

Local 97 Ironworkers



Health & Welfare Plan

September 2010

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PRIVACY POLICY

We, the Trustees for the Local 97 Ironworkers Health & Welfare Plan have adopted the following *Privacy Principles*, which reflect our commitment to safeguarding our Members' personal information:

- Information about you and your communications with the Plan are kept confidential.
- Neither the Administrator, nor the Plan will sell your personal information.
- Information about you is gathered lawfully and fairly.
- Information about you is gathered, used, or disclosed only to provide you with benefits and services as outlined in your plan documents.
- We maintain appropriate procedures to ensure that personal information in our possession is accurate and, where necessary, kept up to date. You are entitled to seek a correction of your personal information if you believe that the information held by the Plan is not accurate.
- You may access your personal information, subject to limited exceptions and conditions.
- Personal information is not disclosed without Member's permission except in limited circumstances as permitted or required by law. However, the Administrator, may share personal information with the Plan's actuaries, agents, consultants or service providers in connection with providing, administering, adjudicating, costing, financially managing and servicing Members' plans and benefit programs.
- Where we choose to have certain services, such as actuarial valuations, provided by third parties, we take all reasonable precautions regarding the practices employed by the service provider to protect your personal information. We ask that they, in turn, undertake to honour the Plan's privacy policy and applicable legislation.
- To protect your personal information against unauthorized access, disclosure, copying, use or modification, or theft or accidental loss, the Plan will maintain appropriate security mechanisms.

– The Trustees

BENEFITS UNDERWRITTEN BY:

Great West Life Assurance Company:
Life Insurance

Local 97, Ironworkers Health & Welfare Plan:
Dental Care
Extended Health Care
Transportation Assistance
Vision Care
Weekly Indemnity
Long Term Disability
Life Insurance

Chartis Insurance Company:
Accidental Death & Dismemberment

Shepell-fgi
Employee Family Assistance Program

Medical Services Plan of BC
Basic Medical Plan

This booklet explains, in general terms, the plan of benefits and coverage in effect. It is not to be considered a contract of insurance. The complete terms of the Plan are set forth in the group policies issued to the Trustees.

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LOCAL 97 IRONWORKERS HEALTH & WELFARE PLAN

The following is an outline of Local 97 Ironworkers Health & Welfare Plan Benefits. They are always subject to review by the Board of Trustees and can and will be changed when it is deemed necessary by the Trustees in order to protect the future viability of the Plan.

Both British Columbia and Alberta have passed legislation affecting the use of self-insured funding for providing benefit plans. In each case, the legislation allows for the use of self-insured funding, subject to disclosing this information to the covered Members in writing.

The Trustees are constantly attempting to provide benefits under the Plan to the Members in the most cost-effective manner. For some benefits it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act.

BENEFIT SCHEDULE

Group Life Insurance	\$50,000.00*
Accidental Death & Dismemberment	\$12,500.00
Weekly Indemnity (per week).....	\$457.00
Long Term Disability (per month)	\$1,000.00
Extended Health Care	as described herein
Dental Care.....	as described herein
Vision Care	as described herein
Basic Medical Plan	as provided by M.S.P (Medical Services Plan of British Columbia)
Employee Family Assistance Program	as described herein

***Note:** All active Members between the ages of 60 and 65 will be covered for \$50,000 of Life Insurance. Members between the ages of 60 and 65, who are not active but are covered for benefits, will continue to be covered for \$25,000 of Life Insurance. Upon attaining age 65, all Members' Life Insurance reduces to \$10,000 and upon attaining age 70, the Life Insurance further reduces to \$5,000.

ATTENTION:

Any Member of Local 97 found to be working for a non-signatory Ironworker Contractor may have their coverage terminated and will forfeit any accumulation to their hourbank.

Part I

ANSWERS TO QUESTIONS WHICH YOU ARE MOST LIKELY TO ASK

Who is eligible for benefits?

Any person working under the Collective Agreement of Local Union 97 of the International Association of Bridge, Structural and Ornamental Ironworkers.

Does a Member have to complete any forms?

Yes. The Member must complete the following forms:

- Fair PharmaCare Registration
- M.S.P. Application Form
- Life Insurance Beneficiary Card

It is most important that EACH Member complete the required forms whether or not he/she is eligible. These forms should be sent to the Administration Office without delay.

How does a Member qualify for benefits?

A person qualifies for benefits when 220 hours or more are reported by the employer within a 5-month period or less. The hours reported are put to the credit of each person's "HOUR BANK".

When will coverage commence?

Coverage will commence on the 1st day of the month following the month (lag) in which sufficient hours are reported and paid to the Plan by the employer(s).

A Member is eligible for all benefits except Weekly Indemnity after satisfying the normal qualifying conditions of the Plan. A Member does not become eligible for Weekly Indemnity coverage until the first day of the second month after the Member has worked, and the Plan has received contributions, for 1,000 hours of work with a participating employer.

Example

HOURS REPORTED

MONTH:	MEMBER A	MEMBER B	MEMBER C
January	50 hours	150 hours	226 hours
February	70 hours	125 hours	lag
March	30 hours	lag	Qualified
April	100 hours	Qualified	-
May	lag	-	-
June	Qualified	-	-

How does the Hour Bank build for future coverage?

Once a person is qualified, additional hours reported will be added to the Hour Bank.

As a Member of Local 97, 110 hours will be withdrawn each month from the Hour Bank for coverage. 8 months' coverage (880 hours) may be accumulated ahead, which will be drawn upon during a period of poor employment, lengthy illness or extended vacation.

A person who is not a Member of Local 97 but who is working under the Local 97 Collective Agreement will have a charge of 130 hours made against his/her Hour Bank. A maximum of up to three months' coverage (390 hours) can be accumulated in the Hour Bank.

It should be noted that Local 97 Ironworkers Health & Welfare Plan has Reciprocal Agreements with the plans of other Locals of the International Association of Bridge, Structural and Ornamental Ironworkers and Members of a Local with a Reciprocal Agreement, will not receive coverage from the Local 97 Ironworkers Health & Welfare Plan. Contributions made on their behalf are remitted to their home Local's welfare plan.

What happens if the Hour Bank falls short for coverage?

If the Hour Bank drops below 110 hours, the Administrator will send out a notice as to the balance in the Hour Bank and the amount required to maintain coverage. If payment of the amount requested is received by the deadline specified on the notice, coverage will be continuous.

Those Members who have a balance of employer hours in their Hour Bank and, although working regularly, do not have sufficient work to maintain the Hour Bank charge, will qualify under "Shortage Hours" and will receive a billing showing the balance of hours required to make up the 110 hours needed each month to provide coverage. Shortage notices do not reduce the maximum months under self-payment.

Please note that non-Members will not be notified when their Hour Bank drops below 130 hours.

Self-payment is only available to a Member who was covered under the Local 97 Ironworkers Health & Welfare Plan. The Fund is subsidizing the rate and a self-pay notice will be sent to each Member showing the amount to be paid.

The first month a Member falls below the 110 hours, but has 90 or more employer hours in his/her Hour Bank, a self-pay notice will not be sent out and the Fund will absorb the difference out of general revenue.

For any Member who must self-pay 20 hours or less, the Plan will pay their MSP premium for that month.

Limitations of Self-Payments

When there are no hours left in the Hour Bank due to unemployment*, extended holidays, etc., self-payments may be continued for 110 hours X the applicable rate per month for a maximum of 6 months, with respect to all benefits *except* **MSP, Long Term Disability and Weekly Indemnity**. Thereafter, this privilege will only be available if the Member is totally disabled and unable to work subject to medical evidence, or a regular or disabled Pensioner drawing from the Ironworkers Pension Plan, Local 97. The maximum duration of self-pay for Pensioners will be set at one year for every 3,000 hours recorded to this Plan.

Members, on self-pay, must obtain their own Medical Services Plan (MSP) coverage. MSP is not available through self-payment. For any Member who must self-pay 20 hours or less, the Plan will pay the MSP premium for that month. To apply for individual MSP coverage contact:

MEDICAL SERVICES PLAN OF B.C.
P.O. BOX 9035 STN PROV GOVT
VICTORIA, B.C.
V8W 9E3

www.healthservices.gov.bc.ca/msp

Self-pay coverage must be continuous from the date of termination of coverage through the Hour Bank. If a Member, whose coverage has lapsed, does not elect to self-pay, he/she must work and report 220 new hours to the Plan (the same commencement as for a new Member).

