BOILERMAKERS LODGE 359
HEALTH AND WELFARE PLAN
for
FIELD MEMBERS

Current as at:
April 1, 2012

PRIVACY POLICY

The Health and Welfare Fund will collect, maintain and communicate only the personal information considered necessary for the effective administration of the Fund and the Health and Welfare Plan. Personal information includes your Social Insurance Number, your work history, names of your dependents, etc. It also includes health information, such as medical or dental information, provided for claims submitted under the Benefit Plans.

Completion of a Member Information Card, and Claim Form, constitutes your express consent for the use of your information for the effective administration for the Fund and Plan. Please note that if you do not consent to the use of your personal information, or terminate such consent at any time, the Administrator may not be able to provide you with a benefit or service under the Fund or Plan.

Personal information will be protected pursuant to the relevant privacy legislation. The Fund and Plan may use and exchange information with relevant persons or organizations (unions, health professionals, institutions, investigative agencies, insurers, re-insurers, regulators) in order to manage the Fund and Plan and your entitlement to the Benefits under the Plan.

Members will have reasonable access to their personal information retained by the Fund and Plans. You must send a written request to the Administrator detailing the information you want to review in this regard. If any of the personal information kept is determined to be inaccurate or incomplete, it will be reviewed and any necessary corrections made.

Questions related to the Privacy Policy of the Fund and Plans should be directed to:

Boilermakers Lodge 359 Health & Welfare Plan
c/o Bilsland Griffith Benefit Administrators
#501 – 4445 Lougheed Hwy., Burnaby, BC V5C 0E4
Phone (Toll Free) 1-877-926-4537
Fax: (604) 433-8894
Email: boilermakers359@bgbenefitsadmin.com

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INTRODUCTION

This Booklet has been prepared to give you an informal summary of the benefits provided under the Boilermakers Lodge 359 Health and Welfare Plan as of *April 1, 2012.*

In the pages which follow, you will find a brief description of the Benefits to which you and your family are entitled. You will also find the rules covering eligibility for Benefits and the procedure that should be followed when you make a Claim. The final determination of any Claim, question or problem which may arise will be governed by the Trust Agreement, the Plan Text and the Insurance Policies. These documents are available at the Administrator's Office for review upon advance request.

If you are in any doubt about whether an expense will be covered under your Plan, please contact the Administrator. If you disagree with the payment of any Claim, notify the Administrator in writing why you disagree and your Claim will be reviewed.

We urge you to review this Booklet carefully so you understand the benefits available under the Boilermakers Lodge 359 Health and Welfare Plan. Should you have any questions regarding your Benefits, do not hesitate to contact the Administrator, who will be pleased to assist you.

The Trustees hope that their efforts in developing a sound program of protection for Members and their families will be of real value to you. We welcome your comments at any time.

Yours sincerely,

The Board of Trustees

For a current list of Trustees, please contact the Administrator.

THE HISTORY OF YOUR PLAN

Since September 1967, Employers who are parties to Collective Agreements with the International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers, Lodge 359 have been contributing to the **Boilermakers Lodge 359 Health and Welfare Fund**. This Fund provides Benefits for eligible Union Members and their eligible Dependents.

The Health and Welfare Fund and Plan are managed by a Board of Trustees appointed by the Union. The duties, responsibilities and authority of the Trustees are set out in a Trust Agreement. The duty of each Trustee is to represent the beneficiaries of the Plan – the Members and their Families.

Over the years your Benefit Plan has been continually revised and updated to reflect the changing needs of the Members and their Families. Some of the Plan's benefits are insured, while some of the Plan's benefits are funded solely by the assets of the Health and Welfare Fund.

The Board of Trustees is responsible for managing the Fund and Plan of Benefits, and deciding what benefits can be provided based on the contributions of Active Members and the financial position of the Fund. ***The Trustees reserve the right to make changes to the Benefit Plan at any time so that the Plan conforms to the available funding and any legislative or regulatory requirements.***

The Trustees have appointed an Administrator, Bilsland Griffith Benefit Administrators Inc., to attend to the day-to-day administration of the Fund and Plan. The Administrator operates under the overall direction of the Board of Trustees.

The Administrator's contact information is as follows:

Bilsland Griffith Benefit Administrators
#501 – 4445 Lougheed Hwy., Burnaby, BC V5C 0E4
Toll Free 1-877-926-4537
Fax (604)433-8894
boilermakers359@bgbenefitsadmin.com

ACTIVE FIELD MEMBERS

SUMMARY OF BENEFITS FOR ACTIVE FIELD MEMBERS

Benefit	Benefit Amount	See Page #
Dental Care Plan	as described	17
Medical Services Plan Of BC	Premium	21
Extended Health Care	as described	22
Vision Care	as described	29
Employee Assistance Program	as described	31
Weekly Indemnity	Employment Insurance Weekly Maximum; Integrated with EI	34
Long Term Disability	75% of gross earnings; Maximum $1,500/month	37
Group Term Life Insurance	$75,000	44
Accidental Death & Dismemberment	$75,000 Principal Sum	47
Out-of-Province/Canada Travel Medical Emergency Insurance	as described	74

GENERAL INFORMATION

Who is eligible?

A Field Member in Good Standing with Lodge 359 of The International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers who meets the Hour Bank requirements.

An individual who is not a Member of Lodge 359 but who is working under a Lodge 359 Collective Agreement is also eligible subject to the regulations set out below.

Are dependents eligible?

Eligible dependents include:

- Your Spouse, defined as the Member's legal or common-law spouse defined as a person of the same or opposite sex who has been residing with the Member continuously for a period of at least one year and has been publicly represented as the Member's spouse in the community in which they reside.
- Your natural or legally adopted child; or step-child or other child under 21 years of age dependent on you for support and living with you in a regular parent-child relationship,
- The age limitation of 21 may be increased up to age 25:
    - If the dependent child is registered as a full time student at an accredited college or university and if such attendance is confirmed in writing;
    - If the dependent child is totally disabled, unmarried, and unemployed or if they are dependent on the eligible Member for financial support by reason of mental or physical disability and are totally and continuously disabled, subject to the provision of evidence supporting the total disability.

Note: Under the Medical Services Plan of BC, a child ceases to qualify as a dependent at the end of the month in which he attains **age 19**. Coverage may extend up to age 25 if in full time attendance at an accredited post-secondary school.

Do any enrollment forms have to be completed?

YES. You must complete a:

- ✓ Member Information Card, *and*
- ✓ Medical Services Plan of BC enrollment form

You can obtain these documents from the Plan Administrator.

How do I qualify for coverage?

Participating employers remit contributions to the Fund on your behalf by the 15th of the month following the month worked. These contributions are accumulated in your Hour Bank account by the Administrator. You will initially qualify for coverage as follows:

1. **A Field Member in Good Standing of Lodge 359** must accumulate ***123* Hours** of work within three (3) consecutive months. Coverage will commence on the first day of the second month following the accumulation of *123* Hours in your Hour Bank. For example:

Work Month	Hours Worked:	Hours Remitted by:	Coverage Eligibility Effective:
January	50	Feb. 15th	
February	60	March 15th	
March	70	April 15th	
Total hours: 180 hours			May 1st

2. **A person who is not a Member of Lodge 359** (e.g. Permit Worker) must accumulate *246* Hours of work within three consecutive months. Coverage will commence on the first day of the second month following the accumulation of ***246* Hours** in your Hour Bank. For example:

Work Month	Hours Worked:	Hours Remitted by:	Coverage Eligibility Effective:
January	60	Feb. 15th	
February	60	March 15th	
March	65	April 15th	
April	65	May 15th	
Total hours: 250 hours			June 1st

3. **Apprentices: The first month's coverage is provided at no cost to the Apprentice; the cost is 100% subsidized by the Fund.** The first month's coverage includes all benefits, *except Weekly Indemnity and Long Term Disability*, retroactive to the first day of the calendar month in which the Union Initiation Fee is paid. **After the first coverage month**, an Apprentice has the option to self-pay to continue coverage (see "Self Pay" section). An Apprentice will be eligible for Weekly Indemnity and Long Term Disability coverage effective with the date of dispatch for work.

   Apprentices Enrolled in an Upgrading Course:

   In the event that an Apprentice's Hour Bank Account balance is reduced to 400 Hours or less while enrolled in an Upgrading Course, *the cost of ongoing benefit coverage is subsidized 100% by the Fund* until completion of the Upgrading Course.

How does my Hour Bank provide for future coverage?

Once you meet the initial eligibility requirements, additional Hours remitted by Contributing Employers on your behalf are accumulated in your Hour Bank. To maintain your coverage, *123* Hours will be withdrawn each month from your Hour Bank.

You can accumulate Hours in your Hour Bank to provide you with coverage for **up to 16 months**. Any amounts accumulated in your Hour Bank in excess of the 16 month maximum are credited to the general reserves of the Fund.

When does my coverage end?

Coverage will end when there are insufficient Hours in your Hour Bank to allow for the required monthly deduction of *123* Hours. At this time, a Member may continue their coverage by exercising the Self-Pay Option (see next section).

How Do I Maintain My Coverage

A) *Self-Pay Option - Active Field Members*

When your Hour Bank balance is insufficient to continue your coverage, the Administrator will mail you a Self-Pay Notice indicating the coverage options, self-payment amounts and payment due date. *Your self-payment must be returned to the Administrator's office by the due date.* ***Late payments are not allowed***. If your self-payment is received by the due date, subsequent Self-Pay Notices will be sent to you on a monthly basis. If you receive a Self-Pay Notice it is important that you act on it immediately.

If you think you should have enough Hours to be covered, call the Administrator immediately upon receiving a Self-Pay notice. It is your responsibility to make sure that you are covered for benefits.

SELF PAY MONTHLY RATES (subject to future changes)

	Rates at 01/01/2012
Option "A"	$167.00
Option "B"	$135.00
Unsubsidized Option "A"	$380.00
Unsubsidized Option "B"	$310.00

As a reminder, Option "A" above includes dental coverage. Option "B" does not include dental coverage.

Notes:

- You must be and remain a Member in Good Standing with the Union to be eligible to self-pay.
- The Self-Pay Options are not applicable to Permit Workers.

IMPORTANT: There are various levels of cost subsidization provided by the Fund to the Active and Disabled Member self-pay rates. Since the ability of the Fund to provide these subsidies is based on its financial position, these subsidies are not guaranteed indefinitely. The subsidy policies are subject to change at any time by the Board of Trustees.

1) **For the first month** in which an Active Field Member's Hour Bank falls below *123* Hours, but contains a minimum of *83* Hours, a Field Member's Benefit coverage is maintained by the Fund *for this first month only*.

   Note: 100% of the cost of this one month's coverage is paid out of the Fund's surplus; the level of this subsidy is subject to change by the Board of Trustees based on the financial position of the Fund.

2) **Following the first month**, a Field Member has the option to self-pay to maintain coverage for a maximum of three (3) consecutive months at reduced rates due to the Fund subsidizing a portion of the cost.

3) **Commencing with the fourth month**:

   A Field Member who is not gainfully employed has the option to continue to self-pay for up to *nine (9) consecutive months at the subsidized rate **subject to a signed declaration stating that the Member was not gainfully employed** during the work month associated with the benefit coverage month.

   *This **subsidized self-payment may *continue for a maximum of nine (9) months*** self-payment (a total of twelve months maximum including the first, second and third self-pay months) as long as you meet the eligibility criteria each month.

   A Field Member who is gainfully employed outside the jurisdiction of Lodge 359 may continue to self-pay at 100% of the cost of benefits (i.e. no rate subsidy is applicable) for up to nine (9) consecutive months (a total of twelve months maximum including the first, second and third self-pay months).

   After the twelve consecutive month self-pay maximum has been reached, any successive periods of self-payment must be separated by a minimum of *369* Hours worked for a participating Employer(s).

B) *Disabled Members*

1. **Subsidized Credits:**

Disabled Members in Receipt of **Weekly Indemnity (WI), WorkSafe BC (WCB) or EI sickness benefits**, are eligible to receive credits, subsidized 100% by the Fund, to continue coverage as follows:

For each working day that you are disabled and provided your **Weekly Indemnity (WI) claim** has been accepted for payment, your Hour Bank will automatically be **credited with eight hours per day subject to a maximum of *123 Hours per month***. Disability Credits for Health & Welfare benefits are provided for a maximum of twelve consecutive months for any one injury.

