in excess of provincial health care plan up to $1,000 per person per lifetime.

5) Prostate tests (special seniors only)

For insured members only, up to $35 per calendar year.

6) Medical bracelets

Subject to medical necessity, maximum of $50 per person per calendar year (requires an official itemized receipt indicating patient's name and item description) as well as date of purchase and amount (cash register receipts will not suffice).

7) Emergency Ambulance

a) Charges for licensed ambulance for response and/or service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient.

b) Air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport.

c) Emergency transport from one hospital to another, only when the original hospital has inadequate facilities.

d) Charges for an attendant when medically necessary.

8) Eyeglass/contact lens/laser eye surgery coverage (Vision Care benefit)

Benefits payable is 100 per cent of a claim to a maximum of $500 per person per 24-month period effective January 1, 2019. As well, effective January 1, 2019 implement Laser eye surgery coverage of up to $3,000 per person per lifetime.

For special senior members and covered dependants of special senior members for the purchase and/or repair of eye wear or laser eye surgery when prescribed by a physician or optometrist to a maximum payable of $900 every 12 months. For cost of laser eye surgery, reimburse $900 every one calendar year until original claim amount, at 100 per cent, has been reimbursed.

Contact the Plumbers Local 170 welfare office for forms and assistance. (Local at 604-526-3434 or, toll-free, 1-800-665-6808). This benefit is administered in-house at the Plumbers Local 170 welfare office.

9) Eye examinations (Vision Care benefit)

Charges for routine eye examinations every calendar year to a maximum of $100 when performed by a physician or optometrist for covered Members and their eligible dependents to the later of age 65 or expiry of his hour bank account; charges in excess of Insured's Provincial Plan. This is administered in-house at the Plumbers Local 170 welfare office, please contact the welfare office for forms and assistance (Phone: 604-526-3434 or toll-free at 1-800-665-6808).

10) Practitioners

Professional services of the following practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a physician.*

Acupuncturist $700
Chiropractor (inclusive of X-rays).....$700
Massage practitioner.....$700
Naturopath.....$700
Physiotherapist
(inclusive of athletic therapy) $700
Podiatrist.....$700
Speech language pathologist.....$700
Psychologist (inclusive of family and
marriage counsellors).....$1,500

Private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence.

11) Hearing aids and repairs

To a lifetime maximum payable of $2,000 every five years per person. Batteries, re-charging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily;

12) Custom Ear Plugs

Custom Ear Plugs that have been prescribed by a physician up to $500 every five years per person. An official itemized receipt along with a physician referral must be submitted.

13) Orthopedic Shoes and Orthotics:

i) when prescribed by a physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, custom made orthopedic shoes (including repairs) and modifications to stock item footwear to a calendar year maximum of $500 for an adult and $300 for a dependant child. A custom made orthopedic shoe is one fabricated from raw materials and specifically designed for the patient,

based on three-dimensional volumetric model of the patient's foot and lower leg;

ii) when prescribed by a physician, podiatrist, chiropractor, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics and arch supports to a calendar year maximum of $400. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet.

Reimbursement at 95 per cent of eligible expenses

1) Drugs

Drugs and medicines (note the EHC deductible is not applicable and special seniors including covered dependants, remain at 100 per cent reimbursement, subject to applicable maximum) as listed on the BC provincial formulary and dispensed by a licensed pharmacist or a physician, in a quantity we consider reasonable:

1) drugs and medicines that legally require a prescription from a physician or dentist, and included with the above;

2) insulin preparations, testing supplies, needles, and syringes for diabetics;

3) vitamin B12 for the treatment of pernicious anemia;

4) allergy serums when administered by a physician;

5) Oral contraceptives, medicated (hormone releasing) IUD's and contraceptive patches;

6) Epi-Pens.

The above items will be reimbursed up to $1,500 per family unless proof of a higher BC Fair PharmaCare Program deductible is provided. If you are a resident of a province other than BC, your drug coverage will be the lesser of your own provincial drug coverage or equivalent coverage entitlement within the BC Fair PharmaCare Program.

2) **Fertility Drugs**

Effective July 1, 2019 reimburse up to $2,500 per person per lifetime for prescribed drugs and treatment. Please note that there is no coverage for administration of the drugs, facility fees or operating room fees.

Reimbursement at 80 per cent of eligible expenses

(Note: Once $1,000 has been paid in a calendar year, further eligible expenses will be reimbursed at 100 per cent, subject to maximums in contract).

1) Hospital

The additional charge (including co-insurance charge) for semi-private or private room accommodation in a hospital or the extended care unit of a hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

2) Dental accident

Dental treatment by a dentist, which is required, performed, and completed within 52 weeks after an accidental injury that occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth.

We pay benefits based on eligible dental services and financial limits in the fee guide in the province/territory of service.