***Please note:** Only Members who are not gainfully employed (other than through Local 97) will be entitled

to self-pay. A declaration must be signed by all Members, including early Pensioners, to this effect. Additional information such as a tax return, may be requested by the Trustees.

Pensioners can have their self-payments for benefits directly withdrawn from their bank account. Please see the Administrator for more details.

How do reports come in?

The Collective Agreement requires that employers report, prior to the 15th day of each month, all hours for which wages are paid to the Member up to the close of the employer's payroll ending closest to the last day of the preceding month. It is advisable that Members keep their own pay slips, as errors may occur in reporting and tabulating.

When does coverage end?

Coverage is always provided on a whole-month basis only and will be terminated when:

- 1) The Hour Bank falls below 110 hours and the Member fails to make a payment by the date specified on the self-pay notice (Members ONLY) in order to bring his/her Hour Bank up to the required hours; or
- 2) 6 consecutive self-payments have already been made to the Fund.

Any Member of Local 97 found to be working for a non-signatory Ironworker Contractor may have their coverage terminated and will forfeit any accumulation to their Hour Bank.

Do not ignore the self-pay notice.

The only sure way to guarantee continuous coverage is to pay by the date specified on the notice. If self-payments are not received for two consecutive months or more coverage will be terminated. In order to recommence self-payments the Member is required to return to work and accumulate sufficient hours in his/her Hour Bank once again.

ONLY ONE NOTICE WILL BE SENT OUT... ACT ACCORDINGLY

If a self-pay notice is received and it is thought to be incorrect, contact the Administration Office immediately. Use the back of the self-pay notice to explain any errors which are believed to exist.

In the event that late hours are reported or other adjustments are found later, the hours will be credited to the Hour Bank for future use.

If coverage terminates, when will coverage recommence?

When 220 hours have been worked and reported to the Plan, the same as commencement for a new person. A Member may not re-qualify by self-payment. If coverage terminates, individual medical coverage should be applied for through:

MEDICAL SERVICES PLAN OF B.C.
P.O. BOX 9035 STN PROV GOVT
VICTORIA, B.C.
V8W 9E3

www.healthservices.gov.bc.ca/msp

DISABILITY CREDITS

When a Member is collecting under the Weekly Indemnity Plan/E.I. Sick Benefits or under Workers' Compensation, will he/she receive assistance with his/her Hour Bank?

Yes. For each day that they are disabled and, provided the claim for the Weekly Indemnity Plan/E.I. Sick Benefits or Workers' Compensation has been accepted for payment, the Hour Bank will be credited with contributions of 8 hours per day, subject to a maximum of 110 hours per month for up to 12 months, and for a maximum of 6 months if the person is not a Member of Local 97 at the rate of 130 hours per month. If the claim is for Weekly Indemnity this will be done automatically, but for Workers' Compensation or E.I. Sick Benefits, a special form should be requested from the Administration office. To qualify for these Disability Credits the Member must be eligible for benefits when the disability commences.

If the Member is disabled longer than the maximum Weekly Indemnity claim of 26 weeks, he/she should apply to the Administration Office for a form so that further Disability Credits may be applied to the Hour Bank.

Please note: Social Insurance Numbers should be included on all correspondence to the Plan.

Social Insurance Numbers are used for identification purposes. Please notify the Administration Office if a dependent is to be added or deleted from the Plan.

Self-pay notices or any other material mailed by or under authority of the Administration Office to the person's last known address is deemed to have been duly received by the addressee.

Notification of a change of address is the duty and responsibility of the Member.

APPRENTICES/B.C.I.T. INSTRUCTORS

Upon graduation from the 1st year course, apprentices will be entitled to receive Health & Welfare coverage for the calendar month following graduation and then will be entitled to self-pay until hours of work are sufficient to provide coverage or the maximum self-pay has been attained. It is understood that Weekly Indemnity will not be covered until the apprentice is at work.

(Effective June 1, 2006) Individuals who pre-apprentice through Local 97 and then begin the Entry Level Trades Training Program (ELTT), will be entitled to full coverage under the Plan, excluding all disability benefits, for up to 6 months, once their Hour Bank runs out, provided they are in school attending the ELTT program.

Registered Apprentices (RA), who attend Ironworking upgrade classes, years 2&3, provided they have less than 4 months of banked hours in their Hour Bank, will be credited with 110 hours (one month of coverage) by the Trade Improvement Committee. These RA's will be permitted to self-pay for a maximum of 6 months if no work is forthcoming.

(Effective January 1, 2007) Apprentices will be given 2 months' coverage upon successful completion of the ELTT program.

B.C.I.T. Instructors will be given one month's coverage, when they are finished teaching. When the instructors return to teach at B.C.I.T., their Hour Bank will be frozen (if they had one) and will remain frozen until they are finished teaching.

CO-ORDINATION OF BENEFITS

If an individual is entitled, as a result of sickness or bodily injury, to receive similar benefits simultaneously under the health insurance benefits of any other group insurance plan (including any service organization or pre-payment plan), to prevent overpayment, benefits payable under this Plan will be co-ordinated with any benefits payable for the same disability under such other plan, in accordance with the Order of Benefit Determination provision indicated in the group policy, to the extent that the total amount paid does not exceed 100% of the incurred covered charges.

INTEGRATION OF BENEFITS

Claims payment will be reduced by any payment payable under a No-Fault Auto Insurance Plan or similar legislation.

What if a Member owes the Plan money?

If a Member owes the Plan any money, then any money due to such Member in the form of benefits will be paid to the Plan rather than the Member, until such debt is repaid in full.

Part II

BASIC MEDICAL PLAN

What identification does a person have?

Each eligible person will be issued a M.S.P. identification card. The group number will be 4823381.

Which benefits are eligible under the Medical Services Plan (MSP)?

The official Medical Services Plan of British Columbia booklet, which explains the details of medical coverage, is available through the Administration Office or on their website at www.healthservices.gov.bc.ca/msp

<p>Members' applications received late by MSP will be billed by MSP back to their last coverage date. The Plan will only cover up to three months of MSP back billing. The balance is the responsibility of the Member.</p>

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

IMMEDIATE, CONFIDENTIAL HELP FOR ANY CONCERN

Your Employee and Family Assistance Program (EFAP) is a confidential and voluntary support service that can help you solve all kinds of problems and challenges in your life.

You and your immediate family members (as defined in your employee benefit plan) can receive support

over the telephone, in person, online, and through a variety of issue-based health and wellness resources. For each concern you are experiencing, you can receive a series of sessions. You can also take advantage of online tools to help manage personal well-being.

You'll get practical, relevant support, fast and in a way that is most suited to your preferences, learning approach and lifestyle. Caring professionals can help you select a support option that works best for you.

IS THE SERVICE CONFIDENTIAL?

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

HOW MUCH WILL IT COST?

There is no cost to use your EFAP. If you need more specialized or longer-term support, your EFAP will help you select an appropriate specialist or service that can provide assistance. While fees for these additional services are your responsibility, some may be covered by your provincial or organizational health plan.

- Personal stress • Depression • Grief and loss
- Anxiety • Aging/midlife issues • Life transitions
- Managing anger • Mental health and well-being
- Crisis situations • Trauma

Manage Relationships and Family:

- Communication • Relationship conflict
- Separation/divorce • Parenting • Domestic abuse
- Blended family issues • Family relationships
- Aging parent concerns

Get Legal Clarity:

- Family Law • Custody • Separation/divorce
- Bankruptcy • Summons/warrants/subpoenas
- Consumer protection

Get Financial Clarity:

- Credit/debt management • Bankruptcy
- Early retirement • Financial aspects of separation/divorce • Financial emergencies

Research Child and Elder Care Resources:

- Child care • Adoption • Maternity/parental leave
- Schooling • Adult day programs

- Nursing/retirement homes

Address Workplace Challenges:

- Workplace conflict • Workplace performance
- Career planning • Violence • Harassment
- Work-life balance • Work-related stress

Tackle Addictions:

- Alcohol • Drugs • Tobacco • Gambling
- Other addictions • Post-recovery support

Understand Nutrition:

- Weight management • Addressing: high cholesterol, high blood pressure, diabetes, heart disease • Boosting energy and stress resilience

Call your Employee and Family Assistance Program (EFAP) toll-free, 24 hours a day, seven days a week for immediate, confidential help:

1.800.268.5211 TTY Service: 1.800.363.6270

Note: When contacting Shepell-fgi be sure to advise them that you are covered under the Local 97 Ironworkers Health & Welfare Plan.

Part III

GROUP LIFE INSURANCE

What are the Life Insurance Benefits?

