

GROUP BENEFITS BOOKLET

Plumbers Local 170 Welfare Plan

**#203 1658 FOSTER'S WAY
DELTA, BC V3M 6S6**

**Phone: 604-526-3434
Toll-Free: 1-800-665-6808
Fax: 604-526-6343**

WWW.PLUMBERS.BC.CA

July 2022

**To all insured members,
Plumbers Local 170 Welfare Plan**

Insurance protection against the financial hardship that so often accompanies unforeseen events such as sickness, accident or death is important to all of us. In order to make this protection available to you, your Plumbers Local 170 Welfare Plan has been arranged to assist in protecting you and your family from these hardships.

This Welfare Plan exists for the sole purpose of providing Health & Welfare benefits to you and your covered dependents. This Welfare Plan is not an insurance company and the Member Life Insurance, and AD&D Disability Waiver Reserves, Extended Health Care, Vision Care, Dental Care, Weekly Wage Indemnity, Long Term Disability, Healthcare Spending Account, Jury Duty, and Drug and Alcohol treatment benefits provided through the Welfare Plan are not insured by an insurance company regulated under the Financial Institutions Act (BC). The Welfare Plan is exempt from the regulatory requirements of the Financial Institutions Act (BC).

The extended health care, vision care and dental care benefits are designed to assist you with the payment of these expenses. It does not pay the total cost of services and supplies. In effect, this Welfare Plan shares the payment of your medical, vision, and dental bills with you.

The life insurance and accidental death & dismemberment benefits are coordinated via Manulife, the emergency travel accident insurance is insured by AIG Insurance Company, while all other benefits (inclusive of extended health care, vision, dental, weekly wage indemnity, drug and alcohol treatment, and jury duty benefits) are self-insured and administered by the Plumbers Local 170 Welfare Plan Administrator, with member/dependant claims adjudicated for extended health care and dental care by Coughlin & Associates Ltd. The Welfare Plan Administrator adjudicates certain benefits including vision care, disability benefits, healthcare spending account, the special senior member's extended health care, weekly wage indemnity, jury duty, and special rehabilitation and drug and alcohol treatment benefits.

We urge you to read your booklet carefully to thoroughly familiarize yourself with the benefits that are available to you and your dependants.

Please note that it is the intention of the trustees to maintain the current benefits available under the Welfare Plan. The trustees however, reserve the right to change the benefit portfolio at any time given legislative revisions and/or the utilization costs of the benefits. Members will be advised accordingly of any required plan revisions.

For further information on your coverage, contact the Plumbers Local 170 Welfare Plan administration office direct at (604) 526-3434 or toll-free 1-800-665-6808. A member of the staff will be pleased to provide you with the necessary information to explain how these provisions apply to your personal situation.

We are pleased to make these arrangements on your behalf and we are certain that your participation in the plan will bring greater security and peace of mind to you and your family.

Sincerely,

**THE BOARD OF TRUSTEES
PLUMBERS LOCAL 170 WELFARE PLAN**

TABLE OF CONTENTS

Page No.

Highlight of benefits.....	
How to make a claim.....	
Pay Direct Drug Card.....	
Definitions	
General information.....	
Member Life Insurance benefit.....	
Basic AD&D Insurance benefit.....	
Bereavement benefit.....	
Weekly Wage Indemnity benefits	
Long-Term Disability benefits.....	
Extended Healthcare.....	
Travel Medical Emergency.....	
Dental care.....	
Healthcare Spending Account (H.S.A.)	
Jury Duty Fund.....	
Special rehabilitation fund drug and alcohol treatment	
Frequently asked questions	
Notice regarding personal information.....	
Privacy	

HIGHLIGHT OF BENEFITS

The highlight of benefits contains a brief summary of your benefits.

LIFE INSURANCE

All hour bank insured members, insured retired members, and associates (under age 75)

Benefit	\$85,000 reducing to \$20,000 at retirement (i.e. receiving a monthly pension)
Termination	Age 75 or retirement (whichever occurs first) for associates and all other insured hour bank members, with exception of self-paying hour bank members whose coverage ceases following 24 consecutive months of self-payment.
Reinstatement	Coverage will reinstate to \$85,000 for retired members upon return to work and satisfying the plan eligibility requirements but not beyond attainment of age 75.
Waiver of premium	On approved disability (refer to booklet for further details).

ACCIDENTAL DEATH & DISMEMBERMENT

All hour bank insured members, insured retired members, and associates (under age 75)

Benefit	\$85,000 reducing to \$20,000 at retirement (i.e. receiving a monthly pension)
Termination	Age 75 or retirement (whichever occurs first) for associates and all other insured hour bank members, with exception of self-paying hour bank members whose coverage ceases following 24 consecutive months of self-payment.
Reinstatement	Coverage will reinstate to \$85,000 for retired members upon return to work and satisfying the plan eligibility requirements but not beyond attainment of age 75.
Waiver of premium	On approved disability (refer to booklet for further details).

BEREAVEMENT BENEFIT

All hour bank insured members, insured retired members, and associates

Benefit Amount	Eligible members entitled to a 3 day benefit (equivalent to 3/7 of WWI benefit) via WWI
Eligibility	All active members and associates who have access to the WWI benefit with verification supplied of death/relationship (obituary/funeral parlour notice, physician or funeral statement, death certificate or memorial card) to cope with the loss of a deceased eligible family members (i.e. children, step children, parents, in-laws, grandparents (includes inlaws), spouse, common-law spouse, brothers, sisters, step-brothers, step-sisters) on a prescribed application form.

WEEKLY WAGE INDEMNITY

All hour bank insured members, apprentices, probationary apprentices, permit workers, and associates

Waiting period	Payable from the first day of non-occupational accident/injury or day surgery or sickness requiring overnight hospitalization. Payable from the fourth day of illness.
Benefit period	Four weeks, then EI sickness benefits (if applicable) up to an additional 11 weeks – maximum 15 weeks (total) payable from the plan
Benefit amount	Equivalent to EI maximum plus \$120 (or 1/7 of the weekly benefit for each day that a benefit is payable)
Tax status	Taxable
Termination age	Age 65

LONG-TERM DISABILITY

*All hour bank insured members and apprentices
(excludes associates)*

Elimination period	Commencement of CPP benefits or alternate date determined by the trustees
Benefit period (max. disability age)	The last day of the month in which the member attains age 62, dies, ceases to receive CPP benefits, fails to participate in a rehabilitative program, or the last day of the month preceding the first day of the month in which retirement takes effect
Benefit amount	1/12 of 70 per cent of basic pre-disability hourly rate of earnings times 1,400 hours
Direct offsets	Disability payments under the pension plan or any other employer-sponsored pension plan; any employer-sponsored disability plan and any provincial or federal government program to which an employer directly contributes, including but not limited to EI, CPP and WCB disability benefits
Tax status	Taxable
Definition of disability	Upon approval of CPP disability benefits
All-source limitation	85 per cent of average of best three consecutive years of earnings
Rehabilitation	Yes. Reimbursement and offset determined by the trustees

EXTENDED HEALTHCARE

All hour bank insured members, insured retired members, eligible disabled members, associates (under age 75), and survivors.

Please note special senior members excluded

Calendar year deductible	No deductible
Reimbursement	<p>100 per cent for certain benefits as noted.</p> <p>100 per cent for Fertility drugs and treatment up to \$5,000 per person per Lifetime.</p> <p>95 per cent of eligible prescription drugs and diabetic supplies listed on the provincial BC Formulary up to \$1,500 per family unless proof of a higher B.C. Fair Pharmacare Program deductible is provided.</p> <p>80 per cent of all other eligible expenses up to \$1,000 and 100 per cent of other eligible expenses exceeding \$1,000 per person or family in a calendar year</p>
Plan maximum	Lifetime maximum to \$1 million per person subject to applicable treatment and travel medical emergency maximums.

100 per cent of eligible expenses

- Ambulance Services	Reasonable and customary charges for emergency services and/or response
- Vaccines	\$250 per person per calendar year for preventative vaccines dispensed by a licensed pharmacist or physician within Canada
- Injection Administration Fees	Effective June 1, 2021, Injection administration fees charged by a physician or pharmacist reimbursed up to \$100 per person per calendar year
- Prolotherapy	\$200 per person per calendar year provided prescribed for ligament, tendon, or muscle repair
- Foldable intraocular lens implants	Lifetime maximum of \$1,000 per person in excess of the provincial health care plan
- Smoking cessation drugs/products (Zyban, nicotine patches & gum, acupuncture)	Lifetime maximum of \$500 per person subject to official receipt (detailing patient name, purchase date, and item)
- Fertility Drugs & Treatment	Lifetime maximum up to \$5,000 per person
- Botox	\$200 per person per calendar year provided prescribed for migraine or hyperhidrosis
- Diagnostic tests (inclusive of PSA, etc.)	Maximum of \$100 per calendar year per active member. (Deductible not applicable)

100 per cent of eligible expenses (continued)

<p>- Medical Bracelets</p>	<p>Subject to medical necessity maximum of \$50 per person per calendar year (requires an official itemized receipt indicating patient's name and item description as well as date of purchase and amount (cash register receipts will not suffice.)</p>
<p>- Vision Care</p>	<p>Subject to a maximum of \$700 every 24 months for prescriptive corrective lenses, no deductible. Laser eye surgery reimbursed \$3,000 per person per lifetime. (Adjudication handled by welfare office).</p> <p>Prescribed Corrective contact lenses for severe medical conditions up to \$700 per person per 24 month period</p> <p>Visual training benefit up to a lifetime maximum of \$1,000 per person</p>
<p>- Eye exams (Vision Care)</p>	<p>Subject to a maximum of \$100 every calendar year when performed by a physician or optometrist for covered members and their eligible dependents to the later of age 65 or expiry of his hour bank account; charges in excess of Insured's Provincial Plan. Additional eye exam for specific medical conditions up to \$100 per person per calendar year.</p>

100 per cent of eligible expenses (continued)

- Paramedical Services	\$700 per person per calendar year, per practitioner maximum including chiropractor (inclusive of X-rays), massage, naturopath, physiotherapist (including athletic therapy), podiatrist, acupuncturist, and speech language pathologist.
- Psychologists (family and marriage counsellors, etc.)	up to \$1,500 per person per calendar year.
- Hearing Aids & Repairs	\$2,000 every five years per person, as prescribed by a physician.
- Pediatric Ear Molds	\$300 per child (age 6 – 18) per calendar year as prescribed by a physician
- Custom Ear Plugs	\$500 every 5 years per person, as <u>prescribed by a physician.</u>

95 per cent of eligible expenses – up to a calendar year maximum out of pocket dispensing fee cost of \$200 per family	
- Drugs	Prescribed drugs (excluding oral contraceptives and nicotine patch) and diabetic supplies. Drug coverage is restricted to those listed on the provincial (BC) formulary being reimbursed up to \$1,500 per family, unless proof of a higher B.C. Fair Pharmacare Program deductible is provided. EHC deductible is not applicable.
80 per cent of eligible expenses	
- In-province expenses	Once \$1,000 has been paid in a calendar year, further eligible expenses will be reimbursed at 100 per cent, subject to maximums in contract
- Hospital room and board	Semi-private or private
- Private nursing	Provided for acute care
- Surgical brassieres	\$500 per person per calendar year
Termination	Hour bank insured members and insured retired members later of age 75, self-pay period or expiry of hour bank. All others earlier of age 65 or expiry of hour bank/self-pay period/defined eligibility (i.e. associates no later than age 65. However, no later than age 62, disabled members may then self-pay to age 75). Retired members may transition to special senior member category following attainment of age 65.

