

*Joint Electrical Industry's*

# **WELFARE PLAN**



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**For information about your claims or  
eligibility or benefits — call, write or email**

## **JOINT ELECTRICAL INDUSTRY'S WELFARE PLAN**

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# PRIVACY POLICY

We, the Trustees of Joint Electrical Industry's Welfare Plan have adopted the following *Privacy Principles*, which reflect our commitment to safeguarding our Members' personal information:

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

— The Trustees

# JOINT ELECTRICAL INDUSTRY'S WELFARE PLAN



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

The Trustees are constantly attempting to provide benefits under the Plan to the Members in the most cost-effective manner. For some benefits 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.

The following is an outline of the Health and Welfare Plan and the benefits in effect.

## **BENEFITS:**

Group Life Insurance	\$70,000.00
Accidental Death & Dismemberment	\$70,000.00 as described herein
Weekly Indemnity Benefit	\$384.00 per week if not entitled to E.I. sick pay. Waiting period 2 weeks from the date of disability. Maximum benefit 26 weeks.
Long Term Disability	\$1,500.00 per month. Waiting period is 28 weeks from the date of disability.
Extended Health Care Medical Plan	as described herein Medical Services Plan of BC (M.S.P.)
Dental Plan	as described herein.
Vision Care	\$300.00 in a 24 consecutive month period.

## **Who is eligible?**

Any Member of the International Brotherhood of Electrical Workers who is working under a Collective Agreement with Locals 230, 258, 993, or 1003 and

such Collective Agreement requiring employer contribution to this Plan.

If owner/operators who are Members in good standing wish to participate in the Plan, they must remit a **minimum** of 115 hours each month, regardless of hours worked per month. If such owner/operators decline to participate or drop out of the Plan, re-entry will not be permitted.

**Do any cards have to be completed?**

Yes. A Member must complete an M.S.P. application form and an enrolment card.

**How does a Member qualify for coverage?**

A Member qualifies when 150 hours or more are reported by the employer within a twelve-month period. The hours reported are credited to the individual in his/her "Hour Bank". Coverage will commence on the 1st day of the second month following the accumulation of 150 hours, due to the time factor in submitting hours, i.e., January hours would be applied towards March coverage. (February is the lag month.)

Each month a Member will have a charge of 100 hours made against his/her Hour Bank. A maximum of up to twelve hundred (1200) hours can be accumulated in a Member's Hour Bank.

**Self-Payment**

Members in good standing of I.B.E.W. Locals 230, 258, 993, or 1003 will be entitled to the following coverage on a self-pay basis.

i) Those Members who have a residue of employer hours in their Hour Bank or who, although working regularly, do not have sufficient work to maintain the Hour Bank charge, will qualify under "**shortage hours**" and will receive a billing showing the balance of hours required to make up the 100 hours needed each month to give a Member coverage under "**Plan A**". **Shortage notices do not reduce the maximum months under self-payment.**

ii) If there are **no** employer hours, a Member has the option of self-paying under,

**Plan "A"**

Life Insurance  
AD & D  
Weekly Indemnity \*  
Extended Health Benefits  
Dental  
Vision Care  
Supplemental Travel  
Medical – M.S.P.

**Plan "B"**

Life Insurance  
AD & D  
Weekly Indemnity \*  
Extended Health Benefits  
Supplemental Travel  
Medical – M.S.P.

\*Weekly Indemnity claims **must** commence within 3 months of **ceasing to work under the Collective Agreement**.

The first month in which a Member falls below 100 employer hours, the Fund will absorb the difference out of general revenue.

**Owners/operators whose company is active in the Electrical Contracting business may not self-pay.**

Self-pay is only available to a Member who was covered under Joint Electrical Industry's Welfare Plan and coverage must be continuous.

A notice showing the amount required to self-pay will be sent to the last known address, and self-payment must be returned within one month of the Member's Hour Bank falling below 100 hours.

Self-payment is available for a maximum of 24 consecutive months subsidized. If a Member wishes to continue to self-pay beyond the 24 months, the cost will be the unsubsidized premium for such benefits.

Members applying for subsidized self-pay are required to sign a statement that they are not working within the Trade, except as authorized by the Business Manager.

PLEASE NOTE: During the months that a Member is self-paying for coverage, the Pay Direct Drug Card will not be activated/re-activated until payment is received by the Administrator and processed. If a prescription is required prior to that, the Member or dependent will be required to pay for the prescription and submit the claim to the Administrator for reimbursement.

Note: if the Member wishes to continue medical benefits only, application should be made directly to:

Medical Services Plan of British Columbia  
Post Office Box 9035 Stn Prov Govt  
Victoria, British Columbia  
V8W 9E3

**When does coverage end?**

Coverage will terminate where there aren't sufficient hours in the "Hour Bank" to allow for a deduction of the applicable monthly Hour Bank charge. As noted above, by self-paying, a Member can remain covered by paying any difference required.

Any Member joining a union other than I.B.E.W. Locals 230, 258, 993, or 1003, or performs non-union work, except as authorized by the Business Manager of any of the above Union Locals, may result in termination of that Member's eligibility for any and all benefits under the Plan, and any hours deposited to his or her Hour Bank may be forfeited to the Fund.

**When a Member is collecting under the Weekly Indemnity Plan/E.I. Sick Pay or Workers' Compensation, will they receive assistance with their Hour Bank?**

Yes. For each day that he/she is disabled and, provided that the claim for the Weekly Indemnity Plan/E.I. Sick Pay or Workers' Compensation has been approved for payment, the Hour Bank will be credited with contributions of 8 hours per day, subject to a maximum of 100 hours per month, for up to 12 months. If the claim is for Weekly Indemnity, this will be done automatically, but for Workers' Compensation or E.I. Sick Pay, a special form should be requested from the Administrator's office. To qualify for these Disability Credits, the Member must be eligible for benefits at the time the disability commences.

