TEAMSTERS' NATIONAL BENEFIT PLAN

PLAN D

January 1, 2014

TEAMSTERS' NATIONAL BENEFIT PLAN - COVERAGE LEVEL D

INDEX

INTRODUCTION

The Plan became effective 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. Terry Tyler
Mr. Richard Van Grol

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

This booklet can be viewed online at www.teamsters31.ca

Consultant and Actuary:

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 Trustees.

SUMMARY OF BENEFITS

- Group Life Insurance $ 50,000
- Accidental Death, Disease & Dismemberment (A.D.& D.) Principal Amount $ 60,000
- Dental see page 21
- Extended Health Benefit (E.H.B.) see page 10
- Weekly Indemnity (W.I.) 75% of pre-disability earnings to a maximum weekly benefit of $ 550
- Long Term Disability (L.T.D.)(monthly) $ 1,000

BENEFITS ARE UNDERWRITTEN BY THE FOLLOWING:

Great West Life Assurance Company

Group Life
Policy No. 325335

AIG Insurance Company of Canada (AIG Canada)

Accidental Death, Disease and Dismemberment
Policy BSC 9112494

Teamsters' National Benefit Plan

Dental	(self insured)
Extended Health	(self insured)
Weekly Indemnity	(self insured)
Long Term Disability	(self insured)

ELIGIBILITY PROVISIONS

Eligible Employees

- Union Members

  You must be a member in good standing of Teamsters Local Union No. 31 and a regular employee or dependent contractor of a participating company. 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 19 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 mentally or physically handicapped to the extent that such child is incapable of self support provided the child relies principally upon you for support and resides with you may be covered for EHB and Dental benefits only.

In the event that you are legally separated or divorced and the courts order you to provide coverage for your dependents, dependents shall include:

- Any child who resides with your former Spouse and meets all other conditions of being a dependent, and

- A former Spouse, provided you have not appointed another Spouse.

Please note the Plan must be provided with a copy of the court document to determine eligibility requirements.

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 (E.H.B.), Group Life and A.D.& 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 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 dependents for 12 months following the last day of the month in which your death occurs;

E.H.B. Coverage for Long Term Disability Claimants. If you became disabled on or after January 1, 1989 and 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 dependents for 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.

Continuing Benefits (Self Pay Provision)

If your coverage under the Plan terminates you may personally apply to continue coverage in the Plan's standard form (*please contact our office for details*) for a maximum of 12 months for E.H.B., Group Life and A.D.& D. If your employer has been providing basic medical (M.S.P.) coverage through the Plan, you may continue this coverage as well. **Application must be received within 30 days of coverage terminating** and subsequent payments must be received by the 15th of each month.

Continuing Benefits are not available if:

- you have attained age 65, or;
- you are totally disabled and receiving Long Term Disability benefits under this Plan. (The Plan currently provides Group Life, A.D.& D. and Extended Health Benefits at no cost to members who are in receipt of Long Term Disability Benefits from the Plan.)

To qualify for Continuing Benefits you must remain a member of the Union in good standing.

This coverage **does not** include **Weekly Indemnity, Long Term Disability or Dental benefits.**

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 dependents 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 and & 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) should be completed and returned to the Plan Administrator. If your employer is providing medical coverage (M.S.P.) through the Plan, you must also complete an M.S.P. application or, if you have medical coverage privately, you must complete a form in which you waive entitlement to this coverage.

Notes:

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 and the Hospital Programs of B.C. 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 that, whenever practical, you should compare prices.

Deductible

The Plan has a $2.00 per prescription deductible on pharmaceuticals.

Maximum Benefit

The maximum benefit payable for prescription drugs 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 Benefits”.

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

In the event of marital breakup, coverage for dependents varies depending upon custody and other coverage in effect. Please see page 6 and/or contact the Plan for further details.

Pharmacare

The Provincial Fair Pharmacare programs 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 (less the $2.00 prescription fee) provided you have not reached the Plans $2,500 annual per person limit.

IMPORTANT --- The Fair Pharmacare program is based on income and it is necessary for you to make application to them 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 drug card will be activated and before any prescription drugs will be eligible for reimbursement.

Eligible Expenses - In Province (reimbursed at 80%)

1) Drugs approved for sale in Canada for the treatment of illness or disease which are available only by prescription and when prescribed by a Physician with the exception of drugs determined by the Trustees to be "lifestyle" drugs. Lifestyle drugs are described under the "Exclusions" section of the booklet on page 18.

