Teamsters Local 213 Miscellaneous Division Health and Welfare Plan

May 2007

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From the Board of Trustees

Teamsters Local Union No. 213

Affiliated with the International Brotherhood of Teamsters, Teamsters Canada and the Canadian Labour Congress.

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To our Members

The Teamsters Local 213 Miscellaneous Division Health and Welfare Plan has been established to provide Health and Welfare benefits for all eligible members and their covered dependents.

This booklet outlines benefits to which eligible members and their dependents may be entitled and outlines the procedures to be followed when making claims.

The Teamsters Local 213 Miscellaneous Division Health and Welfare Plan consists of this booklet, the Trust Agreement establishing the Plan and any contracts which the Trustees enter into.

This booklet has been prepared to provide information about the benefits provided by the Plan. Any disputes regarding claims for those benefits will be resolved by reference to all of the relevant documents and contracts.

Should you require any information on the Plan, please contact the Plan Administrator's office.

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SUMMARY OF BENEFITS

This booklet should be used in combination with information from your Collective Agreement, to determine the benefits to which you are entitled.

Medical Services Plan Of British Columbia (MSP)
Basic medical, hospital and paramedical services provided to all enrolled residents of British Columbia.

Group Life Insurance
The benefit amount shown in your Collective Agreement is payable in the event of your death from any cause.

Accidental Death, Disease And Dismemberment
An additional benefit based upon the Group Life Insurance amount is payable in the event of your accidental death or dismemberment, provided on a 24 hour coverage basis.

Short Term Disability
An amount payable in accordance with your Collective Agreement for a period of 26 or 52 weeks in the event of **non-occupational** illness or injury, not caused by a third party.

Extended Health Care
Coverage for expenses resulting from illness or injury which are not covered under MSP.

Direct Pay Drug Benefit *
Coverage for prescription drugs through the Extended Health Benefit on a direct pay basis to a participating pharmacist.

Long Term Disability
An amount payable in accordance with your Collective Agreement in the event of total disability. This benefit is payable upon the expiration of the Short Term Disability Benefit until age 65.

Dental Care
Coverage for dental services based on the Pacific Blue Cross Dental Fee Schedule or the practitioner's usual and customary fee, whichever is the lesser, and in accordance with the percentage of coverage set out in your Collective Agreement.

*** Refer to your Collective Agreement to see if this benefit is provided.**

Eligibility Requirements

You and your dependents will participate in the Health and Welfare Plan in accordance with the provisions of your Collective Agreement or your employer's Participation Agreement, which may be summarized as follows:

- from the first of the month coincident with or next following 30 calendar days of employment with the same employer for benefits other than Dental benefits, and from the first of the month coincident with or next following 60 calendar days of employment with the same employer for Dental benefits, check your Collective Agreement as this may differ, or
- from the date of employment for transferred members of the Plan.

Enrollment cards must be completed before benefits will be paid.

Coverage

Coverage under the Plan is available to you as the member and your dependents.

Dependent means:

- your spouse; or
- an unmarried child of yours, or of your spouse or your former spouse, under the age of 21 years (19 for MSP) provided such child is mainly dependent on and living with you or your spouse or your former spouse; or
- an unmarried child provided the child is in full-time attendance at a recognized school, college or university and is mainly dependent on you, your spouse or your former spouse; or
- an unmarried mentally or physically challenged child, of yours or of your spouse or your former spouse, of any age, provided such child is mainly dependent on and living with you, your spouse or your former spouse.

Spouse means a person residing with you and designated by you as your spouse.

Transfer Provision

A member who was insured under the Plan will be eligible to rejoin the Plan on the date hired, provided that within the previous 30 day period, you were covered by the Plan with another employer. You must advise the new employer of such eligibility.

Lay-off Coverage

In accordance with the provisions contained in your Collective Agreement (if any), you may be entitled to lay-off coverage on the first of the month following the date of lay-off. Should you return to work with the same employer prior to the lay-off coverage expiry date, your full Plan coverage will be reinstated as of the date you return to work.

Termination of Coverage

Date of employment termination for Short Term Disability and Long Term Disability; end of the month in which employment is terminated for all other benefits.

DESCRIPTION OF BENEFITS

Medical Services Plan of British Columbia (MSP)

Services as provided by the Medical Services Plan of British Columbia.

Group Life Insurance

The amount of Group Life Insurance shown in your Collective Agreement will be paid to your beneficiary at your death from any cause.

Beneficiary

Your beneficiary may be any person or persons you name. You may change your beneficiary at any time, subject to the laws governing such changes, by written notice on a form which can be obtained from the Plan Administrator. If there is no named beneficiary, benefits will be payable to your estate. It is very important that a designated beneficiary be shown on your enrollment card.

Disability

If you become totally disabled while insured and prior to your 65th birthday, your Group Life Insurance will be continued until you reach age 65.

Conversion Privilege

On termination of your Group Life Insurance you can apply for an individual policy with Co-operators Life Insurance Company without providing evidence of health. The policies available are the Ordinary Life Plan, Limited Payment Life, Term to Age 65, or One Year Term Plan (non-renewable) at The Co-operators regular rates. This individual policy may be limited to the lesser of $200,000 or the difference between the amount of insurance at the time of your termination and the amount of insurance for which you are eligible under a new group contract at the time you are exercising your right to convert.

The individual policy will be issued only if a completed application and the required premium are received by The Co-operators within 31 days after your termination of coverage. You will continue to be insured during the 31 day conversion period whether or not you apply for conversion.

Reduction/Termination Due to Age

Your coverage amount will reduce by 50% at age 65. That reduced amount remains unchanged until coverage termination at age 70.

Age Restriction

Group Life Insurance will not be provided if you are age 65 or over when you first join the Plan.

