Pile Drivers, Divers, Bridge, Dock and Wharf Builders Health Benefits Plan

Plan Booklet

Effective January 1, 2024

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INTRODUCTION

Please review this booklet to learn about your group benefits program. The information contained in this booklet is for guidance only. All rights to benefits are governed by the group insurance contracts and the terms of the Plan.

This booklet describes your Plan as of January 1, 2023. The Plan is subject to change at any time. If the Plan changes, the Trustees will send covered members information about the change, including an updated Summary of Benefits.

WHO TO CONTACT

If, after reviewing this booklet, you have any questions regarding your plan, please contact the Plan Office:

PLAN OFFICE / PLAN ADMINISTRATOR
D.A. Townley (A wholly owned subsidiary of Pacific Blue Cross)
Telephone: 604-299-7482
Toll Free: 1-800-663-1356
E-mail: pd2404admin@datownley.com
Web page: pd2404benefits.com

To book an appointment under the Employee and Family Assistance Program, contact:

FSEAP
1.800.667.0993
TTY 1.888.234.0414
Online resources at: www.fseap.bc.ca
password: 2bwell

LIST OF BENEFITS

The following benefits are provided under the Pile Drivers, Divers, Bridge, Dock and Wharf Builders Health Benefits Plan. Further details are provided throughout this booklet.

Benefit	Provider
Employee and Family Assistance Program*	Family Services Employee Assistance Programs (FSEAP)
Group Life	Insured by The Canada Life Assurance Company, Policy #161747
Spouse Life	
Accidental Death & Dismemberment	
Long Term Disability***	
Short Term Disability, integrated with EI	Self-Insured by Trustees** and paid by Blue Cross Life, Policy #903404
Extended Health Care	Self-Insured by Trustees** and paid by Pacific Blue Cross, Policy #903404
Dental	
Basic Medical	BC MSP, Group #3134046 Administered by the Plan Office
Divers Medical Examinations*	Self-Insured by Trustees** and paid by the Administrator

* Available to ALL members in good standing of Local 2404, even if not covered on the hour bank.

** Benefits self-insured by the Trust are not insured by an insurance company regulated under the Financial Institutions Act (British Columbia). The Trust is exempt from the requirements of the Financial Institutions Act (British Columbia)."

*** You are not eligible for Long Term Disability if you have taken your Pile Drivers Pension

ELIGIBILITY REQUIREMENTS

HOW DO YOU ESTABLISH COVERAGE?

Eligibility for benefits is through the Hour Bank. You must:

1. Be a member in good standing of the Pile Drivers, Divers, Bridge, Dock and Wharf Builders Union Local 2404; and
2. Have a minimum of 200 hours, within a period of six consecutive months, reported and paid into the Plan by your employer(s).

Eligibility is determined with a "reporting month". You work this month, your employers report to the Plan Office next month, and the Plan Office applies those hours to your coverage for the month following.

Coverage and Enrolment

Your coverage begins for all benefits on the first day of the month after the above conditions are met. **For Example:**

Month Worked	Member A Hours Reported	Member B Hours Reported
January	140	
February	-	140
March	-	140
April	50	reporting month
May	140	covered
June	reporting month	-
July	covered	-

Any hours that are not used within 6 consecutive months to establish eligibility for coverage (that is, hours that are 7 or more months old) go into the Plan's general fund.

When you are eligible for coverage, the Plan Office will send you an enrolment form for EHC and Dental, an application form for MSP-BC, and a Life and AD&D insurance enrolment card on which you name your beneficiary for those benefits.

Please complete and return enrolment cards promptly. Until you do so:

- Your spouse and dependent children are not covered for EHC, Dental
- Your spouse is not covered for spouse life insurance
- If you die, the life insurance is paid to your estate and could be subject to delay and probate fees.

Continuing Coverage - Hour Bank System

Once you are covered, all the hours your employer reports for you accumulate in your hour bank. Each month, 100 hours are deducted for your coverage.

You may accumulate up to 1,200 hours (12 months of future coverage) in your hour bank to carry you through periods of low employment or vacation, providing you remain a member in good standing of Local 2404. Any hours in excess of 1,200 go into the Plan's general fund.

If your hour bank falls below 100 hours, you may use the self-payment option to remain covered, as explained below.

DEPENDENT COVERAGE

Your dependents are not covered until you enrol them. A dependent for Plan benefits is defined as follows:

- Your spouse:
    - Your legally married spouse OR
    - Your common-law spouse (a person who has lived with you for at least 12 months and is represented as your spouse).
- Your or your spouse's unmarried child under the age of 21, who is financially dependent on and living with you or your spouse.
- Your or your spouse's unmarried child to any age, if they are in full attendance at a recognized school, college or university and financially dependent on you or your spouse.

- Your or your spouse's unmarried mentally or physically handicapped child to any age, who is living with, and financially dependent, on you or your spouse.

Once a dependent child ceases to be a dependent, that dependent may not be eligible again for benefits. If in doubt, check with the Plan Administrator.

Dependent children must be enrolled within sixty days from the date of birth or from the date the child became a dependent, and spouses within sixty days of the date of marriage. To have new dependents included in your coverage, you must provide their names and birthdates. Ask the Plan Office or the Union for the registration form.

HOW DO YOU MAINTAIN COVERAGE IF UNEMPLOYED?

When your hour bank has less than 100 hours, you are no longer covered by the Plan. However, you have the option of paying for the coverage yourself, at the current shortage rate.

You will be notified by mail when your hour bank falls below the 100-hour minimum and told the amount of self-payment required and the date by which it must be paid. You may also check your records at any time with the Plan Office.

You may self-pay for up to 12 consecutive months, provided you remain a Union member in good standing.

If your employer(s) report 40 or more hours in a month, your "self-pay count" is reset to zero, and you could then pay up to 12 consecutive full months from that point.

If your employer(s) report between 1 and 39 hours in a month, your shortage notice would be reduced for the following month, but it will still count as one month's self payment.

For Example:

Monthly coverage required	100 hours
Your hour bank balance is	45 hours
Therefore, you are short	55 hours

To retain coverage for that month, you must pay $83.60 (55 hours @ $1.58 per hour). The maximum shortage payment is $158.00 a month, based on 100 hours @ $1.58 per hour. *(The rate is subject to change.)*

NOTES: You do not have Long Term Disability and Short-Term Disability while self-paying. Furthermore, if you are retired and self-paying, your coverage will include Extended Health and Dental benefits only.

Do not ignore the shortage notice!

You could lose your coverage if you fail to respond. If you make a self-payment and late hours are reported or other adjustments are found later, all hours will be credited to your hour bank for future coverage.

The only sure way to continue your coverage is to pay the shortage by the date specified on the notice.

WHEN DOES COVERAGE END?

Coverage is always provided on a whole month basis only, and will be terminated for you and your dependents, when:

- Your hour bank falls below 100 hours, and you fail to make a self-payment by the specified date to bring your hour bank up to the required 100 hours;
- You reach the maximum number of self-payments;
- You cease to be a member in good standing of the Union. However, if you transfer to another UBCJ local you may remain covered under this Plan until your hours run out, but without a right of self-pay; or
- Upon your death. However, your hour bank will be run-out to provide transitional coverage for your dependents. Dependents of deceased members are not allowed to self-pay to continue coverage.

You will be notified if your coverage has terminated. The notification will be sent to the address in the Plan records.

If you were terminated for failing to pay your shortage notice, you may contact the Plan Office or Union office **immediately** and pay the actual number of hours you were short, plus the full 100 hours to ensure continued coverage for the following month.

WHEN WILL COVERAGE START AGAIN?

If your coverage is terminated, it can start again when 200 hours have been worked and reported to the Plan. This is the same as new member start date outlined at the beginning of this section.

You may not re-qualify by self-payment.

IN CASE OF INJURY OR ILLNESS

If you are injured or become ill, contact your Union office, the Plan office or BC Life immediately to find out whether you are entitled to Short Term Disability (STD) and Long Term Disability (LTD) benefits. If you are, the claim form(s) will be sent to you. Details of the STD and LTD benefits are described in specific sections of this booklet. Other disability benefits are available from this Plan and other sources as described below:

See your doctor **promptly** after becoming disabled, to ensure your disability is documented and that you are receiving the treatment you need. Your disability claim may be delayed or denied unless you see your doctor promptly, follow your doctor's treatment plan, and file your claim on time.

