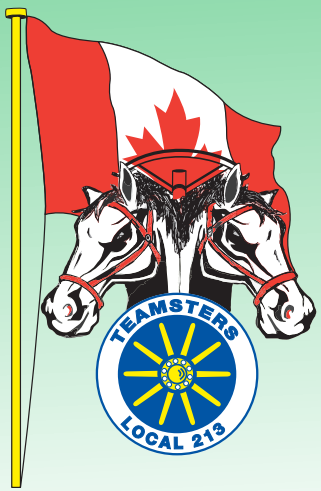
TEAMSTERS LOCAL 213 HEALTH AND WELFARE PLAN

HOUR BANK DIVISION



MEMBER BOOKLET

JUNE 2019

INTRODUCTION FROM THE BOARD OF TRUSTEES

We are pleased to provide a new booklet which outlines your benefits under the Hour Bank Division.

The Teamsters Local 213 Health and Welfare Plan (the **"Plan"**) was established March 1, 1966 to provide health and welfare benefits for all eligible union members and their dependents. The benefits are funded by contributions made by participating employers in accordance with collective agreements.

The Plan is governed by the Health and Welfare Trust Agreement (the **"Trust Agreement"**), the Plan Text adopted by the Trustees under the Trust Agreement (the **"Plan Text"**) and applicable Federal and Provincial laws and regulations.

The Plan is operated under the guidance and supervision of the Board of Trustees of the Teamsters Local 213 Health and Welfare Plan (the **"Board of Trustees"**), whose duties, responsibilities and authority are set out in the Trust Agreement. The Teamsters Local Union No. 213 (the **"Union"**) appoints Trustees who have complete authority in operating the Plan. Only the Trustees can make changes to the Plan coverage as they may deem necessary from time to time. Any issues concerning eligibility for, or the amount of, or entitlement to health and welfare benefits under the Plan will be resolved by the Trustees by reference to the Trust Agreement, the Plan Text, the insurance contracts, and applicable legislation.

The Board of Trustees is responsible for the overall administration of the Plan.

To assist them in carrying out these responsibilities, the Trustees retain professional advisors and service providers to assist in the management of the Plan. The Trustees use the Plan Administration Office to carry out the day-to-day administration duties, and have appointed a trust company which has custody of the health and welfare fund invested assets, an investment manager who directs investments and an actuary to advise on the design and financial operation of the Plan.

The Plan exists for the sole purpose of providing health and welfare benefits to eligible members and their covered dependents. The Plan is not an insurance company, and the short term disability, long term disability in relation to non-federally regulated employers, extended health, prescription drug and dental benefits provided through the Plan are not insured by an insurance company regulated under the British Columbia *Financial Institutions Act*. The Plan is exempt from the regulatory requirements of the British Columbia *Financial* Institutions Act.

The benefits provided under the Plan from time to time are not guaranteed. The Board has full discretion to increase, decrease, amend, revoke or terminate benefits at any time in consideration of the financial position of the plan and any legislative or regulatory requirements, and you will be notified when any benefit changes take place.

This booklet is a summary document only and while it is believed to be accurate in its content, the provisions of the Trust Agreement, the Plan Text, the applicable insurance contracts and applicable legislation will govern exclusively any disputes concerning particular rights or entitlements. For clarity, to the extent that there is any conflict between the content of this booklet and a provision of the Trust Agreement, the Plan Text, an applicable insurance contract or applicable legislation, the provision of the Trust Agreement, Plan Text, insurance contract or legislation (as the case may be) will prevail. This booklet is not a contract and does not confer or grant any rights, contractual or otherwise.

Please read this booklet carefully to understand your benefits and the rules – this booklet provides you with an informal summary of the Plan, the rules regarding eligibility for benefits under the Plan, and the procedures to follow in applying for benefits under the Plan.

The current members of the Board of Trustees of the Plan are:

Walter Canta, Chair
Jason Conway
Anita Dawson
Mike Deneef
Don Doerksen
Rob Moody
Amneet Sekhon

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PLAN ADMINISTRATION OFFICE

If you have any questions about the Plan, your eligibility or coverage, please call or write the Plan Administration Office:

Teamsters Local 213 Members Benefit Plans

490 East Broadway
Vancouver BC V5T 1X3

Telephone:

(604) 879-8627	Vancouver and Lower Mainland
1-800-972-6241	Other areas in BC and the Yukon

Email: inquiries@teamsters213benefits.com

Fax: (604) 872-4725

Website: www.Teamsters213.org/Benefits

Important: Contact the Plan Administration Office if there are any changes to your status or personal information as new enrolment forms must be completed, (eg. address, marital status, spouse, beneficiary update), or if you receive a document from the Plan Administration Office and notice an error.

PLAN CLAIMS ADJUDICATORS & POLICY INFORMATION

Pacific Blue Cross Policy 903213

- Dental (Self-Insured)
- Extended Health Care (EHC) (Self-Insured)
- PBC Medi-Assist: Policy #549 (Emergency Worldwide Travel Assistance)

The Co-operators Life Insurance Company

- Short Term Disability (Self-Insured) Contract G1018
- Long Term Disability (Self-Insured) Contract G1018 or
- Long Term Disability Insured Policy G40547 for Members in Federally Regulated Employment
- Accidental Death and Dismemberment Policy: G1018-200

Great-West Life Assurance Company: Insured Policy #328541

- Group Life Insurance

SUMMARY OF BENEFITS: HOUR BANK DIVISION

Benefits	Amount
1. Group Life Insurance (for Eligible Members Only, terminates age 70)	
- Amount Payable	$61,000
2. Accidental Death & Dismemberment Insurance (for Eligible Members Only, terminates age 70)	
- Amount Payable	$50,000
(policy includes critical disease benefit at 10% (terminates age 65)	
3. Dental Care (for Eligible Members & Dependents)	
- Deductible	$0
- Co-Insurance Part A (Basic Services)	100%
- Co-Insurance Part B (Major Restorative)	80%
- Annual Maximum Part A and Part B Combined	Unlimited
- Co-Insurance Part C – Orthodontic Treatment	50%
- Orthodontic Lifetime Maximum	$3,000 per person
4. Extended Health Care (for Eligible Members & Dependents)	
- Deductible (not applicable to drugs)	$25
- Percentage Reimbursement	80%
- Pay Direct Drugs	Pacific Blue Cross' Low Cost Alternative Pricing
- Plan Maximum	Unlimited
- Emergency Out-of-Province Percentage	100%
- Vision Care Maximum (includes eye exams and laser eye surgery)	$600 max. per 24 mo. period
dependent child under 16 when prescribed	$300 max. per 36 mo. period
- Other Eligible Expenses (Paramedicals, etc.)	As per Extended Health Care section
5. Short Term Disability (for Eligible Members Only)	
- Weekly STD Benefit: 100% of pre disability earnings Up to the maximum weekly sickness benefit payable under the *Employment Insurance Act* (as amended) and related regulations.	Eff. Jan 1, 2019 - $562/week
6. Long Term Disability (for Eligible Members Only)	
- Monthly LTD Benefit	$1,200
Note: This self-insured benefit only applies to Members whose employer is NOT Federally Regulated. If your employer is Federally Regulated (e.g Pe Ben Oilfield or Dawson Construction), your LTD benefit is provided through an insurance policy described in this booklet under "Long Term Disability- Insured Benefit".	
7. MSP *(Not applicable as of January 1, 2020)*	
- Premiums	100%

ELIGIBILITY - NEW MEMBERS

You are eligible to participate in the Plan provided that you are employed by an employer who is required to make contributions to the Plan under a Collective Agreement. You must be and remain in good standing with the Local 213 Union to be eligible for coverage.

Your initial eligibility for coverage is effective after the Plan Administration Office has received both of the following:

a) The required enrolment forms completed in full by you:
   - The Plan's Group Insurance Enrolment card
   - Pacific Blue Cross Application
   - Medical Services Plan of BC Group Application Form (not applicable after December 31, 2019).

   Make sure you send the completed forms to the Plan Administrator Office to activate your coverage once the hours under b) is met.

b) 300 hours from employer remittances under you hour bank account.

   Your coverage is then effective on the *following 1st of the month* (subject to the Eligibility rules above).

The chart below gives an example of how this works:

Work Month	Hours Worked	Remitted by	Coverage eligibility effective date
June	170	July 15th	n/a
July	185	August 15th	September 1st
Total Hours	355 (meets the 300 minimum, and deducting 150 for September coverage leaves a balance of 205)		

ELIGIBILITY - ONGOING COVERAGE

You must remain a member in good standing with the Local 213 Union to be eligible for coverage. Your employer remits contributions for hours you worked as per the Collective Agreement to the Plan Administration Office by the 15th of the month following the month worked.

Your hour bank account is deducted 150 hours each month to pay for the cost of your benefit coverage. The hours accumulate in your hour bank account to the allowed maximum (see “Hour Bank Maximum”).

Note: It is important you keep a record of your hours worked in case there is ever a discrepancy.

Contact the Plan Administration Office to check your hour bank account balance and your coverage status.

Your coverage ceases when your hour bank account falls below 150 hours. Also see the section “Termination of Coverage”. There are Self Pay Options to maintain coverage – see the section “Self Pay Options” which follows. If you have less than 150 hours in your hour bank account, these hours will be maintained in your account for up to a 24 month period as long as you remain a member in good standing with the Local 213 Union.

SELF PAY OPTIONS

When your hour bank account does not have enough hours to continue coverage (it is below 150 hours), the Plan Administration Office will send you a self pay notice (called “Application for Continuing Benefits”). This notice is sent to you one month before your coverage will expire. It details the coverage options available and the costs. If you wish to self pay (also known as “pay-direct”) you must complete the bottom section of the Application for Continuing Benefits notice selecting your option, and return it along with payment if applicable, by the stated due date. Late payments will not be accepted. Following are the Self Pay options:

OPTION 1 - “Shortfall”: Available for one (1) month only

This option provides full coverage - the member’s self-pay cost is the difference due based on the hours short of the required 150. For example: if your hour bank balance is 120 hours, you remit the self pay cost of 30 hours at the last applicable hourly contribution rate (eg. if your employer’s last remittance rate was $2.30, your cost will be 30 hours x $2.30 = $69.00).

OPTION 2 - “Mini Package”: Available for 6 months maximum

This option provides coverage for Life Insurance, Accidental Death and Dismemberment, and MSP*. The member pays the necessary rate to cover the premium costs.

OPTION 3* - “MSP only/Hours By Deduction” Available until Hour Bank Balance Insufficient

This option requires a minimum of 29 hours for 1 adult coverage or 56 hours for 2 adults coverage in your hour bank account. The MSP coverage is paid by deduction of hours until your hour bank balance is insufficient.

OPTION 4 "MSP only"* – Available for up to 24 months maximum

The member's self pay cost is the premium cost. This option can also be chosen after electing options 1, 2, or 3.

**Note: the December 2019 coverage month will be the last month that reflects MSP for Self Pay options as a result of the MSP premium being eliminated January 1, 2020.*

Do not ignore an "Application for Continuing Benefits" notice mailed to you as your options are time-limited and coverage could terminate. Contact the Plan Administration Office if you have any questions about why you received the notice and/or the options available.

If you self pay in a situation where your employer missed the monthly deadline for remitting contributions to the Plan Administration Office, once the late contributions are remitted by your employer such hours will be credited to your hour bank account for future coverage.

Once your self pay option time limit has expired, you will be able to have coverage under the Plan again once you start working for an employer who remits contributions to the Plan and you meet the eligibility rules (see next item).

COVERAGE REINSTATEMENT AFTER A TERMINATION

You must be and remain in good standing with the Local 213 Union to be eligible for coverage.

If your coverage has been terminated for a period less than 6 months, once 150 hours have been remitted on your behalf your coverage will be effective the 1st of the month following the month they are remitted.

If your coverage has been terminated for a period greater than 6 months but less than 24 months, once 150 hours have been remitted on your behalf your coverage will be effective the 1st of the month following the month they are remitted, and subject to you completing and returning the Plan enrolment forms referred to in a) under the "Eligibility – New Members" section.

If your coverage has terminated for more than 24 months, any residual hour bank balance (i.e. less than 150 hours) is forfeited and your coverage reinstatement is subject to both a) and b) under the "Eligibility - New Members" section.

PLAN CREDITS TO YOUR HOUR BANK ACCOUNT – IF DISABLED/INJURED

If you are in receipt of the Plan's Short Term Disability benefit or Workers' Compensation wage loss benefits and were eligible for benefit coverage

when the disability commenced, the Plan will credit your hour bank account for each day such benefit is in effect with hours towards full benefit coverage for up to 12 months. The credits are based on 5 hours per day to a maximum of 150 hours per month, and to a maximum of 1,800 hours in total (150 hours x 12 months). You will be sent a letter confirming you are approved for the credits.

To receive the hour bank credits:

- If you are in receipt of Short Term Disability benefits under the Plan: the credits will be granted to you automatically by the Plan Administration Office.
- If you are in receipt of Workers' Compensation wage loss benefits: you must send the Plan Administration Office a copy of your approval letter from WorkSafeBC and a copy of your WorkSafeBC disability income payment cheque stubs.

  Note: If your disability/injury is the result of a workplace accident and your claim with WorkSafeBC has been denied, you may be entitled to an advance payment of Short Term Disability benefits subject to specific rules – for further details see the section "Workers Compensation Claim" and "Third Party Recovery of Benefits" under the "Short Term Disability Benefit" section.