Accidental Death, Disease & Dismemberment

If death, dismemberment or loss occurs because of injury effected solely through accidental means not due to negligence on your part, and within 365 days after the accident, payment will be made as follows:

	Percentage of Principal Sum
Life	100%
Loss of or Loss of Use of:	
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand or foot and sight of one eye	100%
Speech and hearing in both ears	100%
One leg or one arm	75%
One hand or one foot	66 2/3%
Sight of one eye	66 2/3%
Speech or hearing in both ears	66 2/3%
Thumb and index finger of the same hand	33 1/3%
Hearing in one ear	25%
Quadriplegia (total and irreversible paralysis of all four limbs)	200%
Paraplegia (total and irreversible paralysis of both lower limbs)	200%
Hemiplegia (total and irreversible paralysis of one arm and one leg on the same side of the body)	200%

Maximum Benefits

The Principal Sum is the maximum amount payable for all losses resulting from one accident or Critical Disease with the exception of paraplegia, quadriplegia and hemiplegia where the benefit is 200% of the principal sum.

"Loss" shall mean with regard to hands or feet, 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 index finger, actual severance through or above metacorpophalangeal joints; with regards to speech and hearing,

entire and irrevocable; with regard to paralysis (Quadriplegia, Paraplegia, Hemiplegia), loss must be complete and irreversible paralysis of such limbs. Loss of Use 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.

Critical Disease Benefit

A benefit equal to 10% of the Principal Sum to a maximum of $50,000 is payable if you are diagnosed prior to age 65 with one of the following diseases while insured and become totally disabled for a continuous period of nine months.

Poliomyelitis	Type I Diabetes (Insulin Dependent)
Parkinson's Disease	Amyotrophic Lateral Sclerosis (ALS)
Huntington's Chorea	Peripheral Vascular Disease
Multiple Sclerosis	Necrotizing Fascitis
Alzheimer's Disease	

Total disability is defined as the inability to perform any occupation. Benefits are limited to the first covered critical disease in your lifetime.

Spouse Occupational Training Benefit

If you die, and a loss is payable, The Co-operators will pay the reasonable and necessary expenses actually incurred for books and tuition, within two years of the date of your death, to your spouse who engages in a formal occupational training program in order to become qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, not to exceed $10,000 for all such expenses.

Exposure And Disappearance

If your body has not been found within one year after the date of 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 have suffered loss of life resulting from bodily injury caused by an accident at the time of such disappearance, sinking or wrecking.

Repatriation Benefit

If you suffer loss of life from any cause and were at least 100 kilometres from your normal place of residence, The Co-operators will pay up to $10,000 for the preparation and transportation of your body back to your place of residence.

Rehabilitation Benefit

A maximum benefit of $10,000 will be paid for the services of a licensed rehabilitation provider if you sustain an injury or are diagnosed with one of the above listed Critical Diseases which results in a loss payable and the loss requires that you undergo special training to be qualified to engage in a special occupation that you would not normally have engaged in except for such loss. Services must be provided within two years of the date of the loss.

Family Transportation Benefit

When you sustain a covered loss and are confined as an inpatient in a hospital located not less than 150 kilometers from your normal place of residence, The Co-operators will pay the reasonable expenses actually incurred by all members of your immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to the hospital, not to exceed $3,000 for all such expenses. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometer traveled.

Home Alteration And Vehicle Modification Benefit

In the event you sustain a covered loss and you subsequently require the use of a wheelchair to be ambulatory, The Co-operators will pay a benefit not to exceed $10,000 for the reasonable and necessary expenses actually incurred within two years of the date of the loss for:

a) the cost of alterations to your normal place of residence and/or
b) the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by licensing authorities where required, for the purpose of making the vehicle wheelchair accessible.

Exclusions

No payment will be made for any loss caused by, resulting from or related to any of the following:

- suicide or attempted suicide or self-inflicted injury;
- insurrection or war (whether war is declared or not), or participation in any riot;
- active service in the armed forces of any country;
- travel or flight in any aircraft, or descent from such aircraft, if you were the pilot or a member of the aircraft crew, or if such flight is made for purposes of instruction, training or testing;
- committing, attempting or provoking an assault or criminal offense;
- medical care or treatment of any kind, including surgery.

Age Restriction

Accidental Death, Disease and Dismemberment will not be provided if you are age 65 or over when you first join the Plan.

Short Term Disability

Short Term Disability will be paid to you for loss of income due to **non-occupational** bodily injury or sickness not caused by a third party.
The benefit will be paid from the latest of the following dates:
- the first day of disability due to accident;
- the fourth day of disability due to illness, exertion, exposure or strain;
- the date first seen by a physician after becoming disabled.

The benefit will be paid for a maximum period of 26 or 52 weeks. Refer to your Collective Agreement.

To Claim You Must:

- be unable to perform your regular work;
- have been seen by and be under the personal full-time care of a legally qualified physician, recognized by the College of Physicians and Surgeons of Canada or the United States;
- submit your claim within 30 days of commencement of disability unless special circumstances prevent you from doing so.

Benefits are payable for a maximum of six weeks while you are under the full-time care of a chiropractor in respect of disabilities normally treated by a chiropractor.
This benefit is calculated on a seven day work week basis, which includes Saturday and Sunday.

The Plan does not cover occupational accidents or any condition which entitles you to Workers' Compensation Benefits.

Recurring Disabilities

A later disability, due to the same or related cause, will be considered a continuation of the previous disability claim if you return to work for a period of less than four consecutive weeks.

Benefits Payable Where A Third Party Is Involved

Where you suffer a disability as a result of an injury or sickness for which a third party is, or may be, directly or indirectly, either in whole or in part legally liable, no Short Term Disability benefits are payable under the Plan.
If you have the right to recover money from a third party as compensation for sickness or injury but the liability of the third party has not yet been determined, you may apply to the Plan for an advance payment of any benefit which you may be ultimately entitled to receive under the Plan.
No advance payment of benefits will be made unless you are otherwise eligible to receive benefits and you agree in writing to do the following:

a) Take all steps necessary to recover from the third party, the total of the benefits advanced or to be advanced under this provision, including without limitation, directing your lawyer to repay to the Plan the full amount of the benefits directly from any monies received pursuant to any judgment or settlement;
b) Pay all legal fees incurred in pursuing the action against the third party;
c) Repay to the Plan the full amount of the benefits advanced or to be advanced to you under this provision in the event the claim against the third party is abandoned or settled without the written consent of the Plan;
d) Satisfy all of the terms and conditions of the Plan for eligibility and payment of Short Term Disability as if you were totally disabled;
e) Enter into a Reimbursement Agreement with the Plan setting out the terms and conditions for repayment of the benefits;
f) Consent to the release by the third party of all information in their possession relating to your claim. In the event that any of the above parties decline to provide the required information, you must provide such information which is in your possession as requested by the Plan.

