YOUR BENEFIT PLAN

International Union of Painters and Allied Trades District Council 38 Health and Welfare Trust Fund

Updated February 1, 2016

*****THE INFORMATION CONTAINED WITHIN THIS BOOKLET IS SUBJECT TO CHANGE. PLEASE CHECK WITH THE OFFICE FOR CURRENT RULES AND/OR REGULATIONS.*****

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YOUR PLAN

The IUPAT District Council 38 Health and Welfare Trust Fund (IUPAT DC 38 Health & Welfare Plan) was formed effective January 1, 1999 by merging three separate and distinct health and welfare plans: the Painting Industry Health and Welfare Trust Fund (Local 138); the Glaziers and Glass Workers Welfare Plan (Local 1527); and the Drywall Tapers Health and Welfare Plan (Local 2009).

Through the provision of Medical/Surgical coverage and other group insurance benefits, the Plan will provide protection to its participants when the need arises during periods of illness and unavoidable accidents. The Plan is administered by a Board of Trustees who have entered into agreements with Pacific Blue Cross to provide Dental and Extended Health Care Benefits; BC Life and Casualty Company to provide Short Term Disability Benefits and the Co-Operators Group to provide Life Insurance and Accidental Death, Disease and Dismemberment Benefits. Medical/Surgical Benefits are obtained on a group basis from the Medical Services Plan of BC The Vision Care Benefit, the Bereavement Benefit and the Member Assistance Programme are currently self-insured and paid directly by the Fund from the Plan office.

Your Board of Trustees have, at all times, attempted to provide the maximum amount of protection which could be purchased with available finances. As Trustees, we appreciate your cooperation in protecting the Plan against abuse and unnecessary usage. If benefits are carefully and properly used, it is hoped that your Plan can continue to be improved in the future. However, the Trustees reserve the right to modify or limit any of the provisions contained in the Health and Welfare Plan in accordance with the Trust Deed.

It should be pointed out that this booklet is only a summary and that it is the actual terms of the legal Plan Document which will solely determine the amount of benefits and your right to benefits under the Plan. If there is any conflict between this booklet and the Plan Document, the latter will govern.

This booklet, in conjunction with the Pacific Blue Cross booklet, outlines all the important provisions of the benefits to which the eligible Members and their dependents are entitled, explains the eligibility requirements and outlines the procedure to be followed when claims arise. Please read the information carefully. If you have any questions, please contact the Administrator for further information.

GENERAL INFORMATION

IUPAT DISTRICT COUNCIL 38
HEALTH AND WELFARE TRUST FUND
7621 KINGSWAY
BURNABY BC V3N 3C7

TELEPHONE	**(604) 524-8334**
TOLL FREE	**1-800-266-1527**
FAX:	**(604) 524-8011**
EMAIL:	**benefits@dc38.ca**
WEBSITE:	**www.dc38.ca**

- **ADMINISTRATOR:** Debbie Bremner

- **BOARD OF TRUSTEES:** Pat Byrne, Marv Magnison, Dave Hofmann, Joe Ott, Dan Jajic, Kevin Weston, Justin Chapman

- **YOUR IDENTITY NUMBER is: Your Employee Number**

- **YOUR GROUP NUMBERS are:**

  MEDICAL SERVICES PLAN OF BC
  (Medical/Surgical) 3141389

  PACIFIC BLUE CROSS:

  Active Members:
  Dental & Extended Health: 903838

  Retirees Group:
  Dental & Extended Health: 903639

  BC LIFE & CASUALTY:
  Short Term Disability: 903638

  THE CO-OPERATORS:
  Group Life, ADD&D. 6639

RULES AND REGULATIONS

SCHEDULE OF BENEFITS - FULL PLAN

The Plan provides for the following benefits for covered Members:

- Medical/Surgical Benefits
- Dental Care Benefits
- Non-Occupational Short Term Disability Benefits
- Jury Duty Benefits
- Extended Health Care Benefits
- Vision Care Benefit
- Life Insurance (including ADD&D)
- Spousal Life Insurance
- Bereavement Benefit
- Members' Assistance Program

EMPLOYER REPORTS

Your Collective Agreements require that employers report by the 15th day of each month, all hours earned by you in the preceding calendar month. It is advisable to keep your pay statements and maintain a record of all your employers and the number of hours worked each month so that you can check in the event of an error in reporting.

ESTABLISHING COVERAGE IN THE PLAN

To establish coverage in the Plan you must:

- Be a Member in good standing of District Council 38 (Local Union 138, 163, or 1527) and any future locals designated by the Trustees and be employed by a contractor/employer signatory to an agreement with one of the aforementioned Local Unions; and

- Have the required number of hours (currently 240) worked within a period of six consecutive months reported and paid for by a participating employer and/or reciprocating Local Union; and

- have completed enrollment forms and filed them with the Administrator. If the foregoing conditions have been met, coverage will begin on the first day of the month after the month in which sufficient hours have been reported.

In the case of catastrophic loss, i.e., death of the Member, coverage will commence immediately following completion of working the required number of

hours in the qualifying period, provided that enrollment forms are on file with the Administrator.

EXAMPLE: If your employer(s) report that you have accumulated in excess of the required number of hours during the last six months, coverage would commence as follows:

MONTH	**HOURS REPORTED**
January	-
February	150
March	125
April	Lag Month
May	Coverage Starts

March hours are reported and tabulated in April, therefore April becomes the lag month and coverage would commence May 1st.

Any hours reported and not used within the six consecutive month period to establish your eligibility for coverage (that is, hours that are seven or more months old) will go into the General Fund of the Plan.

If you are not a Member of the Union at the time you would otherwise qualify for coverage, coverage will commence on the first day of the month following the month in which you become a Member of the Union, provided you are still qualified otherwise. Your hour bank will be credited with any hours reported during the period you were not a Member. Maximum six months.

You will be notified by the Administrator as soon as possible after your entitlement to coverage is determined. Once you are covered, the prevailing hourbank charge (in hours) are deducted each month from your hour bank for coverage and additional hours reported are added to your hour bank.