MEMBER DEATH AND DEPENDENT COVERAGE

On your death, the following benefits will continue for your covered dependents until your Hour Bank account has less than 150 hours (no self-pay option applicable):

- EHC
- DENTAL
- MSP (not applicable effective January 1, 2020).

HOUR BANK ACCOUNT MAXIMUM

The maximum number of hours a member can accumulate in their hour bank account is 2,100 hours. This maximum provides for 14 months of coverage if you stop working, eg. layoff, unemployment, retirement (reminder: coverage excludes Long Term Disability after age 65).

Effective December 1, 2019: The maximum number of hours a member can accumulate in their hour bank account is 2,700 hours. This maximum provides for 18 months of coverage if you stop working, eg. layoff, unemployment, retirement (coverage excludes Long Term Disability after age 65).

In the event of your death, any hours in your hour bank account are also used towards providing your eligible dependent(s) with Extended Health and Dental coverage, and MSP (MSP applicable up to December 31, 2019).

Hours in excess of the hour bank maximum go to the general reserves of the Plan. They are used towards offsetting Plan costs, such as providing subsidized benefit coverage given to members in receipt of short term disability or WorkSafeBC benefits, and to members in receipt of Long Term Disability benefits.

RECIPROCITY

The Board of Trustees has Reciprocal Agreements with several other union health & welfare hour bank plans in Canada. The purpose of this type of agreement is to provide for the reciprocal transfer of health & welfare – hour bank plan contributions if a member is temporarily working in another union's jurisdiction and their plan has a Reciprocal Agreement with this Plan. Current reciprocal agreements in force with other health & welfare plans include the General Teamsters Local 362, Teamsters Local 230, Operating Engineers.

Note: reciprocal contributions are processed 2 months after the month worked, because once the contributions are received the month following the month worked, the reciprocal transfer is then processed in the next month.

ELIGIBLE DEPENDENTS

You can enroll your spouse (one only) and certain dependents for coverage under the Plan as outlined below:

A **"Spouse"** is a legally married husband or wife, or a person to whom you are not married but with whom you live and publicly represent as your husband or wife.

Subject to the requirements below, a **"Dependent"** is any natural child, stepchild, legally adopted child, or legal ward (including a sister, brother, niece or nephew if you stand in place of a parent) that is:

a) unmarried

b) mainly supported by you, and

c) under the age of 19 for MSP, or under the age of 21 for EHC and Dental.

Children over the age of 19 for MSP, or over the age of 21 for EHC and Dental, who become employed on a full-time basis, are no longer eligible for coverage.

Children still in school after age 19 can continue to be covered provided they are in full time attendance at an accredited school or university, are unmarried, and mainly supported by you. MSP, if applicable, will continue up to age 25.

Important Note: If you have a change in your Dependent status (eg. new baby), you must advise the Plan Administration Office.

MSP BC

When you and/or your Dependents qualify for coverage under the Plan you will be covered by the Plan for the Medical Services Plan of British Columbia (MSP) subject to the completed MSP application form being received by the Plan Administration Office.

For a copy of the official MSP brochure outlining the benefits, conditions for receiving, and the limitations:

www2.gov.bc.ca/assets/gov/health/health-drug-coverage/medical-services-plan/bc-residents/msp-brochure.pdf

Reminder: any changes you require – especially regarding "eligible dependents" – must be made directly through the Plan Administration Office, NOT through MSP.

Note: As of January 1, 2020, the MSP premium is eliminated and this section will no longer be applicable.

PLAN COVERAGE WHILE A MEMBER IS IN RECEIPT OF LTD

EHC, Dental (50% of Plan A-Basic Services only), Group Life Insurance, and MSP (MSP up to December 31, 2019) will continue to be provided by the Plan as long as you are receiving Long Term Disability benefits under the Plan.

TAXATION OF LIFE, AD&D AND MSP INSURANCE PREMIUMS

Each year in February, the Plan Administration Office will issue each eligible Member a T4A for the premiums paid by the Plan on your behalf for Group Life, Accidental Death and Dismemberment, and MSP (MSP not applicable as of January 1, 2020). You must include the amount indicated on your T4A as income on your tax return.

TERMINATION OF COVERAGE

1. **Member**

An Hour Bank Member will cease to be eligible for benefits on the earliest of the following dates:

a) the later of:
   i. the end of the month in which your Hour Bank balance is below the monthly Hour Bank charge; or
   ii. the end of the month in which such Hour Bank Member ceases to maintain or be able to maintain eligibility for benefits by making personal contributions pursuant to the Self Pay rules;(described in the section "Self Pay Options");

b) the last day of the month in which you are no longer in good standing with the Local 213 Union, or your suspension, withdrawal (for reasons other than due to retirement under the Teamsters Local 213 Pension Plan), or transfer from the Union;

c) the last day of the month of such Hour Bank Member's enlistment in the armed forces of any country;

d) the last day of the month of Hour Bank Member's death;

e) the last day of the month in the event that the employer ceases contributions under the collective agreement with the Union and in which case all credited hours in your hour bank account from that employer will be cancelled (if you have hours in your account related to employment with another employer those hours will not be cancelled);

f) the date of termination of the Plan and Trust Fund; and

g) age 65 for the Long Term Disability benefit, and age 70 for the Group Life Insurance and Accidental Death and Dismemberment benefits. There is no age limit for MSP, STD, EHC and Dental benefit coverage. However, your Group Life Insurance coverage terminates at age 65 if you are disabled and in receipt of Short Term or Long Term Disability Benefits.

2. **Spouse or Dependent**

When an Hour Bank Member's eligibility for benefits ceases, the eligibility for benefits of any eligible Spouse or Dependent will also cease. The eligibility for benefits of any Spouse or Dependent will also cease if and when he or she ceases to be the Spouse or Dependent of the Member, or earlier if he or she becomes ineligible, such as due to age.

CONVERSION OPTIONS WHEN YOUR PLAN COVERAGE TERMINATES:

Group Life Insurance

When your Plan coverage terminates (including due to retirement), you may convert your Group Life Insurance (Great West Life Policy #328541) to an individual policy without evidence of good health, provided you are under age 70. Great-West Life must receive the completed application and first premium payment within 31 days of the date your Plan coverage terminates.

During the 31-day conversion period, the Group Life Insurance the Member was entitled to convert is deemed to have continued in-force under the group policy.

For further information contact: Great West Life 604.685.6521

Accidental Death and Dismemberment

Your AD&D coverage (The Co-operators Policy #G1018-200) can also be converted to a standard individual policy (without 'critical disease' and

other special benefits) provided you are under age 65. The Co-operators must receive your application and the first year's premium within 31 days of the date your group coverage under the Plan terminates. The minimum amount that can be converted is $25,000.

Dental and Extended Health Care

You can also apply for an individual Extended Health Care ("EHC") and/or Dental policy with Pacific Blue Cross. You must apply within 60 days of termination of your group coverage under the Plan or Pacific Blue Cross will not cover pre-existing conditions. You must have been covered under the Plan for EHC and Dental for at least 6 months. All BC residents are eligible for Pacific Blue Cross' individual plans, provided you are covered under the Medical Services Plan of BC (MSP). Applications are accepted regardless of the condition of your health.

Contact: Pacific Blue Cross 604.419.2000 Toll Free 1.877.722.2583

TIME LIMITS FOR CLAIMS

Claims for certain benefits must be filed within the times prescribed in the Plan or the relevant contracts. Failure to file a claim within those time limits could result in your claim being denied.

Where a claim has 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 relevant contracts, the *Limitation Act* or the *Insurance Act*. It is your responsibility to obtain your own independent legal advice with respect to such limitation periods.

HOW TO CLAIM

Refer to the "How to Claim" section under each benefit. The claim forms must be fully completed and submitted within the relevant time limits stated in this booklet 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 that they have been properly signed and dated by all parties.

INSURANCE/BENEFIT FRAUD

Insurance or benefit fraud is defined as an intentional act or omission with a view to illegally obtaining a benefit.

Insurance/benefit fraud or abuse is a crime that directly affects all members covered under the Teamsters Local 213 Health and Welfare Plan. Not only does the plan pay the price for fraud – all members pay if the Trustees have to reduce benefits due to an increase in costs.

Fraud or abuse may be committed by:

a) Billing or claiming for procedures or services not provided.
b) Forging receipts or altering information on actual receipts.
c) Submitting claims for services or products not required or not received.
d) Falsifying claim information or a medical diagnosis to receive benefits.
e) Over-billing by service providers for procedures or services rendered.
f) Receiving disability benefits from more than one source for the same period.
g) Falsely stating that a person is unable to work.

It is a criminal offense to represent a matter of fact that i) is known by the person making it to be false and ii) is made with a fraudulent intent to induce the person to whom it is made to act upon it.

Members of the Plan who obtain, or attempt to obtain, a benefit under the Plan to which they are not entitled (including a benefit that is greater than the benefit to which they are entitled), by submitting false, misleading or inaccurate information may, at the discretion of the Trustees be:

a) Refused payment of every such benefit;
b) Denied coverage under the plan:
c) Declared ineligible for any further benefits under the plan;

unless the member can establish that any discrepancy in the information submitted was due solely to a bona fide error on their part.

GROUP LIFE INSURANCE BENEFIT

Provided you are eligible for a Life Insurance Benefit under the Plan, on your death, Great West Life will pay the amount of Life Insurance stated in the Summary of Benefits.

Beneficiary Designation

The person(s) you have indicated as your beneficiary on your Plan enrolment card will be paid the Life Insurance Benefit. You may also indicate your estate as your beneficiary.

Beneficiary under age 18: The insurance company cannot pay the insurance benefit directly to a child under age 18. If you wish to designate a minor person, it is recommended you appoint an adult trustee to receive and disburse the Group Life insurance benefit and to act on the child's behalf – if you do not, a public trustee may be assigned by the Courts.

If you have not designated a beneficiary, or your designated beneficiary predeceased you, payment will be made to your estate. A notarized copy of probate may be required before payment can be made.

You may change your beneficiary designation at any time. If you wish to do so, it is your responsibility to obtain a new Plan enrolment card from the Plan Administration Office, and then return the completed card to the Plan Administration Office.

Benefit payment

If you die accidentally, the beneficiary (ies) you named on your Plan enrolment card to receive your Group Life Insurance will also receive your AD&D insurance for accidental loss of life.

Termination of Insurance

You are covered for Group Life Insurance until your 70th birthday.

HOW TO CLAIM

Contact the Plan Administration Office to obtain the required claim forms.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

1. The principal amount of AD&D insurance is as per the Summary of Benefits.
2. If you die, suffer dismemberment or permanently lose the use of a designated part of your body within one year of the date of the accident, the benefit as per the summary below will be payable to you if you are living, or if you are deceased to your beneficiary (ies).
3. If you suffer multiple losses in a single accident, you will receive benefits for one loss only (the most serious) resulting from a single accident.

Loss	**% of Insured Amount Payable**
Life	100%
Both arms and both legs	100%
Both hands or both feet	100%
One hand and one foot	100%
One hand and sight in one eye	100%
One foot and sight in one eye	100%
Sight of both eyes	100%
One arm and one leg	75%
One hand or one foot	66-2/3%
Sight of one eye	66-2/3%
Thumb and index finger of one hand	33-1/3%
Speech and hearing in both ears	100%
Speech or hearing in both ears	66-2/3%
Hearing in one ear	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of both legs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Limitations of coverage

If your employment continues after age 65, coverage ceases at age 70.

In addition, coverage applies only to bodily injury caused by an accident, and not as a result of medical care or treatment including surgery. It does not apply when the loss is caused by suicide, intentionally self-inflicted injury, participating in a riot, committing/attempting/provoking an assault or criminal offence, insurrection or declared or undeclared war or act of war, an air crash when you are the pilot or a member of the crew, or active service in the armed forces.

Benefit payment

If you die accidentally, the beneficiary (ies) you named on your Plan enrolment card to receive your Group Life Insurance will also receive your AD&D insurance for accidental loss of life.

AD&D Definitions

- loss of a hand will mean complete severance at or above the wrist.
- loss of an arm will mean complete severance through or above the elbow joint.
- loss of a leg will mean complete severance through or above the knee joint.
- loss of a foot will mean complete severance at or above the ankle.
- loss of a thumb will mean complete loss of one entire phalanx of the thumb.
- loss of a finger will mean the complete loss of two entire phalanges of the finger.
- loss of sight, loss of hearing or loss of speech will mean total and irrecoverable loss of that faculty. If that faculty can be recovered or partially recovered by the use of some device or rehabilitative program, it will be deemed that there was no loss for the purposes of this provision.
- loss of use must be caused by tendon, nerve or bone damage as a result of an accidental injury. Such loss of use must be total and irrecoverable and must be continuous for a period of 12 months. No benefits will be payable for loss of use if benefits for loss by dismemberment are paid or payable as a result of the same injury.
- paralysis will mean complete and irreversible paralysis caused by spine or brain damage as a result of an accidental injury which has continued for a period of 12 months from the date of the injury.
- institution for higher learning for the Education Benefit includes any university, college or trade school.
- immediate family, for the Family Transportation Benefit, means a person who is your spouse, child, father, mother, brother or sister. Other relatives may be considered in the event that no immediate family is living.

Rehabilitation Benefit

In the event a Member sustains a covered loss and the loss requires that the Member participate in a rehabilitation program, in order to be qualified to engage in an occupation in which the Member would not have engaged except for such covered loss, The Co-operators will pay the reasonable and necessary expenses actually incurred for the services of a licensed rehabilitation provider, within two (2) years from the date of the covered loss.