CONTINUATION OF FULL COVERAGE (SHORT-TERM)

You will receive full credit of 100 hours a month to maintain your hour bank and coverage in the Plan as long as you are disabled and receiving one of the following benefits:

- Blue Cross Life Short Term Disability (STD) benefits
- Employment Insurance (EI) Sickness benefits
- Workers Compensation (WCB) Wage Loss (including income continuity or rehabilitation) for occupational claims originating in the Local 2404 bargaining unit, or in an associated bargaining unit for which the member's hours worked are being reciprocated.

Blue Cross Life will automatically advise the Plan Office when you are receiving STD. You must provide cheque stubs or other documentation as proof of WCB or EI benefits.

CONTINUATION OF SELECTED COVERAGE (LONG-TERM)

Group Life and AD&D Insurance

Your life and AD&D insurance may be continued to age 65 without further payment if you become disabled while covered. See the Group Life section of this booklet for more information. This is called "Waiver of Premium" since coverage continues without further premiums being paid. If you apply for LTD, you should apply for Waiver of Premium at the same time. The Plan office can supply and explain the application forms.

Canada Pension Plan

Pensions may be available from the Canada Pension Plan (CPP) for severe and prolonged disabilities, both occupational and non-occupational, provided you meet the qualifications. There is a three-month waiting period before benefits begin. Apply for these benefits through Service Canada – either online, by mail, or in person.

Other

If you remain disabled at the end of your WCB wage loss period, and receive a permanent partial or total disability pension from the WCB, you may apply to the Trustees to continue coverage on the Plan by paying the full cost of benefits.

Note: This coverage does not include STD or LTD.

DEATH OF A MEMBER

The **Life Insurance**, and if applicable, **AD&D Insurance** claim should be referred to the Plan Office as soon as possible so assistance can be provided to the beneficiary.

Dental and **Extended Health Care** coverage for surviving dependents of a deceased covered member may continue depending on the hour bank balance at time of death.

MEMBER RETIREMENT

After you retire, as long as you continue to pay union dues and have hours in your hourbank, your benefit coverage will continue. However, since you will no longer be working, you will not be eligible for disability benefits.

Once your hourbank runs out, you can self-pay for coverage subject to the provisions outlined in the Eligibility Requirements section under "How Do You Maintain Coverage If Unemployed?".

Once you have exhausted your self-pay opportunities, you may be eligible for additional months of Extended Health Care (EHC) coverage only. For every year of full service (1300 hours or more remitted) from 1984, you will be entitled to one month of EHC coverage.

Once you are no longer eligible for Dental and/or EHC coverage through the Plan, you may want to consider purchasing individual coverage either from Pacific Blue Cross or another insurer.

CLAIMS INFORMATION

CLAIMS INFORMATION

Claim forms are available from the Plan Office or the Union office. To help speed claims processing:

- **Enroll** all your dependents with the Plan Office. Claims for unenrolled dependents will be rejected and will have to be reprocessed after enrolment occurs.
- **Advise** the Plan Office if your address changes.
- **Claims forms** are available from the Plan Office, or on the web sites of the insurers for each type of benefit. There are links to the insurance companies on the Plan Office web site.
- Ensure your **ID number** is on all receipts or claims.
- Your **receipts** must be itemized and show that you have paid for the service.
- Pacific Blue Cross does not return receipts for your EHC and Dental claims. Be sure to keep a photocopy or scanned copy of your receipts before sending your claim.
- **Claims Deadlines.** There are claims deadlines for each type of benefit. See the "Claims" sections of the detailed benefits descriptions which follow for deadline information (Dental, Extended Health, Disability, Life Insurance). But for faster reimbursement, send claims in through the year**.**

TAXATION

Your employer contributes to the Plan as required by the collective agreement. This cost is bargained as part of the total compensation package, but it is not deducted from your wages. For the same reason, your employer's contributions to the Plan are NOT a tax deduction for you.

PREMIUMS

Some premiums paid by the Plan on your behalf are a taxable benefit to you. You will receive a T4A near the beginning of each year for the premiums paid by the Plan on your behalf Group Life and Accidental Death and Dismemberment Insurance in the prior year.

Your taxable income is automatically reduced by the amount of your self-payments.

The Trustees consider the overall total hours and funding for the year. Within each coverage year, the Trustees have deemed all self-payments to apply first to taxable premium costs. This means that if you self-paid to continue your coverage at any time during the prior year, we automatically deduct the amount of your cash payment from your taxable benefits in that year.

BENEFITS

If you received Long Term Disability (LTD) or Short-Term Disability (STD) Benefits in the prior year, you will receive a T4A from the insurer for those payments. If you later repay the insurer due to a successful WCB or third-party claim, you will receive an adjustment letter for the repayment.

In each case, you must include the amount in your taxable income for the year.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

The Employee and Family Assistance Program (EFAP) provides Union members and their families with quick, confidential access to experienced professional counsellors and consultants who can help you resolve a broad range of personal and work-related concerns.

In addition to counselling services, your EFAP also provides a variety of work/life services to help you manage your responsibilities and reach your goals.

The program is provided through Family Services Employee Assistance Programs (FSEAP).

FULLY CONFIDENTIAL

Use of the EFAP and any information collected is completely confidential within the full limits of the law. FSEAP counsellors and consultants do not release any information without prior written consent except to protect life and when ordered to do so by a court of law.

TO ACCESS THE EFAP

Simply call the toll-free line: **1-800-667-0993**.

Your call will be answered live 24/7 by a counsellor who will discuss your reason for calling and assess the level of intervention required to address your issue or need. They can provide immediate crisis support as needed, schedule you for the appropriate counselling or work/life service, or help you find specialized resources in your community.

ONLINE HEALTH & WELLNESS RESOURCES

The EFAP also offers an online health and wellness resource library, which includes articles, newsletters, e-books, learning modules and links to web resources to help you deal with life's challenges. Access these online resources at:

www.fseap.bc.ca
password: 2bwell

DIVERS' MEDICAL EXAMINATIONS

Under the Divers 1996 and subsequent Collective Agreements, diving contractors remit an additional contribution per hour on straight time. The Trustees used these contributions to establish a separate fund, which pays for the reimbursement of fees for the regular medical examinations required by WCB to measure how much the pressure is affecting them.

CLAIMS

Send your receipts to the Plan Office for processing. If you are eligible*, and there is a proper receipt for each necessary procedure, you will be reimbursed by the Plan following the next month-end processing.

* All members in good standing of Local 2404 are eligible for reimbursement of divers' medical examination costs.

This section is from a separate booklet provided by Pacific Blue Cross and is included in your plan booklet by the Trustees

PILE DRIVERS, DIVERS, BRIDGE, DOCK AND WHARF BUILDERS HEALTH BENEFITS PLAN

Active Members

Policy Number 903404

INTRODUCTION

This booklet contains information about your Group Benefits. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Group Contract/Policy.

The Group Policy contains a provision removing or restricting the right of the Member to designate persons to whom or for whose benefit insurance money is to be payable.

The Group Contract does not permit a Member or Dependent to designate a personal representative or a beneficiary to receive benefits.

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) and Blue Cross Life Insurance Company of Canada (Blue Cross Life) are referred to as "we", "us", or "our" in this booklet. We will refer to you, the employee/Member, as "you" or "your" in this booklet.

Pacific Blue Cross, the registered trade-name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

Coverage is provided through:

Pacific Blue Cross
Extended Health Care (EHC)
Dental Care

Blue Cross Life
Short Term Disability (STD)

Privacy Policy

We have a Privacy Policy which governs our collection, use, and disclosure of personal information (including personal health information) about individuals who are Members or Dependents. The Privacy Policy requires us to keep such personal information confidential, but does permit use and disclosure of personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of our current Privacy Policy can be obtained from us on request and is also available on our website: www.pac.bluecross.ca. By participating in the group benefit and insurance plans, and submitting claims under those plans, you are consenting to the collection, use, and disclosure of your personal information pursuant to the terms of our Privacy Policy.

