MACHINISTS, FITTERS & HELPERS INDUSTRIAL UNION LOCAL NO. 3 BENEFIT PLAN

ON BEHALF OF MEMBERS OF:

MACHINISTS LOCAL 3
LABOURERS LOCAL 1611
RIGGERS LOCAL 643

Address all inquiries to:

THE ADMINISTRATOR

D.A. Townley

4250 Canada Way
Burnaby, BC V5G 4W6
Phone (604) 299-7482
Facsimile (604) 299-8136
Toll Free 1 (800) 663-1356
Email: machinistsfittersno3admin@datownley.com
(Administration Inquiries)
Email: health@datownley.com (Claims Inquiries)
www.machinistslocal3benefits.org

Effective May 2007
*Including amendments to July 1, 2023

PRIVACY POLICY

We, the Trustees of the Machinists, Fitters & Helpers Industrial Union Local No. 3 Benefit Plan have adopted the following *Privacy Principles*, which reflect our commitment to safeguarding our Members' personal information:

- Information about you and your communications with the Plan are kept confidential.
- Neither the Administrator, nor the Plan will sell your personal information.
- Information about you is gathered lawfully and fairly.
- Information about you is gathered, used, or disclosed only to provide you with benefits and services as outlined in your plan documents.
- We maintain appropriate procedures to ensure that personal information in our possession is accurate and, where necessary, kept up to date. You are entitled to seek a correction of your personal information if you believe that the information held by the Plan is not accurate.
- You may access your personal information, subject to limited exceptions and conditions.
- Personal information is not disclosed without Member's permission except in limited circumstances as permitted or required by law. However, the Administrator may share personal information with the Plan's actuaries, agents, consultants or service providers in connection with providing, administering, adjudicating, costing, financially managing and servicing Members' Plans and benefit programs.
- Where we choose to have certain services, such as actuarial valuation, provided by third parties, we take all reasonable precautions regarding the practices employed by the service provider to protect your personal information. We ask that they, in turn, undertake to honour the Plan's privacy policy and applicable legislation.
- To protect your personal information against unauthorized access, disclosure, copying, use or modification, theft or accidental loss, the Plan will maintain appropriate security mechanisms.

The Trustees

Table of Contents

The following is an outline of the Machinists, Fitters & Helpers Industrial Union Local No. 3 Benefit Plan benefits. The information in this benefits booklet is important to you. It provides the information you need about the group benefits available through the Machinists, Fitters & Helpers Industrial Union Local No. 3 Benefit Plan.

Both British Columbia and Alberta have passed legislation affecting the use of self-insured funding for providing benefit plans. In each case, the legislation allows for the use of self-insured funding, subject to disclosing this information to the covered Members in writing.

The Trustees are constantly attempting to provide benefits under the Plan to the Members in the most cost-effective manner. For some benefits, such as Dental, Weekly Indemnity and some portions of the Extended Health Benefits, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act.

BENEFIT SUMMARY

Medical Services Plan of BC (MSP)	Group No. 3133030
Life Insurance	$100,000
AD&D	$100,000
Wage Indemnity	Equal to EI Weekly Maximum Integrated with EI
CPP Top Up Benefit	$500 per month

Employee/Family Assistance Plan

Extended Health Benefits	100%, No Deductible $1,000,000 Maximum
Prescription Drugs	80%, No Deductible Incl. in EHB Maximum Prior Authorization Program
Out of Province/ Canada Emergency Medical Travel Insurance	$5,000,000 Maximum Per Coverage Period
Vision Care	100%, $800/24 months
Dental	100% Basic Services 75% Major Services 75% Orthodontia
Health Care Spending Account	$500 per cal yr (pro-rated)

ELIGIBILITY DETAILS

Who is eligible?

Any Member in good standing with sufficient hours in their Hour Bank to provide coverage. Some coverage terminates upon attaining a specific age, as specified in this booklet, according to each benefit's contractual terms.

Do any Forms have to be completed?

YES. Within one month of becoming eligible you must complete a Medical Services Plan application form and an Enrolment and Beneficiary card.

How does a person qualify for coverage?

A Member in good standing must accumulate 300 hours of work within 6 consecutive months. Coverage will commence on the 1st day of the second month following the accumulation of 300 hours in your Hour Bank tracked by the Plan Administrator.

EXAMPLE:

Your employer(s) report that you have accumulated in excess of 300 hours during the last 6 months. March hours are reported and tabulated in April, which makes April the Lag Month; your coverage becomes effective May 1.

Month	**Hours Reported**
January	.....
February	160
March	160
April	.....Lag Month
May	.....Coverage Starts

Each month 150 hours will be deducted from your Hour Bank to provide coverage. Any excess hours will accumulate in your Hour Bank for future coverage.

Once coverage starts, you will continue to be covered as long as your Hour Bank contains sufficient hours. Upon qualifying for coverage for the very first time, you will be issued a pay-direct card. You will be issued one card if you have single coverage and two cards (both in the Member's name) if you have dependent coverage. You can use the pay-direct card when you visit your dentist, your ophthalmologist or optometrist, participating paramedical practitioners, when you fill a prescription or make a vision care purchase. Using your card eliminates the requirement to file a claim – your claim is paid directly at point of sale.

A maximum of 6 months' coverage can be accumulated in a Member's Hour Bank

When does coverage end?

a) Coverage will terminate when there are insufficient hours in the Hour Bank to allow for a deduction of 150 hours.
b) Coverage will be terminated immediately and the Hour Bank will be forfeited for any Member who is suspended or issued a withdrawal card.

Disability Credits

When a Member is collecting benefits under the Wage Indemnity Plan, EI Sick Benefits or under Workers' Compensation the Member will receive assistance with their Hour Bank. For each day that the Member is disabled and on a claim that has been accepted for payment, the Member's Hour Bank will be credited with contributions of 5 hours per day, to a maximum of 1200 hours. The Member must request the appropriate form from the Administration Office and return the completed form to apply for Disability Credits. To qualify for Disability Credits, the Member must be eligible for benefits when the disability commences.

If the Member is disabled for longer than the maximum Wage Indemnity claim of 34 weeks the Member should contact the Administration Office to inquire about further disability credits.

Members on WCB/Worksafe BC who are beyond the 8 month Disability Credit time-frame will be permitted to self-pay for a maximum of 6 months. This allowance is in addition to any accrued Hour Bank balance entitlements and any other Self-Pay entitlements.