Payment by The Co-operators for the total of all expenses incurred by any Member will not exceed ten thousand dollars ($10,000) as the result of any one (1) covered loss. Payment does not include incidental expenses including without limitation charges for room and board, ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

If a Member sustains a covered loss and is confined as an inpatient in a hospital located at least one hundred and fifty (150) kilometers from the Member's residence and is under the regular care and attendance of a physician or surgeon, The Co-operators will pay the reasonable expenses actually incurred by all members of the Member's immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to the Member.

This benefit will not exceed the aggregate amount of three thousand dollars ($3,000) for all accommodation and transportation expenses. Payment will not be made for incidental expenses including without limitation charges for board or other ordinary living, travelling or clothing 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 twenty cents ($0.20) per kilometers travelled.

Home Alteration and Vehicle Modification Benefit

If a Member sustains a covered loss and subsequently requires the use of wheelchair to be ambulatory, The Co-operators will pay the reasonable and necessary expenses incurred for the purpose of making the Member's home and vehicle wheelchair accessible. Benefits are payable for the cost of alterations to the Member's principal residence and the cost of modifications to one (1) motor vehicle utilized by the Member, when such modifications are approved by licensing authorities where required.

The expenses must be incurred within two (2) years from the date of the covered loss and are subject to a maximum of $10,000 in the Member's lifetime.

Continuation of Education Benefit

In the event a Member's death occurs as a direct result of a covered loss under this provision, The Co-operators will pay to the Member's beneficiary the Education Benefit stated below for each of the Member's dependent children who are, at the time of the Member's death enrolled as full-time students:

a) in an institution for higher learning above the secondary school level as defined in the province, territory or country of residence; or

b) at the secondary school level but who will enroll as full-time students in an institution for higher learning within three hundred and sixty-five (365) days after the date of death of the Member.

The Education Benefit is equal to the reasonable and necessary expenses actually incurred for tuition and books, subject to the lesser of a maximum of 5% of the Member's Principal Sum or $5,000, for each year the dependent child continues the education, but not to exceed 4 years, which must run consecutively, with respect to any one dependent child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled as a full-time student in an institution for higher learning, but payment will not be made for expenses incurred prior to the death of the Member, or for incidental expenses including without limitation room, board or other ordinary living, travelling or clothing expenses.

If none of the Member's dependent children satisfy the above requirements, The Co-operators will pay an amount of two thousand five hundred dollars ($2,500) to the Member's beneficiary.

Spousal Occupational Training Benefit

In the event a Member's death occurs as a direct result of a covered loss under this provision, The Co-operators will pay the reasonable and necessary expenses actually incurred for tuition and books for the Spouse of the Member to participate in a formal occupational training program to become qualified for active employment in an occupation for which the Spouse would not otherwise have sufficient qualification.

Expenses must be incurred within the two (2) years from the date of the Member's death and are subject to a maximum lifetime payment of ten thousand dollars ($10,000). Payment will not include incidental expenses including without limitation charges for room and board, ordinary living, travelling or clothing expenses.

Repatriation Benefit

In the event the Member's death (due to any cause) occurs out of Canada or if in Canada at least 100 kilometres from the Member's permanent residence, The Co-operators will pay the reasonable and customary expenses incurred for the preparation of the body and its transportation to the funeral home or the place of interment in proximity to the normal place of residence of the deceased. Benefits will not exceed ten thousand dollars ($10,000) for all eligible expenses.

Limitation of Action

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

Where or when applicable legislation permits the use of a different limitation period, no action or proceeding at law or in equity shall be brought against The Cooperators for payment of benefits under the policy or for any other related damages:

- prior to the expiration of 60 days after the claim form has been submitted to The Co-operators; or
- unless brought:
  - where no benefits have been paid, within one year from the expiration of the time within which the claim form is required to be received by The Co-operators or from the date on which The Co-operators first denies the claim for benefits, whichever first occurs; or
  - where benefits have been paid under the provision of the policy, within 1 year of the date on which The Co-operators terminates the payment of benefits.

The time limit within which to commence an action shall expire on the date(s) as specifically provided for in this provision.

ACCESSING YOUR RECORDS

As required by legislation, for insured benefits, you have the right, upon request to obtain a copy of your enrolment card or application for insurance and any written statements or other records not otherwise part of the application that you provided to The Co-operators as evidence of insurability, subject to certain limitations.

For insured benefits, if you are covered under this plan, on reasonable notice, you may also request a copy of the master policy in accordance with the legislation in your province of residence. All requests for copies of documents should be directed to the Plan Administration Office.

CRITICAL DISEASE BENEFIT

If you are eligible for the Critical Disease Benefit and you are diagnosed with a 'critical disease' prior to age 65, 10% of your principle AD&D insurance amount or 10% of $50,000, whichever amount is less, will be paid to you. To qualify, you must be totally disabled from performing all *occupations for at least nine months* as a result of the 'critical disease'.

'Critical disease' includes:

- Alzheimer's Disease,
- Amyotrophic Lateral Sclerosis (ALS),
- Huntington's Chorea,
- Multiple Sclerosis,
- Necrotizing Fasciitis,
- Parkinson's Disease,
- Peripheral Vascular Disease,
- Poliomyelitis, and
- Type I Diabetes (Insulin Dependent).

HOW TO CLAIM

Contact the Plan Administration Office to obtain the required claim form.

When to submit an AD&D claim:

- **Accidental Death Claim**

  If the claim is the result of an accidental death, the claim form must be submitted to The Co-operators within 6 months from the date of death.

- **Critical Disease or Accidental Dismemberment Claims**

  If the claim is for a Critical Disease or Accidental Dismemberment Benefit, the claim form must be submitted to The Co-operators within 9 months from the date of total disability or 12 months from the date of the accidental dismemberment.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after first becoming eligible for the Accidental Death Benefit or Critical Disease Benefit or 18 months for the Accidental Dismemberment Benefit.

Mail claim forms to:

Group Claims Department
The Co-operators
1920 College Avenue
Regina, Saskatchewan
S4P 1C4

The Dental plan will reimburse you for:

- Part A – Basic Services, which includes most routine dental services.
- Part B – Major Restorative Services, such as bridges, crowns and dentures.
- Part C – Orthodontic Services for correction of improper bite.

All expenses are reimbursed at the co-insurance percentages indicated in the Summary of Benefits, and up to the current Pacific Blue Cross Dental Fee Schedule. **You are responsible for any charges in excess of the amounts shown in the Pacific Blue Cross Dental Fee Schedule.**

ESTIMATE OF DENTAL COSTS BEFORE TREATMENT

It is recommended that you ask your dentist for an estimate of the cost of your proposed treatment if it will be greater than $500 - your dentist can determine the portion Pacific Blue Cross will cover before beginning the treatment. You can then decide if you wish to proceed with the treatment knowing what portion of the cost you share, if any.

ELIGIBLE EXPENSES

The following are considered Eligible Expenses:

Part A Dental Benefits - Basic Coverage

1. **Diagnostic**

   All procedures necessary to assist the dentist in evaluating the existing conditions and the dental care required to correct such conditions, including:

   a) examinations and consultations; new patient and recall oral examinations (2 per calendar year); a complete oral examination will not be covered if done more than once in any 36 month period or if Dental Benefits have been paid for any examination during the preceding six months; and

   b) roentgenology with full-mouth x-rays, as required by the attending dentist, once every three years.

2. **Preventive therapy**

   Procedures including:

   a) prophylaxis and scaling of the teeth, twice per calendar year

   b) topical fluoride applications, twice per calendar year. (When prophylaxis and topical fluoride application are carried out at the same time, the fees for each must be combined); and

c) space maintainers when placed primarily to maintain space and not for orthodontic purposes. If a spacer is placed primarily to maintain space and secondarily to regain lost space, then the cost of such appliance will be covered, but not the cost of activating wires and required consultations. If the spacer is placed primarily to regain lost space, then neither the appliance nor the required consultations will be covered.

3. **Oral Surgery**

Extractions and other surgical procedures, including pre and post-operative care. Anesthesia in conjunction with surgery will not exceed the dollar limit in the Fee Schedule.

4. **Restorative Dentistry**

Procedures and restorations including:

a) procedures necessary to restore natural teeth to normal function including amalgams, silicate, plastics, resin or composite procedures, synthetic porcelain and metal prefabricated restorations (metal prefabricated restorations limited to one per tooth every two years).

Gold may only be used where other material would be inadequate and only with the prior approval of Pacific Blue Cross.

The tooth surface is covered only once regardless of the number of restorations placed thereon or therein.

i. restoration services including, where necessary:

ii. inlays and onlays, for the repair of broken-down teeth where other restorative material would be inadequate; Gold inlays or onlays (once per tooth per five-year period) but only when there are three or more surfaces of the tooth to be restored, decay is evident on pre-treatment X-rays and one or more cusps are involved. The maximum benefit that will be paid per tooth is the dollar equivalent of a five surface filling per two year period. If less than three surfaces are treated, the amalgam equivalent for the restoration will be paid. X-rays and study models are required for approval by Pacific Blue Cross prior to start of treatment when an onlay or inlay, or a series of onlays or inlays, is planned;

iii. gold foils, where other material would be inadequate and only with the prior approval of Pacific Blue Cross, but only in cases of repair to existing gold restorations;

iv. prosthetic repair, including all necessary procedures required to repair or reline (but not remaking) fixed or removable appliances such as bridgework and dentures. Repairs or relines to dentures may be carried out by a dentist or dental mechanic.

5. **Endodontics**

   Procedures (including root canal treatment) necessary for the treatment of pulpally involved teeth, including non-vital teeth, limited to one treatment per tooth per life time.

6. **Periodontics**

   Procedures necessary for the treatment of diseases of the soft tissue and the bone surrounding and supporting the teeth. Anesthesia in conjunction with surgery will not exceed the dollar limit in the Fee Schedule.

7. **Emergency Basic Services Treatment**

   Expenses incurred for emergency basic services treatment when travelling outside the province/territory of residence.

Part B Dental Benefits – Major Restorative

The following Dental Benefits are for major restorative services and prosthetics. These benefits cover services required for the major reconstruction of teeth that have deteriorated and the replacement of missing teeth:

1. **Restorative Services**

   All crowns for rebuilding natural teeth where other restorative material cannot be used satisfactorily.

2. **Prosthetics**

   All fixed and removable prosthetics to replace missing natural teeth, including:

   a) Full upper and/or lower denture, once every five years. Full upper and/or lower dentures may be provided by a dental mechanic;

   b) Partial dentures, once every 5 years; and

   c) Crowns and bridges, to artificially replace missing teeth. Includes onlays and/or inlays involved in bridgework;

   d) Expenses incurred to replace such crowns and bridges will not be covered for a period of five years from the date of prior service or if the said prosthetics can be repaired, unless this provision is waived by Pacific Blue Cross.

   e) Lost, stolen or broken dentures will not be replaced.

Part C Dental Benefits – Orthodontic Treatment
(Adults and Dependent Children)

Before commencing treatment, a completed orthodontic treatment plan must be submitted to Pacific Blue Cross for approval. Orthodontic

claims will not be processed until Pacific Blue Cross has approved the treatment plan.

The lifetime maximum per person is as stated in the "Orthodontic Lifetime Maximum" under the heading "Dental Care" in the Summary of Benefits. Lost, stolen or broken appliances will not be replaced.

EXCLUSIONS

The Dental plan does not provide coverage for:

a) A course of treatment started prior to the effective date of coverage (excluding Orthodontia) or completed after the termination date of coverage.

b) Expenses which are eligible for payment under your provincial government medical/hospital plans, any other government authority such as Worker' Compensation, or any other group or individual insurance policy.

c) Charges for completion of claim forms or written reports, broken appointments, oral hygiene or nutritional instruction.

d) Travel expenses for treatment.

e) Additional charges made as a result of changing dentists.

f) Extra charges for procedures which would normally be included in the basic service.

g) Services and supplies for a full month reconstruction for a vertical dimension correction, or for correction of a temporal mandibular joint dysfunction (jaw structure).

h) Procedures to correct congenital malformations or for purely cosmetic reasons.

i) Incomplete, unsuccessful or temporary procedures; recent duplication of services by the same or different dentists; drugs or medicines; pantographic tracings osseous or tissue grafts; implants for dentures and bridgework.

j) Any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence.

k) Expenses for which a third party is liable.

l) Expenses relating to or a result of war, riot or insurrection, or as a result of participating in active service of any armed forces.

m) Expenses arising from a direct or indirect attempt at or commission of an indictable offense under the Criminal Code of Canada or under similar law of any other country.

HOW TO CLAIM

Present your Pacific Blue Cross identification card and the dentist will bill Pacific Blue Cross directly. You are responsible for any portion not covered by the Dental plan. If you pay the dentist directly, you will be reimbursed for your eligible portion of the cost. **Claims must be submitted within 12 months of treatment and will not be paid if submitted after that time.**

EXTENDED HEALTH CARE (EHC)

The Extended Health Care (EHC) plan is designed to help you pay for the cost of many medical expenses and services to the extent that they are not payable or provided by the Provincial Medical Services Plan of BC (MSP), PharmaCare, any other medical plan or plan of insurance, any Hospital Program, the relevant Workers' Compensation Act, or by any public or tax-supposed authority or agency. Pacific Blue Cross assesses your claim based on the claimable limits, the applicable reimbursement percentage, annual deductible and the Plan maximum (stated in the Summary of Benefits). Where no maximum amount is specified Pacific Blue Cross Reasonable Charges apply which are in accordance with the representative fee and prices in an area.

SPECIAL AUTHORITY PROGRAM FOR PRESCRIPTION DRUGS

The BC government's Fair PharmaCare plan helps protect British Columbians from high drug costs by subsidizing eligible drugs prescribed by a physician. You must register for Fair PharmaCare before you are eligible for reimbursement.