If you are totally disabled and receiving **WorkSafe BC (WCB) disability benefits**, **or EI sickness benefits**, you must *forward to the Administrator your WorkSafe BC or EI payment stubs to support your entitlement to Health & Welfare Disability Credits. Disability Credits of 123 Hours per month for Health & Welfare benefits are **provided for a maximum period of twelve consecutive months** for any one injury.*

To qualify for these Disability Credits, you must be eligible for benefits under the rules of the Plan when the disability commences. *Note: Pension Disability Credits are provided to Field Members at a rate of 350 Hours per year and are available for the duration of your WorkSafe BC (WCB) claim – refer to your Pension Plan booklet.*

2. **Self-Pay Option:**

If you are totally disabled and have received the *maximum* disability credits as described above, and you continue to be totally disabled **and in receipt of WorkSafe BC (WCB) disability or Long Term**

Disability (LTD) benefits, you have the option to self-pay to continue coverage.

The self-pay rate for Disabled Members is a reduced rate due to the Fund subsidizing a portion of the cost, which is subject to change by the Board of Trustees. The Administrator will mail you a Self-Pay Notice indicating the self-payment amounts and payment due date. You may self-pay under the Disabled Member category as long as you are in receipt of WorkSafe BC (WCB) disability or LTD benefits.

Coverage for Dependents of a Deceased Member

Upon the death of an **Active Field Member**, any eligible dependents covered at the member's death will be entitled to self-pay, at the prevailing self-pay rate, to continue Health/Dental coverage and the MSP Premium, for up to a maximum of **twelve** consecutive months after the member's death. Note: the Member's Hour Bank account balance, if any, will be applied towards the provision of this 12 month coverage maximum.

Are there any Reciprocal Agreements with other Boilermaker Locals?

YES. If a Field Member of Lodge 359 is working under another construction Local of the International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers, which participates in the Boilermakers National Health and Welfare Fund, it is mandatory that the Member have his contributions earned under that Local's collective agreement reciprocated to the Boilermakers Lodge 359 Health and Welfare Fund.

The Board of Trustees also maintains Reciprocal Agreements with various other union benefit funds in Canada. The Member must complete a "Reciprocity Authorization Form" which is available from the office of the Administrator or the Local Union. Contact the Administrator for further details.

What if I work for a Boilermakers' Shop Employer?

Upon the Administrator receiving notification from the Shop Employer, your Hour Bank can be "frozen" while you are covered under the Shop Plan. Monthly deductions to maintain coverage under this Plan are suspended. Your *Hour Bank can be frozen for up to a maximum of twelve consecutive months*, after which the account balance is forfeited and applied to the general reserves of the Fund.

Are any benefits taxable?

YES. The premium paid by the Plan for your **Life Insurance** and **MSP** premium is a taxable benefit. Any benefit payment you receive from the **Weekly Indemnity and Long Term Disability Plans** are also taxable.

The Administrator will send you a T4A tax form every year if you were in receipt of any taxable benefits.

The Insurer will send a T4A to Members who received Disability benefits.

What if my Personal Information Changes?

Notify the Administrator immediately if your address changes.

If there are changes to your eligible dependents, or your marital status, you must complete a new Member Information Card and send it to the Administrator.

Beneficiary Designation for Life Insurance

When you first complete a Member Information Card you must designate a beneficiary for Life Insurance under the Plan. Also, if you wish to change your beneficiary designation for Life Insurance at any time, you must complete a new Member Information Card and send it to the Administrator.

Naming a beneficiary is important for your Life Insurance. Your beneficiary is the person(s) designated by you to receive benefits in the event of your death. If your designated beneficiary dies before you, that beneficiary's interest will end. If there is no living beneficiary on the date of your death, the benefit is payable to your Estate.

If you appoint a person under age 18 as your beneficiary, you should also appoint a Trustee to receive the benefit and to act on the child's behalf, otherwise a Public Trustee will be assigned by the Courts.

What if I disagree with how my Claim was paid?

Claims are paid based on the Plan Rules. However, you always have the right to appeal if you do not agree with a Claim payment. To do so, send your written appeal to the Administrator. If your appeal is for payment outside of the Plan rules, your appeal will be presented to the Board of Trustees for consideration at their next meeting.

FILING A CLAIM
EXTENDED HEALTH & DENTAL BENEFITS

Claim Forms are available from the Administrator's office.

Make sure that your NAME, ADDRESS and SOCIAL INSURANCE NUMBER, are clearly shown. The Plan Member or their Spouse is authorized to sign the Claim Form (a dependent child cannot sign the Claim Form).

Send your completed Claim Form, along with original receipts/prescriptions, to Multi Employer Benefit Services (MEBS) #302 – 3602 Gilmore Way, Burnaby, BC V5G 4W9. Do not fax your Claim Form – the original is required.

Never sign a blank Claim Form before or after visiting a health care provider. The Claim Form should always be fully completed before you sign it. If you are not sure you have received treatment for what is being billed, ask the provider for an explanation before you sign. Remember, your signature is the Plan's assurance that the services charged were actually received.

As a responsible Plan Member, you play a role in controlling the cost of benefits provided by your Plan. If costs are controlled, benefits can be continued or even enhanced.

Dental claims - the patient receiving the dental services must sign the Claim Form. The Plan's payment is payable to the Member, unless you have assigned benefits to your dentist, in which case the Plan's payment will be payable to the dentist. You will be responsible for any difference between the dentist's charge and the amount paid by the Plan.

Important: The time deadlines for filing a claim with the Administrator are as follows:

Benefit	Deadline for Filing a Claim
Extended Health Care - includes Vision Care (Claims less than $25,000)	18 months after the date of expense
Extended Health Care (Claims over $25,000)	12 months after the date of the injury or commencement of the sickness
Dental Benefits	18 months after the date of expense
Out of Province/Canada Travel Medical Emergency Insurance	See pages 91-93.

Note: If your coverage terminates, claims for Dental, Extended Health and Vision Care benefits must be filed **within 6 months** of the date your coverage ceased.

COORDINATION OF BENEFITS – EXTENDED HEALTH & DENTAL BENEFIT CLAIMS

The Canadian life and health insurance industry has a policy which details coordination of benefits rules. Your Health and Welfare Plan follows these rules.

The Claim filing procedure, agreed to by Canadian health insurers and benefit plans, is as follows:

- If the Claim was incurred by you, file the Claim first with this Plan. If there is an unpaid balance then file the Claim with your Spouse's Plan.
- If your Spouse incurs the Claim, file the Claim first with your Spouse's Plan. Then file with this Plan if there is an unpaid

balance. If your Spouse does not have a benefit plan then file the Claim with this Plan.

- If one of your children incurs the Claim, first submit the Claim to the Plan that covers the Spouse who has the earlier birthday in the calendar year. If your Spouse does not have a benefit plan then file the Claim with this Plan.
- If you and your Spouse are both Members of this Plan, attach a Note to your Claim, giving your Spouse's name and Social Insurance Number.

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

DENTAL CARE PLAN

Eligibility

All eligible Members and their eligible dependents.

Fee Guide

Payment is based on the current fee guide of the College of Dental Surgeons of the Province of British Columbia.

Percentage Payable

Basic Services:	100%
Major Services:	70%
Orthodontics (Dependent Children only)	50%

Calendar Year Benefit Maximum

Basic and Major Services Combined: $2,000 maximum per calendar year, per covered individual.

Orthodontic treatment: $2,000 lifetime maximum per covered eligible Dependent Child under the age of 19.

Important Note:

Where a proposed course of dental treatment will exceed $500.00, a treatment plan detailing the proposed treatment details and providing x-rays, should be sent by your dentist to the Administrator BEFORE the treatment starts. The Administrator will then notify you in writing of the services and fees covered by the Plan. This is strongly recommended so that you and your dentist know the amount covered before the treatment is started, and you are aware of any out-of-pocket expenses you may be required to pay.

Basic Services

Coverage includes all necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, and necessary procedures to prevent the occurrence of oral disease including:

- Oral examinations (2 per calendar year);
- Consultations;
- X-Rays: Complete mouth X-Rays are covered once every three years;
- Cleaning and scaling *(12 units combined per calendar year);*
- Prophylaxis and topical application of fluoride (twice per calendar year);
- Extractions;
- Fixed space maintainers;
- Periodontic treatment for disease of the bone and gums of the mouth, including tissue grafts and occusal guards (but not athletic guards);
- Endodontic treatment, including root canal therapy;
- Restorative Treatments: All necessary procedures for filling teeth with amalgam (non-bonded amalgams only), 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. White fillings are covered for front and molar teeth;
- All necessary procedures required to repair or reline or rebase fixed or removable appliances;
- Repair, resurfacing or recementing crowns, inlays, onlays or bridges;

Major Services:
Prosthetic Appliances, Crowns & Bridges

1. **Crowns and bridges.** Replacements, but only if initial placement was installed for at least 5 years and cannot be made serviceable.
2. **Partial, and/or complete dentures.** These costs are payable but no more frequently than once in 5 years and only if (a) such replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth, or (b) the denture is a stay plate or a similar partial denture, and is being replaced by a permanent denture, or (c) the denture, while in the oral cavity, has been damaged beyond repair as a result of injury while covered.
3. **Charges made by a licensed Denturist** will be recognized for payment, in accordance with a separate Schedule of Allowances.

Orthodontics

Orthodontic coverage is **for eligible dependent children only.**

Orthodontic Claims are eligible for payment only if the treatment commences after the Member has been eligible for coverage and in Good Standing for a minimum period of 12 consecutive months with Lodge 359.

Eligible expenses include:

- Diagnostic procedures, including models;
- Therapy and appliances; and
- Correction of malocclusion.

Emergency Dental Care

If you require emergency dental care while you are traveling or on vacation outside of British Columbia, you are entitled to the services of a duly qualified dentist. These services will be covered as if the service had been provided in British Columbia.

Ineligible Expenses:

a) Correction of congenital malformations;

b) Cosmetic surgery or dentistry for purely cosmetic reasons;

c) Services for treatment of endodontia and periodontal in process at the effective date of your coverage;

d) Charges for broken appointments, completion of claim forms, specialist fees;

e) Services which are eligible for payment by the Medical Services Plan of BC, WorkSafe BC (WCB), Insurance Corporation of British Columbia, 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 for a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;

i) Charges for implantology and services related to implants;

j) Stainless steel crowns on permanent teeth;

k) Protective athletic appliances;

l) Replacement of lost, broken or stolen dentures;

m) Orthodontic treatment or correction of malocculusions, except as specifically provided under “Orthodontics”.

MEDICAL SERVICES PLAN OF BC (MSP) - PREMIUMS

Premiums will be paid on your behalf (and on behalf of any eligible dependents) to the Medical Services Plan of BC on a monthly basis whenever your Hour Bank account is sufficient to provide you with coverage under the Health and Welfare Plan, and provided you or your dependent qualifies for enrolment under Medical Services Plan of BC Rules and Regulations.

You will be required to complete and submit a MSP enrollment form to the Administrator.

Notes:

- If you have coverage under another employer's group plan (eg. your Spouse's employer's plan), it is important that you notify the Administrator to avoid duplicate premium payments by the Plan, and double premium taxation.

- If you or your Spouse has paid an individual MSP premium which is for the same time period that this Plan has paid a premium on your behalf, MSP will refund the premium overpayment to you.

Further information on the Medical Services Plan of BC is available on the Internet: www.health.gov.bc.ca/msp

Please note that dependent status for children ceases at age 19 for the MSP Plan only (or up to age 25 if the dependent child is enrolled in full-time attendance at an approved institution of learning).

EXTENDED HEALTH CARE

Your Health and Welfare Plan's Extended Health Care benefit is an extension of the coverage you receive from the *Medical Services Plan of BC (MSP) or other* Provincial Medical coverage. It is designed to provide additional benefit coverage for you, and your eligible dependents.

Reimbursement

There is no deductible to satisfy – your Plan will reimburse you 100% of all covered expenses, with the exceptions as stated below applicable to Prescription Drugs, and subject to stated calendar year and per visit maximums.

Lifetime Maximum

There is a lifetime maximum amount for all covered expenses combined of:

Covered Persons under 65: $1,000,000

Covered Persons age 65-79 inclusive: $100,000.

At the end of each calendar year, up to $1,500.00 of the lifetime maximum amount that has been paid in benefits will be automatically restored for each covered individual. Benefits in excess of $25,000 paid by this Plan will be limited to those expenses incurred within 52 weeks of the date of covered injury or sickness.

Covered Expenses

"Covered expenses" include the medically necessary services, procedures and supplies listed below **subject to the maximums as stated or, if no maximum is stated the reasonable and customary charges**. The services, procedures and supplies must be received while the person is eligible for coverage and be for an illness or injury that is non-occupational.

