CONSTRUCTION MAINTENANCE AND ALLIED WORKERS CANADA

The CMAW Benefit Plan

www.cmaw.ca/members-info/benefits

ADDRESS ALL BENEFIT PLAN INQUIRIES TO:
The Administrator | The CMAW Benefit Plan
Bilsland Griffith Benefit Administrators
#1000 – 4445 Lougheed Hwy | Burnaby, BC | V5C 0E4
Toll Free: 1.844.366.2629 | F: 604.433.8894
Email: cmaw@bgbenefitsadmin.com

SUMMARY OF PRIVACY POLICY

The Trustees have adopted a Privacy Policy that explains how members' personal information will be collected, used and disclosed. You are encouraged to review that Policy in detail, but key components of the Privacy Policy are set out below:

- Information about you is used to administer your claims for benefits and to administer the Plan more generally.
- Your personal information will not be sold.
- Information about you is gathered lawfully and fairly.
- Information about you is gathered, used, or disclosed to provide you with benefits and services as outlined in your plan documents and the Privacy Policy.
- If you obtain or try to obtain benefits that you know you are not entitled to receive, the Trustees may advise law enforcement and CMAW which sponsors the Plan and bargains contributions to pay for benefits from the Plan.
- 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 Administrator is not accurate.
- You may access your personal information, subject to limited exceptions and conditions.
- Personal information is not disclosed without your 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 your benefits.
- Where we choose to have certain services such as actuarial valuations 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 this privacy policy and all applicable legislation.
- To protect your personal information against unauthorized access, disclosure, copying, use or modification, theft or accidental loss, we will maintain appropriate security mechanisms.

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.

Table of Contents

Summary of Benefits

Group Life Insurance	$100,000
Uninsured Life Benefit	$5,000
Dependent Life Insurance	$25,000/spouse $5,000 each child
Accidental Death and Dismemberment Insurance	$100,000
Dependent Accidental Death and Dismemberment Insurance	$20,000/spouse $5,000 each child
Wage Indemnity sick benefit, integrated with E.I. sick benefits	E.I. weekly maximum
Long-term Disability	$2,000 monthly
Extended Health Care	80% of the first $1,250 of eligible expenses 100% thereafter to a lifetime max of $1 million
Paramedical Services	Paramedical Services are reimbursed at 80% with the exception of massage therapist, physiotherapy, and chiropractor, which are reimbursed at 85%.
Hospital and Medical Items	80% of the first $1,250 of eligible expenses
Travel Assistance	8 claims per illness
Vision Care Benefits	80% to a maximum reimbursement of $480 (80% of $600) every 12 months
Dental Plan	85% of the first $6,000 of eligible Basic and Major and orthodontic expenses per family per calendar year.

PART 1
General Information

How do you establish coverage in the plan?

(1) You must be a Member of the Construction Maintenance and Allied Workers.
(2) You must have a minimum of 120 credited hours, within a period of 12 consecutive months, reported and paid into the Plan by your employer(s).
(3) You must complete an Enrollment and Beneficiary form.

When does coverage commence?

Union Members who have completed an application card will have coverage commencing on the first day of the month following the month in which sufficient eligible hours are reported to the Plan by your employer(s).

Credited hours are added to your Hour Bank based on the hourly employer contribution rate paid on your behalf. The Trustees regularly review the expected contribution rate. If the contribution rate paid on your behalf is less than the expected rate, your credited hours will be prorated accordingly. To confirm the expected contribution rate, go to the benefit plan section of the CMAW website or contact the Plan Administrator.

Example 1:
Your employer(s) report that you have accumulated in excess of 120 hours in the last 12 months. January hours are reported and tabulated in February and March, which makes February and March the 2-month Lag; your coverage becomes effective April 1.

Month	Hours Reported
January	160
February	Lag Month
March	Lag Month
April	Coverage Starts

Example 2:
If January hours are not yet sufficient, then they are added to your bank and included with your February hours to determine eligibility. February hours are reported in March and April, which makes March and April the 2-month Lag; your coverage becomes effective May 1.

Month	Hours Reported
January	80
February	160
March	Lag Month
April	Lag Month
May	Coverage Starts

Once coverage starts, you will continue to be covered as long as your Hour Bank contains sufficient hours.

How does the Hour Bank build for future coverage?
Once you have qualified, additional hours reported will be added to your Hour Bank. Each month 120 hours will be withdrawn from the Hour Bank for coverage. You may accumulate up to 12 months coverage—1, 440 hours in advance which will be drawn upon during a period of unemployment, illness or extended vacation, providing you remain a Member of the Union.

What happens if the Hour Bank falls short for coverage?
If you have accumulated in excess of 120 hours, but not 240 hours in the last 12 months, you are not eligible to self-pay for benefits. If you have accumulated in excess of 240 hours in the last 12 months and if your Hour Bank drops below 120 hours, you will receive a Self- Payment Notice indicating the number of hours you are short in your Hour Bank and the payment amount required to maintain coverage. If you make payment of the amount requested and by the deadline specified on the Notice, your coverage will be continuous.

Example:

Monthly Charge	120 hours
Your Hour Bank	90 hours
You are Short	30 hours

You must contribute 30 hours at the current self-payment rate.

Self-Payment option

In order to assist you in maintaining coverage under the Plan, the following option is available to those Members receiving a Self-Payment Notice.

Full coverage for Group Life, Dependent Life, AD&D, Extended Health Care, Vision, Dental, Travel Assistance and EAP.

NOTE: there is no Wage Indemnity or Long-term Disability coverage during self-paid months.

Maximum Self-Pay

When you have no hours left in your Hour Bank, you may continue to self-pay for up to 18 months.

Disability credits

Should you go on claim for Wage Indemnity, Worker's Compensation, auto insurance wage replacement benefits or EI sickness benefits, you will receive 8 hours for each day you are in receipt of disability benefits, to a maximum of 120 hours per month for a maximum of 6 months. Disability credits will be given automatically while receiving Wage Indemnity benefits; however, in order to obtain Disability credits while receiving Worker's Compensation, auto insurance wage replacement or EI sickness benefits, you must submit a competed Disability Credit form to the Administrator.

Extension of coverage while receiving Long-term Disability Benefits

Members receiving Long-term Disability benefits through the Plan will be provided with continued coverage for Extended Health Care, Vision Care and Dental benefits at no cost.

Right to recover

(1) 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 only pay benefits to the Member if the total of all benefits paid 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 Third Party Reimbursement Agreement.

When does coverage end?