You may accumulate up to twelve month's coverage in your hour bank to carry you through periods of poor employment or vacation. Any hours in excess of the twelve months total will go into the General Fund of the Plan.

LAG MONTH

You may wonder why your coverage must always be paid in advance. A time lag is required by the Trust Fund Administration to operate the hour bank system. Hours earned in a particular month are received by the Administrator from your employer during the following month.

Premiums for the current month's coverage must be paid to the insurer by the first of the month or payment on claims for that month will be delayed.

SELF PAYMENT - FULL COVERAGE PLAN

You will be notified by mail when your hour bank falls below the required hour minimum. You may also check your record at any time with the Administrator. This notice will advise that you are short of hours for the next month's coverage, the amount of the self-payment required and the date by which it must be paid.

The self payment provision for the Full Plan is allowed for as long as you have a minimum of one hour in your hour bank. When you no longer have a minimum hour bank balance, you will be required to change to the Partial or Mini Package.

✯ THE ONLY WAY TO GUARANTEE CONTINUOUS COVERAGE IS TO PAY ✯ THE SELF-PAYMENT NOTICE BY THE DATE SPECIFIED ON THE NOTICE

If you receive a self-payment notice which you think is incorrect, pay the notice by the required due date and send in an accompanying letter explaining why you feel the notice is incorrect.

Shortages can occur because your employer did not report within the required time frame, because your name was accidentally left off the report, because of an error in the number of hours reported, a name misspelled, or an invalid Social Insurance Number was used. If you make a self-payment and late hours are reported or other adjustments are found later, all hours will be credited to your hour bank for future coverage.

TERMINATION OF COVERAGE

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

- When your hour bank balance falls below the minimum required number of hours and you fail to make the self payment required by the specified date. Hour bank balances less than the minimum required number of hours will go into the General Fund of the Plan if the coverage is terminated because a self-payment is not made.

- When you take a clearance card to a non-participating Local. Coverage will be extended for a maximum of two months after the month in which you leave the province of BC on a permanent basis. All hours in your hour bank at termination of coverage for that reason will go into the General Fund of the Plan.

- When you stop being a Member in good standing of the Union. Coverage will be cancelled as of the date on which you are suspended or dropped and any hour bank balance will go into the General Fund of the Plan.

- When you become self-employed or work on a sub-contract basis or go to work outside the Trade. In those cases, coverage will terminate at the end of

the month in which you cease to be a union employee. All hours in your hour bank at termination of coverage for those reasons will go into the General Fund of the Plan. (See Associate Members).

- When you become a contractor signatory to an agreement with the Union or a principal in, or an administrative staff Member of same. In that case coverage will be terminated at the end of the month in which you became a contractor, principal or administrative staff Member. All hours in your hour bank at termination of coverage for those reasons will go into the General Fund of the Plan. (See Associate Members).

- In the event of the death of a Member, coverage for the Member's spouse and eligible dependents will continue for as long as the Member's accumulated Full Coverage hour bank will allow.

- In the event of a decertification from the Union where the Members choose to remain employed by the decertified employer, coverage for the Members will be terminated on the last day of the month in which the decertification occurred.

RE-QUALIFICATION AFTER TERMINATION

To re-qualify for coverage after termination, the conditions outlined in “Establishing Coverage In The Plan”, must be fulfilled as they must for new Members.

IN CASE OF INJURY OR ILLNESS

If you are injured or become ill, notify the Administrator immediately. You will be advised whether or not you are entitled to Short Term Disability Benefits. If you are entitled to Short Term Disability Benefits the necessary claim forms will be sent to you.

DEPENDENT COVERAGE

A Member's registered eligible dependents will be included in the coverage for Medical/Surgical, Extended Health Care and Dental Care Benefits.

Eligible Dependents are:

(a) Medical/Surgical Benefits: (Medical Services Plan of BC)
- the Member's spouse; and
- the Member's dependent children meeting the following requirements:
  - mainly supported by the Member; and
  - unmarried; and
  - 18 years of age or younger; or
  - 24 years of age or younger and in full-time attendance at a school or university

(b) Extended Health Care and Dental Care Benefits:

- the Member's spouse; and
- the Member's dependent children to age 21 or any dependent child who is over 21 and attending a recognized school or college on a full time basis, is mainly financially dependent on the Member or the Member's spouse, and not married or living in a marriage like relationship. A Member must be prepared to prove that an individual claimed as a dependent falls within these requirements.
- the Member's children who are physically disabled or mentally handicapped (who may be over 21 but who are dependent upon the Member for support and for whom the Member is entitled to an income tax exemption), provided each child was insured under the Plan immediately prior to his/her 21st birthday.

Dependents are not covered by the Short Term Disability, Jury Duty and Accidental Death, Disease and Dismemberment Benefits. Dependent children are not covered for life insurance.

Dependent children must be added within 60 days from the date of birth or from the date the child became a dependent, whichever is later, and spouses within 60 days of the date of marriage. Dependents not added within 60 days will be covered from the first day of the calendar month following the date of application or if specifically requested, from the first day of the month in which application is made.

Newborn or adopted children are NOT automatically registered. You must notify the Administrator and provide the child's name and date of birth in order to have them included in your coverage. You must include a copy of the child's birth certificate with your application.

GENERAL

All correspondence (including self-payment notices) will be assumed to have been delivered unless returned to the Plan by the Post Office. You are responsible for keeping the Administrator informed of your correct address. The Administrator will not be responsible for any interruption of coverage caused by your failure to notify the Health and Welfare office of your change of address.

If you are going to be away from your normal place of residence for any length of time (i.e. on extended vacation, working out-of-town, etc.) please check with the Administrator prior to leaving to ensure that your coverage will not lapse for any reason during your absence, and if possible, provide a forwarding address.