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

    - The Plan has a 90 day supply limit on all prescription drugs.

- If a drug 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 be then applied to your Pharmacare deductible. Please ask your pharmacist for further details.

2) Chiropractor - customary fees not exceeding $40 per visit of a licensed chiropractor to a maximum benefit of $350 per person, $750 per family per calendar year (x-rays excluded).

3) Naturopath - customary fees not exceeding $40 per visit of a licensed naturopath to a maximum benefit of $350 per person, $750 per family per calendar year, (testing fees, x-rays and medication excluded).

4) Physiotherapist - customary fees not exceeding $40 per visit of a licensed physiotherapist to a maximum benefit of $350 per person, $750 per family per calendar year.

5) Massage Therapist - customary fee not exceeding $40 per visit of a licensed massage therapist to a maximum benefit of $350 per person, $750 per family per calendar year.

6) Podiatrist - customary fees not exceeding $40 per visit of a licensed podiatrist to a maximum benefit of $350 per person, $750 per family per calendar year (x-rays and appliances excluded).

7) Licensed Psychologist or Registered Clinical Counsellor – counselling with a licensed psychologist or registered clinical counsellor to a maximum per visit fee of $60 to a combined maximum benefit of $350 per person, $750 per family per calendar year.

8) Speech Therapist – customary fees not exceeding $40 per visit of a licensed speech therapist to a maximum benefit of $350 per person, $750 per family per calendar year.

9) Acupuncturist - customary fees not exceeding $40 per visit of a licensed acupuncturist to a maximum benefit of $350 per person, $750 per family per calendar year.

10) Registered Nurse - when referred - customary fees to a maximum 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 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, aircasts, 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 fitted 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 when prescribed by a physician for the treatment of sleep apnea to a combined maximum benefit of $1,600 in any consecutive 36 month period. C.P.A.P. masks, equipment, hoses and fittings once every 12 months (filters excluded).

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 – 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, when prescribed by a Physician, of durable equipment 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 and when satisfactory evidence is received from the Member's Physician that the equipment is medically necessary.

25) Hearing Aids to a maximum benefit of $500 for each ear during any 36 consecutive month period.

26) Assistive Listening Devices 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 $250 per person in any 24

consecutive month period, subject to the 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,
(Subject to Extended Health Benefit Exclusion and Limitations 1.)

29) TNS Equipment – when prescribed by a physician to a maximum benefit of $400 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

The Plan will pay 100% of the treatment fees in a residential treatment centre, licensed by the Province of British Columbia or the Yukon Territories at the normal cost for such treatment as recognized by those governments to a maximum benefit of $4,500. This benefit is available once per lifetime. 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., the Hospital Programs 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 $1000, the prior approval of the Trustees.

As noted above, this coverage is limited to a maximum period of absence from your Province of residence of 6 weeks. <u>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.</u>

<u>Out of Province coverage is not provided for you or your dependents if travelling outside your Province of residence against the advice of your Physician.</u>

All out of Province claims are now facilitated through FrontierMEDEX, an international firm specializing in claims of this nature.

Should you require emergency treatment while travelling please have your hospital or physician call FrontierMedex directly.

Toll free in North America 1-800-527-0218
Worldwide 1-410-453-6330

FrontierMEDEX PLAN Identification Number 347521

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., the Hospital Program 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 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.

4) 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.

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

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

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

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

9) 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.

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

11) Charges of a Physician, Chiropractor, Naturopath, Physiotherapist, Massage Practitioner or Acupuncturist which are:

- For a medical examination required for the use of a third party.
- For the completion of forms or reports for any purpose.
- In excess of the schedule of fees allowed under the government medical plan in your province of residence, whether or not a participant in the Basic Medical Plan.

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

13) 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.

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

15) 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.

16) 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.

17) Services or supplies not listed as covered expenses.

18) 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.

19) 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 18, and 100% for dependent children under age 19.

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

Benefits

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

Eligible Services and Limitations

Basic Services

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 3 years and not within 6 months of a standard 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.

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.

- Composite (tooth coloured) restorations are covered only on permanent anterior or bicuspid teeth. Restoration of molar teeth will be covered at the fee for bonded amalgam restorations.

- 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 bonded amalgam 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.

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 of root planning 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.

6) **Prosthetics** - covered procedures required for the repair or reline of fixed or removable appliances, including the replacement of but not the addition of clasps or teeth to a partial denture.

- Relines or rebases are limited to once 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** or **intravenous sedation** are **not** eligible expenses.

Major Services

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 esthetics, 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 12 month period.

