GROUP BENEFITS BOOKLET

UA Local 170
Health & Wellness Plan

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DELTA, BC V3M 6S6

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July 1, 2023

To All Insured Members
UA Local 170 Health & Wellness 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 UA Local 170 Health & Wellness Plan has been arranged to assist in protecting you and your family from these hardships.

This Health & Wellness Plan exists for the sole purpose of providing Health & Wellness benefits to you and your covered dependents. This Health & Wellness Plan is not an insurance company and the Member Life Insurance, and AD&D Disability Waiver Reserves, Extended Health Care, Vision Care, Dental Care, Weekly Wage Indemnity, Bereavement, Long Term Disability, Healthcare Spending Account, Jury Duty, and Drug and Alcohol treatment benefits provided through the Health & Wellness Plan are not insured by an insurance company regulated under the Financial Institutions Act (BC). The Health & Wellness 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 Health & Wellness 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 AIG Insurance Company, while all other benefits (inclusive of Extended Health Care, Vision Care, Dental Care, Weekly Wage Indemnity, Bereavement, Long Term Disability, Drug and Alcohol treatment, and Jury Duty benefits) are self-insured and administered by the UA Local 170 Health & Wellness Plan Administrator, with member/dependant claims adjudicated for Extended Health Care and Dental care by Coughlin & Associates Ltd. (pay direct prescription drug card coordinated with Telus eClaims). The Health & Wellness Plan Administrator adjudicates certain benefits including vision care, disability benefits, healthcare spending account, 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 Health & Wellness 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 UA Local 170 Health & Wellness 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
UA LOCAL 170 HEALTH & WELLNESS 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, insured retired members, and associates (under age 75)

Benefit	$100,000 (previously $85,000) reducing to $20,000 at retirement (i.e. receiving a monthly pension)
Termination	Age 75 or retirement (whichever occurs first) for associates and 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 $100,000 (previously $85,000) for retired members upon return to work and satisfying the plan eligibility requirements but not beyond attainment of age 75.
Waiver of premium	On approved disability (refer to booklet for further details).

ACCIDENTAL DEATH & DISMEMBERMENT

All hour bank insured members, insured retired members, and associates (under age 75)

Benefit	$100,000 (previously $85,000) reducing to $20,000 at retirement (i.e. receiving a monthly pension)
Termination	Age 75 or retirement (whichever occurs first) for associates and 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 $100,000 (previously $85,000) for retired members upon return to work and satisfying the plan eligibility requirements but not beyond attainment of age 75.
Waiver of premium	On approved disability (refer to booklet for further details).

BEREAVEMENT BENEFIT

All hour bank insured members and associates (under age 65)

Benefit Amount	Eligible members entitled to a $600 benefit (previously being equivalent to 3/7 of WWI benefit payable via WWI).
Eligibility	All active members and associates under age 65 must be covered for the WWI benefit with verification supplied of death/relationship (obituary/funeral parlour notice, physician or funeral statement, death certificate or memorial card) to cope with the loss of a deceased eligible family members (i.e. children, step children, parents, in-laws, grandparents (includes inlaws), spouse, common-law spouse, siblings, stepsiblings) on a prescribed application form.

WEEKLY WAGE INDEMNITY

All hour bank insured members, apprentices, probationary apprentices, permit workers, and associates (under age 65)

Waiting period	Payable from the first day of non-occupational accident/injury or day surgery or sickness requiring overnight hospitalization. Payable from the fourth day of illness.
Benefit period	Four weeks, then EI sickness benefits (if applicable) up to an additional 11 weeks – maximum 26 weeks (total) (previously 15 weeks) payable from the plan
Benefit amount	Equivalent to EI sickness benefit maximum plus $120 based on 7 days (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 (under age 62) - 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

EXTENDED HEALTHCARE

All hour bank insured members, insured retired members, eligible disabled members, associates (under age 75), and survivors.
Please note special senior members excluded

Calendar year deductible	No deductible
Reimbursement	100 per cent for certain benefits as noted. 100 per cent for Fertility drugs and treatment up to $10,000 (previously $5,000) per person per Lifetime. 95 per cent of eligible prescription drugs and diabetic supplies listed on the provincial BC Formulary up to $2,500 per family unless proof of a higher B.C. Fair Pharmacare Program deductible is provided.
Plan maximum	Lifetime maximum to $1 million per person subject to applicable treatment and travel medical emergency maximums.

