Local 97 Ironworkers

Health and Welfare Plan

Address all inquiries to:

D.A.Townley

THE ADMINISTRATOR
LOCAL 97 IRONWORKERS
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*Including amendments to January 2024

PRIVACY POLICY

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

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

The Trustees

The following is an outline of the Local 97 Ironworkers Health & Welfare Plan. The information in this benefits booklet is important to you. It provides the information you need about the group benefits available through the Local 97 Ironworkers Health & Welfare Plan.

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

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

SCHEDULE OF BENEFITS

Medical Services Plan of BC (MSP)	Group No. 4823381
Life Insurance	$100,000*
AD&D	$12,500
Weekly Indemnity	Equal to EI Weekly Maximum Integrated with EI
Long Term Disability	$1,400 per month
Employee and Family Assistance Plan	
Extended Health Benefits	90%, unless otherwise stated
Prescription Drugs	90%, Generic Substitution $9.50 Dispense Fee Cap Prior Authorization Program
Out of Province/Canada Emergency Medical Travel Insurance	$5,000,000 Maximum Per Coverage Period
Vision Care	as described herein
Dental Plan	90% Basic Services 50% Major Services 50% Orthodontia (Dep Child <19)
Transportation Assistance	as described herein

***NOTE:** All Active Members and Non-Members between the ages of 60 and 65 will be covered for $100,000 of Life Insurance. Members between the ages of 60 and 65, who are not active but are covered for benefits, will be covered for $50,000 of Life Insurance. Upon attaining age 65, all Members Life Insurance reduces to $10,000 and upon attaining age 70, the Life Insurance reduces to $5,000.

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

DETAILS of ELIGIBILITY

Who is eligible?

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

Do any Forms have to be completed?

YES. You must complete a Medical Services Plan application form and an Enrolment and Beneficiary card.

If adding a Common-Law spouse after your initial eligibility date the notarized Common-Law Declaration is required.

It is most important that EACH Member and Non-Member complete the required forms. These forms should be sent to the Administrators Office without delay.

How does a person qualify for coverage?

A Member in good standing and Non-Member must accumulate 220 hours of work within a 5 month period. Coverage will commence on the 1st day of the month following the month (lag) in which sufficient hours are reported and paid to the Plan by the employer(s).

A Member or Non-Member is eligible for all benefits except Weekly Indemnity and Long Term Disability after satisfying the normal qualifying conditions of the Plan. Coverage for Weekly Indemnity and Long Term Disability commences the first day of the second month after the Member or Non-Member has worked, and the Plan has received contributions for 1,000 hours of work from a participating employer.

Upon qualifying for coverage, the Member will receive a pay-direct card (one for single coverage or 2 cards for dependent coverage – both will be in the Member's name).

EXAMPLE (all benefits except for Weekly Indemnity and Long Term Disability):

	HOURS REPORTED		
MONTH	**MEMBER A**	**MEMBER B**	**MEMBER C**
January	50 hours	150 hours	226 hours
February	70 hours	125 hours	lag
March	30 hours	lag	qualified
April	100 hours	qualified	–
May	lag	–	–
June	qualified	–	–

Once coverage starts, you will continue to be covered as long as your Hour Bank contains sufficient hours.

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

A person who is not a Member of Local 97 but who is working under the Local 97 Collective Agreement will have a charge of 130 hours made against their Hour Bank. A maximum of 4 months coverage (520 hours) can be accumulated in a Non-Member's Hour Bank.

When does coverage end?

a) Coverage will terminate when there are insufficient hours in the Member's Hour Bank to allow for a deduction of 110 hours. Coverage for a Non-Member will terminate when there are insufficient hours in the Hour Bank to allow for a deduction of 130 hours.

b) Coverage for Members will be terminated immediately and the Hour Bank will be forfeited for any Member who is found to be working for a non-signatory Ironworker Contractor.

Disability Credits

When a Member is collecting benefits under the Weekly Indemnity Plan, EI Sick Benefits or under Workers' Compensation, Members can apply to receive assistance with their Hour Bank. For each day that the Member is disabled and on a claim that has been accepted for payment, the Member's Hour Bank will be credited with contributions of 8 hours per day, subject to a maximum of 110 hours per month for up to 12 months and for a maximum of 6 months for Non-Members at a rate of 130 hours per month. The Member or Non-Member must request the appropriate form from the Administration Office and return the completed form to apply for Disability Credits. To qualify for these Disability Credits, the Member or Non-Member must be eligible for benefits when the disability commences.

If the Member or Non-Member is disabled for longer than the maximum Weekly Indemnity claim of 26 weeks the Member or Non-Member should contact the Administration Office to inquire about further disability credits.

Members on WCB/Worksafe BC will receive Disability Credits for the duration of their claim.

Self-Pay A Member in good standing may continue coverage through self-payment for all benefits except MSP, Weekly Indemnity and Long Term Disability. Non-Members are not eligible to self-pay.

A self-pay notice will be sent to the last known address.

The maximum number of self-pays allowed is 6 consecutive months.

Members who are on Maternity, Paternity or Parental Leave will be permitted to self-pay, once the hours in their Hour Bank are exhausted, for a maximum of 12 months if desired.

Members who are Totally Disabled and unable to work, or a regular or disabled Pensioner drawing from the Ironworkers Pension Plan, Local 97 may self-pay. The maximum duration of self-pay for Pensioners

will be set at one year for every 3,000 hours recorded to the Pension Plan. Pensioners who retire after September 1, 2010 with 25 years or more of contributions to the Ironworkers Local 97 Pension Plan may self-pay indefinitely.

Members on self-pay must arrange for their own Medical Services Plan (MSP) coverage.

To apply for individual MSP coverage contact:

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

PLEASE NOTE: During the months that a Member is self-paying for coverage, the pay-direct card will not be activated/re-activated until payment is received by the Administrator and processed. If a prescription or other eligible benefit that would normally be claimed using the pay-direct card, is required prior to that, the Member or dependent will be required to pay for the expense and submit the claim to the Administrator for reimbursement.

Reminder: Once full coverage has lapsed, in order to be covered again with full benefits, you must re-qualify with 220 hours in a 5 month period.

What happens if the Hour Bank falls short for coverage?

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

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

Non-Members will not be notified when their Hour Bank drops below 130 hours.

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

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

Do Not Ignore the Self-Payment or Shortage Hours Notice

If you receive a Self-Payment or Shortage Hours Notice and you think it is incorrect, contact the Administrator – D.A. Townley:

by telephone: (604) 299-7482
or toll-free: 1-800-663-1356

The only sure way to provide yourself with coverage for a specified month is to pay the Self-Payment or Shortage Hours Notice by the date specified on the Notice.

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

Can hours be suspended while working for another Local?

No, hours cannot be “frozen” while you are covered with another employer.

Are there any reciprocity agreements with other Locals?

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

Are Dependents Covered under the Plan?