- Precision attachments are covered only in connection with fixed bridgework, and then only upon submission of satisfactory evidence that abutment teeth have drifted sufficiently to make routine bridgework impossible.

- Maryland bridges are covered only in cases involving 1 pontic.

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

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.

- 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 an eligible expense, 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., the Hospital Program 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, stolen or broken 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, unkept 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) Free soft tissue grafts – limited to dependent children 18 and under upon review of satisfactory information treatment not being done for cosmetic purposes.

15) Implants.

16) Sedation or general anaesthetic.

Notes:

GROUP LIFE INSURANCE

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 by 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 original 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.teamsters31.ca.

Benefit

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. Great West Life 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 Great West Life for consideration the beneficiary of the member's Group Life benefit must sign a waiver.

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 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. Failure to apply within 15 months of the date on which you became disabled will disqualify you from this benefit.

Conversion Privilege

If your coverage terminates prior to age 65, 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.

Notes:

ACCIDENTAL DEATH, DISEASE AND DISMEMBERMENT INSURANCE (AD&D)

Principal Amount - The Principal Amount is shown on Page 4 of this booklet under Summary of Benefits.

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

Who is Covered?

Class I:	All active permanent members of the Policyholder as defined in the trust agreement and who are under age 75 unless specifically approved.

Amount of Coverage

Class I: **$60,000.00**

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm Three-Quarters of	The Principal Sum
Loss of One Leg	Three-Quarters of The Principal Sum
Loss of One Hand	Two-Thirds of The Principal Sum
Loss of One Foot	Two-Thirds of The Principal Sum
Loss of The Entire Sight of One Eye	Two-Thirds of The Principal Sum

Loss of Thumb and Index Finger of The Same Hand	One-Third of the Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Speech or Hearing	Two-Thirds of the Principal Sum
Loss of Hearing in One Ear	One-Quarter of the Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	Two-Times the Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two-Times the Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two Times the Principal Sum
Loss of Use of Both Arms or Both Hands	The Principal Sum
Loss of Use of One Hand or One Foot	Two-Thirds of the Principal Sum
Loss of Use of One Arm or One Leg	Three-Quarters of the Principal Sum
Loss of Four Fingers of One Hand	One-Third of the Principal Sum
Loss of All Toes of One Foot	One-Eighth of the Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

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

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

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

Indemnity provided under this Section for all losses sustained by any one (1) Insured Person as the result of any one (1) accident, only one of the amounts so stated in said Table, the largest shall be payable.

Disappearance

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

Beneficiary Designation

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

All other benefits shall be payable to the Insured Person.

ADDITIONAL BENEFITS (AD&D)

REPATRIATION BENEFIT

When injuries covered by this policy result in loss of life of an Insured Person outside 100 Km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of $10,000.00.

REHABILITATION BENEFIT

When injuries shall result in a payment being made by the Company under the Accidental Death and Dismemberment Indemnity section of this policy, the Company shall pay in addition:

The reasonable and necessary expenses actually incurred up to a limit of $10,000.00 for special training of the Insured Person provided:

(a) such training is required because of such injuries and in order for the Insured Person to be qualified to engage in an occupation in which he would not have been engaged except for such injuries,

(b) expenses be incurred within two years from the date of the accident,

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

FAMILY TRANSPORTATION BENEFIT

When injuries covered by the policy result in an Insured Person being confined to a hospital, outside 150 Km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the actual expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Person but not to exceed the amount of $10,000.00.

The term "member of the immediate family" means the Spouse (or common-law spouse) parents, grandparents, children age 18 and over, brother or sister of the Insured Person.

SEAT BELT BENEFIT

Benefits under the policy shall be increased by 10% for a covered accident if the insured person's injury or death results while he/she is a passenger or driver of a private passenger type automobile and his/her seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

WAIVER OF PREMIUM

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

(a) The date the Insured Person attains age 65.

(b) The date of the death or recovery of the Insured Person.

(c) The date the Master Policy is terminated.

CONVERSION PRIVILEGE

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

HOME ALTERATION AND VEHICLE MODIFICATION

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

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

(b) The one-time cost of modifications necessary to a motor vehicle, owned by the injured person, to make the vehicle accessible or driveable for the insured Person.

Benefit payments herein will not be paid unless:

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

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

The maximum payable under both Items A and B combined will not exceed $15,000.00.

