TEAMSTERS' NATIONAL BENEFIT PLAN

PLAN SUMMARY

TEAMSTERS LOCAL 31 MEMBERS

January 1, 2025

Teamsters' National Benefit Plan
Table of Contents

ACRONYMS

AD&D	Accidental Death and Dismemberment
CLHIA	Canadian Life and Health Insurance Association
EFT	Electronic Funds Transfer (direct deposit)
EHB	Extended Health Benefits
EI	Employment Insurance
MDF	Member Data Form
MSP	Medical Services Plan of BC
LTD	Long Term Disability
WI	Weekly Indemnity (Short Term Disability)

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

Stan Hennessy, Chair
Mike Hennessy
Caley Fieldhouse

TEAMSTERS' NATIONAL BENEFIT PLAN ADMINISTRATION OFFICE

1610 Kebet Way
Port Coquitlam, BC V3C 5W9

Phone: 604-552-2650 (Toll Free: 1-888-478-8111) Fax: 604-552-2653
Email: benefits.pensions@teamstersbenefits.ca
Website: teamstersbenefits.ca

TEAMSTERS LOCAL NO. 31 UNION OFFICE

1 Grosvenor Square
Delta, BC V3M 5S1

Phone: 604-540-6009 (Toll Free: 1-877-LOCAL31) Fax: 604-540-6073
Website: teamsters31.ca

ACTUARY

Allen Furlong – Actuarial Consultant – Dion Strategic
Ed Lee – Actuarial Investment Consultant – Telus Health

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	MAXIMUM
Group Life Insurance	$50,000
AD&D Principal Amount	$60,000
EHB	Page 8
Dental	Page 16
WI - 75% of pre-disability earnings to a weekly maximum of	$ 695
LTD - 85% of pre-disability earnings to a monthly maximum of	$ 1,200

INSURED BENEFITS ARE UNDERWRITTEN BY THE FOLLOWING:

The Co-Operators
Group Life Insurance and Out of Province Emergency Treatment Provider
Policy 42101
Voluntary (self pay) Optional Life – Policy 42101-2

AIG Insurance Company of Canada (AIG Canada)
AD & D
Policy BSC 9112494A

TELUS ADJUDICARE CLAIMS SUBMISSION

Dental	Carrier 000034, Group 60521
EHB	Carrier 34, Group 60521
Pharmacy (Assure)	Carrier 34, Group 060521

WI and LTD CLAIMS SUBMISSION

Plan Office

ELIGIBLE EMPLOYEE PROVISIONS

Union Members: You must be a Member in good standing of Teamsters Local 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 later. All other provisions of the Plan will all 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 if paragraph (i) does not apply, a person who lives with the Member as husband and wife or 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.

- 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 has been certified by a Physician to be of a permanent intellectual disability or a permanent physical disability and is unable to perform duties in any occupation, provided the Child relies principally upon the Member for support.

- If 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 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 became 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 Date

A. Dental, Extended Health Benefit, Group Life and AD&D

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 of 12 months 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; or,

- 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 late date of the month in which your death occurs.

EHB Coverage for Long Term Disability Claimants

Claimants who qualify to receive LTD Benefits under the Plan will continue to receive EHB coverage for the duration of the LTD claim. This Plan pays for the cost of this Benefit.

Continuation of the Benefit is subject to approval by the Trustees. If death occurs while receiving LTD Benefits, EHB 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 disability waiver provisions of the Group Life and AD&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 WI or LTD Benefits commencing with the date you would have returned to work. If you are receiving EI Benefits, WI or LTD Benefits will not be payable until the EI 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 WI or LTD Disability Benefits commencing with the date you would have returned to work. If you are receiving EI Benefits, WI or LTD Benefits will not be payable until the EI Benefits cease.

Retiree Benefits

EHB and AD&D Benefits are available to eligible Retirees. Please contact the Plan office for details.

