TEAMSTERS' NATIONAL BENEFIT PLAN

PLAN SUMMARY
TEAMSTERS LOCAL 31 DIVISION

January 1, 2021
Electronic Booklet

TEAMSTERS' NATIONAL BENEFIT PLAN

TABLE OF CONTENTS

Introduction	3
Summary of Benefits	4
Eligibility Provisions	5
Extended Health Benefit	10
Dental Benefit	20
Group Life Insurance	27
Accidental Death and Dismemberment	29
Weekly Indemnity Benefit	37
Long Term Disability Benefit	44
Miscellaneous	47
- Dual Coverage - Coordination of Benefits	47
- How to make a Claim	48
- Change of Status	50
- Taxable Benefits	50
- Claim Appeal Process	51

Revised January 1, 2021

INTRODUCTION

The Plan came into effect July 1, 1971, as the result of a Collective Agreement between certain employers and the Union. The Plan operates under the supervision and guidance of a Board of Trustees appointed by the Teamsters Local Union No. 31.

The Trustees operate under an Agreement and Declaration of Trust originally dated July 1, 1971 and revised November 1, 1991.

Board of Trustees:

Mr. Stan Hennessy
Mr. Mike Hennessy
Mr. Caley Fieldhouse

Administration and Claims Office:

Teamsters' National Benefit Plan
1610 Kebet Way,
Port Coquitlam, B.C. V3C 5W9

Telephone:	(604) 552-2650
Toll Free (in B.C.)	1-888-478-8111
Fax:	(604) 552-2653

E-mail : benefits.pensions@teamstersbenefits.ca
Website: www.teamstersbenefits.ca

Consultant and Actuary - HUB (formerly Morneau Shepell)

The purpose of this booklet is to give you a brief description of the Plan and its benefits in general terms. It is not to be considered a contract of insurance. The exact terms of the benefits are detailed in insurance contracts and other formal documents which govern the Plan. Benefits are subject to change by the Board of Trustees.

SUMMARY OF BENEFITS

Benefit	Maximum
• Group Life Insurance	$ 50,000
• Accidental Death, Disease & Dismemberment (AD& D) Principal Amount	$ 60,000
• Dental	see page 20
• Extended Health Benefit (E.H.B.)	see page 10
• Weekly Indemnity (W.I.) 75% of pre-disability earnings to a maximum weekly benefit of	$ 595
• Long Term Disability (L.T.D.)(monthly) (to a maximum of 85% of pre-disability earnings)	$ 1,200

BENEFITS ARE UNDERWRITTEN BY THE FOLLOWING:

The Co-operators

Group Life Insurance and Out of Province Emergency Treatment Provider
Policy No. 42101

Optional Life 42101-2 Voluntary – self pay

AIG Insurance Company of Canada (AIG Canada)

Accidental Death and Dismemberment
Policy BSC 9112494A

Teamsters' National Benefit Plan – self-insured

Dental
Extended Health
Weekly Indemnity
Long Term Disability

ELIGIBILITY PROVISIONS

Eligible Employees

- Union Members

  You must be a Member in good standing of Teamsters Local Union No. 31 (the Union) and a Regular Employee or Dependent Contractor of a Participating Employer. Participation in the Plan is compulsory.

- Non-Union Members

  The salaried Non-Union employees of a Participating Employer who have signed a participation agreement are eligible, provided that at least 90% of all Non-Union employees participate. Any employee who does not join the Plan when first eligible will be required to produce satisfactory evidence of insurability at their own expense to join at a later date. All other provisions of the Plan will apply equally to Union and Non-Union members.

Eligible Dependents

- Your Spouse with whom you reside;

  "Spouse", means a person designated by the Member as a Spouse who is:

  (i) a person who is married to the Member, or

  (ii) if paragraph (i) does not apply, a person who lives with the Member as husband and wife and has done so for the one year period immediately preceding the relevant time, or a person of the same gender who lives in a marriage-like relationship with the Member and has done so for the one year period immediately preceding the relevant time.

- Your or your Spouse's unmarried child under the age of 21 provided the child relies principally upon you for support and resides with you;

- Your or your Spouse's unmarried child under the age of 25 provided the child is in full-time attendance at a recognized school, college or university, relies principally upon you for support and normally resides with you;

- Your or your Spouse's unmarried child of any age who is an unmarried Child of a Member or of the Member's Spouse of any age who has been certified by a Physician to be permanently mentally or physically handicapped to the extent that the Child is incapable of performing the duties of any occupation, provided such Child relies principally upon the Member for support.

- In the event that a Plan Member is legally separated or divorced, coverage for the dependent children will remain in effect. Dependent children shall include any child who resides with the Member's former Spouse and meets all other conditions of being a dependent. The former Spouse is not eligible for benefit coverage.

Effective Date

Coverage for you and your eligible dependents will become effective on the first day of the month coincident with or following the date on which you become an eligible employee as determined in the Collective Agreement between the Union and your employer provided you are actively at work on that date. If you are not actively at work on that date, coverage will commence on the first day that you return to active work.

Termination of Coverage

A. Dental, Extended Health Benefit, Group Life and Accidental Death & Dismemberment.

Coverage for you and your eligible dependents will terminate on the last day of the month in which you cease to be actively employed by a Participating Employer, except:

- if disabled and in receipt of Weekly Indemnity or Long Term Disability Benefits from the Plan coverage may continue (pursuant to the terms of your collective agreement) for a maximum 12 month period provided contributions are paid by your employer;

- if a grievance is invoked upon termination of employment, coverage may continue (pursuant to the terms of your collective agreement) during the period to a maximum of 12 months provided contributions are paid by your employer;

- if your death occurs while you are covered, coverage will continue for your eligible dependents covered under the Plan on the date of your death for a period of 12 months following the last day of the month in which your death occurs;

E.H.B. Coverage for Long Term Disability Claimants. Claimants who become disabled after January 1, 1989 are continuing to receive Long Term Disability benefits (L.T.D.) under this Plan, you will continue to receive E.H.B. coverage for the duration of your Long Term Disability claim at no cost to you.

Continuation of this benefit is subject to approval by the Trustees. If death occurs while receiving L.T.D. benefits, E.H.B. coverage will continue for your eligible dependents covered under the Plan on the date of your death for a period of 12 months following the last day of the month in which your death occurs.

B. Weekly Indemnity and Long Term Disability Benefits

Coverage for the Weekly Indemnity and Long Term Disability benefits and the disability waiver provisions of the Group Life and A.D.& D. benefits will terminate immediately if your employment terminates, you are laid off or you incur any other temporary cessation of active employment with a participating employer, except:

- if layoff or any other temporary interruption of employment occurs and you become disabled within 31 days of the date last worked you may be eligible for Weekly Indemnity or Long Term Disability benefits commencing with the date you would have returned to work. If you are receiving E.I. benefits, WI or LTD benefits will not be payable until E.I. benefits cease.

- if you become disabled during a strike or lock-out within 6 months of the date last worked, you may be eligible for Weekly Indemnity or Long Term Disability benefits commencing with the date you would have returned to work. If you are receiving E.I. benefits, WI or LTD benefits will not be payable until E.I. benefits cease.

Retiree Benefits

Under certain criteria, Extended Health and A.D. & D. benefits are now available to Retirees. Please see the Plan's website or contact the Plan's office for details regarding eligibility.