Self-Pay:

A Member in good standing may continue full coverage through Self-Payment.

A self-pay notice will be sent to the Member's last known address.

The maximum number of self-pays allowable is 6 consecutive months.

PLEASE NOTE: During the months that a Member is self-paying for coverage, the pay-direct card will not be activated/re-activated until payment is received by the Administrator and processed. If a prescription or

other eligible benefit that would normally be claimed using the pay-direct card, is required prior to that, the Member or dependent will be required to pay for the expense and submit the claim to the Administrator for reimbursement.

Reminder: Once full coverage has lapsed, in order to be covered again with full benefits, you must re-qualify with 300 hours in a 6 consecutive month period.

Are there any reciprocity agreements with other Welfare Plans?

YES. From time to time the Trustees may enter into or terminate reciprocity agreements. The Administrator must be contacted to ensure there is reciprocity agreement in place with the Local you are working in and you must advise the Local in which you are working that you a Member of Machinists Fitters and Helpers Local #3 and wish your contributions be transferred to this Plan.

Are Dependents Covered under the Plan?

YES. The Plan will provide MSP, Dental, Extended Health Benefits and Vision Care for:

a) The spouse* of a covered Member
b) Any unmarried child of a covered Member to age 21, (age 19 for MSP) provided such person is mainly dependent on and living with the covered Member;
c) Any unmarried child of a covered Member to any age provided the child is in full-time attendance at a recognized school, college, or university; (age 25 for MSP)
d) Any unmarried mentally or physically handicapped child of a covered Member to any age, provided such person is mainly dependent on and living with the covered Member or the spouse of the covered Member.

*Spouse means the Member's legal spouse, or a person who has been residing with the Member continuously for a period of at least one year and has been publicly represented as the Member's spouse in the community in which they reside.

When completing your application forms for coverage, please include all dependents to be covered. To add, delete or change the dependents covered, obtain a MSP Group Change Form and an Enrolment and

Beneficiary card from the Administrator or your Union Office, and forward it to the Administrator's office.

MEDICAL SERVICES PLAN OF BC (MSP)

When you qualify for coverage, you will be covered by the Medical Services Plan of BC, provided you have completed the required MSP application form. If you are already covered for MSP, it is your responsibility to keep MSP updated on your dependent coverage and if your personal information changes.

LIFE INSURANCE

Each eligible Member is insured for $100,000 of Life Insurance. This amount reduces by 50% at age 65 and terminates at age 70.

This amount 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.

If you do not designate a beneficiary, the insurance will be payable to your estate.

Continuation of Life Insurance on Termination of Coverage

When your coverage with the Plan terminates, you may convert your Life Insurance to an individual policy without a medical examination or health questionnaire. The individual policy would be for an amount not greater than the amount under the group policy and would be available at any time within 31 days after termination of the group insurance. Contact the Administrator for details.

Your life would be continued to be insured, at the conversion rate, under the group policy during the 31 day conversion period, whether or not you apply for an individual policy.

If you Become Totally Disabled

Subject to satisfactory proof, submitted within 12 months from the date the insured person becomes totally disabled, an insured person who is under age 65 and who becomes totally disabled and continues to be disabled for 6 months, as a result of accident, injury or disease will, on written application, be eligible for the total amount of the Life Insurance to remain in force providing the person remains totally disabled, subject to termination at age 65. Proof of total disability will be required from time to time.

Living Assistance Benefit

The Living Assistance Benefit is available as an advance payment of your Basic Life Insurance to help meet the medical or other health and welfare expenses of terminally ill Members under age 65.

Application for this benefit must be approved by the Plan and the Co-operators will confirm that medical evidence meets the Plan's requirements before approving payment.

The amount of money available as a Living Assistance Benefit payment is 50% of your Basic Life Insurance Benefit subject to a maximum benefit of $50,000.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

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

Who is covered?	**Amount of Coverage**
All eligible members under age 70	$100,000
All spouses under age 70	$ 20,000
All eligible dependent children	$ 5,000

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm	Four-Fifths of the Principal Sum
Loss of One Leg	Four-Fifths of the Principal Sum

Loss of One Hand Three-Quarters of The Principal Sum

Loss of One Foot Three-Quarters of The Principal Sum

Loss of the Entire Sight of One Eye
Three-Quarters of The Principal Sum

Loss of Thumb and Index Finger of the Same Hand
One-Third of The Principal Sum

Loss of Speech or Hearing
Three-Quarters of The Principal Sum

Loss of Speech and Hearing
The Principal Sum

Loss of Hearing in One Ear
Two-Thirds of The Principal Sum

Quadriplegia (total paralysis of both upper and lower limbs) Two Times The Principal Sum

Paraplegia (total paralysis of both lower limbs)
Two Times The Principal Sum

Hemiplegia (total paralysis of upper and lower limbs of one side of the body)
Two Times The Principal Sum

Loss of Use of Both Arms or Both Hands
The Principal Sum

Loss of Use of One Hand or One Foot
Three-Quarters of The Principal Sum

Loss of Use of One Arm or One Leg
Four-Fifths of The Principal Sum

Loss of Four Fingers of One Hand
One-Third of The Principal Sum

Loss of All Toes of One Foot
One-Quarter of The Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds. Loss of the Entire Sight of Both Eyes means the total and irrecoverable Loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty (20) degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing. Loss of Hearing in One (1) Ear means the diagnosis of permanent Loss of Hearing in one (1) ear, with an auditory threshold of more than ninety (90) decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing. Loss of Hearing means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than ninety (90) decibels an ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing.

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

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

Disappearance

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

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Member under the Plan's current basic group life insurance policy. In the absence of such designation,

benefits shall be payable to the Estate of the Insured Member.

All other benefits shall be payable to the Insured Member.

Repatriation Benefit

When Injuries covered by this policy result in loss of life of an Insured Member outside 50 Km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of $15,000.00.

Rehabilitation Benefit

If an Insured Member suffers an Injury which results in a payment being made by the Company under the Accidental Death and Dismemberment Indemnity section of this policy, the Company shall pay in addition, the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of the Insured Member provided:

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

b) Expenses be incurred within three years from the date of the accident,

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

Family Transportation

When Injuries covered by the policy result in an Insured Member being confined to a hospital, outside 100 Km from their permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the reasonable and necessary expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Member but not to exceed the amount $15,000.00.