Coverage is always provided on a whole-month basis and will be terminated when:

(1) your Hour Bank falls below 120 hours and you fail to make a self-payment by the specified date, to bring your Hour Bank up to the required 120hours, or;
(2) you cease to be a Member of the Union.

Do not ignore a Self-Payment Notice.

If you receive a Self-Payment Notice and you think it is incorrect, contact the Administrator:

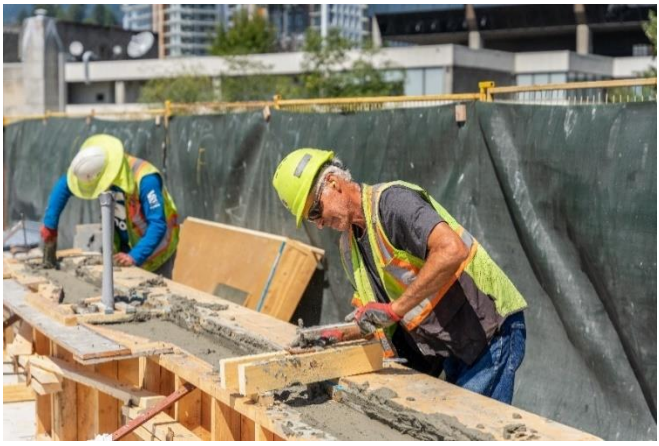
Bilsland Griffith Benefit Administrators
Toll-free at: 1.844.366.2629
#1000 – 4445 Lougheed Hwy
Burnaby BC V5C 0E4
Email:cmaw@bgbenefitsadmin.com

The only certain way to provide yourself with coverage for a specified month is to pay the Self-Payment Notice by the date specified on the Notice.

In the event that late hours are reported or other adjustments are found later, the hours will be credited to your Hour Bank for future use.

If coverage terminates, when will coverage re-commence?

When 120 hours have been reported to the Plan. See “How Do You Establish Coverage in the Plan?” for details. You may not re-qualify by self-payment.



Dependent coverage

A Member's registered eligible dependents will be included in the coverage for Dependent Life, Extended Health Care, Vision, Dental Care, Travel Assistance, EAP and the spouse and dependent AD&D benefits.

Dependents eligible for benefits are:

(1) the Member's spouse* and

(2) unmarried dependent children mainly supported by the Member up to 21 years of age, and up to the age of 25, provided they are attending school, university or college on a full-time basis. Also, dependent children who are disabled and rely upon the Member for support for whom the Member is entitled to an income tax exemption, provided such child was covered under the Plan immediately prior to his/her 21st birthday.

** The legal spouse of the Member, or in absence of a legal spouse, the common-law spouse of the Member. The common-law spouse is a person whom the Member has been living with and that living arrangement must be recognized as a conjugal relationship in the community in which the couple resides. Only one person may qualify as the spouse at any one time.*

The co-habitation period for a common-law spouse is a continuous period of twelve (12) months.

Dependent children must be added within 60 days from the date of birth or from the date the child became a dependent. A spouse must be added within 60 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/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.

Termination of dependent student coverage
A dependent student will automatically be terminated when they reach the maximum dependent age for the benefit.

NOTE: If your dependent's coverage is terminated and he or she is still a student (and less than the maximum age), contact the Administrator's office to arrange for reinstatement.

Co-ordination of benefits

(1) When coordinating benefit payments, Green Shield 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 .
(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:
    i. the amount that would have been payable had it been the primary carrier, or
    ii. 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 coordination 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 claimunder this provision.

PART 2
Group Life Insurance

AMOUNT OF BENEFIT	
All Members who are under age 70	$100,000 ($50,000 for mini plan) reduced 50% at age 65 and a further 50% at age 66.

The Group Life Insurance Benefit is payable to the beneficiary designated by you on your Group Enrollment card, should your death occur from any cause while you are insured under the group policy. If any beneficiary dies before you, the interest of such beneficiary shall, unless otherwise provided, vest in your estate. If you do not designate a beneficiary, the insurance will be payable to your estate.

If you wish to change your beneficiary, proper forms are available from the Administrator's office.

Conversion privilege

In the event of termination or reduction of your coverage on or before age 70, you have the right to convert your Group Life Insurance to an individual Life Insurance policy at the insurance company's rates for such policy, without medical evidence, provided application is made within 31 days of such termination.

In the event of your death within 31 days following termination of coverage, the death benefit would be payable.

Waiver of Premium – Total Disability

While covered, should you receive Long-term Disability benefits under this plan or become totally disabled for more than nine (9) months prior to age sixty-five (65), the amount of your life insurance will continue without payment of premiums while you remain totally Disabled. Satisfactory proof of Total Disability must be submitted to the insurance company within 60 days from when your Long-term Disability benefits commence and thereafter, upon requests by the insurance company. Your life insurance coverage and waiver will terminate when you reach age 65 or recover, whichever occurs first.

Submitting a claim

The time limit within which a group life insurance claim must be made is 180 days from the date of loss.

PART 3
Uninsured Life Benefit

AMOUNT OF COVERAGE	
All Uninsured Members	$5,000

The Union provides a Life Benefit of $5,000 should you die before becoming eligible for coverage under the Plan providing you have completed your union membership card. Payment of this benefit will be made to your Estate.

PART 4
Dependent Life Insurance

This benefit provides life insurance coverage for your spouse and dependent children provided you and your spouse are under age 70. The amount of the benefit is:

Spouse	$25,000
Child (from birth)	$5,000

Total disability waiver of premium

If premiums for your basic life insurance coverage are being waived, premiums for the dependent insurance will also be waived, but only so long as this benefit and your employers' coverage under this benefit remains in force.

PART 5
Accidental Death & Dismemberment

The Basic Accidental Death and Dismemberment benefit 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 a result of an accidental injury which results directly and independently of all other causes and the loss occurs with 365 days of the date of the accident, the benefits indicated below will be paid.

Who is Covered?	Principal Sum
All Members who are under age 70	$100,000 reduced 50% at age 65 and a further 50% at age 66
All Spouses	$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 Entire Eye Sight of One Eye	The Principal Sum
Loss of One Foot and 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 the Thumb and Index Finger of the Same Hand	One-Third of the Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Speech or Hearing	Three-Quarters of 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

SCHEDULE OF LOSSES (Continued)	
Loss of Use of Both Arms or Both Hands	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 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 on 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 irrecoverable loss of the entire sight thereof.