Reinstatement of Coverage

If you are laid off and return to work with the same employer as a regular employee for one full shift (unless other conditions are specified in the Collective Agreement) coverage for E.H.B. and Dental benefits for you and your eligible dependants will be reinstated retroactively to the first day of the calendar month in which you return to work. Your Weekly Indemnity, Long Term Disability, Group Life and Accidental Death, Disease & Dismemberment coverage will be reinstated as of the day you return to work.

Application Forms – Member Data Forms

Your employer has a supply of Member Data forms for you to complete for participation in the Plan. The form(s) must be completed and returned to the Plan Office.

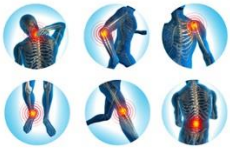
FRAUD

If a Member or Dependent or any other person entitled to Benefits obtains, or attempts to obtain, a Benefit to which such person is not entitled (including a Benefit that is greater than the Benefit to which such person is entitled) by submitting false, misleading, or inaccurate information, or such being submitted on such person's behalf, the Trustees may in their sole discretion but not limited to, take any one or more of the following actions in respect of such person:

1. suspend the payment of Benefits for a period of time;
2. cancel the payment of Benefits;
3. deny coverage under the Plan;
4. declare such person ineligible for future Benefit;
5. inform the Union and/or Participating Employer;
6. commence an action for recovery of Benefits paid,

unless, such person can demonstrate to the Trustees that such person acted in good faith in submitting the claim for Benefits and that any misinformation therein was the result of a bona fide error.

Notwithstanding the above, the decisions of the Trustees in all matters will be final and binding on the Members, Dependents and any other persons entitled to Benefits.



EXTENDED HEALTH BENEFIT (EHB)

This benefit is designed to **assist** you in paying for certain services and supplies not covered under the government's basic medical coverage, the Medical Services Plan of British Columbia. The Plan covers **reasonable and customary charges** for eligible expenses for you and your eligible dependents when required for the treatment of accident, illness or disease. You should be aware that the prices charged by suppliers of services or equipment may vary considerably. We suggest, whenever practical, you should compare prices.

Maximum Benefit

The maximum benefit payable for prescription medications in any calendar year is $2,500 per person. Coverage for other benefits is unlimited for you and your eligible dependents unless specified under the section entitled “Eligible Expenses”.

Co-ordination of Benefits

In the event that an eligible person is also entitled to benefits under any other group insurance program or insurance policy, benefits will be co-ordinated with the other plan or insurer to ensure that the total benefit paid from all sources does not exceed 100% of the reasonable charges for the services and supplies provided.

If your Spouse is covered under another plan, we follow the guidelines of the Canadian Life and Health Insurance Association (CLHIA). These guidelines are used by most, if not all, insurers in Canada.

We are the primary insurer for your expenses. Your Spouse's insurer is the primary carrier for your Spouse's expenses. Dependent children become the primary responsibility of the plan who insures **the parent who has the earliest birth date in the year** (month and day).

If the Plan is the secondary carrier, please remit copies of receipts paid by the primary carrier along with their statement of payment details.

Pharmacare

The Provincial Fair Pharmacare program provides 70% coverage for eligible prescription medications included under their "formulary" once their annual deductible (based on family income) has been reached. If you have reached the Pharmacare deductible, the Plan will continue to pay any portion not covered by Pharmacare provided you have not reached the Plan's annual limit of $2,500 per person.

IMPORTANT --- The Fair Pharmacare program is based on income and it is necessary for you to make application to Health Insurance B.C. for coverage. Proof of registration will be issued by Fair Pharmacare. It will be necessary for you to provide proof of registration to the Plan before your prescription card will be activated and before any prescription medications will be eligible for reimbursement.

E.H.B. Eligible Expenses - In Province (reimbursed at 80% with the exception of prescribed medications which are reimbursed at 100%).

1.) Medications approved for sale in Canada for the treatment of illness or disease which are available **only** by prescription and when **prescribed by a physician**.

a.) Medications determined by the Trustees to be "lifestyle drugs" are excluded from coverage ("lifestyle drugs" are described under "Exclusions and Limitations (EHB)" on page 19 of this Booklet.

b.) Unless your doctor specifically requires that no substitutions be used, the Plan will pay for the generic equivalent of name brand medications.

c.) The Plan has a 90 day supply limit on all prescription medications.

d.) If it is possible that a prescription medication could be covered by Pharmacare under its "special authority" provision, we advise you have your doctor apply to Pharmacare for Special Authority. If Pharmacare approved, this amount will then be applied to your Pharmacare deductible. Please ask your pharmacist for further details.

The following treatment providers must be Registered Practitioners of British Columbia, or similar association in the Province or Territory in which the Member resides up to the limits set out by the Plan.

Claims will only be reimbursed in accordance with the terms of the Plan which includes the requirement that services be paid for using credit card or debit card (rather than cash). Please contact the Plan Administration Office should you have questions regarding the payment for services for which you will seek reimbursement.

2.) Chiropractor - customary fees not exceeding $70 initial visit $50 subsequent visits of a licensed chiropractor to a maximum benefit of $400 per person, $800 per family per calendar year (x-rays excluded).

3.) Naturopath - customary fees not exceeding $240 initial visit $180 subsequent visits of a licensed naturopath to a maximum benefit of $400 per person, $800 per family per calendar year, (testing fees, x-rays and medications excluded).

4.) Physiotherapist, Occupational Therapist or Kinesiologist - customary fees not exceeding $85 initial visit $75 subsequent visits of a licensed provider to a combined maximum benefit of $400 per person, $800 per family per calendar year.

5.) Massage Therapist - customary fee not exceeding $100 for 60 minute visit, $80 for 45 minute visit, $55 for 30 minute visit of a licensed massage therapist to a maximum benefit of $400 per person, $800 per family per calendar year.

6.) Podiatrist - customary fees not exceeding $175 initial visit, $100 subsequent visits of a licensed podiatrist to a maximum benefit of $400 per person, $800 per family per calendar year (x-rays and appliances excluded).

7.) Licensed Registered Psychologist, Registered Clinical Counsellor, Canadian Certified Counsellor or Registered Therapeutic Counsellor – customary fees not exceeding $110 per visit to a maximum benefit of $400 per person, $800 per family per calendar year.

8.) Speech Therapist – customary fees not exceeding $140 for 60 minutes, $70 for 30 minutes of a licensed speech therapist to a maximum benefit of $400 per person, $800 per family per calendar year.

9.) Acupuncturist - customary fees not exceeding $135 initial visit, $100 subsequent visits of a licensed acupuncturist to a maximum benefit of $400 per person, $800 per family per calendar year.

10.) Registered Nurse - when referred - customary fees to a maximum benefit of $10,000 per calendar year. Must not be a relative or a person residing with you.

11.) Crutches, canes and walkers to a maximum of once in any 12 consecutive month period. Replacement items are covered only when original or previously covered equipment is no longer functional.

12.) Artificial limbs and artificial eyes to a maximum benefit of once in any 36 consecutive month period and only if pre-authorization is obtained from the Trustees. Replacement items are covered only when original or previously covered equipment is no longer functional.

13.) Charges for oxygen and its administration, blood or blood plasma and its administration.

14.) Charges for certain ostomy and ileostomy supplies and materials as determined by the Trustees from time to time.

15.) Splints, casts, air-casts, trusses or braces to a limit of once in any 24 consecutive month period for a Member or Spouse and once in any 12 consecutive month period for a Dependent Child but only when custom-made for daily use and prescribed by a physician. Replacement items are covered only when original or previously covered equipment is no longer functional.

16.) Cryocuffs when prescribed by a physician immediately following surgery to a maximum benefit of $250 per calendar year.