Conversion Privilege

On the date of termination of coverage or during the 90-day period following termination of coverage,

you may change your insurance to a Blue Cross Life individual insurance policy.

The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the plan ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of Blue Cross Life. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

Continuance of Coverage

In the case Members who are (1) laid-off on a temporary basis (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of twelve (12) months, subject to payment of premium. If a Member assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Waiver of Premium

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

a) The date the Insured Member attains age 65
b) The date of the death or recovery of the Insured Member
c) The date the Insured Member is no longer eligible for total disability waiver of premium under the Policyholder's group life policy; and
d) The date the Master Policy is terminated.

Seat Belt Rider

Benefits under the policy shall be increased by 10% if the Insured Member's Injury or death results while they are a passenger or driver of a private passenger type automobile and their seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Home Alteration and Vehicle Modification

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

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

b) The lesser of:

   i) the one-time cost of modifications necessary to a motor vehicle, owned by the Injured Insured Member, to make the vehicle accessible or drivable for the Insured Member; and

   ii) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Company.

Benefit payments herein will not be paid unless:

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

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

The maximum payable under both items (a) and (b) combined will not exceed $15,000.00

Dependent Child Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will reimburse the annual tuition, not including room and board, charged by an Institution of Higher Learning per school year for each Dependent Child of such Insured Member up to the lesser of the following amounts:

1) ten thousand dollars ($10,000.00) per school year; or

2) 5% of such Insured Member's Principal Sum.

This benefit is payable annually up to a maximum of four (4) consecutive payments per Dependent Child:

1) only for such Dependent Child who is, at the time of such Insured Member's Loss of Life, enrolled as a full-time student in an Institution of Higher Learning beyond the twelfth (12th) grade level; and
2) only while such Dependent Child continues his or her continuous enrollment in an Institution of Higher Learning.

The Company will reimburse the person who incurred the actual tuition expenses.

Spousal Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the Insured Member's Spouse the actual cost incurred for a professional or trades training program in which such Spouse enrolls for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than thirty (30) months after the Insured Member's Loss of Life. The maximum amount payable for this benefit is fifteen thousand dollars ($15,000.00) per Insured Member.

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

"Institution of Higher Learning" as used herein includes, but is not limited to, any university, private post secondary college or trade school, and any College of General and Vocational Education/Collège d'enseignement général et professionnel (CÉGEP).

Day Care Benefit

If an Insured Member suffers Injury resulting in Loss of Life for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the legal guardian of any surviving Dependent Child of the Insured Member, an amount equal to the lesser of the following:

a) the actual annual cost charged by a commercial and licensed day care centre; or
b) 5% of the Insured Member's Principal Sum; or
c) five thousand dollars ($5,000.00) per year.

This benefit is payable annually for a maximum of four (4) consecutive payments per Dependent Child:

a) and only for such Dependent Child who at the date of the Insured Member's Loss of Life is under age thirteen (13);

b) provided such Dependent Child is enrolled in commercial and licensed day care centre no later than ninety (90) days following the Insured Member's Loss of Life; and

c) provided that the Dependent Child continues his or her enrollment in a commercial and licensed day care centre.

In-Hospital Benefit

If an Insured Member suffers injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses, and as a consequence of such Loss the Insured Member is, pursuant to the instructions of a Physician, confined to a Hospital for more than five (5) consecutive overnight stays, the Company will pay:

a) for a period of confinement in Hospital of more than thirty (30) consecutive overnight stays, 1% of the Insured Member's Principal Sum; or

b) for a period of confinement of thirty (30) consecutive overnight stays or less, one thirtieth (1/30) of the amount determined for each over night stay in Hospital.

The Company will pay this benefit monthly, retroactive to the first (1st) overnight stay of confinement in Hospital. The maximum amount payable for this benefit for all injuries resulting from any one (1) accident per insured is two thousand five hundred dollars ($2,500.00) per month. Benefits are not payable for more than a total of twelve (12) months of confinement for any one (1) accident causing Injury.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than three (3) months, are considered one (1) period of confinement to Hospital for the purposes of calculating this benefit.

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

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

(2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

(3) provides 24-hour a day nursing service by registered or graduate nurses;

(4) has a staff of one or more licensed physicians available at all times;

(5) provides organized facilities for diagnosis, and major medical surgical facilities; and

(6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

If an Insured Member suffers Injury causing Permanent and Total Disability, the Company shall pay the amount which is 100% of the Principal Sum for the Insured Member less any amounts under the Table of Losses which have been paid or which are payable by the Company for Losses of the Insured Member.

EXCLUSIONS

No coverage shall be provided under this contract and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

a) suicide or any attempt thereat by the Insured Member while sane;

b) self inflicted Injury or any attempt thereat by the Insured Member while sane or insane;

c) declared or undeclared war or any act thereof;

d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

f) Injury sustained while the Insured Member is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

g) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial

infarction or heart attack, coronary thrombosis, aneurysm;

h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Member is:
   i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
   ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   iii) riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder.

i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

j) Injury or Loss sustained while the Insured Member is on full-time duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Member is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

k) Injury or Loss sustained while the Insured Member is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while his or her blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;

l) Injury or Loss sustained while the Insured Member is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;

m) the commission or attempted commission by an Insured Member or Injury incurred while an Insured Member is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

n) an act, attempted act or omission taken or made by the Insured Member, or an act, attempted act

or omission taken or made with the Insured Member's consent, for the purposes of interrupting the blood flow to the Insured Member's brain or to cause asphyxiation to the Insured Member whether with intent to cause harm or not; and

o) natural causes.

WAGE INDEMNITY BENEFIT

A benefit equal to the Employment Insurance (E.I.) weekly maximum benefit rate will be paid to each eligible Member who is disabled and unable to work as the result of a non-occupational accident or sickness. Benefit payment commences on the 1st day of a non-occupational accident, and the 4th day of a non-occupational sickness. If you are hospitalized prior to the 4th day of sickness, benefits commence on the 1st day of hospitalization. If a surgical procedure is performed on an out-patient basis, in a general hospital, benefits will commence on the date the surgery was performed.