\$50,000.00* of Life Insurance is payable to the beneficiary designated, should the Member die from any cause while insured under the group policy. A Life Insurance Beneficiary Card must be completed to ensure there is no delay in claim settlement.

***Please note:** Effective January 1, 2008, all active Members between the ages of 60 and 65 will be covered for \$50,000 of Life Insurance. Members between the ages of 60 and 65, who are not active but are covered for benefits, will continue to be covered for \$25,000 of Life Insurance. Upon attaining age 65, all Member's Life Insurance reduces to \$10,000 and upon attaining age 70, the Life Insurance further reduces to \$5,000.

Upon death, to whom are the benefits paid?

A beneficiary may be designated and may also be changed or declared to be for the benefit of the

Member's estate. If any beneficiary dies before the Member, the interest of such beneficiary shall, unless otherwise provided, vest in the Member's estate. If a beneficiary is not designated, the insurance will be payable to the estate.

To change a beneficiary, proper forms are available from the Administration Office.

What happens to the Life Insurance Benefit if coverage ceases?

If the Life Insurance terminates because the Member is no longer eligible, he/she may take out an individual policy with Canada Life Assurance Company without evidence of insurability, at the insurance company's rates then in effect at the Member's attained age.

The individual policy will not exceed the amount of Life Insurance which ceases because of such termination.

If the Life Insurance terminates for the Plan for any reason, conversion may be made for up to \$5,000.00 of the Life Insurance coverage to an individual policy, but only if the Member had been insured under this Plan for at least three years.

Application must be made for the individual policy and the first premium paid within 31 days following the date of termination of the Life Insurance coverage.

Life Insurance will continue to be insured under the group policy during the 31-day conversion period whether or not application is made for conversion.

Only one such converted policy may be in force on a Member's life at any time.

What happens if the Member becomes totally disabled?

Subject to satisfactory proof, submitted within 12 months from the date the Member under age 60 becomes totally and permanently disabled, as the result of an **accident or sickness**, the total amount of the Life Insurance in effect at the time disability commenced will remain in force without further premium charge, provided the Member remains totally and continuously disabled.

Claims for total and permanent disability **must** be submitted to the Administration Office within 12 months of the onset of such disability.

In the event of a terminal illness, it may be possible to receive a portion of the Life Insurance in a lump sum. Please contact the Administration Office.

Part IV

ACCIDENTAL DEATH & DISMEMBERMENT

The Member and his/her registered dependents are insured against the perils described in the "Schedule of Losses". The Basic Accidental Death & Dismemberment plan provides coverage 24-hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If any of the losses listed below in the Schedule of Losses are suffered as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is Covered?

Class I: All Members who are eligible as outlined in Part I of this Booklet.

Class II: All Spouses under age 70.

Class III: All eligible Dependent Children

Amount of Coverage

Class I: \$12,500.00

Class II: \$20,000.00

Class III: \$5,000.00

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands.....	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye.....	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye.....	The Principal Sum
Loss of One Arm.....	3/4 of The Principal Sum
Loss of One Leg	3/4 of The Principal Sum
Loss of One Hand.....	2/3 of The Principal Sum
Loss of One Foot	2/3 of The Principal Sum
Loss of Entire Sight of One Eye	2/3 of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand.....	1/3 of The Principal Sum

Loss of Speech and Hearing	The Principal Sum
Loss of Speech or Hearing	2/3 of The Principal Sum
Loss of Hearing in One Ear.....	1/3 of The Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	2 Times The Principal Sum
Paraplegia (total paralysis of both lower limbs)	2 Times The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body.....	2 Times The Principal Sum
Loss of Use of Both Arms or Both Hands	The Principal Sum
Loss of Use of One Hand or One Foot	2/3 of The Principal Sum
Loss of Use of One Arm or One Leg.....	3/4 of The Principal Sum
Loss of Four Fingers of One Hand	1/3 of The Principal Sum
Loss of All Toes of One Foot	1/4 of The Principal Sum

“Loss” as used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs. As used 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 index finger, means complete severance through or above the first phalange of all four fingers of one hand. As used with reference to toes, means complete severance of both phalanges of all the toes of one foot. As used with reference to eye, means the irrecoverable loss of the entire sight thereof.

“Loss” as used 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 irrevocable loss of hearing in both ears.

“Loss” as used with reference to “Loss of Use”, means the total and irrevocable loss of use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

All claims submitted under this policy for Loss of Use must be verified by agreement between a licensed practicing physician appointed by the Policyholder and a licensed practicing physician appointed by the insurance company, or in the event that the two physicians so appointed cannot arrive at an agreement, a third licensed practicing physician shall

be binding on the Policyholder and the insurance company. This procedure may be waived by the insurance company at its sole discretion.

Exposure and Disappearance

If, by reason of an accident covered by the policy, an Insured Person is unavoidably exposed to the elements and, as a result of such exposure, suffers a loss for which indemnity is otherwise payable hereunder, such loss will be covered under the terms of the policy.

Repatriation Benefit

When injuries covered by this policy result in the loss of life of an Insured Person outside 50km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of \$15,000.00.

Educational Benefit

If indemnity becomes payable for the Accidental Loss of Life of an Insured Person of the Policyholder, the insurance company shall:

1. Pay the lesser of the following amounts to or on behalf of any Dependent Child who, at the date of accident, was enrolled as a full time student in any higher learning beyond the 12th grade level:
 - (a) The actual annual tuition, exclusive of room and board, charged by such institution per school year.
 - (b) \$10,000.00 per school year.
 - (c) 5% of the Insured Person's Principal Sum.

Such amount will be payable annually for a maximum of four consecutive annual payments, only if the Dependent Child continues his/her education.

"Dependent Child" as used herein means any unmarried child under 26 years of age who was dependent upon the Insured Person for at least 50% of his/her maintenance and support.

"Institution of Higher Learning" as used herein includes, but is not limited to, any University, Private College, or Trade School.

2. Pay to or on behalf of the surviving Spouse the actual cost incurred within 30 months from the date of death of the Insured Person as payment for

any professional or trades training program in which such Spouse has enrolled for the purpose of obtaining an independent source of support and maintenance, but not to exceed a maximum total payment of \$10,000.00.

Rehabilitation Benefit

When injuries shall result in a payment being made by the insurance company under the Accidental Death & Dismemberment Indemnity section of this policy, the insurance company shall pay in addition:

The reasonable and necessary expenses actually incurred up to a limit of \$15,000.00 for special training of the Insured Person provided:

- (a) such training is required because of such injuries and in order for the Insured Person to be qualified to engage in an occupation in which he/she would not have been engaged except for such injuries,
- (b) expenses be incurred within three years from the date of the accident,
- (c) no payment shall be made for ordinary living, travelling or clothing expenses.

Family Transportation

When injuries covered by the policy result in an Insured Person being confined to a hospital, outside 100km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a Member of the immediate family, the insurance company shall pay the the actual expenses incurred by the confined Insured Person but not to exceed the amount of \$15,000.00.

The term "Member of the immediate family" means the Spouse (or common-law Spouse) parents, grandparents, children age 18 and over, brother or sister of the Insured Person.

Seat Belt Rider

Benefits under the policy shall be increased by 10% if the Insured Person's injury or death results while he/she is a passenger or driver of a private passenger type automobile and his/her seatbelt is properly fastened. Verification of actual use of the seat belt must be part of the official report of the accident by the investigating officer.

Home Alteration and Vehicle Modification

If an Insured Person receives a payment for Quadriplegia, Hemiplegia or Paraplegia as outlined in

the Schedule of Losses herein and was subsequently required (due to the cause for which payment under such was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

- A. The one-time cost of alterations to the injured person's residence to make it wheelchair accessible and habitable; and
- B. The one-time cost of modifications, necessary to a motor vehicle owned by the injured person, to make the vehicle accessible or driveable for the Insured Person.

Benefit payments herein will not be paid unless:

- (i) Home alterations are made on behalf of the Insured Person and carried out by an experienced individual in such alterations and recommended by a recognized organization providing support and assistance to wheel-chair users; and
- (ii) Vehicle modifications are made on behalf of the Insured Person and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both Items A and B combined will not exceed \$15,000.00.

Day Care Benefits

If indemnity becomes payable under the policy for the accidental loss of life of an Insured Person, the insurance company will pay an amount equal to the lesser of the following amounts:

- (1) The actual cost charged by such day care centre per year, or
- (2) 3% of the Insured Principal Sum, or
- (3) \$5,000.00 per year,

On behalf of any child who was an Insured Person's dependent at the time of such loss and is under age 13 and is currently enrolled or subsequently enrolled in an accredited day care centre within 90 days following such loss.