YES. The Plan will provide MSP, Dental, Extended Health Benefits and Vision Care for:

a) The spouse* of a covered Member;

b) Any unmarried child of a covered Member to age 21, (age 19 for MSP) provided such person is mainly dependent on and living with the covered Member;

c) Any unmarried child of a covered Member to age 25 provided the child is in full-time attendance at a recognized school, college, or university;

d) Any unmarried mentally or physically handicapped child of a covered Member to any age, provided such person is mainly dependent on and living with the covered Member or the spouse of the covered Member.

*The legal spouse of the Employee, or in absence of a legal spouse, the common-law spouse of the Employee. The common-law spouse is a person whom the Employee has been living and that living arrangement must be recognized as a conjugal relationship in the community in which the couple resides. Only one person may qualify as the spouse at any one time.

For those wanting to add a common-law spouse, you must complete a Common-Law Declaration, have it notarized and sent to the Administrator. The co-habitation period for a common-law spouse is a continuous period of one year.

When completing your application forms for coverage, please include all dependents to be covered. To add, delete or change the dependents covered, obtain a MSP Group Change Form and an Enrolment and Beneficiary card from the Administrator or your Union Office, and forward it to the Administrator's Office.

APPRENTICES

Upon graduation from the 1st year course, Apprentices will be entitled to receive Health & Welfare coverage for 2 months following graduation and then will be entitled to self-pay until the hours worked are sufficient to provide coverage or you have made the maximum number of self-payments.

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

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

B.C.I.T. INSTRUCTORS

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

MEDICAL SERVICES PLAN OF BC (MSP)

When you qualify for coverage, you will be covered by the Medical Services Plan of BC, provided you have completed the required MSP application form. If you are already covered for MSP, it is your responsibility to keep MSP updated on your dependent coverage and if your personal information changes. While you are covered for MSP through the Plan, you must advise the Plan Administrator of any changes to your dependents or your address.

LIFE INSURANCE

All Active Members and Non-Members to age 65 will be covered for $100,000 of Life Insurance. Members between the ages of 60 and 65, who are not active but are covered for benefits, will be covered for $50,000 of Life Insurance. Upon attaining age 65, all Member's Life Insurance reduces to $10,000 and upon attaining age 70, the Life Insurance reduces to $5,000.

This amount of insurance is payable to the beneficiary designated by you should your death occur from any cause while you are insured under the group policy.

If you do not designate a beneficiary, the insurance will be payable to your estate.

Continuation of Life Insurance on Termination of Coverage

When your coverage with the Plan terminates, you may convert up to $5,000 of your Life Insurance to an individual policy without a medical examination or health questionnaire but only if the Member had been insured under this Plan for at least three years. Contact the Administrator for details.

Your life would continue to be insured, at the conversion rate, under the group policy during the 31 day conversion period, whether or not you apply for an individual policy.

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

If you Become Totally Disabled

Subject to satisfactory proof, submitted within 12 months from the date the insured person becomes totally disabled, an insured person who is under age 60 and who becomes totally disabled and continues to be disabled for 6 months, as a result of accident, injury or disease will, on written application, be eligible for the total amount of the Life Insurance to remain in force providing the person remains totally disabled, subject to termination at age 65. Proof of total disability will be required from time to time.

Living Assistance Benefit

The Living Assistance Benefit is available as an advance payment of a portion of the Basic Life Insurance to help meet the medical or other health and welfare expenses of terminally ill Members. Please contact the Administrator.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

The Basic Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed below in the Schedule of Losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is covered?	**Amount of Coverage**
All eligible members	$12,500
All spouses under age 70	$20,000
All eligible dependent children	$ 5,000

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm	Four-Fifths of the Principal Sum
Loss of One Leg	Four-Fifths of the Principal Sum
Loss of One Hand	Three-Quarters of The Principal Sum
Loss of One Foot	Three-Quarters of The Principal Sum
Loss of the Entire Sight of One Eye	Three-Quarters of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Third of The Principal Sum
Loss of Speech or Hearing	Three-Quarters of The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Hearing in One Ear	Two-Thirds of The Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	Two Times The Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two Times The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two Times The Principal Sum
Loss of Use of Both Arms or Both Hands	The Principal Sum
Loss of Use of One Hand or One Foot	Three-Quarters of The Principal Sum

Loss of Use of One Arm
or One Leg ..... Four-Fifths of The Principal Sum
Loss of Four Fingers of
One Hand ..... One-Third of The Principal Sum
Loss of All Toes of One Foot ..... One-Quarter of The Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds.

Loss of the Entire Sight of Both Eyes means the total and irrecoverable Loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty (20) degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing. Loss of Hearing in One (1) Ear means the diagnosis of permanent Loss of Hearing in one (1) ear, with an auditory threshold of more than ninety (90) decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing. Loss of Hearing means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than ninety (90) decibels an ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing.

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

All claims submitted under this policy for Loss of Use must be verified by agreement between a licensed practicing physician appointed by the Administrator "the Plan" and a licensed practicing physician appointed by Blue Cross Life "the Company", or in the event that the two physicians so appointed cannot arrive at an agreement, a third licensed practicing physician shall be selected by the first two physicians and the majority decision of the three physicians shall be binding on the Plan and the Company. This procedure may be waived by the Company at its sole discretion.

Disappearance

If the body of an Insured Member has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that such Insured Member shall have suffered loss of life within the meaning of the policy.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Member under the Plan's current basic group life insurance policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Member.

All other benefits shall be payable to the Insured Member.

Repatriation Benefit

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

Rehabilitation Benefit

If an Insured Member suffers an Injury which results in a payment being made by the Company under the Accidental Death and Dismemberment Indemnity

section of this policy, the Company shall pay in addition:

The reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of the Insured Member provided:

a) Such training is required because of such Injuries and in order for the Insured Member to be qualified to engage in an occupation in which they would not have been engaged except for such Injuries,

b) Expenses be incurred within three years from the date of the accident,

c) No payment shall be made for ordinary living, travelling or clothing expenses.

Family Transportation

When Injuries covered by the policy result in an Insured Member being confined to a hospital, outside 100 Km from their permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the reasonable and necessary expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Member but not to exceed the amount $15,000.00.

Conversion Privilege

On the date of termination of coverage or during the 90-day period following termination of coverage, you may change your insurance to a Blue Cross Life individual insurance policy. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the plan ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of Blue Cross Life. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

Continuance of Coverage

In the case Members who are (1) laid-off on a temporary basis (2) temporarily absent from work due

to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of twelve (12) months, subject to payment of premium. If a Member assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Waiver of Premium

In the event an Insured Member becomes totally and permanently disabled and their waiver of premium claim is accepted and approved under the Plan's current group life policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier:

a) The date the Insured Member attains age 65.

b) The date of the death or recovery of the Insured Member.

c) The date the Insured Member is no longer eligible for total disability waiver of premium under the Policyholder's group life policy; and

d) The date the Master Policy is terminated

Seat Belt Rider

Benefits under the policy shall be increased by 10% if the Insured Member's Injury or death results while they are a passenger or driver of a private passenger type automobile and their seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Home Alteration and Vehicle Modification

If an Insured Member receives a payment under The Schedule of Losses herein and was subsequently required (due to the cause for which payment under The Schedule of Losses was made) to use a wheel-chair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

a) The one-time cost of alterations to the Insured Member's residence to make it wheel-chair accessible and habitable; and

b) The lesser of:

i) the one-time cost of modifications necessary to a motor vehicle, owned by the Injured Insured Member, to make the vehicle accessible or drivable for the Insured Member; and

ii) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Company.

