MILLWORKERS HEALTH & WELFARE PLAN
(UNIFOR) FUND

UNIFOR
Local1928

ON BEHALF OF MEMBERS OF

Local No. 1928, Vancouver

Address all plan inquiries to:

The Plan Administration Office
MILLWORKERS HEALTH & WELFARE PLAN (UNIFOR) FUND

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Effective May 1997

*Including amendments to June 1, 2025

PRIVACY POLICY

We, the Trustees of the Millworkers Health & Welfare Plan (Unifor) Fund 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

The following is an outline of the Millworkers Health & Welfare Plan (Unifor) Fund **benefits** for Local 1928**. The information in this benefits booklet is important to you. It provides the information you need about the groupbenefits available through the Millworkers Health & Welfare Plan** (Unifor) Fund**.**

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.

SCHEDULE OF BENEFITS

Life Insurance	$30,000
Accidental Death & Dismemberment	Members $30,000 Spouse $20,000 Child $5,000
Weekly Indemnity Benefit	$400 per week 26 weeks maximum Integrated with E.I.
Extended Health Benefits	80% of 1st $1,000 then 100% (per cal year) unless otherwise described $1,000,000 maximum
Out of Canada Emergency Coverage	$5,000,000 maximum $100,000 (age 65-79)

Vision Care	$500 / 24 months
Dental Plan	90% Basic Services 50% Major Services $2,500 comb. maximum

Details of Eligibility

Who is eligible?

Any Member in good standing who has sufficient hours for coverage.

Do any Forms have to be completed?

YES. You must complete an Enrolment and Beneficiary card and forward these to the Administrator.

How does a person qualify for coverage?

A Member in good standing must accumulate 220 hours of work within 6 consecutive months. Coverage will commence on the 1st day of the second month following the accumulation of 220 hours.

EXAMPLE:

Your employer(s) report that you have accumulated in excess of 220 hours for 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	150
March	150
April	Lag Month
May	Coverage Starts

Each month 110 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, you will receive a pay-direct card (one if you have single coverage or 2 cards if you have dependent coverage – both will be in your name).

A maximum of 8 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 110 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 Weekly Indemnity Benefit Plan, E.I. Sick Benefits or under Workers' Compensation, Members 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 3.65 hours per day, to a maximum of 110 hours per month and up to a maximum of 8 months. The Member must request the appropriate form from the Administration Office and return the completed form to apply for Disability Credits. To qualify for these Disability Credits, the Member must be eligible for full benefits when the disability commences.

If the Member is disabled for longer than the maximum Weekly Indemnity claim of 26 weeks the Member should contact the Administration Office to inquire about further disability credits.

Self-Pay:

A Member in good standing may continue full coverage through self-payment.

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

The following options are available to those who receive a self-pay notice:

PLAN A Full coverage for Group Life, AD&D, Weekly Indemnity Benefit, Extended Health Care, Vision and Dental.

PLAN B Full coverage for all benefits as outlined in Plan A excluding the Weekly Indemnity Benefit coverage.

PLAN C Full coverage for all benefits as outlined in Plan A excluding the Weekly Indemnity Benefit and Dental coverage.

You may change coverage from a more comprehensive plan to a lesser plan during the same period of self-pay but you cannot upgrade your coverage.

The allowable limit for self-payment of benefits is four consecutive months. This provision will not apply to those Members who are disabled and in receipt of WorkSafe BC Benefits or Canada Pension Plan Disability Benefits.

Once a disabled Member's CPP Disability Benefit reverts to CPP Retirement benefits at age 65, that Member is permitted to self-pay for a maximum of four consecutive months.

Members are permitted to top up their hours in their Hour Bank when there are insufficient hours from an employer to meet the full monthly requirement, and this will not be counted in the four consecutive month self-pay maximum until they make their first full self-payment.

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 220 hours in a 6 consecutive month period.

Are there any reciprocity agreements with other Millworkers Health and Welfare Plan Local's? YES. If a Member is working he/she may be entitled to have his/her contributions remitted to the Millworkers Health & Welfare Plan (Unifor) Fund. The Union office must be contacted to ensure there is a reciprocity agreement in place with the local you are

working in, and you must advise the local in which you are working that you are a Member of the Millworkers Health & Welfare Plan (Unifor) Fund and wish your contributions be transferred to this Plan. From time to time the Trustees may enter into or terminate reciprocity agreements.

Are Dependents Covered under the Plan?

YES. The Plan will provide 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, provided such person is mainly dependent on and living with the covered Member;
c) Any unmarried child of a covered Member to age 25 provided the child is in full-time attendance at a recognized school, college, or university;
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 an Enrolment and Beneficiary card from the Administrator or your Union Office, and forward it to the Administrator's office.