BLUE CROSS SCHEDULE OF BENEFITS

The Schedule of Benefits contains a summary of your benefits with Pacific Blue Cross / Blue Cross Life. Please refer to the appropriate page in this booklet for a more detailed benefit description.

Extended Health Care		
Deductible	No deductible	
Reimbursement	**In-Province/Territory Eligible Expenses:**	
	All Eligible Expenses	80%
	Out-of-Province/Territory Eligible Expenses:	
	Emergency	100%
	Non-Emergency	80%
	After $1,000 has been paid for a person or family in a calendar year, further Eligible expenses for that person or family within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.	
Plan Maximum	The lifetime maximum amount of benefits payable for a Member or Dependent is unlimited, subject to the terms and conditions of the Group Contract	
Dependent Children / Spouse	See definition of Dependent.	

Dental Care			
Deductible	No Deductible		
	Plan A Basic Services	**Plan B** Major Restorative Services	**Plan C** Ortho–dontics
Reimbursement	Diagnostic & Preventative 100% Other Basic Services 90%	Crowns and Bridges 70% Dentures and Bruxing Guards 90%	50%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**	**Lifetime**
Financial Limit Per Person	Not Applicable	Not Applicable	$6,000
Dependent Children / Spouse	See definition of Dependent.		

Short Term Disability (STD)				
Weekly Benefit Amount	The current Employment Insurance (EI) maximum.			
Elimination Period	**Injury**	**Hospital**	**Sickness**	**Day Surgery**
	0 days	0 days	7 days	0 days
Maximum Benefit Period	50 weeks, including integration with WCB, EI, or vehicle accident insurance			
Employment Insurance (EI) Carve-Out	If you are eligible for EI sickness benefits: 1) We will pay benefits for the first 7 weeks of disability, and 2) EI will pay benefits for the 8th to 33rd week inclusive, and 3) We will pay benefits for an additional 17 weeks of disability. If you are not paid for EI sickness benefits, we will pay benefits for a maximum of 50 weeks. If your weekly EI sickness benefit is less than 90% of the weekly Benefit amount, we will top up to the weekly Benefit amount during the EI carve-out.			
Termination	Insurance terminates when coverage for Short Term Disability under your hour bank terminates.			

BLUE CROSS GENERAL INFORMATION

DEFINITIONS

Benefit amount
means the reimbursement payable upon satisfaction of all conditions of the Contract.

Benefit review
means our process by which we evaluate or revise the coverage criteria for health products, services and supplies and/or health treatment options, drugs, and dental supplies, dental treatment options, and/or dental products.

Customary
means usual or traditional and well-established as determined by us.

This refers to:

1) the charges for products, services or supplies; and/or

2) the use of products, services or supplies during the course of a treatment for a medical condition

which do not exceed the general level of charges in the absence of insurance made by similar Providers in the area where the charge is incurred for a medical condition comparable in nature and severity to that being treated. The term "area" means a region large enough to obtain a representative cross section of similar Providers.

Deductible
means the initial portion of the Eligible expenses, which you must pay before we will reimburse charges for any Eligible expense.

Dentist
means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, Dentist may also mean dental specialist, denturist, or dental hygienist, depending on the services each may provide.

Dependent
means any of the following persons for whom coverage is provided under this Plan:

1) one Spouse of the Member,
2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
3) any age if the unmarried child is also in full-time attendance at a recognized educational institute, and
4) any unmarried handicapped child of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Handicap status is subject to approval by us. The Dependent must become handicapped while covered as a Dependent under Clause 2 and 3 above.

The Member must be prepared to prove that an individual claimed as a Dependent falls within these requirements.

Duplicate coverage
means that you (and your Dependents) are eligible to claim certain benefits under more than one plan.

Eligible drug
means a drug Health Canada has approved for specific indications and assigned a Drug Identification Number (DIN), and that we have approved following our Benefit review.

Eligible expense
means a charge for any service, supply and/or Eligible drug included in this booklet as a benefit that:

1) subject to our Benefit review, and in our assessment is a Customary charge that is medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician, Dentist, or Nurse practitioner, unless otherwise specified in the benefit description, and
3) is not a cost normally paid, in whole or in part, or provided by a Government plan or any other Provider of health coverage, and

4) was incurred while coverage is valid for the expense being claimed. An expense is "incurred" on the date the service is provided or the supply is received, and
5) is provided by a Practitioner or Provider approved by us.

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing, or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan or in any PBC Provider agreement.

Fee guide
means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed.

Fee schedule
means Schedule 2 of the Pacific Blue Cross Fee schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Government plan
means the health, drug, and dental benefit coverage that Canadian federal, provincial and/or territorial governments provide for their residents.

Hospital
means an institution that is licensed as an accredited Hospital that is staffed and operated for the care and treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment. A hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa. This also includes facilities in which the cost for drugs is a covered benefit under the patient's Government plan.

For the purpose of the Contract, the chronic beds of a Hospital are not considered part of that Hospital.

Life event
means a marriage, divorce, or legal separation, birth or adoption of a child, or a change in the eligibility of a Dependent.

Member
means an employee or other person who has coverage under the Contract.

Physician
means a person legally licensed, certified, or registered to practice medicine and/or surgery, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Physicians. This excludes a Physician residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Physician based on ineligibility, or based on the Physician's qualifications or conduct.

Practitioner
means a person legally licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for that profession. This excludes a Practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

Provider
means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply, or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where

no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. This excludes a Provider related to or residing with you or your Dependent. We reserve the right to refuse the service, medical supply or equipment from the Provider based on ineligibility, or based on the Provider's qualifications or conduct.

Spouse
means your legal Spouse or a person who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your Spouse.

Vendor
means an organization we have retained as an external Provider.

MEMBER INFORMATION/ACCESS TO RECORDS

1) Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.

2) Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.

3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.

4) The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.

5) Upon request, and at no charge to the Member, we will provide the Member with one copy of:
   a) the Member's application for coverage
   b) the current Contract/Policy
   c) any written statement or other record provided to us as evidence of insurability of the Member.

6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.

7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

INTEGRATION WITH GOVERNMENT PLANS

Extended health care benefits are intended to supplement and not overlap benefits under government plans (such as the Medical Services Plan and Fair PharmaCare Program of British Columbia). You are required, as a condition of coverage, to take all reasonable steps to qualify and obtain the fullest extent of coverage, benefits, contribution, or reimbursement available under all applicable government plans. We will also make payment only where permitted by provincial/territorial legislation or other applicable law.

EFFECTIVE DATE OF COVERAGE AND ENROLMENT

If you satisfy the eligibility requirements, your own coverage will become effective automatically. However, you must apply for Dependent coverage (when applicable) within the grace period.

Provided you and your Plan Administrator have complied with our enrolment rules, your coverage effective date is shown on our website at www.pac.bluecross.ca/member/login (for BC members) or at www.mypbcbenefits.onlineclaimsaccess.net (for members outside BC) or from your Plan Administrator.

Should you require additional information about when your coverage starts, please contact your Plan Administrator.

LATE APPLICANTS

If you did not apply during the Enrolment grace period but request coverage later, ask your Plan Administrator to explain the requirements for late enrolment in your Group Plan. Note: Different benefits may have different requirements – evidence of insurability or retroactive premium payment. In some instances, coverage may be denied.

BENEFICIARY

For the benefits provided by Pacific Blue Cross and Blue Cross Life, this plan does not permit you or your Dependents to designate a personal representative or a beneficiary to receive benefits. Any benefit amount owing will be paid to your estate or to you for a deceased Dependent.

IDENTIFICATION (ID) CARDS

We will issue identification (ID) cards for distribution by your Plan Administrator. You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent for your group.

CLAIMS

1) All claims must be submitted to us in English.
2) We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.
3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled or if any Group Contract/Policy exclusions applies.
4) The necessary claim forms are available from your Plan Administrator or on our website www.pac.bluecross.ca/member (for BC members) or at www.pac.bluecross.ca/mypbcbenefits (for members outside BC).
5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid.

DUPLICATE COVERAGE

If you and your Spouse are both Members of Pile Drivers, Divers, Bridge, Dock and Wharf Builders Local 2404, please check with your Plan Administrator to see if Duplicate coverage is allowed for dental and extended health care benefits.