1. In home services of a **registered graduate nurse** (Licensed Vocational nurse where an R.N. is not available), who is not related to the Member or his family; and does not normally live in the Member's home. Nursing must be ordered by a licensed doctor (M.D.) and be medically

necessary for a disability that requires the specialized training of an R.N.

2. Treatment provided by a licensed **Chiropractor, Registered Massage Therapist**, **or Podiatrist**, operating within the scope of his or her license. No amount is payable for any visit for which MSP coverage allowance is payable. Charges will be reimbursed at **100% up to a maximum calendar year benefit of $500.00** per eligible covered individual for each category. X-ray examinations are covered to a maximum of $50.00 per calendar year, per eligible covered individual.

   Podiatry surgery costs are included in the maximum $500 per calendar year benefit.

3. Treatment prescribed by a licensed doctor (M.D.) and provided by a licensed **Speech Therapist,** operating within the scope of his or her license. No amount is payable for any visit for which MSP coverage allowance is payable. Charges will be reimbursed up to a **maximum calendar year benefit of $500.00** per eligible covered individual for each category. X-ray examinations are covered to a maximum of $50.00 per calendar year, per eligible covered individual.

4. Treatment prescribed by a licensed doctor (M.D.) and provided by a registered **Psychologist** operating within the scope of his or her license. No amount is payable for any visit for which MSP coverage is payable. The maximum calendar year benefit is **$500.00** per eligible covered individual.

5. Treatment by a licensed **Naturopathic Physician** or **Acupuncturist** operating within the scope of his or her license, to a **combined maximum of $500.00**, per eligible covered individual, per calendar year. No amount is payable for any treatment for which MSP coverage is payable.

6. Charges by a **Physiotherapist** who is registered and practicing within the scope of his or her license. Charges will be reimbursed at **100%.** No amount will be paid for any

visit for which any MSP coverage is payable. The maximum calendar year benefit is **$500.00** per eligible covered individual.

7. The Plan provides the following reimbursement for **Prescription Drugs and Medicines** (including contraceptives) which require, and can only be obtained, with the written prescription of a licensed doctor (M.D.), or Dentist *and are dispensed by a licensed Pharmacist* (excludes drugs and medicines available for purchase "over the counter").

   100% of the cost of **Generic Brand** Prescription Drugs and Medicines

   75% of the cost of **Name Brand** Prescription Drugs.

   Exceptions will only be made when there is *no equivalent* Generic Brand available or when the doctor specifies on the Prescription "no substitutions."

   - Prescriptions are limited to a **90 day** supply.
   - Eligible expenses include diabetic supplies, and vaccinations.
   - Erectile dysfunction drugs are limited to 8 tablets per month.
   - The maximum lifetime benefit for smoking cessation products (e.g patches, prescription drugs, etc.) is the cost of one course of treatment reimbursed at 50% of the charge.
   - **Prescription Drug expenses exceeding $500.00 per family in a calendar year will only be eligible for reimbursement provided that the Member's Fair Pharmacare Program of BC number is provided** as confirmation of application for this coverage.

8. Prescription Drugs requiring a Special Authority Request (SAR) will be reimbursed for the initial prescription only (maximum 90 day supply) until confirmation of the SAR approval or denial is received by MEBS. SARs are required when your physician is prescribing a medication that is not

on the approved list of covered medications by PharmaCare or it is a medication for which PharmaCare would only provide partial or limited coverage. A listing of drugs and request forms can be found on line at http://www.health.gov.bc.ca/pharmacare/sa/saindex.html. Your pharmacist can also tell you if the medication requires a SAR.

9. **Ambulance charges**, in excess of the amount payable under the covered person's Provincial Health Plan, for professional licensed ambulance service to transport the patient:

   - ❖ from the place of injury (or where illness struck) to the nearest hospital where treatment is available; or
   - ❖ direct transfer from the first hospital where treatment is given to the nearest hospital for needed specialized treatment if not available at the first hospital; or
   - ❖ from a hospital to a convalescent hospital.

   Air or rail ambulance service must be approved in advance.

10. **Initial artificial limbs or eyes, and subsequent reasonable and necessary repairs,** required to replace natural limbs or eyes lost while covered; **crutches, braces, splints; oxygen**, **ostomy supplies**; **corrective prosthetic lenses and frames,** as well as the rental of durable equipment for therapeutic treatment. Rental is based on short term rentals whereby the time period is appropriate to the condition and the rental cost not excessive in comparison to the reasonable and customary purchase cost for the equipment.

11. **Surgical stockings; support hose** – up to two (2) pairs per calendar year.

12. **Dental treatment** necessary to repair or alleviate damage to natural teeth resulting from an accident occurring while covered.

13. **Hearing aids** (including repairs, batteries, recharging devices, or other such accessories) when prescribed by the

attending Certified Ear, Nose and Throat Specialist. The **maximum benefit payable in a five year period is $1,200.00** per covered individual.

14. **Orthopedic shoes** when recommended by a licensed doctor (M.D.) at a **co-insurance of 50%** to a **maximum benefit payment of $250.00 per calendar year** per eligible covered individual.

15. **Arch supports, molds or orthotic devices**, when prescribed by a licensed doctor (M.D.) or podiatrist or chiropodist, to a maximum benefit payment of **$250.00** in a 2 year period per eligible covered individual. Devices needed for sports are not covered.

16. **Hospital charges** for the difference in cost between ward and semi-private, or when medically necessary, private accommodation, or hospice charges where the cost is not more than the foregoing cost differential.

17. **Diagnostic laboratory and x-ray expenses**, including one Prostate Antigen (PSA) test per year.

18. **Wigs** required due to treatment of medical conditions.

19. **Mobility Assistance Devices** (wheelchairs, walkers, etc.) when recommended by a licensed doctor (M.D.). The Plan will pay **50%** of the cost **to a maximum lifetime benefit of $1,000.00** per eligible covered individual.

20. **Continuous Positive Airway Pressure (CPAP) System for obstructive sleep apnea,** when prescribed by a physician as a medical necessity.

21. **BC Pharmacare co-insurance** applicable to eligible expenses under MSP will be reimbursed at 100% percent.

Is treatment for substance abuse covered?

Substance abuse treatment is available through the B.C. Construction Industry Rehabilitation Plan facility. You can obtain more information on this program from their website: www.bcbuildingtrades.org or the Union Office.

Ineligible Expenses:

The Plan will not pay for charges:

1. which are excluded under the General Limitations and not covered by the Plan;
2. which result from any sickness or bodily injury arising out of or in the course of any employment of a covered individual;
3. for eye refractions, or for the cost of fitting of eye glasses and hearing aids, unless this benefit provides otherwise;
4. for hearing tests;
5. for the cost of fitting of contraceptive devices, except for the cost of an intrauterine device (IUD);
6. for medical care or services which are cosmetic unless it is reconstructive surgery to restore tissue damages by disease or bodily injury;
7. for pregnancy tests;
8. for personal comfort items;
9. for myolectric and electric prostheses;
10. for naturopathic or homeopathic medicines or vitamins or for experimental medical treatments or for non-curative reasons;
11. for services which are eligible for payment by the Medical Services Plan of BC, WorkSafe BC (WCB), BC Pharmacare or any tax supported agency. Whether or not the individual covered by this Plan is covered by the other plans;
12. Medical Referrals outside Canada, unless such treatment is not available in Canada and such treatment outside Canada is specifically authorized and paid for, or partially paid for, by the covered person's Provincial or Federal Government Health Insurance Plan;
13. related to bodily injury resulting from War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, rebellion, revolution, insurrection or military power, terrorism.

What expenses are covered if a Member or their eligible dependent must travel for medical treatment purposes?

Effective December 1, 2005 the Plan's policy is as follows:

- The policy is with respect to travel expenses incurred by eligible Members or their eligible dependents who must travel **within the province** for **non-emergency** medical specialist services.
- The travel expenses must be reasonable and customary and required by a physician.
- The travel expenses must not be insured by any other arrangement or provided by any government agency.
- Eligible expenses will be covered at **50% up to a maximum of $500.00 per lifetime per covered individual**.
- Eligible travel expenses include: accommodation, fuel and transportation charges, and meals.
- The doctor (M.D.) referral for the service is required as part of the travel expense claim submission.

For your information, the BC Ministry of Health coordinates a Travel Assistance Program (TAP) which provides travel discounts to eligible B.C. residents who must travel within the province for non-emergency medical purposes. **For more details, contact them at (250) 952 - 2654 (not toll-free), or visit their website at www. healthservices.gov.bc.ca/rural.**

Note: Eligible BC Pharmacare expenses not submitted within the required government deadline are not eligible under this Plan except for the 20% co-insurance.

VISION CARE PLAN

Eligibility

Any Member who is eligible for coverage under the Boilermakers Lodge 359 Health and Welfare Plan will be entitled to submit a claim for Vision Care expenses incurred by the Member or their eligible dependents. The expenses shall be considered incurred on the date of purchase.

Covered Expenses

a) EYE EXAMINATIONS: Routine eye examinations performed by a licensed ophthalmologist or optometrist operating within the scope of his or her license.

b) LENSES AND FRAMES

The following expenses are 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, *including soft or hard contact lenses required after removal of cataracts*;
4. Prescription sunglasses;
5. Prescription safety goggles;
6. Reading glasses purchased off the shelf if the claim is submitted with a prescription.
7. Laser eye surgery (up to the benefit maximum for vision care). Laser eye surgery and corrective lenses/contacts cannot be claimed in the same benefit period.

Payment of Expenses

A) Lenses,frames or laser eye surgery are reimbursed at 100% of the eligible expense to a maximum of **$375.00** per covered individual in any two consecutive calendar years;

eligible dependents to a maximum of **$275.00** in any two consecutive calendar years.

B) Routine Eye Examinations for individuals age 19 to 64 are reimbursed at 100% of the eligible expense to a maximum of **$75.00** per insured in any two consecutive calendar years.

More frequent eye examinations are eligible under MSP if medically required (see below).

Note: MSP presently provides coverage as follows:

- Individuals age 19 to 64 years where the eye examination is *medically required* (ie. ocular disease, trauma or injury; systemic diseases associated with significant ocular risk such as diabetes; medications associated with significant ocular risk.)
- Routine eye examination for those 18 years of age and under, and 65 years of age and over.

Ineligible Expenses:

Replacements for lost, stolen or broken lenses or frames are not covered.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

What is the Boilermakers' Lodge 359 Employee and Family Assistance Plan?

Your Plan includes a benefit program which provides eligible Members and their dependents with confidential, professional counseling services including psychological assessments, short-term therapy and referrals to appropriate service agencies/institutions if long term assistance is required.

Reasons to use the Employee and Family Assistance Program

- You want to "check-in" with someone around balancing your work/life stress
- You don't feel "bad" you just don't feel "right"
- You feel good; you just want to feel better
- You want to change your behavior
- You want to help a co-worker/family member before they are in serious distress
- You want a neutral, non-judgmental perspective
- You feel overwhelmed
- Your efforts at resolving your problems are not working
- Your relationships, work, or personal life are suffering

What Does the Program Offer?

The Employee and Family Assistance Program offers confidential assessment and counseling for the following:

- marital or family problems
- career counseling
- parenting
- communication skills
- alcohol or drug disorders
- psychological disorders
- bereavement
- stress related problems
- phobias
- lifestyle problems
- referrals for financial/legal problems
- eldercare & childcare

How Does the Program Work?

You or your Family Member may contact one of the offices of Homewood Human Solutions directly *to arrange* for an appointment. During the first appointment the problem will be thoroughly assessed and alternatives for resolution reviewed with you. If counseling is considered to be helpful it will be provided by a Homewood Human Solutions staff psychologist. ***Note: 24 hour advance notice must be given regarding appointment cancellations to avoid unnecessary charges to the Welfare Plan.***

What About Confidentiality?

All contacts with Homewood Human Solutions are strictly confidential. No individual inquiring about or receiving service under this Plan will be identified unless you send a written request specifying that an individual be notified that you are receiving services from this Plan.

Who Do I Contact?

You can contact Homewood Human Solutions 24 hours a day 7 days a week at:

1-800-663-1142

WEEKLY INDEMNITY

The Plan provides Weekly Indemnity Benefits for eligible Members if you are disabled and unable to work due to a non-occupational illness or injury as described in this section. The Weekly Indemnity benefit is fully integrated with Employment Insurance (EI) benefits which are payable for a maximum of 15 weeks following the two week EI waiting period. Manulife Financial is the claims adjudicator for the Trustees for this benefit, as well as your Long Term Disability benefit.

If I Qualify for Weekly Indemnity Benefits, When Does Payment Begin?