TRAVEL MEDICAL EMERGENCY INSURANCE

All hour bank insured members, associates, insured retired members (under age 75), eligible disabled members, and survivors (special senior members excluded)

Active hour bank insured members (working)	
Overall maximum	Under age 70 - \$5 million per coverage period Age 70 – 74 - \$2 million per coverage period
Coverage period	90 days per trip
Termination age	Earlier of age 75 or expiry of hour bank account/self-pay)
Pre-existing condition	Not applicable
Survivors	
Overall maximum	Under age 70 - \$5 million per coverage period Age 70 – 74 - \$2 million per coverage period
Coverage period	90 days per trip
Termination age	Earlier of age 75 or 24 months from member's date of death
Pre-existing condition	\$25,000 lifetime maximum for pre-existing condition
Associates	
Overall maximum	Under age 70 - \$5 million per coverage period Age 70 – 74 - \$2 million per coverage period
Coverage period	90 days per trip
Termination age	Earlier of age 75 or expiry of hour bank account/self-pay)
Pre-existing condition	Not applicable

Insured retired members	
Overall maximum	Under age 70 - \$5 million per coverage period Age 70 – 74 - \$2 million per coverage period
Coverage period	90 days per trip
Termination age	Earlier of age 75 or 24 months from member's date of death
Pre-existing condition	\$25,000 lifetime maximum for pre-existing condition

HEALTHCARE SPENDING ACCOUNT (H.S.A)

All hour bank insured members (under age 75)	
Reimbursement	100% of eligible expenses limited to H.S.A. account balance
Eligibility	Local Union 170 Insured Members at July 1, 2022. Refer to H.S.A. section for additional details
Termination	Termination of membership or any break in active insured coverage, or up until June 30, 2023.

DENTAL CARE

All hour bank insured members, insured retired members, associates (under age 75), eligible disabled members, survivors.

Please note special senior member excluded

Deductible	No deductible		
Provincial fee schedule	Current basis, on the date services performed and subject to your province of residence		
	Plan A	Plan B	Plan C
Reimbursement	Basic services	Major restorative services	Orthodontics
	90%	80%	50%
Dependant children only	100%	80%	50%
Frequency plan limits	Each calendar year	Each calendar year	Lifetime
Financial limit per dependant child	\$3,500 * combined with Plan B	\$3,500 * combined with Plan A	\$5,000
Financial limit per member or spouse	\$3,500 * combined with Plan B	\$3,500 * combined with Plan A	\$5,000

** Effective July 1, 2021 (prior \$3,000)*

SPECIAL SENIOR MEMBER (age 65 +)

Eligibility	Age 65 and over, opting not to self-pay for Retired Member Full of Mini coverage, provided a Member in good standing with Local 170 for 5 continuous years prior to 65 th birthday. Member can not re-initiate after age 65.
Benefit Maximum	\$1,200 per family per calendar year to a lifetime maximum of \$25,000 per person, plus up to \$50 per member per calendar year for prostate testing
Eligible Expenses	Reimburse eligible Dental, Extended Healthcare, Visioncare benefit supplies and services and individual private health or travel plans purchased in member's name. Proof must be submitted clarifying individual policy does not include Life nor AD&D coverage due to CRA tax complications
Survivor Benefit	Effective January 1, 2021, extend 50% of benefit maximum up to 24 months
Termination	Death of Special Senior Member (following the survivor benefit period) or no longer a Member in good standing with Local 170

HOW TO MAKE A CLAIM

The following benefits are co-ordinated and/or adjudicated by the **Plumbers Local 170 welfare office**:

- member life insurance and accidental death and dismemberment;
- weekly wage indemnity;
- jury duty fund;
- special rehabilitation fund drug and alcohol treatment;
- special senior members (age 65 and over) extended health benefit claims;
- vision care claims including eye examinations;
- long-term disability benefits;
- healthcare spending account (effective September 2020)

Please contact the welfare office at 604-526-3434 or 1-800-665-6808. Claim forms (including Coughlin & Associates Ltd.) can be obtained from our website:

www.plumbers.bc.ca

CLAIM NUMBERS

IDENTIFICATION NUMBER = member's Social Insurance Number

POLICY NUMBER = 271029

TELUS CARRIER IDENTIFICATION NUMBER = 610105 (the number your dental office will need to submit your dental claim electronically)

Coughlin & Associates Ltd. will adjudicate all other extended health and/or dental benefits with exception of drug card claims (refer to Page 24). In the event of a claim, you or a member of your family should **obtain the proper claim form from the plan administrator (Plumbers Local 170 welfare plan office) or alternatively, an applicable generic claim form from the claim adjudicator's (Coughlin & Associates Ltd.) website www.coughlin.ca.**

The completed claim form can be mailed to:

The claims department
Coughlin & Associates Ltd.
Box 764
Winnipeg, MB R3C 2L4
Toll-free: 1-888-204-1234
Local: (204) 942-4438
Fax: (204) 943-5998

Please note that the original receipts submitted with your claim will not be returned to you as a detailed claims summary provided by the claim adjudicator (Coughlin & Associates Ltd.) on finalization of your claim is sufficient for the purposes of tax reporting and co-ordination of benefits. Alternatively, you can access your claims history from the claim adjudicator's (Coughlin & Associates Ltd.) website at www.coughlin.ca by clicking on "Log On" and entering a temporary password and your identification number detailed on your claims summary.

The claim forms must be signed by the **insured member** and should include your personal identification number, which is your Social Insurance Number.

Dental care

There are two options available to submit your dental claim:

1. Electronic data interchange (EDI)

With **EDI**, your dental claim is sent directly from the member's dental office to Coughlin & Associates Ltd. for claims adjudication. *Coughlin & Associates Ltd. EDI* service uses the secure data networks of **Telus**, the dedicated claims processing network sponsored by the Canadian Dental Association.

To take advantage of Coughlin's **EDI** service, just tell the dentist that Coughlin & Associates Ltd. is your claims adjudicator and present him/her with the following security codes:

- the Coughlin & Associates Ltd. Telus carrier identification number (also known as the BIN number), which is **610105 on the Telus network**;

- your identification number which is your PIN (Social Insurance Number);
- the policy number of your welfare plan, which is 271029.

Not all dental offices are participants of Telus. So, be sure to first ask your dentist or his/her office administrator about Telus access.

2. In case an insured member's dentist is not set up for EDI:

- Obtain a claim form from the plan administrator or Coughlin & Associates Ltd., claims adjudicator, (directly or via the website at www.coughlin.ca)
- Have the dentist/denturist complete Part 1 of the form. You must sign at the appropriate place in Part 1 if you want the dentist/denturist to be paid directly by the welfare plan.
- Complete and sign Part 2 of the form.
- Date and sign the form in member *Authorization and declaration* section.
- Return the completed form promptly to the claims adjudicator.

Pre-authorization

For treatment where the estimated cost is \$500 or more, pre-determination of costs should be obtained from the claims adjudicator.

Have your dentist/denturist or orthodontist complete the appropriate form or section. Mail the form to the claims adjudicator.

For major dental services, please ask your dentist to send the applicable X-rays with the form.

A letter will be sent to the dentist/denturist with a copy to you, showing how much the plan will pay.

Most dentists/denturists will submit claims for payment directly to the claims adjudicator's office. Some dentists/denturists may insist that you pay immediately.

Please note that the portion of your dental claim not covered by the plan is payable immediately to your dentist/denturist.

Extended health care

- Obtain a claim form from the plan administrator or Coughlin & Associates Ltd., claims adjudicator, (directly or via the website www.coughlin.ca or alternatively, www.plumbers.bc.ca).
- Obtain a receipt from the selected specialist, pharmacist, ophthalmologist, optometrist or optician.
- Complete the form and sign at the bottom of the form.
- Return the completed form with original receipts to Coughlin & Associates Ltd.

Note: For prescription drug claims, we will provide you with an Express Scripts prescription drug identification card. Present card when purchasing drugs to cover the cost up to the plan maximum and percentage of coverage.

Submit your Claims Electronically

Paramedical (Chiropractor, Massage Therapist, Physiotherapist) services claims can be submitted directly through the Coughlin Plan Member Portal. Your claim will be adjudicated within two business days.

Some important points to remember:

- The maximum amount that can be claimed is \$500 for paramedical services per claim transaction per covered person. You may not submit a claim for yourself and another person, such as a dependant, at the same time.
- You must be registered with Coughlin's Pre-authorized Deposit plan before the service will be activated.
- Claims are audited randomly. Be sure to keep your claim receipts for one year. If you receive an audit notice, please submit the requested original claim receipts within the timeframe indicated.

Coughlin Plan Member Portal

You can log in to the Coughlin Plan Member Portal at www.coughlin.ca and view your personal benefits and claims account. You can:

- Manage your profile, including updating your mailing address, telephone number, email address, updating your

language of preference and viewing your dependant information.

- Auto-enroll in Pre-Authorized Deposit by entering your banking information directly on the portal. You also have the ability to change your banking information directly on the portal. Your changes will be live immediately – no processing delay. Members will also receive an e-mail notification if any changes are made to their banking information.
- View your claims history and the status of claims, print explanation of benefits statements, view your benefit accumulations/maximums and view your booklet (where applicable).
- Download and print claim submission and administrative forms.

If you are interested in registering, please contact the Claims Department at Coughlin & Associates Ltd. (Telephone: 1-888-204-1234 or E-Mail: winnclaims@coughlin.ca) for assistance.

Pre-Authorized Deposit (PAD)

Eligible reimbursements for extended health and dental care claims can be deposited directly into your bank account within two to five days following their approval. In order to enrol in Coughlin & Associates Ltd.'s PAD program:

- Auto-enroll in PAD by entering your banking information directly on the portal. You also have the ability to change your banking information directly on the portal. Your changes will be live immediately – no processing delay. Members will also receive an e-mail notification if any changes are made to their banking information; **or**
- Print the PAD form from the Coughlin Plan Member Portal or at www.coughlin.ca. Complete and return the form with a void cheque to Coughlin.

To be eligible for PAD, deposits must be made to an accredited Canadian financial institution. Please note that lines of credit are not accepted.

Travel medical emergency

- I.D. cards and travel medical emergency booklets are available from your plan administrator or Coughlin & Associates Ltd.
- In case of emergency, please immediately call
Canada or US → 1-8779-207-5018
or
Outside Canada or US → 1-819-566-3940
Noting:
Policyholder → Plumbers Local 170 welfare plan
Policy number → CMG 9428867
- Claims should be submitted to Global Excel within 90 days from the date a claim arises and in no event later than one year from the date of injury.

Time limitations

- **Health care, Dental care, Vision care, and H.S.A.**

Claims for these benefits must be submitted within 90 days from the date the expense was incurred. However, we must receive your claim by June 30th of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstance. For example, we must receive your receipts for 2021 before June 30, 2022.

- **Travel medical emergency**

Claims must be submitted to Global Excel within 12 months of the date incurred.

- **Life insurance and AD&D**

Claims must be submitted within 12 months of the day of loss.

- **Long-term disability**

A claim for the waiver of premium benefit and long-term disability benefits must be submitted within 12 months of the date disabled.

- **Jury duty fund**

Applications must be made within 14 days of jury duty.

PAY DIRECT DRUG CARD

Insured members of Plumbers Local 170 welfare plan can pay for their prescription drugs at any retail pharmacy in Canada directly through their drug plan using the pay direct card from Express Scripts and Coughlin & Associates Ltd.

With the pay direct drug card, your prescription drug claims will be processed on-the-spot. There are no forms to complete, no payment required outside of the five per cent co-insurance and no waiting for a reimbursement cheque to arrive. Simply present the card to your pharmacist when you purchase prescription drugs. Your claim payment will be processed immediately. It's that simple.

The card can be used by you as well as your spouse and eligible dependants. Remember, the Plumbers Local 170 welfare plan **pay direct drug card is designed to cover only prescription drug costs. It cannot be used for dental, vision, or other health care claims.** (Submit claims for vision directly to Local Union 170 welfare office and all other claim services to Coughlin & Associates Ltd., in the normal fashion.)

You must present the new Express Scripts card to your pharmacist in order to take advantage of this fast and convenient service.