The benefit is payable annually for a maximum of four consecutive payments but only if the Dependent Child continues his or her enrollment in an accredited day care centre.

In-Hospital Indemnity Benefit

If an Insured suffers a loss under the Table of Losses as a result of a covered accident and requires that an

Insured be confined to a hospital for more than five (5) consecutive days, the insurance company will pay:

- a. a monthly benefit of one (1) percent of the Insured's applicable Principal Sum; or
- b. for periods of less than one (1) month, one thirtieth (1/30) of the above monthly benefit per day.

Benefits are retroactive to the first (1st) day of hospital confinement.

This benefit is limited to:

- a. a monthly amount not to exceed \$1,000.00; and
- b. a total of twelve (12) months for any covered accident.

Successive periods of hospital confinement for loss from the same covered accident separated by a period of less than three (3) months will be considered as one (1) period of hospital confinement.

The term "Hospital" is defined as an establishment which meets all of the following requirements:

- (1) holds a license as a hospital (if licensing is required in the Province);
- (2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- (3) provides 24-hour a day nursing service by registered or graduate nurses;
- (4) has a staff of one or more licensed physicians available at all times;
- (5) provides organized facilities for diagnosis, and major medical surgical facilities; and
- (6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

When as the result of injury and commencing within 365 days of the date of the accident an Insured Person is totally and permanently disabled and prevented from engaging in each and every occupation or employment for compensation or profit for which he/she is reasonably qualified by reason of his/her education, training or experience, the insurance company shall pay, provided such disability has continued for a period of twelve consecutive months and is total, continuous and permanent at the

end of this period, the Principal Sum less any other amount paid or payable under the Accidental Death and Dismemberment Indemnity Coverage of the policy as the result of the same accident.

Conversion Privilege

On the date of termination of employment or during the 60-day period following termination of employment, the Member may change his/her insurance to the Chartis Insurance Company's individual insurance policy. The individual policy will be effective either as of the date that the application is received by the insurance company or on the date that coverage under the policy ceases, whichever occurs later. The premium will be the same as would be paid if application for an individual policy was made at that time. Application of an individual policy may be made at any office of the Chartis Insurance Company. The amount of insurance benefit converted to shall not exceed that amount issued during employment.

Continuance of Coverage

In the case of Members of the Policyholder who are (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave coverage shall be extended for a period of twelve (12) months, subject to payment of premium.

If a Member of the Policyholder assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Waiver of Premium

In the event an Insured Person becomes totally and permanently disabled and his/her waiver of premium claim is accepted and approved under the Policyholder's current Group Life Insurance policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier.

- (a) The date the Insured Person attains age 65.
- (b) The date of the death or recovery of the Insured Person.
- (c) The date the Master Policy is terminated.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured

Person under the Policyholder's current basic group Life Insurance policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Person.

All other benefits shall be payable to the Insured Person.

EXCLUSIONS

The accident insurance plan does not cover any loss resulting from:

- Suicide or self-inflicted injuries;
- Full-time service in the Armed Forces;
- Declared or undeclared war or any act thereof;
- Injuries received during aircraft travel except for the purposes of transportation where the Member is travelling as a passenger.

Part V

LONG TERM DISABILITY

If a Member becomes Totally Disabled while insured for the Long Term Disability Benefit, the Plan will pay the benefits for which that Member is eligible in accordance with the provisions of this policy.

Classification	Amount
All eligible persons under age 60	\$1,000.00 no CPP offset

2 year own occupation

Integration provision: 85% from all sources

Waiting Period: 26 weeks of Total Disability

Benefit Duration: up to five years or to age 60, whichever occurs first

Please note: The all source maximum benefit entitlement will be determined in accordance with the following formula:

1,000 hours times the basic hourly rate exclusive of overtime or any additional allowances as outlined in the Collective Agreement in force at the onset of disability times 85 percent.

Benefit Payment Waiting Period

A Member must be Totally Disabled for a period of 26 weeks or for the duration of the Weekly Indemnity benefit period, whichever is greater.

If a Member, who has satisfied some but not all of the Benefit Payment Waiting Period, returns to work for a continuous period of 30 days or less and again becomes Disabled as a result of the same sickness or injury, such later Period of Disability will be deemed by the Plan to be a continuation of the previous Period of Disability, however, the Benefit Payment Waiting Period will be extended by the number of days worked by the Member during that period.

Waiver of Premiums

No premium will be charged for this benefit for a Member while Long Term Disability Benefits are payable under this policy.

Calculation of the Monthly Integrated Benefit

The Monthly Integrated Benefit shall be the Monthly Benefit reduced by an amount equal to the sum of any disability or retirement benefits for which the Member is eligible under:

- a. i) the Canada Pension Plan or Quebec Pension Plan; and
- ii) any workers' compensation legislation in Canada; and
- b. any government disability or retirement benefit plans in any other jurisdiction.

However, no Benefit reduction shall be applied until income from all disability related sources exceeds 85% of the Member's gross predisability earnings at onset of disability and only to the extent that the total income exceeds the 85% threshold.

In no event, however, shall the Monthly Integrated Benefit be less than the Minimum Monthly Benefit shown in the Benefit Schedule.

For the purpose of the calculation of the Monthly Integrated Benefit, any lump sum payment received from any source specified in the definition of "Income from All Sources" shall be converted to equivalent monthly amounts for the period to which such payments relate.

Government Source Income Integration Freeze

During any one Period of Disability, any Cost-of-Living increase in disability benefits under a Government Plan will not reduce the amount of the Monthly Integrated Benefit otherwise payable under this policy if the increase is effective after the due date of the first payment to a Member under this benefit.

Time of Payment

Subject to the terms and conditions of this policy, the Long Term Disability Benefit shall be payable one month following the expiration of the Benefit Payment Waiting Period and at the end of each monthly period thereafter.

Taxability Status

The Plan will administer any payments made under this benefit on the basis of the Taxability Status set out in the Benefit Schedule. However, the Plan shall not be responsible for any taxes or penalties levied by any government in connection with such benefit payments and shall not be liable to the Policyholder or any Member or Employer for any such taxes or penalties.

Termination of Monthly Disability Benefit Payments

Monthly Disability benefit payments payable to a Disabled Member shall terminate on the earliest of the date the Member:

1. engages in any occupation for wage or profit, except as allowed by the provisions of this policy;
2. fails to provide written proof satisfactory to the Plan of continuance of Disability;
3. fails to submit to any medical examination by physicians of the Plan's choice;
4. refuses to follow the treatment recommended for his or her disabling condition by a physician whose specialty encompasses such disabling condition;
5. is no longer receiving regular and ongoing care of a physician;
6. refuses to enter into any Rehabilitation Program that is considered to be appropriate by the Plan;
7. fails to agree in writing to reimburse the Plan, following written request to do so, for any amounts owed to the Plan;
8. ceases to be Disabled;
9. dies;
10. starts to draw a Union Pension; or
11. has received benefits for the Maximum Benefit Payment Period as shown in the Policy.

Recurrent Disability

If a Member who has received benefits under the Long Term Disability Benefit of this policy returns to work for a period of 180 days or less and again becomes Disabled as a result of the same sickness or injury,

such later Period of Disability will be deemed by the Plan to be a continuation of the previous Period of Disability. No new Benefit Payment Waiting Period will be required, however, no benefits are payable for any period of such employment.

Extension of Benefit Payments

If a Member's insurance terminates while Disabled, the Plan will continue to pay benefits, provided:

1. the Member is receiving benefits under the Long Term Disability Benefit of this policy, or is completing the Benefit Payment Waiting Period on the date the insurance terminated;
2. the Member was Disabled on the date the insurance terminated;
3. the Member has remained Disabled since the date the insurance terminated; and
4. notice of Disability is given by the Member to the Plan within six months from:
 - a. the commencement date of Disability with respect to a Member who resides in the province of Quebec,
 - b. the termination date of insurance with respect to a Member who resides in a province other than Quebec.

In no event will benefit payments continue beyond any date specified for the termination of benefit payments.

LIMITATIONS

1. The Plan will not pay benefits for any Period of Disability which directly or indirectly results from or is contributed to by a disability due to:
 - a. a self-inflicted sickness or injury caused while sane or insane,
 - b. any act related to insurrection or war or participation in a riot, or
 - c. the Member's commission or attempted commission of any criminal offense (including an offense related to driving a vehicle while under the influence of alcohol).
2. No amount will be paid for any period:
 - a. during which the Member is imprisoned, or
 - b. on formal leave of absence taken by the Member; or
 - c. a Member collects Union Pension benefits.