**RECIPROCITY**

Joint Electrical Industry's Welfare Plan has entered into agreements with other I.B.E.W. Locals across Canada and the U.S.A. If a Member is working in another Local with whom there is a Reciprocal Agreement in place, the contributions made on his/her behalf will be transferred to Joint Electrical Industry's Welfare Plan.

In addition, Reciprocal Agreements have been signed with certain other trades who are members of the BC and Yukon Building and Construction Trades Council. This enables a Member to receive credit while temporarily working out of another jurisdiction.

It should be noted that any contributions submitted on a Member's behalf from another health and welfare plan would be subject to an adjustment in accordance with the hourly contribution rate.

Before leaving BC to work in another I.B.E.W. jurisdiction, we suggest that the Member be in contact with the Administrator's office to determine the status of his/her Health and Welfare coverage.

## **MEDICAL COVERAGE**

Upon qualifying, a Member will be enrolled in the Medical Services Plan of BC, provided an enrollment form has been completed and submitted to the Administrator.

Details of the Medical Plan are shown in the official M.S.P. brochure. The M.S.P. group number is #4821427 and an identification card will be issued as soon as the Member is eligible for coverage.

If you do not apply for M.S.P. coverage through the Plan at the time you become eligible to do so, the Plan will only make retroactive M.S.P. payments, on your behalf, back six months.

## **GROUP LIFE INSURANCE**

Each eligible Member is insured for \$70,000.00 Life Insurance. A Life Insurance Beneficiary card must be completed to ensure there is no delay in claim settlement.

### **Conversion option**

If an insured Member's Life Insurance terminates because his/her Membership in this Plan terminates, the Member may convert up to 100% (50% after their 65th birthday) of the terminated amount.

If the Member's Life Insurance terminates because this benefit is discontinued and they have been insured under the Plan for the last 5 years, then on or before their 65th birthday, the Member may convert to an individual Life Insurance policy, up to the lesser of:

100% of the terminated amount; or

3 times the current Canada Pension Plan maximum Pensionable Earnings;

less any amount of Group Life Insurance for which they may become eligible within 31 days of the date this benefit terminates; or after their 65th birthday, the Member may convert up to 50% of the terminated amount less any amount of Group Life Insurance for which they may become eligible, within 31 days of the date this benefit terminates, to a maximum amount of \$2,000.00.

A Member may convert to individual permanent insurance under any regular plan then being issued by Manulife Financial;

1-year convertible term insurance (if the Member is under age 65); or

term insurance to age 65.

The Member must apply in writing and pay the first premium to Manulife Financial within 31 days of the date their insurance terminates. The premium rate will be based on their age and class of risk at the time they convert. No medical exam or health questionnaire will be required.

**Extension of benefit**

If a Member dies within 31 days of the date their Life Insurance terminates, the amount they could have converted will be paid as a death benefit even if no application for conversion was made.

**ACCIDENTAL DEATH & DISMEMBERMENT**

The Member and his/her registered dependents are insured against the perils described in the “Schedule of Losses”. The Basic Accidental Death & Dismemberment plan provides coverage 24-hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If any of the losses listed below in the Schedule of Losses are suffered 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?**

Class I: All Members who are eligible as outlined in this Booklet.

Class II: All Spouses under age 70.

Class III: All eligible Dependent Children

**Amount of Coverage**

Class I: \$70,000.00

Class II: \$20,000.00

Class III: \$5,000.00

**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..... 3/4 of The Principal Sum  
Loss of One Leg ..... 3/4 of The Principal Sum  
Loss of One Hand..... 2/3 of The Principal Sum  
Loss of One Foot ..... 2/3 of The Principal Sum

Loss of Entire Sight of

One Eye..... 2/3 of The Principal Sum  
Loss of Thumb and Index Finger

of the Same Hand..... 1/3 of The Principal Sum  
Loss of Speech and Hearing..... The Principal Sum

Loss of Speech or Hearing.... 2/3 of The Principal Sum  
Loss of Hearing in One Ear ... 1/3 of The Principal Sum

Quadriplegia (total paralysis of both

upper and lower limbs) .. 2 Times The Principal Sum  
Paraplegia (total paralysis of both

lower limbs) ..... 2 Times The Principal Sum  
Hemiplegia (total paralysis of upper and lower limbs

of one side of the body.. 2 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 ..... 2/3 of The Principal Sum  
Loss of Use of One Arm or

One Leg..... 3/4 of The Principal Sum  
Loss of Four Fingers of

One Hand..... 1/3 of The Principal Sum  
Loss of All Toes of One Foot. 1/4 of The Principal Sum

“Loss as used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs. As 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 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. As used with reference to eye, means the irrecoverable loss of the entire sight thereof.

“Loss” as 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 irrevocable loss of hearing in both ears.

“Loss” as used with reference to “Loss of Use”, means the total and irrevocable 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 Policyholder and a licensed practicing physician appointed by the insurance company, or, in the event that the two physicians so appointed cannot arrive at an agreement, a third licensed practicing physician shall be binding on the Policyholder and the insurance company. This procedure may be waived by the insurance company 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.

### **Repatriation Benefit**

When injuries covered by this policy result in the loss of life of an Insured Person outside 50km 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.

### **Educational Benefit**

If indemnity becomes payable for the Accidental Loss of Life on an Insured Person of the Policyholder, the insurance company 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 higher learning beyond the 12th grade level:
  - (a) The actual annual tuition, exclusive of room and board, charged by such institution per school year.
  - (b) \$10,000.00 per school year.
  - (c) 5% of the Insured Person’s Principal Sum.

Such amount will be payable annually for a maximum of four consecutive annual payments,

only if the Dependent Child continues his/her education.