How it works

When you purchase prescription drugs, simply present the Plumbers Local 170 welfare plan pay direct card to your pharmacist. The prescription data will be submitted electronically to Express Scripts and your drug claim will be assessed in seconds while you wait. When your claim is approved, the pharmacist will return the card to you.

The card can be used at any pharmacy in Canada.

Note: the drug benefit coverage is subject to five per cent co-insurance, whereby you are responsible for five per cent of the eligible drug cost at the point of sale.

Number of cards to be issued

You will receive two pay direct drug cards; one for you and one for your spouse, if applicable. Upon request, an additional card will be issued in your name for eligible dependants 19-25 and in full-time attendance at college or university.

If your card is lost or stolen, please contact Coughlin & Associates Ltd., toll-free, **1-888-204-1234**.

Only in Canada

The pay direct card cannot be used outside of Canada.

If you forget your card

You can fill your drug prescription without the Plumbers Local 170 welfare plan pay direct drug card. However, your paper drug claim, also subject to a five per cent co-insurance, will have to be submitted to Coughlin & Associates Ltd. for manual processing.

If it doesn't work

Occasionally, there are cases when the drug card is not accepted by a pharmacist's system. This is usually a result of either input error or incorrect data being on file. If you encounter difficulties, ask your pharmacist to confirm or correct key data such as the spelling of your name, birth date, address, etc. Most errors can be corrected on-the-spot.

Otherwise, ask your pharmacist to contact the Express Scripts Pharmacy Help Desk at **1-800-563-3274**. If you continue to run in difficulties, please contact Coughlin & Associates Ltd., at toll free, **1-888-204-1234**.

You can submit your claim to Coughlin & Associates Ltd. at the following address:

Coughlin & Associates Ltd.
Claims department
PO Box 764
Winnipeg, MB R3C 2L4
Phone: (204) 942-4438
Toll-free: 1-888-204-1234

Most claims are processed within 48 hours of receipt by mail.

Co-ordination of benefits with your spouse

If the member's spouse has drug coverage under his/her own group benefit plan, the drug card will not accept prescription drugs purchased for the spouse, as their own plan is the first payer. Likewise, for eligible dependant children, if the spouse's birthdate appears first in the calendar year, the spouse's group benefit plan is considered first payer for the children. The drug claims must first be considered under the spouse's plan and then, if any amount is not covered, the balance may be submitted via a manual paper claim via Coughlin, to the Plumbers Local 170 welfare plan.

If your personal information changes

If you have any changes to your personal information, such as the adding or removal of a dependant, new address, etc., please contact your Local Union 170 welfare plan office for assistance. Phone: 604-526-3434 or toll-free at 1-800-665-6808)

DEFINITIONS

Allowable enrolment period - means within four months from the date the covered member is eligible for coverage.

Coverage effective date – means the date coverage becomes effective as determined by the Plumbers Local 170 welfare plan.

Covered member – means an hour bank member, an associate (max. age 65), a retired member (under age 75), survivors (spouse and eligible dependants), or a special senior member (age 65 and over), as defined in the plan document, who is entitled to benefits in accordance with the plan document.

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

Dentist – means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided and is acting within the scope of that license. For the purpose of this booklet, dentist may also mean dental specialist, or denturist.

Dependant – means any of the following persons for whom coverage is provided under this plan:

- one spouse;
- any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 19 and financially dependent on you or your spouse;
- under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute;
- any functionally impaired child who was insured as a dependent shall remain insured beyond any limiting age for dependents. For the purposes of insurance, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired who is not receiving payments from an aid program and is incapable of self-sustaining employment due to a functional impairment specified in a government regulation and who is wholly dependent upon

the member for support and maintenance within the terms of the Income Tax Act.

Disabled members – means a covered member who is disabled, under the regular care of a physician and in receipt of CPP disability benefits. Such disabled members are extended health and dental benefits on a self-insured pay basis to a maximum of age 75 or recovery, whichever occurs first. Note: LTD benefits cease at age 62.

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

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

Pre-existing condition – means a condition for which medical treatment or advice is required, or for which symptoms were present which would have caused a covered member or covered dependant to seek medical diagnosis or treatment.

Retiree – means a union member who is receiving pension benefits from the union pension plan.

Spouse – means at the relevant time:

- an individual who is married to a covered member and has not been living separate or apart from the covered member for the preceding 12-month period; or only if there is no such person;
- an individual who has lived and co-habited with the covered member in a marriage-like relationship, including a marriage-like relationship between persons of the same gender, for the preceding 12-month period.

Only one spouse is eligible for coverage under the contract at any one time.

GENERAL INFORMATION

Eligibility

This plan is for members of the Plumbers Local 170 welfare plan who work for contributing employers and includes the following:

1) **Union members**

Are members of Local Union 170 participating in the Plumbers Local 170 welfare plan and for whom an employer is obligated to make contributions to the fund.

2) **Associate employees***

“Associate” means either

- i) an individual employed with a participating employer where that individual does not work in the same capacity as union members; or
- ii) an individual who:
 - a) is partner of a participating employer that is a legal partnership, or is a major shareholder company as defined in the union’s collective agreement of a participating employer which is a limited liability company; and
 - b) who does not work in the same capacity as union members,

and for whom the administrator has received the initial associate contribution and for whom the administration continues to receive contributions;

3) **Special senior members**

Are eligible for extended health care, and dental only (refer to page 15 pertaining to maximum coverage) and means an individual age 65 or older who at any time prior to attaining the age of 65:

- i) was an active member, a retired member, or apprentice;
- ii) was in good standing for 5 continuous years;

- iii) was covered for benefits;
- iv) has submitted to the administrator the enrolment documentation required on attaining age 65;
- v) opted not to self-pay for full or mini retired member coverage;
- vi) continues to remain a union member; and
- vii) must not re-initiate after age 65.

4) Retired (Senior) members

Means a union member who is receiving pension benefits from the pension plan.

5) Returning retired (Senior member)

Means a retired member, under age 75, who, after becoming a retired member:

- i) ceased to be an hour bank member; and
- ii) re-accumulates the eligibility hours in the hour bank associated with that retired member.

6) Disabled member

Means a covered member who is disabled, under the regular care of a physician and in receipt of CPP disability benefits. Such disabled members have extended travel medical emergency, extended health, and dental benefits to a maximum of age 62 or recovery, whichever occurs first as LTD benefits cease at age 62. Following age 62, extended health and dental benefits can be extended up to age 75 with travel medical emergency benefit up to age 70, subject to receipt of applicable self-payment as a retired member.

When you become insured initially

1) Union member

For each participant, an account is kept by the plan administrator that shows hours worked with a contributing employer for which contributions have been made on

your behalf for the purpose of group benefits. This account is called an hour bank account.

You and your eligible dependants will become insured on the first day of the second month following accumulation of 220 earned hours in your hour bank account and the first day of the second month following receipt in the administrator's office of the duly completed signed enrolment documentation, provided you are actively at work or available for work on the day you would ordinarily become insured. Should you not be working or available for work on the same day your insurance would ordinarily start, the insurance for you and your dependants will be delayed until you return to work or are available for work.

Each month, 110 hours (monthly maintenance) will be deducted from your hour bank account to cover costs associated with the benefit coverage. The number of hours in the union member's hour bank account may not exceed 1,980 hours (enough to provide 18 months of coverage). Excess hours accumulated over 1,980 hours will be credited to the general reserves of the trust fund.

A permit worker or pre-apprentice can accumulate hours worked in excess of the monthly maintenance, however, upon the end of the month following the date of termination of employment or lay-off, the balance in the hour bank account is forfeited to the general reserves of the trust fund unless the permit worker or pre-apprentice becomes a union member in good standing.

2) Associate employee

For associates and eligible dependants for whom the administrator has received in full, the required contribution as determined by the fund administrator's office, and thereafter ongoing monthly contributions to fund the benefits, is eligible for coverage on the first day of the second month following the month in which the administrator also receives duly completed and signed enrolment documentation for the associate.

3) Special senior member

Special senior members (age 65 and over) are eligible for benefits on the first day of the second month following the month in which the administrator receives duly completed and signed enrolment documentation for the special senior member. The member has opted not to self-pay for full or mini retired member coverage.

Provision for self-pay by a union member

If at the end of any given month, a union member insured under the policy fails to meet the required monthly coverage cost as determined by the rules of the trust fund, such member will be given the opportunity of contributing the necessary amount of monthly coverage cost so that he may continue to be insured. Contact the administrator's office for complete details.

Provided the member continues to be in good standing with the union, *self-payments* means payments of money to the fund in lieu of contributions and is limited to a maximum period of 24 consecutive months for hour bank members; age 75 for retired members with reduced life insurance/AD&D; and for special senior members (age 65 and over), EHC/Dental is extended until the earlier of the member being deceased or no longer a union member in good standing.

Survivor benefit coverage

If you die, the following benefits will be extended to your eligible dependants (spouse and children) as follows:

Actively working hour bank insured or insured disabled members/ associates, insured retirees (under age 75) and insured self-paying members (under age 75)

- Extended health, travel medical emergency, vision and dental benefits up to 24 consecutive months.
- If your surviving children cease to qualify as eligible dependants (as defined earlier in this booklet), the health benefits being continued after your death will terminate on the date they no longer qualify.
- If a dependant is disabled on the date insurance under this continuation terminates, insurance payments for that dependant will be continued until the earlier of the following:
 - the date the disability ends;
 - the date your dependant has received maximum benefits;
 - 90 days from the date the insurance terminated.

Please note: If your dependant is in the hospital on the last day of this 90-day period, insurance payments for that dependant will be continued until the hospital confinement ends or until maximum benefits have been paid.

Special senior members (age 65 and over) and inactive non-insured self-paying members (i.e. if not insured for EHC, vision, dental, TME) are not eligible for the survivor benefit coverage.

Integration with government plans

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

Effective date of coverage and enrolment

Coverage effective as determined by the Plumbers Local Union 170 welfare plan.

Change in amounts of insurance

Please note a change in the amount of your insurance shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are actively at work.

Late applicants

If you did not apply during the allowable enrolment period but request coverage later (for yourself and/or your dependants), ask your plan administrator to explain the requirements for late enrolment in your group plan. **Note:** Different benefits may have different requirements – health evidence or retroactive premium payment. In some instances, coverage may be denied.

Identification (ID) cards

AIG will issue, travel medical emergency, identification (ID) cards for distribution by your plan administrator or claims adjudicator, Coughlin & Associates Ltd.

Only you and your enrolled dependants are entitled to use this card. Should you (or your dependant) allow an ineligible person to use this card, your coverage may be suspended without notice.

You may be asked to substantiate that an individual you claim as a dependant meets the definition of *dependant* for your group.

Duplicate coverage

If you and your spouse have coverage under the Plumbers Local Union 170 welfare plan, please check with your plan administrator to see if duplicate coverage is allowed for dental and extended health benefits.

If you and your spouse have coverage through different employers and you are both enrolled for similar benefits, duplicate coverage is allowed.

If you are eligible for duplicate coverage, you and your family should discuss both plans (and what portion of the benefits you pay) to determine whether it is to your advantage to enrol under more than one plan.

Your plan administrator will advise you if you are eligible to waive certain benefits under this group plan.

Co-ordination of benefits

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

- 1) Dependant 00 is always the primary claimant. Dependant 01 (or 90 to 99) is always the second claimant.
- 2) Dependant children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).

- 3) In situations of separation or divorce, the following order applies:
 - a) the plan of the parent with custody of the child;
 - b) the plan of the spouse of the parent with custody of the child;
 - c) the plan of the parent not having custody of the child;
 - d) the plan of the spouse of the parent in c) above.
- 4) Total reimbursement shall never exceed 100 per cent of the eligible expenses.