3) Medical aids and supplies

Charges for the following services and supplies:

a) oxygen, blood and blood plasma;

b) ostomy and ileostomy supplies;

c) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports;

d) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis;

e) surgical brassieres covered up to $500 per person per calendar year;

f) charges for the following items to the limitation and maximum amounts indicated per calendar year:

i) stump socks..... no maximum
ii) surgical stockings..... two pairs

g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum payable of $500;

4) Standard durable medical equipment

a) Pre-authorization is required from us for expenses in excess of $5,000.

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

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

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

e) Standard durable equipment includes:

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

ii) medical heart and blood glucose monitors, and cardiac screeners;

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

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

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

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

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

5) Medical examinations

Charges for a physician for medical examinations required by government statue or regulation for employment purposes, provided such charges are not payable under a collective agreement.

Exclusions

The following are not included as eligible expenses under your EHC plan:

1) Except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, X-rays, hospital co-insurance, vitamins and/or minerals, contraceptives, , erectile dysfunction drugs, medications used to treat or

replace an addiction or habituation, support stockings, orthotics, arch supports, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of physicians or any person who renders a professional health service in the patient's province of residence.

2) General anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription.

3) Any drug, item or service classified as preventive treatment or administered for preventive purposes, and that is not specifically required for treatment of an illness or injury other than what is specifically listed under eligible expenses.

4) Allergy testing unless rendered by a naturopath.

5) Personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures, and medical laboratory tests.

6) Charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English.

7) Any payment to a pharmacy, a practitioner, or a physician (demanded or received by balanced billing, extra billing or extra charging) that represents an amount in excess of the schedule of costs prescribed by the government plan.

8) That portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits.

9) Expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment.

10) Charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence.

11) Expenses of a dependant hospitalized at the time of enrolment.

12) Services performed by a physician who is related to or resident with you or your spouse.

13) Ambulance charges for work related illness or injury assessed by the Workers' Compensation board to be your employer's responsibility.

14) Retroactive coverage and payment of any expense, including expenses that receive special authorization from PharmaCare.

15) Medical Cannabis.

16) Any other item not specifically included as a benefit.

Claims

1) Since the claims adjudicator or the plan administrator does not return receipts after the claim is processed, you should keep a photocopy of the receipts you submit to us. We will send you a remittance statement for your records each time you submit a claim.

2) If you have duplicate coverage, please review the *Co-ordination of benefits* section under *General information*. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.

3) Certain medical expenses are covered under the government plan. If you submit your claim to us before

you submit your claim to the government plan, we will deduct what the government plan would normally pay (i.e. PharmaCare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design. Information for claiming PharmaCare expenses may be obtained from your pharmacist.

4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:

   a) Obtain a claim form from Coughlin & Associates Ltd, your plan administrator or claims adjudicator.

   b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).

   c) Please submit claims within **90 days** from the date the expense was incurred. However, Coughlin & Associates Ltd., the claims adjudicator, must receive your claim by **June 30th** of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances. For example, the claims adjudicator must receive your receipts for 2019 before June 30, 2020.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM (EFAP)

Your EFAP is a confidential and voluntary support service that can help you take the first step towards change. They will help you find solutions to all kinds of challenges at any age and stage of your life. Whether you have decided to get in shape, are considering buying a new home or want to find a better work-life balance – we have the expert insight to get you on your way.

You and your immediate family members (as defined in your employee benefit plan) can receive support over the telephone, in person, online and through a variety of self-guided resources. You'll get immediate relevant support in a way that is most suited to your preferences, learning approach and lifestyle. Highly qualified, experienced and caring professionals help you select a support option that works best for you.

Your EFAP is completely confidential within the limits of the law. No one, including your employer, will ever know that you have used the service unless you choose to tell them.

There is no cost to use your EFAP, this benefit is provided to you by your employer. You can receive a series of sessions with a professional and if you need more specialized or longer-term support, your EFAP can suggest an appropriate specialist or service that is best suited to your needs. While fees for these additional services are your responsibility, they may be covered by your provincial or organizational health plan.

Professional EFAP Counselling Services

Achieve Well-Being – Stress, Depression, Anxiety, Anger, Crisis Situations, Life Transitions

Manage Relationships and Family – Separation, and Divorce, Elder Care, Relationship Conflict, Parenting, Blended Family Issues

Find Child and Elder Care Resources – Maternity and Parental Leave, Adoption, Child Care Services, Schooling, Adult Day Programs, Nursing and Retirement Homes

Get Legal Advice – Separation and Divorce, Civil Litigation, Custody and Child Support, Wills and Estate Planning

Get Financial Guidance – Credit and Debt Management, Budgeting, Bankruptcy, Financial Emergencies, Changing Circumstances

Deal with Workplace Challenges – Work-Life Balance, Conflict, Career Planning, Bullying and Harassment

Tackle Addictions – Alcohol, Tobacco, Drugs, Gambling, Other Additions, Post-Recovery Support

Improve Nutrition – Weight Management, Boost Energy and Resilience, High Cholesterol, High Blood Pressure, Diabetes, Heart Disease

Focus on Your Health – Identify conditions, Prevent Illness, Manage Symptoms, Discover Natural Healing Strategies, Create an Action Plan for better Health

Accessing your EFAP

24-hour, 7-days-a-week toll-free confidential telephone access via the Care Access Centre to EAP for crisis counselling, risk assessment and matching to appropriate service(s).