Note: The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a physician or a licensed chiropractor – whichever is later – and will be paid only during periods of disability when you are under his or her regular care and following the treatment prescribed. When Certification of disability is made by a chiropractor, any periods beyond 6 weeks must be made by a physician.

Members whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Plan Member qualifies for full coverage under the Plan.

You must make application to E.I. for sick benefits and if you are eligible, benefits from the Plan will cease during the period you are eligible to collect E.I. If you are still disabled after reaching the maximum duration of E.I. sick benefit payments, or if you are not eligible for E.I., or only partially eligible, the Plan will continue benefits for up to a maximum of 34 weeks including the E.I. sick benefit payments.

How to claim for Wage Indemnity:

Take the following steps as soon as possible after you have become disabled:

a) Contact your doctor immediately upon becoming disabled. You must be seen and treated during the time of your disability.

b) Obtain a claim form from the Union office or the Administrator's office and note instructions concerning an E.I. sick claim.

c) Complete the form where indicated and have your doctor complete the physician's portion of the form.

d) Send the completed form to the Administrator without delay.

e) Claim cheques will be sent directly to your home address.

f) Claims for disability must be submitted no later than 30 days after your total disability begins.

Third Party Liability

If you receive benefit payments under this Plan for loss of income for which there may be a cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will entitle the Plan to be reimbursed for any benefits paid, which have been recovered from a third party.

Right to Recover

(a) Where a Member becomes Totally Disabled as a result of an injury or sickness in respect of which

  i) a third party may be, directly or indirectly, either in whole or in part, liable to the Member or

  ii) the Member has a claim for benefits under workers compensation legislation;

  the Plan will not pay benefits to the Member.

(b) In the circumstances described in (a) above, the Plan may, not must, provide financial relief on a periodic (usually bi-weekly) basis to alleviate income loss. The total of all advances made to the Member is fully repayable to the Plan on terms to be settled between the Member and the Plan and incorporated into a written Loan Agreement.

Recurrence of Former Ailments

You will not receive benefits for more than 34 weeks as a result of disability due to any one ailment.

However, a new waiting period and benefit duration period will start if you return to active full-time work for:

a) A period of 2 weeks before you again become disabled because of the same or related cause, or
b) One full day before you again become disabled because of a different or unrelated cause.

EXCLUSIONS and LIMITATIONS:

No benefit will be paid for periods of disability:

- arising from occupational accident or illness, as these are covered by the WorkSafe BC Act;
- arising from your commission of or attempt to commit an assault or criminal offense;
- arising from self-inflicted injuries or sickness;
- substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician;
- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service;
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from E.I., or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence;
- during which the insured is receiving or eligible to receive E.I. benefits;
- if you become disabled during a strike or lockout at your place of employment; however, your rights to benefits will be reinstated when the strike or lockout ends.

TERMINATION OF BENEFIT

Your benefit payments will cease on the earliest date one or more of the following occurs:

- you reach age 65;
- you are no longer disabled;
- you are no longer receiving continuing medical care or treatment from your physician;
- you fail to submit satisfactory proof of continuing disability as required by the Plan;

- you refuse a medical examination by a physician chosen by the Plan;
- you are no longer following the treatment recommended for your disability;
- you leave the province, state or country where you normally work and live, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by the Plan.
- you perform any work for compensation or profit;
- you have reached the maximum of 34 weeks of benefit including any E.I. benefits collected;
- you retire; or
- you die.

CPP TOP UP BENEFIT

The Plan will provide a top-up benefit of $500 for those Members who apply for and receive CPP Disability Benefits for disabilities incurred on or after November 1, 2009. This top-up benefit will be paid until the end of the month in which the Member turns age 65, recovers or dies (whichever occurs first). The top-up benefit will not be paid for any occupational illnesses or injuries.

EMPLOYEE/FAMILY ASSISTANCE PLAN (EFAP)

The EFAP is a voluntary, confidential, short-term counseling and advisory service that connects you and your eligible family members to a network of dedicated professionals who are available to give you assistance 24 hours a day.

This benefit provides professional assistance for wide range of issues such as:

- Personal and work-related stress;
- Couple and marital relationships;
- Childcare and parenting issues
- Family matters;
- Eldercare concerns;
- Depression and anxiety;
- Alcohol and drug abuse;
- Legal matters and financial concerns.

For more information, contact the Plan Administrator for a brochure or go to **www.workhealthlife.com** and enter the organization as "MACHINISTS FITTERS AND HELPERS UNION LOCAL #3 C.L.C. WELFARE PLAN". For immediate help, call Morneau Shepell at 1-844-880-9137.

EXTENDED HEALTH BENEFITS

There is no annual deductible and 80% of eligible prescriptions and 100% of all other eligible expenses will be reimbursed up to a maximum of $1,000,000 per benefit period. Coverage is limited to $25,000** per person per calendar year for Members (and their dependents) who are age 75 or older.

Out of Province/Canada Emergency Medical Travel Insurance coverage is provided to eligible Members and their dependents up to a maximum of $5,000,000 per coverage period. There is no Out of Province/Canada Emergency Medical Travel Insurance coverage for Members (or their dependents) once the Member reaches the age of 75.

The Extended Health Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

Benefits:

The Extended Health Benefit is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax supported agency.

The following are classed as eligible expenses when incurred as the result of necessary treatment of illness or injury and where applicable when ordered by a physician.

1) Prescription Drugs – present your pay-direct card, along with your prescription, to your pharmacist and your prescription drug claim will be adjudicated right at the pharmacy. Using your pay-direct card eliminates the need to send in your prescription receipt and wait for reimbursement. Your Plan provides coverage for prescription drugs and medicines (including oral contraceptives) which require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits.

Drugs and medicines are limited to a 90 day supply. Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Vacation supplies of your medications, which are outside the regular days supply limits must be pre-authorized by the Plan and must be paid for in full by the Member and submitted to the Plan for reimbursement. Drugs and medicines that can normally be purchased "over the counter" are excluded regardless of a prescription having been issued. Fertility drugs, vitamins, preventative drugs, dietary foods and supplements are also excluded. Smoking cessation products will be covered up to a lifetime maximum of $500 per person.

There are a number of prescription drugs which are not eligible under PharmaCare's standard drug formulary, but may be eligible under their Special Authority Program. You may be requested by the Plan to have your doctor apply for Special Authority for one or more of the drugs you have been prescribed. Should PharmaCare approve the application for Special Authority, such drugs will be applied towards your annual PharmaCare deductible.

PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for Fair PharmaCare call 1-800-663-7100 or visit the BC Fair PharmaCare website: **https://my.gov.bc.ca/ahdc/msp-eligibility**

For Members who are self-paying their benefits, please refer to the Self-Payment section of this booklet for information regarding the continued use of the pay-direct card benefit.

Prescription Drug Prior Authorization Program
There are a number of prescription drugs which will now require prior authorization before they can be determined eligible under the Plan. The complete Prior Authorization Listing of these drugs can be found online at: **https://www.telus.com/en/health/prior-authorization-forms**

If your doctor prescribes a drug for you or one of your eligible dependents, that is on the Prior

Authorization Listing, when you take your prescription to the pharmacy, your pharmacist will be advised that you must obtain prior authorization first. You will then need to download the applicable Prior Authorization (PA) form for that drug from: **https://www.telus.com/en/health/prior-authorization-forms** and complete the patient section, have the prescribing physician complete their section of the form, and then send the completed form to where indicated.

This information will be reviewed, and it will be determined whether the required eligibility criteria is met. The decision will be communicated directly with the patient or individual indicated by the patient on the form. If deemed to be eligible, an exception will be added to that patient's Plan record so that the pay-direct card will accept that drug going forward according to the terms of the approval.

It's recommended that you refer to the Prior Authorization Listing while you are with your doctor, so that if a drug they intend to prescribe is on the Listing, the applicable Prior Authorization form can be downloaded, printed, and completed before you leave your doctor's office. If you need assistance accessing a Prior Authorization form, you can contact the claims customer service department at D.A. Townley.

If the prescribed drug is one that must be coordinated with Provincial Fair PharmaCare under Special Authority, you will also be advised to ask that your doctor apply for Provincial Special Authority for that drug on your behalf. This will not impact your ability to fill your prescriptions if it's approved under the Prior Authorization Program, but in order to ensure continued eligibility, the decision from Fair PharmaCare must be received by D.A. Townley within 90 days of the request.

2) Charges in excess of the amount payable under the Insured Person's Basic Medical Plan for professional licensed ambulance service in an emergency including transportation by railroad, boat or airplane, or in acute emergency by air ambulance, from the place where the injury or sickness occurs to the nearest acute general hospital and return fare, including round trip fare

for one attending person (doctor, nurse, first aid attendant), where necessary. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation arranged at the patient's convenience are not eligible expenses.

3) Charges for out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. The maximum for these services will be $10,000 per year to a lifetime maximum of $25,000.

4) You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, kinesiologist, osteopath, speech therapist, acupuncturist, psychologist (including clinical counsellor), podiatrist, chiropractor, naturopath or physiotherapist, who is registered and legally practicing within the scope of their license. These charges will be covered at 100% up to a calendar year maximum of $1,500 per insured person for all practitioners combined.

5) Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies.

6) Charges for walkers, canes and cane tips, crutches, splints, casts, collars and trusses but not elastic or foam supports.

7) Charges for testing supplies, needles and syringes for diabetics.

8) Charges for surgical stockings to a maximum of 2 pair per calendar year.

9) Charges for stump socks.

10) Charges for surgical brassieres up to two per calendar year.

11) One pair of custom fitted orthopaedic shoes or orthotics when prescribed by a physician or

podiatrist and replacements when necessitated by normal wear and tear.

12) Charges for rigid support braces and permanent prosthesis (artificial eyes, limbs, larynxes and mastectomy forms). Myoelectrical limbs are excluded but the Plan will pay the equivalent of a standard prosthesis.

13) Cost of rental or where more economical, purchase of durable equipment for therapeutic treatment including wheelchairs and hospital beds. Electric wheelchairs are covered only when a doctor certifies the patient is incapable of operating a manual wheelchair (e.g. Paraplegic).

14) Charges made by a dentist for the repair or replacement of sound, vital, natural teeth or the setting of a fractured or dislocated jaw if:
    - those services are required as a result of a direct accidental blow to the month and not as a result of an object placed in the mouth;
    - the accident occurred while the person is covered under this benefit; and
    - the charges are incurred within 90 days of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 90 day period.

15) Hospital charges made by an approved acute general hospital in B.C. for private or semi-private room if ward is not available or if required as medically necessary by a physician (not including rental of telephone, T.V. etc.).

16) Costs of hearing aids and repairs to a maximum of $600 in a 60 month period for adults and $800 in a 60 month period for dependent children under the age of 21 when prescribed by a certified Ear, Nose and Throat Specialist. Maintenance, batteries or other accessories will be covered.

17) Wigs and hairpieces required as a result of medical treatment or injury, up to a lifetime maximum of $500 per person.

18) You can use your pay-direct card when you visit a Licensed Optometrist or Ophthalmologist for an eye examination, up to a maximum of $85 every 24 months.

EXCLUSIONS and LIMITATIONS:

The Plan's Extended Health Benefits does not cover:

a) expenses for benefits, care or services payable by or under the Basic Medical Plan, Pharmacare, any Hospital Program or the Worker's Compensation Act, whether or not a claim is made thereunder or provided without cost or at nominal cost by any public or tax-supported authority or agency or for which the Member or dependent can recover from another party.

b) expenses of dental services or care or dentures except as specifically provided in Item 14.

c) any amount of fees in excess of the usual or recognized fees for the service performed.

d) expenses incurred outside the province of residence unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out of Province/Canada Emergency Medical Travel Insurance or if pre-approved under the Medical Referral Benefit as described herein.

e) expenses or services and supplies for cosmetic purposes.

f) expenses caused, contributed to or necessitated as a result of:
   - war or any act of war or participation in a riot or civil insurrection;
   - injury or sickness which was intentionally self-inflected, whether sustained or suffered while sane or insane;
   - occupational illness or injury; or
   - the commission by the person of any unlawful act including an offense under the Criminal Code of Canada.

g) expenses incurred for orthoptic treatment, eyeglasses, contact lenses, hearing aids, or prescriptions for any of them except as specifically provided; (see Vision Care Plan).

h) any expenses that a covered person may obtain as a benefit under any government plan or law.

i) any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of

balanced billing, extra billing or extra charging which represents an amount in excess of the schedule of costs prescribed by the Medical Services Plan.

j) medical cannabis in any and all of its forms.