If you fail to comply with sub-paragraphs a) to f), then the Plan may terminate the advance payment of Benefits.

Rehabilitation Employment/Graduated Return to Work

If you are disabled, receiving benefits and return to work with your employer on a rehabilitative (or graduated return to work) basis, the benefits paid to you by BC Life will be reduced by 50% of any income earned from the rehabilitative employment. The combined total of the benefits from BC Life less 50% of the rehabilitative income, plus the rehabilitative income cannot exceed 100% of your average weekly wage prior to the commencement of the disability. Benefits will only be paid to a maximum of one period of total disability whether due to one or more causes.
Before you will be considered partially disabled and ready for a graduated return to work or able to be part of a rehabilitation program, there must be full agreement from you, your attending physician and your employer.

Limitations

No amount will be payable under this benefit for any loss which results from or is caused by:
- **sickness or bodily injury arising out of or in the course of your employment,**
- intentionally self-inflicted sickness or injury, while sane or insane,
- insurrection or war, whether or not war is declared, or any act incident to such insurrection or war, or participation in any riot,
- medical or surgical care which is cosmetic, unless such care is rendered as a result of injuries caused by an accidental bodily injury while you are insured for this benefit and the loss is incurred while your insurance is in force,
- participation in or attempt or commission of one or more offenses under the Criminal Code of Canada or similar legislation in another jurisdiction.

No amount will be payable under this benefit for any period during which you are imprisoned.

Out Of Country Claims

If you become disabled outside of Canada, you cannot apply for Short Term Disability until you return to Canada.

Long Term Disability

Long Term Disability benefits as shown in your Collective Agreement are payable for any period of Total Disability while covered.

Payments commence upon the expiration of Short Term Disability.

Regular care and attendance by a licensed physician is required. For psychotic disorders you must be under the regular care and attendance of a legally qualified psychiatrist. For continued Total Disability, benefits are paid throughout the maximum benefit period, but not after death, during imprisonment, or beyond age 65.

Definition Of Total Disability

Total Disability means your complete inability, due to injury or sickness, to engage in any gainful occupation for which you are qualified, or may reasonably become qualified by reason of your training, education or experience. Total Disability will be deemed to exist only during a period in which you are under the regular care and attendance of a legally qualified physician of medicine, and will not be deemed to exist while you are engaged in any gainful occupation except that provided under the rehabilitation program as outlined below.

You will not be considered totally disabled and unable to engage in any occupation because of the unavailability of work where you reside.

Rehabilitation Benefit

If you enter into a rehabilitation program for which you receive remuneration, Total Disability will be considered to continue during the rehabilitation period up to 24 months from the date of entry into the program.

If you are receiving remuneration from the rehabilitation program, the amount of the monthly disability benefit will be reduced to the extent that the sum of your disability benefits, the rehabilitation remuneration, and other benefits do not exceed 100% of your rate of earnings immediately prior to becoming disabled.

Benefits will be terminated if you refuse to participate or co-operate in a rehabilitation program which is considered appropriate by the claims adjudicator.

Benefits Payable Where A Third Party Is Involved

Where you suffer a Total Disability as a result of an injury or sickness for which a third party is, or may be, directly or indirectly, either in whole or in part legally liable, no Long Term Disability benefit are payable under the Plan.

If you have the right to recover money from a third party as compensation for sickness or injury but the liability of the third party has not yet been determined, then you may apply to the Plan for an advance payment of any benefit which you may be ultimately entitled to receive under the Plan.

No advance payment of benefits shall be made unless you are otherwise eligible to receive benefits and you agree in writing to do the following:

a) Take all steps necessary to recover from the third party, the total of the benefits advanced or to be advanced under this provision, including without limitation, directing your lawyer to repay to the Plan the full amount of the benefits directly from any monies received pursuant to any judgment or settlement;
b) Pay all legal fees incurred in pursuing the action against the third party;
c) Repay to the Plan the full amount of the benefits advanced or to be advanced to you under this provision in the event the claim against the third party is abandoned or settled without the written consent of the Plan;
d) Satisfy all of the terms and conditions of the Plan for eligibility and payment of Long Term Disability as if you were Totally Disabled;
e) Enter into a Reimbursement Agreement with the Plan setting out the terms and conditions for repayment of the benefits;
f) Consent to the release by the third party of all information in their possession relating to your claim. In the event that any of the above parties decline to provide the required information, you must provide such information which is in your possession as requested by the Plan.

If you fail to comply with sub-paragraphs a) to f), then the Plan may terminate the advance payment of benefits.

Income From Other Sources

The amount of your monthly benefit will be reduced by the amount of any payments you are eligible to receive from Workers' Compensation regardless of the cause of disability.

If you are entitled to receive disability benefits from any other sources (excluding individual policies), the benefits payable under this Plan will be reduced so that the total benefits payable from all sources do not exceed 75% of your pre-disability salary.

Pre-existing Conditions Limitation

If you are absent from work due to sickness or bodily injury at any time during the four week period immediately preceding your effective date of insurance, any disability which is due to the same or related sickness or bodily injury will not be covered until you have completed subsequent to your last day of absence, a period of four consecutive weeks of employment without absence from work due to the same or related sickness or bodily injury.

Exclusions

No amount will be payable under this benefit for any loss which results from or is caused by;

- intentionally self-inflicted sickness or injury, while sane or insane;
- war, insurrections or hostilities of any kind, regardless of whether or not you were actually participating therein;
- medical surgical care which is cosmetic, unless such care is rendered as a result of injuries caused by an accidental bodily injury sustained while you are insured under this benefit and the loss is incurred while your insurance is in force and within the 90 day period immediately following the date the accidental bodily injury is sustained;
- intentional or unintentional use of drugs for non-medical purposes;
- excessive use of alcohol, unless on an active basis in medically supervised programs, to correct such excessive use;
- your commission of, or your attempt to commit a criminal offense excluding any offense related to driving a vehicle.