ASSOCIATE MEMBERS

Participating employers, signatory to an agreement with the Union, principals in, or administrative staff Members of same (not required to be Members of the Union); and self-employed or contractor Members of the Union, registered as such with the Union, may obtain coverage as Associate Members if they make application within 30 days of becoming eligible (either through commencement of employment or becoming signatory to a Collective Agreement in the case of participating employers, their principals or administrative staff; or registration with the Union as self-employed or contractor Member). If application is not made within 30 days and coverage is desired at a later

date, application can be made but the applicant may be required at that time, at his/her own expense, to submit a statement on both medical and oral health by his/her family doctor and dentist, for himself and each of his/her dependents before the application will be considered. Evidence of insurability for such late applicants may also be required. The Trustees may then exclude from the applicant's coverage any pre-existing conditions of the applicant and any of his/her registered dependents or decline to cover the applicant.

Application forms and remittance forms may be obtained from the Administrator. The completed application forms must be submitted to the Administrator accompanied by necessary premiums for coverage. (Two month's premiums in advance are required to commence coverage for an Associate Member). Thereafter, premiums should be submitted by the 15th day of each month following. For administrative purposes, it should be noted that the Associate Member premium for January must be remitted by February 15th and will provide coverage for April. As in the case of late employer remittances, a 10% penalty will also be charged on late payment of Associate Member premiums.

Premium rates are based on the actual cost to the Trust Fund of the benefits provided plus an allowance for administration costs and may be revised when warranted by increase in premiums or administrative costs.

(See Associate Coverage Rate Sheet for monthly premiums)

Coverage for an Associate Member will terminate at the end of the last month for which payment has been made or on termination of full-time employment with the participating employer or on the termination of the agreement with the Union or in the case of self-employed or contractor Members, on being dropped from the Union or on transfer back to regular Membership.

EXCLUSION FROM BENEFITS AND COVERAGE

(a) Any Member of the Plan who obtains, or attempts to obtain, a benefit under the Plan to which they are not entitled (including a benefit which is greater than the benefit to which they are entitled), by submitting false, misleading or inaccurate information may, at the discretion of the Trustees:

- be refused payment of every such benefit; or
- be denied coverage under the Plan; and
- be declared ineligible for any further benefits under the Plan; unless the Member can establish that any discrepancy in the information submitted was due solely to a bona fide error.

(b) It is a criminal offense to represent a matter of fact that is known by the person making it to be false and that is made with a fraudulent intent, to induce the person to whom it is made to act upon it.

IN THE EVENT OF DUPLICATE MSP COVERAGE

It is NOT necessary to maintain your own individual MSP coverage while you are covered through the District Council 38 Health and Welfare Trust Fund. You will be notified when your group coverage comes into effect and you will be notified when your group coverage has been terminated. If you are terminated, BC Medical Services Plan will automatically set up a self-pay account for you and will bill you directly for your coverage.

If you have individual coverage at the time your group coverage comes into effect, and you have prepaid your individual premiums, thus having duplicate coverage, simply write to Medical Services Plan of BC and advise them of the duplication, quoting group and identity numbers for both plans. They will then refund any applicable individual premiums to you.

PARTIAL PLAN

The Trustees have implemented a Partial Package of benefits to be offered to unemployed Members and retirees at a subsidized rate. (**See current Package Outline & Rate Sheet for current rates)**.
Benefits included are:

- Medical/Surgical Benefits
- Dental Benefits
- Jury Duty Benefits
- Extended Health Benefits
- Eyeglass Option
- Life Insurance including AD&D
- Members' Assistance Plan (Counselling Benefits)

The Partial Plan is available to Members registered and available for work with the Union who have run out their hours from Employer Contributions following a period of regular self-payment for the Full Coverage Plan. You may elect to change to the Mini Plan at any time, however you cannot change to the Partial Benefit Package from the Mini Plan. You must have the minimum required number of hours worked within a period of six consecutive months, reported and paid for by a participating employer, before being allowed to return to Full Coverage.

NOTE: You will be allowed to self-pay for a maximum of twelve consecutive months coverage whether it is for the Partial Benefits Package, the Mini Plan or a combination of the two Plans.

MINI PLAN

A Mini Plan has been established to offer basic coverage to unemployed Members at a **subsidized** rate. (**See current Package Outline & Rate Sheet for current rates).**
Benefits included are:

- Medical Surgical Benefits
- Jury Duty Benefits
- Extended Health Benefits
- Eyeglass option

- Life Insurance, including AD&D
- Members' Assistance Plan (Counselling Benefit)

The Mini Plan is available to Members registered for work with the Union who have run off their hours from employer contributions or following a period of regular self-payment for the Full Coverage or Partial Plans.

Once you have chosen coverage under the Mini Plan, you must have the minimum required number of hours worked within a period of six consecutive months reported and paid for by a participating employer before being allowed to return to Full coverage.

RETIRED MEMBERS' BENEFITS

Retired Members who have run out their hour banks will be allowed to maintain coverage under the Mini or Partial Benefits Packages provided they remain Members in good standing with the Union.

The 12 month maximum self-payment time limit is waived for retired Members.

The Life Insurance Benefit reduces to $5,000 at age 65; the ADD&D benefit is reduced by one-half and terminates on your 71st birthday.

PLEASE NOTE: The following expenses are not eligible:

Expenses incurred outside of Canada by a retiree (and/or a dependent of a retiree) for a medical emergency that occurs more than 30 days after their date of departure from Canada and/or expenses incurred outside of Canada by a retiree (and/or a dependent of a retiree) for a pre-existing condition which was diagnosed or treated within 90 days immediately prior to their date of departure.

Retired and/or Life Members who return to work and re-qualify for benefits under the full coverage plan are not eligible for Short Term Disability Benefits.

THE TRUSTEES RESERVE THE RIGHT TO MODIFY OR LIMIT BENEFITS AT ANY TIME.

BASIC MEDICAL AND HOSPITAL BENEFITS

Medical, surgical and obstetrical expenses are covered by the Medical Services Plan of British Columbia. When you or your dependents visit your doctor, your Medical Services Plan Care Card should be presented. Basic hospital expenses for you and your family are normally covered under the Hospital Program of British Columbia. In order to be eligible for coverage, new residents must establish permanent residency in British Columbia for three (3) months.

Applicants are required to provide Personal Health Numbers, (from your BC Care Card) or copies of documents to support Canadian citizenship or immigration status, for all persons listed. Any of the following Canadian documents would be acceptable proof or Citizenship: Canadian Birth Certificate, Passport, or Citizenship Certificate.