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

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

Trustees and a licensed practicing physician appointed by the insurer, 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 insurer. This procedure may be waived by the insurer at its sole discretion.

Exposure and disappearance

If by reason of an accident covered by the policy an insured person is unavoidably exposed to the elements and, as a result of such exposure suffers a loss for which indemnity is otherwise payable hereunder, such loss will be covered under the terms of the policy.

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 insurer 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.

Rehabilitation benefit

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

(1) 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,
(2) expenses be incurred within three years from the date of the accident,
(3) 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 100 km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the insurer shall pay the actual expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined insured person but not to exceed the amount of $15,000.

The term “member of the immediate family” means the spouse (or common-law spouse), parents, grandparents, children under 18, brother or sister of the insured person.

Conversion privilege

On the date of termination of employment or during the 60 day period following termination of employment, you may convert your insurance to the insurance company’s individual insurance policy. The individual policy will be effective either as of the date that the application is received by the insurer or on the date that coverage under the policy ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of the insurer. The amount of insurance benefit converted to shall not exceed that amount issued during coverage.

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 Insurance 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 Insurance Plan Underwriter until one of the following occurs, whichever is earlier.

(1) The date the insured person attains age 65.
(2) The date of the death or recovery of the insured person.
(3) 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 received payment under Part 5 – Schedule of Losses herein, and was subsequently required (due to the cause for which payment under Part 5 – Schedule of Losses was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

(1) The one-time cost of alterations to the injured person's residence to make it wheel-chair accessible and habitable; and
(2) The one-time cost of modifications necessary to a motor vehicle, owned by the injured person, to make the vehicle accessible or drivable for the insured person.

Benefit payments herein will not be paid unless:

(i) Home alterations are made on behalf of the insured person and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and
(ii) Vehicle modifications are made on behalf of the insured person and carried out by an experienced individual in such matters and modifications are approved by the provincial vehicle licensing authorities.

The maximum payable under both Items 1 and 2 combined will not exceed $15,000.

Educational benefit rider

If Indemnity becomes payable for the accidental loss of life of an insured Member of the Plan, under the policy, the insurer shall:

(1) Pay the lesser of the following amounts to or on behalf of any dependent child who, at the date of accident, was enrolled as a full time student in any institution of higher learning beyond the 12th grade level:
   (i) the actual annual tuition, exclusive of room and board, charged by such institution per school year.
   (ii) $10,000 per school year.
   (iii) 5% of the insured Member's Principal Sum.

   Such amount will be payable annually for a maximum of 4 consecutive annual payments, only if the dependent child continues his education.

   "Dependent Child" as used herein means any unmarried child under 26 years of age who was dependent upon the insured 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 within30 months from the date of death of the insured Member as payment for any professional or trades training program 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.

Day care benefit

If indemnity becomes payable under the policy for accidental loss of life of an insured Member, the insurer will pay an amount equal to the lessor of the following amounts:

(1) the actual cost charged by such day care centre per year, or
(2) 3% of the insured's Principal Sum, or
(3) $5,000 per year,

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

The benefit is payable annually for a maximum of 4 consecutive payments but only if the dependent child continues his or her enrollment in an accredited day care centre.

In-hospital indemnity benefit

If an insured suffers loss under the Schedule of Losses as a result of a covered accident and requires that an insured be confined to a hospital for more than 5 consecutive days, the insurer will pay:

(1) a monthly benefit of 1% of the insured's applicable Principal sum; or
(2) for periods of less than 1 month, 1/30th of the above monthly benefit per day.

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

This benefit is limited to:

(i) a monthly amount not to exceed $1,000; and
(ii) a total of 12 months for any covered accident.

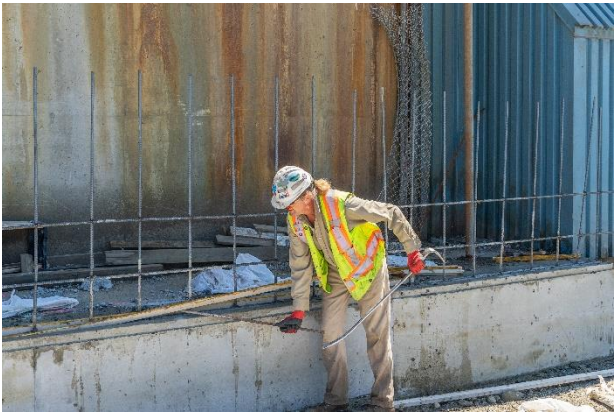
Successive period of hospital confinement for loss from the same covered accident separated by a period of less than 3 months will be considered as 1 period of hospital confinement.

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

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

Permanent total disability indemnity

When, as a result of injury and commencing within 365 days of the accident, an insured person is totally and permanently disabled and prevented from engaging in each and every occupation for employment for compensation or profit for which he is reasonably qualified by reason of his education, training or experience, the insurer shall pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any other amount paid or payable under the Accidental Death and Dismemberment Indemnity Coverage of the policy as a result of the same accident.



Exclusions

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

- Suicide or self-inflicted injuries
- Full-time service in the Armed Forces;
- Declared or undeclared war or any act thereof;
- Injuries received during aircraft travel except for the purposes of transportation where the Member is travelling as a passenger.

PART 6
Wage Indemnity

The EI maximum benefit will be paid to you when you are unable to work because of either an accident or sickness that is not covered by Workers' Compensation or similar legislation.

The benefits commence from the first day of disability if resulting from an accident, or on the fourth day of disability if resulting from an illness. Payments continue as long as you are unable to work, up to a maximum of 26 weeks. Benefits are pro-rated on the basis of a 7 day week.

Benefits will also be paid up to a maximum of 6 weeks when you are under the full-time care of a chiropractor for disabilities that are normally treated by a chiropractor. For benefits beyond the 6 week duration, you must be under the full-time care of a physician and/or surgeon.

Benefits are integrated with EI sick benefits, and will be paid as follows:

- The first 4 weeks will be paid by the Plan at the EI maximum.
- The weeks from 5 to 19 (15 weeks) inclusive, will be paid by EI at a rate determined by EI.
- The balance of the weeks from 20 to 26 will be paid by the Plan, if you are still disabled, at a rate of the EI maximum.

Benefits received under this benefit are taxable.

The maximum period payable from both the Plan and EI is 26 weeks

NOTE: Claims must be filed for EI sick benefits at the same time you apply for Wage Indemnity benefits under the Plan. If you are rejected by EI, the Plan will cover

you for the period not covered by EI, provided you are still disabled under the terms of the Wage Indemnity Plan.