100 per cent of eligible expenses	
- Ambulance Services	Reasonable and customary charges for emergency services and/or response
- Vaccines	$250 per person per calendar year for preventative vaccines dispensed by a licensed pharmacist or physician within Canada
- Injection Administration Fees	Effective June 1, 2021, Injection administration fees charged by a licensed healthcare provider or pharmacist reimbursed up to $100 per person per calendar year
- Prolotherapy	$200 per person per calendar year provided prescribed for ligament, tendon, or muscle repair
- 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)
- Fertility Drugs & Treatment	Lifetime maximum up to $10,000 (previously $5,000) per person
- Erectile Dysfunction Drugs	Calendar year maximum up to $600 (previously 15 pills/3 months) per person
- Botox	$200 per person per calendar year provided prescribed for migraine or hyperhidrosis
- Diagnostic tests (inclusive of PSA, etc.)	Maximum of $100 per calendar year per active member. (Deductible not applicable)

100 per cent of eligible expenses (continued)	
- 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.)
- Vision Care	Subject to a maximum of $700 every 24 months for prescriptive corrective lenses, no deductible. Laser eye surgery reimbursed $3,000 per person per lifetime. (Adjudication handled by Health & Wellness Office). Prescribed Corrective contact lenses for severe medical conditions up to $700 per person per 24 month period Visual training benefit up to a lifetime maximum of $1,000 per person
- 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. Additional eye exam for specific medical conditions up to $100 per person per calendar year.

100 per cent of eligible expenses (continued)	
- 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 $2,500 (previously $1,500) per person per calendar year.
- Hearing Aids & Repairs	$2,000 every five years per person, as prescribed by a licenced healthcare provider.
- Pediatric Ear Molds	$300 per child (age 6 – 18) per calendar year as prescribed by a licensed healthcare provider.
- Custom Ear Plugs	$500 every 5 years per person, as prescribed by a licensed healthcare provider.
- Standard Durable Equipment (previously 80%)	Includes: 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 EHB will pay the manual equivalent; Medical heart and blood glucose monitors, and cardiac screeners; Bi-osteogen systems (when recommended by an orthopaedic surgeon) and growth guidance systems;

100 per cent of eligible expenses (continued)	
	Breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators; Insulin infusion pumps for diabetics – when basic methods are not feasible; Transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain; Transcutaneous electric muscle stimulators (TEMS) required when due to an injury or illness, all muscle tone has been lost.
- 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
95 per cent of eligible expenses	
- 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 $2,500 per family, unless proof of a higher B.C. Fair Pharmacare Program deductible is provided. EHC deductible is not applicable.

Termination	Hour bank insured members and insured retired members later of age 75, 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 75). 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 75), eligible disabled members, and survivors (special senior members excluded)

Active hour bank insured members (working)	
Overall maximum	**Under age 70** - $5 million per coverage period **Age 70 – 74** - $2 million per coverage period
Coverage period	90 days per trip
Termination age	Earlier of age 75 or expiry of hour bank account/self-pay)
Pre-existing stability period	Not applicable
Survivors	
Overall maximum	**Under age 70** - $5 million per coverage period **Age 70 – 74** - $2 million per coverage period
Coverage period	90 days per trip
Termination age	Earlier of age 75 or 24 months from member's date of death
Pre-existing stability period	Not applicable
Associates	
Overall maximum	**Under age 70** - $5 million per coverage period **Age 70 – 74** - $2 million per coverage period
Coverage period	90 days per trip
Termination age	Earlier of age 75 or expiry of hour bank account/self-pay)
Pre-existing stability period	Not applicable