We remind you that while you are covered under this plan, any changes you require for additions or terminations of dependents **must** be done through the IUPAT DC38 Health and Welfare office. Changes cannot be reported directly to the Medical Services Plan of BC.

Under Government regulations, monthly premiums paid on your behalf* to the Medical Services Plan of BC by contributions by your employer are considered **taxable income**. At the end of February each year, you will be sent a T4A form stating the amount you must add to your income for the current taxation year. Any self payments you have made directly to the Plan Office during the year will have been deducted. **Premiums paid on your behalf for life insurance are also a taxable benefit and will be included in your T4A.*

In the event that you are cancelled from this Plan, Medical Services Plan of BC will automatically start billing you directly for this coverage.

EXTENDED HEALTH CARE

Extended Health Care is an extension of your basic Medical and Hospital Benefit and is designed to protect you and your dependents against unusually large expenses arising from a serious accident or illness.

The Pacific Blue Cross Extended Health Care Plan booklet enclosed provides a detailed outline of benefits covered and exclusions. Check with Pacific Blue Cross for specific benefit details pertaining to Paramedical Practitioners to ensure they are registered and if you will be reimbursed. http://www.pac.bluecross.ca/corp/howbenefitswork/faq/ehcfaq.aspx

DEDUCTIBLE AND AMOUNT OF REIMBURSEMENT

*Effective January 1, 2007, the $50.00 Annual Deductible on Extended Benefits has been eliminated

Reminder:

Deadline for submitting claims is June 30th *of the year following the year in which the expense being claimed was incurred. If not received before that date, your claims will not be paid under any circumstances*

We remind you that while you are covered under this plan, any changes you require for additions or terminations of dependents **must** be done through the IUPAT DC38 Health and Welfare office. Changes cannot be reported directly to Pacific Blue Cross.

VISION CARE BENEFIT

Expenses incurred relative to the purchase of corrective prescription lenses and frames or contact lenses, may be claimed. Effective August 1, 2006, Eye Exams are an eligible covered benefit **for Members only**. ***Vision Care Benefits are paid directly from the Fund Office***. Claim forms may be obtained from the office at 7621 Kingsway, Burnaby, BC V3N 3C7, or by phone at (604) 524-8334 or toll free in BC 1-800-266-1527 or from the District Council web site at **www.dc38.ca.**
(See "Quick Reference" sheet for current amounts).

> ***Deadline for claims is June 30th*** *of the year following the year in which the expense being claimed was incurred. Claims received late will not be paid.*

EMERGENCY TRAVEL ASSISTANCE (Medi-Assist)

Medi-Assist is a worldwide emergency medical assistance service available 24 hours a day 7 days a week. In the event of an emergency while travelling worldwide call the nearest MEDI-ASSIST Emergency Access number listed on your MEDI-ASSIST ID card. Have your Pacific Blue Cross Extended Health Benefits ID card and MEDI-ASSIST group number ready for personal identification.

NOTE: It is essential to note that this service DOES NOT TAKE THE PLACE OF TRAVEL INSURANCE, but provides referral services and claims facilitation only. You may contact Pacific Blue Cross directly for information regarding optional travel insurance. Please refer to the Pacific Blue Cross booklet for details.

GROUP LIFE INSURANCE

$50,000 of insurance is payable to the beneficiary designated by you should your death occur from any cause while you are insured under the group policy.

(a) **Termination of Group Life Insurance**: The group life insurance will be terminated:
- as outlined in Part 1 - General Information, Section 6 - termination of coverage, or

- as provided in Section 11 - Associate Members.

(b) **Reduction in the Amount of Group Life Insurance**: The full amount of $50,000 group life insurance will be in force until the end of the month in which the Member's 65th birthday occurs after which the amount will be reduced to $5,000.00.

(c) **Conversion of Group Life Insurance**: When your group life insurance terminates because your Membership in the plan has terminated, you are entitled to take out an individual policy without providing proof of good health.

If you are under 65 at the time of termination, the individual policy may be for any amount up to the amount of coverage in force under the group plan on the date of termination (subject to minimums as required by the insurance company).

You must submit an application and initial premium cheque to the Insurance Company within 31 days following the date on which your coverage under the group plan terminates. As long as this requirement is met, you are entitled to obtain an individual policy regardless of your state of health. The Insurance Company offers several different types of policies for conversion.

(d) **Extension of Life Insurance**: If you die within the 31 day period in which you are entitled to convert your group life insurance coverage to an individual policy, the amount of insurance to which you would be entitled under the policy will be paid to your named beneficiary, whether or not you had applied for conversion.

(e) **Total and Permanent Disability**: If you become totally and permanently disabled before your 60th birthday your life insurance will be kept in force without cost to you or the Plan as long as your disability prevents you from working. You must apply for this Total and Permanent Disability - Waiver of Premium. Proof of total disability will be required from time to time.

(f) **Beneficiary**: You may designate a beneficiary and may change the beneficiary at any time, subject to the laws governing such changes. In the event the beneficiary named is under 18 years of age, a Trustee must be appointed to administer the life insurance benefit on behalf of the beneficiary.

If the beneficiary dies before you, the interest of such beneficiary shall, unless otherwise provided, be vested in your Estate. If you wish to change your beneficiary, proper forms are available from the Administrator.

SPOUSAL LIFE INSURANCE

A benefit * is payable upon the death of your spouse or common law spouse provided the common law spouse has resided with you for a minimum of 12 months and provided that your spouse is listed as a dependent on your extended benefits coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

"Covered Loss" means a Critical Disease, Accidental Death or an Accidental Dismemberment Benefit covered under this Benefit Provision. The Covered Loss must occur prior to the Member's 71st birthday and while the Member is insured under this Provision. In the case of an accident, the Covered Loss must occur within 365 days after the date of the accident.

(A) CRITICAL DISEASE BENEFIT

The Insurance Company will pay to the Member an amount equal to 10% of the Principal Sum, provided the Member has been diagnosed with a Critical Disease while insured under this Provision and has been Totally Disabled from that disease for at least 9 months. Benefits are limited to the first covered Critical Disease in the Member's lifetime.