17.) C.P.A.P. machine or Mandibular Repositioning appliance only in those cases which are determined to be categorized as moderate or severe as diagnosed by clinical evidence performed by a sleep study and when prescribed by a physician for the treatment of Sleep Apnea to a lifetime limit of $1,500 per person. C.P.A.P. masks, hoses and filters once every 12 months.

18.) Custom made Orthopaedic Shoes - when prescribed by a physician – maximum benefit of $150 per pair per person - limit 2 pair per year.

19.) Custom Made Foot Orthotics - when prescribed by a physician, chiropractor or podiatrist for daily use – maximum benefit of $200 per person in any 24 consecutive month period (for dependent children to a maximum benefit of $200 per person in any consecutive 12 month period).

20.) Charges for support hose when prescribed by a physician limited to two (2) pair per calendar year.

21.) Wigs and Hairpieces - when required as a result of medical treatment or accident - maximum benefit of $500 per person per lifetime.

22.) Mastectomy Prostheses - maximum 1 (per side) in any 24 consecutive month period.

23.) Brassieres - following purchase of initial prostheses to a maximum benefit of $150 per calendar year.

24.) Charges for the rental or, where more economical, the purchase, of durable equipment **prescribed by a physician** for therapeutic treatment including hospital beds and wheelchairs, provided, however, that charges for electric wheelchairs or scooters are covered only when **pre-approved by the Trustees**. Coverage for electric wheelchairs or scooters may require additional information from the Member's physician confirming that the equipment is medically necessary.

25.) Hearing Aids, when prescribed by your physician, to a maximum benefit of $500 for each ear during any 36 consecutive month period.

26.) Assistive Listening Devices when prescribed by your physician, to a maximum benefit of $400 limited to one per lifetime.

27.) Prescription eyeglasses, prescription contact lenses or fees for corrective laser eye surgery, when prescribed by a physician to a maximum combined benefit of $300 per person in any 24 consecutive month period. Please note, the Plan requires submission of the **optical prescription, receipt and proof of payment.**

28.) Eye examinations by a licensed optometrist to a maximum benefit of $50 in any 24 consecutive months.

29.) Transcutaneous Nerve Stimulation (TNS) Equipment – when prescribed by a physician to a maximum benefit of $200 per person per lifetime.

30.) Glucometers – when prescribed by a physician to a maximum benefit of $200 per person in any 36 consecutive month period.

31.) Insulin Pumps when prescribed by an endocrinologist to a maximum benefit of $1,600 in any 60 consecutive month period.

32.) Blood Pressure Monitors – when prescribed by a physician to a maximum benefit of $100 per person in any 36 consecutive month period.

33.) Ambulance service in an emergency, and when recommended by a physician, return fare for transportation of the Member or Dependent requiring treatment by ambulance, railroad, boat or airplane, and in an acute emergency by air ambulance, from the place where the sickness or injury occurs to the nearest hospital, including the return fare of 1 attending physician, nurse or first aid attendant, or a parent of a Dependent child, where such person is necessary to care for the patient during transport.

34.) Dental services included as Covered Procedures under the Dental Benefit portion of the Plan, required as the result of a non-occupational accident and performed by a dentist for the restoration, repair or replacement of natural teeth. To be eligible, treatment must occur within one year of the date of injury and must not be the result of a motor vehicle accident in the Province of British Columbia.

35.) Hospital charges for out-patient, emergency ward and short stay facilities.

36.) Hospital room differential for private and semi-private accommodation.

37.) Pulse monitoring equipment on a once per lifetime basis to a maximum of $150, when prescribed by a physician in conjunction with a prescribed heart therapy program.

38.) Treatment as recommended by a physician or podiatrist, for laser treatment for plantar warts that are resistant to the standard therapy. Coverage is limited to $80 per treatment a maximum limit of $350 per person; $750 per family per calendar year.

Treatment for Substance Abuse
Plan Member only

The Plan will pay 100% of the fees for "in-patient" substance abuse treatment in a Residential Treatment Centre recognized and licensed by the Province of British Columbia or the Yukon Territories. The Plan will cover the normal cost for such treatment as recognized by those governments to a maximum benefit of $4,500. Please note, this benefit is available **once per lifetime** and payment will be made directly to the Residential Treatment facility. This benefit is available to Members only - not Dependents.

Eligible Expenses - Out of Province – 6 Week Maximum per out of Province visit

Eligible expenses shall include **reasonable and customary charges incurred during the first six weeks of absence from the Member's Province of residence** for the following expenses as the result of an emergency outside the Province while travelling or on vacation, to the extent that such expenses are not payable or provided under or pursuant to Medical Services Plan of B.C., Pharmacare, any other medical plan or plan of insurance, any Hospital Program or Workers' Compensation Act or by any public or tax supported authority or agency:

1) Charges of a hospital for services, medical supplies, co-insurance and short term stay facilities, ward accommodation and any additional charge for private or semi-private room actually occupied if ward accommodation is not available or if required by a physician, but not charges for the rental of telephones, televisions, radios or similar equipment.

2) Fees of physician and charges for laboratory and x-ray services when ordered by a physician.

3) Charges for drugs available only by prescription when prescribed by a physician but only in sufficient quantity to alleviate an acute medical condition.

4) Charges for local ambulance service to provide transportation to the nearest hospital equipped to provide the required treatment.

5) Charges for transportation, including air transportation on a regular scheduled commercial flight from the hospital providing treatment to a hospital equipped to provide adequate treatment in a patient's city of residence, subject to written approval by the attending physician and, if the total cost of transportation will exceed $1,000, the prior approval of the Trustees.

If you are outside your Province of residence for *longer than 6 weeks,* it will be necessary for you to obtain additional coverage from a travel insurance provider.

Out of Province coverage is *not provided* for you or your dependants if you are travelling outside your Province of residence *against the advice of your physician or if there is a health advisory against travel to your destination as determined by the Government of Canada.*

All Out of Province claims are facilitated through Allianz Global Assistance. Allianz is the dedicated travel insurance provider through Co-operators. Should you require emergency treatment while travelling, please have the attending physician or hospital contact Allianz at: 1-888-440-2667 in Canada & the U.S. All other countries, please call collect: 1-416-340-1316. When calling, please advise your Group Policy Number 42101 along with your Member Plan ID.

Exclusions and Limitations (EHB)

Expenses incurred for the following shall **not** be considered eligible expenses:

1) Expenses for benefits, care, services or supplies payable by or under the Medical Services Plan of B.C., Pharmacare, any Hospital Program, a Workers' Compensation Act, or any Government Authority.

2) Expenses eligible for reimbursement under any other group or individual plan.

3) Expenses incurred as a result of a motor vehicle accident in the Province of British Columbia.

4) Expenses for dental services of any kind including services as the result of automobile accidents in B.C. except as provided under the dental and extended benefit plans in this booklet.

5) Any portion of the fee of a physician not allowable under the Basic Medical Plan except as provided under Eligible Expenses - Out of Province as outlined in this booklet.

6) Any portion of a fee or charge in excess of reasonable charges for the services performed.

7) Expenses incurred outside the Province of residence except as provided under Eligible Expenses - Out of Province as outlined in this booklet.

8) Expenses for services and supplies for cosmetic purposes or for the purpose other than the treatment of sickness or injury.

9) Expenses incurred in the treatment of any sickness or injury for which a person was hospitalized on the effective date of coverage.