General exclusions

- 1) The Plumbers Local 170 welfare plan, claims adjudicator, plan administrator, or AIG will not be liable for any portion of an expense for which you or your dependant is entitled to reimbursement:
 - a) under any other group or individual benefit plan or insurance policy; or
 - b) due to legal liability of any other party.
- 2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
 - a) intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion;
 - b) active duty in the military forces or any nation or international organization, or in any civilian non-combatant unit which serves with such forces in combat;
 - c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country;
 - d) false pretences or fraudulent misrepresentation;
 - e) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventative treatment and services applicable under any Workers' Compensation Act or similar plan.

Termination of coverage

Notwithstanding the applicable benefit age and/or period limitations, please note the following:

Termination of coverage for hour bank members

Coverage for benefits for an hour bank member will cease on the earliest of the following dates:

- 1) the last day of the month in which he ceases to be:
 - a) a union member;
 - b) a permit worker or probationary apprentice, as the case may be, for reason other than becoming an active member; or
 - c) an individual to whom a reciprocal agreement applies and for whom the administrator establishes and maintains an hour bank;
- 2) the last day of the month following the month at the end of which all of the following conditions apply:
 - a) his/her hour bank has less than 110 hours per month (the monthly maintenance hours required to maintain coverage);
 - b) he/she has not been approved for plan paid coverage. Please refer direct to the administrator's office.
 - c) he/she does not qualify for self-payment.
- 3) the deemed date of termination of his/her eligibility for benefits in accordance with the self-payment provisions. Please refer direct to the administrator's office.
- 4) the last day of a month if on that day all of the following conditions apply:
 - a) the hour bank maintained on his behalf has less than the maintenance hours (110 hours per month); and
 - b) he/she is not a special senior member;

- 5) the last day of the month in which his death occurs;
- 6) the date the trust agreement is terminated; and
- 7) the date the member obtains the benefit age limitation.

Termination of coverage for associates

An associate will cease to be eligible for benefits on the earliest of the following dates:

- 1) the first day of the third month after the month in respect of which the administrator does not receive a contribution for the associate;
- 2) the last day of a month in which he attains age 65;
- 3) the last day of the month in which his death occurs;
- 4) the date the trust agreement is terminated;
- 5) the date the associate obtains the benefit age limitation; and
- 6) the date the associate ceases to be an employee of a contributing employer.

Termination of coverage for special senior members

A special senior member will cease to be eligible for benefits on the earliest of the following dates:

- 1) the last day of the month in which he ceases to be a special senior member;
- 2) the last day of the month in which his death occurs; and
- 3) the date the trust agreement is terminated.

Termination of coverage for retired members

A retired member will cease to be eligible for benefits on the earliest of the following dates:

- 1) the last day of the month in which he ceases to be a retired member;
- 2) the last day of the month in which his death occurs; and

- 3) the date the trust agreement is terminated; and
- 4) benefit coverage cease as follows:
 - a) Dental, EHC, and Vision on the later of age 75 or expiry of his hour bank account. Travel medical emergency will cease earlier of age 75 or expiry of hour bank account/self-pay. In effect, a retired member who has returned to work and met/continues to meet the eligibility requirements will be covered for dental, EHC, and vision indefinitely. (Note: other benefits cease at specific ages, LTD age 62, and Life/AD&D cease at age 75, etc. regardless of hour bank status);
 - c) Life and AD&D coverage cease on the earlier of attainment of age 75 or cessation of hour bank/self-pay.

A retired member will transfer to the special senior member classification the day he has attained age 65 provided depleted his hour bank account and opted not to self-pay for full or mini retired member coverage.

Termination of coverage for disabled union members

A disabled insured individual will cease to be eligible for applicable benefits on the earliest of the following dates:

- 1) the last day of the month he/she is no longer deemed totally disabled and receiving disability benefits (i.e. LTD, WCB, etc.);
- 2) the last day of the month in which his death occurs;
- 3) the last day of the month in which he attains age 75 (for early retired members, must self-pay following conclusion of LTD benefit at early retirement age, currently age 62);
- 4) the date the trust agreement is terminated.

REINSTATEMENT OF COVERAGE:

An individual who has ceased to be eligible for benefits may again become eligible for benefits only upon re-qualifying in accordance with the terms of this document. If an individual re-qualifies within six months of ceasing to be eligible for benefits, completion of the enrolment documentation for the basic Life insurance and basic AD&D insurance benefits is required. However, completion of the enrolment

documentation for the other benefits is not required, provided the individual confirms in writing that all of the information contained within the former enrolment documentation remains accurate.

DISABILITY CLAIMS:

All disability claims should be recorded with the plan administrator and Manulife Financial, regardless of whether or not you are eligible to receive Workers' Compensation, CPP disability, auto insurance, or E.I. disability benefits. This recording will assist you should your claims with these agencies be declined either immediately or at a future date. In addition, proper application will be made relative to a waiver of life insurance and AD&D premium which is required within 12 months of the date of initial disability.

DISABILITY PROVISION:

Disabled union member

If a union member is disabled and approved for LTD benefits (or similar coverage), the trust fund will extend coverage for extended health, travel medical emergency, vision, and dental up to age 62 with the appropriate premium payments paid by the trust fund noting life, LTD, AD&D, premiums are subject to waiver of premium if submitted within 12 months of the date of disability and subject to assessment/approval. After this period, the union member may be extended coverage, subject to receipt of applicable self payments to age 75 as a retired member. This provision is subject to review from time to time and it may change at the discretion of the board of trustees due to the financial stability of the plan.

The union member is eligible for this extension of coverage only as long as he/she remains a member in good standing with Plumbers Local 170.

Disabled associate employee

If an associate employee is deemed to be disabled of a long-term nature, extended health, travel medical emergency, vision, and dental care can be extended to age 65 subject to receipt of ongoing required monthly contributions. The life, LTD, and AD&D premiums are subject to waiver of premium, if submitted within 12 months of the date of disability and subject to assessment/approval. Coverage will cease at the earlier of the date of recovery, the date appropriate monthly contribution remittances is not received within the allowable time, or the disabled participant reaches age 65.

RECIPROCAL AGREEMENTS:

Plumbers Local 170 members – union members working in a jurisdiction other than Plumbers Local 170 and on whose behalf contributions are being made to a welfare plan should complete a *Transfer Authority Form* and advise the local union or plan administrator to reciprocate contributions to their “*Home fund*”. This will maintain coverage under the Plumbers Local 170 welfare plan.

TRAVEL CARD MEMBERS:

Employees of employers on whose behalf contributions are made but who are members of other local unions or funds and whose funds have entered into a reciprocal agreement with the Plumbers Local 170 welfare plan will not be eligible for benefits but will have all contributions made on their behalf reciprocated to their "*Home fund*" after they complete the *Transfer Authority Form* available at the Local Union 170 office or from the plan administrator.

THIRD PARTY LIABILITY:

If you or your dependant have the right to recover damages from any person or organization with respect to which benefits are payable by the plan or, if applicable, the insurer, you will be required to reimburse the plan or, if applicable, the insurer, in the amount of any benefits paid out of the damages recovered.

The term "*damages*" will include any lump sum or periodic payments received with respect to: (1) past, present, or future loss of income; and (2) any other benefits, otherwise payable by the plan or, if applicable, the insurer.

If you or your dependant receives a lump sum payment under judgment or settlement for benefits which would otherwise be payable by the plan or, if applicable, the insurer, no further benefits will be paid by the plan, or if applicable, the insurer, until the benefits that would otherwise be payable equal the amount of the lump sum.

If a claim for damages is settled before trial, you will be required to reimburse the plan, or if applicable, the insurer the amount that reasonably reflects the loss of benefits that would otherwise be payable by the plan, or if applicable, the insurer.

You or your dependant must notify the plan administrator of any action commenced against a third party and of any judgment or settlement in the circumstances described above.

MEMBER LIFE INSURANCE BENEFIT

Eligibility

All eligible hour bank insured members, associates, and insured retired members (under age 75) are entitled to the basic life insurance benefits noting self-paying insured members are limited to 24 consecutive months.

Amount of benefit

On the date of death of a covered member, his designated beneficiary is entitled to a lump sum payment as follows:

- 1) \$85,000 if the deceased was an hour bank member at the date of death, subject to a reduction to \$20,000 for self-paying retired member classification, terminating at age 75. Life insurance will reinstate to \$85,000 for retired members who have returned to active employment and satisfied eligibility requirements;
- 2) \$85,000 if the deceased was an associate at the date of death, terminating at age 65; or
- 3) the lump sum amount that would have been payable at the date he became disabled, if the deceased was disabled at the date of death,

and if the deceased was a special senior member, the designated beneficiary will not be entitled to any lump sum payment.

Conversion privilege

If the basic life insurance benefit is not maintained for any reason other than death of a covered member, a covered member may elect to convert all or a portion of his basic life insurance benefit to an individually-owned life insurance policy. Covered members over age 65 are entitled to convert up to the terminated coverage amount.

To exercise the conversion privilege, the covered member must submit to the claims payer for the basic life insurance benefit a completed application within 31 days of the date of such termination. The covered member shall not be required to provide any medical evidence of insurability to the claims payer and the regular premium rates of the claims payer for the individually owned policy of life insurance will apply.

If a covered member dies within the 31 days following termination of coverage for the basic life insurance benefit, then his/her designated beneficiary will be entitled to the basic life insurance benefit as if it had not been terminated.

Exclusions and limitations

The payment of the basic life insurance benefit to the designated beneficiary shall be subject to any exclusion or limitation stated in the contract with the claims payer for the basic life insurance benefit.

Waiver of premium benefit

For covered member's approved for long-term disability (LTD) benefits, the plan will waive the payment of life insurance premiums for such a covered member and the plan will self-insure the applicable insurance coverage.

To qualify for the waiver of premium benefit, the covered member must furnish due proof of disability, satisfactory to the plan.

Premiums will be waived starting with the date the required proof is approved by the plan. Premiums shall not be waived beyond the earlier of the date the member ceases to be totally disabled, or upon attainment of age 62 for members on LTD via the welfare plan, and age 65 for members on LTD via the pension plan.

From time to time, the plan shall have the right to require proof of continuance of the member's totally disability. The member may be required to be examined by a medical examiner designated by the plan, at the plan's expense.

No benefits shall be provided for a member under this benefit if the member fails to submit proof of disability when required.

The amount of life insurance for which premiums shall first be waived shall be the amount in force on the covered member's date of disability. If the amount of insurance would have reduced at a later date based on the *Schedule of insurance* in force on the member's date of disability then the amount of insurance for which premiums are being waived will be reduced in a like manner.

If the member dies while insurance is being continued in accordance with this provision, the amount of insurance that

the plan will pay will be the amount of insurance for which premiums are being waived at the time of death.

If the covered member dies within one year after the date he became totally disabled and unable to work, due to such disability but before due proof of his total disability was furnished to the plan, the plan will pay to his beneficiary the amount of life insurance to which the member was entitled on the date he became so disabled. The plan must receive proof of his death and that he was totally disabled during this period not later than one year after his death.

No further benefit shall be provided for the member under this provision if:

- 1) the covered member ceases to be approved for long-term disability benefits;
- 2) the covered member fails to submit proof of continuance of disability when required;
- 3) the covered member fails to be examined by a qualified physician when required.

If the covered member does not return to active work within 31 days after this benefit ceases, he may apply with the basic life benefit claims payer, to convert the amount of insurance that was subject to this provision as though insurance had ceased on that date due to termination of employment.

If this contract or waiver of premium provision terminates, the plan remains liable to provide waiver of premium benefits for continuous disability caused by an accident or sickness that occurred prior to termination provided a claim is submitted within 12 months of the covered member's last active day at work and due proof of disability, satisfactory to the plan, is furnished within 18 months of the last active working day.

At the end of any 90-day period during which the member was not disabled the plan ceases to be liable for any future waiver of premium benefit for disability caused by an accident or sickness that occurred prior to termination.

However, the plan shall not be liable for waiver of premium benefits after the termination of the contract or waiver of premium provision if a replacing policy is bound contractually or as a matter of law.