3. The Plan will not pay benefits for a Period of Disability due to:
 - a. the chronic use of alcohol or drugs (prescribed or otherwise), or
 - b. the use of any hallucinogen,unless the Member is under active treatment and is participating in a medically supervised rehabilitation program. All substance abuse claims will be paid a maximum WI benefit of 6 weeks, provided they are in a rehabilitation centre and remain there for the full course of treatment.
4. No amount will be payable for any Period of Disability which results from or is caused by a condition:

for which the Member was treated or attended by a physician, or for which prescription drugs were taken, during the 3-month period prior to the effective date of insurance,

until the Member has performed all the duties of his or her regular occupation (on a full-time and full-pay basis) for a 12-month period after the effective date of his or her insurance.

Policyholder Subsidy

The Plan will pay an amount equal to 50% of the remuneration of a Member who is actively participating in an approved Rehabilitation Program provided by the Policyholder for the first 3 months of participation in such Program.

The amount paid to the Member by the Plan will be made as Additional Monthly Income, thus reducing the Policyholder's income payments by 50%.

The Plan's subsidy shall apply only once during any period of Disability.

Eligibility for Total Disability Benefits

A Disabled Member will be eligible for Total Disability Benefit payments if:

1. the Member became Totally Disabled while insured for the Total Disability Benefit,
2. the Member's Total Disability has continued for a period in excess of the Benefit Payment Waiting Period shown in the policy, and
3. as a result of the Disability, the Member
 - a. is absent from work,
 - b. incurs a loss of Earnings, and

- c. is not engaged in any occupation for wage or profit, except as specified under the subsection "Rehabilitation Program".

The Member must submit proof of loss satisfactory to the Plan.

Please Note: Members returning to work, must be cleared in writing to do so by their physician.

Rehabilitation Program

If a Member receiving Total Disability Benefits under this policy, participates in a Rehabilitation Program approved by the Plan, he or she shall be eligible for Disability benefits while participating in the program for a period of up to 24 months, or a longer period if deemed advisable by the Plan. The Rehabilitation Program must be supervised by a physician, and is subject to the continued approval of the Plan.

Amount of Benefit

For purposes of the calculation of the Monthly Integrated Benefit, the Monthly Benefit shall be the Insured Amount shown in the Policy.

The Total Disability Benefit amount shall be the Monthly Integrated Benefit reduced by:

1. 50% of the Member's monthly Net (After-Tax) Earnings under an approved Rehabilitation Program; and
2. an amount equal to the amount by which the Member's
 - a. Income from All Sources, plus
 - b. 100% of the Member's monthly Net (After-Tax) Earnings under the Rehabilitation Programexceeds 100% of the Member's monthly Inflation-Indexed, Pre-Disability Net (After-Tax) Earnings.

DEFINITIONS

When used in the provisions of the Long Term Disability Benefit, each of the following terms is limited in meaning to the definition shown.

Claim Anniversary Date

The date 12 months after the first day for which benefits are payable, and each date 12 months thereafter during the same Period of Disability.

Consumer Price Index

The Consumer Price Index published by Statistics Canada.

If the Consumer Price Index is:

- a. no longer available,
- b. no longer published, or
- c. changed so that it no longer reasonably reflects the rate of change in the cost of living,

then the Plan will determine some other appropriate index to use for these calculations and the CPI Factor will be based on such index.

CPI Factor

A ratio calculated annually at the Claim Anniversary Date by dividing the Consumer Price Index at Claim Anniversary Date* by the Consumer Price Index at commencement date* of Disability, but in no event will the CPI Factor be less than 1.

*The Consumer Price Index is published monthly for a period several months in the past. For calculations based on the Consumer Price Index, the index used will be that published for the month four months prior to the date used for calculation. For example, for any date in January, the index used will be that published for the preceding September.

Disability or Disabled

Respectively, Total Disability or Totally Disabled.

Income from All Sources

The sum of any amounts for which the Member is eligible as:

- a. disability or retirement benefits provided under the Canada Pension Plan or Quebec Pension Plan (Primary and Secondary Income benefits);
- b. any salary continuation from the Employer;
- c. any indemnity for loss of time provided under any other group disability plan, including any professional association plan;
- d. any retirement income provided under any retirement or pension plan of any other employer if the income commenced after the commencement date of Disability;
- e. any indemnity for which the Member is eligible under any Employment Insurance Act, Workers' Compensation Law or similar legislation;
- f. any amount paid or payable under any no-fault automobile insurance policy for disability, loss of income, or wage replacement, if permitted by law;

- g. disability benefits paid by the Plan under this policy.

Inflation-Indexed,

Pre-Disability Net (After-Tax) Earnings

Net (After-Tax) Earnings at commencement of Disability times CPI Factor

Net (After-Tax) Earnings

A Member's Earnings, excluding any Federal and Provincial Income Taxes deducted, and non-voluntary pension plan contributions.

Period of Disability

The period of time from and including the date on which a Member becomes Disabled until the Member ceases to be Disabled due to the same sickness or injury.

Primary Income Benefits

Disability income benefits for which a Member is eligible under the Canada Pension Plan or Quebec Pension Plan, whether or not the Member has dependent children.

Rehabilitation Program

A program of job training or work-related activity approved by the Plan designed to facilitate a Disabled Member's return to employment or any other gainful employment for which the Member is or may become qualified.

Secondary Income Benefits

Disability income benefits for which a Member is eligible under the Canada Pension Plan or Quebec Pension Plan, which are in addition to Primary Income Benefits and are provided in respect of the Member's dependent children.

Total Disability or Totally Disabled

A condition, due to sickness or accidental bodily injury, which requires the regular and ongoing care of a legally qualified Physician appropriate to the sickness or injury and as a result of which the Member is not engaged in any occupation for wage or profit and

1. during the Own Occupation Disability Period, is prevented from performing the substantial duties of his or her own occupation;
2. after the Own Occupation Disability Period, is prevented from performing any gainful occupation
 - a. for which the Member is or may become reasonably qualified by training, education, or experience, and

- b. which will enable the Member to earn at least 67% of his or her Inflation-Indexed, Pre-Disability Earnings.

Part VI

WEEKLY INDEMNITY

A Member is eligible for all benefits except Weekly Indemnity after satisfying the normal qualifying conditions of the Plan. A Member does not become eligible for Weekly Indemnity coverage until the first day of the second month after the Member has worked, and the Plan has received contributions, for 1,000 hours of work with a participating employer.

The Weekly Indemnity benefit provides, from the first claim submitted, a maximum of 26 weeks of benefit. Once the 26-week maximum has been reached, either through one claim or a series of shorter claims, the entitlement to benefits thereafter will be limited to a total of 20 weeks. Once the 20-week maximum has been reached, either through one claim or a series of shorter claims, the entitlement to benefits will be limited to a total of 13 weeks. Once a Member has claimed the final 13 weeks (59 weeks total) he/she is no longer eligible for Weekly Indemnity benefits. Maximum number of weeks includes weeks receiving EI medical payments.

How a Claim is made for non-occupational Weekly Indemnity Benefits:

The following steps must be taken as soon as possible after becoming "disabled" (unable to work):

- (a) Obtain an E.I. Claims Kit from a Post Office or the Employment Office.** The physician's report must be completed and a copy sent to the Administration office in order that they may provide the Member with Disability Credits. See the DISABILITY CREDIT section in this booklet.
- (b) If the Member is **not** eligible for E.I. sick benefits, he/she must obtain a claim form from the Administration Office as he/she is entitled to submit a claim to the Ironworkers Weekly Indemnity Plan, provided a copy of the E.I. rejection letter accompanies the claim. ***Claimants must be under the care of a physician and be treated in person during the period claimed for.***

- (c) Complete the front of the claim form.
- (d) The attending physician must complete the Physician's Statement on the back of the same form. If there is any charge for completing this form, it is the claimant's responsibility.
- (e) the claim should be presented within **30 days** unless special circumstances prevent such.

** A Member claiming for a ***non-occupational accident*** may commence benefits from the 1st day of the accident through to recovery or to the maximum weeks of claim, whichever occurs first at \$457.00 per week. However, the Member must make an application to E.I. at the time of the accident in order that benefits would commence with E.I. on the 15th day. The initial 2 weeks would be paid under the Health & Welfare Plan at \$457.00 per week.