How to claim for wage indemnity

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

(1) Contact your medical doctor immediately on becoming disabled. No benefits are payable prior to the date you are first seen and treated by your doctor.

(2) Obtain both the Plan Member statement and the Attending Physician statement from the Administrator.

(3) You must complete the Plan Member statement.

(4) Ask your doctor to complete the Attending Physician Statement.

(5) It is your responsibility to have both forms sent to the Administrator.

(6) Claims will be assessed by the Co-operators, and once approved, you will receive your benefit cheques by mail at your home address.

(7) Claims should always be sent in within 30 days of commencement of disability, unless special circumstances prevent you from doing so.

(8) 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 the claim, the Trustees reserve the right to obtain a second medical opinion from a physician and/or surgeon of their choice.

Third party liability

Benefits will be paid for disabilities due to an accident in which a third party is liable only when the person undertakes to endeavor to collect, at least the amount of benefits paid, and refund the amount of benefits paid to the Plan. The Trustees may, at their discretion, allow a Member to discontinue action to collect from a third party when, in their opinion, there is little or no hope of collection.

Recurrence of former ailments

You will not receive benefits for more than 26 weeks as a result of disability due to any one ailment. However, if you return to work and are at work for 2 consecutive weeks and again become disabled, it will be considered a new disability

Limitations and exclusions

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

- Injuries or diseases resulting from voluntary participation in a war or riot, or arising while serving as a member of any armed service.
- Routine pregnancy.
- No benefit will be paid for any period for which the person has or will receive vacation pay for an annual vacation.
- No benefit will be payable for any disability if you are imprisoned.
- Any disability covered by ICBC which results from or was in any manner or degree associated with or occasioned by the use of operation of a "vehicle" as defined in the Motor Vehicle Act (British Columbia).
- Injury occurring while committing or attempting to commit a criminal offense including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 milliliters of blood. A "Vehicle" means a vehicle that is drawn, propelled or driven by any means other than muscular power.
- Cosmetic Surgery, unless the surgery is due to an accident or due to the donation of an organ or tissue.
- Injury or sickness for which a third party is liable, except as provided for in the Third Party Liability section.

PART 7
LONG-TERM DISABILITY

The purpose of this benefit is to provide coverage should you become totally disabled as a result of an accidental injury or illness and are unable to work at your own occupation for wage or profit.

YOUR TAXABLE BENEFIT	
Each Member	$2,000 monthly

Benefits will commence on the 183rd day of continuous/consecutive disability.

You are eligible for benefits for a 24 month period from the date disability payments are eligible to begin if you are unable to perform the usual and customary duties of your occupation.

Thereafter, benefits will continue only if you are unable to perform the duties of any occupation.

In no case shall a benefit be paid beyond:

- the date of your 65th birthday, or
- the date you are no longer totally disabled,
- or retirement,
- or the date you engage in any work or occupation other than rehabilitative employment, or
- the date you fail to furnish satisfactory evidence of total disability or refuse to submit to a medical examination by a physician chosen by the insurer, or
- the date you refuse to participate in any rehabilitation program approved by the insurer, whichever occurs first.

Successive periods of disability arising from the same or related cause and separated by less than 6 months will be treated as one period of continuous total disability.

Benefit adjustment

At the time of a claim, your Long-term Disability benefit will be reduced by any disability benefit you are entitled to receive from any Worker's Compensation Act or similar statute, Canada/Quebec Pension Plan, any criminal injuries compensation legislation and any automobile insurance act. The reduction will also include any CPP/QPP retirement benefits; however, will not include any additional amounts payable for dependents or cost of living increases.

If necessary, your Long-term Disability benefit will be further adjusted so that your total income does not exceed 85% of your pre- disability gross salary (net salary if your benefit is non-taxable). This applies to disability benefits from any other source including: pension plan, employer funded salary replacement, other insurance plan whether group or association, damages for loss of income which are payable from any legal action, employment income other than from an approved rehabilitation program and severance.

Rehabilitation program

Based on a determination made by the insurer, a rehabilitation program may be provided to you which could include: assessment (medical, psychological, vocational evaluation), treatment (medical, psychological, vocational intervention, including various programs of therapy), employment (work trial, modified/full or part-time work), services (training strategies and work related activities expected to enhance your ability to return to work or secure employment) and a rehabilitation benefit.

The insurer will have the sole right and discretion in determining whether a rehabilitation program will be provided to you and the services provided as part of that program. If you do not participate in rehabilitation program provided either by the insurer or by another party and approved by the insurer (i.e. Worker's Compensation Act or similar statute, auto plan benefits, Canada/Quebec Pension Plan) or the insurer withdraws approval of your program, then your disability/rehabilitation benefits under this policy will cease.

While you participate in the rehabilitation program your disability benefit will continue, but will be reduced by 50% of any rehabilitative earnings (total earnings from your rehabilitation employment if your benefit is taxable, total earnings less income tax, EI, CPP/QPP if your benefit is non- taxable). Your benefit may be further reduced so that your rehabilitative earnings plus your disability benefit do not exceed 100% of your pre-disability (gross if your benefit is taxable, net if your benefit is non-taxable).

Any rehabilitation program will not extend beyond the end of your own occupation period. Nothing in the rehabilitation program or provision will create any basis for any extension of the own occupation period unless an extension of the duration is recommended and approved in writing by the insurer.

Third party liability

If you become totally disabled due to an injury or disease for which a third party is or may be legally liable, benefits will be paid when you sign (and submit to the insurer) a Reimbursement Agreement.

You will be required to reimburse the insurer for benefits received in accordance with the terms and conditions stated in the Reimbursement Agreement.

You must obtain the written consent of the insurer before compromising or settling the action or cause of action with the 3rd party. Failure to do so may disentitle you to any further benefits under this policy.

Exclusions

(1) No benefit will be payable for any disability resulting from or caused by:

- voluntary participation in an insurrection, war or hostilities of any kind, or riot or civil commotion or;
- any disability covered by ICBC which results from or was in any manner or degree associated with or occasioned by the use of operation of a “vehicle” as defined in the Motor Vehicle Act (British Columbia), or;
- injury occurring while committing or attempting to commit a criminal offense including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 milliliters of blood. A “vehicle” means, a vehicle that is drawn, propelled or driven by any means other than muscular power, or;
- use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment from a rehabilitation centre or an institution provincially recognized for that treatment, or;
- medical or surgical care which is cosmetic in nature or medical care or surgery that is not medically necessary. However, periods of disability due to the donation or an organ or tissue will be covered, or;
- injury or sickness for which a third party is liable, except as provided for in the Third Party Liability section.