Reinstatement of Coverage

If you are laid off and return to work with the same Participating Employer as a regular employee for one shift (unless other conditions are specified in the Collective Agreement) coverage for EHB and Dental Benefits for you and your eligible dependents will be reinstated retroactively to the first day of the calendar month in which you return to work. Your WI, LTD, Group Life and AD&D coverages will be reinstated the day you return to work.

Member Data Form (MDF)

This form is required for enrolment to designate your Beneficiary as well as activate coverage for your dependents. Once the Plan has received the Authorization Form from your employer to activate coverage, an MDF must be completed by you and returned to the Plan office. The form is available on the Plan's website, at the Plan office, or from your employer.

FRAUD

If a Member or Dependent or any other person entitled to Benefits obtains, or attempts to obtain, a Benefit to which such person it 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:

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 Benefits;
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 a 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 BENEFITS (EHB)

This Benefit is designed to **assist** you in the paying for certain services and supplies not covered under the Government's basic medical coverage, the Medical Services Plan or BC (MSP). 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 prices charged by suppliers of services or equipment may vary considerably. We suggest, when practical, compare prices.

Maximum Benefit

The maximum Benefit payable for prescription medications in any calendar year (January 1 – December 31) is $2,500 per person. Please see "Eligible Expenses" on page 9 for Benefit limitations.

Co-ordination of Benefits

In the event that the 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 or 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, benefit providers in Canada.

We are the primary payor for your expenses. Your Spouse's benefit provider is the primary carrier for their expenses. Dependent children become the primary responsibility of the plan of **the parent who has the earliest birthdate in the year (month, day)**.

EHB Eligible Expenses (in province)

Pharmaceuticals – 100%

effective April 1, 2025 the maximum eligible dispensing fee will be increased to $11.99. Dispensing fee can change without notice*

1. Medications approved for purchase 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 – please refer to the "Exclusions and Limitations" on page 13 of this Booklet.
    b.) Unless your doctor specifically requires that no substitutions be used, the Plan will pay for the generic equivalent of the name brand medications.
    c.) The Plan has a strict 90-day supply limit on all prescription medications.

Treatment providers must be Registered Practitioners of BC, or similar association of the Province or Territory in which the Member resides, up to the limits set out by the Plan.

EHB – 80%

Coverage is 80% of the accepted customary fees as approved by the Board of Trustees.*

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 are 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 supplements are excluded.

4. **PHYSIOTHERAPIST / OCCUPATIONAL THERAPIST / 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. **REGISTERED MASSAGE THERAPIST** – customary fees not exceeding $100 for 60-minutes, $80 for 45-minutes, $55 for 30-minutes 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 are excluded.

7. **LICENSED REGISTERED PSYCHOLOGIST, REGISTERED CLINICAL COUNSELLOR, CANADIAN CERTIFIED COUNSELLOR, REGISTERED THERAPEUTIC COUNSELLOR, SOCIAL WORKER (with master's degree)** – 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 the Member.

11. **CRUTCHES / CANES / 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. **PROSTHETIC LIMBS / PROSTHETIC EYES** – to a maximum Benefit of once in any consecutive 36-month period and only if Pre-Authorization is obtained from the Trustees. Replacement items are covered only when the original or previously covered equipment is no longer functional.

13. **OXYGEN** – charges for oxygen and its administration, blood or blood plasma and its administration.

14. **OSTOMY / ILEOSTOMY** – charges for certain ostomy and ileostomy supplies and materials as determined by the Trustees from time to time.

15. **SPLINTS / CASTS / AIR-CASTS / TRUSSES / 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 as 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. **CPAP MACHINE / 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. CPAP masks, hoses, and filters are covered once every 12 months from date of purchase.

18. **ORTHOPAEDIC SHOES** – must be custom-made and prescribed by a physician to a maximum Benefit of $150 per pair, per person. Limit of 2 pair per calendar year.

19. **FOOT ORTHOTICS** – must be custom-made and prescribed by a physician, chiropractor, or podiatrist for daily use to a maximum Benefit of $200 per person in any 24 consecutive month period. Dependent children to a maximum Benefit of $200 per person in any 12 consecutive month period.