If you and your Spouse work for different employers/unions and you are both enrolled for similar benefits, Duplicate coverage is allowed.

COORDINATION OF BENEFITS

If Duplicate coverage is allowed, we pay claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

1) The Member is always the primary claimant. The Spouse is always the secondary claimant.
2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
3) In situations of separation or divorce, the following order applies:
   a) the plan of the parent with custody of the child
   b) the plan of the Spouse of the parent with custody of the child
   c) the plan of the parent not having custody of the child
   d) the plan of the Spouse of the parent in c) above.
4) Total reimbursement shall never exceed 100% of the Eligible expenses.

GENERAL EXCLUSIONS

1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
   a) under any other group or individual benefit plan or insurance policy, or
   b) due to the legal liability of any other party.
2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
   a) war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion

b) suicide or any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence
c) active duty in the military forces of any nation or international organization, or in any civilian non-combatant unit which serves with such forces in combat
d) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
e) false pretences or fraudulent misrepresentation
f) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

LEGAL ACTION

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

TERMINATION OF COVERAGE

The termination date of your coverage will be determined by your Plan Administrator based on the eligibility rules.

RIGHT OF RECOVERY

You are financially responsible for any claims paid by us on your or your Dependent's behalf after coverage is terminated from your benefit plan. You agree to reimburse us for these payments upon receipt of our invoice.

CONVERSION TO AN INDIVIDUAL PLAN

Should your group coverage terminate for any reason, you may purchase an individual plan from Pacific Blue Cross if you live in British Columbia, or an individual plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage, you must ensure that your application and full payment is received by us or Blue Cross within 60 days of the date your

group plan terminates. To be eligible to convert, you must have had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for one of our individual plans under the conversion option, we will waive the Pre-existing condition contained in the individual plan.

Pre-existing condition
means any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12-month period before you apply for the individual plan.

Call our Individual Products Department at 604 419-2200 for an application form.

If you are converting to an individual plan offered by Blue Cross, contact your local Blue Cross organization for full details before your group coverage terminates.

INDIVIDUAL TRAVEL BENEFITS

Individual travel coverage is also available from Pacific Blue Cross. Call 604 419-2200 or 1 800 USE-BLUE (873-2583) outside the Lower Mainland for information.

MEMBER PROFILE (FOR MEMBERS IN BC)

Your Pacific Blue Cross Member Profile (formerly known as CARESnet) is an online service that offers convenient and secure access to your benefit information 24 hours a day. Once logged in you will be able to make and track online claims, get information on benefit coverage and find downloadable claims forms. To access your Member Profile visit: www.pac.bluecross.ca/member/

MY PBC BENEFITS ONLINE PORTAL (FOR MEMBERS OUTSIDE BC)

My PBC Benefits Online Portal is an online service that offers convenient and secure access to your benefit information 24 hours a day. Once logged in, you will be able to make and track online claims, obtain benefit coverage information, and download claim forms. To login, visit: www.pac.bluecross.ca/mypbcbenefits

EXTENDED HEALTH CARE

The Extended Health Care (EHC) plan 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.

DEFINITIONS

Compounded drug
means a drug prepared in a pharmacy following the National Association of Pharmacy Regulatory Authorities for pharmacy compounding, and meeting eligibility criteria as determined by us.

Dispensing fee
means a Pharmacy's fee for dispensing a prescription including professional and technical services as defined by the applicable provincial/territorial legislation.

Experimental Life-sustaining non-prescription drugs
means not approved or broadly accepted and recognized by the Canadian medical profession as an effective, appropriate, and essential treatment of an illness or injury.

Life-sustaining non-prescription drugs
means drugs that are necessary to sustain life, do not legally require a prescription and that meet eligibility criteria as determined by our Benefit review.

Markup
means the total of all amounts added to the manufacturer's list price, meaning the published price at which the drug is available for purchase from the manufacturer in the applicable province/territory, and including any wholesale upcharge, retail markup, and any other amounts in excess of the manufacturer's list price.

Nurse practitioner
means a person legally licensed, certified, or registered to deliver specific health care services, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Nurse practitioners. This excludes a Nurse practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Nurse practitioner based on ineligibility, or based on the Nurse practitioner's qualifications or conduct.

PBC National formulary
means a list of Eligible drugs as determined by us through Benefit review, including:

- drugs that require our prior approval before being eligible, and
- drugs that may be eligible for coverage through government funded programs, including but not limited to Provincial drug plan coverage, with or without requiring prior approval through the program, and other government funded programs or agencies.

We reserve the right on an ongoing basis to add, delete or amend the list of Eligible drugs at our discretion.

Pharmacist
means a person legally licensed, certified, or registered to practice pharmacy and/or dispense drugs, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Pharmacists. This excludes a Pharmacist residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Pharmacist based on ineligibility, or based on the Pharmacist's qualifications or conduct.

Preferred pharmacy
means a pharmacy that participates in our preferred Provider network. A list of current participating pharmacies is available on our website:

www.pac.bluecross.ca/member/ (for BC members) or

www.pac.bluecross.ca/member-privileges/preferred-pharmacy-network/ (for members outside BC)

IN-PROVINCE ELIGIBLE EXPENSES

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician. Unless otherwise indicated, the maximums included here are on a per person basis.

1) Hospital

   The additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

2) Emergency ambulance

   a) charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient
   b) air transport will be covered when time is critical, and the patient's physical condition prevents the use of another means of transport
   c) emergency transport from one hospital to another, only when the original hospital has inadequate facilities
   d) charges for an attendant when medically necessary

3) Drugs

   Charges for an Eligible expense (and on the PBC National formulary for members outside BC) in a quantity we consider reasonable, and as approved by our Benefit review, and

   a) which are dispensed by a Pharmacist, Physician, Dentist, or Nurse practitioner, legally licensed, certified, or registered to practice by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license, including:
      i) life sustaining drugs non-prescription drugs
      ii) insulin preparations, diabetic test strips, lancets, needles, and syringes for diabetes management
      iii) injectable vitamin B12 for the treatment of pernicious anemia
      iv) allergy serums when administered by a Practitioner, or

b) which legally require a prescription from a medical provider legally authorized to do so, including:
   i) compounded drugs
   ii) contraceptive drugs
   iii) drugs indicated for weight loss
   iv) drugs indicated for the treatment of infertility to a lifetime maximum of $3,000
   v) non-flu vaccines

For Members in BC

The ingredient cost of multi-source brand drugs plus Markup will be reduced to the ingredient cost of the lowest cost equivalent generic plus Markup. The ingredient cost of generic drugs and single source brand drugs plus Markup are eligible.

If we receive written confirmation from the prescribing Practitioner that there is a specific adverse effect that prevents the Member from taking the generic, the full ingredient cost of the multi-source brand drug plus Markup will be eligible.

The Markup is eligible to 15% of the manufacturer's list price.

Specific high-cost BC PharmaCare limited coverage drugs are identified by us as our Special Authority Enforcement list. We will reject claims for a drug on this list until we receive confirmation of BC PharmaCare's Special Authority decision for the drug. Once the BC PharmaCare decision (approved or declined) is on file with us, we will consider this drug as eligible based on:

a) if BC PharmaCare approval is confirmed, the approval period determined by BC Pharmacare, or
b) if the BC PharmaCare decision is to decline, and if the request otherwise meets our definition of an Eligible drug, the approval period as determined by Us.

For Members outside BC

The cost of prescription drugs plus Markup is eligible. The Markup is eligible up to the Customary level, as updated from time-to-time.

PBC will integrate with public funding in the Member's province/territory of residence where available and appropriate. If public funding is not available, PBC will conduct manual review of the drug claim and determine eligibility on a case-by-case basis.

For Members residing in Quebec, this plan satisfies the requirements of the Quebec Prescription drug program (RAMQ).

Dispensing fees up to a Customary level, as updated from time-to time, are eligible..