(2) No benefit will be payable for any disability if you are imprisoned.
(3) No benefit will be payable if you are not under continuous care and treatment of a physician who is certified by the Royal College of Physicians and Surgeons in a specialty appropriate to your sickness or injury.
(4) No benefits will be payable during any period that you are on maternity leave, parental leave or any other leave of absence.
(5) No further benefits will be payable from the date you refuse to participate in any rehabilitation program approved by the insurer.

Pre-existing condition limitation

A pre-existing condition is any injury or sickness for which you received medication, treatment or medical advice or for which there were symptoms which would have caused an ordinary person to seek diagnosis, care or treatment within the 90 days immediately prior to becoming insured under the Policy.

No monthly benefit shall be payable for any period of total disability which was caused by or resulting directly or indirectly from a pre-existing condition, unless you have not required treatment, medication or medical advice for a period of 90 days while insured under the Policy or unless you have been insured under the policy for at least 12 months and have not been absent from work due to the pre-existing condition for at least 12 months. Time away from work up to 10 cumulative working days during the 12 month period will be interpreted as not being absent from work.

Submitting a claim

The time limit within which a Long-term Disability claim must be made is 90 days from the date the insurer is liable.

PART 8
Extended Health Care

Extended Health Care is an extension of your coverage through the Provincial Medical Services Plan and is designed to protect you and your dependents against unusually large expenses incurred during a serious accident or illness. The benefits hereunder do not cover any benefits for which provision is made under or pursuant to the Medical Services Act in your province of residence or any amendment to those provisions from

time to time (hereinafter referred to as MSP, or the BC PharmaCare Plan). Please refer to page 5 of this booklet (Summary of Benefits) to review the full reimbursement schedule. Benefits are reimbursed based on the outlined reimbursement percentages.

The following are eligible expenses when incurred as a result of necessary treatment for illness or injury and, where applicable, when ordered by a physician. Eligible expenses are reimbursed at 80%.

(1) Charges for drugs and medicines requiring a physician's prescription and which are dispensed by a licensed pharmacist (maximum 90 day supply). Anti-Obesity, fertility drugs, erectile dysfunction agents and smoking cessation drugs and products (including gum, patches and inhalation) have a combined maximum of $1,000 per calendar year per person. Fertility drugs have a lifetime overall maximum of $3,000, and smoking cessation drugs and products have a $300 maximum per 24 months.

Your plan provides for Mandatory Generic Drug Substitution - this means that reimbursement will be made for the cost of the lowest priced equivalent drug, unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine. Some drugs may require Prior Authorization from Green Shield before they can be reimbursed. Prior authorization drugs tend to be expensive. For each prior authorization drug, Green Shield establishes medical criteria that you must meet before approval for coverage is granted. Check the status of the prescribed drug by asking your physician what drug is being prescribed. Then you can find the status of that drug in one of three ways: use the drug search feature on Plan Member Online Services (via greenshield.ca) or on the Green Shield on the Go mobile app, call GSC at 1.888.711.1119, or ask your pharmacist to submit the drug claim electronically using your GSC ID card.

Members who are BC residents, MUST register for Fair PharmaCare and provide their registration number to Green Shield Canada in order to ensure continued coverage for benefits under this Plan.

(2) Services of a Registered Nurse when ordered by the attending physician in the management of an acutely ill patient to a maximum $10,000 per calendar year. Acutely ill refers to conditions having a sudden onset with a sharp rise and a course less than 60 days. This does not include conditions due mainly to chronic illness, alcoholism, mental illness, drug addiction, tuberculosis or infirmity. Lifetime maximum for services of a Registered Nurse is $25,000.

(3) Emergency transportation to and from a hospital, provided the trip is in a professional land or air ambulance or in an acute emergency by air ambulance to the nearest hospital qualified to provide the necessary treatment. 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.

(4) Charges for oxygen, blood or blood plasma, charges for ostomy supplies or ileostomy supplies, artificial limbs or eyes, crutches, splints, casts, trusses or braces.

(5) Orthopaedic shoes and custom made orthotics are limited to one pair every 12 months for under age 19. For ages 19 and older, limited to one pair every 5 years. Replacements are covered only when necessary due to normal wear and must be prescribed by a licensed medical practitioner.

(6) Cost of rental, or where more economical, purchase of durable equipment for therapeutic treatment, including wheelchairs and hospital beds.

(7) Cost of hearing aids, when prescribed by an ear, nose and throat specialist up to a reimbursement maximum of $800 per person every 5 years. Maintenance and repairs are covered under the Plan. Replacement hearing aids will be paid for only in those cases where the hearing aid cannot be satisfactorily repaired. Molded Earplugs reimbursed to a maximum of $150 every 2 years.

(8) Wigs for temporary or permanent hair loss, when required as a result of a medical condition, up to a lifetime maximum of $500 per person.

(9) Charges made by a physician for a medical examination by a physician for a medical examination required by a government statute or regulation for employment purposes, provided such charges are not covered by the employer under a collective agreement and no claim had been made under the Provincial Medical Services Plan.

(10) Private or semi-private hospital charges made by an approved acute general hospital in your province of residence for coinsurance and short stay charges, and when actually occupied. Rental of telephone or TV, etc., will not be considered eligible expenses.

(11) Fees of a dentist) for repairing damage caused to natural teeth due to accident, provided treatment occurs within 1 year of the date of the accidental injury, and injury occurred while the person was covered under this Plan.

(12) Glucose Monitoring Systems (GMS) and supplies to a maximum of $3,000 per calendar year and insulin pump supplies to a maximum of $2,000 per 3 months.

(13) The following services not covered by your provincial/territorial health plan will be considered eligible only when a diagnosis of gender dysmorphia from a legally qualified physician (M.D.), or nurse practitioner is provided to GSC. Reimbursement will be limited to reasonable and customary charges, up to a maximum of $10,000 per lifetime.

- Foundational (Core) – Transition-related genital and chest/breast surgeries not covered by your province/territorial health plans, as well as vocal surgery, tracheal shave, chest/contouring/breast construction, vaginal dilators, laser hair removal and facial feminization surgery.
- Focused – Non-genital, non-breast/chest enhancement surgeries as follows: nose surgery, liposuction/lipofilling, face/eyelid lift, lip/cheek fillers, hair transplant/implants and gluteal lifets/implants.