Dependent children must be added within sixty days from the date of birth or from the date the child became a dependent. A spouse must be added within sixty days of the date of marriage.

Newborn children are NOT automatically registered. You must notify the Administrator and provide the child's name and date of birth in order to have him or her included in your coverage.

Dependents not added as above 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.

Details of Coverage Provided by the Plan

LIFE INSURANCE

Each eligible Member is insured for $30,000 of Life Insurance.

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

If your insurance terminates on or before your 65th birthday, you may be able to convert your group life insurance to an individual policy, without needing to provide evidence of good health. Your application for the individual policy and the first premium must be received by Co-operators Life within 31 days of the termination of your group life insurance. If your insurance terminates on your 65th birthday, your application must be received by Co-operators Life within 31 days of your 65th birthday. If you die during this period, the amount of group life insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion. The conversion privilege is not available after your 65th birthday.

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 without premium payment, 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 63.

Application for this benefit must be approved by the Plan and the Insurance Company 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.

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 80 If self-paying to age 66	$30,000
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.

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.

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.

Hearing means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than ninety (90) decibels in 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 BC Life and Consulting Company “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 Person has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that such Insured Person shall have suffered loss of life within the meaning of the policy.

Beneficiary Designation

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

All other benefits shall be payable to the Insured Person.

Repatriation Benefit

When injuries covered by this policy result in loss of life of an Insured Person 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 Person provided:

a) Such training is required because of such injuries and in order for the Insured Person to be qualified to engage in an occupation in which he would not have been engaged except for such injuries,
b) Expenses be incurred within 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 Person being confined to a hospital, outside 100Km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the 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 Person 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 the BC Life and Casualty Company's 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 the BC Life and Casualty Company. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

Continuance of Coverage

In the case of employees of the Policyholder who are (1) laid-off on a temporary basis (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of twelve (12) months, subject to payment of premium. If an employee of the Policy-holder 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 Person becomes totally and permanently disabled and his/her 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 Person attains age 65.
b) The date of the death or recovery of the Insured Person.
c) the date of 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 Person's injury or death results while he/she is a passenger or driver of a private passenger type automobile and his/her seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Home Alteration and Vehicle Modification

If an Insured Person 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 Person'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 driveable for the Insured; 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 Person and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and

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

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

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:

a) ten thousand dollars ($10,000.00) per school year; or
b) 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:

a) 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
b) only while such Dependent Child continues his or her continuous enrollment in an Institution of Higher Learning.

The Company will reimburse the person who has 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 College, or Trade School.

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

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 licenced 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 a commercial and licenced 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 licenced day care centre.

In-Hospital Indemnity 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 in accordance with Section 6.6 (a) for each overnight 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 Member 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 licenced 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 active 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 licenced 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.

WEEKLY INDEMNITY BENEFIT

A benefit of $400 per week 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 hospitalized prior to the 4th day of sickness, benefits commence on the 1st day if hospitalized for at least 24 consecutive hours. If a surgical procedure is performed on an out-patient basis in a general hospital, benefits will commence on the 4th day.

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 certified 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.

Benefits are integrated with E.I. sick benefits, and are paid as follows:

- The first 4 weeks will be paid by the Plan at $400.00 per week.
- Weeks 5 to 30 (26 weeks) inclusive, will be paid by E.I. at the rate determined by E.I.

- The balance of weeks from 31 to 37 will be paid by the Plan, if you are still disabled, at a rate of $400.00 per week.

If you are eligible for E.I. sick benefits, 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 37 weeks including the E.I. sick benefit payments.

NOTE: Claims must be filed for E.I. sick benefits at the same time you apply for Weekly Indemnity benefits with the Plan.

How to claim for Weekly Indemnity benefits:
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, shop steward or the Administrator's office and note instructions concerning an E.I. sick claim.
c) Complete the form where indicated.
d) The Union must complete the Authorization at the very bottom of the page.
e) Have your doctor complete the physician's portion of the form.
f) Send the completed form to the Administrator without delay.
g) Claim cheques will be sent directly to your home address.
h) Claim for disability must be submitted no later than 30 days after your total disability begins.
i) Benefits will only 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, the Plan reserves the right to obtain a second medical opinion from a physician and/or surgeon of their choice.

Third Party Liability

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

a) a third party may be, directly or indirectly, either in whole or in part, liable to the Member, such as in the case of a motor vehicle-related accident or injury or
b) the Member has a claim for benefits under workers compensation legislation;

the Plan will not pay benefits to the Member.