Recurring Disabilities

Successive periods of disability arising from the same or related cause and separated by less than four weeks will be treated as one period of continuous Total Disability.

Extended Health Care (EHC)

Extended Health Care supplements your MSP coverage. The Plan does not cover any benefits for which provision is made under or pursuant to the Medicare Protection Act and any amendments to the Act, or the BC Pharmacare Plan.

Benefits Payable Where A Third Party Is Involved

Where you suffer a disability as a result of a work related incident covered by Workers' Compensation, or an injury or sickness for which a third party is, or may be, directly or indirectly, either in whole or in part legally liable, no Extended Health care benefits are payable under the Plan.
If you have the right to recover money from Workers' Compensation or a third party as compensation for sickness or injury but the liability of Workers' Compensation or the third party has not yet been determined, then you may apply to the Plan for an advance payment of any benefit which you may be ultimately entitled to receive under the Plan.
No advance payment of benefits will be made unless you are otherwise eligible to receive benefits and you agree in writing to do the following:

a) Take all steps necessary to recover from Workers' Compensation or the third party, the total of the benefits advanced or to be advanced under this provision, including without limitation, directing your lawyer to repay to the Plan the full amount of the benefits directly from any monies received pursuant to any judgment or settlement;
b) Pay all legal fees incurred in pursuing the action against Workers' Compensation or the third party;
c) Repay to the Plan the full amount of the benefits advanced or to be advanced to you under this provision in the event the claim against Workers' Compensation or the third party is abandoned or settled without the written consent of the Plan;
d) Satisfy all of the terms and conditions of the Plan for eligibility and payment of Extended Health Benefits;
e) Enter into a Reimbursement Agreement with the Plan setting out the terms and conditions for repayment of the benefits;
f) Consent to the release by Workers' Compensation, the third party or the Insurance Corporation of BC (ICBC) of all information in their possession relating to your claim. In the event that any of the above parties decline to provide the required information, you must provide such information which is in your possession as requested by the Plan.

If you fail to comply with sub-paragraphs a) to f), then the Plan may terminate the advance payment of benefits.

Deductible

(Applicable to all Extended Health Care benefits except the Direct Pay Drug Benefit)
The deductible is $25 (single or family) and is applied to the eligible expenses and Vision Care expenses each calendar year. Not more than $25 will be applied against the combined expenses of you and your dependents during any calendar year. If in any calendar year, the eligible expenses incurred do not exceed the deductible, the eligible expenses incurred in the last three months of that calendar year may be applied against the deductible for the next calendar year.

Co-Insurance

For expenses which exceed the deductible amount, the Plan provides for a payment of 100% of such eligible expenses, subject to the outlined limitations and excluding benefits paid by BC Pharmacare.

Maximum Benefits

The overall maximum payable under Extended Health Care is unlimited. However, there are individual benefit maximums for specified Eligible Expenses as outlined in this booklet.

Eligible Expenses

A. Expenses Incurred Inside Your Province Of Residence

Charges for the following:

1. a) drugs purchased from a pharmacist on the prescription

of a physician or, where legally permitted, a dentist for a maximum of 34 days supply per prescription. If you can satisfy Pacific Blue Cross that a larger supply is necessary and more economical, a larger supply may be prescribed up to 100 days per prescription;

b) fees of a registered pharmacist for dispensing drugs or medication;

c) injectable drugs provided by a physician or dentist, but excluding preventative vaccines; and

d) insulin preparations, testing supplies, needles, and syringes for diabetics.

Not covered are charges for Viagra; vitamin injections or preparations; food and mineral supplements; preventative vaccines; drugs or supplies used for contraception or fertility purposes, or to suppress an addiction including those for smoking cessation; drugs which do not by law require a prescription; and drugs not approved under the Food and Drug Act for sale and distribution in Canada.

2. Ambulance service and, when recommended by a physician, return fare for transportation of a patient in an emergency by ambulance, railroad, boat or airplane; in an acute emergency situation, charges by air ambulance from the place where the injury or sickness occurred to the nearest hospital or from the hospital to the patient's residence, including the return fare of one attending physician, nurse, first aid attendant, or other attending person where such person is necessary to care for the patient during transport.
   In an acute emergency, the recommendation of a physician is not required for transportation.
   Expenses for the following are not eligible:
   a) transportation arranged at the patient's convenience;
   b) transportation arranged after waiting for hospital accommodation for a condition not requiring immediate transportation to the hospital; or
   c) transportation for the removal of a patient from one hospital to another except in cases where the hospital from which the patient is removed has inadequate facilities to provide the required treatment.

3. Fees of a registered nurse (other than a registered nurse who is related to or who is residing with you or your dependent) for special duty nursing in an acute case where:
   a) the attendance of a registered nurse is referred by a physician;
   b) the fees are not covered under the provincial hospital program's special nursing services; and
   c) if the service is performed in an acute hospital, the registered nurse providing the service is not an employee of the hospital on duty at that time.
   The maximum payable is $10,000 per calendar year or $25,000 per lifetime, whichever comes first

4. Fees of a registered physiotherapist (other than a physiotherapist who is related to or who is residing with you or your dependent) to a maximum of $200 payable per person per calendar year in addition to charges for X-rays.

5. Fees of a registered massage practitioner (other than a massage practitioner who is related to or who is residing with you or your dependent) to a maximum of $100 payable per person per calendar year.

6. Fees of a registered podiatrist (other than a podiatrist who is related to or who is residing with you or your dependent) to a maximum of $200 payable per person per calendar year in addition to charges for X-rays.

7. Fees of a registered chiropractor (other than a chiropractor who is related to or who is residing with you or your dependent) to a maximum of $200 payable per person per calendar year in addition to charges for X-rays.

8. Fees of a registered naturopathic physician (other than a naturopathic physician who is related to or who is residing with you or your dependent) to a maximum of $200 payable per person per calendar year in addition to charges for X-rays.

9. Fees of an approved acupuncturist (other than an acupuncturist who is related to or who is residing with you or your dependent).

10. Fees of a registered speech language pathologist (other than a speech language pathologist who is related to or who is residing with you or your dependent) to a maximum of $100 payable per person per calendar year.