Medical Referral Benefit

The Medical Referral Benefit provides coverage for reasonable and customary charges for medical and transportation expenses in excess of those expenses covered by the insured person's government health insurance plan, Health Insurance Plan or EHC plan, for the insured person (provided they are under the age of 75) and an approved escort, up to a lifetime maximum of $50,000 per person, as a result of a pre-approved medical referral for treatment, subject to the following conditions:

a) the treatment must not be available within 500 kilometres from your residence; and

b) the medical referral service must be obtained in Canada, if available, regardless of any waiting lists; and

c) your attending Canadian physician and a qualified Canadian medical specialist from an appropriately related medical field must recommend the treatment; and

d) the referral service must be eligible for reimbursement and paid in whole or in part by your government health insurance plan or Health Insurance Plan (a written pre-authorization from your government health insurance plan or Health Insurance Plan outlining their liability is required); and

e) if your government health insurance plan, Health Insurance Plan or EHC plan covers and reimburses the full medical referral expenses, no benefits are payable; and

f) the treatment must not be experimental or investigative in nature; and

g) medical services and travel must take place within 30 days of receiving approval from your government health insurance plan or Health Insurance Plan, unless the earliest possible treatment date exceeds 30 days from the date of approval; and

h) the medical referral must be pre-approved, following submission of a request for pre-approval in writing to Global Excel, along with supporting documentation.

OUT OF PROVINCE/CANADA EMERGENCY MEDICAL TRAVEL INSURANCE

Emergency Medical Travel Insurance provides coverage for eligible Members and their eligible dependents for certain expenses incurred as a result of an emergency while travelling outside your province. This travel insurance is underwritten by the Manufacturers Life Insurance Company (Manulife). Manulife has appointed Global Excel Management (Global Excel) as the provider of all assistance and claims services under this policy.

Coverage Period: 60 days per trip

Policy Number: DAT00013347

Emergency Out of Country coverage has a maximum of $5 Million per coverage period.

IF YOU HAVE AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY BEFORE SEEKING TREATMENT. THEY ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK AND CAN BE CONTACTED BY CALLING:

From Canada and the United States,
call TOLL FREE 1-833-685-2790

From anywhere else in the world,
call COLLECT + 519-735-9448

You must notify Global Excel before obtaining emergency treatment, so that they may:

- confirm coverage
- provide pre-approval of treatment

If it is medically impossible for you to call prior to obtaining emergency treatment, call or have someone call on your behalf as soon as possible.

If you fail to notify Global Excel, the Insurer reserves the right to limit your benefits as follows:

- The Insurer will not pay expenses for benefits that are not approved by Global Excel, if pre-approval is required; and

- In the event of hospitalization, 80% of eligible expenses, based on reasonable and customary charges, to a maximum of $25,000; and
- In the event of an outpatient medical consultation, a maximum of one visit per sickness or injury.

You will be responsible for payment of any remaining charges.

Some treatments require pre-approval in order to be covered (for more details refer to the full Emergency Medical Travel Insurance Booklet). Ask for a copy from the Plan Administrator.

If you do not contact Global Excel prior to seeking treatment, the medical treatment you receive may not be covered by this insurance.

Global Excel can direct you to a medical facility or doctor in your area of travel. If you contact Global Excel at the time of your emergency, they will ensure that your covered expenses are paid directly to the hospital or medical facility, where possible.

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your coverage before you travel, as your coverage is subject to certain limitations and exclusions.

Pre-existing medical condition exclusions may apply to medical conditions and/or symptoms that existed before your trip. Refer to your Schedule of Benefits outlined above your Manulife/Global Excel Assistance Wallet Card to determine how these exclusions affect your coverage and how they relate to your departure date.

In the event of a claim, your medical history will be reviewed after a claim has been reported.

Your insurance provides travel assistance. You are required to contact Global Excel prior to treatment. Coverage is for an unlimited number of trips up to the coverage period for each trip (60 days per trip); however, each trip must be separated by a return to your province.

Coverage must be in effect before you leave your province. You do not need to provide advance notice of your departure date and return date for each trip.

However, you will be required to provide evidence of these dates when filing a claim, for example, an airline ticket or boarding pass.

Claims Procedures – Emergency Out of Province/ Canada Eligible Expenses

You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim:

If in Canada or the United States,
call toll free at: 1-833-685-2790

From anywhere else in the world,
call collect to: + 519-735-9448

During your call, you will be given all the information required to file a claim.

You will be asked to substantiate your claim by providing all required documents. Failure to do so may result in non-payment of your claim. The Insurer is not responsible for fees charged in relation to any such documents. Incomplete documentation will be returned to you for completion.

When making a claim, you may be required to complete a Claim & Authorization Form along with providing supporting documentation such as:

- Complete original unused transportation tickets and vouchers if the Emergency Air Transportation or Return of Travel Companion benefit is used.
- All original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all relevant dates and type of treatment, and the name of the hospital or medical facility and/or physician.
- All original prescription drug receipts (not cash receipts) from the pharmacist, physician, hospital or medical facility showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.
- Proof of your departure date and return date. While boarding passes are preferred, airline tickets or other proof of departure date from your province, may be accepted, provided it contains your name and the location and date of your purchase.
- Any other additional documents pertinent to your claim, as may be required by Global Excel.

Failure to complete the required Claim & Authorization Form in full may delay the assessment of your claim.

All sums under this Plan are in Canadian currency unless otherwise indicated. If you paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

All pertinent documents should be sent to:

Global Excel Management Inc.
73 Queen St. Sherbrooke, Quebec J1M 0C9

Online Claim Submission:
Visit **https://manulife.acmtravel.ca** to submit your claim online. For faster and easier submissions, have all your documents available in electronic format, such as a PDF or a JPEG.

Emergency Out of Country coverage has a maximum of $5 Million per coverage period. There is no Emergency Out of Province/Country coverage for Members (or their dependents) once the Member reaches the age of 75.

VISION CARE
(eyeglasses/contact lenses/laser eye surgery)

The Vision Care Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

Covered Expenses

You can use your pay-direct card for the purchase of the following eligible expenses:

a) single vision, bifocal or trifocal lenses, prescribed by a person legally qualified to make such a prescription;
b) frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable;
c) contact lenses prescribed by a person legally qualified to make such a prescription;
d) prescription sunglasses;
e) laser eye surgery; and
f) prescription safety lenses and frames for

Members where their employer does not cover the full cost of such. The Plan shall be the final payer on these expenses.