Our Intake Specialists are fully bilingual in English and French. 1-844-880-9142.

24-hour, 7-days-a-week secure and confidential access to a range of EAP support services via workhealthlife.com with Online Access. Service fully bilingual in English and French.

24-hour, 7-days-a-week direct access via the Internet to Online Programs, E-Counselling and First Chat. Our trained counsellors are fully bilingual in English and French.

TRAVEL MEDICAL EMERGENCY

The travel medical emergency insurance is designed to cover medical losses arising from sudden and unforeseeable circumstances occurring while you or your eligible dependants are temporarily travelling outside of our province or territory of residence. Your travel accident coverage, provided through RSA Travel and Global Excel Management, will cover the eligible emergency medical expenses as well as help you or your dependants find proper medical care.

Global Excel Management

Global Excel provides professional assistance personnel who are available 24 hours daily, worldwide to participants and their families while travelling outside of their province or territory of residence.

You or your dependants must contact Global Excel when you or your dependants:

- are hospitalized or about to be hospitalized;
- need assistance in locating the proper medical care nearest you;
- are required to provide insurance verifications (may be confirmed by a physician or hospital through Global Excel directly);
- are in an accident and require medical treatment;
- have a medical problem and require translation service;
- encounter any serious medical problems.

Remember, it is your responsibility to contact Global Excel prior to receiving medical treatment or as reasonably possible. Otherwise, you will be responsible for paying the difference between the amount you or your dependants incur and the reasonable and customary costs that would have been paid by Global Excel.

Claims submission

RSA has an agreement with Global Excel to pay claims and co-ordinate the payment of claims with the provincial or territorial health insurance plan. Therefore, insured participants must submit travel claims along with other pertinent information to Global Excel and sign an authorization form allowing Global Excel to recover payment from the provincial or territorial

health insurance plan. In the event of an emergency while travelling outside of your province or territory of residence, please call:

- **Canada and U.S.A.** – 1-866-870-1898
- **Mexico** – 001-800-514-1518
- **Collect** – (819) 566-1898

Your policy number is 1059144.

Highlight of travel medical emergency benefits

RSA group travel coverage		
Plan details	**Hour bank member ***	**Early retirees, survivors and associates ***
Coverage period	60 days per trip	60 days per trip
Overall maximum	$5 million per coverage period	$5 million per coverage period
Termination age	Earlier of age 70 or expiry of hour bank account/self-pay)	*Early retirees* – *Earlier of age 70 or expiry of hour bank/self-pay* *Survivors* – Earlier of age 65 or 24 months. *Associates* – Earlier of age 65 or three months following last contribution received.
Pre-existing clause	* Refer to Exclusions and Limitations – page 82	* $25,000 lifetime maximum for pre-existing condition (excludes associates)

In order to be considered as eligible expenses, many benefits listed in this section require the prior approval of Global Excel.

- Semi-private hospital in-patient charges (until Global Excel determines that further care is no longer required) to a maximum stay of 365 days.

- Medical and surgical charges for services provided by a legally qualified physician or surgeon.

- Laboratory tests and X-rays prescribed by the attending physician that are part of the emergency. **Note**: this policy does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel.

- Registered private duty nursing services, when medically necessary and while hospitalized, to a maximum of $5,000 per insured participant, when approved in advance.

- Paramedical services (including X-rays) of a licensed chiropractor, physiotherapist, podiatrist, or osteopath to a maximum of $250 per profession.

- Ambulance charges for service from the place of illness or accident to the nearest hospital capable of providing appropriate treatment.

- Emergency air transportation when approved and arranged in advance to the nearest appropriate medical facility or Canadian hospital, and to return the insured participant to their province or territory of residence.

- Dental care to natural, vital and sound teeth or permanently attached artificial teeth when caused by a direct accidental blow to the mouth or face. A letter from the attending dentist must be presented indicating treatment was necessary to relieve acute dental pain not present before date of departure. Maximum coverage is $2,000.

- In the event of loss of life, up to $5,000 towards the cost of preparation and transportation of the deceased insured participant to his/her province or territory of residence; or up to $2,500 for cremation or burial at the place of death.

- If you or your dependant is returned to your province or territory of residence under the *Emergency air transportation benefit* or the *Return of deceased benefit*,

the insurer will reimburse the cost of a single one-way economy airfare for a travelling companion to return to Canada, when approved in advance by Global Excel.

- Meals and accommodation, up to $150 per day to a maximum of $3,000 per insured participant, incurred beyond the original duration of the trip by you or another person also covered under this policy when your trip is delayed as a result of injury or illness. This must be authorized in advance by Global Excel.