20. **SUPPORT HOSE / COMPRESSION SOCK / STOCKINGS** – when prescribed by a physician and limited to 2 pair per person, per calendar year.

21. **WIGS / HAIR PIECES** – when prescribed as a result of a medical treatment or accident to a maximum Benefit of $500 per person per lifetime.

22. **MASTECTOMY PROSTHESES** – maximum 1 per side in any 24 consecutive month period.

23. **MASTECTOMY BRASSIERES** – following purchase of initial prostheses to a maximum Benefit of $150 per calendar year.

24. **DURABLE EQUIPMENT** – charges for the rental or, where more economical, the purchase of durable equipment when prescribed by a physician for therapeutic treatment including hospital beds and wheelchairs. Charges for electric wheelchairs and mobility scooters are covered only when pre-approved by the Trustees. Coverage for electric wheelchairs or mobility scooters may require additional information from the physician and/or occupational therapist confirming the equipment is medically necessary.

25. **HEARING AIDS** – when prescribed by a physician to a maximum Benefit of $500 per ear during any 36 consecutive month period.

26. **ASSISTIVE LISTENING DEVICES** – when prescribed by a physician to a maximum Benefit of $400 per person 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 eyewear claims must be paid in full to be considered for reimbursement. Qualification period is 2 years from the date of last purchase.

28. **EYE EXAMINATIONS** – by a licensed optometrist to a maximum Benefit of $50 in any 24 consecutive month period. Qualification period is 24 months from the date of last exam.

29. **TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) 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 one 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 in the Dental Benefit portion of the Plan, required as a 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 the 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 and short stay facilities.

36. **HOSPITAL ROOM** – differential for private and semi-private accommodations.

37. **PULSE MONITORING EQUIPMENT** – when prescribed by a physician in conjunction with a prescribed heart therapy program, to a maximum Benefit of $150 per person, per lifetime.

38. **PLANTAR WART TREATMENT** – as recommended by a physician, for laser treatment for plantar warts that are resistant to standard therapy. Coverage is limited to $80 per treatment to a maximum Benefit of $350 per person, $750 per family, per calendar year.

TREATMENT FOR ADDICTION – PLAN MEMBER ONLY

Coverage for the treatment of addiction ***MUST*** be approved by the Board of Trustees. Treatment coverage is limited to services provided by a licensed treatment facility recognized by the Province of British Columbia or the Yukon Territories to a maximum Benefit of $4,500 per lifetime and is paid directly to the provider.

ELIGIBLE EXPENSES – OUT OF PROVINCE

6 week maximum per Out of Province visit – ***LIFETIME*** maximum of $5,000,000.00 per person.

Eligible expenses shall include **reasonable and customary charges incurred during the first 6 weeks of absence from the Member's province of residence** for the following expenses as a 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 MSP, PharmaCare, any other medical plan or plan 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 occupied if ward accommodation is not available, or if required by a physician, but not charges for the rental of telephones, televisions, internet, radio or similar equipment.

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

3) Charges for eligible medications 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 to obtain additional coverage from a travel insurance provider PRIOR to leaving.

Out of Province coverage is *NOT PROVIDED* for you or your dependents if you are travelling against the advice of your physician, or if the Government of Canada has issued a health advisory or travel advisory to your destination.

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
In Canada and USA: 1-888-440-2667
Worldwide Call Collect: 1-416-340-1316
Group Policy Number 42101
Please also have on hand your Client ID Number / Certificate Number

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 MSP, 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 BC, except as provided under the dental and EHB 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 on Page 12.

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 on page 12.

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 the 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 Service Act of BC.

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, supplements, fertility treatment, or for cosmetic purposes.

15) Expenses for repairs, maintenance, batteries, re-charging devices, or other such accessories for hearing aids, wheelchairs, scooters, and 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 the eligible person of any unlawful act including an offence under the Criminal Code of Canada or similar offence under the laws of any other country.
    - Injuries received due to the operation or a vehicle, if, when the injuries were received, the claimant's blood contained equal to, or more than eighty (80) milligrams of alcohol per one hundred (100) millilitres of blood.