4) Practitioners

Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician or Nurse Practitioner.*

a) acupuncturist..... $1,500

b) chiropractor..... $1,500

c) massage practitioner* ..... no calendar year limit

d) naturopath..... $1,500

e) physiotherapist..... no calendar year limit

f) podiatrist and chiropodist combined $1,500

g) psychologist, clinical counsellor, and online cognitive behavioural therapy combined.... $1,500

h) speech language pathologist..... $1,500

i) private duty care by a registered nurse for a person with an acute condition in the person's home.

* For massage practitioners – Before we can consider further treatments after the 12th visit in a calendar year, we require a note from the patient's attending Physician or Nurse practitioner indicating the nature of illness and prognosis.

5) Online Cognitive Behavioural Therapy

Charges for a program through an eligible Vendor to a maximum of $1,500 per calendar year combined with services of a psychologist and clinical counsellor.

"Online cognitive behavioural therapy" means an internet-based behavioural therapy program.

6) Dental Accident

Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental
means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth.

We pay benefits based on eligible dental services and financial limits in our current Fee schedule, and we pay the fees in our current Fee schedule or, if applicable, the Fee guide in the province/territory of service.

7) Medical aids and supplies provided by a medical supplier (as approved by Pacific Blue Cross)

Charges for the following services and supplies:

a) oxygen
b) ostomy and ileostomy supplies
c) intrauterine contraceptive devices (IUDs)
d) hyaluronic acid injections, when administered by a Physician or Nurse practitioner
e) walkers, canes and cane tips, crutches, casts, and trusses
f) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), when prescribed by a Physician, physiotherapist, or chiropractor as medically necessary after diagnosis of the patient. Myoelectric limbs are excluded, but we will pay the equivalent of a standard prosthesis
g) one mastectomy brassiere per breast prosthesis to a maximum of 2 per lifetime

h) charges for the following items to the maximum amounts indicated per calendar year:

   i) stump socks..... $250

   ii) surgical stockings.....2 pairs

i) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500

j) orthopaedic shoes and orthotics

   i) when prescribed by a Physician, podiatrist, chiropractor, or Nurse practitioner, as medically necessary after diagnosis of the patient, one pair per lifetime of custom made orthopaedic shoes (including repairs) and modifications to stock item footwear. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg, or

   ii) when prescribed by a Physician, podiatrist, chiropractor, physiotherapist, or Nurse practitioner, as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, one pair per lifetime of custom made orthotics. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet

   to a combined limit of one pair per person per lifetime; however, replacements are covered when necessitated by normal wear and tear.

k) hearing aids (excluding batteries, recharging devices, or other such accessories) and repairs to a maximum of $3,000 in a 5-year calendar period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

l) custom molded hearing protection to a maximum of $300 in a 24 month period.

8) Standard durable medical equipment

a) Preauthorization is required from Pacific Blue Cross for expenses in excess of $5,000

b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a Provider may be considered.

c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.

d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.

e) Standard durable equipment includes:

i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent

ii) medical heart monitors and cardiac screeners

iii) continuous glucose monitors and supplies and blood glucose monitors

iv) speech processors and headsets when prescribed for profound deafness to a 5-calendar year period

v) bi-oestrogen systems (when recommended by an orthopaedic surgeon) and growth guidance systems

vi) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators

vii) insulin infusion pumps for diabetics – when basic methods are not feasible

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

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

9) Vision Care, Eye Examinations and Laser Eye Surgery

Charges for the following when prescribed or performed by a Physician or legally authorized optical Provider (as applicable):

a) routine eye examinations for persons between the ages of 19 and 64, and

b) comprehensive eye examinations, and

c) laser eye surgery, and

d) purchase and/or repair of eyewear and charges for contact lens fittings

to a combined maximum of $1,000 in a 12 month period. Charges for non-prescription eyewear are not covered.

OUT-OF-PROVINCE/TERRITORY ELIGIBLE EXPENSES

Out-of-Province/Territory Non-Emergency Eligible Expenses

We will reimburse you (and your Dependents) for non-emergency Eligible expenses incurred while travelling outside your province/territory of residence subject to the Deductible, in-province/territory reimbursement percentage, and maximums. We will not reimburse any expenses payable or provided under a Government plan.

Out-of-Province/Territory Emergency Eligible Expenses

While travelling outside your province of residence, benefits are payable for the following Eligible expenses incurred IN AN EMERGENCY ONLY and when ordered by the attending Physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other Provider of health coverage are not eligible.

1) Local ambulance services when immediate transportation is required to the nearest Hospital equipped to provide the treatment essential to the patient.
2) The Hospital room charge and charges for services and supplies when confined as a patient or treated in a Hospital, to a maximum of 90 days.
   If reasonably possible, we should be notified within 5 days of the patient's admission to Hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the Hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90-day limit may be extended with our expressed written consent.
3) Services of a Physician and laboratory and x-ray services.
4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.
5) Other emergency services and/or supplies if we would have covered them inside your province/territory of residence.

We will only cover Eligible expenses obtained within 60 days of the date you or your Dependent left the country of residence. If hospitalization occurs within the 60-day period, in-patient services are covered until the date of discharge up to a maximum of 90 days. You and your Dependents are required to provide proof of the date of departure and return date to your country of residence, when requested by us.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, during the first 60 days after you initially leave your country of residence, medi-assist will coordinate the following services:

1) locate the nearest appropriate medical care
2) obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians
3) investigate, arrange, and coordinate medical evacuations and related transportation needs
4) arrange and coordinate the repatriation of remains
5) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

Your Pacific Blue Cross worldwide emergency medi-assist card provides instant information on how to contact medi assist. Call the nearest medi assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to medi assist. Have your Pacific Blue Cross Policy, ID, and provincial health care numbers ready for personal identification.

EXCLUSIONS

The following are not included as Eligible expenses under your EHC plan:

1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, Hospital coinsurance, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or

diagnostic procedures or for health examinations of any kind, and professional services of Physicians, Dentists, or Nurse practitioners, or any person who renders a professional health service in the patient's province/territory of residence

2) except as specifically included in this booklet, we pay no drug expenses for:
   a) food replacements, food supplements, and infant foods
   b) administrative charges for injectable medications or infusions
   c) drugs, related preparations, treatments, and services administered during treatment in an emergency room of a Hospital, or as an in-patient in a Hospital, or as an out-patient in a Hospital
   d) drugs, related preparations, treatments, and services administered in a government-funded clinic or treatment facility
   e) general anaesthetic, drugs not approved for sale and distribution in Canada, or medications available without a prescription, or any drug included as a benefit unless approved by our Benefit review process
   f) any expenses identified as exclusions under the Extended Health Care Benefit
3) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic, or Experimental purposes, public ward accommodation, rest cures, and medical laboratory tests
4) except as specifically included in this booklet: charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local Hospitals, or charges for translating documents into English
5) any payment to a pharmacy, a Practitioner, Physician, Dentist, or Nurse practitioner (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the Government plan

6) that portion of a claim normally covered by the Government plan which has been refused on the basis that the claim was not submitted within the Government plan's time limits
7) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
8) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 21 days of the expected delivery date
9) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the Government plan in your province/territory of residence
10) expenses of a Dependent hospitalized at the time of enrolment
11) services performed by a Pharmacist, Physician, Dentist, or Nurse practitioner, who is related to or residing with you or your Spouse
12) services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross
13) fees for ambulance services when an ambulance is called but not used
14) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
15) retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans
16) any other item not specifically included as a benefit
17) legal cannabis, in any form, as defined by Health Canada unless a DIN is assigned to it.

CLAIMS

Electronic Claims

1) When submitting an electronic claim you must:
   a) complete the claim form online and submit electronically to us
   b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to us
   c) if the claim is selected for review by us, you must submit the original receipts and supporting documentation to us within 21 calendar days. If we do not receive this information within this time, your claim will be refused and your ability to submit electronic claims will be removed.
2) We reserve the right to remove your ability to submit electronic claims if you provide false, incomplete or misleading claims information. In such circumstances you will have to submit paper claims with supporting receipts and documentation.
3) You must provide explanation or proof to support the claim or any other information we consider necessary.
4) We must receive an electronic claim by the **applicable deadline**. If your electronic claim is selected for review by us, we will accept the original receipts and supporting documentation after the **applicable deadline**, but within 21 calendar days (see 1c) above) from the date of electronic submission. We will not accept a faxed or scanned claim form and/or receipts. The **applicable deadline** is:
   - for BC members – June 30th of the Calendar year following the year in which the expense was incurred
   - for members outside BC – 18 months from the date the expense was incurred
5) Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Pay Direct

Provided your pharmacy is connected to our electronic processing system, we will pay them directly for prescription drugs and testing supplies for diabetics covered under your EHC plan. Simply show the pharmacist your EHC ID card.