10) Expenses incurred outside a person's province of residence due to therapeutic abortion or childbirth or for complications of pregnancy occurring within 2 months of the expected date of confinement.

11) Charges for contraceptive devices or sterilization procedures that are not covered under the Medical Services Act of B.C.

12) Charges of a Physician or Licensed Practitioner which are:

- For a medical examination required for the use of a third party.
- For the completion of forms or reports for any purpose.

13) Charges for any brace, truss or other device prescribed primarily for protection against injury while participating in sports activities.

14) Charges for any services, supplies, drugs or other products determined by the Trustees not to be an eligible expense including drugs described as “lifestyle” drugs which include but are not limited to treatment for smoking cessation, weight loss, hair growth, erectile dysfunction, vaccines, vitamins, fertility treatment or for cosmetic purposes.

15) Expenses for repairs, maintenance, batteries, re-charging devices or other such accessories for hearing aids, wheelchairs, scooters or other durable equipment.

16) Expenses caused, contributed to or necessitated as the result of:

- War or any act of war or participation in a riot or civil insurrection.
- Sickness or injury which was intentionally self-inflicted, whether sustained or suffered while sane or insane.
- The commission by any eligible person of any unlawful act including an offence under the Criminal Code of Canada or a similar offence under the laws of any other country.
- Injuries received due to the operation of a vehicle, if, when the injuries were received, the claimant's blood contained more than eighty (80) milligrams of alcohol per one hundred (100) millilitres of blood.

17) Services and supplies the person is entitled to without charge by law or for which a charge is made only because the person has insurance coverage.

18) Services or supplies not listed as covered expenses.

19) Services or supplies incurred during any period in which a person has been absent from his Province of residence in excess of 6 consecutive weeks.

20) Ambulance Service:

- Transportation arranged at the patient's convenience.
- Transportation arranged after waiting for Hospital accommodation for a condition not requiring immediate transportation to the Hospital.
- Transportation for the removal of a patient from one Hospital to another except in cases where the Hospital from which the patient is removed has inadequate facilities to provide the required treatment, or as set out under the terms of the Plan.

- Transportation to a Hospital at which the patient is not admitted for emergency treatment.
- Charges for ambulance services where transportation does not actually occur shall be covered to a maximum of once in any 12
- consecutive month period.

DENTAL BENEFIT

This benefit is divided into three separate services:

Basic
100% reimbursement of accepted fees for all eligible persons.

Major (Pre-authorization required)
80% reimbursement of accepted fees for member, Spouse and eligible dependent children over age 21, and 100% for dependent children under age 21.

Orthodontic (Pre-authorization required)
50% reimbursement of accepted fees for all eligible persons.

Maximum Benefit

- The maximum benefit payable for any eligible person for **Basic and Major services combined** performed in any calendar year is $3,000.

- The maximum **lifetime benefit** payable for **Orthodontic services** for any eligible person is $3,000.

Pre-authorization

If the treatment the dentist proposed by the dentist exceeds $500, involves the use of gold, crowns, bridgework or dentures or involves treatment to be provided by a specialist, a treatment plan should be submitted to the Plan office for prior review. A Pre-authorization form will be sent to both you and your dentist confirming the amount that can be paid by the Plan.

Dental Benefit Details

Benefits are based on fee schedule amounts accepted by the Trustees.

The Plan covers most, but not all, of the procedures that are dentally necessary and are included in the general practitioners' fee guide. It is important to note this limitation as your dentist's charges (particularly if you are seeing a specialist) may be higher than those allowed by the Plan.

Fees greater than the benefit payable by the Plan or fees for ineligible services will be your responsibility.

Benefits Payable

All eligible services will be payable based on fee schedules accepted by the Trustees for services performed by a dentist, denturist or dental hygienist.

Co-ordination of Benefits

In the event that an eligible person is also entitled to benefits under any other insurance program or insurance policy, benefits will be co-ordinated with the other plan or insurer to ensure that the total benefit paid from all sources does not exceed 100% of the fee accepted by the Plan.

If your Spouse is covered under another plan, we follow the guidelines of the Canadian Life and Health Insurance Association. These guidelines are used by most, if not all, insurers in Canada.

We are the primary insurer for your expenses. Your Spouse's insurer is the primary carrier for your Spouse's expenses. Dependent children become the primary responsibility of the plan which insures the parent who has the earliest birth date in the year (month and day).

If the Plan is the secondary carrier, you must remit copies of receipts paid by the primary carrier along with their statement of payment details.

Eligible Basic Dental Services and Limitations

1) **Diagnostic Services** - covered procedures necessary in the evaluation of a patient's level of oral health and the dental care required.

   - New Patient and Recall examinations shall be limited to a combined total of two per calendar year.
   - Specific examinations and emergency examinations are limited to a combined total of two per calendar year.
   - Complete examinations are limited to once every 36 months and not within 6 months of a Recall or New Patient examination.
   - Accepted fees for x-rays shall be limited to an aggregate amount in any calendar year equivalent to the accepted fee for a full mouth series of x-rays.
   - Panoramic x-rays are limited to once in any 36 month period.
   - Full mouth series of x-rays are limited to once in any 36 month period.

2) **Preventive Services** - covered procedures necessary for the prevention of disease of the mouth and gums, and for the prevention of caries.

   - Polishing (prophylaxis) and fluoride treatment is limited to twice per calendar year.

- Space maintainers are limited to once every 24 months. Covered only if the purpose of the appliance does not involve tooth movement.

- Pit & fissure sealants, and restorative resins are limited to once per tooth in any 24 month period.

- For scaling, root planing and gingival curettage limits, see Periodontic Services.

3) **Restorative Services** - covered procedures necessary to restore natural teeth which have broken down as the result of decay or fracture to normal health and function, including amalgam, silicate, plastic and synthetic porcelain restorations and stainless steel crowns, but not including any restorations involving the use of gold or procedures classified as inlays, onlays or crowns other than stainless steel or preformed plastic crowns.

- Accepted fees for the restoration of a primary tooth or of any molar tooth shall be limited to an aggregate amount in any 12 month period equivalent to the accepted fee for a 5 surface tooth coloured restoration.

- Accepted fees for the tooth coloured restoration of any tooth shall be limited to an aggregate amount in any 12 month period equivalent to the appropriate accepted fee for a 5 surface, non-etched tooth coloured restoration.

- The restoration of any tooth surface is limited to once in any 12 month period, except that veneer applications are limited to once every 36 months.

- Stainless steel crowns and preformed plastic crowns are not covered if being used temporarily prior to placement of a more expensive crown.

- Composite (white) fillings on molar teeth.

4) **Endodontic Services** - covered procedures necessary for the treatment of the pulp chamber and canal.

5) **Periodontic Services** - covered procedures necessary for the treatment of the soft tissue and bone surrounding the teeth excluding soft tissue grafts and bone grafts.

- Occlusal adjustment is limited to 8 units in any 12 consecutive month period.
- Root planing, scaling and gingival curettage combined to the aggregate maximum of the equivalent of 16 units per calendar year.
- Osseous surgery is limited to once per sextant in any 60 month period.
- Bruxing guards are limited to once in any 24 month period.
- Free soft tissue grafts.

6) **Prosthetics** - covered procedures required for the repair or reline of fixed or removable appliances.

- Relines or rebases are limited to a combined maximum of one per upper and one per lower prosthesis in any 24 month period.
- Tissue conditions and resilient liners twice in any 60 month period.

7) **Oral Surgery** - covered procedures involving the extraction of teeth and surgery involving the mouth and gums.