“Dependent Child” as used herein means any unmarried child under 26 years of age who was dependent upon the Insured Person for at least 50% of his/her 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 months from the date of death of the Insured Person 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.

### **Rehabilitation Benefit**

When injuries shall result in a payment being made by the insurance company under the Accidental Death & Dismemberment Indemnity section of this policy, the insurance company shall pay in addition, the reasonable and necessary expenses actually incurred, up to a limit of \$15,000.00 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/she 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 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 insurance company shall pay the actual expenses incurred by the confined Insured Person but not to exceed the amount of \$15,000.00.

The term “Member of the immediate family” means the Spouse (or common-law Spouse) parents, grandparents, children age 18 and over, brother or sister of the Insured Person.

### **Seat Belt Rider**

Benefits under the policy shall be increased 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 seatbelt is properly fastened. Verification of actual use of the seat belt must be part of the official report of the accident by the investigating officer.

### **Home Alteration and Vehicle Modification**

If an Insured Person receives a payment for Quadriplegia, Hemiplegia or Paraplegia as outlined in the Schedule of Losses herein and was subsequently required (due to the cause for which payment under such was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

- (a) The one-time cost of alterations to the injured person’s residence to make it wheelchair accessible and habitable; and
- (b) The one-time cost of modifications, necessary to a motor vehicle owned by the injured person, to make the vehicle accessible or driveable 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 wheelchair 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.

### **Day Care Benefits**

If indemnity becomes payable under the policy for the accidental loss of life of an Insured Person, the insurance company will pay an amount equal to the lesser of the following amounts:

- (1) The actual cost charged by such day care centre per year, or
- (2) 3% of the Insured Principal Sum, or
- (3) \$5,000.00 per year,

On behalf of any child who was an Insured Person'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 four 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 a loss under the Table of Losses as a result of a covered accident and requires that the Insured be confined to a hospital for more than five (5) consecutive days, the insurance company will pay:

- (a) a monthly benefit of one (1) percent of the Insured's applicable Principal Sum; or
- (b) for periods of less than one (1) month, one thirtieth (1/30) of the above monthly benefit per day.

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

This benefit is limited to:

- (a) a monthly amount not to exceed \$1,000.00; and
- (b) a total of twelve (12) months for any covered accident.

Successive periods of hospital confinement for loss from the same covered accident separated by a period of less than three (3) months will be considered as one (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, other than incidentally, a place for alcoholics or those addicted to drugs.

### **Permanent Total Disability Indemnity**

When as the result of injury and commencing within 365 days of the date of the accident an Insured Person is totally and permanently disabled and prevented from engaging in each and every occupation or employment for compensation or profit for which he/she is reasonably qualified by reason of his/her education, training or experience, the insurance company shall pay, provided such disability has continued for a period of twelve 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 the result of the same accident.

### **Conversion Privilege**

On the date of termination of employment or during the 60-day period following termination of employment, the Member may change his/her insurance to the Chartis Insurance Company of Canada'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 policy ceases, whichever occurs later. The premium will be the same as would be paid if application for an individual policy was made at that time. Application of an individual policy may be made at any office of Chartis Insurance Company of Canada. The amount of insurance benefit converted to shall not exceed that amount issued during employment.

### **Continuance of Coverage**

In the case of Members 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 a Member of the Policyholder 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 Policyholder'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 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 the Master Policy is terminated.

### **Beneficiary Designation**

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Person under the Policyholder'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.

### **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.

## **WEEKLY INDEMNITY**

A benefit of \$384.00 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, if not entitled to E.I. sick pay. The waiting period is 2 weeks from the date of disability. The maximum length of benefit is 26 weeks. Rejection by E.I. must accompany claim.

To make a claim for Weekly Indemnity, carry out the following steps:

- (a) Consult a doctor immediately upon becoming disabled. A Member must be seen and treated during the time of his/her disability.
- (b) Obtain a claim form from the Administrator, union office, or employer and note instructions concerning an E.I. sick claim.
- (c) The form must be completed where indicated and the attending physician must complete the physician's portion of the form.
- (d) The completed claim form must be sent to the Administrator without delay.
- (e) Claim cheques will be sent directly to the Member's home address.

### **LIMITATIONS**

The Plan does not pay weekly benefits for (1) any injury or sickness (a) covered by E.I. sick pay (b) covered by any Workers' Compensation or occupational disease law or the Insurance Corporation of British Columbia, (c) arising from or sustained in the course of any occupation or employment for compensation, profit or gain or, (d) if the Member is not under the active and continuous care of a physician (2) any pregnancy-related illness during a period for which the Member is (a) entitled to receive benefits from the Employment Insurance Commission, or (b) entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the employer by way of contract or agreement, verbal or written.

A Member is not considered Totally Disabled due to the use of drugs or alcohol unless he/she is being actively supervised by and receiving continuous treatment for that disability from a rehabilitation centre, a physician or an institution provincially designated for that treatment.

### **LONG TERM DISABILITY**

A benefit of \$1,500.00 per month will be paid to each eligible Member who is Totally Disabled and unable to work as a result of a non-occupational accident or sickness. The waiting period is 28 weeks from the date of disability. The maximum benefit duration is to age 65.

If an eligible Member becomes Totally Disabled while covered and is:

- seen by, and treated by, a licensed doctor (M.D.) within 31 days of the date of becoming Totally Disabled; and
- absent from work for more than the waiting period;

monthly benefit payments will be made for the period following the waiting period for as long as such Member is:

- Totally Disabled;
- under the ongoing care of a licensed doctor (M.D.); and
- residing in Canada, unless prior approval to the contrary is obtained from the Plan.

but not beyond the end of the month in which the Benefit Duration is completed.

**“Total Disability”** or **“Totally Disabled”** means, during the qualifying period and the next twenty-four months of any one period of disability, that the Member is unable, solely because of disease or accidental bodily injury, to work at his/her own occupation; and thereafter during the continuance of such period of disability, that the Member is unable, solely because of disease or accidental bodily injury, to work at any reasonable occupation.