The pharmacist will charge you only for amounts not covered by us. If you or the pharmacy do not have access to this system, or for other types of expenses, please follow the instructions below.

Paper Claims

1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. We will send you a remittance statement for your records each time you submit a claim.

2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.

3) Certain medical expenses are covered under the provincial/territorial plans. If you submit your claim to us before you submit your claim to the government plan, we will deduct what the government plan would normally pay (e.g. Pharmacare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design.

4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:

    a) Obtain a claim form from your Plan Administrator or our website
    b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).

c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by the **applicable deadline**. If not, your claim will not be paid under any circumstances. The **applicable deadline** is:

- for BC members – June 30th of the Calendar year following the year in which the expense was incurred
- for members outside BC – 18 months from the date the expense was incurred

d) We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

DENTAL CARE

PAYMENT OF BENEFITS

1) We pay benefits based on dental services, financial limits, and treatment frequencies in the Fee schedule. We apply reasonable and customary limits to fee items as applicable.

2) We apply the reimbursement percentage shown in the *Schedule of Benefits* to the fees shown in the Fee schedule / Fee guide.

3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

PLAN A – BASIC PREVENTIVE & RESTORATIVE SERVICES

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible expenses per person include, but are not limited to, the basic services shown below.

1) Diagnostic services
   a) examinations:
      i) complete – provided we've not paid for another exam by the same Dentist in the past 6 months –1 per 3-year period for BC members, or 2 per 36 month period for members outside BC
      ii) recall – 2 per calendar year
      iii) specific – 2 per calendar year
      iv) consultations (as a separate appointment)
   b) x-rays
      i) diagnostic
      ii) panoramic – 1 per 24-month period for BC members
      iii) complete mouth series – 1 per 36-month period

      All x-rays combined shall not exceed the dollar limit for a complete mouth series.
   c) diagnostic models – 1 set per calendar year.

2) Preventive services
   a) scaling, (for members outside BC, including root planning to a combined limit of 15 units per calendar year)
   b) polishing – 2 per calendar year

c) topical application of fluoride – 2 per calendar year
d) fixed space maintainers
e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2-year period. No age limit.

3) Restorative services
   a) fillings to restore tooth surfaces broken down as a result of decay:
      i) amalgam (silver coloured) fillings
      ii) composite (tooth coloured) fillings on all teeth
      For BC members – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period
      For members outside BC – limited to a maximum of once per surface in a 24 month period on the same tooth.
   b) metal prefabricated restorations on primary and permanent teeth – once per tooth in a 2 year period.
   c) inlays or onlays - only 1 inlay or onlay on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals – 1 per tooth in a 5-year period.

5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
   a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
   b) root planning (for members outside BC, including scaling to a combined limit of 15 units per calendar year)
   c) gingival curettage – 1 per sextant in a 5-year period for BC members (or 6 services in a 60 month period for members outside BC)
   d) osseous surgery – 1 per sextant in a 5-year period for BC members (or 6 services in a 60 month period for members outside BC)

6) Prosthetic repairs
   a) removal, repairs, and recementation of fixed appliances (for members outside BC, to a combined limit of 4 units per calendar year)
   b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2-year period
   c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5-year period
   d) gold foil – only when used to repair existing gold restorations.

7) Surgical services
   a) extractions
   b) other routine oral surgical procedures
   c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule.
   d) implants to a combined maximum of $3,000 per calendar year and limited to a lifetime maximum of $3,000 per tooth.

PLAN B – MAJOR RESTORATIVE SERVICES

You are eligible for Plan B services when your Dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

Mounted x-rays and/or diagnostic casts may be required for our approval.

Plan B services include, but are not limited to, the following:

1) Prosthodontic Services
   a) removable
      i) complete upper and lower dentures
      ii) partial upper and lower dentures
   b) fixed bridges.

2) Restorative Services
   a) inlays and onlays involved in bridgework
   b) veneers
   c) crowns and related services.

3) Periodontal Appliances – burxing guards – 2 applicances in a 5-year period (no benefit is payable for the replacement of lost, broker, or stolen bruxing guards).

Limitations

1) Only 1 major restorative service involving the same tooth will be covered in a 5-year period.

2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.

3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5-year period.

4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.

5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our Fee schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

PLAN C – ORTHODONTICS

Benefits are payable for orthodontic services performed on or after the effective date of your coverage. Plan C is designed to cover orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations

1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.

2) No benefit is payable for the replacement of appliances which are lost or stolen.

3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.

4) Treatment performed solely for splinting is not covered.

EMERGENCY TREATMENT OUTSIDE YOUR PROVINCE OF RESIDENCE

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province/territory of residence, you require emergency dental care. You will be reimbursed according to our Fee schedule. This will not apply to the services of a dental hygienist.

EXCLUSIONS

The following are not Eligible expenses under your dental plan:

1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
2) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
3) procedures performed for congenital malformations or for purely cosmetic reasons
4) charges for drugs, pantographic tracings, and grafts
5) anaesthesia not done in conjunction with surgery, and charges for facilities, equipment, and supplies
6) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
7) incomplete or temporary procedures
8) recent duplication of services by the same or different Dentist
9) any extra procedure which would normally be included in the basic service performed
10) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
11) any item not specifically included as a benefit
12) travel expenses incurred to obtain dental treatment.

CLAIMS

1) Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. We suggest that your Dentist submit an outline of the proposed services to us **before you start treatment.** This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.

2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment received later than **12 months** from the date the service is performed (**18 months** from the service date for members outside BC).

3) We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:

    a) name of the Dentist

    b) name and birth date of the person receiving the dental care

    c) your group, ID, and Dependent(s) numbers (this information is on your ID card)

    d) your home mailing address

    e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:

   a) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive:
      i) a claim form signed by the patient that is either submitted with a receipt or is signed by the dental provider showing the services performed and the fee charged, or
      ii) an electronic claim showing the services performed and the fee charged. The dental provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

   b) For pay direct claims, we will pay the benefit amount to the Dentist directly for services provided under this benefit plan when we receive:
      i) a claim form showing the services performed and the fee charged, signed by the patient and the dental provider, or
      ii) an electronic claim showing the services performed and the fee charged. The dental provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

5) Orthodontic Claims Procedures

   a) Receipts

      Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.

   b) Claiming deadlines
      i) We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
      ii) Reimbursement is made if the complete and correct claims information is received within 1 year of the due date. However, no benefit is payable for claims not received within **12 months** of the due date (**18 months** of the due date for members outside BC).

c) Treatment plan

i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.

ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.

iii) We will retain your treatment plan on file. If we do not have your treatment plan on file, we are unable to pay:

- your initial fee/down payment
- your monthly/quarterly fees
- one time appliance fees

iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

d) Monthly or quarterly fees

i) If you are paying monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us which are over 12 months old (18 months old for members outside BC) will not be reimbursed.

ii) If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.

iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

SHORT TERM DISABILITY

DEFINITIONS

Day surgery
means admission to a public general Hospital for a surgical procedure where the patient is released from the Hospital the same day. Note: diagnostic procedures do not qualify as a surgical procedure.

Hospitalization
means admission to a public general Hospital for at least 1 overnight stay as an in-patient.

Recurrent disability
means a disability that is related to or due to the same cause(s) as a prior disability for which you received benefit payments.

BENEFIT

We will pay short term disability (STD) benefits when you are disabled and prevented from working as a result of an accident or sickness for which Workers' Compensation benefits are not payable.

The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a Physician or chiropractor – whichever is later – and will be paid only during periods of disability when you are under their regular care and following the treatment prescribed. Certification of disability beyond a 6 week period must be made by a Physician.

The weekly Benefit amount, the elimination period, and the maximum benefit period are shown in the Schedule of Benefits.