Classification	Amount of Principal Sum
Each Member under 65 years of age	Flat $100,000.00
Each Member 65 years of age or older	Reduces to a flat $50,000.00

(B) ACCIDENTAL DEATH BENEFIT

If the Insurance Company is furnished with proof that a Member's death occurs as a direct result of accidental bodily Injuries occasioned solely through external, violent and accidental means without negligence on the Member's part, the Insurance Company will pay an amount equal to 100% of the Principal Sum to the Member's beneficiary.

(C) ACCIDENTAL DISMEMBERMENT BENEFIT

If the Insurance Company is furnished with proof that a Member sustains one of the following losses, resulting directly and independently of all other causes from bodily Injuries occasioned solely through external, violent and accidental means, without negligence on the Member's part, the Insurance Company will pay:

(1) An amount equal to 200% of the Principal Sum for:
   (a) paraplegia (total paralysis of both lower limbs), or
   (b) hemiplegia (total paralysis of one side of the body), or
   (c) quadriplegia (total paralysis of all four limbs), or

(d) loss of use of both arms, or
(e) loss of use of both legs, or
(f) loss of use of one arm and one leg on the same side of the body.

(2) An Amount equal to 100% of the Principal Sum for:
(a) loss of both arms or both legs, or
(b) loss of both hands or of both feet, or
(c) loss of sight of both eyes, or
(d) loss of one hand and one foot, or
(e) loss of use of both hands, or
(f) loss of use of both feet, or
(g) loss of one hand or arm and one leg, or
(h) loss of sight of one eye and one hand or one foot, or
(i) loss of speech and hearing in both ears

(3) An amount equal to 75% of the Principal Sum for:
(a) loss of one arm, or
(b) loss of use of one arm, or
(c) loss of one leg, or
(d) loss of use of one leg.

(4) An amount equal to 66 2/3% of the Principal Sum for:
(a) loss of one hand, or
(b) loss of one foot, or
(c) loss of speech, or
(d) loss of hearing in both ears, or
(e) loss of sight of one eye, or
(f) loss of use of one hand, or
(g) loss of use of one foot.

(5) An amount equal to 33 1/3% of the Principal Sum for:
(a) loss of the thumb and index finger of the same hand, or
(b) loss of four fingers of one hand, or
(c) loss of hearing in one ear.

(6) An amount equal to 25% of the Principal Sum for the loss of all toes of one foot.

(D) REHABILITATION BENEFIT

In the event a Member sustains a covered loss and the loss requires that the Member participate in a rehabilitation program in order to be qualified to engage in an occupation in which the Member would not have engaged except for such covered loss, the Insurance Company will pay the reasonable and necessary expenses actually incurred for the services of a licensed rehabilitation provider, within two (2) years from the date of the covered loss.

Payment by the Insurance Company for the total of all expenses incurred by any Member will not exceed ten thousand dollars ($10,000) as the result of any

one (1) covered loss. Payment does not include incidental expenses including, without limitation, charges for room and board, ordinary living, travelling or clothing expenses.

(E) FAMILY TRANSPORTATION BENEFIT

If the Member sustains a covered loss and is confined as an inpatient in a hospital located at least one hundred and fifty (150) kilometers from the Member's residence and is under the regular care and attendance of a Physician or Surgeon, the Insurance Company will pay the reasonable expenses actually incurred by all Members of the Member's immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to the Member.

This benefit will not exceed the aggregate amount of three thousand dollars ($3,000) for all accommodation and transportation expenses. Payment will not be made for incidental expenses including, without limitation, charges for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of twenty cents ($0.20) per kilometer travelled.

(F) HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

If a Member sustains a covered loss and subsequently requires the use of a wheelchair to be ambulatory, the Insurance Company will pay the reasonable and necessary expenses incurred for the purpose of making the Member's home and vehicle wheelchair accessible. Benefits are payable for the cost of alterations to the Member's principal residence and the cost of modifications to one (1) motor vehicle utilized by the Member, when such modifications are approved by licensing authorities where required.

The expenses must be incurred with two (2) years from the date of the covered loss and are subject to a maximum of $10,000.00 in the Member's lifetime.

(G) CONTINUATION OF EDUCATION BENEFIT

In the event a Member's death occurs as a direct result of a covered loss under this provision, the Insurance Company will pay to the Member's beneficiary the Education Benefit stated below for each of the Member's dependent children who are, at the time of the Member's death enrolled as full-time students:

(1) in an institution for higher learning above the secondary school level as defined in the Province, territory or country of residence; or

(2) at the secondary school level but who will enroll as full-time students in an institution for higher learning within three hundred and sixty-five (365) days after the date of death of the Member.

The Education Benefit is equal to the reasonable and necessary expenses actually incurred for tuition and books, subject to the lesser of a maximum of five percent (5%) of the Member's principal sum or five thousand dollars ($5,000), for each year the dependent child continues the education, but not to exceed four (4) years, which must run consecutively, with respect to any one (1) dependent child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled as a full-time student in an institution for higher learning, but payment will not be made for expenses incurred prior to the death of the Member, or for incidental expenses including, without limitation, room, board or other ordinary living, travelling or clothing expenses.

If none of the Member's dependent children satisfy the above requirements, the Insurance Company will pay an amount of two thousand five hundred dollars ($2,500) to the Member's beneficiary.

(H) SPOUSAL OCCUPATIONAL TRAINING BENEFIT

In the event a Member's death occurs as a direct result of a covered loss under this provision, the Insurance Company will pay the reasonable and necessary expenses actually incurred for tuition and books for the Spouse of the Member to participate in a formal occupational training program to become qualified for active employment in an occupation for which the spouse would not otherwise have sufficient qualification.

Expenses must be incurred within two (2) years from the date of the Member's death and are subject to a maximum lifetime payment of ten thousand dollars ($10,000). Payment will not include incidental expenses including without limitation charges for room and board, ordinary living, travelling or clothing expenses.