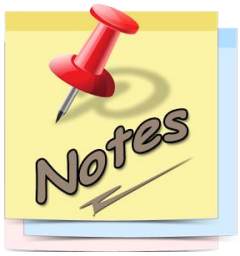
17) Services and supplies the person is entitled to without charge by law or for which a charge is made only because the person has insurance coverage.

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 services:
    - 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 or 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, 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 BENEFITS

This Benefit is divided into three separate services:

- **BASIC** – 100% reimbursement of accepted fees for all eligible persons.

- **MAJOR** (Predetermination required) - 80% reimbursement of accepted fees for Member, Spouse and eligible dependent children ***over*** the age of 21; 100% for dependent children ***under*** the age of 21.

- **ORTHODONTIC** (Predetermination required) – 50% reimbursement of accepted fees for all eligible persons.

MAXIMUM BENEFIT

- The maximum Benefit payable for all eligible persons for Basic and Major services ***COMBINED*** is $3,000 in any calendar year (January 1 to December 31).

- The maximum ***LIFETIME*** Benefit payable for Orthodontic services for all eligible persons is $3,000.

PREDETERMINATION

If the proposed dental treatment exceeds $500, involves the use of gold, crowns, bridgework or dentures, or involves the treatment to be provided by a specialist, a treatment plan should be submitted to the Plan office for prior review. A copy of the Predetermination will be sent to both the Member and the dentist confirming the amount that will be eligible for payment 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 practitioner's 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 the responsibility of the Member.

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 exceed100% of the accepted fee by the Plan.

If your Spouse is covered under another plan, we follow the guidelines of CLHIA. These guidelines are used by most, if not all, insurers in Canada.

We are the primary payor for your expenses. Your Spouse's benefit provider is the primary payor for their expenses. Dependent children become the primary responsibility of the plan which insures the parent who has the earliest birthdate in the year (month and day).

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 every 36 months.
    - Full mouth series of x-rays are limited to once every 36 months.

2) **Preventative 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 and fissure sealants, and restorative resins are limited to once per tooth in any 24- month period.
    - For scaling, root planning, and gingival curettage limits, see periodontic Services on page 18.

3) **Restorative Services** – covered procedures necessary to restore natural teeth which have broken down as a 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 molars.

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 planning, 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) **Prosthetic Services** – 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 conditioning 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 the 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 once in any 60-month period and not within 24 months of a partial denture in the same arch.
    - Partial dentures 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 Dependent is covered under the Plan.

- Examinations, 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 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 if coverage had 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 MSP, 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 crown, 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.

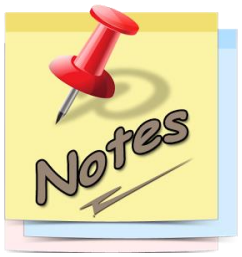
10) Porcelain facings on crowns or pontics on second or third molars.

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 designated on the MDF the Plan has on record. 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 a signed copy of beneficiary appointments be submitted to the Plan's office.

Please contact the Plan office if you wish to confirm your beneficiary on file. You may change your beneficiary whenever you wish, subject to applicable laws, by completing a Change of Beneficiary form. This form is available at the Plan office or online at 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 when the 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 of $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

While covered under the Plan, should you become disabled due to sickness or accident, and qualify for LTD Benefits under the Plan, your Group Life Insurance will continue in effect while you remain in receipt of LTD and are under the age of 65. Medical evidence must be submitted upon request.

If you become disabled, as defined in the LTD 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 the conversion privilege. This is only available to Plan Members under the age of 70.

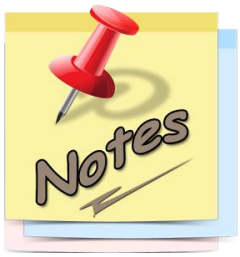
Conversion Privilege

Only for Plan Member 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 several 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 would ordinarily pay if your applied for an individual policy at that time. If you become deceased during this 31-day period, your Group Life Insurance will be paid whether or not you have applied for an individual policy.

