SOUTHERN INTERIOR HEALTH AND WELFARE PLAN

Established by:

- Local Unions 1-405, 1-417 and 1-423 represented by United Steelworkers (USW) and
- Interior Forest Labour Relations Association

under the terms of the British Columbia Southern Interior Master Agreement

Plan Booklet
Effective January 1, 2023

CUPE 1816

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INTRODUCTION

In accordance with the provisions of the British Columbia Southern Interior Master Agreement, three Trustees have been appointed by USW and three by the Interior Forest Labour Relations Association. The six Trustees are responsible for the placement and administration of the Plan.

Employer Trustees	**Union Trustees**
J. Roos	P. McGregor
J.F. Mongeau	J. Lawrence
S. Durward	G. Farquhar

The Trustees have appointed D.A. Townley (a wholly owned subsidiary of Pacific Blue Cross) to administer the Plan.

This booklet is an outline of the benefits provided by the Southern Interior Health and Welfare Plan and is not a contract. This Plan only covers those benefits shown in the "Summary of Benefits". Each covered employee may study a copy of the Plan Text at any time by contacting his employer or local union office.

For your information and convenience, we have included references to other negotiated benefits (LTD, Pension) and certain government programs (BC MSP, CPP).

In all cases, the provisions of each Plan Text govern the actual benefits provided.

WHO TO CONTACT

Your employer or local union will have a supply of change of beneficiary forms, change of name forms and claim forms. If difficulties arise in the use of these forms, or if after reviewing this booklet you have any questions regarding your plan, please contact the Plan Office:

PLAN OFFICE / PLAN ADMINISTRATOR

D.A. Townley (a wholly owned subsidiary of Pacific Blue Cross)
4250 Canada Way, Burnaby, BC V5G 4W5
Telephone: 604-299-7482
E-mail: sihwp@datownley.com
Website: http://sihwp.ca

OTHER CONTACTS

BC Medical Services Plan
Coverage for basic medical, surgical and hospital care is provided through the Medical Services Plan of British Columbia. For information you should contact your employer or:

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

Pension / Long Term Disability (LTD)
For information on the Pension Plan or the LTD Plan, you should contact your local union office, your Employer, or the plan administrator, **IWA-Forest Industry Pension and LTD Plans**

Pension Plan queries:	pension@iwafibp.ca
LTD Plan or Rehab queries:	ltdrehab@iwafibp.ca
Main switchboard:	604-433-6310 or 1-800-663-4384 (tollfree)
Pension information:	604-433-5862 or 1-800-913-0022 (tollfree)

SUMMARY OF BENEFITS

Life Insurance *Insured by The Canada Life Assurance Company ("Canada Life")*	$140,000 (Effective Jul 1/19)
Accidental Death & Dismemberment (AD&D) *Insured by Canada Life*	$140,000 Principal Sum (Effective Jul 1/19)
Weekly Indemnity (WI) *Self-insured by the Trust*, paid by Blue Cross Life*	$750/week (Effective Jan 1/23, *thereafter, adjusted to the EI maximum weekly benefit + $100)* 26 week maximum
Dental Plan *Self-insured by the Trust*, paid by Pacific Blue Cross*	Plan A - 80% Plan B - 60% Plan C - 60%, to a lifetime maximum $4,000 per person
Extended Health Care *Self-insured by the Trust*, paid by Pacific Blue Cross*	$75 annual deductible 80% reimbursement $300,000 Lifetime Maximum (effective Jul 1/17) See details in this booklet, but including: • Vision Care - $400 per person per 24 months • Medical Travel - $1,000 per person per calendar year

* Benefits self-insured by the Trust are not insured by an insurance company regulated under the Financial Institutions Act (British Columbia). The Trust is exempt from the requirements of the Financial Institutions Act (British Columbia)."

NOTE: Designated part-time employees are covered for full benefits except that WI is one-half of the regular amount. Cost of benefits other than WI is shared equally between the employer and the designated part-time employee.

ELIGIBILITY AND EFFECTIVE DATE

You must be hired to regularly work four (4) or more days per week by an employer who participates in this Plan unless you work under an approved compressed work week schedule.

Coverage starts on the first day of the month following completion of the probationary period, if you are actively at work; otherwise on the day you are actively at work; except for:

- Group Life Insurance, which starts on the date following completion of your probationary period; and

- Extended Health Care benefits, for which coverage starts on the first day of the month following the date you are hired.

NOTE: Designated part-time employees are also covered, as of date of designation, subject to the approval of the Trustees.

An enrolment card must be completed. These cards are available from your employer.

If you last worked in covered employment under this Plan or a plan arranged between Forest Industrial Relations Limited, Council on Northern Interior Forest Employment Relations, Canfor Limited, or Weldwood of Canada Limited, and USW within the previous 18 months, coverage will commence on the date you start work.

If you return to regular full time employment within 18 months from the time your life insurance coverage was being continued as a disabled employee under one of the plans in the above paragraph (for instance, while you were receiving benefits from the IWA-Forest Industry LTD Plan), your coverage will commence on the date of return to employment.