11. Fees of a registered psychologist (other than a psychologist who is related to or who is residing with you or your dependent) to a maximum of $200 payable per person per calendar year.

12. Fees of a dentist for repairs or replacement of prosthetics or natural teeth to a maximum based on the Pacific Blue Cross Dental Fee Schedule or the dentist's usual and customary fee, whichever is less, in your province of residence current at the time the expense was incurred. The services of the dentist must have been necessary due to an injury to the natural teeth or prosthetics caused by a direct external blow to the mouth or face resulting in immediate damage and not by an object intentionally or unintentionally being placed in the mouth. The treatment must have commenced within one year from the date of the injury.

13. Fees of a Christian Science practitioner, if listed in the Christian Science Journal.

14. Charges for oxygen and its administration, blood or blood plasma and its administration, ostomy or ileostomy supplies, artificial limbs or eyes, crutches, splints, casts, trusses or braces prescribed by a physician.

15. Charges for one pair of custom fitted orthopedic shoes per lifetime (including repairs), or one pair of custom made foot orthotics per lifetime (and replacements when necessitated by normal wear and tear); the order of a physician, podiatrist, or chiropractor is required plus written confirmation from the provider indicating the shoe or orthotic was specially designed and made from a 3-D volumetric model of the lower leg and/or foot using raw materials. **Contact Pacific Blue Cross or the Plan Administrator for an orthopedic shoe or custom foot orthotics claiming checklist before incurring any expenses and to obtain a copy of the required Orthopedic Shoe Fabrication Form, or Orthotic Fabrication And Casting Form which must be submitted with the claim.**

16. a) Charges (pre-authorization is required from Pacific Blue Cross for expenses in excess of $5,000) for the purchase (one per lifetime) of an electric wheelchair or manual wheelchair or an electric scooter, walker, hospital bed (manual type), respirator or cardiac screener for the management of a long term disability (a disability that lasts longer than 52 consecutive weeks). Charges for an electric wheelchair or electric scooter are eligible only when the patient is physically incapable of operating a manual wheelchair. Reimbursement will be made on the basis of customary charges for standard equipment purchased from a medical supplier. Replacement and/or repair of an electric or manual wheelchair or an electric scooter will be paid only after it has been determined by Pacific Blue Cross that this equipment is no longer functional; or

    b) charges (pre-authorization is required from Pacific Blue Cross for expenses in excess of $5,000) for the rental of an electric wheelchair or a manual wheelchair or an electric scooter, walker, hospital bed (manual type), respirator or cardiac screener for the management of a short term disability (a disability that lasts 52 consecutive weeks or less). Reimbursement will be made monthly, on the basis of the customary monthly rental charges for standard equipment and will not exceed the total purchase price for similar equipment.

17. Charges for two pairs of surgical stockings per person per calendar year.

18. Charges for two mastectomy brassieres per person per calendar year.

19. Charges for a glucose monitor to a maximum lifetime benefit payable of $250 per person.

20. Charges made by an acute care hospital for medical supplies and for a semi-private, or a private room. Charges for the rental of telephones, televisions, radios or similar equipment will not be reimbursed.

21. Charges for hearing aids for you and your dependents when prescribed by a certified ear, nose and throat specialist to a maximum of $400 in a 48 month period. Repairs, maintenance, batteries or other accessories will not be covered.

22. Charges for wigs or hairpieces when required as a result of medical treatment for injury or illness to a maximum lifetime benefit payable of $500 per person.

23. Charges for diagnostic and laboratory tests, radium treatments and X-ray examinations when authorized by a physiotherapist, naturopath, chiropractor or podiatrist.

Vision Care

Expenses incurred for the purchase of corrective lenses and frames, or contact lenses, when prescribed by a physician or optometrist. The per person maximum payable in any 24 month period is $200 or the amount shown in your Collective Agreement.

For a dependent child under 16 years of age, expenses incurred for special problems of visual acuity upon presentation of a letter of recommendation by a legally licensed ophthalmologist up to a maximum of $300 payable per child in any 36 month period.

B. Emergency Expenses Incurred Outside Your Province Of Residence

1. In the event of an acute emergency while outside your province of residence, charges made by an acute care hospital for medical supplies and for a semi-private room, or a private room if a semi-private room is not available. Charges for the rental of telephones, televisions, radios or similar equipment will not be reimbursed.

2. Customary charges for the services of physicians, and laboratory and X-ray services when ordered by the attending physician in the event of an emergency will be reimbursed to the extent that such charges exceed the amounts allowed under MSP.

3. Fees of a registered nurse for special duty nursing in an acute case due to an emergency will be reimbursed up to the amount that would have been paid if the medical service had been provided in your province of residence.

4. Charges for prescription drugs prescribed by the attending physician in sufficient quantity to alleviate an acute case in an emergency.
5. Charges for ambulance services requiring immediate transportation to the nearest hospital equipped to provide the necessary emergency treatment.
6. Charges for a regular scheduled flight, when ordered by the attending physician to transport the patient from the original hospital to an acute hospital nearest to the patient's place of residence equipped to provide the necessary treatment.
7. Charges for emergency medical services and/or supplies that would have been covered under MSP if the emergency had occurred in the patient's province of residence.

Medi-Assist Worldwide Emergency Medical Assistance

Pacific Blue Cross and Can Assistance will provide medical referral services to you and your dependents in emergency situations while travelling worldwide. Referrals will be made to physicians who will supervise medical care and if necessary will arrange emergency transportation. Trained multi-lingual personnel will also be available to assist travel companions.