Benefit payments herein will not be paid unless:

i) Home alterations are made on behalf of the Insured Member and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

ii) Vehicle modifications are made on behalf of the Insured Member and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items (a) and (b) combined will not exceed $15,000.00

Dependent Child Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will reimburse the annual tuition, not including room and board, charged by an Institution of Higher Learning per school year for each Dependent Child of such Insured Member up to the lesser of the following amounts:

a) ten thousand dollars ($10,000.00) per school year; or

b) 5% of such Insured Member's Principal Sum.

This benefit is payable annually up to a maximum of four (4) consecutive payments per Dependent Child:

a) only for such Dependent Child who is, at the time of such Insured Member's Loss of Life, enrolled as a full-time student in an Institution of Higher Learning beyond the twelfth (12th) grade level; and

b) only while such Dependent Child continues their continuous enrollment in an Institution of Higher Learning.

The Company will reimburse the person who incurred the actual tuition expenses.

Spousal Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the Insured Member's Spouse the actual cost incurred for a professional or trades training program in which such Spouse enrolls for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than thirty (30) months after the Insured Member's Loss of Life.

The maximum amount payable for this benefit is fifteen thousand dollars ($15,000.00) per Insured Member.

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

"Institution of Higher Learning" as used herein includes, but is not limited to, any university, private post secondary college or trade school, and any College of General and Vocational Education/ Collège d'enseignement général et professionnel (CÉGEP).

Day Care Benefit

If an Insured Member suffers Injury resulting in Loss of Life for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the legal guardian of any surviving Dependent Child of the Insured Member, an amount equal to the lesser of the following:

a) the actual annual cost charged by a commercial and licenced day care centre; or

b) 5% of the Insured Member's Principal Sum; or

c) five thousand dollars ($5,000.00) per year.

This benefit is payable annually for a maximum of four (4) consecutive payments per Dependent Child:

a) and only for such Dependent Child who at the date of the Insured Member's Loss of Life is under age thirteen (13);

b) provided such Dependent Child is enrolled in commercial and licenced day care centre no later than ninety (90) days following the Insured Member's Loss of Life; and

c) provided that the Dependent Child continues their enrollment in a commercial and licenced day care centre.

In-Hospital Benefit

If an Insured Member suffers injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses, and as a consequence of such Loss the Insured Member is, pursuant to the instructions of a Physician, confined to a Hospital for more than five (5) consecutive overnight stays, the Company will pay:

a) for a period of confinement in Hospital of more than thirty (30) consecutive overnight stays, 1% of the Insured Member's Principal Sum; or

b) for a period of confinement of thirty (30) consecutive overnight stays or less, one thirtieth (1/30) of the amount determined for each overnight stay in Hospital.

The Company will pay this benefit monthly, retroactive to the first (1st) overnight stay of confinement in Hospital.

The maximum amount payable for this benefit for all injuries resulting from any one (1) accident per insured is two thousand five hundred dollars ($2,500.00) per month.

Benefits are not payable for more than a total of twelve (12) months of confinement for any one (1) accident causing Injury.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than three (3) months, are considered one (1) period of confinement to Hospital for the purposes of calculating this benefit.

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

(1) holds a license as a hospital (if licensing is required in the province);

(2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

(3) provides 24-hour a day nursing service by registered or graduate nurses;

(4) has a staff of one or more licensed physicians available at all times;

(5) provides organized facilities for diagnosis, and major medical surgical facilities; and

(6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

If an Insured Member suffers Injury causing Permanent and Total Disability, the Company shall pay the amount which is 100% of the Principal Sum for the Insured Member less any amounts under the Table of Losses which have been paid or which are payable by the Company for Losses of the Insured Member.

EXCLUSIONS

No coverage shall be provided under this contract and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

a) suicide or any attempt thereat by the Insured Member while sane;

b) self inflicted Injury or any attempt thereat by the Insured Member while sane or insane;

c) declared or undeclared war or any act thereof;

d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

f) Injury sustained while the Insured Member is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

g) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;

h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Member is:

   i) riding as a passenger in any aircraft not intended or licenced for the transportation of passengers; or

   ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

   iii) riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder.

i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

j) Injury or Loss sustained while the Insured Member is on full-time duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Member is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

k) Injury or Loss sustained while the Insured Member is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while their blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;

l) Injury or Loss sustained while the Insured Member is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licenced Physician;

m) the commission or attempted commission by an Insured Member or Injury incurred while an Insured Member is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under

the laws of the jurisdiction where the act was committed; and

n) an act, attempted act or omission taken or made by the Insured Member, or an act, attempted act or omission taken or made with the Insured Member's consent, for the purposes of interrupting the blood flow to the Insured Member's brain or to cause asphyxiation to the Insured Member whether with intent to cause harm or not; and

o) natural causes.

WEEKLY INDEMNITY BENEFIT

Weekly Indemnity Benefits will be paid to each eligible Member or Non-Member who is disabled and unable to work as the result of a non-occupational accident or sickness. Benefit payment commences on the 1st day of a non-occupational accident, and the 8th day of a non-occupational sickness. If you are hospitalized benefits commence on the 1st day of hospitalization. If a surgical procedure is performed on an out-patient basis, in a general hospital, benefits will commence on the date the surgery was performed.

Note: Benefit will not commence prior to the day you are seen and treated by a physician. Members or Non-Members whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Plan Member or Non-Member qualifies for coverage under the Plan.

The Weekly Indemnity benefit provides, from the first claim submitted, a maximum of 26 weeks of benefit. Once the 26 week maximum has been reached, either through one claim or a series of shorter claims, the entitlement to benefits thereafter will be limited to a total of 20 weeks. Once the 20 week maximum has been reached, either through one claim or a series of shorter claims, the entitlement to benefits will be limited to a total of 13 weeks. Once a Member or Non-Member has claimed the final 13 weeks (59 weeks in total) they are no longer eligible for Weekly Indemnity benefits.

The maximum number of weeks includes weeks the Member or Non-Member is receiving EI medical payments.

How to claim for Weekly Indemnity:

Take the following steps as soon as possible after you have become disabled:

a) Contact your doctor immediately upon becoming disabled. You must be seen and treated during the time of your disability.

b) Obtain an EI Claims Kit from the Employment Office.** The physician's report must be completed and a copy sent to the Administration Office in order that they may provide the Member with Disability Credits.

c) If the Member is not eligible for EI sick benefits, they must obtain a claim form from the Administration Office as they are entitled to submit a claim to the Ironworkers Weekly Indemnity Plan, provided a copy of the EI rejection letter accompanies the claim. **Claimants must be under the care of a physician and be treated in person during the period claimed for.**

d) Complete the front of the claim form.

e) The attending physician must complete the Physician's Statement on the back of the same form. If there is any charge for completing this form, it is the claimant's responsibility.

f) Claim for disability must be submitted no later than 30 days after your total disability begins unless special circumstances prevent such.