Recurrence of Former Ailments

The Member will not receive benefits for more than 26 weeks as a result of disability due to any one ailment. However, a new waiting period and benefit duration period will start if the Member returns to active full-time work for:

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

EXCLUSIONS and LIMITATIONS:

No benefit will be paid for periods of disability:

- arising from a motor vehicle-related accident or injury where ICBC or a third party may be, directly or indirectly, either in whole or in part, liable to the Member;
- arising from occupational accident or illness, as these are covered by the WorkSafe BC/WCB 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 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;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire; or
- you die.

EXTENDED HEATH BENEFITS

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.

There is an annual deductible of $75 for single Members, $150 per couple and $200 per family. If in any calendar year the eligible expenses incurred do not exceed the deductible, the eligible expenses incurred during the last three months of that calendar year may be applied against the deductible in the next calendar year.

After the deductible has been satisfied, Extended Health benefits are provided at the rate of 80% of the first $1,000 of eligible paid expenses, followed by 100% of all other eligible expenses incurred in the balance of the calendar year, up to a lifetime maximum of $1,000,000.

Out of province emergency medical coverage is reimbursed at 100%, has no deductible and is provided to eligible Members and their dependents up to a maximum of $5,000,000 per coverage period.

Benefits:

Upon qualifying for coverage, you will receive a pay-direct card (one if you have single coverage or 2 cards if you have dependent coverage – both will be in your name).

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. The Plan provides coverage for prescription drugs and medicines (excluding 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. Fertility drugs are covered to a maximum of $5,000 per lifetime. Drugs and medicines that can normally be purchased "over the counter" are excluded regardless of a prescription having been issued. Smoking cessation products, vitamins, preventative drugs, dietary foods and supplements are also excluded.

There are a number of prescription drugs which are not eligible under PharmCare'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://pharmacare.moh.hnet.bc.ca

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 60 days.

4) You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, speech therapist, acupuncturist, psychologist (includes registered clinical counsellors and licensed social workers), podiatrist, chiropractor, naturopath or physiotherapist, who is registered and legally practicing within the scope of his/her license. These charges will be covered up to a calendar year maximum of $350 per insured person for each practitioner category. (applicable to expenses incurred on or after January 1, 2021)

   X-rays are not a covered expense.

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 4 pair per calendar year.

9) Charges for stump socks.

10) Charges for surgical brassieres up to 4 per calendar year.

11) One pair of custom fitted orthopaedic shoes when prescribed by a physician or podiatrist and replacements when necessitated by normal wear and tear.

12) One pair of custom made orthotics to a maximum of $350 per calendar year when prescribed by a physician or podiatrist.

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

14) 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).

15) 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 mouth 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 12 months of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 90 day period.

16) 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.).

17) Costs of hearing aids and repairs to a lifetime maximum of $500 when prescribed by a certified

Ear, Nose and Throat Specialist. Maintenance, batteries or other accessories will not be covered.

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

EXCLUSIONS and LIMITATIONS:
The Plan's Extended Health Benefit does not cover:

a) expenses for benefits, care or services payable by or under the Basic Provincial 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 15.

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

d) expenses incurred outside the Province of British Columbia 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 Emergency Eligible Expenses.

e) expenses of 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 Provincial 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 Provincial Medical Plan.

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

Out-of-Province/Canada Emergency Eligible Expenses

Reasonable and Customary charges for services and supplies required as a result of a medical emergency occurring while travelling if:

- you are or your dependent is covered under a Basic Provincial Medical Plan; and
- treatment could not have been delayed until return to Canada.

Emergency Medical Insurance & Travel Assistance

While you are travelling outside your Province of residence carry the wallet card that has been provided to you.

Travel insurance is designed to cover losses arising from sudden or unforeseeable circumstances occurring while you are temporarily travelling outside your province or territory of residence. It is important that you read and understand your Plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provisions of the Policy, the provisions of the Policy shall govern. The Plan has contracted Viator/ Global Excel Management Inc. (called Global Excel) to provide medical assistance and claims services under the Policy. This is a summary of benefits. A complete booklet is available from the Plan Administrator.

Coverage Period: 90 days per trip.

IN THE EVENT OF AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY

The emergency telephone numbers are listed on the back of the Medical Assistance Card provided.

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the policy expressly requires the prior approval or authorization of Global Excel, on the basis of the reasonable and customary costs that would have been payable for such expenses by the insurer in accordance with the terms and conditions of the policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the reasonable and customary costs reimbursed by the insurer.