DAY CARE BENEFIT

If indemnity becomes payable under the policy for accidental loss of life of an Insured Member, the Company will pay an amount equal to the lesser of the following amounts:

1 The actual cost charged by such day care center per year, or

2 3% of the Insured's Principal Sum, or

3 $5,000.00 per year,

On behalf of any child who was an Insured's dependent at the time of such loss and is under age 13 and is currently enrolled or subsequently enrolled in an accredited day care center within 90 days following such loss.

The benefit is payable annually for a maximum of four consecutive payments but only if the dependent child continues his or her enrollment in an accredited day care center.

EDUCATIONAL BENEFIT

If indemnity becomes payable for the accidental loss of life of an Insured Member of the Holder, under the policy, the Company shall:

1. Pay the lesser of the following amounts to or on behalf of any dependent child who, at the date of accident, was enrolled as a full time student in any institution of higher learning beyond the 12th grade level:

   (a) The actual annual tuition, exclusive of room and board, charged by such institution per school year.
   (b) $5,000.00 per school year.
   (c) 5% of the Insured Employee's Principal Sum.

Such amount will be payable annually for a maximum of four consecutive annual payments, only if the dependent child continues his education.

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

"Institution of higher learning" as used herein includes, but is not limited to, any University, Private College, or Trade School.

2. Pay to or on behalf of the surviving Spouse the actual cost incurred within 30 months from the date of death of the Insured Employee as payment for any professional or trades training program in which such Spouse has enrolled for the purpose of obtaining an independent source of support and maintenance, but not to exceed a maximum total payment of $10,000.00.

CONTINUANCE OF COVERAGE

In the case of Members of the Policyholder who are (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, or (5) terminated from their present employment; coverage shall be extended for a period of twelve (12) months, subject to payment of premium.

If an employee of the Policyholder assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

FUNERAL EXPENSE

When injuries covered by this policy result in accidental loss of life of an Insured Person, the Company will pay the actual expense incurred for preparing the deceased for burial and funeral expenses subject to a maximum of $ 5,000.00.

IN-HOSPITAL INDEMNITY BENEFIT

If an Insured suffers a loss under the Table of Losses as a result of a covered accident and requires that an Insured be confined to a hospital for more than five (5) consecutive days, the Company will pay:

(a) a monthly benefit of one (1) percent of the Insured's applicable Principal Sum; or
(b) for periods of less than one (1) month, one thirtieth (1/30) of the above monthly benefit per day.

Benefits are retroactive to the first (1st) day of hospital confinement.

This benefit is limited to:

(a) a monthly amount not to exceed $1,000.00; and
(b) a total of twelve (12) months for any covered accident.

Successive periods of hospital confinement for loss from the same covered accident separated by a period of less than three (3) months will be considered as one (1) period of hospital confinement.

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

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

(2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
(3) provides 24-hour a day nursing service by registered or graduate nurses;
(4) has a staff of one or more licensed physicians available at all times;
(5) provides organized facilities for diagnosis, and major medical surgical facilities; and
(6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

SERIOUS ILLNESS

If, while coverage is in effect and coverage has been in effect on the Insured Person for a period of not less than 90 days, the Insured Person is then diagnosed with any one of the covered illnesses listed below and the Insured Person satisfies the following conditions:

a) has been hospitalized as an in-patient continuously for at least 48 hours,
b) survives for a period of thirty days after the diagnosis has been made,
c) the Insured Person is under the age of 65,

the Company will pay 10% of the Principal Sum up to a maximum indemnity of $6,000.00

Covered Illnesses:

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

The Company shall only be obligated to pay the Critical Illness benefit once, notwithstanding that an Insured Person may be diagnosed with more than one of the covered illnesses.

EXCLUSIONS

The accident insurance plan does not cover any loss resulting from:

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 a passenger in a aircraft having a current and valid air worthiness certificate.
3. declared or undeclared war or any act thereof
4. active full time service in the armed forces of any country.

This description is a summary of the principal features of the Plan which is covered by the terms of the insurance contract with AIG Insurance Company of Canada.

Notes:

WEEKLY INDEMNITY (WI)

The Plan

If you are unable to work because of a non-occupational accident or sickness your Weekly Indemnity benefits may be paid to you each week up to a maximum of 26 weeks for any one period of disability while you are so disabled and under the care of a legally qualified physician.

Waiting Period

Benefits are payable from the 1st day if disability 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 doctor within the 1st 4 days of disability, benefits will be paid from the date of 1st visit.

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 Trustees 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.