A) **When the disability is due to a non-occupational illness or injury, there is an 8 week waiting period before benefits will commence.** You must make a claim for EI sickness benefits. If you qualify for EI then your claim is paid by EI during the first 17 weeks. If you do not qualify for EI, then you must wait 8 weeks before this Plan will commence Weekly Indemnity payments.

B) **If hospitalized overnight or day surgery is required** – benefits commence on the 1st day of such hospitalization and are paid for up to two weeks (EI waiting period). If you are still disabled after these first two weeks, you must make a claim for EI sickness benefits. If you do not qualify for EI sickness benefits, your Weekly Indemnity claim will continue based upon the Administrator receiving from you a copy of your EI claim denial.

Benefits are **paid for a maximum of 52 weeks** at the Employment Insurance (EI) maximum paid per week (In 2012, $485.00 per week).

You must be under the ongoing care of a licensed physician (M.D.) deemed appropriate by Manulife Financial for the impairment causing the disability, and be treated in person during the period claimed for, and be actually losing income or would lose income at time of dispatch or self-pay. Your licensed physician (M.D.) must certify that you are unable to work on account of a non-occupational injury or illness.

If your EI sickness benefit terminates, or you are not entitled to EI sickness benefits, you must provide the Administrator with a copy of EI's notification confirming your status.

The Plan does not pay Weekly Indemnity benefits for:

1. any injury or sickness
   (a) any day for which you work for pay or profit;
   (b) covered by any WorkSafe BC (WCB), occupational disease law, or the Insurance Corporation of British Columbia (ICBC), or any plan or program established pursuant to a provincial automobile insurance act;
   (c) arising from or sustained in the course of any occupation or employment for compensation, profit or gain;
   (d) while you are not under active medical care and receiving regular treatment;
   (e) resulting from the use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment for that disability from a rehabilitation centre, a physician or an institution provincially designated for that treatment;
   (f) resulting from or contributed to by war, insurrection, rebellion or participation in a riot or civil commotion; purposely self-inflicted injury; or commission of (or attempt to commit) an assault or criminal offence; or
2. any pregnancy related illness during a period for which the individual
   (a) is entitled to receive benefits from Employment Insurance, or
   (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence, which will be

defined as a 17 week period starting eleven weeks before the expected date of delivery.

How to Claim:

1. Complete the Weekly Indemnity Claim Form, and have your doctor complete the Attending Physician's Statement portion of the Claim Form. You must be actively treated by a licensed physician (M.D.) *throughout* your disability;

2. Send the fully completed Claim Form, along with any applicable back-up documentation, to the Administrator immediately.

IMPORTANT: Your completed claim form MUST be received by the Administrator within 90 days from the date of disability, or your claim will be denied.

3. Apply for Employment Insurance sickness benefits at your local EI office (address obtainable in the blue pages of the phone book or the internet at: www.hrsdc.gc.ca).

Notes:

- ***Physician fees for form completion are not covered by the Plan.*** *You are responsible for the payment of any such fees.*
- If there is any uncertainty about the nature, or length, of your disability you may be requested to have an independent medical examination by a Physician appointed by this Plan.
- If your disability is expected to progress for some time, the Administrator will provide the Plan's Long Term Disability Insurer with your claim information.

Benefit Payments:

Accrued Weekly Indemnity benefits will be paid at the end of each bi-weekly period provided satisfactory evidence of continuing disability has been provided to Manulife Financial.

LONG TERM DISABILITY

The Plan provides Long Term Disability (LTD) benefits for eligible Members who qualify and provide proof of total disability satisfactory to Manulife Financial.

In order to qualify for benefits, you must be receiving acceptable standard professional treatment for the condition being treated including, where appropriate, treatment by a relevant and certified specialist.

Gross Monthly Benefit (Taxable)

75% of gross pre-disability monthly earnings, subject to a maximum benefit of $1,500 per month.

Waiting Period

The waiting period starts when you first become Totally Disabled (see definition below) while insured, and ends once you reach age 61 (age 60 for Permit Workers), provided the disability is continuous.

If the disability is not continuous, the days the Member is disabled will be accumulated to satisfy the waiting period provided:

1) no interruption is longer than 2 weeks;
2) the disabilities arise from the same or related disease or injury.

The waiting period is 52 consecutive weeks prior to **age 61** (age 60 for Permit Workers) if applicable.

Maximum Benefit Period

Long Term Disability benefits are payable up to the maximum benefit period which is age 61 (age 60 for Permit Workers).

Definition of Disability

Totally Disabled means that, solely because of an illness or accidental bodily injury you are under the continuous care of a physician and:

- **for the first 24 months following the qualifying period** you are unable to perform the essential duties of your **own occupation** (i.e. type of work, not just your own job); and
- **thereafter**, you continue to be disabled to the extent that you cannot work at **any occupation** for which you are, or may become, reasonably qualified by education, training or experience.

You must be seen by, and treated by, a licensed physician (M.D.) within 31 days of the date you became Totally Disabled. You must be absent from work for the 52 week Waiting Period.

Monthly LTD Benefit Payments

Monthly LTD benefit payments are made at the end of each month, and will be made to you for the period following the 52 week Waiting Period for as long as you are Totally Disabled and under the ongoing care of a licensed physician (M.D.). In order to be eligible to receive monthly LTD benefit payments you must be residing in Canada, unless prior approval to the contrary is obtained from the Insurer.

All Source Maximum

Your total monthly income while disabled cannot be greater than **85% of gross monthly earnings** as of the date of disability. If your total income is greater than 85%, the Long Term Disability Benefit from this Plan will be reduced by the amount of such excess.

If you are participating in a Rehabilitation Program, total monthly income while disabled cannot be greater than 100% of gross monthly earnings as of the date of disability. If your total monthly income is greater than 100%, the Long Term Disability Benefit

from this Plan will be reduced by the amount of such excess.

Total Monthly Income includes:

- Long Term Disability Benefits payable under this Plan;
- Income or benefits from a different or lesser paid occupation (not related to a rehabilitation program under this Plan);
- Any WorkSafe BC (formerly Workers Compensation) law or similar law;
- Any other plan or program of any government of any subdivision or agency of the government, including any plan or program established pursuant to a provincial automobile insurance act;
- Income or benefits payable under any group insurance because the Member is disabled or retired;
- With respect to a disabled Member participating in a Program of Rehabilitation, income from any job approved under said program will be considered under the All Source Maximum clause only to ensure that the Member's income does not exceed 100% of gross pre-disability earnings.

The following are NOT considered income for All Source Maximum purposes:

- The Canada or Quebec Pension Plan (CPP/QPP) benefits;
- Income from any group disability or retirement benefits prior to the Member becoming totally disabled;
- Income from any individual disability insurance, excluding any accidental benefits payable under an automobile insurance policy.

Earnings are defined as regular income paid by your employer before you became Totally Disabled, including overtime pay, averaged over the previous 60 month period (or less, if employed for a lesser period) prior to the date the Member became Totally Disabled, but excluding bonuses. A retroactive change in Earnings will be deemed to be effective on the date the change was determined.

Rehabilitation

If you recover enough from your disability to be able to work full-time or part-time at any job under a rehabilitation program approved in writing by the Plan, you will still be deemed to be Totally Disabled. Your benefit will be reduced only by the amount needed to keep your disability benefit income plus your rehabilitative income at the same level as your pre-disability Earnings.

If you refuse to participate in a rehabilitation program recommended by the Plan, your benefit payments will be terminated.

You will not be required to accept any job that would pay you less than 60% of your pre-disability inflation indexed earnings after receiving the first 24 months of disability benefits.

Recurrent Disability

Any consecutive period of Total Disability that is due to the same or a related cause and separated by return to active full-time work for less than six months (two weeks during the Waiting Period) will be deemed to be one period of Total Disability. Only the initial Waiting Period will apply, provided the first period begins while you are covered under this Benefit.

Recovery of Benefits

If you receive a benefit from this Plan in excess of what should have been paid, the Plan has the right to recover the amount of such excess from you or deduct it from future monthly benefits payable to you.

Third Party Liability

If you receive benefit payments under this Plan for loss of income for which there may be a cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will entitle the Plan to be reimbursed for any amount(s), including interest, you recover from a third party for:

- loss of income; or
- medical or dental expenses;

which, together with any amount(s) paid or payable under any of the Benefits of this Plan, would exceed your actual loss. Following notification to the Plan of payment by a third party of any judgment or settlement, further disability benefit payments under this Plan will terminate until the Plan has been reimbursed.

If a lump sum payment is made under judgment or settlement for loss of future income, no further disability benefits will be paid under this Plan until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

How to Claim

A claim for Long Term Disability benefits must be filed with the Administrator within 6 months after the end of the 52 week waiting period.

Appeal Procedure

If your LTD claim is denied or terminated, you may appeal by submitting a written notice of appeal to the Insurer within 60 days of the date of the Insurer's notice of denial or termination. Medical or other supporting documentation must be submitted to the Insurer within six months of the date of the notice of denial or termination. Expenses incurred in connection with obtaining the supporting documentation are the responsibility of the Member.

If you have any questions regarding the appeal process, contact the Administrator for assistance.

Exclusions and Limitations

No benefit shall be payable:

1) for any portion of a period of disability unless the Member is receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. The Member will not be paid for any portion of a period of disability during which he does not participate in the treatment program recommended by said

physician;

2) for any portion of a period of disability during which the Member is receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;

3) for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addiction, unless the Member is participating in a recognized substance withdrawal program;

4) for disability resulting from injury or disease which occurred while the Member is on active duty in the armed forces of any country, state, or international organization or for disability resulting from war or act of war, whether declared or undeclared;

5) for disability resulting from participation in the commission of a criminal offence;

6) for the portion of a period of disability during which the Member is:

   - imprisoned in a penal institution, OR
   - confined in a hospital, or similar institution, as a result of criminal proceedings.

7) for a disability resulting from an accident which occurs while the Member is operating a motor vehicle and the blood contains more than 50 milligrams of alcohol in 100 milliliters of blood (0.05%);

8) for disability resulting from insurrection, rebellion or participation in a riot or civil commotion;

9) for disability resulting from intentionally self-inflicted injury or disease or attempted self-destruction, whether the Member is sane or insane;

10) during any leave of absence (including maternity leave);

11) for a disability which commences on or after the date a strike or layoff begins, subject to any provincial Employment or Labour Standards Act;

12) to an insured Member who refuses to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending physician, or on the advice of an independent medical opinion;

13) to an insured Member who refuses or fails to complete and return, or comply with the terms of the Loan and Replacement Agreement, in accordance with the Subrogation provisions.

Pre-existing Condition Limitation

If, during the first twelve months that you are insured, you become Totally Disabled, directly or indirectly, because of an illness or injury for which you:

- received medical treatment, consultation, care or service including diagnostic tests; or
- took prescribed drugs;

during the 90-day period before the date you became insured, no benefit payments will be made.

If, after the first twelve months that you are insured, but before you have been insured for 24 months, you again become Totally Disabled because of the same or a related cause, you must:

- have returned to active full-time work for at least six months; and
- be absent from work for more than the Waiting Period; before benefit payments will be made.

Waiver of Premium

No premium is required to be paid for this Benefit during a period for which you are entitled to receive LTD benefit payments.

Extension of Benefit

If you are Totally Disabled on the date your coverage terminates, you will be entitled to the same benefit as though your insurance had not terminated.

GROUP TERM LIFE INSURANCE COVERAGE

Your Plan provides your beneficiary with a benefit in the event of your death while insured.

The amount of the Group Term Life Insurance is shown in the Summary on Page 4 for Active Field Members, and Pages 52-54 for Pensioners.

Beneficiary Designation for Life Insurance

A death benefit is payable to the last beneficiary designation on record with the Administrator, as shown on the Member Information Card you completed and submitted to the Administrator. If your designated beneficiary is deceased, or no beneficiary has been designated, the death benefit is payable to your Estate.

If you designate more than one beneficiary, the proceeds will be split equally unless you otherwise stipulate. In the event that your beneficiary predeceases you, benefits will be payable to your Estate.

You may change your beneficiary designation for the Life Insurance benefit by completing a new Member Information Card – contact the Administrator.

How to Claim

Contact the Administrator to obtain a Claim Form. A claim for Life Insurance benefits must be submitted within **6 months** from the date of death.

Waiver of Premium

If you are totally and permanently disabled for 6 consecutive months, the total amount of the Group Term Life Insurance will remain in force without further premium charge providing the disability begins before age 65. Proof of disability must be submitted by completion of a Waiver of Premium form within eighteen months of the start of disability.