- Charges for a single round trip economy airfare to the bedside of an insured participant and up to $150 per day for meals and commercial accommodation incurred to a combined maximum of $3,000 for any one spouse, parent, child, brother, sister or business partner to be with the insured participant who is confined to hospital and will be an in-patient for at least three days outside of his/her province or territory of residence, or if deceased, to identify the deceased prior to the release of the body, where necessary.

- If you or your dependant is returned to your province or territory of residence under the *Emergency air transportation benefit*, RSA will reimburse the cost of a single one-way economy airfare to return to trip destination, when approved by the medical director of Global Excel, as soon as the attending physician determines the insured participant requires no further treatment. A re-occurrence or any problems or complications related to the initial emergency treatment will not be covered.

- Prescription drugs (limited to a 30-day supply per prescription unless insured participant is confined to hospital).

- An allowance of $250 while hospitalized as an in-patient. (This benefit is intended to help defray incidental costs such as parking, telephone calls, taxis, etc.)

- Return of your vehicle (owned or rented) if neither you nor anyone travelling with you is able to drive, to a maximum expense of $5,000.

- Medical appliances when approved in advance for crutches, casts, splints, canes, slings, trusses, braces, walkers and temporary rental of a wheelchair, if prescribed by a physician or surgeon.

Exclusions and limitations

- Persons travelling outside of their province or territory of residence for the purpose of obtaining medical treatment.

- All benefits described shall be eligible only on the submission of certification by the attending physician or surgeon that the services were for the immediate relief of acute pain or suffering. Charges for treatment which could have been delayed (on medical evidence) until return to their province or territory of residence will not be considered eligible.

- Any expenses normally covered or reimbursable under a government health insurance plan or under *Other insurance*.

- Any trip booked or commenced contrary to medical advice or after being diagnosed with a terminal illness.

- Any medical condition for which, prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization could be required while travelling.

- Treatment, surgery or medication that is not medically necessary in connection with an emergency that the insured participant elects to have provided outside Canada when medical evidence indicates that the insured participant could return to Canada to receive such treatment. The delay to receive treatment in Canada has no bearing on the application of this exclusion.

- Treatment or surgery during a trip when the trip is undertaken for the purpose of securing or with the intent of receiving medical or hospital services, whether or not such trip is taken on the advice of a physician.

- Cardiac catheterization, angioplasty, and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by Global

Excel prior to being performed, except in extreme circumstances wherein such surgery is performed on an emergency basis immediately upon admission to hospital.

- Hospitalization or services rendered in connection with general health examinations for "check-up" purposes, treatment of an ongoing condition, regular care of a chronic condition, home healthcare, investigative testing, rehabilitation or ongoing care or treatment in connection with drugs, alcohol or any other substance abuse or non-compliance with any prescribed medical therapy or treatment.

- Treatment for mental, psychological or emotional disorders unless such disorder requires immediate hospitalization.

- Treatment or hospital confinement of mother or child as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the four weeks before and/or after the expected delivery date, unless otherwise specified in the master policy.

- Any claims or expenses directly or indirectly arising from or in consequence of war, invasion, act of foreign enemy, declared or undeclared hostilities, civil war, rebellion, revolution, military power or service in the armed forces.

- Terrorism or by any activity or decision of a government agency or any other entity to prevent, respond to or terminate terrorism except for ensuring loss or damage which results directly from fire or explosion. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss or damage.

- Committing or attempting to commit an illegal act or a criminal offence.

- Suicide, attempted suicide or self-inflicted injury, whether the insured participant is sane or insane.

- Expenses incurred as a result of an insured participant's abuse of medication, drugs, alcohol or other toxic substances.

- Participation in professional sports, or motorized or mechanically-assisted racing or speed contests (an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event).

- Loss or damage to eyeglasses, sunglasses, contact lenses, hearing aids, prosthetic teeth, limbs or devices.

- The replacement of an existing prescription whether by reason of renewal or inadequate supply of the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada, or which are not medically necessary as a result of an emergency.

- Upgrading charges and cancellation penalties for airline tickets, unless approved in advance by Global Excel.

DENTAL CARE

Payment of benefits

1) The claims adjudicator, Coughlin & Associates Ltd., to pay benefits based on dental services, financial limits and treatment frequencies in the fee schedule.

2) The claims adjudicator, Coughlin & Associates Ltd., to apply the reimbursement percentage shown in the *Highlight of benefits* to the fees shown in the fee schedule/fee guide as follows:

    a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia – the fees in the fee schedule;

    b) for services performed in Canada but outside British Columbia – the fees in the fee guide in the province/territory of service;

    c) for services performed outside Canada if your province of residence is not British Columbia – the fees in the fee guide in your province/territory or residence.

3) Fees in excess of the amount shown in the applicable fee schedule/fee guide will be your responsibility.

Plan A – Basic preventative & restorative services

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible expenses per person include, but are not limited to, the basic services shown below.