- In cases of multiple extractions in 1 quadrant or surgical site, the most expensive procedure shall be considered the first extraction and other procedures to be subsequent extractions.
- Fees for general anaesthetic.

Eligible Major Dental Services and Limitations

1) **Restorative Services** - covered procedures necessary for the fabrication of or repair to crowns, fixed bridges, onlays or veneers.

- Onlays (inlays) on anterior teeth are covered only where the incisal edge of the tooth is involved. Onlays on posterior teeth only where the

mesial, distal and occlusal surfaces are involved plus one or more cusps.

- A crown, onlay or other major restoration only where a prior major restoration has not been performed to the same tooth within the previous 60 months.

- A crown or onlay is covered only where satisfactory evidence is submitted to indicate that, because of decay or fracture or because of other deterioration of tooth structure, the tooth could not be restored with conventional filling material as a Basic Service.

- Crowns, onlays or veneers required for the purpose of aesthetics, restoring occlusion, restoring vertical dimension or for the treatment of temporomandibular joint dysfunction are not covered.

- Porcelain facings on crowns or bridges for permanent second molars are not covered. Accepted fees will be limited to the fee for a full gold unit.

- The accepted fee for any crown or onlay will be reduced by any benefit paid for a Basic Restoration to that tooth within the previous 6 month period.

2) **Prosthetic Services** - covered procedures required for the fabrication of full and partial dentures.

- Complete upper and lower dentures only once in any 60 month period and not within 24 months of a partial denture in the same arch.

- Partial dentures only once in any 60 month period.

Orthodontic Services

Covered procedures required for the correction of malocclusion, including examination, diagnosis, appliances and treatment fees. Services are covered only if they are performed while the Member or Dependant is covered under the Plan.

- Examination, diagnosis and appliance fees in aggregate are limited to 40% of the entire treatment cost.
- Monthly treatment fees are payable as services are provided. Accepted fees for monthly adjustments will be limited to the total of the fees proposed for this portion of treatment divided by the number of months estimated as the active treatment period.
- Under no circumstances will the Plan cover fees for services paid in advance of the actual treatment dates.
- The Plan does not cover fees for the repair or replacement of lost, stolen or broken appliances.
- ***In all cases involving orthodontia, an "Orthodontic Treatment Plan" must be completed by the dentist and submitted to the Plan for approval before appliances are inserted.***

Extension of Coverage

The following services will be considered eligible expenses, if completed within 30 days following the date on which coverage of the eligible person is terminated, provided that the service would have been an eligible expense had coverage remained in effect:

- Completion of root canal treatment if the pulp chamber was opened while the person was covered.
- Crowns, bridges or gold restorations if the tooth or teeth are prepared for crowns while the person was covered.
- Full or partial dentures if the final impression was taken while the person was covered.

Exclusions (Dental)

Expenses incurred for the following shall not be considered eligible expenses:

1) Services not performed by a Dentist, Denturist or Dental Hygienist.

2) Services that are not, in the opinion of the Trustees, necessary or customarily provided to maintain or restore oral health.

3) Any service not specifically included as a covered procedure in the fee schedule adopted by the Trustees.

4) Services for which any benefits are or could be payable under the Medical Services Plan of B.C., Pharmacare, a Workers' Compensation Act or any Government Authority.

5) Services required as the result of a motor vehicle accident in the Province of British Columbia.

6) Services commencing prior to the effective date of coverage.

7) Replacement or modification of crowns, bridges, gold restorations or dentures which are less than 5 years old.

8) Replacement of lost or stolen appliances.

9) Crowns or onlays if required solely for the purpose of restoring occlusion or vertical dimension.

10) Porcelain facings on crowns or pontics on second or third molars.

11) Charges for incomplete, unsuccessful or temporary procedures, missed appointments and completion of forms.

12) Services provided that are primarily cosmetic in nature.

13) Services required for the correction of congenital malformations or temporomandibular joint dysfunction.

14) Implants.

GROUP LIFE INSURANCE – THE CO-OPERATORS – POLICY 42101

In the event of your death from any cause while your Group Life Insurance is in force, the Principal Amount will be payable to your **designated beneficiary**. This benefit is not assignable.

Beneficiary

Your Group Life Insurance will be paid to the beneficiary you named on the Member Data form provided to the Plan. If no such designation has been filed, the benefit will be paid to your Estate. It is very important that beneficiary information is kept up to date and that the signed copy of beneficiary appointments be submitted to the Plan's office.

Please call the Plan's office if you wish to confirm who is on file as your named beneficiary. You may change your beneficiary whenever you wish, subject to applicable laws, by completing a change of beneficiary form available from the Plan's office or online at www.teamstersbenefits.ca

Benefit Amount

See page 4 of this booklet entitled "Summary of Benefits".

Living Benefit

As a Member, you may be eligible for a Life Advance under the Plan's Group Life policy. Co-operators will consider a request for a Life Advance where life expectancy is 24 months or less. The maximum amount of the Life Advance is the lesser of 50% of the Group Life Insurance benefit or $50,000.

Before a claim is submitted to Co-operators for consideration, the beneficiary of the member's Group Life benefit must sign a waiver.

Group Life Coverage if Disabled

Should you, while covered under this Plan, become disabled due to sickness or accident and qualify for Long Term Disability benefits under this Plan your Group Life Insurance will continue in effect while you remain in receipt of Long Term Disability benefits and are younger than age 65. Medical evidence must be submitted upon request.

If you become disabled, as defined in the Long Term Disability section of this booklet, and are receiving benefits under the Workers' Compensation Act, you may qualify for continuation of your Group Life Insurance coverage by applying to the Plan within 15 months of the date you become disabled. Qualification will be dependent upon the receipt of satisfactory medical evidence. **Please note, failure to apply within 15 months of the date on which you became disabled will disqualify you from this benefit.**

Conversion Privilege – for those Plan Members under the age of 70

If your Benefit Plan coverage terminates you may, within 31 days of termination, convert your Group Life Insurance, without a medical examination, to one of a number of individual life insurance policies available from the insurance company. The policy will be effective at the end of the 31 day period, and the premiums will be the same as you would ordinarily pay if you applied for an individual policy at that time. If you die during this 31 day period, your Group Life insurance will be paid whether or not you have applied for an individual policy.

Optional Life – Self pay

Please contact our office for further information.

Basic Accidental Death & Dismemberment Insurance Plan
For: Teamsters'' National Benefit Plan
AIG Insurance Company of Canada
Policy No.: BSC 9112494A

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your family with insufficient financial resources to fulfill their financial responsibilities.

Your Employer has provided you with Accident Insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance, or loss of use of a limb, sight, speech or hearing.

How It Works

You are automatically covered for a Principal Sum in the amount of $60,000.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history. **24/7 Worldwide Coverage -** Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

Definitions

"Insured Member" means you, if you are a Member of the Policyholder who is under the age of 75, and per the definition under the Policy.

Eligible Dependents:

"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (*ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).*

Beneficiary Designation

You have the option to designate a beneficiary, should you choose not to, in the event of accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your Current Group Life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Company will pay in one installment the indicated percentage of the Principal Sum as set out in the following Table of Losses. If more than one loss is sustained, only one benefit shall be payable, the largest.