In an emergency the policy covers expenses that are:

- incurred outside the province or territory of residence of the insured person;
- medically necessary;
- reasonable and customary costs;
- incurred as a result of an emergency due to sudden and unforeseen sickness and/or injury occurring during the coverage period;
- in excess of those covered by the Government Health Insurance Plan or other insurance under which you may have coverage;
- legally insurable; and
- subject to the overall maximum per insured person of $5,000,000 per coverage period if under 70 or $100,000 if age 70 to 79.

Claims Procedures – Out of Province/Canada Emergencies

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

a) include the policy number, the patient's name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
b) submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or physician;
c) provide the original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;
d) provide proof of the departure date(s) and return date(s);
e) provide written proof of claim within ninety (90) days of the date of receipt of services covered under the policy;
f) provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;
g) sign and return the authorization form, provided by Global Excel, allowing the insurer to recover payment from the Canadian provincial or territorial Government Health Insurance Plan. The insurer will coordinate and pay your claim to the participating medical providers and where permitted, coordinate claims directly with the Canadian provincial or territorial Government Health Insurance Plan on your behalf; and
h) return the unused portion of your air ticket to Global Excel if the Emergency Air Transportation benefit is used.

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. Any information not provided may result in a delay in processing your claim.

All pertinent documents should be sent to:

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

Policy Number: DAT00013348

Emergency Out of Country coverage has a maximum of $5 Million per coverage period if under age 70 and $100,000 if between the ages of 70 and 79.

VISION CARE

(eyeglasses/contact lenses/laser eye surgery)

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

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

a) one set of single vision, bifocal or trifocal lenses, prescribed by a person legally qualified to make such a prescription;
b) one set of 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) eye exams.

Combined, these expenses are covered at 100% of the actual expense incurred or $500, whichever is the lesser, during any 24 consecutive month period.

Laser eye surgery will be reimbursed at 100% up to a maximum of $1,000, provided there was no vision claim within the 24 months prior to surgery and no vision claim will be available until 24 months after the surgery.

EXCLUSIONS and LIMITATIONS

The cost of the following items are excluded from this Plan:

a) duplicate or spare eye glasses or any lenses or frames thereof;
b) safety goggles, sun glasses (plain or prescription);
c) replacement or lost, stolen or broken lenses or frames.

DENTAL PLAN

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 90% of the amount charged or 90% 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
   - 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 planing (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 for dependent children under 18
- 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 (composite restorations on molars are not covered)
- 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 24 months
- denture rebases for dentures at least 2 years old, once every 24 months
- resilient liner in relined or rebased dentures, once every 24 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 excluding grafts.

8) Anesthesia
General anesthesia required in relation to oral surgery.

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

The following services are eligible for coverage at the lesser of 50% of the amount charged, or 50% 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 required.
- 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 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.

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

Pre-Treatment Estimate of Major Restorative

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

Where alternative procedures are available, benefit payments will be based on the least expensive procedure.

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 missed 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;
- orthodontia;
- 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.

TO MAKE A CLAIM

Extended Health Benefits, Vision Care and Dental

Use your benefit 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 benefit card, these expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the claims payment portal or mobile app (see page 38 for details). Alternatively, claim forms can be obtained from the Plan website: millworkersuniforbenefits.org.

Standard BC 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. These too are available online: millworkersuniforbenefits.org

When submitting eligible claims, please be sure to include:

– Your Name (please print)
– Your Address
– Your Certificate Number/Client ID
– Your Local Union

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

- The claims payment website or mobile app
- by email to questions@millworkersuniforbenefits.org
- by fax to 905-946-2535
- drop off or mail to **Millworkers Unifor Benefits**
  45 McIntosh Drive
  Markham, ON L3R 8C7

COORDINATION OF BENEFITS:

1) When coordinating benefit payments, the Plan 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 coordinated 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.

CLAIMS PAYMENT SERVICE

Go to: millworkers.onlineclaimsaccess.net and look for the "Register" button. Click on the link. Complete all the required fields.

Your Group Number and Certificate Number are found on your benefit card.

You can download the free app by visiting the App Store for IOS devices or Google Play for Android devices. Search "My Health Benefits". Once downloaded, you can register or sign in to your account.

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 millworkers.onlineclaimsaccess.net or the 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).

NOTES:

NOTES:

Benefits Provided by:

The Co-operators #G644
Account 001
Life Insurance

Millworkers Health & **Welfare Pla**n
(Unifor) Fund **#9661**
Weekly Indemnity
Extended Health Care
Vision
Dental

BC Life and Casualty Company
#79396006
Accidental Death & Dismemberment

The Manufacturer Life Insurance Company
(Manulife) **#**DAT00013348
partnered with Global Excel
Out of Province Emergency Medical
and Travel Insurance

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.