1) **Diagnostic services**

    a) examinations

        i) complete, provided we have not paid for any other exam by the same dentist in the past six months – one per three-year period;

        ii) recall – two per calendar year;

iii) specific – two per calendar year;
iv) consultations (as a separate appointment) – two per calendar year.

b) X-rays

i) diagnostic;
ii) panoramic – one per two-year period;
iii) complete mouth series – one per three-year period;

All X-rays combined shall not exceed the dollar limit for a complete mouth series.

c) diagnostic models – one set per calendar year.

2) **Preventative services**

a) scaling;

b) polishing – two per calendar year;

c) topical application of fluoride – two per calendar year;

d) fixed space maintainers;

e) preventative restorative resins and pit and fissure sealants – combined limit of one per tooth in a two-year period. No age limit.

3) **Restorative services**

a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a five surface filling per tooth in a two-year period

i) amalgam (silver coloured) fillings;
ii) composite (tooth coloured) fillings;
iii) white composite fillings.

b) stainless steel crowns on primary and permanent teeth, once per tooth in a two-year period;

c) inlays or onlays – only one inlay or onlay on the same tooth will be covered in a five-year period.

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

4) **Endodontics**

For the treatment of disease of the pulp chamber and pulp canal including, but not limited to, root canals, one per tooth in a five-year period.

5) **Periodontics**

For the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts which are included under Major Restorative Services, but including the following:

a) occlusal adjustment and recontouring – a combined yearly limit shown in our *Fee schedule*;

b) root planning;

c) gingival curettage – one per sextant in a five-year period;

d) osseous surgery – one per sextant in a five-year period;

6) **Prosthetic repairs**

a) removal, repair, and re-cementation of fixed appliances;

b) re-base and re-line of removable appliances – a combined limit of one per upper and one per lower prosthesis in a two-year period;

c) tissue conditioning: two per upper and two per lower prosthesis in a five-year period;

d) gold foil – only when used to repair existing gold restorations.

7) **Surgical services**

a) extractions;

b) other routine oral surgical procedures;

c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our *Fee schedule*.

Plan B – Major restorative services

You are eligible for Plan B services when your dentist recommends replacement of your missing teeth or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

Mounted X-rays and/or diagnostic casts may be required for our approval.

Plan B services include, but are not limited to, the following:

1) **Prosthodontic services**

a) removable

i) complete upper and lower dentures;
ii) partial upper and lower dentures.

b) fixed bridges.

2) **Restorative services**

a) inlays or onlays involved in bridgework;

b) veneers;

c) crowns and related services.

3) **Major Periodontal Services**

a) Bruxing guards, two appliances in a five-year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards);

b) Periodontal grafts, including soft tissue and bone grafts.

4) **Implants and Implantology**

Implant dental surgery and related oral surgical services such as abutment insertion, ridge augmentation, bone preservation; implant related periodontal surgery; and subsequent implant retained appliance.

Limitations

1) Only one major restorative service involving the same tooth will be covered in a five-year period.

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

3) Only one upper and one lower denture (complete or partial) is eligible in a five-year period.

4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.

5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our fee schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage. If coverage terminates during a course of orthodontic treatment for which we have started payments, we will continue to pay, up to but not exceeding the amount that would have been paid in the 12-month period immediately following the termination date of coverage. This provision will not apply if this contract is terminated.

Plan C covers orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations

1) The lifetime benefit maximum under Plan C is shown in the *Highlight of benefits*.

2) No benefit is payable for the replacement of appliances that are lost or stolen.

3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.

4) Treatment performed solely for splinting is not covered.

Emergency treatment outside your province of residence

You are entitled to the services of a dentist if, while travelling or on vacation outside your province of residence, you require emergency dental care. You will be reimbursed according to our fee schedule.

Exclusions

The following are not eligible expenses under your dental plan:

1) Items not listed in the fee schedule and fees in excess of those listed in the fee schedule.

2) Any item not specifically included as a benefit.

3) Charges for broken appointments, oral hygiene, or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English.

4) Procedures performed for purely cosmetic reasons.

5) Charges for drugs and pantographic tracings.

6) Anaesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies.

7) Charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint.

8) Incomplete or temporary procedures.

9) Recent duplication of services by the same or different dentist.

10) Any extra procedure which would normally be included in the basic service performed.

11) Services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits.

12) Travel expenses incurred to obtain dental treatment.

Claims

1) It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your dentist submit an outline of the proposed services to the Coughlin & Associates Ltd., claims adjudicator, **before you start treatment.** This is important especially when your dentist is recommending extensive dental work. This will help you understand what portion of the dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your dentist.

2) Please submit claims within **90 days** of the completed date of service (earlier if possible). Failure to submit a claim within the 90-day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will the claims adjudicator pay any claim or adjustment submitted later than June 30 of the calendar year following the year in which the expense being claimed was incurred.