**A Member claiming for a non-occupational accident may commence benefits from the 1st day of the accident through to recovery or to the maximum weeks of the claim, whichever occurs first. The Member must make an application to EI at the time of the accident in order that benefits would commence on the 8th day.

On what basis are the Weekly Indemnity Benefits paid?

Claim cheques are mailed to your home address at the end of each 7 day period, provided that the Member is not eligible for EI sick benefits, including Saturdays and Sundays. Benefit payments commence on the 1st day of a non-occupational accident or the 8th day of a sickness. If hospitalized prior to the 8th day of a disability, benefits commence on the 1st day of hospitalization provided the Member is not eligible for EI sick benefits.

All substance abuse claims will be paid a maximum Weekly Indemnity benefit of 6 weeks provided that you are in a rehabilitation centre and remain there for the full course of treatment.

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

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

Will further medical reports be required?

Yes, depending on the nature of the illness and in addition, you may be required to have an independent medical examination.

Please note: Members and Non-Members returning to work, must be cleared in writing to do so by their physician.

Third Party Liability

Where a Member becomes Totally Disabled as a result of an injury or sickness in respect of which

a) a third party may be, directly or indirectly, either in whole or in part, liable to the Member, such as in the case of a motor vehicle-related accident or injury; or

b) the Member has a claim for benefits under workers compensation legislation;

the Plan will not pay benefits to the Member.

EXCLUSIONS and LIMITATIONS:

No benefit will be paid for periods of disability:

- arising from a motor vehicle-related accident or injury, as these are covered by ICBC or similar Insurance (Vehicle) Act;
- arising from occupational accident or illness, as these are covered by the WorkSafe BC/WCB Act;
- arising from your commission of or attempt to commit an assault or criminal offense;
- arising from self-inflicted injuries or sickness;
- substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician;

- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service;
- during which the insured is receiving or eligible to receive EI benefits;
- if you become disabled during a strike or lockout at your place of employment; however, your rights to benefits will be reinstated when the strike or lockout ends.

TERMINATION OF BENEFIT

Your benefit payments will cease on the earliest date one or more of the following occurs:

- you are no longer disabled;
- your are no longer receiving continuing medical care or treatment from your physician;
- you fail to submit satisfactory proof of continuing disability as required by the Plan;
- you refuse a medical examination by a physician chosen by the Plan;
- you are no longer following the treatment recommended for your disability;
- you leave the province, state or country where you normally work and live, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by the Plan;
- you perform any work for compensation or profit;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire; or
- you die.

LONG TERM DISABILITY

If a Member or Non-Member becomes Totally Disabled while covered under the Long Term Disability Benefit, the Plan will pay the benefits for which that Member is eligible in accordance with the following:

All eligible Members under age 65*:	Flat $1,400
Benefit Waiting Period:	26 weeks of total disability
Duration Period:	5 years or to age 65* whichever occurs first
Definition of Disability:	2 year own occupation
All Source Maximum:	85% for all sources
Taxable Status:	Taxable

*age 60 for LTD claims incurred prior to January 1, 2011

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

1,000 hours times the basic hourly rate exclusive of overtime or any additional allowances as outlined in the Collective Agreement in force at the onset of disability times 85% divided by 12.

Benefit Payment Waiting Period

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

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

Calculation of Monthly Integrated Benefit

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

a) i) the Canada Pension Plan or Quebec Pension Plan; and

ii) any Worker's Compensation legislation in Canada; and

b) any government disability or retirement benefit plans in any other jurisdiction.

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

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

Government Source Income Integration Freeze

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

Time of Payment

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

Taxability Status

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

Termination of Monthly Disability Benefit Payments

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

1. engages in any occupation for wage or profit, except as allowed by the provisions of this policy;

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

Recurrent Disability

If a Member who has received benefits under the Long Term Disability Benefit of this policy returns to work for a period of 180 days or less and again becomes Disabled as a result of the same sickness or injury, such later Period of Disability will be deemed by the Plan to be a continuation of the previous Period of Disability. No new Benefit Payment Waiting Period will be required, however, no benefits are payable for any period of such employment.

Extension of Benefit Payments

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

1. the Member is receiving benefits under the Long Term Disability Benefit of this policy, or is completing the Benefit Payment Waiting Period on the date the coverage terminated;
2. the Member was Disabled on the date the coverage terminated;
3. the Member has remained Disabled since the date the coverage terminated; and
4. notice of Disability is given by the Member to the Plan within six months from:
   a) the commencement date of Disability with

respect to a Member who resides in the province of Quebec,

b) the termination date of coverage with respect to a Member who resides in a province other than Quebec.

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

LIMITATIONS

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

   unless the Member is under active treatment and is participating in a medically supervised rehabilitation program. All substance abuse claims will be paid a maximum Weekly Indemnity benefit of 6 weeks, provided they are in a rehabilitation centre and remain there for the full course of treatment.
4. No amount will be payable for any Period of Disability which results from or is caused by a condition for which the Member was treated or attended by a physician, or for which prescription drugs were taken, during the 3 month period prior to the effective date of insurance, until the Member has performed all the duties of their regular

occupation (on a full-time basis) for a 12 month period after the effective date of their insurance.

Eligibility for Total Disability Benefits

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

1. the Member became Total Disabled while insured for the Total Disability Benefit,
2. the Member's Total Disability has continued for a period in excess of the Benefit Plan Waiting Period, and
3. as a result of the Disability, the Member
   a. is absent from work,
   b. incurs a loss of Earnings, and
   c. is not engaged in any occupation for wage or profit, except as specified under the subsection "Rehabilitation Program".

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

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

Rehabilitation Program

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

Amount of Benefit

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

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

1. 50% of the Member's monthly Net (after-tax) Earnings under an approved Rehabilitation Program; and
2. an amount equal to the amount by which the Member's

a. Income from All Sources; plus
b. 100% of the Member's monthly Net (after-tax) Earnings under the Rehabilitation Program

exceeds 100% of the Member's monthly Inflation Indexed, Pre-Disability Net (after-tax) Earnings.

DEFINITIONS

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

Claims Anniversary Date

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

Consumer Price Index

The Consumer Price Index published by Statistics Canada.

If the Consumer Price Index is:

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

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

CPI Factor

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

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

Disability or Disabled

Respectively, Total Disability or Totally Disabled.

Income from All Sources

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

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

Inflation-Indexed,
Pre-Disability Net (after-tax) Earnings

Net (after-tax) Earnings at commencement of Disability times CPI Factor.

Net (after-tax) Earnings

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

Period of Disability

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

Primary Income Benefits

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

Rehabilitation Program

A program of job training or work-related activity approved by the Plan designed to facilitate a Disabled

Member's return to employment or any other gainful employment for which the Member is or may become qualified.

Secondary Income Benefits

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

Total Disability or Totally Disabled

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

1. during the Own Occupation Disability Period, is prevented from performing the substantial duties of their own occupation;
2. after the Own Occupation Disability Period, is prevented from performing any gainful occupation
   a. for which the Member is or may become reasonably qualified by training, education, or experience, and
   b. which will enable the Member to earn at least 67% of their inflation-indexed, Pre Disability Earnings.