RECURRENT DISABILITY

A Recurrent disability will be considered part of the prior disability if, after receiving STD benefits, you returned to work on a full-time basis and were able to perform all the essential duties of your occupation for less than 2 weeks. Once you have resumed work on a full-time basis and have been at work for 2 consecutive weeks, any subsequent injury or sickness will be considered a new disability.

GRADUATED RETURN TO WORK

If you return to work on a gradual rehabilitative basis, you will have your benefit reduced by 50% of any income earned from the rehabilitative employment. The combined total of your benefit plus the rehabilitative income will not exceed 100% of your earnings prior to the date your disability started.

Benefits will continue for a maximum of 1 period of disability as outlined under *Recurrent Disability*, whether due to 1 or more illnesses.

In consultation with you, your Plan Administrator, and with your Physician's agreement, we will determine your eligibility for this program and its duration.

EXTENDED BENEFIT

If you are disabled when this insurance terminates, your STD benefits will continue as though your insurance had not terminated, up to the maximum benefit period, provided you remain disabled.

COORDINATION WITH OTHER INCOME SOURCES

Your STD payment will be coordinated with benefits received from other sources so that the total benefits received, for the same disability, will not exceed your normal take home pay on the date you became disabled.

THIRD PARTY LIABILITY

Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse us when you receive payment from the third party.

ARE BENEFITS TAXABLE?

Benefits are taxable.

TERMINATION OF BENEFIT

Your benefit payments will cease on the earliest date 1 or more of the following occurs:

1) you are no longer receiving continuing medical care and treatment from your Physician
2) you fail to submit satisfactory proof of continuing disability as required by us
3) you refuse a medical examination by a Physician chosen by us
4) you are no longer following the treatment recommended for your disability
5) you are not entitled to benefits payable by the Employment Insurance Sickness benefit because you are not in Canada
6) you are no longer disabled
7) you perform any work for compensation or profit
8) the end of the maximum benefit period indicated in the Schedule of Benefits
9) you die.

EXCLUSIONS

Benefits are not payable for any period of disability:

1) arising from any of the following:
    a) an injury or sickness sustained while operating any form of transportation, including but not limited to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat, with a blood alcohol level which exceeds the legal limit in the jurisdiction where the injury occurs, or under the influence of other intoxicating or mind-altering substances
    b) participation in a criminal offense
    c) civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation
    d) a pregnancy related sickness
        i) during any period of formal maternity leave and/or parental leave
        ii) during any period in which Employment Insurance (EI) benefits are being paid

e) substance abuse, including alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your Physician
f) medical or surgical care, which is cosmetic, unless such care is rendered as a result of injury or sickness

2) that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless we agree in writing
3) while you are
   a) in a jail or penitentiary
   b) on leave of absence or paid vacation
   c) receiving benefits for the same or related disability from WCB or similar legislation
4) if you become disabled during a strike or lockout at your place of employment; however, your right to benefits will be reinstated when the strike or lockout ends.

CLAIMS

1) Obtain a claim form from your Plan Administrator, as soon as possible after you become disabled.
2) Complete the employee's statement and sign the form on both sides.
3) Return the form to your Plan Administrator for completion of the employer's portion.
4) Have your Physician complete and sign the medical portions of the form.
5) We must receive satisfactory proof of claim within **30 days** following the end of the Elimination period. Failure to submit a claim within the 30 day limit will not invalidate the claim if special circumstances prevail.
6) We may request supplementary reports to update the medical information on file. Any cost for completion of medical reports will be your responsibility.
7) Incomplete claim forms will cause a delay in the payment of your benefits.

This section is from a separate booklet provided by Canada Life and is included in your plan booklet by the Trustees

PILE DRIVERS, DIVERS, BRIDGE, DOCK AND WHARF BUILDERS HEALTH BENEFITS PLAN

Active Members

Policy Number: 161747

CANADA LIFE INTRODUCTION

We are pleased to offer you our services. As we adhere to principles of inclusion, all genders are incorporated in the language used in our communications with you.

Canada Life™ is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website at www.canadalife.com for:

- information and details on Canada Life's corporate profile and our
- products and services
- investor information
- news releases
- contact information
- online claims submission

Customer Complaints

We are committed to addressing your concerns promptly, fairly and professionally. Here is how you may submit your complaint.

- Toll-free:
  - Phone: 1-866-292-7825
  - Fax: 1-855-317-9241
- Email: ombudsman@canadalife.com
- In writing:

The Canada Life Assurance Company
Ombudsman's Office T262
255 Dufferin Avenue
London, ON N6A 4K1

For additional information on how you may submit a complaint, please visit www.canadalife.com/complaints.

The information provided in the booklet is intended to summarize the provisions of Group Policy No. 161747. If there are variations between the information in the booklet and the provisions of the policy, the policy will prevail to the extent permitted by law.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Plan is underwritten by

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Canada Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

Quebec Time Limit for the Payment of Benefits

Where Quebec law applies, benefits will be paid in accordance with the terms of the plan within the following time period:

- for death benefits, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is no waiting period, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is a waiting period, 30 days from the expiry of the waiting period provided the required proof of claim has been received.
- for any other benefit, 60 days following receipt of the required proof of claim.

Plan Office Role

The plan office's role is limited to providing employees with information and not advice.

Protecting Your Personal Information

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with
- payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship

- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Canada Life's and its affiliates' internal data management and analytics
- preparing regulatory reports, such as tax slips

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Canada Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

CANADA LIFE BENEFIT SUMMARY

This summary must be read together with the benefits described in this booklet.

Member Life Insurance	$100,000
Dependent Life Insurance	
Spouse	$30,000
Member Accidental Death and Dismemberment	
Principal Sum	$100,000
Long Term Disability Income Benefits	
Waiting Period	350 days
Amount	$3,000

CANADA LIFE GENERAL INFORMATION

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the first day of the month after you accumulate 200 hours in your hour bank within a 6-month period, ending on or after the effective date of this policy.

- You and your dependents will be covered as soon as you become eligible.

Your coverage terminates when you are no longer eligible, there is less than 100 hours in your hour bank, you do not make a required self-funded top up or the policy terminates, whichever is earliest.

- Your dependents' coverage terminates when your insurance terminates or your dependent no longer qualifies, whichever is earlier.
- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. See your plan office for details.
- When your coverage terminates, you may be entitled to an extension of benefits under the plan. See your plan office for details.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

A common-law spouse is a person who has been living with you in a conjugal relationship for at least 12 months.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your plan office.

MEMBER LIFE INSURANCE

On your death, Canada Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan office will explain the claim requirements to your beneficiary.

- If you become disabled while insured, Canada Life may waive the premiums on your life insurance after the waiting period, throughout the benefit period.

  The waiting period is the same as the waiting period under the long term disability income benefit.

  A benefit period is the period of time after the waiting period during which you satisfy the disability definition under the long term disability income benefit. A benefit period will not continue past your 65th birthday.

- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your plan office for details.

DEPENDENT LIFE INSURANCE

If one of your dependents dies, Canada Life will pay you the dependent life insurance benefit. Your plan office will explain the claim requirements.

- If you are disabled and the premiums for your employee life insurance are waived, your dependent life insurance will also continue without premium payment until your own coverage terminates or your dependents no longer qualify.
- If your spouse's insurance terminates on or before their 65th birthday, your spouse may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. See your plan office for details.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

If you suffer one of the losses listed below as the result of an accident which occurs while you are insured, you will be paid the factor or portion of the Principal Sum shown opposite the loss in the table below. The loss must occur no later than 365 days after the accident. For loss of use, the loss must be continuous for 365 days. If you suffer multiple losses to the same limb as the result of the same accident, only the loss providing the highest amount payable will be paid.

If you die as a result of an accident, Canada Life will pay the Principal Sum to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan office will explain the claim requirements to your beneficiary.

The Principal Sum is the maximum amount that will be paid for all injuries resulting from the same accident. For paraplegia, hemiplegia, and quadriplegia, the maximum amount that will be paid for all injuries resulting from the same accident is two times the Principal Sum.