Table of Losses

Loss coverage per accident ....No Limitation to Number of Losses Incurred per Accident

Loss of Life..... 100%
Loss of Both Hands..... 200%
Loss of Both Feet..... 200%
Loss of Entire Sight of Both Eyes..... 100%
Loss of One Hand **100%**
Loss of One Foot **100%**
Loss of One Hand and the Entire Sight of One Eye 100%
Loss of One Foot and the Entire Sight of One Eye 100%
Loss of One Arm.....**80%**
Loss of One Leg..... 80%
Loss of The Entire Sight of One Eye.....**75%**
Loss of Thumb and Index Finger of the Same Hand 33%
Loss of Speech and Hearing in both ears 100%
Loss of Speech or Hearing in both ears..... 75%
Loss of Hearing in One Ear..... 33%
Quadriplegia (total paralysis of both upper and lower limbs) 200%
Paraplegia (total paralysis of both lower limbs) 200%
Hemiplegia (total paralysis of upper and lower limbs of one side of the body) 200%
Brain death..... 100%
Loss of Use of Both Arms or Both Hands..... 200%
Loss of Use of One Hand or One Foot 75%
Loss of Use of One Arm or One Leg 80%
Loss of Four Fingers of One Hand..... 33%
Loss of All Toes of One Foot 75%
Loss of use of both arms or both legs 200%
Loss of use of thumb and index finger..... 33%

"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the first phalange; “Fingers” means the complete severance through or above the first phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes” means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Rehabilitation Benefit

Pays the expenses incurred for occupational training to a maximum of $15,000 if such expenses are incurred within 2 years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a one-time benefit of up to $50,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation
Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 150 kilometres from home.

Repatriation Benefit
Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Seat Belt Benefit
Pays an additional benefit of 10% of the Principal Sum to a maximum of $25,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit
Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense
Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Serious Illness Benefit (Non-Cancer)

Pays an additional benefit of 10% of the Principal Sum to a maximum of $6,000 if you are diagnosed with the following covered serious illness:

- ✓ Amyotrophic Lateral Sclerosis (ALS)
- ✓ Multiple Sclerosis
- ✓ Necrotizing Fascitis
- ✓ Parkinson's Disease
- ✓ Acute Poliomyelitis
- ✓ Peripheral Vascular Disease
- ✓ Huntington's Chorea
- ✓ Alzheimer
- ✓ Type 1 Diabetes (Insulin Dependent)
- ✓ Major Burns (3rd degree
- ✓ Major Organ Failure Requiring Transplant
- ✓ Motor Neuron Disease
- ✓ Major Organ Transplant

Please see the Policy for specific diagnosis requirements. You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This is a one-time benefit even if you are diagnosed with more than one covered serious illness.

Waiver of Premium

Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage

Your coverage will continue for up to 12 months during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Conversion Privilege Benefit

If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Bereavement Benefit

Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of the accident.

Burn Benefit

Pays a percentage of the Principal Sum up to a maximum of $25,000 if you suffer a 3rd degree burn by means of exposure to fire, heat, caustics, electricity or radiation. Please see the Policy for details.

Identification Benefit

Pays a benefit of up to $15,000 for the transportation and commercial lodging of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Policy Exclusions

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt thereat by the Insured Person while sane or self-destruction or any attempt thereat by the Insured Person while insane
2. injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in Part B of Section II, Definition of Injury and Scope of Coverage
3. declared or undeclared war or any act thereof
4. active full time service in the armed forces of any country

Aggregate Limit Per Accident

The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date

Your coverage begins on the date you satisfy the definition of “Insured Employee”.

Termination Date

Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;

3. the date you no longer satisfy the definition of an Insured Employee; or
4. the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

This booklet provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

Notes:

WEEKLY INDEMNITY BENEFIT (WI)

Plan Member Benefit Only

Weekly Indemnity (short term) disability benefits are designed to assist you if you are unable to work because of a non-occupational accident or sickness. Weekly Indemnity benefits are payable on a weekly basis to a maximum of 26 weeks for any one period of disability while you are totally disabled from work and under the care of a legally qualified physician.

Waiting Period

Benefits are payable from the 1st day of the disability if it is the immediate and direct result of an accident. There is a waiting period of 3 days for all other disabilities, including disabilities resulting from accidents which occurred more than 30 days previously or involving pre-existing medical conditions.

If you do not see a physician within the first 4 days of disability, benefits will be paid from the date of your first visit to your physician.

Amount of Benefit - See page 4 of this Booklet entitled “Summary of Benefits”.

Disability

To qualify for benefits you must be completely unable, because of accident or sickness, to perform the duties of your regular job. Your disability must be supported by medical evidence satisfactory to the Plan establishing that you are unable to work. Failure by a Member to provide medical information or other proof of loss within 60 days of the date on which it is requested by the Plan will cause benefits to cease.

WI Claims of a Short Duration - at the discretion of the Plan Administrator, for illness related claims where the Plan’s office has confirmation that a Member has returned to work after 5 consecutive calendar days (please note this includes weekends), **the physician’s statement will not be required.**

Please note, the Short Duration W.I. Claims **still require the completion of page 1 of the Weekly Indemnity Claim form by both the Plan Member and the Employer**. *If submitted and page 1 is not completed **in full** the Weekly Indemnity form will be returned and may require the completion of the physician's statement.*

Rehabilitative Employment

The Trustees may approve rehabilitative employment during a period of your disability, however your WI benefit shall be reduced by 50% of your weekly earnings from such rehabilitative employment. In the event that your income from rehabilitative employment and the WI benefit exceed 100% of weekly earnings, your WI benefit shall be further reduced by such excess amount.

Third Party Claims

If you become disabled as a result of an accident for which a third party is, or may be, directly or indirectly either in whole or in part legally liable, **no Weekly Indemnity benefits will be paid unless you:**

1) Agree to repay the Trustees the full amount of the benefits paid or to be paid by entering into a Reimbursement Agreement with the Trustees outlining the terms and conditions of repayment.

2) Take all steps necessary to recover from the third party the total of the benefits advanced or to be advanced by this Plan, including directing your lawyer to repay the Trustees the full amount of the benefits paid directly from any monies received from any judgement or settlement.

3) Obtain the written consent of the Trustees before compromising or settling the action or cause of action with the third party.

Workers' Compensation Claims – WorkSafeBC

If you suffer an unusual delay in obtaining a decision from WorkSafeBC regarding your claim or if you are appealing the denial of a WorkSafeBC claim with the assistance of a Workers Advocate or if following the denial of a claim for WorkSafeBC benefits, the Trustees deem that the pursuit of an appeal of such denial would not be justified, the Trustees may, at their sole discretion, approve payment of Weekly Indemnity (WI) benefits. Payment of such WI benefits will be limited to the extent that it will not exceed the amount that the Trustees believe may be payable by WorkSafeBC should that claim be accepted.

WI benefits, in this situation would be subject to you signing a “Reimbursement Agreement” with the Plan. By signing the agreement you confirm that if WorkSafeBC benefits are subsequently paid for the same period of disability for which you have received WI benefits, **you will repay the Plan in full**. Failure to do so would fall under the “Recovery of Benefit Overpayments”.

Recovery of Benefit Overpayments

If there are circumstances where WI benefits have been paid to a Member to which there was no entitlement, the Trustees shall have the right to recover such overpayment through the use of any legal procedures or from future WI benefits payable under the Plan.

Limitations (WI)

1) You must remain under the care of and be following the prescribed treatment of a legally qualified physician acting within the scope of his profession throughout your period of disability and the attending physician must provide satisfactory medical evidence to support your inability to work.

2) If you are under the care of and being treated by a qualified chiropractor, dentist, naturopath or podiatrist, but not a physician, benefits are payable for a **maximum 6 weeks**.