The Special Authority Program for Prescription Drugs is a mandatory provision under the EHC Plan.

Your physician must complete a Special Authority Request form, and apply to PharmaCare for Special Authority on your behalf. The forms are available online, but most doctors' offices will have the forms on site. All forms must be completed by a licensed physician and faxed to the number indicated on the form.

PharmaCare will notify your physician of their decision by fax or by mail, and your physician will contact you and provide you with a copy of PharmaCare's decision document. You may be asked to submit the decision document to Pacific Blue Cross along with future related claims.

If your application was approved, PharmaCare will cover all or a portion of your drug cost (once your PharmaCare deductible has been satisfied) for the duration of time indicated on the decision document. Follow your standard claiming procedure with Pacific Blue Cross.

A full list of eligible Special Authority drugs is available at:
www.health.gov.bc/pharmacare/sa/criteria/genericbrandtable.html

ELIGIBLE EXPENSES

A. INCURRED INSIDE THE PROVINCE/TERRITORY OF RESIDENCE

1. **Practitioners:**

Acupuncturist – Reasonable charges of a registered acupuncturist (no maximum per person per calendar year);

Chiropractor - fees of a registered chiropractor (other than a chiropractor who is related to or who is residing with the Member or Dependent), up to a maximum of $500 payable per person per calendar year, in addition to charges for x-rays. The prescription of a physician is not necessary for such fees to be eligible for coverage;

Massage Practitioner - fees of a registered massage practitioner (other than a massage practitioner who is related to or who is residing with the Member or Dependent), up to a maximum of $500 payable per person per calendar year.

Naturopathic Doctor - fees of a registered naturopathic doctor (other than a naturopathic doctor who is related to or residing with the Member or Dependent), up to a maximum of $500 payable per person per calendar year. The prescription of a physician is not necessary for such fees to be eligible for coverage;

Nurse – fees of a registered nurse in the patient's home or in a hospital (does not cover the fees of a registered nurse employed by the hospital; other than a nurse who is related to or residing with the Member or dependent), up to a maximum of $10,000 per person per calendar year or $25,000 per lifetime, whichever occurs first, for private care in an acute condition: the prescription of a physician is necessary.

Physiotherapist - fees of a registered physiotherapist (other than a physiotherapist who is related to or residing with the Member or Dependent), up to a maximum of $500 per person per calendar year. The prescription of a physician is not necessary for such fees to be eligible for coverage.

Podiatrist - fees of a registered podiatrist and x-rays (other than a podiatrist who is related to or who is residing with the Member or Dependent), up to a combined maximum of $500 payable per person per calendar year. The prescription of a physician is not necessary for such fees to be eligible for coverage;

Psychologist or Registered Counsellor - fees of a registered psychologist or registered counsellor (other than a psychologist or counsellor who is related to or who is residing with the Member or Dependent), up to a maximum of $500 payable per person per calendar year.

Speech Therapist - fees of a registered speech therapist (other than a speech therapist who is related to or who is residing with the Member or Dependent), up to a maximum of $500 payable per person per calendar year.

2. **Ambulance services** - charges for ambulance services (including air ambulance) for a patient requiring immediate transportation to the nearest hospital equipped to provide the necessary emergency treatment;
3. **Artificial limbs & braces** – Reasonable charges for oxygen and its administration (includes oxygen equipment), ostomy or ileostomy supplies, artificial limbs or eyes, crutches, splints, casts, trusses or braces and permanent prostheses (artificial limbs and eyes), prescribed by a physician; the plan will also pay for the repair or replacement of worn prostheses and braces.
4. **Braces, Supports and Prosthetics** – Pacific Blue Cross will require a practitioner's note for these claims. Accepted practitioners include licensed chiropractors, physiotherapists and physicians.
5. **Brassieres** - charges for brassieres when required as a result of medical treatment for injury or sickness, up to a maximum of two per person per lifetime;
6. **Dental treatment (for accidental injuries)** - fees of a dentist for repairs or replacement of prosthetics or natural teeth, up to a maximum amount based on the fee schedule in the Member's province or territory of residence current at the time the expense is incurred, provided that the services of the dentist were necessitated by an injury to the prosthesis or natural teeth 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. Payments will not be made for temporary, duplicate or incomplete procedures, or for correcting unsuccessful procedures. The treatment must occur within 52 weeks after the date of the injury or such longer period approved by Pacific Blue Cross.
7. **Diabetic testing supplies** - charges for testing supplies and equipment, insulin preparations, testing supplies, needles, and syringes for diabetic, electronic blood glucose monitors and insulin infusia pumps for the management of diabetes. The maximum lifetime benefit for a glucometer is $250 per person. Charges for pump supplies are not covered; the Reasonable Charge is 3,000 test strips per member per calendar year. If it can be proved it is a medical necessity, PBC will grant a larger supply.
8. **Disability assists/Standard Durable Medical Equipment**
   a) Charges over $5,000 must be pre-approved by Pacific Blue Cross.

b) Charges for the purchase, one per person per lifetime, of an electric wheelchair or manual wheelchair or an electric scooter, walker, hospital bed (manual type), respirator or cardiac screener for a management of a disability that lasts longer than 52 consecutive weeks. Charges for an electric wheelchair or electric scooter are eligible for coverage if the patient is physically incapable of operating a manual wheelchair. Reimbursement will be made only on the basis of usual 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 such equipment is no longer functional; or

c) Charges for the rental 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 disability that lasts 52 consecutive weeks or less. Reimbursement will be made monthly, on the basis of the usual monthly rental charges for standard equipment from a medical supplier and will not exceed the total purchase price for similar equipment;

d) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators when prescribed (eg. CPAP);

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

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

g) walking aids: canes - $150 per person per 2 calendar years; crutches - $300 per person per 2 years from service date of first eligible claim; walkers - $700 per person per 5 calendar years from service date of first eligible claim; walker accessories - $450 per person per 2 years from service date of first eligible claim;

9. **Drugs – charges for the following drugs, supplies and services:**

a) Drugs that are approved for use by the Federal Government of Canada and that have a Drug Identification Number (DIN), purchased from a Registered pharmacist with a DIN on the prescription of a physician or a dentist (where legally permitted), up to a maximum of a 100 day supply per prescription. If the Member or Dependent can satisfy that a larger supply is necessary and more economical, a larger supply may be prescribed up to 200 days per prescription;

Note: Pacific Blue Cross limits coverage of narcotics and high cost drugs to a <u>35 day supply</u> per prescription.

b) Pay Direct Drugs: Pacific Blue Cross' Low Cost Alternative Pricing based on Reasonable Charges for mark-up. Payment of a brand name drug will be considered when Pacific Blue Cross receives written confirmation from the prescribing physician that there is a specific medical requirement for a particular brand name drug.

NOT COVERED are:

- vitamin injections or preparations
- food and mineral supplements
- preventative vaccines, drugs or supplies used for contraceptive or fertility purposes
- drugs or supplies used to suppress an addiction including those for smoking cessation
- drugs which do not by law require a prescription,
- drugs not approved under the *Food and Drug Act* (Canada) for sale and distribution in Canada.

c) Fees of a Registered pharmacist for dispensing drugs or medication;

d) Injectable drugs provided by a physician or a dentist, but excluding preventative vaccines; and

c) Supplies required for the administration of a prescribed drug;

10. **Hearing aids** - charges incurred for the purchase of hearing aids when prescribed by a physician or supplied by recognized audiologist on the recommendation of a physician, up to a maximum of $2,000 per 48 month period. Repairs, maintenance, batteries, recharging devices and other such accessories will not be covered;
11. **Hospital** - charges from a hospital for medical supplies and for a semi-private room or a private room. Charges for the rental of telephones, television, radios or similar equipment will not be covered;
12. **Laboratory tests** - charges for diagnostic and laboratory tests, radium treatments and x-ray examinations when authorized by a naturopath or a chiropractor;
13. **Orthotics** – charges for one pair per calendar year of orthotics and custom made orthopedic shoes, up to a combined maximum of *$500* payable per eligible Dependent child per calendar year, up to a combined maximum of *$750* payable per Member, or Spouse per calendar year. The prescription of a physician, podiatrist, chiropractor, or nurse practitioner is necessary for such charges to be eligible for coverage;

    Pacific Blue Cross requires the following items for Orthopedic Shoes:

    - a completed claim form
    - original receipt

- a copy of the current prescription outlining the medical diagnosis from a physician, podiatrist or chiropractor
- Written confirmation from the person who made the product indicating that the shoes were manufactured from raw material, using a 3-D volumetric model of the patient's foot and lower leg, made of raw materials and were specifically designed for the individual.

Pacific Blue Cross requires the following items for Orthotics:

- a completed claim form
- original receipt indicating that payment has been made in full
- a copy of the current prescription outlining the medical diagnosis from a physician, podiatrist, chiropractor, or physiotherapist
- a copy of your biomechanical assessment, which must be performed in person by your provider
- Written confirmation from the person who made the product indicating that the orthotic was fabricated from raw material, using a 3-D volumetric model of the patient's foot, using one of the following casting techniques:
  - Plaster of paris slipper cast
  - Semi-weight bearing foam casting box
  - 3-D contact digitizing
  - 3-D laser imaging scanning

14. **Surgical stockings** - charges for surgical stockings, up to a maximum of two pairs per person per calendar year;
15. **Transportation** – charges for transportation including:
    a) ambulance services, when advised by a physician; and
    b) in an acute emergency charges for transportation by air ambulance, from the place where the injury or sickness occurs to the nearest hospital. In an acute emergency, the advice of a physician is not required for transportation.
    c) flight - charges for a regularly scheduled flight, when ordered by the attending physician to transport a patient from the original hospital to the hospital nearest to his or her place of residence equipped to provide the necessary treatment;

    Charges for the following are NOT ELIGIBLE for coverage:

    - transportation arranged at the patient's convenience;
    - transportation arranged after waiting for hospital accommodation for a condition not requiring immediate transportation to the hospital; and

- transportation for the removal of a patient from one hospital to another, except in cases where the hospital in which the patient is removed has inadequate facilities to provide the required treatment;

16. **Vision Care** –charges incurred for the purchase of corrective lenses and frames or contact lenses when prescribed by a physician or registered optometrist, eye exams, and laser eye correction surgery, up to a maximum of $600 per person per 24 month period;

    Charges incurred for special problems of visual acuity suffered by a Dependent child under the age of 16, upon presentation of a letter of recommendation by a registered ophthalmologist, up to a maximum of $300 per child per 36 month period; and

17. **Wigs or hairpieces** - charges incurred for the purchase of wigs or hairpieces when required as a result of medical treatment for sickness (includes alopecia areata, alopecia universalis, or alopecia totalis) or injury, to a lifetime maximum of $500 per person.

B. INCURRED OUTSIDE PROVINCE/TERRITORY – NON-EMERGENCY ELIGIBLE EXPENSES

Reimbursement is for non-emergency eligible expenses incurred while travelling outside your province/territory of residence subject to the deductible, reimbursement percentage, and maximums. Not reimbursed are any expenses payable or provided under a government plan.

C. INCURRED OUTSIDE OF PROVINCE/TERRITORY OF RESIDENCE – EMERGENCY ELIGIBLE EXPENSES

When travelling outside of your province/territory of residence, the following benefits are payable as eligible expenses incurred in an emergency only and when ordered by the attending physician.

Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are not eligible.

1. **Hospital** – charges by a hospital for medical supplies and for a semi-private room or a private room. Charges for the rental of telephones, televisions, radios or similar equipment will NOT be covered. For a medical emergency outside of BC, air ambulance from the out-of-province hospital to the closest possible hospital in your province of residence. The service must be requested by the attending physician. Expenses in excess of $1,000 must be approved in advance by Pacific Blue Cross.
2. **Nurse** - fees of a registered nurse for special duty nursing in an acute emergency.

3. **Physicians** - customary charges for the services of physicians and laboratory and x-ray services when ordered by the attending physician.
4. **Prescription drugs** - charges for prescription drugs prescribed by the attending physician in sufficient quantity to alleviate an acute medical condition.
5. Charges incurred outside of BC as a result of a medical emergency are reimbursed at 100%.

Emergency Travel Assistance Worldwide - MEDI-ASSIST - Pacific Blue Cross and CanAssistance will provide you and your dependents "Worldwide Emergency Medical Assistance" which is for emergencies which occur while travelling.

Medi-Assist will coordinate the following services:

a) locate the nearest appropriate medical care;

b) obtain consultative and advisory services and supervision of medical care by qualified licensed physicians;

c) investigate, arrange and coordinate medical evacuations and related transportation;

d) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your dependents may require when in distress;

Before you leave Canada, make sure you have your "Medi-Assist" ID card with you. The back of the card provides the telephone numbers to contact.

If you need help in an emergency:

a) Call the nearest number listed on the back of the card; which is:

   In Canada and the US: 1.888.699.9333 (toll free)

   Outside Canada and the US: Contact an International operator and ask for a collect call to 604.419.4487.

b) If necessary, call collect or contact the local telephone operator for help in placing your call to Medi-Assist;

Have your Pacific Blue Cross Policy, ID, and provincial health care numbers ready for personal identification.

Charges for the above referral services are 100% covered under the Plan and are not subject to a deductible.