Upon the latter of attainment of age 60, or if in receipt of retirement benefits from the Boilermakers Pension Plan, insurance kept in force under the Waiver of Premium provision will reduce to $10,000.00. If a person under age 65 is totally and permanently disabled as a result of an occupational accident or occupational sickness, the total amount of the Group Term Life Insurance will remain in force.

Conversion Option

Your Life Insurance continues for 31 days following either the termination of your coverage, or your classification changing to one in which you are not insured. During this 31 day period you may convert the amount of your Group Term Life Insurance, provided you are under 65 years of age, to any individual whole life or convertible one-year term or term to age 65 plan without submitting evidence of health.

The amount of the individual policy shall not exceed the amount of insurance for which you were insured when coverage was discontinued, subject to a maximum of $200,000 less any amount you become eligible for under a replacing contract of group life insurance.

The individual plan may be:

- non-convertible term insurance to age 65;
- a permanent plan that Manulife Financial offers to the public at the time of conversion; or
- one-year non-renewable term insurance which may be converted while it is in force to any plan described above.

The premium rate will be determined from your age and class of risk at the time of conversion.

Note: The conversion privilege does not apply for loss if insurance terminates when you reach a certain age or upon your retirement.

You must apply to the Insurer in writing and pay the first premium to the Insurer within 31 days of the date your insurance terminates. The premium rate will be based on your age and class of risk at the time you convert. No medical exam or health questionnaire will be required.

If you wish to convert your Life Insurance benefit you must contact the Manulife Financial Assurance Company at 1-888-626-8543. The Plan's Policy Number is 31238.

Extension of Benefit

If you die within 31 days of the date your Group Term Life Insurance terminates, the amount that could have been converted will be paid as a death benefit even if no application for conversion was made.

Waiver of Premium for Disability

If, while insured, you become totally disabled for six consecutive months before age 65 your Life Insurance will be continued free of charge until you cease to be totally disabled or you reach age 65, whichever occurs first. To qualify, you must be unable to perform any work for compensation or profit or to engage in any business or occupation. You must submit proof of your continuing disability as required by the Insurer.

Note: If you are in receipt of WorkSafe BC benefits, in order to apply for the Waiver of Premium Benefit you must notify the Administrator of your disability. You must file a claim within one year of becoming Totally Disabled.

ACCIDENTAL DEATH and DISMEMBERMENT

If an eligible Member sustains an accidental bodily injury while insured and if an insured loss occurs as a direct result and within one year of the accident, the following will be paid to you, if living, or if deceased to your Beneficiary.

The Principal Sum is shown in the Summary on Page 4 for Active Field Members, and Pages 52-54 for Pensioners.

Loss of Use of:	Percentage of Principal Sum
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand or One Foot	100%
One Hand or Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Leg or One Arm	75%
Either Hand or Foot	66-2/3%
Sight of One Eye	66-2/3%
Speech or Hearing	66-2/3%
Hearing in One Ear	25%
Thumb and Index Finger OR Four Fingers of the Same Hand	33-1/3%
All Toes of One Foot	12-1/2%
*Quadriplegia (Total & Irreversible paralysis of all four limbs)	200%
*Paraplegia (Total & Irreversible paralysis of both lower limbs)	200%
*Hemiplegia (Total & Irreversible paralysis of one arm and one leg on the same side of the body)	200%

Both Hands or Arms 100%

One Arm or One Leg 75%

One Hand or One Foot.....66-2/3%

"Loss" with regard to hands and feet shall mean actual severance through or above wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight; with regard to leg or arm, actual severance through or above knee or elbow joint; with regard to thumb and fingers, actual severance through or above metacarpophalangeal joints; with regard to toes, actual severance through or above metatarsophalangeal joints; with regard to speech and hearing, entire and irrecoverable; with regard to paralysis (Quadriplegia, Paraplegia, Hemiplegia), loss must be the complete and irreversible paralysis of such limbs. Loss of Use of an arm, hand, leg or foot must be total and irrecoverable and must be continuous for 12 months after which the benefit for Loss of Use is payable, provided such nerve damage is determined to be permanent.

The **maximum benefit** amount payable to an Insured Person for paralysis benefits between all policies with the Insurer (RBC Insurance) shall not exceed $1,000,000.

Exposure and Disappearance

If loss results from unavoidable exposure to the elements and an amount is otherwise payable hereunder, such loss will be payable under the terms of the Insurance Policy.

If your body has not been found within one year after the date of the disappearance, sinking or wrecking of the vehicle in which you were an occupant at the time of the accident and under such circumstances as would otherwise be covered hereunder, it will be presumed that you had suffered loss of life resulting from bodily injury caused by an accident at the time of such disappearance, sinking or wrecking.

Benefits payable under this Plan are paid in addition to any other insurance benefit which may be in effect at the time of the accident.

Rehabilitation Benefit

When “injuries” result in a payment being made by the Insurer under the Loss Schedule (see above) of this Plan, the Insurer will also pay:

The reasonable and necessary expenses actually incurred, up to a limit of $10,000, for your special training provided that:

a) such training is required because of such “injuries” and in order for you to be qualified to engage in an occupation in which you would not have been engaged except for such “injuries”; and

b) the special training expenses are incurred within two (2) years from the date of the accident.

No payment will be made for ordinary living, traveling or clothing expenses.

Repatriation

If, as the result of a covered accident, you suffer loss of life, at least 100 kilometers away from your Principal City of Residence, the Insurer will pay up to $10,000 for the preparation and transportation of your body to your City of Residence.

Waiver of Premium

Should you become totally disabled from an accident or sickness and Waiver of Premium has been accepted under this Plan’s Group Term Life Insurance Program, coverage shall continue as long as total disability continues, until the earlier of attainment of age 65, termination of employment or termination of the Master policy.

Exclusions

This insurance does not provide benefits for losses resulting from suicide or attempted suicide; self-inflicted injuries; nuclear war, or war declared or undeclared between a country of North America and/or the states of the former Soviet Union, China, France or the United Kingdom; full-time service in any Military organization; travel in any aircraft or aerial device as a pilot or

crew member, except while riding as a passenger in any air-craft having a current and valid airworthiness certificate and which is operated by a person holding a cur-rent and valid pilot's license with a rating authorizing the person to pilot such aircraft; or travel in the Policyholder's owned or leased aircraft.

How To Claim

A claim must be filed **within 6 months** after the date of loss. Contact the Administrator to obtain a Claim Form.

RETIRED FIELD MEMBERS

SUMMARY OF BENEFITS FOR PENSIONERS

1) **A Pensioner under the Boilermakers Pension Plan who does not wish to Self-Pay** to continue coverage (see below), is entitled to a Term Life Policy of $2,000 at no cost to the Pensioner.

2) **A Pensioner under the Boilermakers Pension Plan, may elect to continue coverage from one of the following four Self-Pay options at retirement:** (Note: the monthly self-pay costs shown reflect the coverage costs and subsidy levels in force at the time this booklet was distributed, and are subject to change at any time by the Board of Trustees.)

SELF PAY - PLAN A
Monthly Cost: $115.00

		See Page:
Group Term Life Insurance	$10,000	44
Accidental Death & Dismemberment	$10,000 Principal Sum	47
Dental Care Plan	as described	60
Medical Services Plan (MSP) of BC	MSP premium payment	64
Extended Health Care	as described	65
Vision Care	as described	72
Employee Assistance Program	as described	31
Out of Province/Canada Travel Medical Emergency Insurance	as described	74

SELF PAY - PLAN B
Monthly Cost: $91.00

		See Page:
Group Term Life Insurance	$75,000 to Age 60, thereafter reducing to $10,000 (Principal Sum)	44
Accidental Death & Dismemberment	$75,000 to Age 60, thereafter reducing to $10,000	47
Dental Care Plan	NOT AVAILABLE	
Medical Services Plan (MSP) of BC	MSP premium payment	64
Extended Health Care	as described	65
Vision Care	as described	72
Employee Assistance Program	as described	31
Out of Province/Canada Travel Medical Emergency	as described	74

SELF PAY - PLAN C
Monthly Cost: $162.00, reducing to $115.00 at age 60

		See Page:
Group Term Life Insurance	$75,000 to Age 60, thereafter $10,000	44
Accidental Death & Dismemberment	$75,000 to Age 60, thereafter reducing to $10,000 (Principal Sum)	47
Dental Care Plan	as described	60
Medical Services Plan (MSP) of BC	MSP premium payment	64
Extended Health Care	as described	65
Vision Care	as described	72
Employee Assistance Program	as described	31
Out of Province/Canada Travel Medical Emergency	as described	74

SELF PAY - PLAN D
Monthly Cost: $139.00, reducing to $91.00 at age 60

		See Page:
Group Term Life Insurance	$10,000	44
Accidental Death & Dismemberment	$10,000	47
Dental Care Plan	NOT AVAILABLE	
Medical Services Plan (MSP) of BC	MSP premium payment	64
Extended Health Care	as described	65
Vision Care	as described	72
Employee Assistance Program	as described	31
Out of Province/Canada Travel Medical Emergency	as described	74

GENERAL INFORMATION

Who is eligible?

Any Field Member of Lodge 359 of The International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers who was covered immediately prior to retirement and who is receiving Pension benefits from the Boilermakers Pension Trust Fund, is covered only as indicated in the Summary of Benefits for Pensioners section.

Are my dependents eligible?

Your eligible dependents include:

- Your Spouse, defined as the Member's legal or common-law spouse defined as a person of the same or opposite sex who has been residing with the Member continuously for a period of at least one year and has been publicly represented as the Member's spouse in the community in which they reside.

- Your natural or legally adopted child; or step-child or other child under 21 years of age dependent on you for support and living with you in a regular parent-child relationship,
- The age limitation of 21 may be increased up to age 25:
    - If the dependent child is registered as a full time student at an accredited college or university and if such attendance is confirmed in writing;
    - The dependent child is totally disabled, unmarried, and unemployed children or if they are dependent on the eligible Member for financial support by reason of mental or physical disability and are totally and continuously disabled, subject to the provision of evidence supporting the total disability.

    Note: Under the Medical Services Plan of BC, a child ceases to qualify as a dependent at **age 19**. Coverage may extend up to age 25 if in full time attendance at an accredited post-secondary school.

Do any enrollment forms have to be completed?

YES. You must have on file with the Administrator a completed:

✓ Member Information Card, *and*
✓ Medical Services Plan of BC enrollment form

You can obtain these documents from the Plan Administrator.

Coverage for Dependents of a Deceased Pensioner

Upon the death of a covered Retired Field Member, any eligible dependent(s) covered at the Retiree's death will be entitled to self-pay to continue the coverage as per the Self-Pay Plan Option chosen by the Retired Field Member at retirement, for up to a maximum of **twelve** consecutive months after the Member's death.

Are any benefits taxable?

YES. The premium paid by the Plan for your **Life Insurance** and **MSP** premium is a taxable benefit. *The Administrator will send you a T4A tax form every year if you were in receipt of any*

taxable benefits.

What if my Personal Information Changes?

Notify the Administrator immediately if your address changes.

If there are changes to your eligible dependents, or your marital status, you must complete a new Member Information Card and send it to the Administrator.

Beneficiary Designation for Life Insurance

When you first complete a Member Information Card you must designate a beneficiary for Life Insurance under the Plan. Also, if you wish to change your beneficiary designation for Life Insurance at any time, you must complete a new Member Information Card and send it to the Administrator.

Naming a beneficiary is important for your Life Insurance. Your beneficiary is the person(s) designated by you to receive benefits in the event of your death. If your designated beneficiary dies before you, that beneficiary's interest will end. If there is no living beneficiary on the date of your death, the benefit is payable to your Estate.

If you appoint a person under age 18 as your beneficiary, you should also appoint a Trustee to receive the benefit and to act on the child's behalf, otherwise a Public Trustee will be assigned by the Courts.

What if I disagree with how my Claim was paid?

Claims are paid as based on the Plan Rules. However, you always have the right to appeal if you do not agree with a Claim payment. To do so, send your written appeal to the Administrator. If your appeal is for payment outside of the Plan rules, your appeal will be presented to the Board of Trustees for consideration at their next meeting.

FILING A CLAIM – EXTENDED HEALTH & DENTAL BENEFITS

Claim Forms are available from the Administrator's office.

Make sure that your NAME, ADDRESS and SOCIAL INSURANCE NUMBER, are clearly shown. The Plan Member or their Spouse are authorized to sign the Claim Form (a dependent child cannot sign the Claim Form).