The covered expenses described above will be paid at 100%, up to a combined maximum of $800 per covered person during any period of 24 consecutive months.

DENTAL

The Dental Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

The Plan provides pay-direct claims processing using your pay-direct card. Present your pay-direct card to the receptionist when you arrive at your dentist's office for your appointment.

Part I – Basic Services

The following services are eligible for coverage at the lesser of 100% of the amount charged or 100% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment.

1) Diagnostic Services
   All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:
   - Oral examinations: limited to two in any calendar year; however, complete oral examinations are limited to one in any 36 month period
   - Specific examinations provided the Plan has not paid for any other exam by the same dentist in the past 60 days
   - Consultations (as a separate appointment) limited to two per calendar year.
   - Dental x-rays: bite-wing x-rays are limited to one set in any 6 month period, full mouth x-rays are limited to one set in any 36 month period, and panoramic film is limited to one x-ray in any 36 month period
   - Diagnostic models: limited to 1 set per calendar year.

2) Preventative Services
   All necessary procedures to prevent the occurrence of oral disease, including:

- Cleaning (limited to twice in any calendar year)
- Scaling and root planning (combined maximum of 16 units per calendar year)
- Topical application of fluoride (limited to two applications in any calendar year)
- Pit and fissure adhesive sealants limited to once per tooth every 24 months
- Fixed space maintainers on primary teeth for dependent children under 18.

3) Surgical Services

All necessary procedures for extractions and other routine oral surgical procedures normally preformed by a dentist.

4) Restorative Services

All necessary procedures for:

- Filling teeth with amalgam, silicate, acrylic or composite restorations
- Replacement restorations if at least 12 months has elapsed since initial placement.
- Stainless steel crowns on primary teeth
- Gold Foil only when used to repair existing gold restorations.

5) Prosthetic Repairs and Maintenance

Repair if a 6-month period has elapsed since the last date on which the dentures were provided. Denture maintenance, after the 3 month post insertion care period, including:

- denture relines for dentures at least 6 months old, once every 36 months
- denture rebases for dentures at least 2 years old, once every 36 months
- resilient liner in relined or rebased dentures, once every 36 months.

6) Endodontia (Root Canals)

All necessary procedures required for pulpal therapy and root canal filling. Repeat treatment is covered only if the original treatment fails after the first 18 months.

7) Periodontia

All necessary procedures for the treatment of tissues supporting the teeth including grafts.

8) Anesthesia

General anesthesia required in relation to oral surgery to a maximum of $175 per calendar year.

Part II – Major Services
Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for coverage at the lesser of 75% of the amount charged, or 75% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment:.

- Inlays, onlays and gold foils will be covered only when other material cannot be used satisfactorily. Patients choosing gold where other materials would suffice will be responsible for the cost difference. A pre-authorization is suggested.
- Initial installations of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Partials may only be provided by a dentist.
- Initial placement of a crown (including porcelain crowns) or veneers and their replacement if at least 5 years has lapsed.
- Replacement of an existing full or partial denture, or fixed bridgework, if the existing denture or fixed bridgework was installed 5 years prior to its replacement and cannot be made serviceable. Dentures misplaced, lost or stolen will not be replaced at the Plan's expense. If the teeth/tooth was missing before being eligible under the Plan, you must be covered under the plan for 2 years before this would be considered an eligible expense.

Charges made by a licensed Denturist will be recognized for payment, in accordance with a separate Schedule of Allowances.

Part III – Orthodontia (dependent children under 21 and adults)

For orthodontia services performed by an orthodontist payment will be made at 75% to a maximum lifetime limit of $2,500.00. Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced at the Plan's expense.

Pre-Treatment Estimate of Major Restorative & Orthodontic Charges

Prior to the commencement of treatment, the dentist should provide a summary of charges for the proposed course of dental care. The Plan will then provide a written estimate of the maximum amount for which payment will be made.

Alternative Services:

If alternative services may be performed for the treatment of a dental condition, the maximum amount shown in the Suggested Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

Emergency Dental Care Anywhere in the World

In an EMERGENCY, while you are travelling or on vacation outside of your Province of residence, you are entitled to the services of a duly qualified dentist and will be reimbursed at the lower of the actual cost or the amount that would have been paid had the service been rendered in Province of residence.

EXCLUSIONS and LIMITATIONS

The Plan's Dental benefits do not cover payment for:

- items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- dental care which is cosmetic;
- dental care provided under a medical plan provided by an employer or government.
- which, in the absence of coverage, there would be no charge;
- stainless steel crowns on permanent teeth;
- protective athletic appliances;
- anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- replacement of a lost or stolen prosthesis;
- incomplete and temporary procedures;
- implants;
- any dental charge for services which were started prior to the date of coverage; or

- dental treatment which was ordered while covered, (which included lab work and impressions), but was not installed or delivered until more than 31 days after the dental benefit terminated.

Expenses recoverable under any other Plan will be co-ordinated with payments from this Plan, so that total payment received will not exceed the expenses actually incurred.

What is the maximum amount that will be paid for any one person?

There is no limit for Part I and II coverage. The maximum amount that will be paid for Part III (Orthodontia) is $2,500.00 per lifetime per covered Member or dependent.

HOW TO FILE A CLAIM

Extended Health Benefits, Vision Care and Dental

Use your pay-direct card when you fill a prescription, when you visit participating paramedical practitioners, when you have an eye examination, for dental visits and vision care purchases. If you do not use your pay-direct card, these expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the **D.A. Townley *My Claims*** portal or mobile app (see page 39 for details).

Alternatively, claim forms for Extended Health Benefits and Vision Care can be obtained from the Administrator's Office or your Union Office. Standard B.C. Dental claim forms are usually provided by your dentist, but if required, Dental claim forms can also be provided by the Administrator's Office or your Union Office.

When submitting eligible claims, please be sure to include:

- Your Name (please print)
- Your Address
- Client ID
- Your Local Union

All claims for reimbursement should be forwarded, along with applicable receipts, to the Administrator via:

- the **D.A. Townley *My Claims*** portal or mobile app
- by email to health@datownley.com
- by fax to (604) 299-8136

• mail to **D.A. Townley**
4250 Canada Way
Burnaby BC V5G 4G3

All receipts must be received by the Administrator within 12 months of the date of service to be considered for payment.