Optional Life Insurance

This is a self pay provision. Please contact the Plan office for further details.



Basic Accidental Death & Dismemberment Insurance (AD&D)
AIG Insurance Company of Canada
Policy Number: BSC 9112494A

Why Do 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 resources to fulfil their financial responsibilities.

Your Plan 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 or a limb, sight, speech, or hearing.

How Does It Work?

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

What Do You Get?

Broad Accident Insurance Coverage – Your plan provides comprehensive AD&D Benefits for injuries as a result of covered accidents.

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

Definitions

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

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 more than 25 hours per week; or (iii) by reason of intellectual or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Canadian Income Tax Act .

Beneficiary Designation

You have the option to designate a beneficiary; however, should you choose not to, in the event of accidental or 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 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 on 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 Use 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 confinement 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 for 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 150km 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 50km 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 the age of 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 Fasciitis
- ✓ 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 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.

Continuation of Coverage – Your coverage will continue for up to 12 months during a temporary layoff, short term disability leave, approved leave of absence, or maternity leave, provided premiums are paid.

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.

Burns 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 as least 150km 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 threat by the Insured Person while sane or self-destruction, or any attempt threat by the Insured Person while insane;

2. injury sustained as a 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 of 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 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 by the Company.

Effective Date

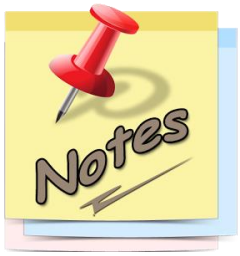
Your coverage begins on the date you satisfy the definition of “Insured Employee”.

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.



WEEKLY INDEMNITY BENEFIT (WI)

Plan Member ONLY – must apply within 90 days of date of disability

WI (short term) Disability Benefits are designed to assist you if you are unable to work because of a non-occupational accident or sickness. WI 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 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 duties at 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, (including weekends), the physician's statement will ***NOT*** be required.

Please note, Short Duration WI 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 WI Form will be returned and may require 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 employment. In the event that your income from rehabilitative employment and the WI Benefits exceeds 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, WI Benefits will ***NOT*** 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 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 Worker's 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 the 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 their 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 of 6 weeks**.

3) If your leave your Province of residence during a period of disability, Benefits will not be paid.

4) The Plan may request that you have an independent medical examination and you 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 of 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 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 that 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 the subsequent portion of a Disability Period, (past 10 weeks but before the 26-week maximum), a successive absence from work will be considered 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 WI claim can be considered.

9) If an investigation reveals that you are not following the 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 willfully 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 – 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 or by 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 claimants blood contained equal to, or 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 maternity / parental leave.

8) During any period when Employment Insurance Disability Benefits are payable.

9) While you are or could be entitled to LTD Benefits.

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

11) For a disability which commenced outside the Member's Province of resident during any period deemed to be a 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 in-patient.

LONG TERM DISABILITY (LTD)
Plan Member ONLY

LTD 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 monthly for as long as you remain totally disabled but not beyond the month in which you become 65 years of age.

Amount of Benefit

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

Employment Insurance (EI) Integration

LTD Benefits are not eligible during the 26-week period following the expiration of your WI 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

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 CPP Disability Benefits), or any other group insurance plan exceeds 85% of your pre-disability earning.

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 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 LTD 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 – 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 their 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 the 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 resident during a period of disability, Benefits will not be paid unless:
    - Your 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 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 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 application 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 in or consequence of have 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 claimants blood contained equal to or 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 your while you were eligible for LTD Benefits.

5) During 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 renumeration or profit except as outlined under Rehabilitative Employment.

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

ON-LINE CLAIM SUBMISSION

The following information may be useful to you when you are claiming Benefits under the Plan. If you require additional information or assistance, please contact the Plan office.

ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE / PURCHASE

DENTAL CLAIMS

Telus Adjudicare (E-Dental)
Carrier 34 / Group 60521 / Client ID (certificate number)

EHB CLAIMS

Telus Adjudicare
Carrier 34 / Group 60521 / Client ID (certificate number)

PRESCRIPTION CLAIMS

Telus Assure
Carrier 000034 / Group 060521 / Client ID (certificate number)

Please submit the claims through the "Teamsters' National Benefit Plan" App

You can also access the claims submission portal through your desktop by logging on at:

tnbp.onlineclaimsaccess.net

Please ensure you are registered. If you require assistance, please contact the Plan office. Further directions are also available on our website: teamstersbenefits.ca

DISABILITY CLAIMS

WI Claim Forms are available on our website or at the Plan office. Please submit your WI or LTD claims directly to the Plan office:

Mail: 1610 Kebet Way, Port Coquitlam BC V3C 5W9
Email: benefits.pensions@teamstersbenefits.ca
Fax: 604-552-2653

DUAL COVERAGE (CO-ORDINATION OF BENEFITS)

If 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 Plan or insurer to ensure that the

total Benefit paid from all sources does not exceed 100% of the reasonable charges for the services or supplies provided.

If your Spouse is covered under another plan, we follow the guidelines of CLHIA. These guidelines are used by most, if not all, insurers in Canada.

We are the primary payor for your expenses. Your Spouse's benefit provider is the primary payor for their expenses. Dependent children become the primary responsibility of the plan who insures **the parent who has the earliest birthdate in the year (month / day)**.

PRESCRIPTION MEDICATIONS

Your pharmacy will bill the Plan for your expenses as well as any eligible dependents in which we are the primary Plan. Your Spouse's plan will be billed for their expenses as well as any eligible dependents in which they are the primary plan for. Once the primary plan has paid, you may then submit to the Plan office for secondary plan adjudication.

DENTAL CLAIMS

If your dental office does not bill electronically, please have them submit a **Standard Dental Claim Form** directly to the Plan office.

For orthodontic services, please submit your receipts as treatment occurs. Please note the Plan does ***NOT*** provide payment in advance of treatment.

GROUP LIFE AND AD&D

Please contact the Plan office directly for the necessary forms.

WI

Claims must be submitted within 90 days of the onset of disability. Claims forms are available on our website. Please complete the Plan Member section, have your employer complete their section, along with the attending physician's statement (page 2 of the form).

LTD

Claims must be submitted within 120 days of the end of qualification period (EI Sickness Benefits). If you received the WI Benefit for the maximum period, please contact the Plan office to request the necessary forms to apply for the LTD Benefit. **PLEASE NOTE:** If you have received WorkSafeBC Benefits for 6 months or more, please contact the Plan office to determine your possible entitlement to continuation of your Life Insurance and AD&D.

DISABILITY WAIVER

The disability waiver provision (continuation of coverage while you are disabled) under the Group Life and AD&D is automatically included once your claim has been accepted for LTD Benefits.

If you are totally disabled, and are receiving Benefits from WorkSafeBC, you **must contact the Plan office with your claim number**.

CHANGE OF STATUS

You must report to the Plan office immediately if:

- you change your mailing address or any contact information.
- you wish to change your beneficiary.
- your marital status changes.
- the number of, and or the name of your dependents change.
- you change your name.
- you change your Social Insurance Number.

Please note that 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 provision 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 amount of WI and LTD Benefits received by you are also considered taxable income.

T4A's are issued each year prior to the end of February. Pursuant to the Income Tax Act, **you must include** this income when filing your taxes.

CLAIM APPEAL PROCESS

In those instances where a Member feels that a **claim** for a WI, LTD, Dental, or EHB 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 an unsatisfactory manner to the Member. Requests received after 90 days will be denied.

2) 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 the deliberations.

The Trustees will, as soon as reasonably possible, review the request, 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;

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.

3) 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 to the issues. The Committee will include at least two trustees.

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

5) 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 on the Plan to accommodate individual Member's concerns.

6) 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.