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 involving a motor vehicle or any other circumstance for which a third party is, or may be, directly or indirectly either in whole or in part legally liable, or if during any Period of Disability a Member's primary cause of disability is a result of a motor vehicle accident or any other circumstance for which a third party is, or may be, directly or indirectly either in whole or in part legally liable, no WI 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.

Workers' Compensation Claims – WorkSafe BC

If you suffer an unusual delay in obtaining a decision for WorkSafe BC benefits or if you are appealing the denial of a WorkSafe BC claim, or if following the denial of a claim for WorkSafe BC 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 WI benefits provided you agree in writing to repay all WI benefits received if WorkSafe BC benefits are subsequently paid for the same period of disability. Payment of such benefits will be limited to the extent that it will not exceed the amount that the Trustees believe may be payable by WorkSafe BC should that claim be accepted.

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 (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 and 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) 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 for less than one week (1) has occurred.

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

6) 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 for less than one full day (1) has occurred it will be considered the **same disability period.**

7) **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.

8) 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.

9) Entitlement to Benefits shall terminate 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 (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."

Notes:

LONG TERM DISABILITY (LTD)

The Plan

If you become totally disabled and such disability has existed for more than 6 consecutive months you will be paid monthly benefits for as long as total disability lasts, but not beyond the month in which you attain age 65.

Amount of Benefit

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

E.I. 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, you must be unable to engage in any occupation for which you are reasonably qualified by education, training or experience.

Reduction of Benefits

The Long Term Disability benefit will be reduced so that the total 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 does not exceed 85% of pre-disability earnings.

Any income received from the Workers’ Compensation Board relating to the same disability may also reduce the benefit payable under this section.

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 involving a motor vehicle or any other circumstance for which a third party is, or may be, directly or indirectly either in whole or in part legally liable, or if during any Period of Disability a Member's primary cause of disability is a result of a motor vehicle accident or any other circumstance for which a third party is, or may be, directly or indirectly either in whole or in part legally liable, no LTD 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 his profession throughout your period of disability and the attending physician must provide satisfactory medical evidence to support your inability to work. 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 WI 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.

MISCELLANEOUS

The following supplementary information may be useful to you if you wish to obtain a benefit from the Plan. If you require additional information or guidance, call the Plan's office and the staff will be pleased to assist you.

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

How to Make a Claim

Prescription Drugs

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 Drug Card, and you should only have to pay your portion of the eligible expense.

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.

Please note that the drug 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.teamsters31.ca and mail it to us along with **original** receipts. Please note, the Plan will return the original receipts to you with your claim payment. We do, however, recommend that you always make copies of receipts.

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 Administrator.

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

For orthodontic services, receipts should be submitted as expenses are paid.

Group Life and Accidental Death, Disease & Dismemberment

Contact the Plan Administrator for the necessary forms.

Weekly Indemnity

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

Obtain a form from your employer and when you, your employer and your doctor have all completed the form, forward it to the Plan Administrator.

Long Term Disability

Claims must be submitted within 90 days of the end of the qualification period.

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

If you have received WCB benefits for 6 months or more contact the Plan Administrator to determine your possible entitlement to continuation of your Life Insurance and Accidental Death, Disease and Dismemberment benefit.

Disability Waiver Claims

Claims for the disability waiver provision (continuation of coverage while you are disabled) under the Group Life insurance and Accidental Death and Dismemberment benefits must be made to the insurer within 15 months of the date you become disabled. These applications are included in the process of applying for the Long Term Disability benefit.

If you are totally disabled and receiving benefits from WorkSafe BC., you must apply within 15 months of the commencement of your disability or you will not be entitled to this benefit. Contact the Plan's office for instructions on applying.

Change of Status

It is to your benefit to notify your employer and the Plan 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 dependents change.

5) You change your name.

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 Medical premiums, Group Life insurance premiums and AD&D premiums paid on your behalf by an employer may be considered taxable income. The amounts of Weekly Indemnity and Long Term Disability benefits received by you may also be 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. You must include this income when filing your tax return.

Medical Services Plan of B.C. (M.S.P.)

Coverage under the Medical Services Plan of B.C. (M.S.P.) is not provided as a Plan benefit, but in some instances the Plan provides an administrative service to employers with respect to the processing of eligibility forms. You should check with your employer to determine if M.S.P. is administered through the Plan or if it is provided directly by the employer.

The Medical Services Plan of BC (M.S.P.) and Pharmacare, including Fair Pharmacare (referred to on Page 11) can be contacted at the numbers below:
In Vancouver: 604 683-7151
Other: Toll-free: 1 800 663-7100

Notes:

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 his 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 Members' 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.