Insured retired members	
Overall maximum	**Under age 70** - $5 million per coverage period **Age 70 – 74** - $2 million per coverage period
Coverage period	90 days per trip
Termination age	Earlier of age 75 or 24 months from member's date of death
Pre-existing stability period	Not applicable

HEALTHCARE SPENDING ACCOUNT (H.S.A)

All hour bank insured members (under age 75)	
Reimbursement	100% of eligible expenses limited to H.S.A. account balance. Subject to REASONABLE and CUSTOMARY (R&C). Any HSA claims for Members that H&W benefits have cancelled MUST be submitted to H&W Office **no later than 7-days following their cancellation date from the benefit plan.**
Eligibility	Local Union 170 Insured Members at **July 1, 2023**. 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, 2024.
Vision care	Subject to R&C with a Maximum of 4-pairs of glasses per 24-month period.
Submission for reimbursements	Health & Wellness Office *Mail to:* #203 – 1658 Fosters Way, Delta, BC, V3M 6S6 *Email to:* **info@plumbers.bc.ca**

DENTAL CARE

All hour bank insured members, insured retired members, associates (under age 75), eligible disabled members, survivors.
Please note special senior member excluded

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	$3,500 * combined with Plan B	$3,500 * combined with Plan A	$5,000
Financial limit per member or spouse	$3,500 * combined with Plan B	$3,500 * combined with Plan A	$5,000

SPECIAL SENIOR MEMBER (age 65 +)

Eligibility	Age 65 and over, opting not to self-pay for Retired Member Full of Mini coverage, provided a Member in good standing with Local 170 for 5 continuous years prior to 65th birthday. Member can not re-initiate after age 65.
Benefit Maximum	$1,300 (previously $1,200) per family per calendar year to a lifetime maximum of $25,000 per person, plus up to $50 per member per calendar year for prostate testing
Eligible Expenses	Reimburse eligible Dental, Extended Healthcare, Visioncare benefit supplies and services and individual private health or travel plans purchased in member's name. Proof must be submitted clarifying individual policy does not include Life nor AD&D coverage due to CRA tax complications
Survivor Benefit	Effective January 1, 2021, extend 50% of benefit maximum up to 24 months
Termination	Death of Special Senior Member (following the survivor benefit period) or no longer a Member in good standing with Local 170

HOW TO MAKE A CLAIM

The following benefits are co-ordinated and/or adjudicated by the **UA Local 170 Health & Wellness Office:**

- member life insurance and accidental death and dismemberment;
- weekly wage indemnity;
- bereavement;
- jury duty fund;
- special rehabilitation fund drug and alcohol treatment;
- special senior members (age 65 and over) extended health benefit claims, Visioncare claims, HSA Dental claims;
- vision care claims including eye examinations;
- long-term disability benefits;
- healthcare spending account (effective September 2020)

Extended Healthcare and Dental care Claims

Paper Claims

Please contact the Health & Wellness 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

The completed claim form can be mailed to:

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. The claim forms must be signed by the **insured member**.

Member Portal – Electronic Claims

Coughlin & Associates Ltd. offers plan members the option to submit claims for prescription drugs, health and dental online. To access this service, please register at Coughlin's plan member portal at https://coughlin.onlineclaimsaccess.net/ or download the mobile app from the App Store or Google Play. Once you are on the portal or have accessed the app:

- Follow the on-screen instructions and provide your group and certificate numbers, both of which can be found on your all-in-one benefits card.

Once registered, click *Submit a Claim* to get started with online claiming.