EMPLOYEE AND FAMILY ASSISTANCE PLAN (EFAP)

The EFAP is a voluntary, confidential, short-term counseling and advisory service that connects you and your eligible family members to a network of dedicated professionals who are available to give you assistance 24 hours a day.

This benefit provides professional assistance for a wide range of issues such as:

- Personal and work-related stress;
- Couple and marital relationships;
- Childcare and parenting issues;
- Family matters;
- Eldercare concerns;
- Depression and anxiety;

- Alcohol and drug abuse;
- Legal matters and financial concerns.

For additional information, please refer to the brochure available from the Administrator.

Access the Employee and Family Assistance Program (EFAP) 24/7 by phone, web or mobile app.

Visit: **one.telushealth.com**
login username: **97ironworkers**
password: **eap**

or call **1-844-880-9137**

EXTENDED HEALTH BENEFITS

There is no annual deductible. In-Canada expenses are reimbursed at 90% unless otherwise indicated and all In-Canada eligible expenses will be reimbursed up to a lifetime maximum of $1,000,000 if under age 80 and to a lifetime maximum of $20,000 if age 80 or older.

Out of Province/Canada Emergency Medical Travel Insurance coverage is provided to eligible Members and their dependents under age 80 up to a maximum of $5,000,000 per coverage period. Those 80 years and older do not have Out of Province/Canada Emergency Medical Travel Insurance coverage but may use what is remaining of their $20,000 lifetime maximum towards such expenses. It is recommended that if you or a dependent is 80 years or older that you purchase Travel Insurance.

The Extended Health Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

Benefits:

The Extended Health Benefit is designed to help you pay for specified services and supplies incurred by you and your dependents, when not provided under a government health plan or by a tax supported agency.

Upon qualifying for coverage, you will receive a pay-direct card (one if you have single coverage or 2 cards

if you have dependent coverage – both will be in your name).

The following are classed as eligible expenses when incurred as the result of necessary treatment of illness or injury and where applicable when ordered by a physician.

1) Prescription Drugs – (Generic Substitution Always) – present your pay-direct card, along with your prescription, to your pharmacist and your prescription drug claim will be adjudicated right at the pharmacy. Reimbursement of prescription drugs is based on the cost of the lowest priced generic equivalent drug. Using your pay-direct card eliminates the need to send in your prescription receipt and wait for reimbursement. Your Plan provides coverage for prescription drugs and medicines (including oral contraceptives) which require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits. Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Vacation supplies of your medications, which are outside the regular days supply limits must be pre-authorized by the Plan and must be paid for in full by the Member and submitted to the Plan for reimbursement. Smoking cessation products will be covered up to a combined lifetime maximum of $500 per person. Dispensing fees over $9.50 per prescription are not covered by this Plan.

   Drugs and medicines that can normally be purchased "over the counter" are excluded regardless of a prescription having been issued. Fertility drugs, vitamins, preventative drugs, dietary foods and supplements are also excluded.

   There are a number of prescription drugs which are not eligible under BC's Fair PharmaCare drug formulary, but may be eligible under their Special Authority Program. You may be requested by the Plan to have your doctor apply for Special Authority for one or more of the drugs you have been prescribed. Should Fair PharmaCare approve the application for Special Authority, such drugs will be applied towards your annual Fair PharmCare deductible.

PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for the Fair PharmaCare Program call 604-683-7151 from Vancouver and toll-free 1-800-663-7100 from the rest of BC. If you prefer to go on-line to the Fair PharmaCare website, the address is:
https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/who-we-cover/fair-pharmacare-plan/register-for-fair-pharmacare

For Members who are self-paying their benefits, please refer to the Self-Payment section of this booklet for information regarding the continued use of the pay-direct card.

Prescription Drug Prior Authorization Program

There are a number of prescription drugs which will now require prior authorization before they will be deemed as eligible under the Plan. The complete Prior Authorization Listing of these drugs can be found online at: **https://www.telus.com/en/health/prior-authorization-forms**

If your doctor prescribes a drug for you that is on the Prior Authorization listing, when you take your prescription to the pharmacy, your pharmacist will be advised that you must obtain prior authorization first. You will then need to download the applicable Prior Authorization (PA) form for that drug from: **https://www.telus.com/en/health/prior-authorization-forms** and complete your section, have your doctor complete a section, and then send the completed form to where indicated. This will be reviewed and the outcome of the assessment will determine eligibility. The decision will be communicated directly with the patient. If deemed to be eligible, an exception will be added to that patient's Plan record so that the pay-direct card will accept that drug going forward.

It's recommended that you refer to the Prior Authorization Listing while you are with your doctor, so that if the drug they wish to prescribe is

on the Listing, the applicable Prior Authorization Form can be printed and completed before you leave your doctor's office.

If the prescribed drug is one that must be coordinated with the Provincial Fair PharmaCare Plan under Special Authority, you will also be advised to ask that your doctor apply for Provincial Special Authority for that drug on your behalf. This will not impact your ability to fill your prescription if it's approved under the Prior Authorization Program, but in order to ensure continued eligibility, the decision from Fair PharmaCare must be received by D.A. Townley within 90 days of the request.

2) Charges in excess of the amount payable under the Insured Person's Basic Medical Plan for professional licensed ambulance service in an emergency including transportation by railroad, boat or airplane, or in acute emergency by air ambulance, from the place where the injury or sickness occurs to the nearest acute general hospital and return fare, including round trip fare for one attending person (doctor, nurse, first aid attendant), where necessary. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation arranged at the patient's convenience are not eligible expenses.

3) Charges for out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. The maximum for these services will be $25,000 per illness/injury.

4) Convalescent Home or Physical Rehabilitation Facility room and board charges, excluding charges for chronic care, if the Insured Person's residence in the institution:
   1. is certified as medically necessary by a Physician,

2. occurs within 48 hours after a Hospital stay of at least 5 consecutive days, and
3. is due to the same sickness or accidental bodily injury which was the reason for the Hospital stay.

Charges are limited to the difference between the Provincial Medical Allowance for Room and Board charges, and the institution's charge, up to $8.50 per day for a maximum of 30 days per disability.

5) You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, speech therapist, acupuncturist, psychologist, podiatrist, chiropractor, naturopath or physiotherapist, who is registered and legally practicing within the scope of their license. These charges will be covered at 50% up to a calendar year maximum of $400 per insured person for each practitioner.
6) Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies.
7) Charges for walkers, canes and cane tips, crutches, splints, casts, collars and trusses but not elastic or foam supports.
8) Charges for testing supplies, needles and syringes for diabetics.
9) Charges for surgical stockings to a maximum of 3 pair per calendar year.
10) Charges for stump socks.
11) Charges for surgical brassieres up to 4 per calendar year.
12) Cataract surgery foldable lens.
13) Two pair of custom built orthopaedic shoes when prescribed by a physician or podiatrist and replacements when necessary due to normal wear and tear to a maximum of $400 per calendar year. Modifications to stock items are not a covered expense.
14) Two pair of custom fitted orthotics when prescribed by a physician or podiatrist and replacements when necessary due to normal wear and tear to a maximum of $400 per calendar year.
15) Charges for rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes and

mastectomy forms). Myoelectrical limbs are excluded but the Plan will pay the equivalent of a standard prostheses.