Send your completed Claim Form, along with original receipts/prescriptions, to Multi Employer Benefit Services (MEBS) #302 – 3602 Gilmore Way, Burnaby, BC V5G 4W9. Do not fax your Claim Form – the original is required.

Never sign a blank Claim Form before or after visiting a health care provider. The Claim Form should always be fully completed before you sign it. If you are not sure you have received treatment for what is being billed, ask the provider for an explanation before you sign. Remember, your signature is the Plan's assurance that the services charged were actually received.

As a responsible Plan Member, you know that you play a role in controlling the cost of benefits provided by your Plan. If costs are controlled, benefits can be continued or even enhanced.

Dental claims - the patient receiving the dental services must sign the Claim Form. The Plan's payment reimbursement is payable to the Member, unless you have assigned benefits to your dentist, in which case the Plan's payment will be payable to the Dentist. You will be responsible for any difference between the Dentist's charge and the amount paid by the Plan.

<u>Important</u>: The time deadlines for filing a claim with the Administrator are as follows:

Benefit	Deadline for Filing a Claim
Extended Health Care - includes Vision Care (Claims less than $25,000)	18 months after the date of expense
Extended Health Care (Claims over $25,000)	12 months after the date of the injury or commencement of the sickness
Dental Benefits	18 months after the date of expense
Emergency Out of Province Hospital/Medical	See pages 91-93.

Note: If your coverage terminates, claims for Dental, Extended Health and Vision Care benefits must be filed **within 6 months** of the date your coverage ceased.

COORDINATION OF BENEFITS – EXTENDED HEALTH & DENTAL BENEFIT CLAIMS

The Canadian life and health insurance industry has a policy which details coordination of benefits rules. Your Health and Welfare Plan follows these rules.

The Claim filing procedure, agreed to by Canadian health insurers and benefit plans, is as follows:

- If the Claim was incurred by you, file the Claim first with this Plan. If there is an unpaid balance then file the Claim with your Spouse's Plan.
- If your Spouse incurs the Claim, file the Claim first with your Spouse's Plan. Then file with this Plan if there is an unpaid balance. If your Spouse does not have a benefit plan then file the Claim with this Plan.
- If one of your children incurs the Claim, first submit the Claim to the Plan that covers the Spouse who has the earlier birthday in the calendar year. If your Spouse does not have a benefit plan then file the Claim with this Plan.
- If you and your Spouse are both Members of this Plan, attach a Note to your Claim, giving your Spouse's name and Social Insurance Number.

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

DENTAL CARE PLAN

Eligibility

All Pensioners who have opted to continue coverage via Self-Pay Option A or C, and their eligible dependents.

Fee Guide

Payment is based on the current fee guide of the College of Dental Surgeons of the Province of British Columbia.

Percentage Payable

Basic Services:	100%
Major Services:	70%

Calendar Year Benefit Maximum

Basic and Major Services Combined: $1,000 maximum per calendar year, per insured individual.

Important Note

Where a proposed course of dental treatment will exceed $500.00, a treatment plan detailing the proposed treatment details and providing x-rays, should be sent by your dentist to the Administrator BEFORE the treatment starts. The Administrator will then notify you in writing of the services and fees covered by the Plan. This is strongly recommended so that you and your dentist know the amount covered before the treatment is started, and you are aware of any out-of-pocket expenses you may be required to pay.

Basic Services

Coverage includes all necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, and necessary procedures to prevent the occurrence of oral disease including:

- Oral examinations (2 per calendar year);
- Consultations;
- X-Rays: Complete mouth X-Rays are covered once every three years;
- Cleaning and scaling *(12 units combined per calendar year);*
- Prophylaxis and topical application of fluoride (twice per calendar year);
- Extractions;
- Fixed space maintainers;
- Periodontic treatment for disease of the bone and gums of the mouth, including tissue grafts and occusal guards (but not athletic guards);
- Endodontic treatment, including root canal therapy;
- Restorative Treatments: All necessary procedures for filling teeth with amalgam (non-bonded amalgams only), 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. White fillings are covered for front and molar teeth;
- All necessary procedures required to repair or reline or rebase fixed or removable appliances;
- Repair, resurfacing or recementing crowns, inlays, onlays or bridges;

Major Services:
Prosthetic Appliances, Crowns & Bridges

1. **Crowns and bridges**. Replacements, but only if installed for at least 5 years and cannot be made serviceable.
2. **Partial, and/or complete dentures**. These costs are payable but no more frequently than once in 5 years and only if (a) such replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth, or (b) the denture is a stay plate or a similar partial denture, and is being replaced by a permanent denture, or (c) the denture, while in the oral cavity, has been damaged beyond repair as a result of injury while covered.
3. **Charges made by a licensed Denturist** will be recognized for payment, in accordance with a separate Schedule of Allowances.

Emergency Dental Care

If you require emergency dental care while you are traveling or on vacation outside of British Columbia, you are entitled to the services of a duly qualified dentist. These services will be covered as if the service had been provided in British Columbia.

Ineligible Expenses:

a) Correction of congenital malformations

b) Cosmetic surgery or dentistry for purely cosmetic reasons;

c) Services for treatment of endodontia and periodontal in process at the effective date of your coverage;

d) Charges for broken appointments, completion of claim forms, specialist fees;

e) Services which are eligible for payment by the

Medical Services Plan of British Columbia, WorkSafe BC, Insurance Corporation of British Columbia, 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 for a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction; or

i) Charges for implantology and services related to implants;

j) Stainless steel crowns on permanent teeth;

k) Protective athletic appliances;

l) Replacement of lost, broken or stolen dentures;

m) Orthodontic treatment or correction of malocculusions.

MEDICAL SERVICES PLAN OF BC (MSP) - PREMIUM

Premiums will be paid on your behalf (and on behalf of any eligible dependents) to the Medical Services Plan of BC on a monthly basis whenever your Hour Bank account is sufficient to provide you with coverage under the Health and Welfare Plan, and provided you or your dependent qualifies for enrollment under Medical Services Plan of BC Rules and Regulations.

You will be required to complete and submitted a MSP enrollment form to the Administrator.

Notes:

- If you have coverage under another employer's group plan (eg. your Spouse's employer's plan), it is important that you notify the Administrator to avoid duplicate premium payments by the Plan, and double premium taxation.

- If you or your Spouse has paid an individual MSP premium which is for the same time period that this Plan has paid a premium on your behalf, MSP will refund the premium overpayment to you.

Further information on the Medical Services Plan of BC is available on the Internet: www.health.gov.bc.ca/msp

***Please note that dependent status for children ceases at age 19 for the MSP BC Plan only** (for up to age 25 if the dependent child is enrolled in full-time attendance at an approved institution of learning.)*

EXTENDED HEALTH CARE

Your Health and Welfare Plan's Extended Health Care benefit is an extension of the coverage you receive from the *Medical Services Plan of B.C. (MSP)* or other Provincial Medical coverage. It is designed to provide additional benefit coverage for you, and your eligible dependents.

Reimbursement

There is no deductible to satisfy – your Plan will reimburse you 100% of all covered expenses, with the exceptions as stated below applicable to Prescription Drugs, and subject to stated calendar year and per visit maximums.

Lifetime Maximum

There is a lifetime maximum amount for all covered expenses combined of:

Covered Persons under 65: $1,000,000

Covered Persons age 65-79 inclusive: $100,000.

At the end of each calendar year, up to $1,500.00 of the lifetime maximum amount that has been paid in benefits will be automatically restored for each covered individual. Benefits in excess of $25,000 paid by this Plan will be limited to those expenses incurred within 52 weeks of the date of covered injury or sickness.

Covered Expenses

"Covered expenses" include the medically necessary services, procedures and supplies listed below **subject to the maximums as stated OR, if no maximum is stated, the reasonable and customary charges**. The services, procedures and supplies must be received while the person is eligible for coverage and be for an illness or injury that is non-occupational.

1. **Nursing Care**

   a) Private duty nursing care by a **registered graduate**

nurse (R.N.) (licensed vocational nurse where an R.N. is not available) who is not related to the Member or his family; and does not normally live in the Member's home. Nursing must be ordered by a licensed doctor (M.D.) and be medically necessary for a disability that requires the specialized training of an R.N., expenses limited to **$10,000 in any consecutive 12 month period.**

b) **Nursing Home Care** in an approved facility for payment of the ward rate under the Provincial Health Plan) is limited to **$100 per month in any consecutive 12 month period.**

2. Treatment provided by a licensed **Chiropractor, Registered Massage Therapist**, **or Podiatrist** operating within the scope of his or her license. No amount is payable for any visit for which MSP coverage allowance is payable. Charges will be reimbursed at **100% up to a maximum calendar year benefit of $200.00** per eligible covered individual for each category. X-ray examinations are covered to a maximum of $50.00 per calendar year, per eligible insured individual.

3. Treatment prescribed by a licensed doctor (M.D.) and provided by a licensed **Speech Therapist,** operating within the scope of his or her license. No amount is payable for any visit for which MSP coverage allowance is payable. Charges will be reimbursed up to a **maximum calendar year benefit of $200.00** per eligible covered individual for each category. X-ray examinations are covered to a maximum of $50.00 per calendar year, per eligible covered individual.

4. Treatment prescribed by a licensed Doctor (M.D.) and provided by a registered **Psychologist** operating within the scope of his license. No amount is payable for any visit for which MSP coverage is payable. The maximum calendar year benefit is **$200.00** per eligible covered individual.

5. Treatment by a licensed **Naturopathic Physician** or **Acupuncturist** operating within the scope of his or her license, to a combined maximum of **$200.00**, per eligible covered individual, per calendar year. No amount is payable for any treatment for which MSP coverage is payable.

6. Charges by a **Physiotherapist** who is registered and

practicing within the scope of his license. Charges will be reimbursed at **100%.** No amount will be paid for any visit for which any MSP coverage is payable. The maximum calendar year benefit is **$500.00** per eligible covered individual.

7. The Plan provides the following reimbursement for **Prescription Drugs and Medicines** (including contraceptives) which require, and can only be obtained, with the written prescription of a licensed Physician, or Dentist *and dispensed by a licensed Pharmacist* (excludes drugs and medicines available for purchase "over the counter").

   100% of the cost of **Generic Brand** Prescription Drugs and Medicines

   75% of **Name Brand** Prescription Drugs.

   Exceptions will only be made when there is *no equivalent* Generic Brand available or when the Physician specifies on the Prescription "no substitutions."

- Prescriptions are limited to a **90 day** supply.
- Eligible expenses include diabetic supplies, and vaccinations.
- Erectile dysfunction drugs are limited to 8 tablets per month.
- The maximum lifetime benefit for smoking cessation products (e.g. patches, prescription drugs, etc.) is the cost of one course of treatment reimbursed at 50% of the charge.
- **Prescription Drug expenses exceeding $500.00 per family in a calendar year will only be eligible for reimbursement provided that the Member's Fair Pharmacare Program of BC number is provided** as confirmation of application for this coverage.
- Prescription Drugs requiring a Special Authority Request (SAR) will be reimbursed for the initial prescription only (90 days supply) until confirmation of the SAR approval or denial is received by MEBS. SARs are required when your physician is prescribing a medication that is not on the approved list of covered medications by PharmaCare or it is a medication for which PharmaCare would only provide partial or limited coverage. A listing of drugs and request forms can

be found on line at http://www.health.gov.bc.ca/pharmacare/sa/saindex.html. Your pharmacist can also tell you if the medication requires a SAR.

8. **Ambulance charges**, in excess of the amount payable under the covered person's Provincial Health Plan, for professional licensed ambulance service to transport the patient:

   - ❖ from the place of injury (or where illness struck) to the nearest hospital where treatment is available; or
   - ❖ direct transfer from the first hospital where treatment is given to the nearest hospital for needed specialized treatment if not available at the first hospital; or
   - ❖ from a hospital to a convalescent hospital.

   Air or rail ambulance service must be approved in advance.

9. **Initial artificial limbs or eyes and subsequent reasonable and necessary repairs,**required to replace natural limbs or eyes lost while covered; **crutches, braces, splints; oxygen, ostomy supplies; corrective prosthetic lenses and frames,** as well as the rental of durable equipment for therapeutic treatment.

10. **Surgical stockings; support hose** – up to two (2) pairs per calendar year.

11. **Dental treatment** necessary to repair or alleviate damage to natural teeth resulting from an accident occurring while covered.

12. **Hearing aids** (including repairs, batteries, recharging devices, or other such accessories) when prescribed by the attending Certified Ear, Nose and Throat (CENT) Specialist. The **maximum benefit payable in a five year period is $1,200.00** per insured individual. For dependent children under 16 years of age, the maximum benefit is $300.00 per eligible dependent child, in a five year period.