### **Recurrent Disability**

Any consecutive period of Total Disability that is:

- due to the same or a related cause; and
- separated by return to active full-time work for less than six months (two weeks during the waiting period);

will be deemed to be one period of Total Disability with only the initial waiting period applying, provided the first period begins while the Member is covered under this Benefit.

### **Benefit Offsets**

Benefits will be reduced by any amount necessary to limit the income payable (or would have been payable had the Member applied for it):

- as a Long Term Disability Benefit;
- from any job for pay or profit (except under an approved rehabilitation or partial disability program); or
- because the Member is disabled or retired under any plan required or provided by a government or

pursuant to a statute, such as, but not limited to, Workers' Compensation and any Automobile Insurance Act; and

- because the Member is disabled or retired under any other group insurance, benefit, or other arrangement for members of a group (whether on an insured basis or not).

to 85% of pre-disability earnings.

Should income be received from any of the above sources payable:

- as a retroactive award, benefit payments will be adjusted to reflect any overpayment that may have been made;
- other than monthly, such income will be converted to a monthly basis; or
- in a lump sum payment for loss of future income, no further benefits will be paid until such time as the sum of the benefit payments otherwise payable equals the amount of each sum.

This benefit will not be reduced by income payable from:

- the Canada or Quebec Pension Plan (CPP/QPP);
- disability or retirement benefits at the level that the Member was receiving them prior to the date of becoming Totally Disabled under this Benefit; or
- any individual disability insurance, exclusive of accident benefits payable under an automobile policy.

### **Recovery of Benefits**

If a benefit is received from this Plan in excess of what should have been paid, the Plan has the right to recover the amount of such excess from the Member or deduct it from future monthly benefits payable.

### **Rehabilitation**

If the Member recovers enough from his/her disability to be able to work full-time or part-time at any job under a rehabilitation program approved in writing by the Plan, the Member will still be deemed to be Totally Disabled and his/her benefit will only be reduced by the amount needed to keep the disability benefit income plus his/her rehabilitative income at the same level as their pre-disability earnings.

If a Member refuses to participate in a rehabilitation program recommended by the Plan, benefit payments will be terminated.

If a Member is Totally Disabled but able to work under a program approved in writing by the Plan and perform at any time the duties of any occupation on a part-time basis, he/she will still be entitled to a benefit which will only be reduced by the greater of 50% of the income received from such work or the amount needed to keep the disability benefit income plus the income received from such work at the same level as his/her pre-disability earnings.

### **Third Party Liability**

If a Member receives benefit payments under this Plan for loss of income for which there may be a cause of action against a third party, the Member will be required to complete a Reimbursement Agreement. This will entitle the Plan to be reimbursed for any amount(s), including interest, recovered from a third party for:

- loss of income; or
- medical or dental expenses;

which, together with any amount(s) paid or payable under any of the Benefits of this Plan, would exceed the actual loss.

Following notification to the Plan of payment by a third party of any judgment or settlement, further disability benefit payments under this Plan will terminate until the Plan has been reimbursed the amount set out in the Reimbursement Agreement.

If a lump sum payment is made under judgment or settlement for loss of future income, no further disability benefits will be paid under this Plan until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

### **Exclusions and Limitations**

No benefit will be paid for the period in which a Member is entitled to pregnancy or parental leave by statute, contract or employer arrangement.

Benefit payments may be terminated if a Member:

- fails to provide proof of ongoing disability when requested to do so;
- refuses or fails to complete and return or comply with the terms of the Reimbursement Agreement in accordance with the Third Party Liability provision;
- fails to report for a medical examination, as often

- as may reasonably be required, by a licensed doctor (M.D.) of the Plan's choice; or
- is not receiving accepted standard professional treatment for the condition being treated and, where appropriate, treatment by a relevant and certified specialist.

No benefit will be paid for any disability that results from or is contributed to by:

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- purposely self-inflicted injury;
- commission of, or attempt to commit, an assault or criminal offense;
- chronic alcoholism, or use of narcotics, barbiturates or hallucinogens, unless the Member is receiving ongoing active professional treatment deemed appropriate for the condition being treated; or
- a pre-existing condition as described below.

### **Pre-existing Condition Limitation**

If, during the first twelve months that a Member is covered, he/she becomes Totally Disabled, directly or indirectly, because of an illness or injury for which he/she:

- received medical treatment, consultation, care or service including diagnostic tests; or
- took prescribed drugs;

during the 90-day period before the date of becoming covered, no benefit payments will be made.

If, after the first twelve months that a Member is covered, but before he/she has been covered 24 months, the Member again becomes Totally Disabled because of the same or a related cause, he/she must:

- have returned to active full-time work for at least six months; and
- be absent from work for more than the waiting period;

before benefit payments will be made.

### **Waiver of Premium**

No premium is required for this Benefit during a period for which a Member is entitled to receive benefit payments, up to the age of 65.

### **Extension Benefit**

If a Member is Totally Disabled on the date his/her

coverage terminates, he/she will be entitled to the same benefit as though such insurance had not terminated.

## **EXTENDED HEALTH CARE**

Extended Health Care is an extension of medical coverage and is designed to provide protection against many of the expenses incurred during a period of illness.

### **Description of Benefit**

Covered Expenses are reimbursed at 80% of the cost of any such expenses. There is a deductible of \$100.00 per Member or family per calendar year, applied to prescription drugs only.

There is a total maximum amount of \$1 million available to each Member and \$1 million for each eligible dependent during a lifetime. For Members aged 65-79 inclusive, benefits will be limited to \$100,000.00. From age 80 onward, benefits will be limited to \$20,000.00. At the end of each year, up to \$1,500.00 of this maximum will be restored automatically. Benefits in excess of the \$25,000.00 provided by Joint Electrical Industry's Welfare Plan self-insured Extended Health Care program will be limited to those expenses incurred within 52 weeks of the date of the covered injury or sickness.