3) A separate claim form is required for each member of your family who has received dental services. Be sure to include the following information on the claim form:

   a) name of the dentist;

   b) name and birthdate of the person receiving the dental care;

   c) your group, ID, and dependant(s) numbers;

d) your home mailing address;

e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your dependants are covered by two plans, your dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

4) Before your dentist starts treatment, please ask about billing. The claims adjudicator may pay in either two ways:

a) pay the dentist directly for services provided under this dental plan when they receive a claim form signed by the dentist, certifying these services were performed and the fee charged; or

b) if you have paid your dentist directly, we will reimburse you the benefit amount when we receive a claim form or receipts signed by your dentist. We will send you a cheque when the claim is processed.

5) Orthodontic claims procedures

a) Claims requirements

When treatment commences, the claims adjudicator will require a completed dental claim form stating the monthly or quarterly change and the months to which it applies, to establish that treatment is in progress. Please note that reimbursement will be based on the monthly or quarterly fees as outlined in the treatment plan and not on the amount or date of payment, even if treatment is prepaid.

b) Claiming deadlines

i) Please submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).

ii) Reimbursement is made if the complete and correct claims information is received within one year of the due date. However, no benefit is payable for claims not received by June 30 of

the calendar year following the year in which the expense being claimed was incurred.

c) Treatment plan

i) Have your orthodontist complete the *Certified Specialist in Orthodontics Standard Information* form (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.

ii) If the payment schedule or treatment changes, the claims adjudicator will require a revised treatment plan for review.

iii) The claims adjudicator will retain your treatment plan on file. If they do not have your treatment plan on file they are unable to pay:
- your initial fee/down payment;
- your monthly/quarterly fees;
- one-time appliance fees.

iv) Claims for consultations, exams and records (X-rays, study models, etc.) will be reimbursed without a treatment plan on file.

d) Monthly or quarterly fees

i) If you are paying in monthly or quarterly instalments, submit receipts for the monthly or quarterly fees on a regular basis as treatment progresses. Claims receipts received by the claims adjudicator that are over one year old will not be reimbursed.

ii) If you paid any amount to the dentist before treatment is complete, the claims adjudicator will allow an initial payment amount and then pro-rate the balance into monthly payments to you throughout the treatment plan period.

iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

HEALTHCARE SPENDING ACCOUNT (H.S.A.)

Purpose

The Trustees are pleased to advise that they have implemented a Healthcare Spending Account (H.S.A.) on behalf of all qualifying members and their dependents that are covered for benefits at July 1, 2019. The purpose of this benefit is to allow additional coverage to members and their dependents, which is beyond the coverage already provided by the Welfare Plan.

Active Insured Members - Will receive a one-time (minimum $600) allocation (per household) in their H.S.A. account. The allocation of this benefit has been based on your hours worked in 2018 provided you have worked at least 270 hours in the 2018 calendar year. This benefit will be for eligible expenses incurred on or after July 1, 2019, to June 30, 2020. Any unused remaining balance in the members H.S.A. after the one-year period will be returned to the Plan following a seven-day run-off period (i.e. July 7, 2019). Future allocations, if any, will be subject to the financial stability of the Plan.

Returning to Work Retired or Senior Member – A member over the age of 65 who is covered under the Welfare Plan at July 1, 2019, and has the required amount of hours to be covered under their hour bank. The Healthcare Spending Account will cease once you are no longer an hour bank member. Any unused remaining balance in the members H.S.A. will be forfeited back to the plan. Furthermore, you must also remain a member in good standing with Local 170.

Eligibility

In order to receive this benefit, a member must remain in good standing with Local 170, be covered under the Welfare Plan at July 1, 2019, and have continuous coverage. Currently, the Plan deducts 110 hours per month of coverage. When a member's hour bank falls below the required 110 hours, a self-payment notice is mailed to the member to allow the member to make payment for continuous coverage. If the member does not elect to continue coverage through self-payment their benefits will cancel, and any remaining balance in your H.S.A. will be forfeited back to the Plan and will not be reinstated at a later date.

In order to receive this benefit, a member over the age of 65 (Returning to Work Retired/Senior Member) must remain in good standing with Local 170, be covered under the Welfare Plan at July 1, 2019 and have continuous coverage. Currently, Local 170 Plan deducts 110 hours per month for coverage. The Health Spending Account will be available ONLY while you are covered on your hour bank. Once your hour bank falls below the required 110 hours per month your benefits will cancel, and any remaining balance in your H.S.A. will be forfeited back to the Plan and will not be reinstated at a later date.

This benefit is in accordance with allowable medical expense/services within Section 118.2(2) of the Canadian Income Tax Act and Regulation 5700 under a private services plan. Please note a list of eligible medical expense is available via the CRA website at
www.cra-arc.gc.ca/medical/#mdcl_xpns.

The Trustees have elected to forfeit any remaining balances after one year from initial allocation (i.e. July 1, 2019) to the Plan following a seven-day run-off period (i.e. on July 7, 2020).

Reimbursement

In order to receive reimbursement you must submit your claim on the Coughlin & Associates claim form with your original receipt, which is the same procedure as regular claims covered by the Plan.