3) If you leave your Province of residence during a period of disability benefits will not be paid unless:

   - you obtain approval from the Trustees and your physician to leave; and

   - you remain under the care of a physician while absent from the province.

4) The Plan may request that you have an independent medical examination and will arrange for the appointment and pay for any charges made by the physician. Failure to attend such an examination could result in the termination of your benefits.

5) Benefits payable, in those instances where a Member elects to reside outside Canada, shall be limited to the Benefit that would be payable if the Member resided in the Province in which the Member is employed.

6) During the first 10 weeks of a claim, a successive absence from work will be considered to be the **same period of disability** if the cause is the same or related to the cause of the 1st absence and a return to full time work of **less than one (1) week** has occurred.

If a successive absence is from an unrelated cause and a return to full time work of **less than one (1) full day** has occurred, it will be considered the **same disability period**.

7) During any subsequent portion of a Disability Period, (past 10 weeks but before the 26 week maximum) a successive absence from work will be considered to be the **same period of disability** if the cause is the same or related to the cause of the 1st absence and a return to full time work for less than 30 full days has occurred.

If a successive absence is from an unrelated cause and a return to full time work of **less than one (1) full day** has occurred, it will be considered the **same disability period.**

8) **For successive disabilities which occur after 26 weeks of benefits have been paid,** if the cause is the same or related to the cause of the 1st absence**, a return to** work of **6 months** is required before a new claim for Weekly Indemnity benefits can be considered.

9) If any investigation reveals that you are not following prescribed treatment or that your activities during a period of disability are inconsistent with the definition of disability under the terms of the Plan, your benefits will cease.

10) Pursuant to the terms of the Plan, entitlement to Benefits shall be determined by the Trustees as of the date any Member knowingly and wilfully provides information to the Plan in support of an application for Benefits or a continuation of Benefits that is false, misleading or fraudulent where the information is material to the adjudication of a claim made by the Member.

EXCLUSIONS – Weekly Indemnity (WI)
Benefits shall not be payable:

1) For a disability caused by or resulting from intentionally self-inflicted bodily injury or sickness, while sane or insane.

2) For a disability caused by or resulting from participation in rebellion, riot, or insurrection, war, whether war has been declared or not, or by full or part-time service in any armed forces.

3) For a disability caused by or resulting from participation in or consequence of having participated or having attempted to participate in the commission of an offence under the Criminal Code of Canada or a similar offence under the laws of any other country, or for a disability caused by or resulting from the operation of a vehicle if, when the injuries were received, the claimant's blood contained more than eighty (80) milligrams of alcohol per one hundred (100) millilitres of blood.

4) For a disability caused by or resulting from medical or surgical care which is cosmetic, unless such care is rendered as a result of injuries caused by an accident sustained by you while you were eligible for WI benefits.

5) For any disability which is an occupational disability (incurred in the course of a Member's employment).

6) While you are on paid scheduled vacation.

7) During a Maternity/Parental Leave.

8) During any period when Employment Insurance disability benefits are payable.

9) While you are or could be entitled to Long Term Disability benefits.

10) During any period in which you engage in any occupation for remuneration or profit except as outlined under Rehabilitative Employment in the Weekly Indemnity section of this booklet.

11) For a disability which commenced outside the Member's Province of residence during any period deemed to be vacation or its equivalent, nor during any period prior to the Member returning to his Province of residence except during any period the Member is hospitalized as an "in-patient."

LONG TERM DISABILITY BENEFIT (LTD)

Plan Member Benefit Only

Long Term Disability benefits under the Plan provide coverage if you become totally disabled and such disability has existed for more than 6 consecutive months. The benefits are provided on a monthly basis for as long as you remain totally disabled but not beyond the month in which you attain age 65.

Amount of Benefit

See page 4 of this booklet entitled “Summary of Benefits.”

Employment Insurance (EI) Integration

Long Term Disability benefits are not payable for the 15 week period following expiration of your Weekly Indemnity claim if you are or could be eligible for sickness benefits through the Employment Insurance Act.

Definition of Disability

During the 30 month period following the date on which you became disabled, “disability” means the complete inability due to accident or sickness to engage in your regular occupation. After that period, the disability must be preventing you from engaging in **any occupation** for which you are reasonably qualified by education, training or experience.

Possible Reduction of Benefits

Long Term Disability (LTD) benefits will be reduced in cases where the Plan’s LTD benefit **together with** income received due to the disability from any government program (such as C.P.P. disability benefits) or any other group insurance plan exceeds 85% of your pre-disability earnings.

WorkSafeBC benefits relating to the same disability may also reduce the LTD benefit payable.

Rehabilitative Employment

The Trustees may approve rehabilitative employment during a period of your disability. However, your LTD benefit shall be reduced by 50% of your monthly earnings from such rehabilitative employment. In the event that your income from rehabilitative employment and the LTD benefit exceed 100% of monthly earnings, your LTD benefit shall be further reduced by such excess amount.

Third Party Claims

If you become disabled as a result of an accident for which a third party is, or may be, directly or indirectly, either in whole or in part, legally liable, no Long Term Disability benefit will be paid unless you;

1) Agree to repay the Trustees the full amount of the benefits paid or to be paid.

2) Take all steps necessary to recover from the third party the total of the benefits advanced or to be advanced by this Plan, including directing your lawyer to repay the Trustees the full amount of the benefits paid directly from any monies received from any judgement or settlement.

3) Enter into a reimbursement agreement with the Trustees outlining the terms and conditions under which the benefits are to be repaid.

4) Obtain the written consent of the Trustees before compromising or settling the action or cause of action with the third party.

Recovery of Benefit Overpayments

The Trustees shall have the right to recover from you, through the use of any legal procedures or from future benefits under the Plan, any benefits paid to you to which there was no entitlement.

Limitations – Long Term Disability (LTD)

1) You must remain under the care of and be following the prescribed treatment of a legally qualified physician acting within the scope of his profession throughout your period of disability. The Plan must receive satisfactory medical evidence from the attending physician confirming your inability to work due to disability. Failure by a Member or his physician to provide medical information or other proof of loss within 60 days of the date on which it is requested by the Plan will cause benefits to cease.

2) No benefit shall be payable during a period in which a Member is entitled to receive sickness benefits under the Employment Insurance Act.

3) If you leave your Province of residence during a period of disability benefits will not be paid unless:

- you obtain approval from the Trustees and your physician to leave; and

- you remain under the care of a physician while absent from the province.

4) The Plan may request that you have an independent medical examination and will arrange for the appointment and pay for any charges made by the physician. Failure to attend such an examination could result in the termination of your benefits.

5) Successive absences from work will be considered to be the same period of disability if the cause is the same or related to the cause of the 1st absence and you had returned to full time work for less than 6 calendar months.

6) Successive absences from work will be considered a new period of disability if the cause is entirely unrelated to the cause of the 1st absence and you had returned to full time work for 1 full day.

7) If any investigation reveals that you are not following prescribed treatment or that your activities during a period of disability are inconsistent with the definition of disability under the terms of the Plan your benefits will cease.

8) Entitlement to Benefits shall terminate as of the date any Member knowingly or wilfully provides information to the Plan in support of an application for Benefits or a continuation of Benefits that is false, misleading or fraudulent where the information is material to the adjudication of a claim made by the Member.

EXCLUSIONS (LTD)

Benefits shall not be payable:

1) For a disability caused by or resulting from intentionally self-inflicted bodily injury or sickness, while sane or insane.

2) For a disability caused by or resulting from participation in rebellion, riot, or insurrection, war, whether war has been declared or not, or by full or part-time service in any armed forces.