Out-of-Province emergencies

Emergency medical, surgical, hospital and other similar expenses incurred by a covered member or his/her eligible dependents while travelling on vacation outside of Canada will be eligible under this Plan just as they are while in Canada (provided it is within 60 days of leaving Canada).

This benefit is provided through GSC Travel Assistance through Allianz. In the event of an emergency the insured must immediately contact Allianz (the company appointed to provide medical assistance and claims services). Allianz will open a claim file, assist in locating proper medical care, verify coverage and assist in coordinating payment of the claim with the Provincial Medical Plan and the Plan's policy. A Medical Assistance Card with worldwide contact numbers, for the Allianz Emergency coverage should be carried by the Insured when travelling.

Covered expenses include:

(1) reasonable and customary charges for hospital services and accommodation up to a standard ward rate in a public general hospital.
(2) reasonable and customary charges for physician's services required.

Employees working outside of Canada must arrange for additional coverage.

Travel Limitations and Exclusions

(1) Upon notification of the necessity for treatment of an accidental injury or medical emergency, GSC's Assistance Medical Team reserves the right to determine whether repatriation is appropriate if the patient's medical condition will require immediate or scheduled care. Such repatriation is mandatory, where the Assistance Medical Team determines that the patient is medically fit to travel and appropriate arrangements have been made to admit the patient into the provincial government health care system of their province of residence. Repatriation will ensure continued coverage under the plan. Should the patient opt not to be repatriated or elects to have such treatment or surgery outside their province of residence, the expense of such continuing treatment will not be an eligible benefit;

The patient must contact GSC Travel Assistance within 48 hours of commencement of treatment. Failure to notify us within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum, whichever is the lesser of the two;

(2) Please note that any pre-existing condition at time of travel must be stable for 90 days immediately preceding your departure. Which means:

a) your pre-existing/pre-diagnosed medical condition:
i) has been controlled by the consistent use of the same medications and dosages (excluding changes in medication that regularly occur as part of your ongoing treatment, or decreases in dosage resulting from an improvement in your pre-existing or pre-diagnosed medical condition) prescribed by a legally qualified medical professional;

ii)has not, in the reasonable opinion of a legally qualified medical professional, required additional treatment for a recurrence, complications or any other reason related either directly or indirectly to your pre-existing or pre-diagnosed medical condition;

b) you have not consulted a legally qualified medical professional for, or had investigated or diagnosed, a new medical condition for which you have not received medical treatment;

c) you have not scheduled/are not awaiting any future appointments for non-routine examinations, consultations, tests or investigations (including results) for an undiagnosed medical condition;

d) you have not scheduled/are not awaiting any exploratory surgical procedures for an undiagnosed medical condition or surgical procedures for a diagnosed medical condition.

Please note, there may be other limitations and exclusions that are outlined by Green Shield Canada. Please contact your plan administrator for more details.

Amount of reimbursement

Eligible expenses are reimbursed at 100% to a maximum lifetime of $1,000,000. This is combined with all other eligible expenses under the EHC benefit.

Emergency dental treatment

Emergency dental care will be provided anywhere in the world. If, while you are traveling or on vacation outside your province of residence, you require Dental Care as a result of an accidental blow to your mouth, you are entitled to services of a duly qualified dentist in the event of such emergency and will be reimbursed up to $2,000. Itemized statements must be provided with claims.

Exclusions and Limitations

Your Extended Health Care Plan does not cover:

(1) expenses for benefits, care or services payable by or under your Provincial Medical Plan, PharmaCare, any Hospital Program or the Worker's Compensation Act, whether or not a claim is made there under or provided without cost or at normal cost by any public or tax-supported authority or agency, or for which the Member or dependent can recover from another party;

(2) the expenses of a physician, except as described under "Out of Province Emergencies" for emergency treatment while travelling outside your province of residence and as limited thereby;

(3) expenses caused, contributed to or necessitated as a result of war or any act of war (whether declared or undeclared) invasion, acts of terrorism or acts of foreign enemies, civil war, rebellion, revolutions or civil insurrection;

(4) expenses incurred due to orthoptic treatment, refractions, eye glasses, contact lenses, hearing aids or prescriptions for any of them (except as expressly provided);

(5) expenses incurred due to dental services with the exception of those set out in Part 12 and the Dental Accident benefits as laid out under Part 8, Item 11

(6) any portion of a specialist's fee not allowable under the Provincial Medical Plan due to non- referral; or any amount of fees charged by any practitioner in excess of the recognized fees for such service;

(7) expenses incurred due to service and supplies for cosmetic purposes;

(8) expenses incurred outside the province on an elective basis. Services will only be allowable for an unexpected illness or injury while the insured person is temporarily visiting in other provinces of Canada or other countries, or

(9) expenses contributed to or caused by occupational disabilities.

Fair PharmaCare Program
The British Columbia Government introduced the Fair PharmaCare Program in May 2003. Under this program the annual family deductible was changed from a flat $1,000 to a percentage of your net family income. All BC residents are required to register for this program. Failure to do so will result not only in your deductible increasing to $10,000 but may also prevent us from honouring your claims until you register.

To register for the Fair PharmaCare Program call 604.683.7151 from Vancouver and toll-free 1.800.663.7100 from the rest of BC. If you prefer to go on-line to the Fair PharmaCare website the address is http://www2.gov.bc.ca/gov/content/health

Once you have registered please contact Green Shield Canada to provide them with your registration number. You can contact them as follows:

- Customer Service Centre online via www.greenshield.ca or call 1.888.711.1119

If you already provided your PharmaCare Registration Number on your Group Insurance Enrolment Card there is no need to submit it again.

PART 9
Paramedical Services

The following expenses are covered when you or your eligible dependents receive services rendered by a "Licensed, Certified, or Registered" practitioner.

(i) Fees of a massage therapist up to a maximum reimbursement of $2,400 per person per calendar year.

(ii) Fees of a physiotherapist up to a maximum reimbursement of $2,400 per person per calendar year.

(iii) Fees of a chiropractor up to a maximum reimbursement of $2,400 per person per calendar year. X-rays taken by a chiropractor will not be covered.

(iv) Fees of a naturopathic physician up to a maximum reimbursement of $1,200 per person per calendar year. X-rays taken by a naturopathic physician will not be covered.

(v) Fees of an acupuncturist up to a maximum reimbursement of $1,200 per person per calendar year.

(vi) Fees of a speech therapist, when prescribed by a specialist up to a maximum reimbursement of $1,200 per person per calendar year.