(I) SEAT BELT BENEFIT

If the Member while insured is a passenger or driver of a private passenger type automobile and is involved in an accident for which a benefit is payable, the benefit will be increased by 10% if the Member was wearing a seat belt properly fastened. Verification of actual use of the seat belt must be part of the official report of the accident or certified by the investigation police officer.

(J) REPATRIATION BENEFIT

In the event the Member's death (due to any cause) occurs outside the Member's normal place of residence (at least 100 kilometers) the Insurance Company will pay the reasonable and customary expenses incurred for the preparation of the body and its transportation to the funeral home or the place of interment in proximity to the normal place of residence of the deceased. Benefits will not exceed ten thousand dollars ($10,000) for all eligible expenses.

(K) GENERAL PROVISIONS APPLICABLE TO ALL ACCIDENTAL DEATH, DISEASE AND DISMEMBERMENT BENEFITS

(1) Maximum Benefit

In no case shall an amount greater than the principal sum be paid for all covered losses sustained by a Member resulting directly or indirectly from the same accident or critical disease with the exception of paraplegia, hemiplegia and quadriplegia where the benefit payable is 200% of the principal sum.

(2) Total Disability Waiver

If premiums for the basic life insurance coverage under this policy are being waived, then premiums for the Accidental Death, Disease and Dismemberment benefit will also be waived, but only so long as the policy remains in force.

(3) Definitions:

(a) loss of hand shall mean severance at or above the wrist.
(b) loss of foot shall mean severance at or above the ankle.
(c) loss of thumb shall mean complete loss of one entire phalanx of the thumb.
(d) loss of index finger shall mean the complete loss of two entire phalanges of the index finger.
(e) loss of sight, loss of hearing or loss of speech shall mean total and irrecoverable loss of that faculty. If that faculty can be recovered or partially recovered by the use of some device or rehabilitative program, it shall be deemed that there was no loss for the purpose of this provision.
(f) loss of use must be caused by tendon, nerve or bone damage. Such loss of use must be total and irrecoverable and must be continuous for a period of 12 (twelve) months after which any benefit is payable, provided such disability is determined to be permanent.
(g) paralysis shall mean complete and irreversible paralysis caused by brain, spine, muscle or nerve damage as a result of an accident or covered critical disease which has continued for a period of 12 (twelve) months from the date of the accident or diagnosis of critical disease, after which any benefit is payable under this benefit provision.
(h) institution for higher learning for the Education Benefit includes any university, college or trade school.
(i) hospital, for the Family Transportation Benefit, means an institution licensed as a hospital, open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with (24) twenty-four hour nursing services. Hospital will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or education

care, or a rest home, nursing home or convalescent hospital.

(j) regular care and attendance, for the Family Transportation Benefit, means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

(k) immediate family, for the Family Transportation Benefit, means a person who is the spouse, son, daughter, father, mother, brother, sister, of the Member. Other relatives may be considered in the event that no "immediate family" are living.

(4) Exclusions

No benefits will be paid if the Member's covered loss is caused by or results directly or indirectly from one or more of the following:

(a) Suicide or attempted suicide or self-inflicted injury while sane or insane, or

(b) Insurrection or war (whether war be declared or not) or participation in any riot, or

(c) Active service in the armed forces of any country, or

(d) Travel or flight in any aircraft, or descent from such aircraft, if the Member is a pilot or a Member of the crew of the aircraft, or if such flight is made for purposes of instruction, training or testing, or

(e) Committing, attempting or provoking an assault or criminal offense including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 millilitres of blood. A "vehicle" means, a vehicle that is drawn, propelled or driven by any means other than muscular power, or

(f) medical care or treatment of any kind including surgery.

SHORT TERM DISABILITY (STD)

(Note: You must be covered on the **FULL Plan at the time of your illness or injury in order to claim for STD Benefits.)**

This is a sickness and accidental injury benefit and provides for payment during any period during which you are totally disabled and prevented from performing work of any kind, solely as a result of a **non-occupational accident or illness.**

The benefit will commence on the first day of disability resulting from an accident or hospitalization or on the eighth day of disability resulting from an illness.

Benefits are integrated with Employment Insurance (EI) sick benefits.

*Effective January 1, 2006, Retired and/or Life Members who return to work and re-qualify for benefits under the full coverage plan are not eligible for Short Term Disability Benefits.

Please contact the Health & Welfare office for forms and current rates, rules and regulations.

CLAIMING FOR BENEFITS

Take the following steps as soon as possible after you have become disabled:
Contact your Medical Doctor immediately on becoming disabled. Benefits commence upon the completion of the waiting period or the date you first saw a Medical Doctor, whichever is the latest.

- Obtain a claim form from your Plan Administrator.
- You must complete the front of the claim form and sign it on both sides.
- Ask your doctor to complete the Physician's Statement on the back of the same form.
- It is your responsibility to have the claim form sent to the Administrator for authorization.
- Claims will be assessed by BC Life & Casualty and when approved, you will receive your benefit cheques by mail at your home address.
- Claims must be sent in within 30 (thirty) days of commencement of disability unless special circumstances prevent you from doing so.
- Benefits will be paid when a Member is under the full time care of a physician and/or surgeon. Where there is any doubt as to the validity of a claim, BC Life reserves the right to obtain a second medical opinion from a physician and/or surgeon of their choice.
- Benefits can also be paid for a period of up to six weeks for any one disability on the signature of a chiropractor. For benefits beyond six weeks the signature of the medical doctor will be required.

NO FAULT, UNINSURED OR HIT AND RUN ACCIDENTS

No benefits will be paid to Members who have a right or claim to indemnity under Section 20 or 24 of the Insurance (Motor Vehicle Act) or a right or claim to receive accident benefits under Part 7 of the Insurance (Motor Vehicle Act) Revised Regulation (1984).

THIRD PARTY LIABILITY

With the exception of Accidents described in the previous paragraph Benefits will be paid for disabilities for which a third party is or may be in whole or in part legally liable only where the Member agrees in writing to do the following:

- Take all steps to recover from the Third Party, the total of the Benefits advanced, including without limitation, directing the Member's lawyer to repay to BC Life & Casualty the full amount of the Benefits directly from any monies

received pursuant to any judgement or settlement.