Coughlin & Associates will automatically apply any remaining health or dental benefit expenses not covered by the basic Plan (i.e. deductibles, claims that have exceeded the allowable maximum, etc.) to the extent of your Healthcare Spending Account (H.S.A.), if any, unless you indicate on the applicable claim form that you do not want to have Coughlin & Associates apply remaining claim expenses automatically to your H.S.A.

The balance of your Healthcare Spending Account will be reported on your most recent claim cheque summary provided by Coughlin & Associates or can be obtained by contacting them at 1-888-204-1234.

Coordination of Benefits (dual coverage with your spouse)

If you are submitting claims that require redirection to your spouse's plan for coordination of benefits, Coughlin & Associates will not automatically apply to your H.S.A. Any remaining balance following coordination of benefit with your spouse's plan will need to be submitted (summary statement from your spouse's insurer), to Coughlin & Associates in order to have applied to your H.S.A. Furthermore, for Dental claims submitted electronically from your dental office on behalf of you or your eligible dependent, you must contact Coughlin & Associates to apply any remaining balance not covered by the Plan to your H.S.A. balance.

Termination

In the event of termination of Membership or Active Insured status, from the Plumbers Local 170, the remaining Healthcare Spending account balance will be immediately forfeited to the Trust Fund.

Death

In the event of a Union Member's death, coverage will be extended to the surviving dependants as follows:

1. Spouse – until the balance of the Healthcare Spending Account is depleted.
2. Dependent Children – until they no longer qualify as dependants under the Group Insurance Plan or the balance of the Healthcare Spending Account is depleted.

Reinstatement

Reinstatement of a Union Member's Healthcare Spending Account is not applicable as it is a requirement that a Member maintain a positive status with the Plumbers Local 170.

Marital Separation / Divorce

As per the provisions for the insured benefits, the Healthcare Spending Account will not be extended to the spouse following separation or divorce. Alternatively, eligible dependent children will continue to be eligible for participation at the discretion of the Union Member.

List of Eligible Medical Expenditures

A list of eligible medical expenses is available via the Plan Member Portal on the Plan Administrator's website at www.coughlin.ca, or by accessing the CRA website via the link www.cra-arc.gc.ca/medical/#mdcl_xpns..

To determine the outstanding balance in a Member's individual HSA, the Member should refer to his/her latest claims cheque record, or alternatively contact the Plan Administrator at (204) 942-4438 or Toll Free 1-888-204-1234, or alternatively via the Plan Administrator's website at www.coughlin.ca by clicking on "Logon" and entering a temporary password detailed on your claims summary.

JURY DUTY FUND

Eligibility

- Must be an active member of Local 170.
- Eligible if not working when selected.
- Must have worked for a contributing employer within the last five years.
- Employers must have contributed to the jury duty fund.
- Includes Members subpoenaed to go to court as a witness.

How benefits are paid

- Member is paid 100 per cent of his/her base rate at last day of employment (Journeyman rate). Maximum eight hours per day including holiday pay.
- Apprentices who are members of the union are paid 100 per cent of the applicable apprentice rate of pay at last day of employment. Maximum eight hours per day including holiday pay.
- Maximum of 90 working days on straight time hours only.
- Effective February 9, 1989, contributions are also paid to the welfare and pension fund on behalf of the member.
- The entire reimbursement comes from the welfare office. No reimbursement is paid by the employer.
- The member keeps the daily fee paid to him by the sheriff's office.

How to apply

- Must apply within 14 days of receiving a summons for jury duty.
- Request an application for the Piping Industry Jury Duty Fund from the Health & Welfare office.

- This must be completed and returned to the administrator's office with a copy of the summons and a form from the sheriff's office verifying the days served for selection and/or on the panel.

- All jury duty reimbursements must be authorized for payment by the administrator and referred to the welfare board of trustees for the official minutes.

Not eligible

- A permit or probationary apprentice.

- Associates.

- Retired or receiving any benefit from the plan.

- Serving over 90 days.

SPECIAL REHABILITATION FUND
DRUG AND ALCOHOL TREATMENT

Eligibility

- A member in good standing with Local 170.
- Member eligibility on an ex-gratis basis is not contingent upon being covered under the welfare plan.
- A member must not be claiming Employment Insurance benefits while collecting payments from this fund.
- For the covered union member who is eligible for benefits, the trustees may, after a full and thorough investigation, decide at any time that such member is or is not eligible for this benefit.
- Member must be in a recognized treatment centre program.
- It is intended that this benefit is available to members on a one-time basis. Exceptions to this rule would have to be brought before the board of trustees and supported with a recommendation from a rehabilitation program and documentation reviewing the members work history.

Benefits payable

- Benefits are payable from the start date of the recognized rehabilitation program (no seven-day waiting period).
- Maximum payable 28 days or six weeks, dependant upon the length of the program.
- No member will receive payment beyond five weeks without providing an Employment Insurance proof of rejection letter.
- A member who is in a recognized treatment centre program may be able to claim a further four weeks of benefits, if attending an outpatient program. Must be under the care of a physician and must have received approval by the welfare board of trustees.