EXCLUSIONS

Expenses incurred for the following will not be considered Eligible Expenses under the Plan:

a) Services payable by or under the Basic Medical Plan, PharmaCare, any Hospital Program or the relevant Workers' Compensation Act whether or not a claim is made thereunder; services provided without cost or at nominal cost by any public or tax supported authority or agency or for which the patient can recover from another party; dental services or care of dentures, except as specifically provided under the "Eligible Expenses" section as applicable; services of a medical or dental practitioner not allowable under the Basic Medical Plan as a result of non-referral;

b) Drugs and medicines, which can be bought without a prescription; vitamin injections or preparations, as well as the following:
   - food and mineral supplements
   - preventative vaccines, drugs or supplies used for contraceptive or fertility purposes
   - drugs or supplies used to suppress an addiction including those for smoking cessation
   - drugs which do not by law require a prescription
   - drugs not approved under the *Food and Drug Act* (Canada) for sale and distribution in Canada

c) Any amount of fees in excess of the usual or recognized fees for the services performed;

d) Services outside the province or territory of residence, unless resulting from an unexpected injury or sickness incurred by a patient, while the patient is temporarily traveling outside the province or territory of residence and then only to the extent provided under the "Eligible Expenses" section as applicable;

e) Services and supplies for cosmetic purposes;

f) Services necessitated as a result of:
   - War, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
   - Suicide or any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence
   - Active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat

- A direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada, or similar law of any other country
- False pretenses or fraudulent misrepresentation

g) Eye examinations, orthoptic treatment, eye glasses, contact lenses, hearing aids, or prescriptions for any of them, except as specifically provided under the "Eligible Expenses" section as applicable;

h) Elastic stockings, air humidifiers and purifiers;

i) The treatment of any injury or sickness for which a patient is hospitalized at the time he becomes eligible for coverage under this section, provided however that in respect of a sickness, if such sickness re-occurs after a three month period during which it required no treatment, expenses relating to such sickness incurred from that time on will be included as Eligible Expenses;

j) A medical examination or the services of a Physician if required solely for the use of a third party;

k) Anti-obesity treatments including proteins, dietary or food supplements, whether or not prescribed for medical reasons;

l) Expenses incurred prior to the time the Patient becomes eligible for benefits under this section;

m) The cost of transportation:
- arranged at a patient's convenience;
- arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation; or
- 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;

n) The investigation, arrangement and co-ordination of the repatriation of a deceased patient and any related transportation charges;

o) Remedies prescribed by a naturopath or a podiatrist, HCG injections, services of Victorian Order of Nurses or Graduate or Licensed Practical Nurses, services of religious or spiritual healers, occupational therapy and rest cures.

p) Charges for the completion of claim forms or reports, communication costs, delivery and mailing or handling charges, interest or late payment charges;

q) Expenses which a third party is liable; and

r) Expenses incurred outside your province of residence due to therapeutic abortion, childbirth, or complications related to pregnancy occurring within two months of the expected delivery date.

HOW TO CLAIM - EHC

1. When submitting an electronic claim the Member must:
   a) complete the claim form online and submit it electronically to Pacific Blue Cross
   b) keep original receipts and documentation to support the claim for 12 months from the date the Member submits the claim to Pacific Blue Cross
   c) if the claim is selected for review by Pacific Blue Cross, the Member must submit the original receipts and supporting documentation to Pacific Blue Cross within 21 calendar days. If Pacific Blue Cross does not receive this information within this time, the Member's claim will be refused and your ability to submit electronic claims will be removed.
2. Pacific Blue Cross reserves the right to remove a Member's ability to submit electronic claims if the Member provides false, incomplete or misleading claims information. In such circumstances the Member will have to submit paper claims with supporting receipts and documentation.
3. When submitting a paper claim the Member must:
   a) complete the claim form and submit the claim form with original receipts and supporting documentation to Pacific Blue Cross, or
   b) if Pacific Blue Cross is not the primary paying plan, submit a paper claim with an explanation of benefits statement from the primary payer and photocopies of supporting receipts and documentation.
4. The Member must provide explanation or proof to support the claim or any other information Pacific Blue Cross considers necessary.
5. Proof of claim is at the Member's expense.
6. Pacific Blue Cross **must receive an electronic or paper claim by December 31st of the calendar year** following the year in which the expense was incurred. To be eligible for payment, a paper claim must include the claim form with receipts and supporting documentation. **For an electronic claim selected for review by** Pacific Blue Cross, **the original receipts and supporting documentation will be accepted after the December 31st deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission.** Pacific Blue Cross will not accept a faxed or scanned claim form and/or receipts.
7. Payment of the claim will be directed to the Member entitled to receive payment, unless Pacific Blue Cross agrees to the Member's request to assign payment directly to a third party.
8. When a Member has benefits, which permit different providers to submit claims for Eligible Expenses directly to Pacific Blue Cross, Pacific Blue Cross will pay the providers for these Eligible Expenses.

9. If the Plan Contract should terminate, Pacific Blue Cross must be given written notice of any eligible claim within one hundred eighty (180) days following the termination in respect of benefits relating to accidental damage to teeth arising from an accident that occurred before the termination of the Contract.
10. Co-ordination of Benefits: If a Patient is entitled to reimbursement of Eligible Expenses under another insurance policy or plan, Pacific Blue Cross has the right to reduce the amount of the EHC Benefit payable by the amount necessary to ensure that the total amount payable under all insurance policies and plans is not more than 100% of the charges incurred by such Patient.
11. **Emergency Medical Services Incurred Inside Province/Territory of Residence:** The provincial Medical Services Plan (MSP) and the Extended Health Care Plan (through Pacific Blue Cross) share most of the cost of such medical expenses. Pacific Blue Cross will forward claims for MSP on a member's behalf. Therefore, you only need to submit your claim once through Pacific Blue Cross.

    Call the Plan Administration Office for the Pacific Blue Cross and MSP claim forms used for claiming these expenses. Complete and sign both forms, and attach all original receipts and required documentation. Then submit them to Pacific Blue Cross for reimbursement.

GROUP VOLUNTARY TRAVEL INSURANCE OPTION (MEMBER OPTION)

This travel insurance option is available through Pacific Blue Cross (PBC) to Members covered under the Plan.

PBC's available options are extensive and include services such as trip cancellation, loss of luggage, etc.

Your Extended Health Care Plan covers out-of-country **medical expenses** in the event of an **emergency**. Therefore, purchasing additional individual travel insurance may be an option you want to consider before travelling out of country.

IMPORTANT NOTE: PBC requires that you purchase the "Group Voluntary Travel Insurance" within the last 72 hours of purchasing your trip in order to be covered for **trip cancellation** coverage.

For details please visit www.pac.bluecross.ca/travelweb/tripdetails.aspx

SHORT TERM DISABILITY BENEFIT

Eligibility

The Short Term Disability Benefit provides a Member with a bi-weekly income if you are totally disabled, meaning unable to work at your regular occupation due to a disabling non-work related Bodily Sickness or Injury.

"Bodily Sickness" includes disease or illness and may include i) mental and nervous disorders provided that they are being treated under the supervision of a Physician, and ii) illness resulting from pregnancy and complications arising during or immediately following pregnancy, including premature termination, but not including normal births at or near the expected date of delivery.

"Injury" means an accidental bodily trauma which is sustained by the Member, resulting directly and independently of all other causes and that is manifest within 30 days after the accident which is the proximate cause of such trauma.

Qualification Period

STD payments will commence from the latest of the following dates:

a) The first day of disability due to an accident;
b) The fourth day of disability due to an illness;
c) The day you were first seen by a Physician after becoming disabled.

Note: You must be under the full-time medical care of a Physician or licensed chiropractor or licensed dentist. **"Physician"** means a doctor or surgeon, who is Doctor of Medicine (M.D.) and duly licensed to practice medicine. The Physician must not be related to the Member.

"Suspension" means the temporary deprivation, without pay, of a Member's right to work for an employer for disciplinary reasons, whether for a specified or an indefinite period of time.

If you were suspended by your employer before becoming disabled, then:

a) if the Suspension is for a specified period of time, the calculation of the Qualification Period will begin on the date of such disability; however, no STD Benefits will be payable to you until the later of the expiry of the Qualification Period or the end of the Suspension; or
b) if the Suspension is for an indefinite period of time, no STD Benefits will be payable to you, unless you were disabled, and under the full time care and following the advice of a Physician prior to the suspension.

Initial Disability Period If you are covered for STD Benefits, payment of STD Benefits will start following expiry of the Qualification Period. No more than one benefit is payable during any period of disability whether you are disabled by one or more causes.

Successive Disability Period When you received STD Benefits under this Plan and return to active work for less than 28 days, and you make a claim for the renewal of benefits due to a recurrence of the same or related Injury or Bodily Sickness, STD Benefits will commence the day following the expiry of the Qualification Period less the number of days of total disability during the previous disability period. However, if you returned to work and become disabled from different and unrelated causes, it will be considered a new period of disability (a new claim) and you will have to have to wait for expiry of the Qualification Period before payments will start.

Payment

The weekly STD benefit payable is the lesser of 100% of the Member's Basic Weekly earnings, or the EI maximum (see "Summary of Benefits"). Note: the EI maximum benefit rate is typically increased on January 1st each year. The STD benefit is calculated on a seven-day workweek basis, which includes Saturday and Sunday. Benefit cheques are issued every two weeks by The Co-operators.

STD Benefits will NOT commence while a Member is:

a) on a leave of absence (eg. if you are on a leave of absence and your claim is eligible, STD Benefits commence on the 1st day you would have been scheduled to return to work if not disabled);

b) on strike or is locked-out by his or her employer. In the event of a strike or lock-out, no new claim will be accepted as of 12:01 a.m. on the date that such strike or lock-out commences. Benefits being paid at such time will be continued in accordance with the provisions of this section 4, but no new benefit will be commenced, except when the Member's disability period commenced prior to 12:01 a.m. on the date such strike or lock -out commences; or

c) outside of Canada or any state of the United States of America.

The disability period for any Member who becomes disabled while he is on leave of absence, on strike or is locked-out by his employer, or is outside Canada or any state of the United States of America, will commence on the first day the Member would otherwise have returned to work with his employer, except for reason of his disability.

Loss of any license required for work is not considered in assessing your disability.

Taxable Benefit

Your STD Benefit payments are considered taxable income. The Co-operators will withhold income tax from your payments. Contact your Co-operators disability claims adjudicator if you wish to have more tax deducted.

Reductions

Your STD benefit will be reduced by any benefits or income you receive, or are entitled to apply for and receive from the following sources (which are considered first payer):

a) Any group insurance, wage continuation plan, or disability benefit scheme under any pension plan;

b) Any compulsory act of law, excluding no-fault automobile insurance;

c) Any employer, excluding benefits or income received from rehabilitative employment, vacation pay received from an employer and banked overtime earned prior to the date disabled; and

d) Any payment made by the employer to the Member as a result of the termination of the Member's employment.

For greater certainty, it is confirmed that any benefit or income the Member receives, or is entitled to apply for and receive, from the following sources, shall not reduce the amount of STD Benefits payable to a Member

a) The Canada Pension Plan or Quebec Pension Plan;

b) A personal insurance policy; or

c) Any income or benefit the Member was receiving prior to the first day of disability.

The Co-operators must be advised of all income received or payable from the above sources. You are required to provide either a statement of income received or payable, or proof your application for benefits has been declined.

Maximum Benefit Payment Period

When your claim is signed by a Physician, STD payments will be made for a maximum of 52 weeks for any one disability period for which you can continue to be totally disabled.

When your claim is signed by a chiropractor, STD benefits payments will be made for a maximum of four weeks for any one period for which you are disabled.

When your claim is signed by a dentist, STD benefit payments will be paid for a maximum of two weeks if you are prevented from working due to a dental problem and are being treated by the appropriate dental practitioner.

Drug addiction and alcohol addiction are considered an illness when treatment is in a recognized rehabilitation facility (facility costs are not an eligible expense).

The benefit payment period will commence on the date immediately following the Qualification Period and will continue up to and including the earliest of:

a) the last day on which you are disabled;

b) the last day of the maximum benefit payment period;

c) the date you are in receipt of retirement benefits under the Teamsters Local 213 Pension Plan, or any other employer sponsored pension plan;

d) the date of failure to provide satisfaction of continued disability, or requested written proof;

e) the date of your death.

Failure to see a Physician

If a Member making a claim for STD Benefits fails to see a Physician as often as the cause and nature of the disability medically requires, or fails to see a Physician during a period of 30 consecutive days without written approval of The Co-operators, his STD Benefits payable will cease as of the day he fails to see the Physician as required or upon the expiration of the said 30 day period, whichever is earlier.

Graduated Return to Work and Rehabilitation

Rehabilitative employment or a graduated return to work is possible provided there is a full agreement from you, your attending Physician, your employer, and the claims adjudicator, The Co-operators. You must participate and cooperate in any rehabilitation program approved by The Co-operators.

The benefits paid to you by The Co-operators will be reduced by 50% of your income earned during this rehabilitative or graduated work period. The combined total of your income cannot exceed 100% of your average weekly wage prior to the start of your disability.

STD Benefits will cease on the earlier of the date the Member refuses to participate in any rehabilitation program recommended or approved by The Co-operators including but not limited to, any rehabilitation program offered through Worker's Compensation, the Canada Pension Plan, or the Insurance Corporation of British Columbia (ICBC), and the withdrawal of The Co-operators approval of the rehabilitation program.

Disputes

In the event of any dispute regarding the extent of medical care required or whether a Member is disabled, the matter may be referred to an independent Physician appointed by the Trustees or their designated nominee and the opinion of such independent Physician will be conclusive and binding on the Trustees and the Member. The costs and expenses of such referral and such opinion will be paid by the Trustees, but only if the opinion supports the Member's position. In the event such opinion does not support the Member's position, the Member shall be liable for all costs and expenses of such referral.