Ineligible Expenses

The following are not eligible expenses and will not be reimbursed:

1. Expenses for benefits, care or services payable by or under MSP, Pharmacare, any Hospital Program or the Workers' Compensation Act whether or not a claim is made; or provided without cost or at nominal cost by any government, public or tax supported authority or agency or for which you can recover from another party.
2. Services where a physician, whether or not a participant in MSP, seeks compensation by means of balanced or extra billing.
3. The excess cost for medical services which exceed the fees under the schedule of costs prescribed by MSP, except those eligible expenses outlined in Section B on page 8.
4. Services which relate to or are necessitated by reason of:
   a) intentionally self-inflicted injury or illness, suicide or attempted suicide, while sane or insane;
   b) injury or illness resulting from willful participation in an act of war, riot or insurrection including, but not limited to, any war declared or undeclared, and armed aggression resisted by the armed forces of any country, combination of countries or international organizations;
   c) participation in or attempt or commission by you or your dependent of one or more offenses under the Criminal Code of Canada or similar legislation in another jurisdiction;
   d) occupational illness or injury, unless rejected by the Workers' Compensation Board as non-occupational.
5. Any portion of the fee of a physician not allowed under MSP as a result of non-referral.
6. Expenses for dental services or dentures, except as specifically provided in number 12 on page 7.
7. Expenses for medical services and supplies for cosmetic or elective surgery.
8. Expenses incurred for orthoptic treatment, eye glasses, contact lenses, hearing aids, including prescriptions for any of them except as specified on page 8 under Vision Care.
9. Expenses incurred prior to the time you or your dependent became eligible for coverage under this plan.
10. The cost of transportation:
    a) arranged at a patient's convenience, or
    b) arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation; or
    c) for the removal of a patient from one hospital to another, except in cases where the hospital from which the patient is removed has inadequate facilities to provide the required treatment, in the opinion of the attending physician.
11. Expenses incurred for the investigation, arrangement and coordination of the repatriation of a deceased member and/or dependent, and any related transportation charges.
12. Expenses relating to medical treatment, services or supplies incurred by a pregnant woman while travelling outside Canada and within 21 days of the expected termination date of pregnancy as determined by her attending physician.
13. Expenses incurred outside Canada for medical services and/or supplies that would not be covered under MSP, unless these out-of-country expenses were incurred in an emergency.
14. Any other item not specifically included under **Eligible Expenses.**

Co-ordinaton Of Benefits

If you or your dependents are entitled to eligible expenses under another insurance policy or plan with respect to the same charges, Pacific Blue Cross will reduce the amount payable to ensure that the total amount payable under all insurance policies and plans is not more than 100% of the charges incurred by you or your dependent.

Direct Pay Drug Benefit

(check your Collective Agreement to determine if you have this benefit)

What Is Covered?

This benefit includes prescribed drugs sold to you by a pharmacist on the prescription of a medical doctor, dentist or podiatrist for your use or for the use of one of your registered dependents.

How Does The Benefit Work?

You go to the pharmacist of your choice. Give him/her your prescription to fill. At the same time, advise the pharmacist you are covered under the Pacific Blue Cross Direct Pay Drug Benefit and show your identity card. You must satisfy the pharmacist that you are covered under the Plan for this benefit and are the rightful holder of the Identification Card. Your pharmacist:

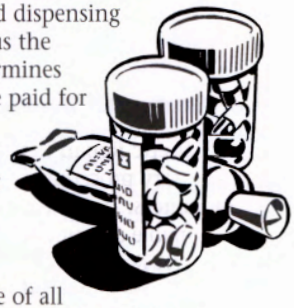
a) if a participating pharmacist and you are known to him/her, or can give adequate identification, he/she will bill directly to Pacific Blue Cross for payment;
b) if not a participating pharmacist, you will be provided with a receipt that you can send to Pacific Blue Cross for reimbursement.

Do You Have To Pay Any Of The Cost?

You do not have to pay the pharmacist any portion of the cost, provided he/she is a participating pharmacist and the charges do not exceed the cost of the medication to the pharmacist plus the recommended dispensing fee.

How Is The Amount Paid To The Pharmacist Determined?

Pacific Blue Cross will pay to you or directly to your pharmacist the usual and customary charge, provided it does not exceed the cost of the medication to the pharmacist, plus the recommended dispensing fee. The cost of the medication plus the recommended dispensing fee determines the maximum amount that will be paid for each prescription. There is no maximum limit on the amount of benefit that will be paid for you or on your behalf in any year.



Is Anything Not Covered?

The benefit is designed to take care of all your prescribed drug expenses except Viagra and drugs prescribed exclusively for contraceptive purposes, items that do not require a prescription and drug expenses covered by public or publicly-supported bodies.

Specifically, the following expenses are not paid for:

- patent or proprietary medicines;
- mechanical appliances;
- bandages and dressings;
- cosmetics and cosmetic aids;
- prescription accessories;
- vitamin preparations;
- diagnostic agents or preparations;
- artificial sweeteners;
- drugs provided or available from or paid for by Workers' Compensation or any public agency, including the Department of Veterans' Affairs;
- drugs required because of an act of war, participation in a riot or disorderly conduct, commission of an illegal act or injuries or illnesses that are self-inflicted;
- amounts prescribed in excess of normal requirements (the benefit will pay for up to a 34 day supply if such amount is considered necessary and, in cases of continuing illnesses and where it is more economical, will pay for up to a 100 day supply);
- drugs covered under another plan (Pacific Blue Cross will not pay benefits for persons covered under two plans; they must select which plan they wish to belong to);
- drugs provided by such societies as: Cancer Society; Cystic Fibrosis Society; Canadian Arthritic Society; and other like societies.

Out Of Province Expenses

If expenses are incurred for prescribed drugs as a result of an emergency while travelling outside BC, such expenses will be covered provided the prescription was prescribed by a licensed practitioner and the prescribed drugs obtained would have been covered if they had been obtained in BC, and provided sufficient information is obtained to enable Pacific Blue Cross to assess the claim. Reimbursement will not exceed the amount that would have been paid had the drugs been obtained in BC.

Caution:

1) A participating pharmacy normally may be expected to extend credit to a covered person and to make a claim to Pacific Blue Cross for payment but is not obliged to do so. Presentation of your card is like cashing a cheque. If you cannot satisfy the pharmacist as to your coverage and identity and he/she requires you to pay cash, obtain the necessary receipt and Pacific Blue Cross will reimburse you.