Point of Sale Claims Submission

For Drug, Dental, and select Health claims you may use your all-in-one Benefits Card for direct bill payment (POS). Your claims can be submitted through a Point-Of-Service (POS) claims system provided by an approved list of healthcare providers. The following information (found on your all-in-one Benefits Card) must be provided to the provider:

Dental:

1) Bin # 000034 on Telus Adjudicare network
2) Group Number # 60463
3) Individual certificate number (printed on your card)

Health :

1) Bin #34 on Telus Adjudicare network
2) Group Number # 60463
3) Individual certificate number (printed on your card)

Dentalcare and Health claims must be made within eighteen (18) months from the date of service.

Pre-Authorized Deposit (PAD)

Pre-authorized Deposit is the fastest way for plan members to receive claim reimbursements. Claim reimbursement deposits can be made into your bank account within two to five business days following the approval of your claim and eliminate both the wait for cheques to arrive by mail and the trip to the bank.

This is for Coughlin & Associates reimbursements only. For Vision Care, H.S.A. reimbursements through PAD, please contact the Health & Wellness office at 604-526-3434.

To enroll in the Coughlin's PAD program:

- Login to Coughlin's plan member portal
- Click on your profile icon and select *Direct Deposit*

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

Pre-Authorization

For treatment where the estimated cost is $500 or more, predetermination of costs should be obtained from the Plan Administrator.

Have your dentist/denturist complete the appropriate form or section. Mail the form to Coughlin & Associates.

For a proposed treatment plan which includes crown or bridgework, 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.

Travel Medical Emergency Claims

- I.D. cards and travel medical emergency booklets are available from Coughlin & Associates Ltd.
- In case of emergency, please immediately call
  Canada or US → 1-877-207-5018
  or
  Outside Canada or US → 1-819-566-3940
  Noting:
  Policyholder → UA Local 170 Health & Wellness Plan - Policy number → CMG 9428867
- Claims should be submitted to AIG Global Excel within 90 days from the date a claim arises and in no event later than one year from the date of injury.

Time limitations

- **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 2023 before June 30, 2024.

- **Travel Medical Emergency**

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

- **Life and AD&D Insurance**

  Claims must be submitted within 12 months of the day of loss. Contact the Health & Wellness office: 604-526-3434

- **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. Contact the Health & Wellness office: 604-526-3434

- **Jury Duty fund**

  Applications must be made within 14 days of jury duty. Contact the Health & Wellness office: 604-526-3434

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 UA Local 170 Health & Wellness Plan.

Covered member – means an hour bank member, an associate, a retired member, survivors (spouse and eligible dependants), or a special senior member, as defined in the plan document, who is eligible for 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 functionally impaired child who was insured as a dependent shall remain insured beyond any limiting age for dependents. For the purposes of insurance, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired who is not receiving payments from an aid program and is incapable of self-sustaining employment due to a functional impairment specified in a government regulation and who is wholly dependent upon the member for support and maintenance within the terms of the Income Tax Act.

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 on a self-insured pay basis to a maximum of age 75 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 UA Local 170 Health & Wellness Plan who work for contributing employers and includes the following:

1) Union members

Are members of Local Union 170 participating in the UA Local 170 Health & Wellness 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 extended health care, and dental only (refer to page 15 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 in good standing for 5 continuous years;

3) Special senior members

iii) was covered for benefits;

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

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

vi) continues to remain a union member; and

vii) must not re-initiate after age 65.

4) Retired Member

Means a Union Member for which an Employer has remitted Health & Wellness contributions on their behalf to the Plan, and is either receiving pension benefits from the UA 170 Pension Plan or if they did not participate in the UA 170 Pension Plan have signed a Participation Agreement for Retired Members on Municipal Pension Plan.

5) Returning Senior member

Means a retired member, 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 have extended travel medical emergency, extended health, and dental benefits to a maximum of age 62 or recovery, whichever occurs first as LTD benefits cease at age 62. Following age 62, extended health, dental and travel medical emergency benefits can be extended up to age 75, subject to receipt of applicable self-payment as a retired member.