13. **Orthopedic shoes** when recommended by a licensed Doctor (M.D.) at a co-insurance of 50% to a **maximum benefit payment of $250.00 per calendar year** per eligible

covered individual.

14. **Arch supports, molds or orthotic devices**, when prescribed by a licensed Doctor (M.D.) or podiatrist or chiropodist at 50% to a maximum benefit payment of **$200.00** in a calendar year per eligible covered individual. Devices needed for sports are not covered.

15. **Hospital charges** for the difference in cost between ward and semi-private, or when medically necessary, private accommodation, or hospice charges where the cost is not more than the foregoing cost differential.

16. **Diagnostic laboratory and x-ray expenses**, including one Prostate Antigen (PSA) test per year.

17. **Wigs** required due to treatment of medical conditions.

18. **Mobility Assistance Devices** (wheelchairs, walkers, etc.) when recommended by a licensed doctor. The Plan will pay 50% of the cost **to a maximum lifetime benefit of $1,000.**

19. **Continuous Positive Airway Pressure (CPAP) System for obstructive sleep apnea,** when prescribed by a physician as a medical necessity.

20. **B.C. Pharmacare co-insurance** applicable to eligible expenses under MSP will be reimbursed at 100% percent.

Ineligible Expenses:

The Plan will not pay for charges:

1. which are excluded under the General Limitations;
2. which result from any sickness or bodily injury arising out of or in the course of any employment of a covered individual;
3. for eye refractions, or for the cost of fitting of eye glasses and hearing aids, unless this benefit provides otherwise;
4. for hearing tests;
5. for the cost of fitting of contraceptive devices, except for the cost of an intrauterine device (IUD);
6. for medical care or services which are cosmetic unless it is

reconstructive surgery to restore tissue damages by disease or bodily injury;

7. for pregnancy tests;

8. for personal comfort items;

9. for myolectric and electric prostheses;

10. for naturopathic or homeopathic medicines or vitamins, or for experimental medical treatments or for non-curative reasons;

11. for services which are eligible for payment by the Medical Services Plan of BC, WorkSafe BC (WCB), BC Pharmacare or any tax supported agency. Whether or not the individual covered by this Plan is covered by the other plans;

12. Medical Referrals outside Canada, unless such treatment is not available in Canada and such treatment outside Canada is specifically authorized and paid for, or partially paid for, by the covered person's Provincial or Federal Government Health Insurance Plan;

13. related to bodily injury resulting from War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, rebellion, revolution, insurrection or military power, terrorism.

Note: Eligible British Columbia Pharmacare expenses not submitted within the required government deadline are not eligible under this Plan except for the 20% co-insurance.

What expenses are covered if a Member or their eligible dependent must travel for medical treatment purposes?

Effective December 1, 2005 the Plan's policy is as follows:

- The policy is with respect to travel expenses incurred by eligible Members or their eligible dependents who must travel **within the province** for **non-emergency** medical specialist services.
- The travel expenses must be reasonable and customary and required by a physician.
- The medical services must not be insured by any other arrangement or provided by any government agency.
- Eligible expenses will be covered at **50% up to a maximum of $500.00 per lifetime per covered individual**.
- Eligible travel expenses include: accommodation, fuel and transportation charges, and meals.
- The doctor (M.D.) referral for the service is required as part of the travel expense claim submission.

For your information, the BC Ministry of Health coordinates a Travel Assistance Program (TAP) which provides travel discounts to eligible B.C. residents who must travel within the province for non-emergency medical purposes. **For more details, contact them at (250) 952 - 2654 (not toll-free), or visit their website at www. healthservices.gov.bc.ca/rural.**

VISION CARE PLAN

Eligibility

Any Pensioner who has opted to Self-Pay for coverage (see Summary of Benefits section) under the Boilermakers Lodge 359 Health and Welfare Plan will be entitled to submit a claim for Vision Care expenses incurred by the Member or their eligible dependents. The expenses shall be considered incurred on the date of purchase.

Covered Expenses

a) *EYE EXAMINATIONS: Routine eye examinations performed by a licensed ophthalmologist or optometrist operating within the scope of his or her license.*

b) *LENSES AND FRAMES*

The following expenses are 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, *including soft or hard contact lenses required after removal of cataracts*;
4. Prescription sunglass;
5. Prescription safety goggles;
6. Reading glasses purchased off the shelf if the claim is submitted with a prescription.
7. Laser eye surgery (up to the benefit maximum for vision care). Laser eye surgery and corrective lenses/contacts cannot be claimed in the same benefit period.

Payment of Expenses

Lenses, frames or laser eye surgery are reimbursed at 100% of the eligible expense to a maximum of **$275.00** per insured in any two consecutive calendar years

Routine Eye Examinations for individuals age 19 to 64 are reimbursed at 100% of the eligible expense to a maximum of **$75.00** per insured in any two consecutive calendar years.

More frequent eye examinations are eligible under MSP if medically required (see below).

Note: MSP provides coverage as follows:

- Individuals age 19 to 64 years where the eye examination is *medically required* (i.e. ocular disease, trauma or injury; systemic diseases associated with significant ocular risk such as diabetes; medications associated with significant ocular risk.)
- Routine eye examination for those 18 years of age and under, and 65 years of age and over.

Ineligible Expenses:

Replacements for lost, stolen or broken lenses or frames are not covered.

OUT OF PROVINCE/CANADA 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.*

Note: To be eligible you must be:

- Covered under the Government Health Insurance Plan of your province or territory of residence, and the Boilermakers Lodge 359 Health and Welfare Plan
- Have your place of employment in Canada
- Have your permanent residence in Canada

Trip Maximum:

180 days per Trip

Overall Maximum per Insured:

- Eligible Members under age 65: $1,000,000 per Trip
- Eligible Members age 65 to 79, inclusive: $100,000 per Trip

Note: the Trustees strongly encourage you to establish whether you are covered for Plan benefits BEFORE you travel, and that you purchase additional out of country medical insurance.

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

(The emergency telephone numbers are also listed on the back of the Medical Assistance Card provided– if you do not have a card contact the Administrator).

Canada or U.S.A. Toll Free	***1-866-870-1898***
Mexico Toll Free	***001-800-574-1518***
Collect, from anywhere	***819-566-1898***

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.

Your Plan provides Out-of-Province/Canada Group Travel Medical Emergency Insurance (Viator Plan) through a policy underwritten by Royal & Sun Alliance Insurance Company of Canada, and administered by Expert Travel Financial Security (E.T.F.S.) Inc. (called “ETFS”), a member of the ETFS Financial Group.

The Out-of-Province/Canada Group Travel Medical Emergency Insurance 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;

and subject to the Overall Maximum per Insured Person specified in the Schedule of Benefits.

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.

3. **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 Coverage Period 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 of preparation and transportation of the deceased Insured Person to their province or territory of residence in the event of death due to a 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.

INELIGIBLE EXPENSES:

The Policy does not cover losses or expenses related in whole or in part, directly or indirectly, to any of the following:

1. Treatment or services normally covered or reimbursable under a Government Health Insurance Plan or under other insurance you might have.
2. Any Trip booked or commenced contrary to medical advice or after you are diagnosed with Terminal Illness.
3. Any medical condition for which, prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization could be required while travelling.
4. Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that you elect to have provided outside Your province or territory of residence when medical evidence indicates that You could return to Your province or territory of residence to receive such treatment. The delay to receive treatment in your province or territory of residence has no bearing on the application of this exclusion.
5. Treatment or surgery during a Trip when the Trip is undertaken for the purpose of securing or with the intent of receiving medical or Hospital services, whether or not such Trip is taken on the advice of a Physician.
6. Cardiac catheterization, angioplasty, and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by Global Excel prior to being performed, except in extreme circumstances where such surgery is performed on an Emergency basis immediately upon admission to Hospital.
7. Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel,
8. Hospitalization or services rendered in connection with general health examinations for "check-up" purposes, treatment of an Ongoing Condition, regular care of a chronic

condition, home health care, investigative testing, rehabilitation or ongoing care or treatment in connection with drugs, alcohol or any other substance abuse or non-compliance with any prescribed medical therapy or treatment and medical treatment of an acute Sickness and/or Injury after the initial Emergency has ended (as determined by the Medical Director of Global Excel).

9. A disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless hospitalized.

10. Emergency air transportation and/or car rental unless approved and arranged in advance by Global Excel.

11. Treatment not performed by or under the supervision of a Physician or licensed dentist.

12. Treatment or hospitalization of mother or child as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the four (4) weeks before or after the expected delivery date.

13. War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, rebellion, revolution or military power.

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

15. Committing or attempting to commit an illegal act or a criminal act.

16. Suicide (including any attempt thereat) or self-inflicted injury, whether or not you are sane.

17. Service in the armed forces.

18. Participation in any sport as a professional athlete (for which you are remunerated), or in motorized or mechanically-assisted racing or speed contests (defined as an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event).

19. Loss or damage to eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices and resulting prescription thereof.
20. The replacement of an existing prescription whether by reason of loss, unless otherwise specified elsewhere in the Policy, renewal or inadequate supply or the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada or which are not required as a result of an Emergency.
21. Upgrading charges and cancellation penalties for airline tickets, unless approved in advance by Global Excel.
22. The cost of any airline ticket covered under the Policy where Your ticket may be exchanged or used for the same purpose.
23. Crowns and root canals.
24. Treatment or services received in the province where you attend school or work on a full-time basis or in your home country, if you are a foreign student studying in Canada or a non-resident working in Canada.

GENERAL PROVISIONS AND LIMITATIONS:

1. **You Must Give Notice to Global Excel**: In the event of a Sickness and/or Injury likely to give rise to an Emergency, you must give immediate notice to Global Excel. Failure to do so may limit the benefits payable under the Policy. 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.

2. **Transfer or Medical Repatriation**: During an Emergency (whether prior to admission or during a covered hospitalization), the Insurer reserves the right to:

   a) transfer you to one of Global Excel's preferred health care providers, and/or

   b) return you to your province or territory of residence

   for the medical treatment of your Sickness and/or Injury where this poses no danger to Your life or health. If you choose to decline the transfer or return when declared medically stable by the Medical Director of Global Excel, the Insurer will be released from any liability for expenses incurred for such Sickness and/or Injury after the proposed date of transfer or return. Global Excel will make every provision for your medical condition when choosing and arranging the mode of your transfer or return and, in the case of a transfer, when choosing the Hospital.

3. **Limitation of Benefits**: Once you are deemed medically stable to return to Canada (with or without medical escort) either in the opinion of the Medical Director of Global Excel or by virtue of discharge from a medical facility, Your Emergency will be deemed to have ended, whereupon any further consultation, treatment, recurrence or complication related to the Emergency will no longer be eligible for coverage under the Policy.

4. **Misrepresentation and Non-Disclosure**: Your entire coverage under the Policy shall be voidable if the Insurer determines, whether before or after loss, that You or the Policyholder have concealed, misrepresented or failed to disclose any material fact or circumstance concerning the Policy or your interest therein, or if you or the Policyholder refuse to disclose information or to permit the use of such information, pertaining to any of the Insured Persons under the Policy. Consequently and following a loss, no claim shall be payable by the Insurer and you shall be solely responsible for all expenses relating to your claim, including medical repatriation costs.

5. **Subrogation**: If you suffer a loss covered under the Policy, the Insurer is granted the right from you to take action to

enforce all your rights, powers, privileges, and remedies, to the extent of benefits paid under the Policy, against any person, legal person or entity which caused such loss. Additionally, if "no fault" benefits or other collateral sources of payment of medical expenses are available to you, regardless of fault, the Insurer is granted the right to make demand for, and recover, those benefits. If the Insurer institutes an action it may do so at its own expense, in your name, and you will attend at the place of loss to assist in the action, in addition to providing the Insurer all information, cooperation and assistance the Insurer may reasonably require. If you institute a demand or action for a covered loss, you shall immediately notify the Insurer so that the Insurer may safeguard its rights.

Notwithstanding any provisions in the Policy to the contrary, the Insurer's rights under this paragraph shall be governed by the laws of the state, province, or district where the loss occurs, or where benefits under the Policy are paid.

You shall take no action after a loss that will impair the rights of the Insurer set forth in this paragraph and shall do all such things as are necessary to secure such rights.

6. **Arbitration**: Notwithstanding any clause in the Policy, the parties hereto undertake to submit to an arbitration procedure, to the exclusion of the courts, any present or future dispute relating to a claim.

   The arbitration proceedings shall be governed by the arbitration law in force in the Canadian province or territory of residence of the Participant. The parties agree that any action will be referred to arbitration.