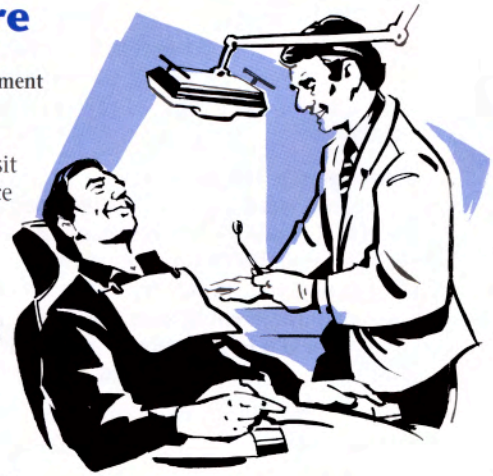
2) Identification cards issued by Pacific Blue Cross must not be treated carelessly or abused. If lost or misplaced, Pacific Blue Cross must be advised in writing immediately. The cards cannot be used by an individual who is not covered.

3) Do not indicate to the pharmacist that you or a dependent of yours is covered unless you are certain. Possession or reproduction of an identification card is not enough.

4) False statements made to the pharmacist or false claims made to Pacific Blue Cross are criminal offenses.

Dental Care

(refer to your Collective Agreement for reimbursement percentages)



You will be issued an identification card. Visit a dentist of your choice and show this card. Discuss the services proposed to be rendered and the amount of the fee and the amount, if any, which you will be required to pay.

Your dentist is not required to obtain prior approval from Pacific Blue Cross before rendering services. However, where the costs of services are other than a nominal charge, it is recommended that your dentist make an eligibility check. This eligibility check can be done by forwarding a form to Pacific Blue Cross showing the treatment planned. By using the pre-authorization form, you can be assured of the amount you may be required to pay. This avoids any embarrassment should you not be eligible for the proposed benefits. This eligibility check confirms to the dentist:

- whether you or your dependents are covered;
- whether the proposed services are a benefit under your Plan;
- whether financial or other limitations have been reached.

Using your identification cards when you are not covered may result in prosecution.

When the dentist has completed the work, he/she will complete a claim form on your behalf and forward it to Pacific Blue Cross for payment. If your dentist does not wish to forward the claim form directly to Pacific Blue Cross you may arrange to pay the dentist and you will be reimbursed by Pacific Blue Cross.

In all cases, when desiring services from your dentist under the Plan, advise him/her that you are enrolled in the Plan and discuss the charges to be made for the services and what you may be required to pay as your portion of the cost.
Only those services in the Pacific Blue Cross Dental Fee Schedule are covered benefits.

Part "A"

The benefits under this section are those services that are required to maintain teeth in good order and normal restoration services to restore them to good order.

1. **Diagnostic services:**
   All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment. This includes:
   a) examinations, consultations and diagnostic aids;
   b) standard oral examinations - two per calendar year;
   c) complete oral examination - once in any three year period;
   d) X-rays - up to the maximum established by Pacific Blue Cross;
   e) full mouth X-rays; once in any three year period.

2. **Preventive services:**
   Necessary procedures to prevent the occurrence of oral diseases including:
   a) prophylaxis and topical fluoride application - twice in one calendar year.
   b) space maintainers - to maintain space, not to obtain more space.

3. **Surgical Services:**
   Necessary procedures for extractions and other surgical procedures performed by a dentist.

4. **Endodontic Services:**
   Treatment of disease of the pulp chamber and pulp canal.

5. **Periodontic Services:**
   Procedures necessary for the treatment of diseases of the soft tissue (gums) and the bones surrounding and supporting the teeth, but not tissue grafts.

6. **Restorative Services:**
   Necessary procedures for filling teeth with amalgam, silicate (synthetic porcelain), acrylic (plastic), and composite resin restoration of tooth surfaces which have been broken down as a result of decay process, including stainless steel crowns.

7. **Major Restorative Services: (pre-authorization is recommended)**
   Inlays, onlays and gold foils will be covered only when other materials cannot be used satisfactorily. Patients choosing gold where other materials would suffice will be responsible for the difference in cost.

8. **Prosthetic Repair Services And Relines:**
   Necessary procedures required to repair fixed or removable appliances. However, repairs will not be paid for unless a reasonable amount of time elapses between requiring these services. Relines will not be covered more often than once in a 24 month period. Services of a temporary nature pending fabrication of a new denture are not covered.

Part "B" (pre-authorization is recommended)
The benefits under this section are those services required for major construction of teeth that have deteriorated and for replacement of teeth that are missing. Services in this area will not be covered more often than once every five years.

1. Crowns
   For rebuilding natural teeth where other restorative material cannot be used satisfactorily.

2. Prosthetics
   Removable Prosthetics - full upper and lower dentures or partial dentures. These will not be provided more often than once every five years.
   Crowns and Bridges - to artificially replace missing teeth with a fixed prosthesis. Where a crown and bridge has been paid by Pacific Blue Cross, a replacement of such crown and bridge will not be paid for except when approved by Pacific Blue Cross because of special circumstances.
   Appliances lost, broken or stolen will not be replaced.

Part "C"
Orthodontia
Claims incurred for orthodontic services performed by an orthodontist. Payment will be made based on the current Pacific Blue Cross Dental Fee Schedule.
You will become eligible for orthodontic services on the effective date of dental coverage. Appliances lost or stolen will not be replaced.

Extension Of Orthodontia Eligibility
Orthodontia treatment in progress on the termination date of Plan coverage will continue to be covered for 12 months. This extension of orthodontia coverage does not apply if your employer discontinues participation in the Plan.

What Portion Of The Dental Expenses Will Be Paid By The Plan?
The amount that will be paid will be calculated in accordance with the current Pacific Blue Cross Dental Fee Schedule or the dentist's usual and customary fee, whichever is less. Upon referral by a general practitioner, specialists' fees will be paid at 110% of the Pacific Blue Cross Dental Fee Schedule.
Part A services are paid at 100% of the fee amount.
Parts B and C services are paid at the percentage of the fee amount as shown in your Collective Agreement.

What Services Are Not Covered?
Payment is not made for:
- fees in excess of the Pacific Blue Cross Dental Fee Schedule;
- cosmetic dentistry, temporary procedures, hygiene instruction, tissue grafts, drugs and medicines, and implants;
- treatment covered by Workers' Compensation or publicly supported plans;
- services required as a result of an accident for which a third party is liable;
- charges for services commenced prior to the effective date of coverage; or completed after the termination date of coverage;
- charges for completing forms;
- any service in conjunction with temporal mandibular joint (TMJ) problems.