COORDINATION OF BENEFITS:

1) When co-ordinating benefit payments, D.A. Townley will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the Eligible expense was incurred.
2) If the Member or Dependent is also covered under the Spouse's plan or under any other group plan which provides similar benefits, payment will be co-ordinated and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the Eligible Expense (for dental, the fee guide applies).
3) The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.
4) The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:
   a) the amount that would have been payable had it been the primary carrier, or
   b) 100% of all Eligible expenses reduced by all other benefits payable for the same expenses by the primary carrier.
5) If the other plan does not contain a co-ordination of benefits clause, payment under that plan must be made before the Plan will pay under this provision.
6) Extended health care plans with dental accident coverage determine benefits before dental plans.
7) If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.
8) When the Plan has paid benefits to the Member to the limit of the Pharmacare deductible, the Plan will pay their portion of the Eligible expenses based on the plan's reimbursement percentage.
9) The Member will provide the information required to implement this provision. It is the Member's responsibility to present a copy of the original

claim form and the remittance statement or cheque stub when making further claim under this provision.

HEALTH CARE SPENDING ACCOUNT (HCSA)
(effective July 1, 2023)

This benefit provides an entitlement of $500 per year per Member, regardless of whether the Member has single or dependent coverage under the Plan. The Member's initial entitlement will be prorated to the month they qualify for coverage. For example, if the Member qualifies for coverage July 1st, the initial entitlement will be $250 for the balance of that calendar year. These funds are available to claim any unpaid portion of eligible benefits that are not reimbursed in full under the Plan and after coordinating benefits with a spouse's benefit plan, where applicable. Provided the Member remains eligible for coverage under the Plan, an additional $500 will be contributed to their HCSA account on January 1st of each subsequent year.

Funds are available in the HCSA for 12 months from the end of the calendar year in which they were contributed. If the Member does not fully claim a current year's HCSA entitlement, the balance of the entitlement contributed that year will be carried forward into the next calendar year to be used for expenses incurred in that new calendar year and will be forfeited at the end of the carry-forward year. For example, any unclaimed entitlement earned in 2023 will be carried forward into 2024 and will be forfeited (expire) December 31, 2024 if any portion remains unclaimed. The funds contributed in 2024 will be available until December 31, 2025. Members can view their available balance in the **D.A. Townley *My Claims*** portal or mobile app or call D.A. Townley's claims department for assistance.

Expenses incurred during a calendar year must be reimbursed using that same calendar year's entitlement (or the previous year's entitlement if the funds were carried forward, where applicable). No unpaid portion of a HCSA claim may be carried into the next year for further reimbursement. For example, if a $400 expense were incurred in November 2023, any available 2023 entitlement would be applied to this claim and the 2024 entitlement could not be used to pay the balance. This claim would be considered closed.

Upon termination of coverage, the Member has 30 days to submit any eligible expenses to the Plan, provided they were incurred while the Member was eligible for HCSA coverage. Any unclaimed entitlements following termination will be forfeited. If the Member requalifies for coverage later that same year, any forfeited entitlement from that same year will be reinstated but can only be used to reimburse eligible expenses that were incurred while the Member was eligible for coverage. If the Member already claimed their HCSA entitlement prior to coverage terminating, the Member must wait until the next new calendar year for a new entitlement, provided they remain eligible for benefits.

How a Claim is Made (HCSA)
The HCSA is the final payer of expenses so all expenses must first be claimed under a Member's regular benefits and any benefits they may have through a spouse's benefit plan before they may be claimed under the HCSA benefit. Claims can be submitted using the **D.A. Townley *My Claims*** portal or mobile app. You can also indicate clearly on your regular benefits claim form that you want any unpaid balance applied to your HCSA. It is important to clearly indicate this on the claim form so that the adjudicator will notice it.

Members have 60 days at the beginning of a new calendar year to submit eligible expenses that were incurred in the previous year. These expenses will be paid from any entitlement balance that was available at the end of the previous year. Claims incurred during the previous year, which are received after February 28th, will be returned unpaid.

D.A. TOWNLEY *MY CLAIMS* PORTAL and MOBILE APP

Go to: **www.datownley.com/myclaims/** and look for Online Registration in the resources section on the right side of the page. Click on the link. Complete all the required fields and acknowledge that you have read the terms and conditions.

Click on the Submit button and it will automatically direct you to the ***My Claims*** portal. Set up your account on the ***My Claims*** portal by clicking on Register Account. Enter your group number (11244) and your Client ID number from your pay-direct card, along with your postal code and date of birth. Then click Next. Set up your username and password.

Please note: you can only create one username and password for the same coverage. Then click Sign Up and accept the terms and conditions. Now you can download the free **D.A. Townley *My Claims*** app by visting the App Store for IOS devices or Google Play for Android devices. Once downloaded, register your account on the portal and app, then you are ready to sign in using your username and password that you assigned.

DIRECT DEPOSIT

If you have not already done so, you can sign up for Direct Deposit for your claims reimbursements. Get your reimbursement faster and have the funds deposited directly into your bank account rather than waiting for a physical cheque. On the **D.A. Townley *My Claims*** portal or app, click on the Person icon on the top navigation. Go to Update Direct Deposit and enter your banking information (this can be found on the bottom of a personal cheque, from your online banking app or by calling your financial institution directly.)

Benefits Provided by:

The Co-operators
#G419
Life Insurance

Machinists, Fitters & Helpers
Industrial Union Local No. 3
Benefit Plan
#11244
Wage Indemnity
CPP Top-Up
Extended Health Benefits
Vision Care
Dental
Health Care Spending Account

Blue Cross Life
#79396051
Accidental Death & Dismemberment

Manulife Group Travel Insurance
 # DAT00013347
Global Excel Management Inc.
Out of Province/Canada Emergency
Medical Travel Insurance

Morneau Shepell
#7023
Employee/Family Assistance
Plan (EFAP)

This booklet explains in general terms the Plan of benefits and coverage in effect. It is not to be considered a contract of insurance. The complete terms of the Plan are set forth in the group policies issued to the Trustees.

JULY 2023

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