On what basis are the Weekly Indemnity Benefits of \$457.00 per week paid?

Claim cheques are mailed to the Member's home address at the end of each 7-day period on the basis of \$65.28 per day up to a maximum of \$457.00 per week, provided the Member is not eligible for E.I. sick benefits, including Saturdays and Sundays. Benefit payment commences on the 1st day of a non-occupational accident or the 15th day of a sickness. If hospitalized prior to the 15th day of disability, benefits commence on the 1st day of hospitalization, provided the Member is not eligible for E.I. sick benefits during that period.

All substance abuse claims will be paid a maximum WI benefit of 6 weeks, provided they are in a rehabilitation centre and remain there for the full course of treatment.

Is it necessary to consult a physician in person before making a claim for Weekly Indemnity Benefits?

Yes. The physician's report is required to establish the record of the Member's inability to work and regular medical attendance will be required for the duration of the claim.

Will further medical reports be required? Yes, depending on the nature of the illness and in addition, it may be required to have an independent medical examination by the Plan's physician.

Members returning to work, must be cleared in writing to do so by their physician.

LIMITATIONS AND EXCLUSIONS

The Plan does not pay weekly benefits for:

- (1) any injury or sickness
 - (a) covered by E.I. sick benefits;
 - (b) covered by any Workers' Compensation or Occupational Disease Law;
 - (c) covered by the Insurance Corporation of British Columbia;
 - (d) arising from or sustained in the course of any occupation or employment for compensation, profit, or gain;
- (2) any pregnancy related illness during a period for which the claimant
 - (a) is entitled to receive benefits from the Employment Insurance Commission; or
 - (b) is entitled to pregnancy leave of absence by reason of Provincial or Federal stature, or any greater period of leave as granted by the employer by way of contract or agreement, verbal or written.
- (3) any Member who is in receipt of Canada Pension Plan Disability benefits.

Part VII DENTAL CARE

Eligible Members and their registered dependents* are entitled to the following Dental services when performed by a dentist:

**Spouse of an Insured Person, and unmarried dependent children to age 21, unless the dependent child is attending a recognized school, college or university on a full-time basis, in which case the maximum age will be 25. A child is not a dependent if he/she is eligible for or entitled to benefits under this Plan as a Member.*

PLAN A Basic Services

The following services are eligible for reimbursement on the lesser of 90% of the amount charged or 90% of the current B.C. College of Dental Surgeons' Fee Guide.

(i) *Diagnostic Services:*

All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required Dental treatment, including:

Recall oral examinations (one during any period of 6 consecutive months for dependent children under the age of 19, one during any period of 9 consecutive months for adults).

Complete oral examination only once every 3 years.

Consultations

X-rays (complete mouth X-ray will be covered only once in a 3-year period).

(ii) *Preventive Services:*

All necessary procedures to prevent the occurrence of oral disease, including:

Scaling and root planing, 16 units per calendar year

Topical application of fluoride (one during any period of 6 consecutive months for dependent children under the age of 19, one during any period of 9 consecutive months for adults).

Fixed space maintainers

(iii) *Surgical Services:*

All necessary procedures for extractions and other surgical procedures normally performed by a dentist.

(iv) *Restorative Services:*

All necessary procedures for filling teeth with amalgam, synthetic porcelain, or plastic; and stainless steel crowns. Gold will be provided as a filling material only when teeth cannot be restored with the above filling materials.

(v) *Prosthetic Repairs:*

All necessary procedures required to repair or reline fixed or removable appliances.

(vi) *Endodontia: (Root Canals)*

All necessary procedures required for pulpal therapy and root canal filling.

(vii) *All necessary procedures for the treatment of tissues supporting the teeth.*

(viii) *General anaesthesia required in relation to oral surgery.*

PLAN B Prosthetic Appliances and Crown and Bridge procedures

The cost of the following items will be eligible for reimbursement on the lesser of 50% of the amount charged or 50% of the B.C. College of Dental Surgeons' Fee Guide.

- (a) Crowns and bridges;
- (b) Partial and/or complete dentures but not more often than once in two years.

Dentures lost, broken or stolen will not be replaced.

Charges made by a licensed denturist will be recognized for payment, in accordance with a separate schedule of allowances.

A maximum payment of \$2,000.00 per calendar year per individual family Member is available for Basic Services and Prosthetic Appliances and Crown and Bridge procedures combined.

PLAN C Orthodontics

50% will be paid by the Plan and 50% by the Member for dependent children to their 19th birthday. Payment of claims to be paid on the basis of eligibility and work completed.

Appliances lost, broken or stolen will not be replaced.

The maximum lifetime benefit for Orthodontic treatment will be \$4,000.00 per patient, applicable to Orthodontia work in progress or that commences on or after May 1, 2008.

Emergency Dental Care Anywhere in the World

In an EMERGENCY if you require Dental Care while you are travelling or on vacation outside of British Columbia you are entitled to the services of a duly qualified dentist and will be reimbursed up to the amount that would have been paid had the service been rendered in British Columbia.

EXCLUSIONS

- (a) Treatment of congenital malformations.
- (b) Cosmetic surgery or dentistry for purely cosmetic reasons.
- (c) Services for treatment of endodontia and periodontia in process at the effective date of coverage.
- (d) Charges for broken appointment.

- (e) Services which are paid for by the Medical Services Plan of British Columbia, Workers' Compensation Board or any tax supported agency.
- (f) Charges for any treatment where it is established that a third party is liable at law to make payment.
- (g) Replacement of an existing denture which, in the opinion of the attending dentist, is or can be made satisfactory.
- (h) Charges in excess of the College of Dental Surgeons of British Columbia Fee Guide.
- (i) Orthodontia, (straightening of teeth, etc.) except for dependent children to their 19th birthday.

How a Claim is Made

1. On the first visit to the dentist advise the receptionist that a completed Dental claim form will be required.
2. Submit the completed form to the Administration Office within 90 days of incurring expense along with the dentist's bill or receipt. Please ensure that the Member's **name, address, Social Insurance Number** and **Local Union** are clearly shown.
3. If the dentist's bill was paid in full then the cheque issued will be payable to the Member. If the dentist's bill was not paid, then the cheque will be payable to the dentist and mailed to him. The Member will be responsible for the difference between the dentist's charge and the amount paid by the Plan.

Part VIII

EXTENDED HEALTH CARE

Eligible Members and their registered dependents* are entitled to the Extended Health Care benefit.

**Spouse of an Insured Person, and unmarried dependent children to age 21, unless the dependent child is attending a recognized school, college or university on a full-time basis, in which case the maximum age will be 25. A child is not a dependent if he/she is eligible for or entitled to benefits under this Plan as a Member.*

What are Extended Health Care benefits?

Extended Health Care is an extension of medical coverage and is designed to protect the Member and his/her dependents against many of the expenses incurred during a period of illness.

Is there a deductible and what percentage is reimbursed?

There isn't a calendar year deductible. All eligible expenses will be reimbursed at 90%.

Covered Expenses

Covered expenses included under the Plan are the charges for the following services and supplies received while insured, for the treatment of non-occupational injuries and diseases.

- (1) Services of a graduate nurse (Licensed vocational nurse where a R.N. is not available) when ordered by the attending physician in the management of an acutely ill patient. Private Duty Nursing coverage is limited to \$25,000.00 per injury or sickness.
- (2) Treatment by a licensed chiropractor, podiatrist, speech therapist*, acupuncturist*, naturopath, clinical psychologist, physiotherapist, masseur*, (operating within the scope of their license), will be reimbursed at 50% up to a maximum of \$400.00 per person per calendar year for each category. Payment of X-ray examinations required up to \$50.00 per calendar year.

*Care or service must be certified as necessary by the attending physician.

- (3) Prescription Drugs - Pay Direct Drug Card Benefit - present your drug card, along with your prescription, to your pharmacist and your prescription drug claim will be instantly adjudicated right at the pharmacy. Using your drug card eliminates the need to send in your prescription receipt and wait for reimbursement. Your Plan provides coverage for drugs and medicines that require a prescription by law and which must be dispensed by a licensed pharmacist.

Smoking cessation products will be covered up to a combined lifetime maximum of \$500.00 per person.

There are a number of prescription drugs which are not eligible under PharmaCare's standard drug formulary, but may be eligible under their Special Authority Program. You may be requested by the Plan to have your doctor apply for Special

Authority for one or more of the drugs you have been prescribed. Should PharmaCare approve the application for Special Authority, such drugs will be applied towards your annual PharmaCare deductible.

Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Vacation supplies of your medications, which are outside of the regular days supply limits, must be preauthorized by the Plan and must be paid for in full by the Member and submitted to the Plan for reimbursement.

PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for Fair PharmaCare call 1-800-387-4977 or visit the Government of BC Website and follow the links to the BC PharmaCare site: www.gov.bc.ca

- (4) Professional ambulance service.
- (5) Initial artificial limbs or eyes required to replace natural limbs or eyes lost while insured. Crutches, splints, oxygen as well as rental of iron lung and durable equipment for therapeutic treatment.
- (6) Dental treatment necessary to repair or alleviate damage to natural teeth resulting from an accident occurring while insured, provided the expense is incurred within two years from the date of such accident.
- (7) Hearing aids for non-occupational conditions only, when prescribed by the attending certified Ear, Nose and Throat Specialist. The maximum benefit during a 5-year period shall not exceed \$400.00 per person and does not include payment for repairs and maintenance, batteries or recharging devices, or other such accessories.
- (8) Custom built Orthotics, prescribed by a medical doctor or podiatrist, are limited to two pair per calendar year to a maximum of \$400.00.
- (9) Custom built Orthopaedic Shoes limited to two pair per calendar year, when needed as a result of a disability incurred while insured for this benefit, to a maximum of \$400.00 per pair.
- (10) Hospital charges for the difference between ward cost and semi-private, or when medically necessary, private accommodations.

- (11) "Routine" eye examinations that are not covered by the Medical Services Plan of BC will be reimbursed at 90% up to a maximum of \$75.00 every 24 months.
- (12) Co-insurance charges of up to \$8.50 per day for those private hospitals approved by the Ministry of Health to a maximum of 30 days confinement for any one period of illness.

Is there a lifetime maximum?

Yes, the lifetime maximum for Extended Health Care expenses, including Out of Canada coverage, is \$1,000,000 for all Members who are less than 80 years old. Upon attaining age 80 and onward, benefits will be limited to \$20,000. At the end of each year up to \$1,500 of this maximum, which has been paid in benefits, will be restored automatically. Benefits in excess of the \$20,000.00 provided by Local 97 Self Insured Extended Health Care Benefits program will be limited to those expenses incurred within 52 weeks of the date of covered injury or sickness.

**OUT-OF-PROVINCE/CANADA
GROUP TRAVEL MEDICAL
EMERGENCY INSURANCE**

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances occurring while you are temporarily travelling outside your province or territory of residence. It is important that you read and understand your Plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provisions of the Policy, the provisions of the Policy shall govern. The Insurer has contracted Global Excel Management Inc. (called "Global Excel") to provide medical assistance and claims services under the **Policy Number 32445234**.

**IN THE EVENT OF AN EMERGENCY, YOU MUST
CALL GLOBAL EXCEL IMMEDIATELY:**

The emergency telephone numbers are listed on the back of the Medical Assistance Card provided.

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the Policy expressly requires the prior approval or authorization of Global Excel, on the basis of the Reasonable and Customary Costs that would have been payable for such expenses by the Insurer in accordance with the terms and conditions of the Policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the Reasonable and Customary Costs reimbursed by the Insurer.

The Policy covers expenses that are:

- incurred outside the province or territory of residence of the Insured Person;
- Medically Necessary;
- Reasonable and Customary Costs;
- incurred as a result of an Emergency due to sudden and unforeseen Sickness and/or injury occurring during the Coverage Period;
- in excess of those covered by the Government Health Insurance Plan or other insurance under which you may have coverage; and
- legally insurable;

subject to the overall maximum of \$1,000,000 per coverage period for each active Member under the age of 80 and his/her eligible dependents.

In the event of an Emergency, the following benefits are payable under the Policy. However, certain expenses, as specified below, are covered only if you obtain the prior approval of Global Excel.

1. **Hospital Accommodation:** Room and board costs up to the semi-private room rate charged by the Hospital. If Medically Necessary, expenses for treatment in an intensive or coronary care unit are also covered. If coverage terminates for any reason during your Hospital stay, benefits continue until discharge, to a maximum of one year. In no case will expenses for In-patient stays be covered for a period greater than 365 days per Insured Person.
2. **Physician Charges:** Charges for treatment by a Physician.
3. **Diagnostic Services:** Laboratory tests and x-rays prescribed by the attending Physician and that are part of the Emergency treatment. The Policy does not cover magnetic resonance imaging (MRI),

cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel.

4. **Paramedical Services:** The services (including x-rays) of a licensed chiropractor, physiotherapist, podiatrist or osteopath, to the maximum specified in the Benefit Summary section of the Schedule of Benefits, per Insured Person, per profession listed above, when approved in advance by Global Excel.
5. **Prescriptions:** Drugs, including injectable drugs, and sera that can only be obtained upon medical prescription, that are prescribed by a Physician and that are supplied by a licensed pharmacist when Medically Necessary for Emergency treatment, except when needed to stabilize a chronic condition or a medical condition which you had before your Trip. This benefit is limited to a 30-day supply per prescription, unless you are hospitalized.
6. **Ambulance Services:** When reasonable and Medically Necessary, licensed ground ambulance service to the nearest medical facility.
7. **Medical Appliances:** When approved in advance by Global Excel, minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and/or the temporary rental of a wheelchair when prescribed by the attending Physician, obtained outside your province or territory of residence and Medically Necessary.
8. **Private Duty Nurse:** The professional services of a registered private nurse, when Medically Necessary and while hospitalized, to the maximum specified in the Benefit Summary section of the Schedule of Benefits, per Insured Person, when approved in advance by Global Excel.
9. **Emergency Air Transportation:** When approved and arranged in advance by Global Excel:
 - a) air ambulance to the nearest appropriate medical facility or to a Canadian Hospital for immediate Emergency treatment;
 - b) transport on a licensed airline with an attendant (where required) to return you to your province or territory of residence for immediate Emergency treatment.
10. **Transportation to Bedside:** When approved in advance by Global Excel, a single round-trip economy airfare from Canada plus up to the amounts specified in the Benefit Summary section

of Schedule of Benefits for the cost of meals and commercial accommodation for one of the following: Spouse, parent, child, brother, sister or business partner, to:

- a) be with you if you are travelling alone and have been hospitalized as the result of an Emergency. To be payable, this benefit requires that you eventually be hospitalized as an In-patient for at least three (3) consecutive days outside your province or territory of residence and that the attending Physician provide written certification that the situation was serious enough to warrant the visit; or
- b) identify the deceased Insured Person prior to the release of the body, where necessary.

The Insurer will only reimburse covered expenses evidenced by original receipts.

11. **Return of Travelling Companion:** If you are returned to your province or territory of residence under the Emergency Air Transportation benefit or the Return of Deceased benefit, the Insurer will reimburse the cost of a single one-way economy airfare for a travelling companion to return to Canada, when approved in advance by Global Excel.
12. **Treatment of Dental Accidents:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits per Insured Person for Emergency dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth, provided the Injury was caused by an external, accidental blow to the mouth or face. You must consult a Physician or dentist immediately following the Injury. Treatment must begin during the Coverage Period and be completed prior to returning to your province or territory of residence. An accident report is required from a Physician or dentist for Claims purposes.
13. **Meals and Accommodation:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits per Participant, for the cost of commercial accommodation and meals for the Participant and/or any of his/her Dependents when their Trip is extended beyond the last day of the scheduled Trip due to the Sickness and/or Injury suffered by an Insured Person. This benefit must be authorized in advance by Global Excel. The fact that you are unable to travel must be certified by the attending Physician and supported with original receipts from commercial organizations.

14. **Vehicle Return** To the maximum specified in the Benefit Summary section of the Schedule of Benefits if neither you, nor someone travelling with you, are able to operate your Vehicle, whether owned or rented, during your Trip due to Sickness and/or injury. Arrangements and payment will be made for the return of the Vehicle to your home in your province or territory of residence or the nearest appropriate rental agency. Benefits will only be payable for a single person to return the Vehicle when approved and/or arranged in advance by Global Excel. This benefit does not cover wages lost by the person driving your Vehicle. The Insurer will only reimburse covered expenses evidenced by original receipts.

15. **Return of Deceased:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits towards the cost or preparation and transportation of the deceased Insured Person to their province or territory of residence in the event of death due to Sickness and/or Injury.

In the case of cremation and/or burial at the place of death of the Insured Person, this benefit is limited to \$2,500.

The cost of the casket or urn is not covered.