Workers' Compensation Claim

The Plan does not cover occupational accidents or any condition which entitled you to Workers' Compensation benefits. However, if your claim is initially rejected or delayed you may submit a claim - see the next section for further information.

Third Party Recovery of Benefits

No STD Benefits are payable under the Plan in the situation of a third party injury, eg. car accident or Workers' Compensation Claim. However, if you have the right to recover money from a third party, as compensation for Bodily Sickness or Injury, but the liability of the third party has not yet been determined, you may apply for STD Benefits. **Before STD Benefits will be paid, you must agree in writing to terms and conditions for the repayment of the benefits by signing the Plan's Reimbursement Agreement which The Co-operators will provide to you. If ICBC may be liable for providing compensation for an injury caused by a car accident, you must sign the Plan's Disclosure Agreement in place of the Plan's Reimbursement Agreement.**

You must:

a) Take all steps necessary to recover from the third party the total of the benefits paid in STD Benefits, including directing your lawyer to repay to the plan the full amount of the benefit 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 STD Benefits advanced to you plus interest at the *Court Order Interest Act* 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 STD as if you were totally disabled;

e) Enter into a Reimbursement or Disclosure Agreement (as applicable) with the Plan setting out the terms and conditions for repayment of the benefits, which The Co-operators will provide to you;

f) Consent to the release by the third party (including, without limitation, ICBC) of all information in their possession relating to the claim. In the event any of the above parties decline to provide the required information, you must provide such information that is in your possession as requested by the Plan.

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

LIMITATIONS & EXCLUSIONS:

No STD Benefits are payable for a disability which results from:

a) Intentionally self-inflicted Bodily Sickness or Injury, sustained while sane or insane;

b) Insurrection or war (whether or not war has been declared) or participation in any riot;

c) Active service in the armed forces of any country;

d) The commission or attempted commission of any unlawful act;

e) Cosmetic medical or surgical care, unless such care is rendered as a result of an injury sustained while a Member; or

f) Bodily Sickness or Injury to which the relevant Workers' Compensation Act applies.

A Member will not be entitled to receive any STD benefits during a disability period while the Member:

a) Is institutionalized in a penitentiary or jail;

b) Resides outside Canada or any state of the United States of America and is not subject to Canadian payroll deductions;

c) Is disabled as the result of the actions of a third party and the Member has not executed the Plan's Reimbursement Agreement.

d) Is absent from Canada without the prior consent of The Co-operators or the Trustees.

HOW TO CLAIM

Contact the Plan Administration Office to obtain the required claim form.

All of the items set out below must be completed, and all forms submitted to The Co-operators within 90 days of the date you became disabled or your claim will be denied.

Therefore as soon as possible after you become disabled you should:

a) See your doctor immediately (if you have not already done so);

b) Obtain the Plan's disability claim form from the Plan Administration Office or The Co-operators;

c) Complete the Employee Statement on the claim form and ensure that you have fully completed and signed the form;

d) Have your employer complete the Employer Statement;

e) Have your doctor complete the Attending Physician Statement;

f) Have all three completed statements sent to The Co-operators as soon as possible.

If you are traveling outside of Canada and become disabled, you can apply for STD Benefits after you return to Canada but within the claim filing deadline.

Limitation of Action

No action at law or in equity may be brought against the Plan or the Trustees to recover STD Benefits prior to the expiration of 60 days after a claim has been filed in accordance with the requirements in the "How to Claim Section".

No action may be brought against the Plan or the Trustees after the expiry of two years from the time that all claim application forms are required to be received by The Co-operators.

LONG TERM DISABILITY BENEFIT

Long Term Disability (**"LTD"**) provides you with a monthly income if you are unable to work due to a disabling non-work related Bodily Sickness or Injury which extends beyond your STD Benefit claim. You are eligible for the LTD Benefit amount as per the Summary of Benefits.

Note: LTD Benefits for those Members **who work in Federally Regulated employment** are administered on an **insured basis** as per Group Policy No. G. 40547 between the Trustees and The Co-operators Life Insurance Company effective July 1, 2014 **(see page 51 for details)**. At the time of publication of this booklet, the Federally Regulated employers participating in the Hour Bank Division of the Plan were Pe Ben Oilfield and Dawson Construction. Please contact the Plan Administration Office if you are not sure whether you work in Federally Regulated employment.

Qualification Period

"Qualification Period" means the later of:

a) the first 52 weeks of a disability period; or

b) the length of time during a disability period during which the Member is receiving a STD Benefit on account of his disability pursuant to section 3, or is receiving illness, injury or quarantine benefits pursuant to the Employment Insurance Act.

Definition of Disabled

a) During the Qualification Period, your inability to engage in your normal occupation, as a result of Bodily Sickness or Injury; and

b) After the Qualification Period, your inability to engage in ANY occupation or employment for wages or compensation for which you are reasonably qualified by education, training or experience or may reasonably become so qualified.

Notes:

"Bodily Sickness" means disease or illness and may include mental and nervous disorders provided that they are being treated under the supervision of a Physician and illness resulting from pregnancy and complications arising during or immediately following pregnancy, including premature termination, but not including normal births at or near the expected date of delivery.

"Injury" means an accidental bodily trauma which is sustained by you, resulting directly and independently of all other causes and that is manifest within 30 days after the accident which is the proximate cause of such trauma.

You will not have to requalify for LTD Benefits if your disability reoccurs within 28 days of your return to work. However, if you suffer a different disability during this 28 day period, you will have to requalify for LTD Benefits.

Failure to see a physician

If you fail to see a Physician as often as the cause and nature of the disability medically requires, or fail to see a Physician during a period of 30 consecutive days without written approval of The Co-operators, your LTD benefits will cease as of the day you fail to see the Physician as required or upon the expiration of the said 30 day period, whichever is the earlier.

"Physician" means a doctor or surgeon, who is a Doctor of Medicine (M.D.) and duly licensed to practice medicine. The Physician must not be related to the Member.

LTD Benefits will NOT commence while a Member is:

a) on a leave of absence;

b) on strike or is locked-out by his employer. In the event of a strike or lock-out, no new claim will be accepted as of 12:01 a.m. on the date that such strike or lock-out commences. Benefits being paid at such time will be continued in accordance with the provisions of this section 4, but no new benefit will be commenced, except when the Member's disability period commenced prior to 12:01 a.m. on the date such strike or lock -out commences; or

c) outside of Canada or any state of the United States of America.

The disability period for any Member who becomes disabled while he is on leave of absence, on strike or is locked-out by his employer, or is outside Canada or any state of the United States of America, will commence on the first day the Member would otherwise have returned to work with his employer, except for reason of his disability.

Loss of any license required for work is not considered in assessing your disability.

Payment

LTD payments begin after expiry of Short Term Disability Benefits. Your LTD payments are coordinated with other income or disability benefits for which you may qualify as stated in the "Reductions" section.

LTD Benefits will be payable at the end of each month during the benefit payment period and any balance remaining unpaid at the end of a benefit payment period will be payable on the last day of the period. The amount of such payment will be equal to the number of days of disability from the last payment of LTD Benefits to the end of the benefit payment period divided

by 30 and multiplied by the amount of monthly LTD Benefits being paid to such Member.

Your payments will continue up to and including the earliest of:

a) the last day on which you are disabled;

b) the last day of the month in which you turn 65;

c) the date you are in receipt of retirement benefits under the Teamsters Local 213 Pension Plan, or any other employer sponsored pension plan;

d) the date of failure to provide requested written proof, satisfactory to The Co-operators of your continued disability; or

e) the date of your death.

You must also be under the full-time care and supervision of a Physician who is acceptable to The Co-operators, and be following the treatment prescribed by your attending Physician or specialist.

Taxable Benefit

Your LTD payments are considered taxable income because employers contribute to the coverage cost. The Co-operators will withhold income tax from your monthly LTD payments. Contact your Co-operators case manager if you wish to have more tax deducted each month.

Reductions

LTD Benefits will be reduced by any benefit or income you receive, or are entitled to apply for and receive, from the following sources, which will be considered the first payer:

a) any group insurance, wage continuation plan, or disability benefit scheme under any pension plan;

b) any compulsory act of law, excluding no-fault automobile insurance;

c) any employer, excluding benefits or income received from rehabilitative employment, vacation pay received from an employer and banked overtime earned prior to the date disabled;

d) any payment made by the employer to the Member as a result of the termination of the Member's employment; and

e) any other source, other than:
   - The Canada Pension Plan or the Quebec Pension Plan; or
   - a personal insurance policy; or
   - any income or benefit the Member was receiving prior to becoming Disabled.

Your LTD Benefits will be further adjusted so that your gross income from all sources does not exceed 100% of your pre-disability average gross monthly earnings immediately prior to the start of your disability.

Graduated Return to Work and Rehabilitation

A rehabilitation program may be provided to you by The Co-operators. Such program may include rehabilitation assessment, rehabilitative employment, rehabilitative treatment, and/or rehabilitation services. The Co-operators will have the sole discretion to determine whether or not a rehabilitation program is appropriate for a Member.

You will continue to receive LTD benefits if you receive advance approval from The Co-operators and continue to participate in the approved rehabilitation program, or a similar program through another source. The program may include rehabilitative employment on a full-time, part-time or modified work basis, or rehabilitative assessment, treatment or other services such as training strategies.

Your LTD Benefits will be further adjusted so that your gross income from all sources does not exceed 100% of your pre-disability average gross monthly earnings.

The rehabilitation program may not extend beyond 24 months from the commencement of the LTD Benefits.

LTD Benefits will cease on the earlier of:

a) the date the Member refuses to participate in any rehabilitation program recommended or approved by The Co-operators, including but not limited to, any rehabilitation program offered through Workers' Compensation, the Canada Pension Plan or the Insurance Corporation of British Columbia (ICBC); and

b) the withdrawal of The Co-operators' approval of your rehabilitation program.

Disputes

In the event of any dispute regarding the extent of medical care required by The Co-operators or whether a Member is disabled, the matter may be referred to an independent Physician appointed by The Co-operators or the Trustees and the opinion of such independent Physician will be conclusive and binding on the Trustees and the Member, and the costs and expenses of such referral and such opinion will be paid by the Trustees, but only if the opinion supports the Member's position. In the event such opinion does not support the Member's position, the Member shall be liable for all costs and expenses of such referral.

Workers' Compensation Claim

The Plan does not cover occupational accidents or any condition which entitled you to Workers' Compensation benefits. You may appeal to Workers' Compensation if your claim is terminated.

Third Party Recovery of Benefits

If your disability is caused by, in whole or impart, a third party who is or may be legally liable to compensate such Member monetarily for pain and suffering sustained and loss and damage suffered by such Member, including, without limitation, both past and future loss of earnings, you must take such action as may be necessary, including an action at law, to recover compensation equal to or greater than the total amount of the LTD Benefits paid to such Member plus interest at the *Court Order Interest Act* rates applicable to the period between the commencement of payment of LTD Benefits to such Member and the date upon which such Member's claim for compensation is finalized.

In the event that such Member, when required to do so by the Trustees, fails to take such action when, in the opinion of the Trustees, it is reasonable for such Member to do so, the Trustees will be entitled to cease payment of all further LTD Benefits to such Member.

No LTD Benefits are payable under the Plan in the situation of a third party recovery (eg. by the driver of the other vehicle in a car accident). However, if you have the right to recover money from a third party, as compensation for Bodily Sickness or Injury, but the liability of the third party has not yet been determined, you may apply for LTD Benefits. **Before LTD Benefits will be paid, you must agree in writing to terms and conditions for the repayment of the benefits by signing the Plan's Reimbursement or Disclosure Agreement as applicable, which The Co-operators will provide to you.**

You must:

a) Take all steps necessary to recover from the third party the total of the benefits paid in LTD Benefits, including directing your lawyer to repay to the plan the full amount of the benefit 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 to you 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 liability and payment of LTD as if you were totally disabled;

e) Enter into a Reimbursement or Disclosure Agreement (as applicable) with the Plan setting out the terms and conditions or repayment of the benefits;

f) Consent to the release by the third party (including, without limitation, ICBC) of all information in their possession in relation to your claim. In the event any of the above parties decline to provide the required information, you must provide such information that is in your possession as requested by the plan.

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

LIMITATIONS & EXCLUSIONS

No LTD Benefits will be payable if the disability results from:

a) Intentionally self-inflicted Bodily Sickness or Injury, while sane or insane;

b) Participation in a rebellion, riot or insurrection, war (whether or not war has been declared) or by full or part-time service in any armed forces;

c) The commission or attempted commission of any lawful act;

d) Cosmetic medical or surgical care, unless such care is rendered as a result of an injury sustained while a Member; or

e) Bodily Sickness or Injury to which the relevant Workers' Compensation Act applies.

LTD Benefits will be paid to you during a disability period subject to the following conditions:

a) except as otherwise provided by The Co-operators, the Member must be under the full-time care and following the advice of a Physician during any disability period for which LTD Benefits are payable;

b) the Member must participate and cooperate in any rehabilitation program under the direction of, or prescribed by a Physician, and approved by The Co-operators;

c) during any disability period, LTD benefits will be paid either on account of Bodily Sickness or Injury, but not on account of both;

d) payment of LTD Benefits will commence following the expiration of the Qualification Period.

e) when you received LTD Benefits under this Plan and return to active work for less than 28 days and you make a claim for the renewal of benefits due to a recurrence of the same or related Injury or Bodily Sickness, LTD Benefits will commence the day following the expiry of the Qualification Period less the number of days of total disability during the previous disability period. However, if you returned to work and become disabled from different and unrelated causes, it will be considered a new period

of disability (a new claim) and you will have to have to wait for expiry of the Qualification Period before payments will start.

f) if the Member is suspended by his employer before becoming disabled, then:
   - if the suspension is for a specified period of time, the calculation of the Qualification Period will begin on the date of such disability; however, no LTD Benefits will be payable to the Member until the later of the expiry of the Qualification Period or the end of the suspension; or
   - if the suspension is for an indefinite period of time, no LTD benefits will be payable to the Member, unless the Member was disabled, and under the full time care and following the advice of a Physician prior to the suspension.