BASIC AD&D INSURANCE BENEFIT

Eligibility

All hour bank insured members, associates, and insured retired members (under age 75), noting self-paying insured members are limited to 24 consecutive months, will be entitled to the basic AD&D insurance benefits in accordance with the contract issued by the appointed insurer (i.e. claims payer).

Amount of benefit

If a covered member suffers any loss as a direct result of bodily injury caused by an accident and such loss occurs within 365 days after the date of the accident and is listed in the contract with the claims payer for this benefit, there shall be paid to the covered member, or if the accident results in death of the covered member, to his designated beneficiary, a lump sum payment determined as follows:

- 1) if he/she suffers only one loss, by multiplying the “principal amount” referred to in this section by the percentage for that loss listed in *Schedule of losses* in the contract with the claims payer for this benefit;
- 2) if he/she suffers multiple losses, by multiplying the principal amount referred to in this section and the insurer contracts by the percentage that is the highest of all his multiple losses suffered as listed in the *Schedule of losses* in the contract with the claims payer for this benefit.

Principal amount

The principal amount of basic AD&D insurance benefits, as referred to in the *Schedule of benefits*, is determined as follows:

- 1) \$85,000 if the covered member was an hour bank member at the date of loss, subject to a reduction to \$20,000, for retired member classification, terminating at age 75. AD&D will reinstate to \$85,000 for retired members who have returned to active employment, and satisfied eligibility requirements;
- 2) \$85,000 if the covered member was an associate at the date of loss, terminating at age 65; or

- 3) the lump sum amount that would have been payable at the date he became disabled, if the covered member was disabled at the time of loss;

and if the covered member was a special senior member, he/she or his/her designated beneficiary will not be entitled to any lump sum payment.

SCHEDULE OF BENEFITS

<u>For loss of</u>	<u>Percentage of the principal sum</u>
---------------------------	---

Life	100%
Entire sight of one eye	66 2/3%
Speech	66 2/3%
Hearing in one ear	33 1/3%
All toes of one foot	25%

<u>For loss or loss of use of</u>	
--	--

One arm	75%
One leg	75%
One hand	66 2/3%
One foot	66 2/3%
Thumb and index finger or at least four fingers of one hand	33 1/3%

<u>For total paralysis of</u>	
--------------------------------------	--

Both upper and lower limbs (Quadriplegia)	200%
Both lower limbs (Paraplegia)	200%
Upper and lower limbs of one side of body (Hemiplegia)	200%

Principal sum means the amount of insurance indicated in the *Summary of benefits*.

"Loss" as used above 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 finger means the complete severance at or above the metacarpophalangeal joint; as used with reference to toe, means the complete severance at or above the

metatarsophalangeal joint; and as used with reference to eye, means the irrecoverable loss of the entire sight thereof.

"Loss" as used above 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.

"Loss" as used above with reference to quadriplegia, paraplegia and hemiplegia means the complete and irreversible paralysis of such limbs.

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

Indemnity provided under this section for all losses sustained by any one insured individual, as the result of one accident shall not exceed the following:

- 1) The principal sum for all losses except quadriplegia, paraplegia and hemiplegia.
- 2) Two times the principal sum, or the principal sum if loss of life occurs within 90 days after the date of the accident with respect to quadriplegia, paraplegia and hemiplegia.

EXCLUSIONS

This plan does not cover a period of hospitalization which is less than five days with respect to the *Hospital indemnity benefit* nor any loss, fatal or non-fatal, caused or contributed to by:

- 1) self-destruction or self-inflicted injury, whether the insured individual be sane or insane;
- 2) declared or undeclared war or any act thereof;
- 3) riding as a passenger or otherwise in any vehicle or device for aerial navigation other than as provided in the part entitled *Aircraft coverage*;
- 4) committing, attempting, or provoking, an assault or criminal offence (except for an accident which occurs while the member is operating a motor vehicle and the

blood contains more than 80 milligrams of alcohol in 100 millilitres of blood [.08 per cent]).

Your accidental death and dismemberment plan also includes the following benefits, which are briefly described. Please contact your plan administrator for complete details and limitations.

Aggregate limit

\$5 million per accident for all insured individuals.

Waiver of premium benefit

If a covered member becomes disabled and qualifies for the waiver of premium benefit under his/her life insurance coverage, the plan will also waive the payment of accidental death and dismemberment insurance premiums for that covered member and the plan will self-insure the applicable insurance coverage.

The amount of accidental death and dismemberment insurance for which premiums shall first be waived shall be the amount in force on the member's date of disability. If the amount of insurance would have reduced at a later date based upon the *Schedule of insurance* in force on the member's date of disability, then the amount of accidental death and dismemberment insurance for which premiums are being waived will be reduced in a like manner.

A member's entitlement to waiver of premium benefits cease on the earlier of:

- 1) the date the waiver of premium for life insurance ceases;
- 2) the date the coverage terminates.

Aircraft coverage

Coverage while riding as a passenger but not as a pilot or member of the crew.

Exposure and disappearance

Loss due to unavoidable exposure to the elements. Loss of life resulting from bodily injury caused by an accident at the time of a disappearance, sinking or wrecking.

Repatriation benefit

The insurer will pay the reasonable and customary expenses incurred for the transportation of the body of the deceased insured individual to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased, subject to a maximum of \$10,000.

Occupational training benefit

(Applicable to member coverage only)

In the event of your accidental death, the insurer will pay the reasonable and customary expenses incurred within three years following the date of the member's accident for a spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, subject to a maximum of \$10,000.

Rehabilitation benefit

(Applicable to member coverage only)

In the event that you sustain an accidental injury which results in a loss payable and such injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, the insurer will pay the reasonable and customary expenses incurred for such training subject to a maximum of \$10,000 for any one accident.

Family transportation benefit

In the event that you sustain an accidental injury and are confined in a hospital located more than 150 kilometres from your normal place of residence, the insurer will pay the reasonable expenses incurred by all members of your immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to the confined insured individual, subject to a maximum of \$1,000.

Immediate family means a person at least 18 years of age who is the spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the member.

Seat belt benefit

In the event that you sustain an accidental injury payable under this benefit, the amount of principal sum will be increased by 10 per cent if, at the time of the accident, you were:

- 1) wearing a properly fastened seat belt;
- 2) driving or riding in a vehicle driven by a driver who was neither intoxicated nor under the influence of drugs, unless taken as prescribed by a physician, at the time of the accident. Intoxication and being under the influence of drugs is as defined by the local jurisdiction where the accident occurred.

Hospital indemnity

A daily benefit (1/30th of one per cent of your principal sum, maximum of \$2,500 per month) will be payable if you are confined in a hospital for at least five days and under the care of a physician for an accidental injury payable under this benefit, subject to a maximum of 365 days per accident.

Education benefit

(Applicable to member coverage only)

In the event of your accidental death, the insurer will pay the *Education benefit* stated below for each of your dependant children who are enrolled as full-time students in an institution for higher learning within 365 days following date of death of the member.

The *Education benefit* is equal to the reasonable and customary expenses actually incurred, subject to the lesser of five per cent of your principal sum, or \$5,000, for each year the dependant child described above continues his education on a full-time basis in an institution for higher learning, but not to exceed four years, which must run consecutively, with respect to any one dependant child.

Institution for higher learning includes any university, college, CEGEP or trade school.

WEEKLY WAGE INDEMNITY BENEFITS

Eligibility

- Active hour bank insured members, apprentices, probationary apprentices, permit members and associates are eligible if they are covered under the welfare plan in the month of disability.
- Members making self-payments, if making full subsidized payments and registered on the out-of-work board in the month of disability. The member must be covered for the duration of the WWI claim at least on mini benefits.
- Member must have worked within the last 90 days for a contributing employer.
- Members must be unable to perform work of any kind and suffered loss of wages.
- Member must be under a physician's care for the disability.
- Member cannot receive WWI benefits for more than two claims in a two-year period, without trustee approval.
- Member must make written application to the welfare plan office.

Benefits payable

- Equivalent to the EI maximum plus \$120 per week based on a seven-day week.
- Benefits begin on the first day of an accident/injury (including assault) or overnight hospital stay or day surgery (providing you have been seen by a doctor). Benefits begin on the fourth day for an illness.
- Maximum duration 15 weeks, but not beyond age 65.
- If the member is already on an Employment Insurance (EI) claim, the claim should be changed to a disability claim. If still disabled after claim runs out, the member should contact the office for further benefits.

- If not already on claim, the member must apply for EI disability benefits, if he/she is to be off longer than four weeks.
- The welfare plan will pay for four weeks; then EI will become the payer. If the member is still disabled after EI claims is finished, the member should apply to the welfare office for the balance of weeks up to 15 weeks maximum, but not beyond age 65.
- If the member does not qualify for EI nor WCB, a letter of rejection must be submitted to the office to start a claim.
- WWI benefits are taxable.

Successive claims

Absences from work due to disability are considered to be the same period of disability unless separated by:

- two complete consecutive weeks of active, full-time work; or
- one full day of work if the disability is due to a different cause.

How to make a claim

- Contact the administrator's office and a claim form will be sent to you for completion.
- When this has been returned to the office, a *Physician's Statement* will be sent to your doctor for information regarding your claim.
- A claim cannot be started until this has been returned.
- If required, further information may be required from your doctor to continue your claim.
- Weekly wage indemnity payments are issued on Wednesday of each week.
- Maximum claim is 15 weeks, based on medical information.

A covered member is not eligible for weekly wage indemnity if:

- 65 years of age or over;
- receiving pension benefits from the Plumbers Local 170 pension plan;
- receiving Workers Compensation wage loss benefits;
- disabled due to a no fault automobile insured accident, unless unable to work due to the accident for a period under eight days;
- works more than half his/her shift he/she cannot claim for that day;
- any new illness or injury occurs during an established claim. Then, it is considered to be in the same period of disability and will not result in additional benefits.
- on strike or lock-out.
- While enrolled and attending school.

No benefits will be paid for periods of disability arising from:

- disability existing prior to commencement of coverage;
- occupational accident or illness covered by the WCB Act;
- self-inflicted injuries;
- injuries or illnesses resulting from war, participating in a riot or arising while serving as a member of an armed service;
- substance abuse unless participating in an approved rehabilitation program;
- an accident while operating a vehicle, vessel or aircraft while impaired;
- disability resulting from cosmetic surgery or treatment.

LONG-TERM DISABILITY BENEFITS

Eligibility

- A member in good standing with the union.
- A covered member of the Plumbers Local 170 welfare plan at the time of disability.
- If making self-payments, you must be paying at either full or mini subsidized rate in month of disability.
- Must be under age 62.
- Not retired.
- Must be *totally and permanently* disabled as defined in the welfare plan document and under the care of a physician.

Definition of “Totally and permanently” disabled

- Disability can be either physical or mental. To be considered disabled, the condition must be *severe* and *prolonged*. *Severe* means the condition prevents regular employment working at any job even part-time. *Prolonged* means the condition is long-term and has an indefinite duration.
- Must be in receipt of Canada Pension Plan disability benefits.
- Long-term disability benefits commence on the date CPP benefits take effect.

How long-term disability benefits calculated

- The monthly benefit is equal to 70 per cent of your last regular basic hourly rate of earnings multiplied by 1,400 and divided by 12.
- Total annual disability income from all sources is limited to 85 per cent of the average of a disabled member’s best three consecutive years of earnings in covered employment.

- There is an offset for disability income from CPP (excluding benefits for dependant children) and WCB.
- There is also an offset for any income received from weekly wage indemnity for the same period of LTD benefits. And any other pension plan or long term disability plan to which the participating employers directly contribute, including Employment Insurance Act benefits.
- All-source test is applied if there is a disability income from no fault automobile insurance plan.
- LTD benefits are taxable.

When long-term disability benefits end

- Last day of month in which you die.
- Date you cease to be totally and permanently disabled.
- Date you cease to be entitled to Canada Pension Plan disability benefits.
- Date you refuse or fail to participate in a rehabilitation program.
- Last day of the month in which you attain age 62.
- Last day of the month preceding the month you retire.
- If a member is not under the care of a legally qualified physician recognized by the trustees.
- For eligible members who become disabled, and after a full and thorough investigation, the trustees may at any time decide that such a member is or is not totally and permanently disabled.