16) Cost of rental or where more economical, purchase of durable equipment for therapeutic treatment including wheelchairs and hospital beds. Electric wheelchairs are covered only when a doctor certifies the patient is incapable of operating a manual wheelchair (e.g. Paraplegic).

17) Charges made by a dentist for the repair or replacement of sound, vital, natural teeth or the setting of a fractured or dislocated jaw if:
    - those services are required as a result of a direct accidental blow to the month and not as a result of an object placed in the mouth;
    - the accident occurred while the person is covered under this benefit; and
    - the charges are incurred within 24 months of the date of the accident.

18) Hospital charges made by an approved acute general hospital in B.C. for the difference between ward cost and semi-private room , or if required as medically necessary by a physician, private accommodation (not including rental of telephone, T.V. etc.).

19) Hearing aids, when prescribed by a doctor, including repairs will be reimbursed at 50% up to a maximum of $2,000 per person every 5 years for adults and children. Does not require the prescription to be made by an Ear, Nose and Throat Specialist. Maintenance, batteries or other accessories will not be covered.

20) Wigs and hairpieces required as a result of medical treatment or injury, up to a lifetime maximum of $500 per person.

21) You can use your pay-direct card when you visit a Licensed Optometrist or Ophthalmologist for an eye examination, up to a maximum of $75 every 24 months.

EXCLUSIONS and LIMITATIONS:

The Plan's Extended Health Benefits does not cover:

a) expenses for benefits, care or services payable by or under the Basic Medical Plan, PharmaCare, any Hospital Program or the Worker's Compensation

Act, whether or not a claim is made thereunder or provided without cost or at nominal cost by any public or tax-supported authority or agency or for which the Member or dependent can recover from another party.

b) expenses of dental services or care or dentures except as specifically provided in Item 17.

c) any amount of fees in excess of the usual or recognized fees for the service performed.

d) expenses incurred outside the province of residence unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out of Province/Canada Emergency Medical Travel Insurance or if pre-approved under the Medical Referral Benefit as described herein.

e) expenses of services and supplies for cosmetic purposes.

f) expenses caused, contributed to or necessitated as a result of:
   - war or any act of war or participation in a riot or civil insurrection;
   - injury or sickness which was intentionally self-inflected, whether sustained or suffered while sane or insane;
   - occupational illness or injury; or
   - the commission by the person of any unlawful act including an offense under the Criminal Code of Canada.

g) any expenses that a covered person may obtain as a benefit under any government plan or law.

h) any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging which represents an amount in excess of the schedule of costs prescribed by the Medical Services Plan.

i) medical cannabis in any and all of its forms.

Medical Referral Benefit

The Medical Referral Benefit provides coverage for reasonable and customary charges for medical and transportation expenses in excess of those expenses

covered by the insured person's government health insurance plan, Health Insurance Plan or EHC plan, for the insured person and an approved escort, up to a lifetime maximum of $75,000 per person, as a result of a pre-approved medical referral for treatment, subject to the following conditions:

a) the treatment must not be available within 500 kilometres from your residence; and
b) the medical referral service must be obtained in Canada, if available, regardless of any waiting lists; and
c) your attending Canadian physician and a qualified Canadian medical specialist from an appropriately related medical field must recommend the treatment; and
d) the referral service must be eligible for reimbursement and paid in whole or in part by your government health insurance plan or Health Insurance Plan (a written pre-authorization from your government health insurance plan or Health Insurance Plan outlining their liability is required); and
e) if your government health insurance plan, Health Insurance Plan or EHC plan covers and reimburses the full medical referral expenses, no benefits are payable; and
f) the treatment must not be experimental or investigative in nature; and
g) medical services and travel must take place within 30 days of receiving approval from your government health insurance plan or Health Insurance Plan, unless the earliest possible treatment date exceeds 30 days from the date of approval; and
h) the medical referral must be pre-approved, following submission of a request for pre-approva in writing to Global Excel, along with supporting documentation.

Out of Province/Canada Emergency Medical Travel Insurance

Emergency Medical Travel Insurance provides coverage for eligible Members and their eligible dependents under the age of 80 for certain expenses incurred as a result of an emergency while travelling outside your province. This travel insurance is

underwritten by the Manufacturers Life Insurance Company (Manulife). Manulife has appointed Global Excel Management (Global Excel) as the provider of all assistance and claims services under this policy.

Coverage Period: 60 days per trip

Policy Number: DAT00013357

Emergency Out of Country coverage has a maximum of $5 Million per coverage period. There is no Emergency Out of Province/Country coverage for Members (or their dependents) once the Member reaches the age of 80.

IF YOU HAVE AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY BEFORE SEEKING TREATMENT. THEY ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK AND CAN BE CONTACTED BY CALLING:

From Canada and the United States,
call TOLL FREE 1-833-685-2790

From anywhere else in the world,
call COLLECT + 519-735-9448

You must notify Global Excel before obtaining emergency treatment, so that they may:

- confirm coverage
- provide pre-approval of treatment

If it is medically impossible for you to call prior to obtaining emergency treatment, call or have someone call on your behalf as soon as possible. If you fail to notify Global Excel, the Insurer reserves the right to limit your benefits as follows:

- The Insurer will not pay expenses for benefits that are not approved by Global Excel, if pre-approval is required; and
- In the event of hospitalization, 80% of eligible expenses, based on reasonable and customary charges, to a maximum of $25,000; and
- In the event of an outpatient medical consultation, a maximum of one visit per sickness or injury.

You will be responsible for payment of any remaining charges.

Some treatments require pre-approval in order to be covered. For more details refer to the full Emergency Medical Travel Insurance Booklet, available from the Plan Administrator.

If you do not contact Global Excel prior to seeking treatment, the medical treatment you receive may not be covered by this insurance. Global Excel can direct you to a medical facility or doctor in your area of travel. If you contact Global Excel at the time of your emergency, they will ensure that your covered expenses are paid directly to the hospital or medical facility, where possible.

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your coverage before you travel, as your coverage is subject to certain limitations and exclusions.

Pre-existing medical condition exclusions may apply to medical conditions and/or symptoms that existed before your trip. Refer to your Schedule of Benefits outlined above your Manulife/Global Excel Assistance Wallet Card to determine how these exclusions affect your coverage and how they relate to your departure date. In the event of a claim, your medical history will be reviewed after a claim has been reported.

Your insurance provides travel assistance. You are required to contact Global Excel prior to treatment.

Coverage is for an unlimited number of trips up to the coverage period for each trip (60 days per trip) however, each trip must be separated by a return to your province.

Coverage must be in effect before you leave your province. You do not need to provide advance notice of your departure date and return date for each trip. However, you will be required to provide evidence of these dates when filing a claim, for example, an airline ticket or boarding pass.

Claims Procedures – Out of Province/Canada Emergency Expenses

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

If in Canada or the United States,
call toll free at: 1-833-685-2790

From anywhere else in the world,
call collect to: + 519-735-9448

During your call, you will be given all the information required to file a claim. You will be asked to substantiate your claim by providing all required documents. Failure to do so may result in non-payment of your claim. The Insurer is not responsible for fees charged in relation to any such documents. Incomplete documentation will be returned to you for completion.