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.

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 pre-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 pre-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 the member 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 75 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

Upon Member's death, 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 75) and insured self-paying members (under age 75)

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

- 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.

Inactive non-insured self-paying members (i.e. if not insured for EHC, vision, dental, TME) are not eligible for the survivor benefit coverage.

Special Senior members (age 65 and over) Survivor benefit coverage, contact the Health & Wellness office: 604-526-3434.

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 UA Local 170 Health & Wellness 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
AIG travel medical emergency cards are now included in the all-in-one benefits card; distributed 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 UA Local 170 Health & Wellness 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.

Co-ordination of benefits (continued)
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 UA Local 170 Health & Wellness Plan, claims adjudicator, plan administrator, or AIG 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:

<u>Termination of coverage for hour bank members</u>

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 they cease 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) their hour bank has less than 110 hours per month (the monthly maintenance hours required to maintain coverage);
   b) they have not been approved for plan paid coverage. Please refer direct to the administrator's office.
   c) they do not qualify for self-payment.

3) the deemed date of termination of their 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 their behalf has less than the maintenance hours (110 hours per month); and
   b) they are not a special senior member;

5) the last day of the month in which 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 they attain age 75;
3) the last day of the month the 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 they cease to be a special senior member;
2) the last day of the month in which death occurs; and
3) the date the trust agreement is terminated.

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 they cease to be a retired member;
2) the last day of the month in which death occurs; and
3) the date the trust agreement is terminated; and
4) benefit coverage cease as follows:

    a) Dental, EHC, and Vision on the later of age 75 or expiry of their hour bank account. Travel medical emergency will cease earlier of age 75 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, and vision indefinitely. (Note: other benefits cease at specific ages, LTD age 62, and Life/AD&D cease at age 75, etc. regardless of hour bank status);
    b) Life and AD&D coverage cease on the earlier of attainment of age 75 or cessation of hour bank/self-pay.

Termination of coverage for Retired Members (continued)

A retired member will transfer to the special senior member classification the day they have attained age 65 provided depleted their hour bank account and opted not to self-pay for full or mini retired member coverage, and have completed and signed enrolment documentation applying to be a Special Senior Member.

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 they are no longer deemed totally disabled and receiving disability benefits (i.e. LTD, WCB, etc.);

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

3) the last day of the month in which they attain age 75 (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.

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, 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 75 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 they remain a member in good standing with UA Local 170.

Disabled associate employee

If an associate employee is deemed to be disabled of a long-term nature, extended health, travel medical emergency, 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:

UA Local 170 members – union members working in a jurisdiction other than UA Local 170 and on whose behalf contributions are being made to a Health & Wellness 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 UA Local 170 Health & Wellness 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 UA Local 170 Health & Wellness 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 75) 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) $100,000 (previously $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 75. Life insurance will reinstate to $100,000 (previously $85,000) for retired members who have returned to active employment and satisfied eligibility requirements;

2) $100,000 (previously $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 their 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 Health & Wellness 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 the member became totally disabled and unable to work, due to such disability but before due proof of the member's 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 the member became disabled. The Plan must receive proof of the member's death and that the member was totally disabled during this period not later than one year after the date of 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, the member 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 75), 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 they suffer 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 they suffer 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) $100,000 (previously $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 75. AD&D will reinstate to $85,000 for retired members who have returned to active employment, and satisfied eligibility requirements;

2) $100,000 (previously $85,000) if the covered member was an associate at the date of loss, terminating at age 75; or

Principal amount (continued)

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, they or their 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 their 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 they 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, child, father, mother, sibling, 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 their 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 Health & Wellness 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 Health & Wellness Plan Office.