(vii) Fees of a chiropodist or podiatrist up to a maximum reimbursement of $1,200 per person per calendar year. X-rays taken by a chiropodist or podiatrist will not be covered.

(viii) Fees of a psychologist, (including registered clinical counselors and social workers) up to maximum reimbursement of $1,200 per calendar year.

Exclusions and Limitations
Exclusions and limitations for your Extended Health Care Plan under Part 8 apply to Paramedical Services. Please see Part 8 above.

PART 10
Vision Care Benefit

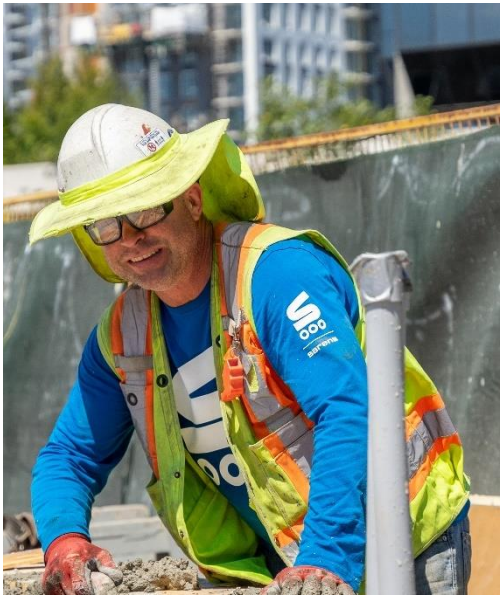
The following expenses shall be eligible for reimbursement at 80% up to a maximum of $480 (80% of $600) per person per 12 month period. There is no deductible applied to this benefit.

(1) Single vision, bifocal or trifocal lenses, prescribed by a person legally qualified to make such a prescription;
(2) Frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable;
(3) Contact lenses prescribed by a person legally qualified to make such prescription.

Eye exams which are not covered under any other Plan, up to a maximum reimbursement of:

- under 17: $60 per person every 12 months,
- 17 and over: $100 per person every 24 months.

Laser Eye Surgery will be reimbursed at 80% to a lifetime maximum of $900 per person.



PART 11
Dental Plan

Basic services

The benefits under this section are those services that are required to maintain teeth in good order and normal restoration services to restore them to good order.

The following services are eligible for reimbursement on 85% of the amount charged.

(1) DIAGNOSTIC SERVICES

Necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment. This includes examinations, consultations, pathological reports and other diagnostic aids as may be deemed necessary. The Plan will cover 2 standard oral examinations each calendar year. The Plan will cover a complete full examination only if the Plan has not paid for a complete full examination during the past 36 consecutive months. The Plan will cover full-mouth x-rays once every 24 months. The Plan will cover 2 bitewing x-rays per calendar. Other x-ray expenses are covered, subject to a calendar year maximum.

(2) PREVENTATIVE SERVICES

Necessary procedures to prevent the occurrence of oral disease, including:

(i) prophylaxis and topical fluoride application twice in one calendar year.

(ii) space maintainers (to maintain space, not to obtain more space).

(3) SURGICAL SERVICES

Necessary procedures for extractions and other surgical procedures normally performed by a general practicing dentist.

(4) ENDODONTIC SERVICES

Necessary procedures required for pulpal therapy and root canal filling.

(5) PERIODONTIC SERVICES

Procedures necessary for the treatment of diseases of the soft tissue (gums) and the bones surrounding and supporting the teeth but not tissue grafts.

(6) RESTORATIVE SERVICES

Necessary procedures for filling teeth with amalgam silicate (synthetic porcelain), acrylic (plastic), and composite resin (anterior only) restorations for restoring tooth surfaces which have been broken down as a result of decay process, including stainless steel crowns.

(7) PROSTHETIC REPAIR SERVICES AND RELINES

Necessary procedures required to repair or reline fixed or removable appliances. Repairs or relines to dentures may be obtained from a dentist or a duly licensed dental mechanic. Relines will be covered after 6 months of receiving the procedure. Within the first 6 months, the expectation is reline costs should be included in the overall cost of the completed procedure. Services of a temporary nature, pending fabrication of a new denture, are not covered.

Prosthetic appliances and crown and bridge procedures

The benefits under this section are those services required for major reconstruction of teeth that have deteriorated, and for replacement of teeth that are missing, with crowns, bridges and dentures. These services will not be covered more often than once every 5 years on the same tooth.

The cost of the following services will be eligible for reimbursement on 85% of the amount charged .

(8) CROWNS, INLAYS & ONLAYS

(i) Crowns, if at least 5 years has elapsed since last provided.

(ii)Inlays or onlays, and gold foils are covered only when other restorative materials cannot be used satisfactorily

(ii) Dental Implants

(9) PARTIAL AND/OR COMPLETE DENTURES AND BRIDGEWORK

(iii) Initial installation 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.

(iv) 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.

Orthodontic

Benefits are payable for orthodontic services performed after the effective date of coverage. The Plan covers orthodontic services provided to maintain, restore or establish functional alignment for the upper and lower teeth.

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. Treatment performed solely for splinting is not covered.

When a lump sum fee has been paid toward orthodontic treatment, the total amount of the claim will be split into separate portions to allow for payment of an initial fee (approximately one-third of the total lump sum), and the balance of the claim will be divided into monthly fees of equal amounts to be reimbursed over the duration of the treatment. Receipts for payment must be received by GSC no later than 12 months from the date the service is incurred while treatment is in progress, not at the end of the treatment.

New Plan Members: the $6,000 eligible expense maximum is prorated based on Plan Member's coverage effective date, as follows:

COVERAGE DATE	PRORATED MAXIMUM
January 1st	$6,000 per family per calendar year (paid at 85%, maximum $5,100)
February 1st	$5,500 per family per calendar year (paid at 85%, maximum $4,675)
March 1st	$5,000 per family per calendar year (paid at 85%, maximum $4,250)
April 1st	$4,500 per family per calendar year (paid at 85%, maximum $3,825)
May 1st	$4,000 per family per calendar year (paid at 85%, maximum $3,400)
June 1st	$3,500 per family per calendar year (paid at 85%, maximum $2,975)
July 1st	$3,000 per family per calendar year (paid at 85%, maximum $2,550)
August 1st	$2,500 per family per calendar year (paid at 85%, maximum $2,125)
September 1st	$2,000 per family per calendar year (paid at 85%, maximum $1,700)
October 1st	$1,500 per family per calendar year (paid at 85%, maximum $1,275)
November 1st	$1,000 per family per calendar year (paid at 85%, maximum $850)
December 1st	$500 per family per calendar year (paid at 85%, maximum $425)

Services not covered

(1) cosmetic dentistry, temporary dentistry, oral hygiene instruction, tissue grafts, drugs and medicines;

(2) treatment covered by WorkSafe BC or publicly supported plans;

(3) services required as a result of an accident for which a third party is liable;

(4) charges for services commencing prior to date of coverage or provided after termination of coverage;

(5) charges for completing forms;

A maximum payment of $5,100 per family, per calendar year is available for Basic Service, Prosthetic Appliances, Crowns and Bridges and Orthodontic Services combined.