No LTD benefits shall be payable for any disability resulting from:

- a criminal offense;
- an intentionally self-inflicted injury or sickness;

- an injury or illness sustained in military service;
- substance abuse, unless participating in an approved rehabilitation program;
- operating a vehicle, vessel or aircraft while impaired by drugs or alcohol.

Other benefits available to members receiving long-term disability benefits

- Accrual is credited each year, at the industry average, to members who are active in the pension plan and have at least five years of credited service.
- The member can apply for plan paid coverage for all plan benefits for which the member and his dependants qualify. This benefit is effective on the same effective date as LTD and ceases when LTD benefits cease.
- Members awaiting qualification for LTD benefits can apply for plan paid coverage for a 12 month period. Must be applying to CPP and provide medical information regarding disability.

How To Make A claim

- A claim for waiver of premium and long-term disability benefits must be submitted within 12 months of the date disabled.
- A claim cannot be assessed until this has been returned.
- If required, further information may be required from your doctor to continue your claim.

Note: If the LTD benefits of a covered member cease before his/her retirement, due to either return to gainful employment or to being determined not to be totally and permanently disabled, and if he/she is again determined to be totally and permanently disabled within five months of cessation of his/her LTD benefits, by a cause related to the original disability, then the covered member shall have the LTD benefits originally granted to him/her reinstated from the date the trustees determine him/her to be disabled again.

EXTENDED HEALTHCARE

The extended health care (EHC) plan is designed to help you pay for specified services and supplies incurred by you and your dependants, when not provided under a government health plan or by a tax supported agency.

All dollar limits included in the benefit descriptions are **claimable** unless specifically shown as **payable**.

To determine the benefit amount **claimable**, Coughlin & Associates Ltd., the claims adjudicator, assesses the claim as follows:

- calculates the total eligible expense;
- applies the claimable limits;
- subtracts the deductible, when applicable;
- applies the reimbursement percentage;
- applies the EHC plan maximum.

To determine the benefit amount **payable**, Coughlin & Associates Ltd., assesses the claim as follows:

- calculates the total eligible expense;
- subtracts the deductible, when applicable;
- applies the reimbursement percentage;
- applies the payment limits;
- applies the EHC plan maximum.

Deductible

No deductible applicable.

Definitions

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

- 1) in our assessment, is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth;
- 2) was ordered or referred by a physician or dentist, unless otherwise specified in the benefit description;

- 3) is not a cost normally paid (in whole or part) or provided by a government plan or any other provider of health coverage;
- 4) is incurred while your coverage is valid. An expense is incurred on the date the service is provided or the supply is received.

It does not include any payment to a pharmacy or a practitioner (demanded or received by balanced billing, extra billing, or extra charging) that represents an amount in excess of the schedule of costs prescribed by the government plan. PharmaCare's low cost alternative and reference based pricing will not be applied unless specified in this booklet.

Physician – means only a doctor or surgeon who is a doctor of medicine (MD) duly licensed to practice medicine in Canada or any state of the United States of America and who is recognized by the College of Physicians and Surgeons in the province or state in which treatment is rendered.

Practitioner – means an individual who is currently licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided or, where no such authority exists, has a certificate of competency from the professional body that establishes standards of competence and conduct for the profession, and is acting within the scope of that license.

In-province eligible expenses

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

Reimbursement at 100 per cent of eligible expenses

1) Vaccines

Vaccines dispensed by a licensed pharmacist or physician within Canada for preventative purposes reimbursed effective June 1, 2021 up to \$250 per person per calendar year on a reasonable and customary basis. No benefit shall be payable for any charges incurred for the administration of a vaccine.

- 2) **Injection Administration Fees**
Effective June 1, 2021, Injections administration fees charged by a physician or pharmacist reimbursed up to \$100 per person per calendar year.
- 3) **Diagnostic tests**
Covers diagnostic testing that is not covered by provincial health care (inclusive of prostate blood testing, etc.) for covered individuals, excluding special senior members and their covered dependants, maximum of \$100 per calendar year per person;
- 4) **Smoking cessation products**
Covered up to \$500 per person per lifetime subject to official receipt (detailing patient name, purchase, date, item). Includes nicotine patches and gum, Zyban, acupuncture.
- 5) **Fertility Drugs & Treatment**
Effective January 1, 2021, reimburse up to \$5,000 per person per lifetime for prescribed drugs and treatment. Please note that there is no coverage for administration of drugs, facility fees or operating room fees.
- 6) **Botox**
Effective June 1, 2021, Botox prescribed for the treatment of migraines and/or hyperhidrosis covered up to \$200 per person per calendar year.
- 7) **Foldable intraocular lens implants**
Coverage in excess of provincial health care plan up to \$1,000 per person per lifetime.
- 8) **Prolotherapy**
Effective June 1, 2021, Prolotherapy injections into a joint or other body part to assist in ligament, tendon or muscle repair covered up to \$200 per person per calendar year.
- 9) **Medical bracelets**
Subject to medical necessity, maximum of \$50 per person per calendar year (requires an official itemized receipt indicating patient's name and item description) as well as date of purchase and amount (cash register receipts will not suffice).
- 10) **Emergency Ambulance**
 - a) Charges for licensed ambulance for response and/or service to and from the nearest Canadian hospital

equipped to provide the type of care essential to the patient.

- b) Air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport.
- c) Emergency transport from one hospital to another, only when the original hospital has inadequate facilities.
- d) Charges for an attendant when medically necessary.

11) Eyeglass/contact lens/laser eye surgery coverage (Vision Care benefit)

Benefits payable is 100 per cent of a claim to a maximum of \$700 per person per 24-month period effective January 1, 2022. As well, effective January 1, 2019 implement Laser eye surgery coverage of up to \$3,000 per person per lifetime.

Effective January 1, 2022, prescribed Corrective contact lenses for severe medical condition up to \$700 per person per 24 month period if vision in better eye can be improved to a 20/40 level with a contact lenses, but not with glasses.

Effective June 1, 2021, Visual training benefit up to a lifetime maximum of \$1,000 per person provided the vision therapy program is prescribed by a doctor of optometry to improve conditions like crossed eyes, lazy eye, etc. Visual Therapy generally used for many problems that cannot be treated with eyeglasses or contact lenses alone.

Contact the Plumbers Local 170 welfare office for forms and assistance. (Local at 604-526-3434 or, toll-free, 1-800-665-6808). This benefit is administered in-house at the Plumbers Local 170 welfare office.

12) Eye examinations (Vision Care benefit)

Charges for routine eye examinations every calendar year to a maximum of \$100 when performed by a physician or optometrist for covered Members and their eligible dependents to the later of age 65 or expiry of his hour bank account; charges in excess of Insured's Provincial Plan. Effective June 1, 2021, additional eye exam up to \$100 per person calendar year for specific medical condition (glaucoma, diabetes, dry eye disease, macular

degeneration, retinopathy, and cataract) if coverage exhausted with Provincial Health Plan.

This is administered in-house at the Plumbers Local 170 welfare office, please contact the welfare office for forms and assistance (Phone: 604-526-3434 or toll-free at 1-800-665-6808).

13) Practitioners

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

Acupuncturist.....	\$700
Chiropractor (inclusive of X-rays).....	\$700
Massage practitioner.....	\$700
Naturopath.....	\$700
Physiotherapist (inclusive of athletic therapy)	\$700
Podiatrist.....	\$700
Speech language pathologist.....	\$700
Psychologist (inclusive of family and marriage counsellors).....	\$1,500

Private duty care by a registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province of residence.

14) Hearing aids and repairs

To a maximum payable of \$2,000 every five years per person. Batteries, re-charging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

15) Custom Ear Plugs

Custom Ear Plugs that have been prescribed by a physician up to \$500 every five years per person. An official itemized receipt along with a physician referral must be submitted.

16) Pediatric Ear Molds

Effective June 1, 2021, Pediatric ear molds prescribed by a physician for children 6 to 18 years of age covered up to \$300 per calendar year. An official receipt along with a physician referral must be submitted.

17) Orthopedic Shoes and Orthotics:

- i) when prescribed by a physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, custom made orthopedic shoes (including repairs) and modifications to stock item footwear to a calendar year maximum of \$500 for an adult and \$300 for a dependant child. A custom made orthopedic shoe is one fabricated from raw materials and specifically designed for the patient, based on three-dimensional volumetric model of the patient's foot and lower leg;
- ii) when prescribed by a physician, podiatrist, chiropractor, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics and arch supports to a calendar year maximum of \$400. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet.

Reimbursement at 95 per cent of eligible expenses

Drugs

Drugs and medicines (note the EHC deductible is not applicable and special seniors including covered dependants, remain at 100 per cent reimbursement, subject to applicable maximum) as listed on the BC provincial formulary and dispensed by a licensed pharmacist or a physician, in a quantity we consider reasonable:

- 1) drugs and medicines that legally require a prescription from a physician or dentist, and included with the above;
- 2) insulin preparations, testing supplies, needles, and syringes for diabetics;
- 3) erectile dysfunction drugs, effective March 1, 2020, up to a maximum of 15 pills every 3 months;
- 4) vitamin B12 for the treatment of pernicious anemia;
- 5) allergy serums when administered by a physician;

- 6) Oral contraceptives, medicated (hormone releasing) IUD's and contraceptive patches;
- 7) Epi-Pens.

The above items will be reimbursed up to \$1,500 per family unless proof of a higher BC Fair PharmaCare Program deductible is provided. If you are a resident of a province other than BC, your drug coverage will be the lesser of your own provincial drug coverage or equivalent coverage entitlement within the BC Fair PharmaCare Program.

Reimbursement at 80 per cent of eligible expenses

(Note: Once \$1,000 has been paid in a calendar year, further eligible expenses will be reimbursed at 100 per cent, subject to maximums in contract).

1) Hospital

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

2) Dental accident

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

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

We pay benefits based on eligible dental services and financial limits in the fee guide in the province/territory of service.

3) Medical aids and supplies

Charges for the following services and supplies:

- a) oxygen, blood and blood plasma;
- b) ostomy and ileostomy supplies;
- c) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports;
- d) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis;
- e) surgical brassieres covered up to \$500 per person per calendar year;
- f) charges for the following items to the limitation and maximum amounts indicated per calendar year:
 - i) stump socks.....no maximum
 - ii) surgical (compression) stockings two pairs

The official receipt must indicate the compression factor (minimum 20+ factor being purchased from a medical practitioner or supplier).

- g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum payable of \$500;

4) Standard durable medical equipment

- a) Pre-authorization is required from us for expenses in excess of \$5,000.
- b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.
- c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We

may request trade-in or return of replaced equipment.

- d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
- e) Standard durable equipment includes:
 - i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent;
 - ii) medical heart and blood glucose monitors, and cardiac screeners;
 - iii) bi-osteogen systems (when recommended by an orthopedic surgeon) and growth guidance systems;
 - iv) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators;
 - v) insulin infusion pumps for diabetics – when basic methods are not feasible;
 - vi) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain;
 - vii) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

5) Medical examinations

Charges for a physician for medical examinations required by government statute or regulation for employment purposes, provided such charges are not payable under a collective agreement.

Exclusions

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

- 1) Except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, X-rays, hospital co-insurance, vitamins and/or minerals, contraceptives, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of physicians or any person who renders a professional health service in the patient's province of residence.
- 2) General anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription.
- 3) Any drug, item or service classified as preventive treatment or administered for preventive purposes, and that is not specifically required for treatment of an illness or injury other than what is specifically listed under eligible expenses.
- 4) Allergy testing unless rendered by a naturopath.
- 5) Personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures, and medical laboratory tests.
- 6) Charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English.
- 7) Any payment to a pharmacy, a practitioner, or a physician (demanded or received by balanced billing, extra billing or extra charging) that represents an amount in excess of the schedule of costs prescribed by the government plan.