If you return from leave of absence granted under Article XI, Section 3(a) of the Master Agreement (appointed or elected to Union office), or if you are return to the bargaining unit from a supervisory position, your coverage for Life and AD&D Insurance and Weekly Indemnity will commence on the date of return to employment and your coverage for Extended Health Care and Dental will commence on the first of the month following.

If you are disabled and not at work on the date your coverage is to start, you will be covered under the Plan on the date you return to active employment.

TERMINATION OF EMPLOYMENT

Your coverage for the various benefits provided under the Plan stops at different dates based on the date of termination of your employment which are as follows:

- **Extended Health Care and Dental** - the end of the month in which your termination of employment occurs.
- **Weekly Indemnity and Accidental Death & Dismemberment** – the date of your termination of employment.
- **Group Life Insurance** - 31 days after the date of your termination of employment.

If you are leaving active IWA employment you may wish to continue to provide you and your dependents with individual Extended Health Care and/or Dental benefits provided outside the terms of this Plan by Pacific Blue Cross. Contact your local union, employer or the Plan Office for details.

If you or a covered dependent are in the process of having orthodontic work done when you terminate, work approved prior to such termination will not continue to be paid for by the Southern Interior Health and Welfare Plan.

When your employment ends, your employer will issue you a Transfer Card. **Keep this card** and give it to your new employer. As long as you become regularly employed with a participating employer (or any plan arranged with the Associations and Companies referred to under the Eligibility and Effective Date section of this booklet) within 18 months of your date of termination, your coverage will be immediate, and you will not have to wait until you complete your probationary period.

CONVERSION OF GROUP LIFE INSURANCE

If you die within the 31-day period following termination of coverage, your group life insurance will be paid. In that 31-day period you have the right to convert all or part of your group life insurance to an individual policy without a medical examination.

This can be a valuable option, especially if you are not in good health. Contact your employer, local union or the Plan Office for further information.

The rate charged by the insurance company would depend on your age and on the type of individual policy you choose.

The 31 day period to exercise this conversion option begins to run from the date of termination of employment or end of lay-off extension. It does not run from the end of the month in which termination of employment or end of lay-off extension occurs.

LAYOFF/LEAVES OF ABSENCE

LAYOFF

If you are laid off, your coverage will continue as follows:

- less than 4 months seniority - no layoff extension
- four months but less than one year's seniority - three months extension from exact date of layoff
- one year or more seniority - six months extension from exact date of layoff

Unless you re-establish your coverage by returning to active employment in accordance with the provisions of the Plan:

- **Weekly Indemnity and Accidental Death and Dismemberment** coverage stops on the exact date your lay-off extension ends;
- **Group Life Insurance** coverage continues for 31 days following the exact date your lay-off extension ends; and
- **Dental and EHC** coverage stops at the end of the month in which your lay-off extension ends.

In the event of layoff your employer will issue you a Transfer Card. **Keep this card** to give to your employer when you return to work so that you are always properly covered under the Plan.

REINSTATEMENT OF LAYOFF COVERAGE

Layoff coverage will be reinstated if you return to regular full time employment for ten working days within a floating period of thirty consecutive days. If you return to work for at least one working day and less than ten working days you will be covered for the balance of that month, in addition to any layoff coverage you are entitled to if the recall occurred during the period of layoff coverage.

LEAVES OF ABSENCE

Your coverage under this Plan will continue during the whole period for which leave is granted for the following reasons:

- The period in respect of which you receive compensation from WorkSafeBC, temporary disability wage loss or income continuity benefits.
- The period in respect of which you receive Weekly Indemnity benefits under this Plan.
- If you are suspended, Weekly Indemnity coverage will continue during the period of such suspension; however, benefits will not be paid during your period of suspension. The five day waiting period for disability caused by illness commences from the day following the end of your period of suspension.
- If you are absent on leave of absence granted:
  - because of pregnancy and/or parental leave,
  - for apprenticeship under a provincial apprenticeship program,
  - because of bereavement,
  - for jury duty,
  - for Union business,
  - to campaign as a candidate for Federal, Provincial or Municipal elective public office, or
  - for part time, intermittent service in the capacity of an elected or appointed municipal officer.

If you are on **leave of absence** for compassionate reasons, extended vacation or for educational or training purposes (other than apprenticeship under a provincial apprenticeship program):

- Life and AD&D coverage **will** continue, paid for by your employer.
- Extended Health Care and Dental **will** continue, paid for by you.

- Weekly Indemnity coverage will continue; however, benefits **will not** be paid during your period of leave if you become disabled during your leave of absence. If you become disabled during your leave of absence, the waiting period for Weekly Indemnity, if applicable, commences on the later of:
  - the day following the expiry of your leave or
  - if you are outside the province of B.C., the day you return to B.C. (unless you are confined to a hospital recognized by the B.C. Medical Plan).

If you are on **leave of absence** granted under Article XI, Section 3(a) of the Master Agreement (appointed or elected to Union office), or if you are transferred to a supervisory position, this is treated as a termination of employment for Plan purposes, and coverage ends as described under "TERMINATION OF EMPLOYMENT".