"Suspension" means the temporary deprivation, without pay, of a Member's right to work for an employer for disciplinary reasons, whether for a specified or an indefinite period of time.

g) A Member will not be entitled to receive any LTD benefits during a disability period while the Member:
   - is institutionalized in a penitentiary or jail;
   - resides at a place other than his ordinary residence or at a hospital, without the consent of the Trustees or The Co-operators;
   - resides outside Canada or any state of the United States of America; or
   - is disabled as the result of the actions of a third party and the Member has not executed a Reimbursement Agreement.

HOW TO CLAIM

Specific instructions will be provided by The Co-operators.

Written proof of a claim must be submitted within three months from:

a) The expiration of your STD payments, or

b) The date you become eligible for LTD Benefits, whichever is sooner.

Limitation of Action

No action at law or in equity may be brought against the Plan or the Trustees to recover under this section prior to the expiration of 60 days after a Proof of Claim has been filed in accordance with the requirements in the "How to Claim" section.

No action may be brought against the Plan or the Trustees after the expiry of two years from the time that such Proof of Claim is required to be received by The Co-operators under "Limitation of Liability".

Limitation of Liability

The Trustees will have no liability if either a Proof of Claim or a Physician's certificate or both are not received by The Co-operators within 90 days after the Member becomes eligible for LTD Benefits.

LONG TERM DISABILITY – INSURED BENEFIT FOR MEMBERS WHO WORK IN FEDERALLY REGULATED EMPLOYMENT

INTRODUCTION

Since July 1, 2014, the Federal government has required that Federally Regulated employers that provide a Long Term Disability (LTD) plan for their employees must insure the plan with a provincially licensed insurer. As a result, the Board of Trustees established an Insured LTD Plan with The Co-operators Life Insurance Company, the terms of which are set out in Policy G. 40547 (the **"Policy"**).

You are covered under the Policy if your employer is one of the following (list current at booklet print date):

- Pe Ben Oilfield
- Dawson Construction

This section of the booklet outlines the general coverage information for your Insured LTD Benefits if you are a Member who works for a Federally Regulated employer. You are encouraged to read and understand the benefits that are provided for you and save this information in a safe place. If you have any questions, please contact the Plan Administration Office.

Your employer and the Plan Administration Office are responsible for submitting all required premiums, reporting all new enrolments, terminations or any benefit changes and keeping all records up to date.

This section of the booklet is meant to provide general information about your Insured LTD Plan under the Policy. It is not a legal contract. The master Policy G. 40547 issued by Co-operators Life Insurance Company to Trustees of the Teamsters Local 213 Health and Welfare Plan determines the benefits, amounts and effective dates that apply to you and shall be the final basis for the settlement of all claims. Where there is a discrepancy or conflict between the description in this booklet and the Policy, the terms and conditions of the Policy prevail.

INSURED SCHEDULE OF BENEFITS

This Insured Schedule of Benefits must be read together with the benefit details described in this section of the booklet.

LONG TERM DISABILITY BENEFITS

Benefit Formula:	Flat $1,200 per Member.
Monthly Benefit:	The amount calculated using the benefit formula. The maximum Monthly Benefit is the lesser of $1,200 or the amount calculated using the formula for the All Source Maximum.
All Source Maximum:	85% of pre-disability gross Salary
Occupational Coverage:	yes, 24-hour coverage
Elimination Period:	- for Injury 365 consecutive Days - for Sickness 365 consecutive Days
Own Occupation Period:	none - must be Totally Disabled from any and all occupations from the end of the Elimination Period
Maximum Benefit Duration:	to age 65
Recurrent Total Disability:	6 months
Tax Status:	Taxable
CPP/QPP Offset:	none
Termination age:	Member's 65th birthday
Waiver of premium waiting period:	is equal to the Long Term Disability Elimination Period. Waiver of premium terminates at age 65.

GENERAL INFORMATION

To be eligible to participate in the Insured LTD Plan under the Policy you must be:

- a member, in good standing, of the Union,
- actively working on a regular permanent basis,
- employed under a collective agreement requiring contributions to be made to the Teamsters Local 213 Health & Welfare Plan and your employer participates in the Hour Bank Plan and falls under "Federally Regulated" employment,
- insured under a government health insurance plan and reside in Canada,
- under age 65, and
- hired on or before the Insured LTD Plan effective date of July 1, 2014 or if hired later, on the first day of the month following the month in which you have accumulated at least 300 credited hours of active work in your Hour Bank.

The Co-operators considers you to be actively working if you are:

- actually working at your employer's place of business or a place where your employer requires you to work in Canada,
- able to perform and actually performing all the usual and customary duties of your occupation on a full pay status and on a regular and continuous basis for the number of hours regularly scheduled for that day, or
- absent due to scheduled vacation, weekends, statutory holidays or shift variances.

The Plan Administration Office will provide you with the group enrolment form and/or other forms necessary to apply for your coverage. You must complete all forms and return them to the Plan Administration Office. *This is detailed in this booklet under the heading "Eligibility" in the "General Information" section.*

When does my coverage begin?

Your coverage takes effect the 1st of the month following the month in which you have accumulated at least 300 credited hours of Active Work (see General Information/Eligibility and coverage sections), and all required enrolment forms completed and received by the Plan Administration Office provided you are actively at work on that date.

If you were not actively at work on the date your insurance would normally become effective or increase, then that insurance will not take effect until the first full day you are again actively at work.

When does coverage end?

Your coverage terminates the earliest of:

- the end of the month in which your Hour Bank balance is below the monthly Hour Bank charge; or if you are making Self Pay Contributions, the end of the month in which you cease to maintain or be able to maintain eligibility for benefits by making Self Pay Contributions
- the date your employer no longer has a collective agreement with the Union
- the last day of the month that your Union membership has been terminated, suspended, or withdrawn
- the date you are no longer actively at work (except for maternity/parental/family leave where legislated)
- the end of a period for which premiums have been paid for your insurance
- the date you cease to be in a class of employees eligible for insurance
- the date you reach the termination age specified in the insured schedule of benefits
- the date you withdraw funds from your employer's pension plan
- the last day of the month upon your enlistment in the armed forces of any country
- the date this Policy or the employer's coverage under this Policy terminates

Accessing your records

As required by legislation, for insured benefits, you have the right, upon request, to obtain a copy of your enrolment card or application for insurance and any written statements or other record not otherwise part of the application that you provided to The Co-operators as evidence of insurability, subject to certain limitations.

For insured benefits, on reasonable notice, you may also request a copy of the Policy in accordance with the legislation in your province of residence. All requests for copies of documents should be directed to the Plan Administration Office or The Co-operators Group Client Service Centre.

Third Party Liability

If you become totally disabled due to an injury or sickness for which a third party is, or may legally become liable, you must sign a reimbursement or disclosure agreement (as applicable) and submit it to The Co-operators before any benefits will be paid. The reimbursement and disclosure agreements outline the terms for reimbursing The Co-operators when you settle the claim with the third party. To continue to qualify for any future benefits, it

is important that you obtain written consent from The Co-operators before settling any claim with the third party.

LONG TERM DISABILITY BENEFITS

What am I insured for?

To qualify for Insured LTD Benefits, your claim must provide satisfactory proof that, while insured under this plan, you became totally disabled and therefore unable to work.

- "totally disabled" means that the Member is, as a result of a medically diagnosed condition:
  (i) prevented from engaging in any occupation or performing work of any sort for wage, remuneration or profit for which the Member is able or may reasonably become able, by means of education, training or experience, and
  (ii) is not engaged in any occupation or performing work of any sort for wage, remuneration, or profit, other than an approved rehabilitation program.

  The Member will not, however, be considered to be totally disabled or prevented from engaging in any occupation or performing any work of any sort for wage, remuneration or profit by virtue of the unavailability of such occupation(s) or work in the place in which the Member resides.

  A Member who must hold a permit or licence to perform his/her duties will not be considered totally disabled solely because such permit or licence has been withdrawn or not renewed.

The purpose of this benefit is to insure for wage loss should you become totally disabled as a result of a medically diagnosed sickness or injury and unable to work. Therefore, if there is no lost income, benefits are not payable.

The monthly benefit for which you are covered is based on your monthly salary and the benefit formula indicated in the insured schedule of benefits. The amount payable is the monthly benefit amount less the reductions listed under the benefit reduction section in this section of the booklet.

What conditions do I need to satisfy before and during payment of benefits?

Independent Medical Assessment

It is a condition prior to the initial payment of Insured LTD Benefits and any continuing payment of benefits that you will, if The Co-operators requires, undergo medical assessment(s), by one or more medical practitioners chosen by The Co-operators.

Continuous Obligation

Your obligation to undergo medical assessment exists during any period for which you claim Insured LTD Benefits.

Participation in Rehabilitation Program

It is a condition prior to and while you are receiving Insured LTD Benefits, that you will, where requested by The Co-operators, participate in a rehabilitation program considered appropriate by The Co-operators, including but not limited to an approved rehabilitation program offered through worker's compensation legislation or similar statute.

Pre-existing Condition Limitation

Pre-existing condition means a sickness or injury for which you sought medical investigation, diagnosis, treatment, care medication or medical advice, or for which there were symptoms which would have caused a person acting reasonably to seek medical investigation, diagnosis, care, treatment, medication or medical advice within the 90 day period immediately prior to becoming insured under the Policy.

No monthly benefits will be payable for any period of total disability which results directly or indirectly from a pre-existing condition, unless:

- you have not required treatment, medication, or medical advice for the condition for a continuous period of at least 90 days immediately following the effective date of your Insured LTD Plan coverage, or
- you have been insured continuously under this Insured LTD Plan for at least 12 months (from the date your insurance became effective or reinstated) and you have not been absent from work during the 12 month period as a result of the preexisting condition. Time away from work up to 10 cumulative working days during the 12 month period will be interpreted as not being absent from work.

  There is no pre-existing condition limitation for Members who were members of the Plan immediately prior to July 1, 2014 and covered under the Plan for the self-insured Long Term Disability benefits (G1018).

Payment of Monthly Benefits

Where The Co-operators receives satisfactory proof that you:

- are and have been totally disabled since the disability date,
- have suffered a loss of income,
- are receiving and following reasonable and customary treatment prescribed and rendered by a physician or where The Co-operators considers appropriate, a specialist, and
- have satisfied all of the other relevant conditions contained in the Policy,

The Co-operators will, subject to the provisions of the Policy, continue to pay you a monthly benefit.

When will benefits begin?

Your Insured LTD Benefits will begin the day following the end of the elimination period indicated in the insured schedule of benefits or the day following the end of the period during which you are receiving short term disability benefits under the Plan or salary continuation benefits from any other source, whichever is later.

The elimination period refers to the time frame of total disability that must be satisfied before you qualify to make a claim for benefits. Insured LTD Benefits are not payable and premiums are not waived during this period.

What if I work during the Elimination Period? (your elimination period is 365 days)

If you return to work for a period of 14 consecutive days or less, your elimination period will be considered to be uninterrupted, but the days you worked will be added to the end of your elimination period. If you return to work for more than 14 days, your elimination period will be reinstated and you will be required to satisfy the complete elimination period before benefits are eligible to be paid.

Recurrence of Total Disability

Your total disability is considered a recurrence if it arises from the same or related sickness or injury within 6 months from the date your Insured LTD Benefits ended.

Benefits are pro-rated for partial months

Monthly Insured LTD Benefits payable for periods less than a full month will be pro-rated based on the actual number of days in the applicable month.

Are my benefits taxable?

Your benefit payments are taxable if your employer pays any portion of the premium. The tax status of your Insured LTD Benefits is stated in the Insured Schedule of Benefits.

Rehabilitation Program

A Rehabilitation Program is provided at the discretion of The Co-operators and may include rehabilitation assessment, and/or rehabilitative employment, and/or rehabilitative treatment, and/or rehabilitation services recommended and approved by The Co-operators.

Approval of Rehabilitation Program

The rehabilitation benefit is only temporary as it is intended to help you work your way up to full time duties or hours of some type of reasonable employment based on your education and experience. However, in some situations, a rehabilitation program can turn into a permanent accommodation or position, and for this reason, the covered benefit is limited to a maximum of 24 months. After this, your earnings would be considered income from another source, and the 'all source maximum' provision outlined in this booklet would apply.

The Co-operators will have sole discretion in determining whether or not a rehabilitation program is appropriate and/or provided for any employee. Once the rehabilitation program is approved, The Co-operators may issue, if eligible, monthly Insured LTD Benefits to a totally disabled employee who continues to participate and cooperate in an approved rehabilitation program.

The rehabilitation program duration will be determined by The Co-operators, however it will not extend beyond the end of the own occupation period indicated in the schedule of benefits or 24 months from the date of your disability, whichever is later, unless an extension of the duration is recommended and approved in writing by The Co-operators.