- 8) That portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits.
- 9) Expenses incurred, outside your province of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment.
- 10) Charges incurred outside your province of residence for continuous or routine medical care normally covered by the government plan in your province of residence.
- 11) Expenses of a dependant hospitalized at the time of enrolment.
- 12) Services performed by a physician who is related to or resident with you or your spouse.
- 13) Ambulance charges for work related illness or injury assessed by the Workers' Compensation board to be your employer's responsibility.
- 14) Retroactive coverage and payment of any expense, including expenses that receive special authorization from PharmaCare.
- 15) Medical Cannabis.
- 16) Breast Pump.
- 17) Any other item not specifically included as a benefit.

Claims

- 1) Since the claims adjudicator or the plan administrator does not return receipts after the claim is processed, you should keep a photocopy of the receipts you submit to us. We will send you a remittance statement for your records each time you submit a claim.
- 2) If you have duplicate coverage, please review the *Coordination of benefits* section under *General information*. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding

the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.

- 3) Certain medical expenses are covered under the government plan. If you submit your claim to us before you submit your claim to the government plan, we will deduct what the government plan would normally pay (i.e. PharmaCare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design. Information for claiming PharmaCare expenses may be obtained from your pharmacist.
- 4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
 - a) Obtain a claim form from Coughlin & Associates Ltd, your plan administrator or claims adjudicator.
 - b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
 - c) Please submit claims within **90 days** from the date the expense was incurred. However, Coughlin & Associates Ltd., the claims adjudicator, must receive your claim by **June 30th** of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances. For example, the claims adjudicator must receive your receipts for 2021 before June 30, 2022.

TRAVEL MEDICAL EMERGENCY

Travel assistance is provided by Global Excel Management Inc. With centres worldwide they will:

- help locate the most appropriate medical facility for you.
- confirm coverage with AIG Insurance Company of Canada and assure the hospital that you are covered.
- guarantee payment for hospitalization, if necessary.
- arrange for admission to a hospital.
- provide translation services.
- contact your own doctor for recommendations, when required.
- contact your family and employer, when required.
- arrange for/co-ordinate emergency medical evacuation. and
- co-ordinate your return home.

How to Claim

If you require emergency medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately. If circumstances prevent you from calling Global Excel Management Inc. right away, you should contact them as soon as you can. Global Excel Management Inc. will help ensure that you receive the medical care you need and, if possible, will make claims payment arrangements directly with the hospital or service provider.

If you contact GLOBAL EXCEL MANAGEMENT INC. right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

If you are not able to contact Global Excel Management Inc. before being billed for the charges, or if your medical needs are minor in nature (i.e., costing less than \$500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip. In any case, your claim should be submitted no later than 90 days after the expense was incurred. Global Excel Management Inc. and the insurance company are not responsible for dealing with any payment reminders or collection notices that you receive from medical providers.

To make a claim for out-of-pocket expenses, contact a Global Excel Management Inc. operator at:

From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

Give the operator your name and your Policy Number: CMG 9428867.

The operator will send you a claim form. When you complete the form, provide the patient's name and provincial health plan number and your certificate number. Be sure to attach detailed statements and original receipts showing the services rendered and the charges for each service.

Mail your completed claim form and attachments to:

Global Excel Management Inc.
73 Queen Street
Lennoxville, QC, J1M 1J3

Please make sure you obtain your medical records, statements, or detailed receipts at the time of treatment and/or discharge, to submit with your claim. All claims must be submitted to Global Excel Management Inc. as soon as possible, and no later than 90 days after the expense was incurred.

DENTAL CARE

Payment of benefits

- 1) The claims adjudicator, Coughlin & Associates Ltd., to pay benefits based on dental services, financial limits and treatment frequencies in the fee schedule.
- 2) The claims adjudicator, Coughlin & Associates Ltd., to apply the reimbursement percentage shown in the *Highlight of benefits* to the fees shown in the fee schedule/fee guide as follows:
 - a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia – the fees in the fee schedule;
 - b) for services performed in Canada but outside British Columbia – the fees in the fee guide in the province/territory of service;
 - c) for services performed outside Canada if your province of residence is not British Columbia – the fees in the fee guide in your province/territory or residence.
- 3) Fees in excess of the amount shown in the applicable fee schedule/fee guide will be your responsibility.

Plan A – Basic preventative & restorative services

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

- 1) **Diagnostic services**
 - a) examinations
 - i) complete, provided we have not paid for any other exam by the same dentist in the past six months – one per three-year period;
 - ii) recall – two per calendar year;
 - iii) specific – two per calendar year;

iv) consultations (as a separate appointment) – two per calendar year.

b) X-rays

i) diagnostic;

ii) panoramic – one per two-year period;

iii) complete mouth series – one per three-year period;

All X-rays combined shall not exceed the dollar limit for a complete mouth series.

c) diagnostic models – one set per calendar year.

2) **Preventative services**

a) scaling;

b) polishing – two per calendar year;

c) topical application of fluoride – two per calendar year;

d) fixed space maintainers;

e) preventative restorative resins and pit and fissure sealants – combined limit of one per tooth in a two-year period. No age limit.

3) **Restorative services**

a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a five surface filling per tooth in a two-year period

i) amalgam (silver coloured) fillings;

ii) composite (tooth coloured) fillings;

iii) white composite fillings.

b) stainless steel crowns on primary and permanent teeth, once per tooth in a two-year period;

c) inlays or onlays – only one inlay or onlay on the same tooth will be covered in a five-year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material;

4) **Endodontics**

For the treatment of disease of the pulp chamber and pulp canal including, but not limited to, root canals, one per tooth in a five-year period.

5) **Periodontics**

For the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts which are included under Major Restorative Services, but including the following:

- a) occlusal adjustment and recontouring – a combined yearly limit shown in our *Fee schedule*;
- b) root planning;
- c) gingival curettage – one per sextant in a five-year period;
- d) osseous surgery – one per sextant in a five-year period;

6) **Prosthetic repairs**

- a) removal, repair, and re-cementation of fixed appliances;
- b) re-base and re-line of removable appliances – a combined limit of one per upper and one per lower prosthesis in a two-year period;
- c) tissue conditioning: two per upper and two per lower prosthesis in a five-year period;
- d) gold foil – only when used to repair existing gold restorations.

7) **Surgical services**

- a) extractions;
- b) other routine oral surgical procedures;
- c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our *Fee schedule*.

Plan B – Major restorative services

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

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

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

1) **Prosthodontic services**

- a) removable
 - i) complete upper and lower dentures;
 - ii) partial upper and lower dentures.
- b) fixed bridges.

2) **Restorative services**

- a) inlays or onlays involved in bridgework;
- b) veneers;
- c) crowns and related services.

3) **Major Periodontal Services**

- a) Bruxing guards, two appliances in a five-year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards);
- b) Periodontal grafts, including soft tissue and bone grafts.

4) **Implants and Implantology**

Implant dental surgery and related oral surgical services such as abutment insertion, ridge augmentation, bone preservation; implant related periodontal surgery; and subsequent implant retained appliance.

Limitations

- 1) Only one major restorative service involving the same tooth will be covered in a five-year period.
- 2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.
- 3) Only one upper and one lower denture (complete or partial) is eligible in a five-year period.
- 4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
- 5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our fee schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed on or after the effective date of your coverage. If coverage terminates during a course of orthodontic treatment for which we have started payments, we will continue to pay, up to but not exceeding the amount that would have been paid in the 12-month period immediately following the termination date of coverage. This provision will not apply if this contract is terminated.

Plan C covers orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations

- 1) The lifetime benefit maximum under Plan C is shown in the *Highlight of benefits*.
- 2) No benefit is payable for the replacement of appliances that are lost or stolen.

- 3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
- 4) Treatment performed solely for splinting is not covered.

Emergency treatment outside your province of residence

You are entitled to the services of a dentist if, while travelling or on vacation outside your province of residence, you require emergency dental care. You will be reimbursed according to our fee schedule.

Exclusions

The following are not eligible expenses under your dental plan:

- 1) Items not listed in the fee schedule and fees in excess of those listed in the fee schedule.
- 2) Any item not specifically included as a benefit.
- 3) Charges for broken appointments, oral hygiene, or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English.
- 4) Procedures performed for purely cosmetic reasons.
- 5) Charges for drugs and pantographic tracings.
- 6) Anaesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies.
- 7) Charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint.
- 8) Incomplete or temporary procedures.
- 9) Recent duplication of services by the same or different dentist.
- 10) Any extra procedure which would normally be included in the basic service performed.
- 11) Services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits.

12) Travel expenses incurred to obtain dental treatment.

Claims

- 1) It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your dentist submit an outline of the proposed services to the Coughlin & Associates Ltd., claims adjudicator, **before you start treatment.** This is important especially when your dentist is recommending extensive dental work. This will help you understand what portion of the dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your dentist.
- 2) Please submit claims within **90 days** of the completed date of service (earlier if possible). Failure to submit a claim within the 90-day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will the claims adjudicator pay any claim or adjustment submitted later than June 30 of the calendar year following the year in which the expense being claimed was incurred.
- 3) A separate claim form is required for each member of your family who has received dental services. Be sure to include the following information on the claim form:
 - a) name of the dentist;
 - b) name and birthdate of the person receiving the dental care;
 - c) your group, ID, and dependant(s) numbers;
 - d) your home mailing address;
 - e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your dependants are covered by two plans, your dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

- 4) Before your dentist starts treatment, please ask about billing. The claims adjudicator may pay in either two ways:
 - a) pay the dentist directly for services provided under this dental plan when they receive a claim form signed by the dentist, certifying these services were performed and the fee charged; or
 - b) if you have paid your dentist directly, we will reimburse you the benefit amount when we receive a claim form or receipts signed by your dentist. We will send you a cheque when the claim is processed.

- 5) Orthodontic claims procedures
 - a) Claims requirements

When treatment commences, the claims adjudicator will require a completed dental claim form stating the monthly or quarterly change and the months to which it applies, to establish that treatment is in progress. Please note that reimbursement will be based on the monthly or quarterly fees as outlined in the treatment plan and not on the amount or date of payment, even if treatment is prepaid.
 - b) Claiming deadlines
 - i) Please submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
 - ii) Reimbursement is made if the complete and correct claims information is received within one year of the due date. However, no benefit is payable for claims not received by June 30 of the calendar year following the year in which the expense being claimed was incurred.
 - c) Treatment plan
 - i) Have your orthodontist complete the *Certified Specialist in Orthodontics Standard Information* form (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.

- ii) If the payment schedule or treatment changes, the claims adjudicator will require a revised treatment plan for review.
 - iii) The claims adjudicator will retain your treatment plan on file. If they do not have your treatment plan on file they are unable to pay:
 - your initial fee/down payment;
 - your monthly/quarterly fees;
 - one-time appliance fees.
 - iv) Claims for consultations, exams and records (X-rays, study models, etc.) will be reimbursed without a treatment plan on file.
- d) Monthly or quarterly fees
- i) If you are paying in monthly or quarterly instalments, submit receipts for the monthly or quarterly fees on a regular basis as treatment progresses. Claims receipts received by the claims adjudicator that are over one year old will not be reimbursed.
 - ii) If you paid any amount to the dentist before treatment is complete, the claims adjudicator will allow an initial payment amount and then pro-rate the balance into monthly payments to you throughout the treatment plan period.
 - iii) As long as your coverage remains in effect, the monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first. Orthodontic claims will be cancelled the day of the coverage month, which a person ceases to be a covered member.

HEALTHCARE SPENDING ACCOUNT (H.S.A.)

Purpose

The Trustees are pleased to advise that they have implemented a Healthcare Spending Account (H.S.A.) on behalf of all qualifying members and their dependents that are covered for benefits at July 1, 2022. The purpose of this benefit is to allow additional coverage to members and their dependents, which is beyond the coverage already provided by the Welfare Plan.