Loss	**Amount Payable**
Life	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
Speech and Hearing in both ears	Principal Sum
One arm or one leg	3/4 Principal Sum
One hand or one foot or sight of one eye	1/2 Principal Sum
Speech	1/2 Principal Sum
Hearing in both ears	1/2 Principal Sum
Thumb and index finger or at least 4 fingers of one hand	1/4 Principal Sum
All toes of one foot	1/8 Principal Sum

Loss of Use	Amount Payable
Both arms and both legs (quadriplegia)	2 X Principal Sum
Both legs (paraplegia)	2 X Principal Sum
One arm and one leg on the same side of the body (hemiplegia)	2 X Principal Sum
One arm and one leg on different sides of the body	Principal Sum
Both arms or both hands	Principal Sum
One hand and one leg	Principal Sum
One leg or one arm	3/4 Principal Sum
One hand	1/2 Principal Sum

AD&D Insurance will be continued without further premium payment during any period your Life Insurance is being continued under the waiver of premium benefit. Your insurance under this waiver of premium will terminate automatically when this benefit terminates.

SURGICAL REATTACHMENT

If you suffer the loss of a limb that is surgically reattached, Canada Life will pay 50% of the amount that would have been payable if the loss had been permanent, regardless of the amount of use regained. The balance of the benefit will be payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

REPATRIATION

If you die as the result of an accident that is at least 150 kilometres away from your home, Canada Life will pay up to $2,500 for the preparation and transportation of your body to the place of burial or cremation.

EDUCATIONAL BENEFIT FOR DEPENDENT CHILDREN

If benefits are payable under this benefit provision for your death, Canada Life will pay the tuition fees for enrolling your dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must have been enrolled:

- as a full-time student at a post-secondary institution at the time of the accident causing your death, or
- as a full-time student at the secondary school level at the time of the accident causing your death and enrols as a full-time student at a post-secondary institution within 365 days after the accident.

Canada Life will pay up to 5% of the Principal Sum, or $5,000, whichever is less, for each year of full-time post-secondary school enrolment. Canada Life will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment.

Limitations

No benefits will be paid for tuition expenses incurred before the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

FAMILY TRANSPORTATION BENEFIT

If you are hospitalized more than 150 kilometres from your home as a result of an injury for which benefits are payable under this benefit provision, Canada Life will pay up to $2,000 for transportation and lodging expenses for one family member to join you.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $.44 per kilometre travelled.

Limitation

Meal expenses are not covered.

OCCUPATIONAL TRAINING BENEFIT FOR SPOUSES

If benefits are payable under this benefit provision for your death, Canada Life will pay for expenses associated with your spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify.

Canada Life will pay up to 10% of the Principal Sum, or $10,000, whichever is less.

Limitations

No benefits will be paid for expenses incurred more than 3 years after the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

EDUCATIONAL BENEFIT

If benefits are payable under this benefit provision for an injury that requires you to change occupations, Canada Life will pay the tuition fees for enrolling you as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, you must enrol at a post-secondary institution within 365 days after the accident. Canada Life will pay up to $10,000.

Limitations

No benefits will be paid for tuition expenses incurred before the accident, expenses incurred more than 2 years after the accident causing the injury, or room or board or other ordinary living, travelling, or clothing expenses.

WHEELCHAIR BENEFIT

If benefits are payable under this benefit provision for an injury that requires the use of a wheelchair for you to be ambulatory, Canada Life will pay for alterations to your principal residence to make it wheelchair accessible and habitable, and modifications to a motor vehicle you use to make it accessible to and driveable by you.

Benefits for home alterations are payable only if the person or persons making the changes are experienced in home alterations for wheelchairs, and recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if the person or persons making the changes are experienced in vehicle modification for wheelchairs, and the modifications are approved by the provincial vehicle licensing authority.

Canada Life will pay up to $10,000 for all home and vehicle modifications combined.

Limitations

No benefits will be paid for expenses incurred more than 365 days after the accident, or for subsequent alterations to your home or vehicle after an initial claim for benefits has been made under this wheelchair benefit provision.

GENERAL LIMITATIONS

No benefits are paid for injury or death resulting from:

- Intentionally self-inflicted injury or suicide, regardless of your state of mind and whether or not you were able to understand the nature and consequences of your actions
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed
- Any form of illness or physical or mental infirmity
- Medical or surgical treatment, except surgical reattachment
- War, insurrection or voluntary participation in a riot
- Service in the armed forces of any country
- Air travel serving as a crew member, or in aircraft owned, leased or rented by your employer, or air travel where the aircraft is not licensed or the pilot is not certified to operate the aircraft

HOW TO MAKE A CLAIM

- To claim benefits for yourself, ask your plan office for a claim form. Complete it and return it to your plan office.
- If you die accidentally, your plan office will explain the claim requirements to your beneficiary.
- Claims should be submitted as soon as possible, but no later than 15 months after the loss.

LONG TERM DISABILITY INCOME BENEFITS

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled as defined by the policy or you reach age 60, whichever comes first. Check the Benefit Summary for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.
- Long Term Disability (LTD) benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from performing the essential duties of your regular occupation, and, except for any employment under an approved rehabilitation plan, you are not employed in any occupation that is providing you with income equal to or greater than your amount of LTD insurance under this plan, as shown in the Benefit Summary.
- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications.
- Loss of any license required for work will not be considered in assessing disability.
- After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.
- Because your employer contributes to the cost of LTD coverage, benefits are taxable.
- Your LTD insurance will not continue past the end of the day before the date you reach age 60.

OTHER INCOME

Your LTD benefit is reduced if the total of it and the other income you are entitled to receive while you are disabled exceeds 80% of your monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount. Other income includes:

- disability benefits you or another member of your family is entitled to on the basis of your disability under the Canada Pension Plan or Quebec Pension Plan that are paid directly to you
- retirement benefits under the Canada Pension Plan or Quebec Pension Plan
- benefits under any Workers' Compensation Act or similar law
- loss of income benefits under an automobile insurance plan, to the extent permitted by law
- loss of income benefits available through legislation, except for Employment Insurance benefits and automobile insurance benefits, which you or another member of your family is entitled to on the basis of your disability
- the wage loss portion of any criminal injury award
- disability benefits under a plan of insurance available through an association
- employment income, disability benefits, or retirement benefits related to any employment except for income from an approved rehabilitation plan (termination pay, severance benefits, and any similar termination of employment benefits, including any salary paid in lieu of notice, are included as employment income under this provision)

Earnings received from an approved rehabilitation plan are not used to further reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

Cost-of-living increases in the other income listed above, that take effect after the benefit period starts, except for income from an approved rehabilitation plan, are not included.

VOCATIONAL REHABILITATION

Vocational rehabilitation involves a work-related activity or training strategy that is designed to help you return to your own job or other gainful employment, and is recommended or approved by Canada Life. In considering whether to recommend or approve a rehabilitation plan, Canada Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to work.

MEDICAL COORDINATION

Medical coordination is a program, recommended or approved by Canada Life, that is designed to facilitate medical stability and provide you with cost effective, quality care. In considering whether to recommend or approve a medical coordination program, Canada Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate medical stability.

LIMITATIONS

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.
- Any period after you fail to participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist. If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.
- Any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by Canada Life.
- Any period after you fail to participate or cooperate in an approved rehabilitation plan.
- Any period after you fail to participate or cooperate in a recommended medical coordination program.
- Any period after you fail to participate or cooperate in a required medical or vocational assessment.
- The scheduled duration of a leave of absence.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.
- Any period in which you are outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Canada Life pre-authorized the absence prior to your departure.
- Any period of incarceration, confinement, or imprisonment by authority of law.
- Disability arising from war, insurrection, or voluntary participation in a riot.

CONVERSION PRIVILEGE

If you change jobs, you may apply for an individual LTD conversion policy without medical evidence. You must apply and pay the first premium no later than 31 days after you start your new job, and you must start your new job no later than 6 months after you leave your present one. Your application must be acceptable according to Canada Life's underwriting rules in effect for individual disability insurance conversion policies at the time of application. See your plan office for details.

HOW TO MAKE A CLAIM

To submit paper claims, obtain an Employee Claim Submission Guide (form M4307B) and follow the guide's instructions. You can get this form from your plan office.

Please ensure that your claim is submitted to Canada Life as soon as possible, but no later than 3 months after proof of your claim has been requested.