Change of dentist

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

To make a claim

Dental, extended health and vision care:

Claim forms can be obtained by visiting the Green Shield Website at http://www.greenshield.ca or,

Call the Green Shield Customer Service Centre at **1.888.711.1119**.

Both the original receipts and the forms can be sent to Green Shield Canada at:

Attn: Drug Department
P.O. Box 1652
Windsor, ON N9A 7G5

Attn: Hospital/ Vision Department
P.O. Box 1615
Windsor, ON N9A 7J3

Attn: Medical Items
P.O. Box 1623
Windsor, ON N9A 7B3

Attn: Out-of-Country Department
P.O. Box 1606
Windsor, ON N9A 6W1

Attn: Professional Services
P.O. Box 1699
Windsor, ON N9A 7G6

Attn: Dental Department
P.O. Box 1608
Windsor, ON N9A 7G1

All claims must be received by GSC no later than 12 months from the date the expense was incurred.

Member website & direct deposit

You can arrange to have your claim reimbursements for Extended Health, Vision and Dental directly deposited into your bank account by completing the Direct Deposit Registration form, also available on the Green Shield Canada website at www.greenshield.ca

PART 12
Travel Assistance

This benefit assists members to reach the nearest specialized medical services where such services are not available locally.

- $25 deducted from the cost of return fare, balance is reimbursed at 85%. On a doctor's recommendation, the fare of an accompanying member of the family or guardian will be reimbursed.
- Per diem allowance of $60 per day for meals and expenses to a maximum of 8 days.
- Up to $80 per day additional reimbursement for accommodation expenses (receipts are required).
- The program will reimburse a maximum of 8 claims per family member per illness.

PART 13
BEREAVEMENT LEAVE

YOUR TAXABLE BENEFIT
75% wage replacement for up to 5 days

Bereavement leave benefits are payable to any employed, covered member unless their employer provides paid bereavement leave. If the employer provides bereavement leave and benefit is less than what the CBP plan provides, the member will be eligible for a top-up.

Bereavement leave benefits are available in the event of the death of an immediate family member: spouse, father, father-in-law, brother, grandfather, grandchild, child, mother, mother-in-law, sister, grandmother.

The plan will pay you wage replacement of 75% of your current rate for up to 5 days leave from work.

To claim this benefit, you must complete the Bereavement Leave Claim form, including confirmation from your supervisor and a copy of your last pay stub. You must have been working at the time of the bereavement leave.

Bereavement Leave is considered taxable income.

PART 14
EMPLOYEE and FAMILY ASSISTANCE PLAN

Reach out. Get help. Feel better.
Immediate and confidential support.

CMAW has partnered with Inkblot to provide you with easy to access support for your life, work and mental health challenges – any time – any place. Inkblot's services are voluntary and immediately available, 24/7/365. Your initial individual consultation is complimentary, including 3 additional counseling hours sponsored by CMAW. Subsequent sessions cost just $90/hour which are covered through your GSC benefits coverage.

You and your eligible family members can receive support over the telephone, in person, online, and through a variety of health and wellness resources. For each concern you are experiencing, you can receive a series of private sessions with an expert. You can also take advantage of online tools to help manage your and your family's health. You'll get practical and fast support in a way that is most suited to your preferences, learning preference and lifestyle.

To get started, visit www.cmawefap.ca

Rights to copies of documents

Effective July 1, 2012, if an employee/member lives in British Columbia or Alberta, they have the right to request, with reasonable notice, copies of documents that relate to the Plan. Legislation allows for them to obtain copies of the following documents:

- Their enrolment form or application for insurance
- Any written statement or other record, not otherwise part of the application, provided to the insurer as evidence of insurability
- A copy of the contract/policy

The first copy will be provided at no cost to the employee/member and a fee may be charged for subsequent copies. All requests for copies of documents should be directed in writing to Bilsland Griffith Benefit Administrators.

Legal action

Every action or proceeding against the Plan for the recovery of benefits payable under the Contract is absolutely barred unless commenced within the time set out in the Insurance Act.

Benefits Provided by:

Co-operators, #8931
Life Insurance
Dependent Life Insurance
Wage Indemnity
Long-term Disability

CMAW Benefit Plan
Travel Assistance
Bereavement Leave

CMAW Union Member Assistance
Uninsured Life Benefit

Green Shield Canada

Call the Green Shield Customer Service Centre at 1.888.711.1119

Extended Health Benefits
Vision Care
Dental Plan

Emergency Out of Country Travel
For assistance dial 1.800.936.6226 within Canada and the United States or call collect 0.519.742.3556 when traveling outside Canada and the United States. These numbers appear on your GSC Identification Card.

AIG, BSC 9426228
Accidental Death and Dismemberment

Inkblot
www.cmawefap.ca
Employee and Family Assistance Program

For additional information or assistance, please contact the Plan Administrator:

- Please quote Identity or Social Insurance Number on all correspondence to the Plan.
- Always be sure to notify the Plan of any change of address.

Bilsland Griffith Benefit Administrators
1000 – 4445 Lougheed Hwy, Burnaby, BC V5C 0E4
Toll Free: **1.844.366.2629**
Fax: 604.433.8894
Email: **cmaw@bgbenefitsadmin.com**

Assistance can also be obtained through your local union office.

The pictures enclosed in this booklet are of CMAW members working. We would like to thank everyone for their participation.

CMAW
CONSTRUCTION MAINTENANCE AND ALLIED WORKERS CANADA
BENEFIT PLAN

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www.cmaw.ca/members-info/benefits

FOR ADDITIONAL INFO OR ASSISTANCE, PLEASE CONTACT THE PLAN ADMINISTRATOR:

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#1000 – 4445 Lougheed Hwy | Burnaby, BC V5C 0E4
Toll Free: 1.844.366.2629 | F: 604.433.8894
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