16. **Incidental Expenses:** To the maximum specified in the Benefit Summary section of the Schedule of Benefits for your out-of-pocket expenses such as telephone charges, television rental and parking while you are hospitalized for an Emergency and the expenses are incurred as a direct result of such hospitalization. The Insurer will only reimburse covered expenses evidenced by original receipts.

Notice and Proof of Claim

In the event that Global Excel is not contacted immediately, the Insured Person, or a beneficiary entitled to make a claim, or the agent of any of them, shall:

- a) give written notice of claim by delivery thereof or by sending it by registered mail to Global Excel not later than thirty (30) days from the date the claim arises under the Policy;
- b) within ninety (90) days from the date a claim arises under the Policy, furnish Global Excel such proof of claim as is reasonably possible in the circumstances of the Emergency giving rise to the claim and the loss occasioned thereby, the right of the claimant to receive payment, his age and the age of the beneficiary, if relevant; and

- c) if required by Global Excel, provide a satisfactory certificate stating the cause for which the claim is made and the duration of the disability, if applicable.

Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the prescribed period above does not invalidate the claim if the notice or proof is given or furnished as soon as is reasonably possible, in no event later than one (1) year from the date of Injury or the date a claim arises under the Policy on account of Sickness if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Insurer to Furnish Forms For Proof of Claim

Global Excel, on behalf of the Insurer, shall furnish forms for proof of claim within fifteen (15) days after receiving notice of claim, but where the claimant has not received the forms within that time he may submit his proof of claim in the form of a written statement of the cause or nature of the Emergency giving rise to the claim.

Claims Procedures

You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim, you must:

- a) include the Policy number, the patient's name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
- b) submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or Physician;
- c) provide the original prescription drug receipts (not cash receipts) from the pharmacist, Physician or Hospital showing the name of the prescribing Physician, prescription number, name of preparation, date, quantity and total cost;
- d) provide proof of the departure date(s) and return date(s);
- e) provide written proof of claim within ninety (90) days of the date of receipt of services covered under the Policy;
- f) provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;

- g) sign and return the authorization form, provided by Global Excel, allowing the insurer to recover payment from the Canadian provincial or territorial Government Health Insurance Plan. The Insurer will coordinate and pay your claim to the participating medical providers and where permitted, coordinate claims directly with the Canadian provincial or territorial Government Health Insurance Plan on your behalf; and
- h) return the unused portion of your air ticket to Global Excel if the Emergency Air Transportation benefit is used.

All amounts in the plan are in Canadian currency unless otherwise indicated. If you have paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Any information not provided may result in a delay in processing Your claim.

All pertinent documents should be sent to:



Global Excel®

®The Global Excel logo is a registered trademark of Global Excel Management Inc.

Global Excel Management Inc.
73 Queen St.
Sherbrooke, Quebec
J1M 1J3

Tel.: 1-866-870-1898 (toll free) or (819) 566-1898 (collect) during business hours (EST).

EXCLUSIONS AND LIMITATIONS

The Extended Health Care benefit does not cover incurred expenses for, contributed to, or caused by:

- (a) the failure of any person to make claim for and receive benefits within the time and in the manner prescribed under or pursuant to the Basic Medical Plan to which you are entitled.
- (b) The expense of a physician and/or surgeon except as described under “Out-of-Province/Canada Group Travel Medical Emergency Insurance” for emergency treatment while travelling outside British Columbia and is limited thereby.
- (c) war or act of war or participation in a riot or civil insurrection.
- (d) suicide or any attempt thereof.
- (e) orthoptic treatment and refractions.
- (f) Dental services except as set out in (6) of “Covered Expenses.”

- (g) any portion of a specialist's fee not allowable under the Basic Medical Plan due to non-referral, or any amount of fees charged by any practitioner in excess of the recognized fees for such service.
- (h) services which are eligible for payment by the Medical Services Plan of British Columbia, Workers' Compensation Board or any tax supported agency, without cost or at nominal cost by public authorities.
- (i) services and supplies for cosmetic reasons.
- (j) expenses incurred outside the Province, on an elective basis. Service will only be allowable for an unexpected illness or injury while the Insured Person is temporarily visiting outside the Province.
- (k) eligible expenses must be submitted to the Administration Office during the calendar year following the year in which expenses were incurred.

Part IX VISION CARE

Eligible Members and their registered dependents* are entitled to the Vision Care benefit.

**Spouse of an Insured Person, and unmarried dependent children to age 21, unless the dependent child is attending a recognized school, college or university on a full-time basis, in which case the maximum age will be 25. A child is not a dependent if he/she is eligible for or entitled to benefits under this Plan as a Member.*

Covered Expenses

The following expenses shall be eligible for reimbursement:

1. Single vision, bifocal or trifocal lenses, prescribed by a person legally qualified to make such prescription;
2. Frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable;
3. Contact lenses prescribed by a person legally qualified to make such prescription.
4. For Members only, Laser Eye Surgery will be reimbursed in installments of up to \$300.00 every 24 consecutive months, up to a maximum of \$1,200.00.

EXCLUSIONS

The cost of the following items are excluded from this Plan:

- (a) Safety goggles, sun glasses (plain or prescription).
- (b) Replacement of lost, stolen or broken lenses or frames.

Payment of Expenses

The maximum amount payable during any period of 24 consecutive months shall be 100% of the actual expense incurred or \$300.00, whichever is the lesser for an eligible adult. A maximum amount of \$200.00 payable during any period of 12 months for an eligible dependent to age 19.

How a Claim is Made

Submit eligible claims within 90 days of incurring the expense. Please follow directions outlined on the reverse side of the Extended Health Care Benefit claim form, which is available through the Administration Office or the Plan website.

Part X

TRANSPORTATION ASSISTANCE

Eligibility

Any person who is covered under the Local 97 Ironworkers Health & Welfare Plan will be entitled to submit transportation expenses for him/herself or for an eligible dependent. (Eligible dependent is defined as one who is covered by the Local 97 Ironworkers Health & Welfare Plan.)

Covered Expenses

The following expenses shall be eligible for reimbursement:

The actual cost of transportation, up to a maximum of 75% of the amount equal to the round trip commercial economy class airfare for transportation within British Columbia or Alberta or the Yukon Territory from the commercial airport nearest to the Member's residence in British Columbia where regularly scheduled airlines depart from to the commercial airport located nearest to the facility recommended by the patient's physician where treatment, diagnostic tests or examination takes place. Within each calendar year no more than six (6) trips will be eligible for reimbursement. If, on the physician's recommendation, the patient requires an

accompanying person, payment shall be made on the basis of 50% of the airfare subject to the conditions as outlined, but only if air transportation is involved.

Lodging

In conjunction with transportation charges, lodging expenses up to a maximum of 30 days in a calendar year at a rate not to exceed \$30.00 per day, for a patient receiving treatment outside their area of residence, on presentation of the appropriate medical documentation and receipts, will be recovered.

EXCLUSIONS

The following are excluded from payment:

- (a) The cost of transportation from the patient's home to the nearest airport from which regular scheduled airlines depart.
- (b) The cost of transportation from the airport at the city of destination to the place where treatment, examination or tests take place.
- (c) Any accident or sickness which is the responsibility of the Workers' Compensation Board, Insurance Corporation of British Columbia or any other third party.
- (d) Any journey where the round trip is less than 150 miles.
- (e) Treatment for services not medically required.

How a Claim is Made

- (1) The attending physician must complete a form confirming the diagnosis, the facility or name of physician who will see the patient and the date and time of appointment, also if the patient requires an accompanying person.
- (2) The physician who renders the treatment, examination or test will complete a form confirming the visit(s).
- (3) Payment of expenses will be made directly to the Member, subject to receipt of the applicable forms.
- (4) Should the patient be transported by car or bus, reimbursement will be 75% of the actual cost.

FOR FURTHER INFORMATION

**For information about your claims or eligibility
or benefits — call or write**

LOCAL 97 IRONWORKERS HEALTH & WELFARE PLAN

**101 - 4190 Lougheed Highway
Burnaby, BC V5C 6A8**

Telephone (604) 299-7482

Toll Free 1-800-663-1356

Email: ironworkershw@datownley.com

www.ironbenefits.org

CHANGE OF ADDRESS

Please advise the Administration Office of any
change of address.

Include all information shown below.



MAILING INSTRUCTIONS

When writing the Administrator, be sure to include
in your letter the following information:

- (a) Your name (clearly written).
- (b) Your residence address.
- (c) Your Social Insurance Number.
- (d) Your telephone number.
- (e) Local Union.