Benefits payable

- Equivalent to the EI maximum plus $120 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 day surgery (providing you have been seen by a doctor). Benefits begin on the fourth day for an illness.
- Maximum duration *26* weeks (total) (previously 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 they are to be off longer than four weeks.
- The Health & Wellness 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 Health & Wellness Office for the balance of weeks up to *26* weeks (total) (previously 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 WWI application package 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 payments are issued on Wednesday of each week.
- Maximum claim is 26 weeks (total) (previously 15 weeks) based on medical information.

A covered member is <u>not</u> eligible for weekly wage indemnity if:

- 65 years of age or over;
- receiving pension benefits from the UA Local 170 pension plan;
- receiving Workers Compensation wage loss benefits;
- disabled due to a no fault automobile insured accident, unless unable to work due to the accident for a period under eight days;

A covered member is <u>not</u> eligible for weekly wage indemnity if (continued):

- works more than half their shift they 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 UA Local 170 Health & Wellness 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 Health & Wellness 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.

How long-term disability benefits calculated (continued)

- 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 no fault automobile insurance plan.

- 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 their retirement, due to either return to gainful employment or to being determined not to be totally and permanently disabled, and if they are again determined to be totally and permanently disabled within five months of cessation of their 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.

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 licensed healthcare provider, 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.

Licensed Healthcare Provider - means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person. Doctors, nurse practitioner, and occupational therapists are examples of health care providers.

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 licensed healthcare provider or 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 within Canada for preventative purposes reimbursed effective June 1, 2021 up to $250 per person per calendar year on a reasonable and customary basis. No benefit shall be payable for any charges incurred for the administration of a vaccine.

2) Injection Administration Fees
Effective June 1, 2021, Injections administration fees charged by a licensed healthcare provider or pharmacist reimbursed up to $100 per person per calendar year.

3) Diagnostic tests

Covers diagnostic testing that is not covered by provincial health care (inclusive of prostate blood testing, etc.) for covered individuals, excluding special senior members and their covered dependants, maximum of $100 per calendar year per person;

4) 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.

5) Fertility Drugs & Treatment

Effective January 1, 2023, reimburse up to $10,000 (previously $5,000) per person per lifetime for prescribed drugs and treatment. Please note that there is no coverage for administration of drugs, facility fees or operating room fees.

6) Erectile Dysfunction Drugs

Effective July 1, 2023, up to a maximum of $600 per calendar year.

7) Botox

Effective June 1, 2021, Botox prescribed for the treatment of migraines and/or hyperhidrosis covered up to $200 per person per calendar year.

8) Foldable intraocular lens implants

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

9) Prolotherapy

Effective June 1, 2021, Prolotherapy injections into a joint or other body part to assist in ligament, tendon or muscle repair covered up to $200 per person per calendar year.

10) 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).

11) 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.

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

Benefits payable is 100 per cent of a claim to a maximum of $700 per person per 24-month period effective January 1, 2022. As well, effective January 1, 2019 implement Laser eye surgery coverage of up to $3,000 per person per lifetime.

Effective January 1, 2022, prescribed Corrective contact lenses for severe medical condition up to $700 per person per 24 month period if vision in better eye can be improved to a 20/40 level with a contact lenses, but not with glasses.

Effective June 1, 2021, Visual training benefit up to a lifetime maximum of $1,000 per person provided the vision therapy program is prescribed by a doctor of optometry to improve conditions like crossed eyes, lazy eye, etc. Visual Therapy generally used for many problems that cannot be treated with eyeglasses or contact lenses alone.

Contact the UA Local 170 Health & Wellness 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 UA Local 170 Health & Wellness Office.

13) 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.

Effective June 1, 2021, additional eye exam up to $100 per person calendar year for specific medical condition (glaucoma, diabetes, dry eye disease, macular degeneration, retinopathy, and cataract) if coverage exhausted with Provincial Health Plan.

This is administered in-house at the UA Local 170 Health & Wellness office, please contact the Health & Wellness

Office for forms and assistance (Phone: 604-526-3434 or toll-free at 1-800-665-6808).

14) Practitioners (reimbursed by Coughlin & Associates)

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)	$2,500 (previously $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.