Eligible expenses must be submitted to the Administration Office during the calendar year following the year in which expenses were incurred.

### **Covered Expenses**

Covered expenses included under the Plan are the charges for the following services and supplies received while insured, for the treatment of non-occupational injuries and diseases.

1. Prescription Drugs – Pay Direct Drug Card Benefit – present your drug card, along with your prescription, to your pharmacist and your prescription drug claim will be instantly adjudicated right at the pharmacy. Using your drug card eliminates the need to send in your prescription receipt and wait for reimbursement. Your Plan provides coverage for drugs and medicines that require a prescription by law and which must be dispensed by a licensed pharmacist.

If you are being dispensed a name brand drug, for which there is a generic alternative available, the Plan will cover the cost of the name brand drug, but only up to the cost of the generic alternative. Exceptions will be made for drug intolerance and lack of availability of the generic alternative. If your doctor handwrites “no substitutes” on the prescription, the Plan will reimburse the cost of the name brand drug. Fertility drugs are not an eligible expense. Smoking cessation products will be covered up to a lifetime maximum of \$500 per person.

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

The Plan will cover the cost of dispensing a 34-day supply for medications that are classified as a treatment for an acute condition, and a 100-day supply for those classified as a maintenance medication. Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Vacation supplies of your medications, which are outside of the regular days supply limits, must be pre-authorized by the Plan and must be paid for in full by the Member and submitted to the Plan for reimbursement.

Members who are BC residents, must register for PharmaCare and provide their registration number to the Plan Administrator in order to ensure continued coverage for benefits under this Plan.

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

2. Treatment by a Licensed Chiropractor, Naturopath, \*Acupuncturist, Podiatrist, Speech Therapist or Psychologist – duly qualified and registered, will be reimbursed per practitioner

each calendar year at the rate of \$10.00 per visit for the first 12 visits, followed by the submitted amount up to a maximum aggregate amount of \$200.00 per person, to a maximum of \$500.00 per family, per calendar year when required.

\*Care or services must be certified as necessary by the attending physician

3. Expenses for Physiotherapy by a person duly qualified and registered and legally engaged in the practice of physiotherapy, will be reimbursed each calendar year at the rate of \$10.00 per visit for the first 12 visits, followed by the submitted amount, provided such services, by duration and type, have been prescribed by a physician.
4. Massage therapy expenses will be reimbursed at the rate of \$10.00 per visit for the first 12 visits, followed by the submitted amount, to a maximum of \$200.00 per insured person per calendar year, on a doctor's referral that is required to be renewed each year.
5. The cost of routine bi-annual eye examinations for adults aged 19-65 will be reimbursed up to a maximum of \$65.00 per insured person every 2 years.
6. The cost of a Registered Graduate Nurse (R.N.) other than a nurse who ordinarily resides in the patient's home, or who is a family member of the Member or the spouse, when ordered by the attending physician in the management of an acutely ill patient.
7. Anaesthesia, oxygen, blood and blood products.
8. Rental of an iron lung or other durable medical or surgical equipment.
9. Artificial limbs and eyes.
10. The cost associated with diagnosis and assessment by a person duly qualified and registered and legally engaged in the practice of psychology, on the written recommendation of a physician.
11. Emergency Dental treatment necessary to natural teeth as a result of an accident.
12. The fees of a professional ambulance service when used to transport the individual from the place where they are injured by an accident or stricken by a disease, to the first hospital where treatment is given.

13. Hearing aids for dependent children under sixteen years of age, when prescribed by an attending Certified Ear, Nose and Throat Specialist. The maximum benefit during a five year period shall not exceed \$300.00 per child and does not include payment for repairs and maintenance, batteries or re-charging devices, or other such accessories.
14. The cost of orthopedic shoes will be reimbursed at 50% when recommended by a licensed doctor (M.D.) up to a maximum benefit payment of \$250.00 per calendar year.
15. Arch supports, molds or orthotic devices, but not for sports, when recommended by a licensed doctor (M.D.) or podiatrist, will be reimbursed at 50% up to a maximum payment of \$400.00 per calendar year.
16. Prostate Screening Assessments (PSA Tests)
17. Hospital Services and Supplies:
  - Hospital charges for the difference between ward cost and semi-private or, when deemed to be medically necessary by the attending physician, private accommodations.
  - Hospital charges made by an approved acute general hospital in BC for co-insurance and short stay charges.
18. The hospital co-insurance charge, if applicable, when confined in a convalescent hospital approved by the Province of British Columbia for up to 120 days during any period of disability provided the individual is admitted to the convalescent hospital within 14 days following confinement in an acute general hospital. All confinements in a convalescent hospital will be considered as one period of disability unless confinements are separated by at least 90 days.

### **Exclusions**

No benefit will be paid by the Plan for:

- the expense of a physician and/or surgeon except as described under “Out-of-Province Benefits” for emergency treatment while travelling outside British Columbia and is limited thereby.
- any expense associated with war or act of war or participation in a riot or civil insurrection.
- any expense associated with suicide or any attempt thereat.

- orthoptic treatment and refractions.
- dental services except as set out in (11) of “Covered Expenses.”
- any portion of a specialist’s fee not allowable under the Basic Medical Plan due to non-referral, or any amount of fees charged by any practitioner in excess of the recognized fees for such service.
- services which are eligible for payment by the Medical Services Plan of British Columbia, Workers’ Compensation board or any tax supported agency, without cost or at nominal cost by public authorities.
- services and supplies for cosmetic reasons.
- expenses incurred outside the Province, on an elective basis. Service will only be allowable for an unexpected emergency illness or injury while the Insured Person is temporarily visiting outside the Province.