When you or your dependent is entitled to coverage under more than one plan, benefit payment will be co-ordinated so that the total payment received does not exceed 100% of dental expenses actually incurred.

Emergency Treatment
Emergency dental care will be provided anywhere in the world. If, while you are travelling or on vacation outside of British Columbia, you require dental care as a result of an emergency, you are entitled to services of a duly qualified dentist in the event of such emergency, and will be reimbursed up to the amount that the Plan would have paid had the services been rendered in British Columbia.

Change Of Dentist
You may not change your dentist during the course of treatment without prior approval of Pacific Blue Cross. This does not prevent you from going to the dentist of your choice. If you find it necessary to change your dentist after a course of treatment has commenced, the proper procedure is to tell both dentists concerned and notify Pacific Blue Cross that you propose to change dentists. Provided there is no duplication of service, Pacific Blue Cross will approve the change. If you fail to carry out this procedure and fail to advise both dentists, payment will not be made to the second dentist.

Claims Information

Information can be obtained from your employer through the Plan Administrator's office.
The claims forms must be fully completed and submitted within the relevant time limits to ensure payment.
If the forms have to be returned due to incomplete data, the claim cannot be processed quickly. Please ensure that all questions are answered on the forms and they have been properly signed by all parties.

Group Life Insurance and Accidental Death, Disease and Dismemberment

Specific instructions and forms can be obtained from the Plan Administrator's office.

Short Term Disability

As soon as possible after you become disabled, you should:

- see your doctor immediately (if you have not already done so);
- obtain a claim form from your employer or the Plan Administrator's office;
- complete the "Employee's Statement" on the front of the claim form and ensure that you have fully completed and signed the form;
- have your employer complete the "Employer's Statement";
- have your doctor complete the "Attending Physician's Statement" on the reverse side of the same form;
- have the form sent to BC Life and Casualty by either your doctor or yourself.

Claims must be submitted within 90 days of your date of disability.

Extended Health Care (EHC)

You must accompany your receipts with information that will identify you as a member. Receipts for small amounts should be accumulated and submitted at your convenience. All receipts for the previous calendar year must be sent in by the end of the following year.
Complete a claim form in accordance with the directions on the reverse side of the EHC claim form and submit it to Pacific Blue Cross along with your original receipts. The receipts should have sufficient information to identify the member of your family, the date on which the expense was incurred and the services provided, or the type of medication prescribed. Claims should be submitted as soon as you have accumulated eligible receipts in excess of the $25 calendar year deductible. Claim forms can be obtained from the Plan Administrator's office, or your employer.

Pharmacare

BC Pharmacare provides for reimbursement to all BC residents for prescription drugs purchased in BC that are supported by an official BC Pharmacare receipt, and certain prosthetic appliances. BC Pharmacare reimburses 70% of prescribed drug expenses after their required deductible. Your Extended Health Care Benefit is co-ordinated with BC Pharmacare so that there is not a duplication of payment.

Direct Pay Drug Benefit *

A participating pharmacist will send the bill directly to Pacific Blue Cross for payment. Prescription drug expenses not sent directly to Pacific Blue Cross can be claimed on claim forms available from the Plan Administrator's office.

*** Refer to your Collective Agreement to see if this benefit is provided.**

Long Term Disability

Claim forms and specific instructions can be obtained from the Plan Administrator's office.

Dental Care

Use your identification card and refer to page 11 of this booklet for instructions. Claims must be submitted within 12 months from the date the expense was incurred.

Taxable Benefits

The premium paid on your behalf by the Plan for the following benefits is considered taxable income by Canada Revenue Agency. Therefore, you will receive a T4A showing the premium amount paid for:

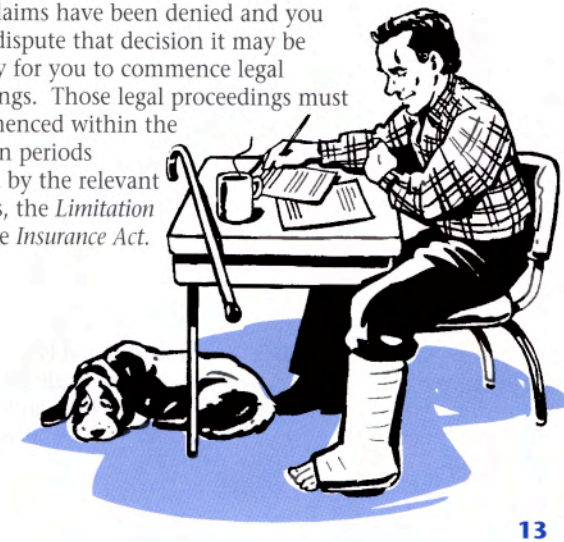
- Group Life Insurance
- Medical Services Plan of BC (MSP)

Canada Revenue Agency may treat disability benefits paid to you from the Claims Adjudicators as taxable income. In such cases you will receive a T4A.

Time Limits

Claims for certain benefits must be brought within the times prescribed in this booklet or the relevant contracts. Failure to bring a claim within those time limits could result in your claim being denied.

Where claims have been denied and you wish to dispute that decision it may be necessary for you to commence legal proceedings. Those legal proceedings must be commenced within the limitation periods provided by the relevant contracts, the *Limitation Act* or the *Insurance Act*.



For Further Information

Please contact:

Teamsters Local 213
Miscellaneous Division
Health and Welfare Plan

490 East Broadway
Vancouver, BC V5T 1X3
Telephone: (604) 879-8627
Toll-Free: 1-800-972-6241
Fax: (604) 872-4725
Email: inquiries@teamsters213benefits.com

When writing, please be sure to include the following information:
Your name, the name of your employer, your address, your telephone number, your identification number (Social Insurance Number), and your group number.
Please notify the Plan Administrator of any change of address, or dependent status.

Plan Administrator

Teamsters Local 213 Members Benefit Plans
490 East Broadway
Vancouver, BC V5T 1X3

Claims Adjudicators

Pacific Blue Cross (EHC and Dental)

BC Life and Casualty (Short Term Disability)

The Co-operators (Group Life Insurance; Accidental Death, Disease and Dismemberment; and Long Term Disability)