- Pay all legal fees and disbursements incurred in pursing the action against the Third Party;
- Repay to BC Life & Casualty the full amount of the benefits advanced in the event the claim against the Third Party is abandoned or settled without the written consent of BC Life & Casualty.
- Enter into a Reimbursement Agreement with BC Life & Casualty setting out the terms and conditions for repayment of the Benefits.
- Consent to the release by the Third Party or Insurance Corporation of BC of all information in their possession relating to the Member's claim.

RECURRENCE OF FORMER AILMENTS

If you return to work and are at work for two consecutive weeks and again become disabled, it will be considered a new disability period.

LIMITATIONS AND EXCLUSIONS

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

- occupational accidents or illnesses; or
- self-inflicted injuries and diseases (with the exception of alcoholism or drug addiction); or
- injuries or diseases resulting from war, or participation in a riot, or arising while serving as a Member of any armed force; or
- the commission by the Member of any unlawful act including an offence under the Criminal Code of Canada.
- a pregnancy related illness: during any period of formal Maternity Leave taken by the Member pursuant to Provincial or Federal Law or pursuant to mutual agreement between the Member and her employer; and
- during the period commencing with the tenth week prior to the expected week of maternity confinement and ending with the sixth week after such confinement; and
- during any period in which the Member is paid Employment Insurance Commission Maternity Benefits.

No benefits will be paid for any period for which the person has, or will receive vacation pay or an annual vacation or for any period of disability that commenced prior to the effective date of coverage.

OTHER INSURANCE COVERAGE

If you have other insurance coverage, you may not draw more in all benefits than you would normally earn. In such event, your benefits from this Plan would be reduced proportionately.

OVERPAYMENT OF BENEFITS

In the event of an overpayment of benefits by BC Life and Casualty, the Member will be required to reimburse BC Life & Casualty the full amount of the overpayment.

JURY DUTY BENEFIT

Benefits will be payable from the first day the Member serves on a jury in a courtroom and will be paid at the rate of sixty percent (60%) of the Members' *actual wage loss* plus twelve percent (12%) holiday pay for a maximum of fifty-two (52) weeks. This is a taxable benefit and T-4A's will be issued at the year end. Actual wage loss is defined as wages earned from a contributing employer or by a Member holding a valid dispatch issued by the Union.

DENTAL CARE

Dental Care Benefits are provided by Pacific Blue Cross and cover those services that are routinely performed in the offices of general practising dentists. Covered services are only those services listed in the PBC Dental fee schedule. When services are performed by a specialist, upon referral by a general practitioner, the fee paid is the PBC Dental Fee Schedule increased by ten percent (10%).

(a) HOW TO USE YOUR DENTAL PLAN

You will be issued with a Pacific Blue Cross Dental Plan Identity Card. Visit a dentist of your choice and show him this card. Discuss with him the services he proposes to render, the charges that he will make for those services and the amount, if any, you will be required to pay as your portion of the cost.

Most dentists will bill PBC directly for the portion of the cost covered by the Plan when the work has been completed, requiring you to pay only the balance. If, in your discussion with the dentist before the work is commenced, you are told that you must pay the full cost, and submit your claim to PBC for reimbursement, you have the right to choose another dentist who will bill PBC directly. Dentists who intend to charge in excess of the current fee schedule should first obtain your consent.

Your dentist is not required to obtain prior approval from PBC before rendering services. However, where the cost of services is other than a nominal charge, it is recommended that your dentist make an eligibility check. He can make this eligibility check by forwarding to PBC a form showing the treatment planned. This avoids any

embarrassment between you and your dentist should you not be eligible for the proposed benefits. He can find out by making this eligibility check:

- whether or not you or your dependents are covered; and
- whether or not the proposed services are a benefit under your Plan; and
- whether or not financial or other limitations have been reached.

Members are reminded that using your identity card when you are not so covered may result in prosecution.

(b) BENEFITS;

PART "A": The Plan will pay a percentage of the cost of services provided under Part "A". The amount that will be paid will be calculated in accordance with the current PBC Dental Fee Schedule, or the dentist's usual and customary fee, whichever is lesser. The PBC Booklet provides a detailed outline of benefits covered and exclusions.

PART "B": Under Part "B" the plan will pay a percentage of the cost of services provided for crowns and bridges and a percentage of the cost of services provided for dentures. The amount that will be paid will be calculated in accordance with the current PBC Dental Fee Schedule or the dentist's usual and customary fee, whichever is lesser.

The benefits under this section are those services required for major reconstruction of teeth that have deteriorated and for replacement of teeth that are missing such as crowns, bridges and dentures. It should be noted that services in this area will not be covered more often than once every five years. Please refer to the Schedule of Benefits for current rates. The PBC Booklet provides a detailed outline of benefits covered and exclusions.

PART "C": Benefits under this section are for the diagnosis and treatment of dental disorders with the use of appliances. Note: A complete Orthodontic services plan must be approved by PBC before treatment is started.

Please refer to the Schedule of Benefits for rates. The PBC Booklet provides a detailed outline of benefits covered, and exclusions.

We remind you that while you are covered under this plan, any changes you require for additions or terminations of dependents **must** be done through the IUPAT DC38 Health and Welfare office. Changes cannot be reported directly to Pacific Blue Cross.

(c) EMERGENCY TREATMENT

Emergency dental care will be provided anywhere in the world. If, while you are travelling or on vacation outside of British Columbia, you require dental care as a result of an emergency, you are entitled to the services of a duly qualified dentist in the event of any such emergency, and will be reimbursed up to the amount the Plan

would have paid had the services been rendered in British Columbia. Itemized statements must be provided with claims.

(d) CHANGE OF DENTIST

If you find it necessary to change your dentist after a course of treatment has commenced, please tell both dentists concerned and notify Pacific Blue Cross. Provided that there is no duplication of services, payment can be made.

BEREAVEMENT BENEFIT

When a Member passes away, there are usually time lags involved before the life insurance benefits are paid to the beneficiary. In the meantime, there are the normal day to day expenses to be paid by the Member's family. In some cases, bank accounts are frozen and safety deposit boxes are sealed until the estate is settled. In order to assist the Beneficiary and help to alleviate the financial burdens incurred in an already stressful situation, a Bereavement Benefit has been instituted. (See current Rate Sheet for amounts).