15) Hearing aids and repairs

To a 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.

16) Custom Ear Plugs

Custom Ear Plugs that have been prescribed by a licensed healthcare provider up to $500 every five years per person. Please submit an official itemized receipt along with a referral that includes a diagnosis that must state for a hearing loss or to prevent hearing loss.

17) Pediatric Ear Molds

Effective June 1, 2021, Pediatric ear molds prescribed by a licensed healthcare provider for children 6 to 18 years of age covered up to $300 per calendar year. An official receipt along with a physician referral must be submitted.

18) Orthopedic Shoes and Orthotics:

i) when prescribed by a licensed healthcare provider, 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 licensed healthcare provider, 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.

19) Standard durable medical equipment (previous 80%):

a) 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;

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

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

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

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

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

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

20) 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.

21) 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.

22) 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 (compression) stockings..... two pairs

The official receipt must indicate the compression factor (minimum 20+ factor being purchased from a medical practitioner or supplier).

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;

23) Medical examinations

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

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 listed items (under drugs) will be reimbursed up to $2,500 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.

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, 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.

The following are not included as eligible expenses under your EHC 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 licensed healthcare provider or physician who is related to or resides 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) Breast Pump.
17) 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 explanation of benefits 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 explanation of benefits 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) Obtain a claim form from Health & Wellness office or Coughlin & Associates Ltd., claims adjudicator.
   a) 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); or electronic submissions.
   b) 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 2023 before June 30, 2024.

TRAVEL MEDICAL EMERGENCY

Travel assistance is provided by AIG Global Excel Management Inc. With centres worldwide they will:

- help locate the most appropriate medical facility for you.
- confirm coverage with AIG Insurance Company of Canada and assure the hospital that you are covered.
- guarantee payment for hospitalization, if necessary.
- arrange for admission to a hospital.
- provide translation services.
- contact your own doctor for recommendations, when required.
- contact your family and employer, when required.
- arrange for/co-ordinate emergency medical evacuation. and
- co-ordinate your return home.

How to Claim

If you require emergency medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately. If circumstances prevent you from calling Global Excel Management Inc. right away, you should contact them as soon as you can. Global Excel Management Inc. will help ensure that you receive the medical care you need and, if possible, will make claims payment arrangements directly with the hospital or service provider.

If you contact GLOBAL EXCEL MANAGEMENT INC. right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

If you are not able to contact Global Excel Management Inc. before being billed for the charges, or if your medical needs are minor in nature (i.e., costing less than $500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip. In any case, your claim should be submitted no later than 90 days after the expense was incurred. Global Excel Management Inc. and the insurance company are not responsible for dealing with any payment reminders or collection notices that you receive from medical providers.

Travel assistance is provided by AIG Global Excel Management Inc.

To make a claim for out-of-pocket expenses, contact a Global Excel Management Inc. operator at:

From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

Give the operator your name and your Policy Number:
CMG 9428867.

The operator will send you a claim form. When you complete the form, provide the patient's name and provincial health plan number and your certificate number. Be sure to attach detailed statements and original receipts showing the services rendered and the charges for each service.
Mail your completed claim form and attachments to:

Global Excel Management Inc.
73 Queen Street
Lennoxville, QC, J1M 1J3

Please make sure you obtain your medical records, statements, or detailed receipts at the time of treatment and/or discharge, to submit with your claim. All claims must be submitted to Global Excel Management Inc. as soon as possible, and no later than 90 days after the expense was incurred.

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 remains in effect, the monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first. Orthodontic claims will be cancelled the day of the coverage month, which a person ceases to be a covered member.

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, 2023. The purpose of this benefit is to allow additional coverage to members and their dependents, which is beyond the coverage already provided by the Health & Wellness Plan.