When making a claim, you may be required to complete a Claim & Authorization Form along with providing supporting documentation such as:

- Complete original unused transportation tickets and vouchers if the Emergency Air Transportation or Return of Travel Companion benefit is used.
- All original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all relevant dates and type of treatment, and the name of the hospital or medical facility and/or physician.
- All original prescription drug receipts (not cash receipts) from the pharmacist, physician, hospital or medical facility showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.
- Proof of your departure date and return date. While boarding passes are preferred, airline tickets or other proof of departure date from your province, may be accepted, provided it contains your name and the location and date of your purchase.
- Any other additional documents pertinent to your claim, as may be required by Global Excel.

Failure to complete the required Claim & Authorization Form in full may delay the assessment of your claim.

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

All pertinent documents should be sent to:
Global Excel Management Inc.
73 Queen St. Sherbrooke, Quebec J1M 0C9

Online Claim Submission:

Visit **https://manulife.acmtravel.ca** to submit your claim online. For faster and easier submissions, have all your documents available in electronic format, such as a PDF or a JPEG.

Emergency Out of Country coverage has a maximum of $5 Million per coverage period. There is no Emergency Out of Province/Country coverage for Members (or their dependents) once the Member reaches the age of 80.

VISION CARE

(eyeglasses/contact lenses/laser eye surgery)

The Vision Care Plan will cover you and your eligible dependents.

You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

Covered Expenses

You can use your pay-direct card for the purchase of the following eligible expenses:

a) single vision, bifocal or trifocal lenses, prescribe by a person legally qualified to make such a prescription;
b) frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable;
c) contact lenses prescribed by a person legally qualified to make such a prescription;
d) laser eye surgery for Members and Non-Members only (no coverage for dependents) (pay-direct card cannot be used)

Payment of Expenses

The maximum amount payable during any period of 24 consecutive months shall be 100% of the actual expense incurred or $500.00, whichever is the lesser for an eligible adult. A maximum amount of $300.00 is payable during any period of 12 consecutive months for dependent children to age 19.

For Members and Non-Members only, Laser Eye Surgery will be reimbursed in installments of up to $500.00 every 24 consecutive months, up to a lifetime maximum of $2,000. There is no Laser Eye Surgery coverage for dependents.

EXCLUSIONS and LIMITATIONS

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

a) duplicate or spare eye glasses or any lenses or frames thereof;
b) safety goggles, sun glasses (plain or prescription);
c) replacement or lost, stolen or broken lenses or frames.

DENTAL

The Dental Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

The Plan provides pay-direct claims processing using your pay-direct card – present your pay-direct card to the receptionist when you arrive at your dentist's office for your appointment.

Basic and Major Services combined have an annual maximum of $2,700.

Part I – Basic Services

The following services are eligible for reimbursement of the lesser of 90% of the amount charged or 90% of the Dental Association Fee Guide (General Practitioner) in the Province of residence.

1) Diagnostic Services

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

- Oral examinations: limited to one in any 6 consecutive month period for dependent children under the age of 19 and once in any 9 consecutive month period for adults and dependent children 19 years of age and older; however, complete oral examinations are limited to one in any 36 month period
- Specific examinations
- Consultations (as a separate appointment)
- Dental x-rays: bite-wing x-rays are limited to one set in any 6 month period, full mouth x-rays are limited to one set in any 24 month period, and panoramic film is limited to one x-ray in any 36 month period
- Diagnostic models: limited to reasonable and customary.

2) Preventative Services

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

- Cleaning and the topical application of fluoride (limited to once in any 6 consecutive month period for dependent children under the age of 19 and once in any 9 consecutive month period for adults and dependent children 19 years of age or older year)
- Scaling and root planing (combined maximum of 16 units per calendar year)
- Pit and fissure adhesive sealants limited to once per tooth every 24 months for dependent children under the age of 19
- Fixed space maintainers on primary teeth for dependent children under 18.

3) Surgical Services

All necessary procedures for extractions and other routine oral surgical procedures normally preformed by a dentist.

4) Restorative Services

All necessary procedures for:

- Filling teeth with amalgam, silicate, acrylic or composite restorations
- Replacement restorations if at least 12 months has elapsed since initial placement.
- Stainless steel crowns on primary teeth

- Gold Foil only when used to repair existing gold restorations.

5) Prosthetic Repairs and Maintenance

Repair if a 6-month period has elapsed since the last date on which the dentures were provided.

Denture maintenance, after the 3 month post insertion care period, including:

- denture relines for dentures at least 6 months old, once every 36 months
- denture rebases for dentures at least 2 years old, once every 36 months
- resilient liner in relined or rebased dentures, once every 36 months.

6) Endodontia (Root Canals)

All necessary procedures required for pulpal therapy and root canal filling. Repeat treatment is covered only if the original treatment fails after the first 18 months.

7) Periodontia

All necessary procedures for the treatment of tissues supporting the teeth including grafts.

8) Anesthesia

General anesthesia required in relation to oral surgery.

Part II - Major Services

Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for reimbursement of the lesser of 50% of the amount charged, or 50% of the Dental Association Fee Guide (General Practitioner) in the Province of residence.

- Inlays, onlays and gold foils will be covered only when other material cannot be used satisfactorily. Patients choosing gold where other materials would suffice will be responsible for the cost difference. A pre-authorization is suggested.
- Initial installations of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Partials may only be provided by a dentist.

- Initial placement of a crown or veneers and their replacement if at least 5 years has lapsed.
- Replacement of an existing full or partial denture if at least 2 years has lapsed
- Fixed bridgework, if the existing bridgework was installed 5 years prior to its replacement and cannot be made serviceable.
- Dentures misplaced, lost or stolen will not be replaced at the Plan's expense.

Charges made by a licensed Denturist will be recognized for payment, in accordance with a separate Schedule of Allowances.

Part III - Orthodontia (dependent children under 19 years of age)

For orthodontia services performed by an orthodontist payment will be made at 50% to a maximum lifetime limit of $4,000.00. Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced at the Plan's expense.

Pre-Treatment Estimate of Major Restorative & Orthodontic Charges

Prior to the commencement of treatment, the dentist should provide a summary of charges for the proposed course of dental care. The Plan will then provide a written estimate of the maximum amount for which payment will be made.

Alternative Services:

If alternative services may be performed for the treatment of a dental condition, the maximum amount shown in the Suggested Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

Emergency Dental Care Anywhere in the World

In an EMERGENCY, while you are travelling or on vacation outside of your Province of residence, you are entitled to the services of a duly qualified dentist and will be reimbursed at the lower of the actual cost or the amount that would have been paid had the service been rendered in Province of residence.