3) For a disability caused by or resulting from participation in or consequence of having participated or having attempted to participate in the commission of an offence under the Criminal Code of Canada or a similar offence under the laws of any other country or for a disability caused by or resulting from the operation of a vehicle if, when the injuries were received, the claimant's blood contained more than eighty (80) milligrams of alcohol per one hundred (100) millilitres of blood.

4) For a disability caused by or resulting from medical or surgical care which is cosmetic, unless such care is rendered as a result of injuries caused by an accident sustained by you while you were eligible for LTD benefits.

5) During a Maternity/Parental Leave.

6) During any period when Employment Insurance disability benefits are payable.

7) During any period in which you engage in any occupation for remuneration or profit except as outlined under Rehabilitative Employment.

8) For a disability caused by or resulting from a motor vehicle accident.

MISCELLANEOUS

The following supplementary information may be useful to you when you are claiming benefits under the Plan. If you require additional information or guidance, call the Plan's office and the staff will be pleased to assist you.

You may mail, email or fax claims to our office. For email claim submissions, PDF document format only will be accepted. No cell phone photos; your claim will be returned.

Email: benefits.pensions@teamstersbenefits.ca

Fax: **604-552-2653**

The Plan also provides direct deposit. The applicable forms are available on the Plan website. www.teamstersbenefits.ca

Dual Coverage – Co-ordination of Benefits

In the event that an eligible person is also entitled to benefits under any other group insurance program or insurance policy, benefits will be co-ordinated with the other plan or insurer to ensure that the total benefit paid from all sources does not exceed 100% of the reasonable charges for the services and supplies provided.

If your Spouse is covered under another plan, we follow the guidelines of the Canadian Life and Health Insurance Association. These guidelines are used by most, if not all, insurers in Canada.

We are the primary insurer for your expenses. Your Spouse's insurer is the primary carrier for your Spouse's expenses. Dependent children become the primary responsibility of the plan who insures **the parent who has the earliest birth-date in the year (month and day**).

If the Plan is the secondary carrier, you must remit copies of receipts paid by the primary carrier along with their statement of payment details.

How to Make a Claim

Prescription Medications

For persons for which we have primary responsibility (see Dual Coverage - Coordination of Benefits, above), the Plan will pay its portion of your claim to the Pharmacist at the time you get your prescription filled. Simply give the Pharmacist the information from your prescription medication card.

If we are not the primary insurer, you should make copies of the receipts and then claim the expense with your Spouse's plan. Once the primary insurer has settled the claim, complete an Extended Health Benefit Claim form and send the copy of the receipt and the other insurer's claim details to us. If you are submitting your claims by email, claim forms and receipts must be submitted in PDF format.

Please note that the prescription medication card does not work outside of Canada **and will only be activated if you have provided the Plan with Proof of Registration under the Fair Pharmacare program.**

Other Expenses

For any other eligible expenses obtain an Extended Health Benefit Claim form from your Employer, the Plan's office or online at www.teamstersbenefits.ca Claim forms must be completed in full and submitted to the Plan along with photocopies of your receipts. When submitting claims by email, your claim form and receipts **must be** submitted in PDF format.

Claims for any calendar year must be submitted within 12 months from the end of that calendar year.

Dental

For basic and major services a B.C. Standard Dental Claim form (most dentists maintain a supply) must be completed by the dentist and forwarded to the Plan Office.

Claims must be submitted within 12 months of the date in which the service was performed.

For orthodontic services, expense receipts should be submitted as treatment occurs. Please note the Plan does not provide payment in advance of treatment.

Group Life and Accidental Death & Dismemberment

Contact the Plan office for the necessary forms.

Weekly Indemnity

Claims must be submitted within 90 days of the onset of disability.

Obtain a form from your Employer or online @ www.teamstersbenefits.ca
Please complete the Plan Member section, then have your employer complete their section along with your physician. Once the form is fully completed, then forward it to the Plan office.

Long Term Disability

Claims must be submitted within 120 days of the end of the qualification period. (Employment Insurance Sickness Benefits)

If you receive the Weekly Indemnity benefit for the maximum period contact the Plan Administrator to request the necessary forms to apply for the Long Term Disability benefit.

Please note, if you have received WorkSafeBC benefits for 6 months or more contact the Plan office to determine your possible entitlement to continuation of your Life Insurance and Accidental Death and Dismemberment benefit.

Disability Waiver

The disability waiver provision (continuation of coverage while you are disabled) under the Group Life insurance and Accidental Death and Dismemberment is automatically included once your claim has been accepted for Long Term Disability benefits.

If you are totally disabled and receiving benefits from WorkSafeBC, you must contact our office with your claim number.

Change of Status

It is to your benefit to notify your employer and the Plan office immediately, if:

1) You change your mailing address.
2) You wish to change your beneficiary.
3) Your marital status changes.
4) The number and/or name of your dependants change.
5) You change your name.
6) You change your social insurance number.

Note: Not having the correct information on file may result in non-payment of your claim or may delay the payment of benefits.

Taxable Benefits

Under the provisions of the current Income Tax Act, the monthly cost of Group Life insurance premiums and AD&D premiums paid on your behalf by an Employer are considered taxable income. The amounts of Weekly Indemnity and Long Term Disability benefits received by you are also considered taxable income.

Each year, prior to the end of February, the Plan will issue a T4A for your taxable benefits for the previous year for Group Life and AD&D premiums and any applicable Weekly Indemnity or Long Term Disability benefits. You must include this income when filing your tax return.

Claim Appeal Process

In those instances where a Member feels that a claim for a Weekly Indemnity benefit, Long Term Disability benefit, Dental benefit or Extended Health benefit has been denied or settled in a manner unsatisfactory to the Member, the Member shall have the right to present a request for appeal to the Trustees:

1. The Member must present in writing to the Trustees of the Plan a request to have the claim reviewed. The request for review must be sent to the Administrator of the Plan at the Plan's address within 90 days of the date on which the claim was denied or settled in a manner unsatisfactory to the Member. Requests received after this time period will be denied.

   The request should clearly state the reasons that the Member feels should justify a review of the claim and should be accompanied by supporting medical or other information that will assist the Trustees in their deliberations.

   The Trustees will, as soon as is reasonably possible after receiving the request for review, examine the claim and advise the Member that:

   a) The information provided with the request for review is sufficient to allow a reversal of the original claim decision, or;
   b) The Trustees are satisfied that the original claim decision was correct under the terms of the Plan and a Hearing will not be granted, or;
   c) The information provided with the request is insufficient to allow reversal of the original decision, but further investigation is warranted.

      The Trustees will set a date for a Hearing of the Claims Review Committee at which time the Member may present his case and supporting information in person.

2. The Claims Review Committee will be comprised of those persons determined by the Trustees to be best suited to arrive at a fair and reasonable resolution of the issues. The Committee will include at least two Trustees.

3. The Member may be required to attend the Hearing but may be represented by or assisted by their Union Business Representative.

4. In submitting claims for review, Members should be aware that the Trustees are able to:

   a) Interpret information that is submitted with respect to a claim to determine if the claim meets the conditions specified by the Plan,

   b) Amend the terms of the Plan with respect to coverage on the understanding that it applies to all Members but are not able to make exceptions to the terms of the Plan to accommodate individual Member's concerns.

5. ***All decisions made by the Trustees with respect to the determination of a Member's entitlement to benefits are final and binding on all parties involved in accordance with Article VI of the Plan's Agreement and Declaration of Trust.***