### **Out-of-Province Emergency Eligible Expenses**

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances occurring while temporarily travelling outside the insured’s province or territory of residence for up to a maximum of 60 days per trip. It is important that the Plan be read and understood before travelling. In the event of any discrepancy between the provisions of a booklet or other document held and the provisions of the Policy, the provisions of the Policy shall govern. The insurer has contracted Viator/Global Excel Management Inc. (called Global Excel) to provide medical assistance and claims services under the Policy.

### **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.

**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; and
- legally insurable; subject to the overall maximum per insured person of:  
All eligible active Members under age 65:  
\$1,000,000 per Coverage Period  
All eligible Members age 65 to 79 inclusive:  
\$100,000 per Coverage Period.

In the event of an emergency, the following benefits are payable under the policy. However, certain expenses, as specified below, are covered only if you obtain the prior approval of Global Excel.

1. **Hospital Accommodation:** Reasonable and customary room and board costs up to the semi-private room rate charged by the hospital. If medically necessary, expenses for treatment in an intensive or coronary care unit are also covered. If coverage terminates for any reason during your hospital stay, benefits continue until discharge, to a maximum of one year. In no case will expenses for In-patient stays be covered for a period greater than 365 days per insured person.
2. **Physician Charges:** Reasonable and customary charges for treatment by a physician.
3. **Diagnostic Services:** Reasonable and customary charges for laboratory tests and x-rays prescribed by the attending physician and that are part of the emergency treatment. The policy does not cover magnetic resonance imaging

(MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel.

4. **Paramedical Services:** The services (including x-rays) of a licensed chiropractor, physio-therapist, podiatrist or osteopath, to the maximum of \$250 per insured person, per profession listed above, when approved in advance by Global Excel.
5. **Prescriptions:** Drugs, including injectable drugs, and sera that can only be obtained upon medical prescription, that are prescribed by a physician and that are supplied by a licensed pharmacist when medically necessary for emergency treatment, except when needed to stabilize a chronic condition or a medical condition which you had before your trip. This benefit is limited to a 30-day supply per prescription, unless you are hospitalized.
6. **Ambulance Services:** Reasonable and customary costs when reasonable and medically necessary, for licensed ground ambulance service to the nearest medical facility.
7. **Medical Appliances:** When approved in advance by Global Excel, reasonable and customary costs for minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and/or the temporary rental of a wheelchair when prescribed by the attending physician, obtained outside your province or territory of residence and medically necessary.
8. **Private Duty Nurse:** The professional services of a registered private nurse, when medically necessary and while hospitalized to the maximum of \$5,000 per insured person, when approved in advance by Global Excel.
9. **Emergency Air Transportation:** When approved and arranged in advance by Global Excel, the reasonable and customary costs for:
  - a) air ambulance to the nearest appropriate medical facility or to a Canadian hospital for immediate emergency treatment;
  - b) transport on a licensed airline with an attendant (where required) to return you to your province or territory of residence for immediate emergency treatment.

10. **Transportation to Bedside:** When approved in advance by Global Excel, a single round-trip economy airfare from Canada plus up to \$150 per day up to a maximum of \$3,000 for the cost of meals and commercial accommodation for one of the following: Spouse, parent, child, brother, sister or business partner, to:
- a) be with you if you are travelling alone and have been hospitalized as the result of an emergency. To be payable, this benefit requires that you eventually be hospitalized as an in-patient for at least three (3) consecutive days outside your province or territory of residence and that the attending physician provide written certification that the situation was serious enough to warrant the visit; or
  - b) identify the deceased insured person prior to the release of the body, where necessary.

The insurer will only reimburse covered expenses evidenced by original receipts.

11. **Return of Travelling Companion:** If you are returned to your province or territory of residence under the Emergency Air Transportation benefit or the Return of Deceased benefit, the insurer will reimburse the cost of a single one-way economy airfare for a travelling companion to return to Canada, when approved in advance by Global Excel.
12. **Treatment of Dental Accidents:** Up to \$2,000 per insured person for emergency Dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth provided the Injury was caused by an external, accidental blow to the mouth or face. You must consult a physician or Dentist immediately following the Injury. Treatment must begin during the coverage period and be completed prior to returning to your province or territory of residence. An accident report is required from a physician or Dentist for claims purposes.
13. **Meals and Accommodation:** Up to \$150 per day to a maximum of \$3,000 per trip per participant, for the cost of commercial accommodation and meals for the participant and/or any of his/her dependents when their trip is extended beyond the last day of the coverage period due

to the sickness and/or Injury suffered by an insured person. This benefit must be authorized in advance by Global Excel. The fact that you are unable to travel must be certified by the attending physician and supported with original receipts from commercial organizations.

14. **Vehicle Return:** Up to \$5,000 if neither you, nor someone travelling with you, are able to operate your vehicle, whether owned or rented, during your trip due to sickness and/or injury. Arrangements and payment will be made for the return of the vehicle to your home in your province or territory of residence or the nearest appropriate rental agency. Benefits will only be payable for a single person to return the vehicle when approved and/or arranged in advance by Global Excel. This benefit does not cover wages lost by the person driving your vehicle. The insurer will only reimburse covered expenses evidenced by original receipts.
15. **Return of Deceased:** Up to \$5,000 towards the cost of preparation and transportation of the deceased insured person to their province or territory of residence in the event of death due to a sickness and/or injury.

In the case of cremation and/or burial at the place of death of the insured person, this benefit is limited to \$2,500.

The cost of the casket or urn is not covered.

16. **Incidental Expenses:** Up to \$250 for your out-of-pocket expenses such as telephone charges, television rental and parking while you are hospitalized for an emergency and the expenses are incurred, as a direct result of such hospitalization. The insurer will only reimburse covered expenses evidenced by original receipts.