Active Insured Members - Will receive a one-time minimum $700 allocation (per household) in their H.S.A. account. The allocation of this benefit has been based on your hours worked in 2022 provided you have worked at least 220 hours in the 2022 calendar year. This benefit will be for eligible expenses incurred on or after July 1, 2023, to June 30, 2024. 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, 2024). 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 Health & Wellness Plan at July 1, 2023, 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 a covered 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 Health & Wellness Plan at July 1, 2023, 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 Health & Wellness Plan at July 1, 2023 and have continuous coverage. Currently, Local 170 Plan deducts 110 hours per month for coverage. The Health Spending Account (H.S.A.) 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, 2023) to the Plan following a seven-day run-off period (i.e. on July 7, 2024).

Claims Submission

For claims submitted via paper claim, any remaining Health, Vision, or Dental benefit expenses not covered by the basic may be applied to the extent of your H.S.A. Contact the Health & Wellness Office for H.S.A. reimbursement details.

For online submissions via the Claims Member Portal or Coughlin Mobile App, locate your explanation of benefit statement to submit to the Health & Wellness office for H.S.A. reimbursement.

For claims submitted electronically (eClaim) from a Provider's office (i.e. no claim form submitted) on behalf of you or your eligible dependents, the H.S.A. will not be applied automatically.

If you are submitting claims that require redirection to your spouse's plan for coordination of benefits, we will not automatically apply to your H.S.A. Subsequently, any remaining balance following coordination of benefits with your spouse's plan will need to be submitted to the Health & Wellness office along with an explanation of benefit statement from your spouse's Insurer.

Obtaining H.S.A. Balance
You can obtain your remaining H.S.A. balance by contacting the Plan Administrator.

Please note that Members cannot utilize their account for cash withdrawals or pay a provider directly (i.e. the account balance must be used to reimburse Vision, Health or Dental related expenses). Furthermore, Members must remain in good standing with the Local Union to be eligible for the balance in their H.S.A.. Upon termination as a Union Member, any remaining balance in your account will be forfeited back to the Plan and not reallocated.

Termination
In the event of termination of Membership or Active Insured status, from the UA 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 UA 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 on the Plan Administrator's website at www.plumbers.bc.ca, or by accessing the CRA website via the link www.cra-arc.gc.ca/medical/#mdcl_xpns, and searching eligible medical expenses.

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 their 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 Health & Wellness and Pension Fund on behalf of the member.
- The entire reimbursement comes from the Health & Wellness 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 & Wellness 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 Health & Wellness 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 Health & Wellness 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 Health & Wellness board of trustees.

- A member may otherwise be eligible for financial assistance, beyond the residential treatment, only if the request is brought to the Health & Wellness 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 Health & Wellness plan office.

- The member should contact the Health & Wellness 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 Health & Wellness 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 under age 70 are covered up toa Lifetime maximum of $5 million and ages 70 to 74 up to a Lifetime Maximum of $2 million in travel medical emergency insurance, whether travelling for business or personal reasons.. The travel medical emergency insurance (policy number is # CMG 9428867 is provided through AIG. All-in-one 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 AIG, as soon as possible, by calling in Canada and the U.S., 1-877-207-5018; and from anywhere else, you can call collect at 1-(819) 566-3940.

   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 please ask them to use:

   a. Bin # 000034 on Telus Adjudicare network
   b. Group Number # 60463
   c. Individual certificate number (printed on your card)

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 All-in-one 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 15 for complete details.

NOTICE REGARDING PERSONAL INFORMATION

When you apply for coverage under the Health & Wellness Plan, the UA Local 170 Health & Wellness plan administrator, Coughlin & Associates Ltd. (claims adjudicator), Manulife (Life, AD&D, and LTD), and the out-of-country travel insurer AIG, 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, AIG, 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, AIG, 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 UA Local 170 Health & Wellness 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 Health & Wellness Plan are committed to respecting your right to privacy and safeguarding your personal information. For more information regarding the privacy policy, please contact the UA Local 170 Health & Wellness 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.