This benefit will be paid to the "Designated Beneficiary" of a covered Member, upon suitable proof of death. In the absence of a named beneficiary, this benefit will not be paid. Any dispute on this benefit will be finally decided by the Plan Trustees.

The Bereavement Benefit is in addition to the Group Life Insurance coverage already in effect. The "Beneficiary Designation" forms used for the Group Life Policy will be used to determine the beneficiary for the Bereavement Benefit.

Please ensure that you have up to date Beneficiary Forms on file with the Fund Office.

MEMBERS' ASSISTANCE PROGRAM

This Program is designed to assist Members and their families with problems that, until recently, were seldom recognized or supported. The Program is to provide Members and their families with access to a full range of counselling services which will be administered in strict confidentiality.

The Program is designed to be confidential, comprehensive, flexible and perhaps most important of all, it is easy to use. There is no need for a referral from your family Doctor or anyone else. It is the Member's choice of a legitimate professional counselling service.

A. Administration

The Program will be based on a reimbursement basis for services. To ensure confidentiality, the counsellor will not be asked for a report. The Member will submit paid receipts on a claim form and will be reimbursed a percentage of their expenses according to the current rates. (Please refer to the Schedule of Benefits for rates).

B. Services Covered

The Plan covers all health related counselling services provided by Psychologists and legitimate professional Counsellors. These services include assistance with:

- Emotional and behavioural problems, including all diagnostic and treatment services.
- Marital or family problems including marriage counselling.
- Adjustment problems including grief and bereavement.
- Career related stress reactions.
- Diagnosis and treatment of learning problems.
- Medical disorders having an emotional component including hypertension, pain control (in cooperation with your family doctor).
- Coping with life-threatening illnesses (in co-operation with your family doctor).

C. Services Not Covered

Services provided by the Provincial Government or a Government Agency, including Workers' Compensation Board or the Insurance Corporation of British Columbia or services provided by the Construction Industry Rehabilitation Plan, or services covered under the Extended Health Care Plan or Agency established with the IUPAT Collective Agreements are not covered.

D. Who is eligible for benefits?

Members and dependents covered are eligible for benefits provided by the Employee Assistance Program.

HOW TO MAKE A CLAIM: Claim forms are available at the Plan Office and will be reimbursed to the Member directly by the IUPAT District Council 38 Health & Welfare Plan.

REHABILITATION PLAN

Also available to the Members of the Plan are the services of:

The BC Construction Industry Rehabilitation Plan
501 - 3292 Production Way
Burnaby, BC V5A 4R4
604-521-8611 ♢ 1-888-521-8611

The Plan is available to assist any Member with alcohol or drug related problems at the above address, or by telephoning (604) 521-8611. (Collect calls are welcomed). Members may also contact our Plan Administrator at the Fund Office for assistance in this area.

It should be noted that this Plan's counselling services include family, financial and emotional problems where related to alcohol/addiction or relapse and assistance is available to Members' spouses and dependents. Recovery is very often a family affair.

REMINDERS - PROTECT YOUR COVERAGE

- ✓ Be sure to notify the Administrator immediately of any change of address or any change in the number of your dependents.
- ✓ When you become unemployed, be sure to check the status of your coverage by contacting the Administrator and be sure to remit any self-payments required when you are so notified.
- ✓ Prior to seeking any necessary service or benefits within the scope of the plan, it is advisable that you **confirm your eligibility by contacting the Administrator.**

DISCLAIMER

This booklet contains an outline of the Benefits as arranged by your Trustees with the Medical Services Plan of BC, Pacific Blue Cross, BC Life and Casualty Company and the Co-operators Insurance.

In all cases, the group contracts, the regulations of the Medical Services Plan of BC, the by-laws of Pacific Blue Cross and the provisions of the Group Life Policy govern the actual benefits provided.

E&OE

REASONS FOR HAVING A WILL: *REMINDER TO ALL MEMBERS*

(1) The ability to choose the Executor or Administrator of your estate. This will eliminate any delays that could occur should one have to be appointed.
(2) The right to choose your beneficiaries.
(3) The opportunity to select your dependent's guardians (if applicable).
(4) The right to designate what will become of your assets and personal effects in the manner you choose, bearing in mind the rights at law of the dependents.

Who Can Draw A Will

(a) Any adult person of sound mind who has the understanding of the extend or your affairs and who has the knowledge of the moral and rightful claims to share in the property to be disposed of.
(b) Generally a Lawyer, Trust Company or a Notary will assist in the preparation of this document and register it with the Director of Vital Statistics.

Naming The Executor

(a) A Spouse; probably a good choice where the estate is straight-forward.
(b) Alternate Executor may be desirable in the event of a common illness or accident should they occur.
(c) The Executor should be consulted prior to being named so as to obtain his or her consent to act in that capacity.

Changes And Storage

(a) Alterations or amendments may be done when the need arises without making a new will, however, these must comply with legal form.
(b) A will should not be stored in a safety deposit box as, when death occurs, all assets are frozen. The same applies to life insurance policies. They should be stored in a safe place or with a certain person. A statement in a safety deposit box indicating where the will is stored may be advisable providing the document has been registered with the Director of Vital Statistics.

Fees And Advantages

(a) Certain fees have been revoked eliminating death duties as of January 24, 1977, however, probate fees are still in effect but are nominal.
(b) Costs of drawing a will are small compared to the costs that may be involved if there is no will.
(c) Life insurance benefits should be made payable to a designated person or persons rather than to "estate" as this may forego the possibility of certain fees, duties and creditors. RRSP's should have designation of beneficiary.

PROTECT YOUR DEPENDENTS - PLAN YOUR FUTURE AS WELL AS THEIRS

- ☞ **MAKE A WILL**
- ☞ **DESIGNATE YOUR BENEFICIARY**
- ☞ **KEEP YOUR PENSION AND HEALTH BENEFITS PLANS AWARE OF ANY CHANGE IN BENEFICIARY OR ADDRESS.**