EXCLUSIONS and LIMITATIONS

The Plan's Dental benefits do not cover payment for:

- items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- dental care which is cosmetic;
- dental care provided under a medical plan provided by an employer or government.
- which, in the absence of coverage, there would be no charge;
- stainless steel crowns on permanent teeth;
- protective athletic appliances;
- anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- replacement of a lost or stolen prosthesis;
- incomplete and temporary procedures;
- implants;
- any dental charge for services which were started prior to the date of coverage; or
- dental treatment which was ordered while covered, (which included lab work and impressions), but was not installed or delivered until more than 31 days after the dental benefit terminated.

Expenses recoverable under any other Plan will be co-ordinated with payments from this Plan, so that total payment received will not exceed the expenses actually incurred.

TRANSPORTATION ASSISTANCE

Eligibility

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

Covered Expenses

The following expenses shall be eligible for reimbursement:

The actual cost of transportation, up to a maximum of 75% of the amount equal to the round trip commercial economy class airfare for transportation within British Columbia or Alberta or the Yukon Territory from the commercial airport nearest to the Member's residence in British Columbia where regularly scheduled airlines depart from to the commercial airport located nearest to the facility recommended by the patient's physician where treatment, diagnostic tests or examination takes place.

Within each calendar year no more than six (6) trips will be eligible for reimbursement. If, on the physician's recommendation, the patient requires an accompanying person, payment shall be made on the basis of 50% of the airfare subject to the conditions as outlined, but only if air transportation is involved.

Lodging

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

EXCLUSIONS

The following are excluded from payments:

a) The cost of transportation from the patient's home to the nearest airport from which regular scheduled airlines depart.

b) The cost of transportation from the airport at the city of destination to the place where treatment, examination or tests take place.

c) Any accident or sickness which is the responsibility of WCB/WorkSafe BC, Insurance Corporation of British Columbia or any other third party.

d) Any journey where the round trip is less than 250 kilometers.

e) Treatment for services not medically required.

How a Claim is Made

1) The attending physician must complete a form confirming the diagnosis, the facility or name of the physician who will see the patient and the date and time of the appointment, also if the patient required an accompanying person.

2) The physician who renders the treatment, examination or test will complete a form confirming the visit(s).

3) Payment of expenses will be made directly to the Member, subject to receipt of the applicable forms.

4) Should the patient be transported by car or bus, reimbursement will be 75% of the actual cost.

TO MAKE A CLAIM

Extended Health Benefits, Vision Care and Dental

Use your pay-direct card when you fill a prescription, when you visit participating paramedical practitioners, when you have an eye examination, for dental visits and vision care purchases. If you do not use your pay-direct card, these expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the **D.A. Townley *My Claims*** portal or mobile app (see page 53 for details).

Alternatively, claim forms for Extended Health Benefits and Vision Care can be obtained from the Administrator's Office, your Union Office or from the Plan's website: **http://ironbenefits.org/health-and-welfare-plan/filing-a-claim/**

Standard B.C. Dental claim forms are usually provided by your dentist, but if required, Dental claim forms can also be provided by the Administrator's Office, your Union Office or also from the Plan's website: **http://ironbenefits.org/health-and-welfare-plan/filing-a-claim/**

Both the receipts and the fully completed forms should be sent to the Administrator. All receipts must be received by the Administrator within 24 months of the date the expense is incurred to be considered for payment.

When submitting eligible claims, please be sure to include:

- Your Name (please print)
- Your Address
- Client ID
- Your Local Union

All claims for reimbursement should be forwarded, along with applicable receipts, to the Administrator via:

*the **D.A. Townley *My Claims*** portal or mobile app

*by email to health@datownley.com

*by fax to (604) 299-8136

*drop off or mail to **D.A. Townley**
4250 Canada Way
Burnaby BC V5G 4G3

COORDINATION OF BENEFITS:

1) When co-ordinating benefit payments, D.A. Townley will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the Eligible Expense was incurred.
2) If the Member or Dependent is also covered under the Spouse's plan or under any other group plan which provides similar benefits, payment will be co-ordinated and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the Eligible Expense (for dental, the fee guide applies).
3) The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.
4) The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:
   a) the amount that would have been payable had it been the primary carrier, or
   b) 100% of all Eligible Expenses reduced by all other benefits payable for the same expenses by the primary carrier.
5) If the other plan does not contain a co-ordination of benefits clause, payment under that plan must be made before the Plan will pay under this provision.
6) Extended health care plans with dental accident coverage determine benefits before dental plans.

7) If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.
8) When the Plan has paid benefits to the Member to the limit of the PharmaCare deductible, the Plan will pay their portion of the Eligible Expenses based on the plan's reimbursement percentage.
9) The Member will provide the information required to implement this provision. It is the Member's responsibility to present a copy of the original claim form and the remittance statement or cheque stub when making further claim under this provision.

D.A. TOWNLEY *MY CLAIMS* PORTAL and MOBILE APP

Go to: **www.datownley.com/myclaims/** and look for Online Registration in the resources section on the right side of the page. Click on the link. Complete all the required fields and acknowledge that you have read the terms and conditions.

Click on the Submit button and it will automatically direct you to the *My Claims* portal. Set up your account on the *My Claims* portal by clicking on Register Account. Enter your group number (70682) and your Client ID number from your pay-direct card, along with your postal code and date of birth. Then click Next. Set up your username and password. Please note: you can only create one username and password for the same coverage. Then click Sign Up and accept the terms and conditions. Now you can download the free **D.A. Townley *My Claims*** app by visting the App Store for IOS devices or Google Play for Android devices. Once downloaded, register your account on the portal and app, then you are ready to sign in using your username and password that you assigned.

DIRECT DEPOSIT

If you have not already done so, you can sign up for Direct Deposit for your claims reimbursements. Get your reimbursement faster and have the funds deposited directly into your bank account rather than waiting for a physical cheque. On the **D.A. Townley *My Claims*** portal or app, click on the Person icon on

the top navigation. Go to Update Direct Deposit and enter your banking information (this can be found on the bottom of a personal cheque, from your online banking app or by calling your financial institution directly.)

RIGHTS TO COPIES OF DOCUMENTS

Effective July 1, 2012, if an employee/member lives in British Columbia or Alberta, they have the right to request, with reasonable notice, copies of documents that relate to the plan. Legislation allows for them to obtain copies of the following documents:

- Their enrollment form or application for insurance
- Any written statement or other record, not otherwise part of the application, provided to the insurer as evidence of insurability
- A copy of the contract/policy

The first copy will be provided at no cost to the employee/member and a fee may be charged for subsequent copies. All requests for copies of documents should be directed in writing to D.A. Townley.

LEGAL ACTION

Every action or proceeding against the plan for the recovery of benefits payable under the Contract is absolutely barred unless commenced within the time set out in the Insurance Act.

Benefits Provided by:

Manulife Financial
#115358
Life Insurance

Local 97 Ironworkers Health & Welfare Plan #70682
Weekly Indemnity
Long Term Disability
Extended Health Care
Vision
Dental
Transportation Assistance

Blue Cross Life
#79396001
Accidental Death & Dismemberment

Manulife Group Travel Insurance
 # DAT00013357
Global Excel Management Inc.
Out of Province/Canada Emergency Medical Travel Insurance

TELUS Health
#7018
Employee and Family Assistance Plan

Medical Services Plan of BC
#4823381
Basic Medical Plan

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

JAN 2024

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