Active Insured Members - Will receive a one-time (minimum \$700) allocation (per household) in their H.S.A. account. The allocation of this benefit has been based on your hours worked in 2021 provided you have worked at least 220 hours in the 2021 calendar year. This benefit will be for eligible expenses incurred on or after July 1, 2022, to June 30, 2023. Any unused remaining balance in the members H.S.A. after the one-year period will be returned to the Plan following a seven-day run-off period (i.e. July 7, 2023). Future allocations, if any, will be subject to the financial stability of the Plan.

Returning to Work Retired or Senior Member – A member over the age of 65 who is covered under the Welfare Plan at July 1, 2022, and has the required amount of hours to be covered under their hour bank. The Healthcare Spending Account will cease once you are no longer a covered member. Any unused remaining balance in the members H.S.A. will be forfeited back to the plan. Furthermore, you must also remain a member in good standing with Local 170.

Eligibility

In order to receive this benefit, a member must remain in good standing with Local 170, be covered under the Welfare Plan at July 1, 2022, and have continuous coverage. Currently, the Plan deducts 110 hours per month of coverage. When a member's hour bank falls below the required 110 hours, a self-payment notice is mailed to the member to allow the member to make payment for continuous coverage. If the member does not elect to continue coverage through self-payment their benefits will cancel, and any remaining balance in your H.S.A. will be forfeited back to the Plan and will not be reinstated at a later date.

In order to receive this benefit, a member over the age of 65 (Returning to Work Retired/Senior Member) must remain in good standing with Local 170, be covered under the Welfare Plan at July 1, 2022 and have continuous coverage. Currently, Local 170 Plan deducts 110 hours per month for coverage. The Health Spending Account (H.S.A.) will be available ONLY while you are covered on your hour bank. Once your hour bank falls below the required 110 hours per month your benefits will cancel, and any remaining balance in your H.S.A. will be forfeited back to the Plan and will not be reinstated at a later date.

This benefit is in accordance with allowable medical expense/services within Section 118.2(2) of the Canadian Income Tax Act and Regulation 5700 under a private services plan. Please note a list of eligible medical expense is available via the CRA website at www.cra-arc.gc.ca/medical/#mdcl_xpns.

The Trustees have elected to forfeit any remaining balances after one year from initial allocation (i.e. July 1, 2022) to the Plan following a seven-day run-off period (i.e. on July 7, 2023).

Reimbursement

In order to receive reimbursement you must submit your claim on the Coughlin & Associates claim form with your original receipt, which is the same procedure as regular claims covered by the Plan. Reimbursement is subject to reasonable and customary charges.

Effective September 1, 2020, Local Union 170 Welfare and Welfare Office assumed the adjudication of the H.S.A. (previously Coughlin). Any remaining health or dental benefit expenses not covered by the basic Plan (i.e. deductibles, claims that have exceeded the allowable maximum, etc.) adjudicated by Coughlin & Associates will be reimbursed by the Plumbers Local 170 Welfare Plan Office to the extent of your H.S.A., if any, upon receipt of the Explanation of Benefits (EOB) and supporting receipts, if applicable.

Please contact the Plumbers Local 170 Welfare Plan Office for the balance of your Healthcare Spending Account.

Coordination of Benefits (dual coverage with your spouse)

If you are submitting claims that require redirection to your spouse's plan for coordination of benefits, any remaining

balance following coordination of benefit with your spouse's plan will need to be submitted (summary statement from your spouse's insurer), to Local 170 Health & Welfare Office by June 30, 2022.

Termination

In the event of termination of Membership or Active Insured status, from the Plumbers Local 170, the remaining Healthcare Spending account balance will be immediately forfeited to the Trust Fund.

Death

In the event of a Union Member's death, coverage will be extended to the surviving dependants as follows:

1. Spouse – until the balance of the Healthcare Spending Account is depleted.
2. Dependent Children – until they no longer qualify as dependants under the Group Insurance Plan or the balance of the Healthcare Spending Account is depleted.

Reinstatement

Reinstatement of a Union Member's Healthcare Spending Account is not applicable as it is a requirement that a Member maintain a positive status with the Plumbers Local 170.

Marital Separation / Divorce

As per the provisions for the insured benefits, the Healthcare Spending Account will not be extended to the spouse following separation or divorce. Alternatively, eligible dependent children will continue to be eligible for participation at the discretion of the Union Member.

List of Eligible Medical Expenditures

A list of eligible medical expenses is available via the Plan Member Portal on the Plan Administrator's website at www.plumbers.bc.ca, or by accessing the CRA website via the link www.cra-arc.gc.ca/medical/#mdcl_xpns, and searching eligible medical expenses.

To determine the outstanding balance in a Member's individual HSA, the Member should contact the Plan Administrator at 604-526-3434 or Toll Free 1-800-665-6808.

JURY DUTY FUND

Eligibility

- Must be an active member of Local 170.
- Eligible if not working when selected.
- Must have worked for a contributing employer within the last five years.
- Employers must have contributed to the jury duty fund.
- Includes Members subpoenaed to go to court as a witness.

How benefits are paid

- Member is paid 100 per cent of his/her base rate at last day of employment (Journeyman rate). Maximum eight hours per day including holiday pay.
- Apprentices who are members of the union are paid 100 per cent of the applicable apprentice rate of pay at last day of employment. Maximum eight hours per day including holiday pay.
- Maximum of 90 working days on straight time hours only.
- Effective February 9, 1989, contributions are also paid to the welfare and pension fund on behalf of the member.
- The entire reimbursement comes from the welfare office. No reimbursement is paid by the employer.
- The member keeps the daily fee paid to him by the sheriff's office.

How to apply

- Must apply within 14 days of receiving a summons for jury duty.
- Request an application for the Piping Industry Jury Duty Fund from the Health & Welfare office.

- This must be completed and returned to the administrator's office with a copy of the summons and a form from the sheriff's office verifying the days served for selection and/or on the panel.
- All jury duty reimbursements must be authorized for payment by the administrator and referred to the welfare board of trustees for the official minutes.

Not eligible

- A permit or probationary apprentice.
- Associates.
- Retired or receiving any benefit from the plan.
- Serving over 90 days.

SPECIAL REHABILITATION FUND DRUG AND ALCOHOL TREATMENT

Eligibility

- A member in good standing with Local 170.
- Member eligibility on an ex-gratis basis is not contingent upon being covered under the welfare plan.
- A member must not be claiming Employment Insurance benefits while collecting payments from this fund.
- For the covered union member who is eligible for benefits, the trustees may, after a full and thorough investigation, decide at any time that such member is or is not eligible for this benefit.
- Member must be in a recognized treatment centre program.
- It is intended that this benefit is available to members on a one-time basis. Exceptions to this rule would have to be brought before the board of trustees and supported with a recommendation from a rehabilitation program and documentation reviewing the members work history.

Benefits payable

- Benefits are payable from the start date of the recognized rehabilitation program (no seven-day waiting period).
- Maximum payable 28 days or six weeks, dependant upon the length of the program.
- No member will receive payment beyond five weeks without providing an Employment Insurance proof of rejection letter.
- A member who is in a recognized treatment centre program may be able to claim a further four weeks of benefits, if attending an outpatient program. Must be under the care of a physician and must have received approval by the welfare board of trustees.

- A member may otherwise be eligible for financial assistance, beyond the residential treatment, only if the request is brought to the welfare board of trustees for consideration and approval. This could include detox treatment.

How to apply for benefits

- All payments to eligible members, will be processed and approved in the welfare plan office.
- The member should contact the welfare plan office and an application form will be sent for completion. This form will have to be signed by a representative from the rehabilitation centre.
- When this form has been returned to the office, a form will be sent to the member's attending physician for completion.

FREQUENTLY ASKED QUESTIONS

Below are a few questions that have been raised by our members and we wanted to provide the information to all of our members. If there are additional questions that you have that we have not answered below, please feel free to contact the welfare plan administrator office, or Coughlin & Associates Ltd., the claims adjudicator.

1. When travelling on business or vacation and I have an emergency or accident, whom do I contact for assistance?

Your travel medical emergency insurance is fully insured. Each applicable hour bank insured member, associates, insured retired member, and survivor is covered for \$5 million in travel medical emergency insurance, whether travelling for business or personal reasons. Age restrictions vary by class. The travel medical emergency insurance (policy number is #1059144 is provided through AIG. Wallet cards with the relevant information have been issued for each member. If you are travelling and an emergency or accident occurs, you must report the incident to AIG, as soon as possible, by calling in Canada and the U.S., 1-866-870-1898; and from anywhere else, you can call collect at (819) 566-1898.

Prior to travelling, if you or your eligible dependent(s) have a known medical condition, we encourage you to contact Coughlin & Associate Ltd. (Toll Free 1-888-204-1234) for clarification of coverage, as it may not be applicable subject to the circumstances associated with your medical condition.

2. My dentist advised that to transmit a dental claim through the EDI system at the dental office I need a policy number and BIN number (may refer to carrier number). What are the numbers that are to be given to the dentist?

Coughlin & Associates Ltd., the claims adjudicator, does not use a policy number for administering claims. However, if your dentist requires a number to transmit a claim through the EDI system, please ask them to use the number 271029.

In addition, the BIN or carrier number is 610105.

- 3. When I submit a claim through the EDI system at the dentists office will Coughlin & Associates Ltd., send the cheque directly to my dentist?**

Yes, Coughlin and Associates Ltd., will reimburse the dentist directly (via mail), provided you have assigned the benefits payable to the dentist. Furthermore, an *explanation of benefits*, reflecting the payment to the dentist will be forwarded to the member for their records and review.

- 4. Where can I get a health or dental claim form to send to Coughlin & Associates Ltd. or my drug card for automatic transaction at the pharmacy?**

You can contact the plan administrator or Coughlin & Associates Ltd. the claims adjudicator, (toll-free 1-888-204-1234) for a health or dental claim form, or for co-ordination of the drug card. Or visit their website at www.coughlin.ca.

- 5. Where do I send my claims?**

Refer to the section *How to make a claim* on page 15 for complete details.

NOTICE REGARDING PERSONAL INFORMATION

When you apply for coverage under the welfare plan, the Plumbers Local 170 welfare plan administrator, Coughlin & Associates Ltd. (claims adjudicator), Manulife (Life, AD&D, and LTD), and the out-of-country travel insurer AIG, will set up a file with personal information relevant to your benefit coverage under the plan.

The purpose of this file is to permit Manulife, AIG, the plan administrator, and Coughlin & Associates Ltd. to administer all financial services provided to you, and to keep information specific to the insurer, plan administrator, and Coughlin's business relationship with you. This includes the following:

- underwriting and financial reporting;
- claims adjudication and management;
- internal and external audits;
- preparation of regulatory and statutory reports;
- assisting you in planning your financial security.

The member files are kept in the office of the plan administrator, Manulife, AIG, and Coughlin & Associates Ltd. for access when required for insurance purposes.

You have the rights to access and correct the information in your file. A request for access or correction must be in writing and may be sent to the Plumbers Local 170 welfare plan administrator, Suite #203 – 1658 Foster's Way, Delta, BC, V3M 6S6.

PRIVACY

Effective January 1, 2004, the federal Personal Information Protection and Electronic Documents Act (PIPEDA) governs the collection, use and disclosure of all personal data by all Canadian commercial organizations. Thus, every transaction involving the handling of personal data (collection, use, transfer, disclosure, storage, accessing, processing, etc.) has to be conducted in accordance with the Act.

The trustees of the welfare plan are committed to respecting your right to privacy and safeguarding your personal information. For more information regarding the privacy policy, please contact the Plumbers Local 170 welfare plan administrator or privacy officer directly at 604-526-3434 or, toll-free, 1-800-665-6808, or Coughlin & Associates Ltd. at toll-free, 1-888-204-1234, or visit www.coughlin.ca.