- A member may otherwise be eligible for financial assistance, beyond the residential treatment, only if the request is brought to the welfare board of trustees for consideration and approval. This could include detox treatment.

How to apply for benefits

- All payments to eligible members, will be processed and approved in the welfare plan office.

- The member should contact the welfare plan office and an application form will be sent for completion. This form will have to be signed by a representative from the rehabilitation centre.

- When this form has been returned to the office, a form will be sent to the member's attending physician for completion.

FREQUENTLY ASKED QUESTIONS

Below are a few questions that have been raised by our members and we wanted to provide the information to all of our members. If there are additional questions that you have that we have not answered below, please feel free to contact the welfare plan administrator office, or Coughlin & Associates Ltd., the claims adjudicator.

1. When travelling on business or vacation and I have an emergency or accident, whom do I contact for assistance?

Your travel medical emergency insurance is fully insured. Each applicable hour bank insured member, associates, insured retired member, and survivor is covered for $5 million in travel medical emergency insurance, whether travelling for business or personal reasons. Age restrictions vary by class. The travel medical emergency insurance (policy number is #1059144 is provided through RSA. Wallet cards with the relevant information have been issued for each member. If you are travelling and an emergency or accident occurs, you must report the incident to RSA, as soon as possible, by calling in Canada and the U.S., 1-866-870-1898; and from anywhere else, you can call collect at (819) 566-1898.

Prior to travelling, if you or your eligible dependent(s) have a known medical condition, we encourage you to contact Coughlin & Associate Ltd. (Toll Free 1-888-204-1234) for clarification of coverage, as it may not be applicable subject to the circumstances associated with your medical condition.

2. My dentist advised that to transmit a dental claim through the EDI system at the dental office I need a policy number and BIN number (may refer to carrier number). What are the numbers that are to be given to the dentist?

Coughlin & Associates Ltd., the claims adjudicator, does not use a policy number for administering claims. However, if your dentist requires a number to transmit a claim through the EDI system, please ask them to use the number 271029.

In addition, the BIN or carrier number is 610105.

3. When I submit a claim through the EDI system at the dentists office will Coughlin & Associates Ltd., send the cheque directly to my dentist?

Yes, Coughlin and Associates Ltd., will reimburse the dentist directly (via mail), provided you have assigned the benefits payable to the dentist. Furthermore, an *explanation of benefits*, reflecting the payment to the dentist will be forwarded to the member for their records and review.

4. Where can I get a health or dental claim form to send to Coughlin & Associates Ltd. or my drug card for automatic transaction at the pharmacy?

You can contact the plan administrator or Coughlin & Associates Ltd. the claims adjudicator, (toll-free 1-888-204-1234) for a health or dental claim form, or for co-ordination of the drug card. Or visit their website at www.coughlin.ca.

5. Where do I send my claims?

Refer to the section *How to make a claim* on page 16 for complete details.

NOTICE REGARDING PERSONAL INFORMATION

When you apply for coverage under the welfare plan, the Plumbers Local 170 welfare plan administrator, Coughlin & Associates Ltd. (claims adjudicator), Manulife (life, AD&D, and LTD), Shepell (EFAP), and the out-of-country travel insurer RSA, will set up a file with personal information relevant to your benefit coverage under the plan.

The purpose of this file is to permit Manulife, RSA, Shepell, the plan administrator, and Coughlin & Associates Ltd. to administer all financial services provided to you, and to keep information specific to the insurer, plan administrator, and Coughlin's business relationship with you. This includes the following:

- underwriting and financial reporting;
- claims adjudication and management;
- internal and external audits;
- preparation of regulatory and statutory reports;
- assisting you in planning your financial security.

The member files are kept in the office of the plan administrator, Manulife, RSA, Shepell, and Coughlin & Associates Ltd. for access when required for insurance purposes.

You have the rights to access and correct the information in your file. A request for access or correction must be in writing and may be sent to the Plumbers Local 170 welfare plan administrator, Suite #203 – 1658 Foster's Way, Delta, BC, V3M 6S6.

PRIVACY

Effective January 1, 2004, the federal Personal Information Protection and Electronic Documents Act (PIPEDA) governs the collection, use and disclosure of all personal data by all Canadian commercial organizations. Thus, every transaction involving the handling of personal data (collection, use, transfer, disclosure, storage, accessing, processing, etc.) has to be conducted in accordance with the Act.

The trustees of the welfare plan are committed to respecting your right to privacy and safeguarding your personal information. For more information regarding the privacy policy, please contact the Plumbers Local 170 welfare plan administrator or privacy officer directly at 604-526-3434 or, toll-free, 1-800-665-6808, or Coughlin & Associates Ltd. at toll-free, 1-888-204-1234, or visit www.coughlin.ca.