Global Excel is available to take your calls 24 hours a day, 7 days a week.

Emergency Call Centre – No matter where you travel, professional assistance personnel is ready to take your call. Global Excel can also provide you with Canada Direct instructions and codes so that you only deal with Canadian telephone operators.

Referrals – Global Excel can refer you to the preferred medical providers (hospitals, clinics and physicians) that are closest to where you are staying. With a

referral, it is less likely that you will have to pay for services out of pocket.

**Benefit Information** – Explanation of your coverage is available to you and to the medical providers who are treating you.

**Medical Consultants** – Global Excel’s team of medical professionals, available 24 hours a day, will monitor the services given in the event of a serious emergency. If necessary, Global Excel will help you return to Canada for the care you need.

**Urgent Message Relay** – In the event of a medical emergency, Global Excel will contact your travelling companion to keep him/her advised of your medical situation and will help you exchange important messages with your family.

**Interpretation Service** – Global Excel can connect you to a foreign language interpreter when required for emergency services in foreign countries.

**Direct Billing** – Whenever possible, Global Excel will instruct the hospital or clinic to bill the insurer directly.

**Claims Information** – Global Excel will answer any questions you have about the eligibility of your claim, standard verification procedures and the way that the benefits under the policy are administered.

### **Claims Procedures**

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 in the Plan are in Canadian currency unless otherwise indicated. If you have 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 Street  
Sherbrooke, Quebec J1M 1J3

Tel.: 1-866-870-1898 (toll free) or  
(819) 566-1898 (collect) during business hours (EST)

## **SUPPLEMENTAL TRAVEL**

### **Eligibility**

Any Member who has current coverage will be entitled to submit eligible transportation costs for themselves or their eligible dependents.

Eligible dependents shall mean the spouse and unmarried children under 21 years of age of a Member qualified for coverage under this Plan.

## **Covered Expenses**

The benefit will provide eligible Members reimbursement of eligible transportation costs for themselves or their eligible dependents for transportation within British Columbia, Alberta or Yukon Territory, up to a maximum equal to 75% of the cost of the lowest possible commercial economy round trip airfare. This will be based on the commercial airport nearest the Member's permanent BC or Yukon address, where regularly scheduled airlines depart from, to the commercial airport located nearest to the facility recommended by the patient's doctor where treatment, diagnostic test or examination takes place.

Mileage on a vehicle will be reimbursed at the rate equivalent to the Treasury Board of Canada Secretariat Travel Directive Appendix B Kilometric Rate applicable at the time.

An accommodation allowance of \$30.00 per day for a maximum of 3 days will be paid to a Member upon presentation of an official receipt in conjunction with the Supplemental Travel eligibility rules for a maximum of 4 trips per calendar year.

Airfare as defined above for one attendant will be permitted when medically required by the attending physician.

In each calendar year no more than 4 trips will be eligible for reimbursement.

## **Exclusions**

- a) The cost of transportation from the patient's home to the nearest airport from which regularly scheduled airlines depart.
- b) The cost of transportation from the airport at the city of destination to the place where treatment, examination or tests take place.
- c) Any per diem allowance.
- d) Any accident or sickness which is the responsibility of the Workers' Compensation Board or other Government Agency.
- e) Any round trip journey less than 550 km.

## **DENTAL CARE PLAN**

A Dental Plan is provided for Members and their eligible dependents which includes spouse and unmarried dependent children under 21 years of age.

## **Part I Basic Dental**

The following services are eligible for reimbursement of 75% of the lesser of the amount charged or the College of Dental Surgeons of BC Fee Guide.

### **1. Diagnostic Services:**

Those basic procedures necessary to assist the Dentist in evaluating the existing conditions to determine the required Dental treatment including:

Oral examinations – two per year. **COMPLETE ORAL EXAMINATION** once in a 3-year period. X-rays – limited to the equivalent of one full mouth series per year. Complete mouth X-rays will be covered once in any 3-year period. Consultations (as a separate appointment).

### **2. Preventive Services:**

Those basic procedures necessary to prevent the occurrence of oral disease, including;

Cleaning and topical application of fluoride – twice a year.

Scaling.

Band and loop space retainers.

### **3. Surgical Services:**

Those basic procedures necessary for extractions and other basic surgical procedures normally performed by a Dentist.

### **4. Restorative Services:**

Those basic procedures necessary for filling teeth with amalgam, synthetic porcelain, and stainless steel crowns.

Anesthetics administered in connection with oral surgery or other covered Dental services.

Injections of antibiotic drugs by the attending Dentist.

### **5. Prosthetic Repairs:**

Those basic procedures required to repair or reline fixed or removable appliances. Repairs to complete upper and/or lower dentures may be performed by either a licensed Dentist or a duly licensed Dental Mechanic.

### **6. Endodontics**

Those basic procedures necessary for pulpal therapy and root canal filling. Root Canal therapy will be limited to once per tooth per lifetime of Member.

## **7. Periodontics:**

Those basic procedures necessary for the treatment of tissues supporting the teeth.

Treatment in the case of each Dental Expense, must have been made by a legally qualified Dentist, except that cleaning and scaling of teeth may be performed by a registered Dental nurse, if such treatment is rendered under the supervision and direction of such Dentist.

## **PART II – Prosthetic Appliances and Crown and Bridge Procedures**

The cost of the following items will be eligible for reimbursement of 75% of the lesser of the amount charged or the College of Dental Surgeons of BC Fee Guide.

1. Crowns and/or bridges.
2. Onlays and/or inlays involved in bridgework.
3. Partial dentures.
4. Complete upper and lower dentures – these may be provided by a Dentist or duly licensed Dental Mechanic.
5. Gold inlays or onlays will be provided as a filling material only when teeth which, in the professional opinion of a Dentist, cannot be restored with any other material.