7. **Applicable Law**: The Policy is governed by the law of the Canadian province or territory of residence of the Participant. Any legal proceeding by the Insured Person, his heirs or assigns shall be brought in the courts of the Canadian province or territory of residence of the Participant.

8. **Other Insurance**: If, at the time of loss, You have insurance from another source, or if there is any other party responsible for benefits provided under the Policy, the

Insurer will pay covered expenses only in excess of those covered by that other insurer or other responsible party, including credit cards, private or public health plans, private or provincial auto plans, or any other insurance, whether collectable or not, which provides the Insured Person with some or all of the benefits and coverage provided under the Policy. If, however, that other insurance is also "excess only", the Insurer will coordinate payment of all eligible claims with that other insurer. All coordination follows the Canadian Life and Health Insurance Association guidelines. In no case, will the Insurer seek to recover against employment related plans if the lifetime maximum for all in country and out-of-country benefits is $50,000 or less.

10. **Rights of Examination**: To be entitled to payment of benefits provided under the Policy, the Participant, on his own behalf and on behalf of his Dependents hereby authorizes any physician, health professional, hospital, institution and any other organization to forward to the Insurer or its representatives, all information, reports or documents that they may require.

    The Participant hereby authorizes the Insurer to communicate directly with any physician, health professional, hospital, institution or other organization to obtain any information required for the assessment of claims and hereby relieves the persons concerned of all legal responsibility which could arise from the disclosure of such information.

    In the event of death, the Insurer will require that a death certificate be filed with the claim. Furthermore, the Insurer has the right to request an autopsy and review any autopsy report, if not prohibited by law.

11. **Limitation of Actions**: An action or proceeding against the Insurer for the recovery of a claim under the Policy shall not be commenced more than one (1) year (two (2) years in the Northwest Territories, three (3) years in the province of Quebec) after the date the insurance money became payable or would have become payable if it had been a valid claim.

12. **Availability of Care**: Neither the Insurer nor Global Excel shall be responsible for the availability or quality of any medical treatment (including the results thereof) or transportation at the vacation destination, or Your failure to obtain medical treatment during the Coverage Period.

13. **Evidence of Age**: The Insurer reserves the right to request proof of age of any Insured Person.

14. **Assignment**: Benefits under the Policy may not be assigned

15. **When Money Payable**: All money payable under the Policy shall be paid by the Insurer within sixty (60) days after it has received due proof of claim.

16. **Continuance of Individual Coverage During Absence from Work**: If a Participant is absent from work due to disability, temporary lay-off, authorized leave of absence, strike or any other work stoppage, the insurance will be continued as long as the Participant remains covered under the Policyholder's basic group extended health care plan.

17. **Examination of the Policy**: The Policy, including any endorsements, will be kept at the office of the Policyholder. You may consult the Policy during the regular business hours of the Policyholder.

AUTOMATIC EXTENSION OF COVERAGE PERIOD

The Coverage Period per Trip will automatically be **extended up to 72 hours**, provided the Participant has not reached the Termination Age, if:

a) You are hospitalized due to a medical Emergency on the last day of coverage. Your coverage will remain in force for as long as you are hospitalized and the 72-hour extension commences upon release from Hospital;

b) a late train, boat, bus, plane, or other Vehicle in which you are a passenger causes you to miss your scheduled return to your province or territory of residence (including by reason of weather);

c) the private automobile in which you are travelling is involved in a traffic accident or mechanical breakdown that prevents you from returning to your province or territory of residence on or before your return date;

d) You must delay your scheduled return to your province or territory of residence due to a medical Emergency.

All claims incurred after your original scheduled return date must be supported by documented proof of the event resulting in your delayed return.

INTERNATIONAL ASSISTANCE SERVICES

Global Excel is available to take your calls 24 hours a day, 7 days a week.

Emergency Call Centre — No matter where you travel, professional assistance personnel is ready to take your call. Global Excel can also provide you with Canada Direct instructions and codes so that you only deal with Canadian telephone operators.

Referrals — Global Excel can refer you to the preferred medical providers (Hospitals, clinics and Physicians) that are closest to where you are staying. With a referral, it is less likely that you will have to pay for services out of pocket.

Benefit Information — Explanation of your coverage is available to you and to the medical providers who are treating you.

Medical Consultants — Global Excel's team of medical professionals, available 24 hours a day, will monitor the services given in the event of a serious Emergency. If necessary, Global Excel will help you return to Canada for the care You need.

Urgent Message Relay — In the event of a medical Emergency, Global Excel will contact your travelling companion to keep him/her advised of your medical situation and will help you exchange important messages with your family.

Interpretation Service — Global Excel can connect you to a foreign language interpreter when required for Emergency services in foreign countries.

Direct Billing — Whenever possible, Global Excel will instruct the Hospital or clinic to bill the Insurer directly.

Claims Information — Global Excel will answer any questions you have about the eligibility of your claim, standard verification procedures and the way that the benefits under the Policy are administered.

DEFINITIONS

"Accident" means a fortuitous, sudden, unforeseen and unintentional event exclusively attributable to an external cause resulting in bodily Injury.

"Actively at Work" means the employee is physically and mentally capable of doing each and every function of his/her occupation, on the basis of the minimum number of hours worked per week specified in the Schedule of Benefits. If an employee is not actively at work due to vacation, holidays, a non-scheduled working day, maternity or parental leave, then actively at work means the capability to perform the employee's normal duties at the employee's normal place of employment on the same basis as the employee who is actively at work.

"Coverage Period" means the number of consecutive days specified in the Schedule of Benefits during which You are covered under the Policy when You take a Trip and which is calculated as of the commencement date of Your Trip.

"Dependent" means the Spouse and the unmarried child of the Participant or Spouse, who is under the age limit specified in the Schedule of Benefits, is dependent on the Participant for support and is not employed on a full-time basis. A dependent child who is physically or mentally disabled and totally dependent on the Participant for support will continue to be eligible provided he/she was covered as a Dependent under the Policy before attaining such age limit.

"Emergency" means the occurrence of a Sickness and/or Injury during the Coverage Period that requires immediate Medically Necessary treatment for the relief of acute pain or suffering, other than experimental or alternative treatment, and such treatment cannot be delayed until your return to Canada.

"Global Excel" and **"Global Excel Management Inc."** mean the company appointed by the Insurer to provide medical assistance and claims services under the Policy.

"Government Health Insurance Plan" means the health care coverage provided by Canadian provincial and territorial governments to their residents.

"Hospital" means an institution which is designated as a hospital by law; which is continuously staffed by one or more Physicians available at all times; which continuously provides nursing services by graduate registered nurses; which is primarily engaged in providing diagnostic services and medical and surgical treatment of a Sickness and/or Injury in the acute phase, or active treatment of a chronic condition; which has facilities for diagnosis, major surgery and in-patient care. The term Hospital does not include convalescent, nursing, rest or skilled nursing facilities, whether separate from or part of a regular general hospital, nor a facility operated exclusively for the treatment of persons who are mentally ill, aged, or drug or alcohol abusers.

"Immediate Family Member" means Your Spouse, son, daughter, father, mother, brother, sister, stepson, stepdaughter, stepfather, stepmother, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother.

"Injury" means any unexpected and unforeseen harm to the body that is caused by an Accident, that you sustained during the Coverage Period and that requires Emergency treatment that is covered by the Policy.

"In-patient" means a patient who occupies a Hospital bed for more than twenty-four (24) hours for medical treatment and for which admission was recommended by a Physician when Medically Necessary.

"Insurer" means Royal & Sun Alliance Insurance Company of Canada who provides this insurance.

"Medical Assistance Card" means the card provided to the Participant and on which the following information is shown: name of the Policyholder, Policy Number, Coverage Period per Trip and emergency telephone numbers.

"Medically Necessary", in reference to a given service or supply, means such service or supply:

a) is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;
b) is not experimental or investigative in nature;
c) cannot be omitted without adversely affecting the condition of the Insured Person or quality of medical care;
d) cannot be delayed until the Insured Person returns to his province or territory of residence.

"Ongoing Condition" means an acute Sickness and/or Injury that requires continuing care and/or treatment after the initial Emergency has ended as determined by the Medical Director of Global Excel.

"Participant" means a Member whom the Policyholder identifies as being entitled to coverage under the Policy and for whom the Policyholder has paid the required premium.

"Physician" means a medical practitioner whose legal and professional standing within his or her jurisdiction is equivalent to that of a doctor of medicine (M.D.) licensed in Canada, who is duly licensed in the jurisdiction in which he or she practices, who prescribes drugs and/or performs surgery and who gives medical care within the scope of his or her licensed authority. A Physician must be a person other than You or Your Immediate Family Member.

"Policy" means the group travel emergency medical insurance contract issued to, and on file with, the Policyholder, bearing the policy number specified in the Schedule of Benefits.

"Policyholder" means the company or organization specified in the Schedule of Benefits and to which the Policy is issued.

"Reasonable and Customary Costs" means costs that are incurred for approved, covered medical services or supplies that do not exceed the standard fee of other providers of similar standing in the same geographical area, for the same treatment of a similar Sickness and/or Injury.

"Sickness" means a disease or disorder of the body that results in loss while this coverage is in effect. The sickness must be sufficiently serious to prompt a reasonably prudent person to consult a physician for the purpose of medical treatment.

"Spouse" means the person to whom the Participant is legally married or with whom he has been residing for the cohabitation period specified in the Schedule of Benefits.

"Terminal Illness" means you have a condition that is cause for the Physician to estimate that You have less than six (6) months to live.

"Termination Age" means the age specified in the Schedule of Benefits at which the Participant's coverage terminates. Dependents beyond the Termination Age may be covered provided that the Participant has not yet reached the Termination Age.

"Terrorism" means an ideologically motivated unlawful act or acts, including but not limited to the use of violence or force or threat of violence or force, committed by or on behalf of any group(s), organization(s) or government(s) for the purpose of influencing any government and/or instilling fear in the public or a section of the public.

"Trip" means a journey that you undertake which commences on the date of your departure from Your province or territory of residence and ends when You return to Your province or territory of residence.

"Vehicle" means any automobile, station wagon, mini-van, sports utility vehicle (for on-road use), motorcycle, pick-up truck or a mobile home, camper truck or trailer home under 11 meters (36 feet in length), used exclusively for the transportation of passengers other than for hire, in which the Insured Person is a passenger or driver during the Trip.

"You", **"Your"** and **"Insured Person"** mean any one of the Participant or the Participant's Dependents covered under the Policy.

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 of Claim or Proof of Claim

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, and 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.

FILING A CLAIM

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 sums 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 related documents should be sent to:

Global Excel®

Global Excel Management Inc.
73 Queen St.
Sherbrooke, Quebec
J1M 0C9
Group 1057051

FINAL NOTES:

When writing the Administrator be sure to include the following:

- Your Name
- Your Address
- Your Social Insurance Number

Direct all inquiries to the Administrator:

Bilsland Griffith Benefit Administrators
Boilermakers Lodge 359 Health and Welfare Plan
#501 – 4445 Lougheed Hwy
Burnaby, BC
V5C 0E4

Toll Free: 1(877) 926-4537
Fax: (604) 433-8894
Email: boilermakers359@bgbenefitsadmin.com

POLICY INFORMATION

SELF-FUNDED Policy (Self-Insured) - Dental Care, Extended Health Benefits, Vision Care

ROYAL & SUN ALLIANCE INSURANCE COMPANY OF CANADA
GLOBAL EXCEL/VIATOR
Policy No. 1057051 – Emergency Out of Canada Benefits

MEDICAL SERVICES PLAN OF BC
Group #4823407

HOMEWOOD HUMAN SOLUTIONS
- Employee Assistance Program

MANULIFE FINANCIAL
Policy No. 31238 - Group Term Life Insurance,
Policy No 84915 – Weekly Indemnity,
Policy No 31238 - Long Term Disability Benefits

TRUSTEES' SERVICE PROVIDERS:

The Trustees are empowered to retain professional advice and services in order to assist them in the management of the Pension Plan. The Trustees' service providers are as follows:

Auditor: Meyers Norris Penney
Bank: Royal Bank of Canada
Consultant: Morneau Shepell
Custodian: RBC Dexia Investor Services
Education: International Foundation of Employee Benefit Plans (IFEBP) and Multi-Employer Benefit Council of Canada (MEBCO)
Investment Managers: Phillips Hager & North, Connor Clark & Lunn, Northleaf Investments, Gryphon Investments
Legal Counsel: Lawson Lundell
Third Party Administrator: Bilsland Griffith Benefit Administrators