Calculation of Monthly Benefits during a rehabilitation employment period

If you participate in rehabilitative employment approved by The Co-operators, your Insured LTD Benefit will be reduced by 50% of your rehabilitative earnings. The monthly benefit payable during rehabilitative employment will be calculated after 4 weeks of earnings have been reported to The Co-operators, payable monthly and adjusted periodically.

Your Insured LTD Benefit may be further reduced by any amount necessary to reduce the total income you receive from all sources to 100% of the monthly salary for which you were insured immediately prior to the start of your disability. If your benefit is non-taxable, your total income from all sources will be limited to 100% of the salary for which you were insured immediately prior to the start of your disability less your deductions for income tax, EI and CPP/QPP.

Cessation of Monthly Benefits

Your Monthly benefits will cease on the earliest of:

- the date you refuse to participate or co-operate in any rehabilitation program recommended or approved by The Co-operators including but not limited to any rehabilitation program offered through any worker's compensation legislation or similar statute, auto plan benefits or Canada Pension Plan, or

- the withdrawal of The Co-operators' approval of your rehabilitation program.

Benefit Reductions:

What reductions occur when determining my Long Term Disability Benefit payment?

All Source Maximum - Ceiling on the Monthly Benefit

The amount of your taxable benefit will be limited to the lesser of the amount of insurance for which you are covered or 85% of your predisability gross monthly salary.

All Source Compensation - Direct Reductions

Your monthly Insured LTD Benefit will be reduced directly by one or more of the following, which you are receiving or entitled to receive at the time your benefits commence and/or while benefits, are paid:

- any government plan benefits (such as benefits under the relevant Workers' Compensation Act or similar statute; there is no offset for CPP/QPP benefits),
- any auto plan benefits,
- any compensation for loss of income you receive from a third party or are entitled to receive after your disability date.

All Source Compensation - Indirect Reductions

If the total of the following all source compensation and your monthly benefit exceeds 85% of your pre-disability gross monthly salary your Insured LTD Benefit will be further reduced by:

- any amount you are entitled to under an employer funded salary replacement benefit as a result of your disability, and
- any compensation you receive or are eligible to receive while employed or while performing work of any sort, excluding rehabilitative earnings which are considered under the rehabilitation program, and
- any payment made to you by your employer as a result of termination of your employment including without limitation any payment made by way of settlement or judgement, and
- any disability benefits you are eligible to receive under any other group or association plan as a result of being an employee of a group or a member of an association.

Failure to Apply or Accept Other Benefits

Except for retirement benefits, any benefit is considered paid when you are entitled to it, whether or not it has been awarded or received. If it has not

been awarded or received, The Co-operators will have the right to estimate the income according to the terms of any plans or legislation involved. Retirement benefits are considered payable when they are actually received.

Where you do not qualify for part or all of the all source compensation because of failure to apply in a timely and satisfactory manner (or appeal where so advised by The Co-operators), The Co-operators reserves the right to reduce your monthly Insured LTD Benefit by the amount of all source compensation which you would have been eligible for or received had a proper application or appeal been made.

Lump sum conversion to Monthly Benefit

Where you receive or have the option of receiving part or all of the all source compensation as a lump sum payment, The Co-operators will, acting reasonably, pro-rate the lump sum payment and reduce your monthly benefit as if the lump sum had been paid on a monthly basis.

Repayment of Benefits

Where you receive all source compensation that includes compensation for a period for which monthly benefits have been paid, The Co-operators will convert the payment to a monthly payment and recalculate your monthly Insured LTD Benefit that should have been paid. You are responsible to repay The Co-operators any overpayment of Insured LTD Benefits.

Total Disability Waiver of Premium

The Co-operators will waive the Insured LTD Plan premiums while you are receiving benefits.

When do my Long Term Disability Benefits terminate?

No monthly Insured LTD Benefits will be paid beyond:

- the date you cease to be totally disabled, or
- the benefit duration indicated in the schedule of benefits or your 65th birthday, whichever first occurs, or
- the date you begin working in any occupation, except as provided for under the rehabilitation program, or
- the date you refuse to participate or cooperate in any rehabilitation program recommended or approved by The Co-operators including but not limited to any rehabilitation program offered through workers' compensation legislation or similar statute, or
- the date you refuse to participate or cooperate in *a reasonable and customary treatment program* approved by The Co-operators, or
- the date of your death, or

- the date you retire, or were scheduled to retire, or
- the date you withdraw or receive a pension from the Teamsters Local 213 Pension Plan.

A reasonable and customary treatment program is systematic treatment that is:

- generally accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of the medically diagnosed condition, and
- of a nature, intensity, frequency and duration essential to the diagnosis or management of the medically diagnosed condition involved, and
- prescribed and rendered by a physician or where considered appropriate by The Co-operators for the nature of the medically diagnosed condition, the treatment must be prescribed and rendered by a specialist.

No monthly benefits will be payable during any period while you are:

- serving a sentence for a criminal or provincial offense whether you are imprisoned in a halfway house, a correctional facility, or any other form of detention, or
- absent from Canada longer than 3 months due to any reason, unless The Co-operators agrees in writing in advance to continue to pay your Insured LTD Benefits during this period, or
- receiving short term disability benefits under the Plan or salary continuation benefits from any other source, or
- on maternity/parental or compassionate (family) leave and receiving or eligible to receive employment insurance (EI) benefits or maternity or parental benefits from any other source, or
- becomes disabled during a work stoppage, including but not limited to strike, lay-off, lock-out, suspension or leave of absence, except as provided below:

Maternity/Parental and Compassionate Leave

If you become totally disabled while on maternity/parental or compassionate leave, provided premiums have been paid, the elimination period will commence on your disability date and Insured LTD Benefits will begin on the later of the end of the elimination period or the date you were scheduled to return to active work.

A scheduled maternity/parental or compassionate leave is deemed to commence on the date agreed upon by you and your employer and end on the date you were scheduled to return to active work. If a child is born prior to the date upon which your maternity leave is scheduled to commence, the leave is deemed to commence on the date of birth.

If your employer is required to provide benefits during the health related portion of your maternity leave as a result of law or legislation, the elimination period will begin on the date your child is born and benefits will begin after you have satisfied the elimination period.

What limitations are there on* Insured *LTD* Benefits*?

No monthly Insured LTD Benefits will be payable for any period of disability resulting directly or indirectly from any of the following:

- intentionally self-inflicted injury suffered whether sane or insane, or
- insurrection, war (whether declared or not), voluntary participation in a civil riot or commotion, or
- committing or provoking an assault, committing or attempting to commit a criminal offense, or
- a situation where the disability results from injuries sustained in, or directly or indirectly from, a vehicle accident where you were driving a vehicle involved in the accident and had either:
  - alcohol in your blood in excess of 80 milligrams of alcohol per hundred millilitres of blood
  - your ability to operate the vehicle impaired by drugs or alcohol or a combination of the two
- medical care which is not medically necessary to treat an injury or sickness or which is of a cosmetic nature. The donation of an organ or tissue will be considered necessary medical care, or
- any injury or sickness for which a third party is, or may legally be liable, except as provided for under the third party liability provision in the Policy.

The Claims Process:

When to submit an Insured LTD Plan claim

The Co-operators must receive written notice of a claim for disability benefits within 30 calendar days from the first day that you were not actively at work due to disability. **If you are receiving short term disability benefits under the Plan in respect of which a claim form had been submitted to The Co-operators you shall not be required to submit a further claim form.**

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 180 days from the first day that you were not actively at work due to disability.

If you are totally disabled and receiving benefits under any worker's

compensation legislation or similar statute, you should still submit an application for Insured LTD Benefits to The Co-operators according to the above procedure. You may also be eligible to receive Canada Pension Plan (CPP) or Quebec Pension plan (QPP) disability benefits. Applications can be obtained from your nearest CPP or QPP office.

Where do I find a claim form if I need to submit one?

Claim forms are available from your Plan Administration Office.

Our team in the Group Client Service Centre would also be happy to assist you via telephone or email.

To avoid delays, complete the claim form in its entirety, and always include:

- your full name as it appears on your pay stub
- your personal identification number (i.e. certificate number)
- your employer's name, and
- your group policy number, G. 40547

Proof of Claim

You are required to prove your entitlement to benefits under your plan and to provide notice of claim in accordance with the Policy provisions. You must provide information required to prove your entitlement to benefits and must also authorize The Co-operators to obtain information from other sources for this purpose (if required). From time to time, The Co-operators will ask you to provide them with proof of your total disability. Whenever The Co-operators requests information or authorization, it must be submitted within the time limit requested. If not submitted within this time, you will not be entitled to benefits. Expenses incurred for providing this information will be your responsibility.

When should I submit my claim form?

To permit prompt assessment, initial notice of claim should be submitted no later than the time limits described in each benefit section. **If you are receiving short term disability benefits under the Plan in respect of which a claim form had been submitted to The Co-operators you shall not be required to submit a further claim form.**

Claim forms can be mailed to:

Group Claims Department
The Co-operators
1920 College Avenue
Regina, Saskatchewan
S4P 1C4

Payment

Insured LTD payments begin after expiry of Short Term Disability Benefits. Your LTD payments are coordinated with other income or disability benefits for which you may qualify as stated in the "Reductions" section.

Insured LTD Benefits will be payable at the end of each month during the benefit payment period and any balance remaining unpaid at the end of a benefit payment period will be payable on the last day of the period. The amount of such payment will be equal to the number of days of disability from the last payment of Insured LTD Benefits to the end of the benefit payment period divided by the number of days of the calendar month and multiplied by the amount of monthly Insured LTD Benefits being paid to such Member.

Your payments will continue up to and including the earliest of:

a) the last day on which you are disabled;

b) the last day of the month in which you turn 65;

c) the date you are in receipt of retirement benefits under the Teamsters Local 213 Pension Plan, or any other employer sponsored pension plan;

d) the date of failure to provide requested written proof, satisfactory to The Co-operators of your continued disability; or

e) the date of your death.

You must also be under the full-time care and supervision of a Physician who is acceptable to the The Co-operators, and be following the treatment prescribed by your attending Physician or specialist.

Limitation of Action

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or any other applicable legislation.

Where or when applicable legislation permits the use of a different limitation period, no action or proceeding at law or in equity shall be brought against The Co-operators for payment of benefits under the Policy or for any other related damages:

- prior to the expiration of 60 days after the claim form has been filed in accordance with the requirements of the Policy; or
- unless brought:
  - where no benefits have been paid, within one year from the expiration of the time within which the claim form is first required by

the Policy or from the date on which The Co-operators first denies the claim for benefits, whichever first occurs; or

- where benefits have been paid under the provision of the Policy, within 1 year of the date on which The Co-operators terminates the payment of Insured LTD Benefits.

The time limit within which to commence an action shall expire on the date(s) as specifically provided for in this provision and in no event shall it be extended to each and every monthly payment accruing after the date(s).

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

If you are eligible for and wish to receive benefits under the Insured LTD Policy, The Co-operators must gather personal information about you. The Co-operators uses this personal information for the purposes of providing the Insured LTD Plan administration services and insurance products to you. Maintaining the security of your personal information is a top priority and The Co-operators' systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Detailed information regarding your rights with respect to personal information is on the claim form.

SERVICE PROVIDERS TO THE BOARD OF TRUSTEES

PLAN ADMINISTRATION OFFICE:	TEAMSTERS LOCAL 213 MEMBERS BENEFIT PLANS 490 East Broadway Vancouver BC V5T 1X3 Email: inquiries@teamsters213benefits.com Telephone: (604) 879-8627 Vancouver and Lower Mainland Toll Free 1-800-972-6241 Other areas in BC and the Yukon Fax: (604) 872-4725 Website: www.Teamsters213.org/Benefits
ACTUARY/CONSULTANT:	MORNEAU SHEPELL
AUDITOR:	MNP LLP
BANK:	GULF AND FRASER FINANCIAL
CUSTODIAN:	CIBC MELLON
INVESTMENT MANAGER:	PHILLIPS HAGER & NORTH
INVESTMENT ADVISOR:	STRATEGIC INCOME SECURITY SERVICES
LEGAL COUNSEL:	LAWSON LUNDELL LLP

PRIVACY OF YOUR PERSONAL INFORMATION

The Plan Administration Office, Teamsters Local 213 Members Benefits Plans, (on behalf of the Board of Trustees of the Teamsters Local 213 Health and Welfare Plan), has adopted a Privacy Policy. The Privacy Policy governs the collection, use and disclosure of Personal Information for the purposes of administering the Plan.

"Personal Information" means information about an identifiable individual including:

a. name;
b. date of birth;
c. address;
d. work history;
e. personal identification numbers including the Social Insurance Number;
f. medical information;
g. claims history; and
h. identity of spouse and eligible dependents.

Personal Information does not include statistical information or information in the aggregate that does not identify a particular individual.

Administration of the Plan requires the collection, use and disclosure of Personal Information about the members of the Plan. The Board is required to adhere to the relevant Personal Information protection legislation when dealing with the Personal Information of its members (and their spouses and eligible dependents), and by extension, the Plan Administration Office must adhere to that legislation as an agent or delegate of the Board.

The Privacy Policy applies to Personal Information collected or used by the Board themselves or by the Plan Administration Office in the course of administering the Plan, including Personal Information about members, former members, spouses and other beneficiaries.

The Privacy Policy explains why Personal Information will be collected, used and disclosed in respect of the Plan, the principles that will govern such collection, use and disclosure and the steps that will be followed when Personal Information protection issues arise.

The Privacy Policy is available on the website:
http://www.teamsters213.org/benefits/
or you may request a written copy from the Plan Administration Office.

Your Social Insurance Number and other Personal Information will only be used for the purpose of managing and administering your health and welfare benefits.

NOTES