No benefits will be paid for duplication of the above services within a five-year period or for the replacement of dentures that are lost or stolen. Broken dentures may be repaired (under Part 1) but will not be replaced.

Any fees agreed to in excess of the Fee Schedule are your responsibility.

## **PART III – Orthodontia**

Claims will be paid on the basis of eligibility and work completed. This benefit is only applicable to eligible dependent children up to age 21. Reimbursement will be made at 75%.

Appliances lost, broken or stolen will not be replaced.

The Orthodontist must complete a “Certified Specialist in Orthodontics Standard Information Form” (the treatment plan) before treatment starts. Once the payment schedule or treatment starts, if the payment schedule or treatment changes, the Plan requires a revised treatment plan for review. The Plan will retain the treatment plan on file. If the treatment

plan is not on file, the Plan is unable to pay the initial fee/down payment, the monthly/quarterly fees or the one-time appliance fees. Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

Receipts for monthly or quarterly fees should be submitted on a regular basis, as treatment progresses. The amount paid will be pro-rated over the estimated months of active treatment. For example, when braces are on the teeth, the estimated length of treatment will be on the treatment plan. As long as coverage is in effect, monthly or quarterly reimbursements will be made to the Member until the overall Dental dollar maximum is reached or the treatment is complete, whichever occurs first.

**A maximum payment of \$2,500.00 per calendar year, per family, is available for Part I, Part II and Part III expenses combined.**

### **Emergency Dental Care anywhere in the World**

In an EMERGENCY if Dental Care is required while travelling or on vacation outside of British Columbia those insured are entitled to the services of a duly qualified Dentist and will be reimbursed up to the amount that would have been paid had the service been rendered in British Columbia.

### **Services Not Covered**

1. Services which are provided by the Medical Services Act of British Columbia, the Workers' Compensation Board or any other similar agency or services for which any third party is liable.
2. Procedures with respect to congenital malformations or procedures for purely cosmetic reasons.
3. Charges for broken appointments, oral hygiene or nutritional instruction, or protective athletic appliances.
4. Charges for pantographic tracings.
5. Incomplete, unsuccessful or temporary procedures.
6. Recent duplication of services by the same or different Dentists.
7. Procedures commenced prior to the effective date of coverage.
8. Any extra procedure which would normally be included in the basic service performed.

9. Any hospital charges for board and room and other necessary services and supplies, in connection with injuries or diseases of a Dental nature.
10. Charges for completion of claim forms.
11. 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.
12. Those services which are not in accordance with the generally established principles of the College of Dental Surgeons of BC.

## **DENTAL CLAIMS PROCEDURE**

To make a claim:

1. A Member will be reimbursed on the basis of the receipt and information supplied when the claim is initially submitted. However, there will be occasions where a detailed claim form is necessary.
2. Submit the claim to the Administrator ensuring that the Member's NAME, ADDRESS, SOCIAL INSURANCE NUMBER or CERTIFICATE NUMBER and LOCAL UNION are clearly shown.
3. If the Dentist was paid by the Member, the cheque issued will be payable to the Member. If the Dentist has not been paid, the cheque will be payable to the Dentist and mailed to him. The Member will be responsible for the difference between the Dentist's charge and the amount paid by the Plan.

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**It is recommended that an expense estimate be obtained and the Administrator be consulted before undertaking a prolonged course of treatment.**

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## **VISION CARE PLAN**

### **Eligibility**

Any Member who has qualified for coverage under Joint Electrical Industry's Welfare Plan will be entitled to submit eligible Vision expenses for themselves and his/her eligible dependents.

Eligible dependents shall mean the spouse and unmarried children under 21 years of age of a Member qualified for coverage under this Plan.

### **Covered Expenses**

The following expenses shall be eligible for reimbursement.

1. One set of single vision, bifocal or trifocal lenses, prescribed by a person legally qualified to make such prescription;
2. One set of frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable.
3. One set of contact lenses prescribed by a person legally qualified to make such prescription.
4. Corrective eye surgery\*.

### **Exclusions**

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

- (a) Safety goggles, sun glasses (plain or prescription);
- (b) Replacement of lost, stolen or broken lenses or frames.

### **Payment of Expenses**

The maximum amount payable during any period of 24 consecutive months (regardless of consecutive months of coverage) shall be 100% of the actual expenses incurred to a maximum of \$300.00 for an eligible Member or for an eligible dependent.

\*Reimbursement of the cost of corrective eye surgery can be reimbursed using the available balance under the Vision Care entitlement for up to a maximum of 5 Vision Care entitlement cycles, provided the Member/dependent is eligible at the time of each submission.

### **Instructions**

In submitting eligible claims, please follow directions outlined on the reverse side of the Extended Health Benefits claim form which is available through the Union or Administrator's office.

**WHEN WRITING THE ADMINISTRATOR BE SURE TO INCLUDE THE FOLLOWING:**

- The Member's Name,
- The Member's Address,
- The Member's Social Insurance Number/  
Certificate Number,
- The Member's Local Union.

### **IMPORTANT**

**The Administrator must be advised of any change of address or addition or deletion of dependents.**



*Benefits Administered by:*

**D.A. TOWNLEY**  
**& ASSOCIATES LTD.**

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*Benefits Underwritten by:*

**MANULIFE FINANCIAL (Policy #02600)**

Life Insurance  
Long Term Disability

**CHARTIS INSURANCE COMPANY OF CANADA**  
**(Policy #25721108)**

Accidental Death & Dismemberment

**JOINT ELECTRICAL INDUSTRY'S**  
**WELFARE PLAN (Policy #2600)**

Weekly Indemnity  
Dental Plan  
Extended Health Care (In Province Benefits)  
Vision Care  
Supplemental Travel

**ETFS / GLOBAL EXCEL (Policy #32445237)**

Out of Province Emergency Benefits

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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.

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