GENERAL INFORMATION

DEFINITIONS

Coverage Effective Date
means the date coverage becomes effective based on the provisions of your collective agreement and the Southern Interior Health & Welfare Plan. These provisions are at the beginning of this booklet under "Eligibility".

Deductible
means the initial portion of the Eligible expenses, which you must pay before we will reimburse charges for any Eligible expense.

Dentist
means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, Dentist may also mean dental specialist or denturist.

Dependent
Your dependents for EHC, Vision Care and Dental include:

- your Spouse; and
- any unmarried child* who is financially dependent on you or your Spouse and is under age 21, or
- any unmarried child* who is financially dependent on you or your Spouse and is under age 26 provided he or she is also in full-time attendance at a recognized educational institute, or
- any unmarried handicapped child* of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Handicap status is subject to approval by Pacific Blue Cross. The Dependent must become handicapped while covered as a Dependent under one of the clauses noted above.

** Child includes a stepchild, legally adopted child, or legal ward (but not a foster child) of you or your Spouse.*

You must be prepared to prove that persons, other than your Spouse, who are claimed as dependents, are actually dependent on you for support.

Note: When a dependent reaches age 21, Pacific Blue Cross will notify your employer that he or she is about to be terminated. If he or she is a student, complete and return the form supplied to ensure continued enrollment. You will be asked to confirm each year that he or she is still in school.

Duplicate coverage
means that you (and your Dependents) are eligible to claim certain benefits under more than one plan.

Fee guide
means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed. For Alberta, the Fee guide means the current Alberta Blue Cross Usual and Customary fee guide.

Fee schedule
means Schedule 2 of the Pacific Blue Cross Fee schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Member
means an employee or other person who has coverage under the Contract.

Physician
means a person legally licensed, certified, or registered to practice medicine and/or surgery, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a

certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Physicians. This excludes a Physician residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Physician based on ineligibility, or based on the Physician's qualifications or conduct.

Practitioner
means a person legally licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for that profession. This excludes a Practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

Spouse
means your legal Spouse or a person who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your Spouse.

ACCESS TO DOCUMENTS

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

LEGAL ACTIONS

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation (e.g. Limitations Act, 2002 in Ontario, Quebec Civil Code).

APPEALS

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

BENEFIT LIMITATION FOR OVERPAYMENT

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days of Canada Life sending you a notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

OUT-OF-POCKET MEDICAL & DENTAL EXPENSES

INTEGRATION WITH GOVERNMENT PLANS

Extended Health Care benefits are intended to supplement and not overlap benefits under government plans such as the Medical Services Plan and Fair PharmaCare Program of British Columbia. You are required, as a condition of coverage, to take all reasonable steps to qualify and obtain the fullest extent of coverage, benefits, contribution, or reimbursement available under all applicable government plans. We will also make payment only where permitted by provincial legislation or other applicable law.

Information on registering for PharmaCare may be obtained from your pharmacist, from the PharmaCare web site, or by calling toll-free in BC 1-800-387-4977.

PharmaCare Formulary

All prescription drugs **on the PharmaCare formulary** ("Full Benefit" drugs) will be directly paid at the pharmacy.

All prescriptions for **PharmaCare "Non-Benefit" drugs** will also be directly paid at the Pharmacy. The yearly maximum for PharmaCare "Non-benefit" drugs is $2,000 per year per family.

For **PharmaCare "Limited Benefit"** drugs, ask your doctor to submit a Special Authorization Request (SAR) to PharmaCare.

- If PharmaCare grants Special Authority for a Limited Benefit drug, it is covered similar to a Full Benefit drug (but see Special Handling below!).
- If you DO NOT have Special Authority for a Limited Benefit drug, OR if you have Special Authority but PBC doesn't know, it is treated to the same as a Non-Benefit drug.

Special Handling for Limited Benefit Drugs if you have Special Authority

- Tell your pharmacist NOT to enter your prescriptions for any Limited Benefit drug with Special Authority on your Southern Interior drug card.
- Most pharmacies can set it up to do this automatically but we suggest you tell the pharmacist every time you fill such a prescription!
- You pay the full cost at the counter, and submit your receipt to PBC for reimbursement, with a copy of the Special Authority approval which PharmaCare gave your doctor.
- The Plan pays 80% of drug costs (net of PharmaCare payment if any) ***(no annual limit!)***

Limited Benefit Drugs are treated this way to ensure you are reimbursed properly, and to protect your family's $2,000 annual maximum, and overall health lifetime maximum.

PBC set up its system to automatically pay up to $2,000 of Non-Benefit drugs at the counter, for your convenience. Unfortunately, without a manual override to show there is a Special Authority approval on file, the system treats Limited Benefit drugs as Non-Benefit.

That means if you have Special Authority for a Limited Benefit drug and you fill a prescription using your Drug Card, the system will pay for it, but only up to the $2,000 limit combined with any Non-Benefit drugs your family may need.

Although it is not required, it is in your best interest to use a PharmaCare Full Benefit drug, or get Special Authorization for a Limited Benefit drug because:

- PharmaCare (PHC) medications can cost far less.
- These less expensive medications usually treat your condition just as well.
- Drugs accepted by PharmaCare will not count towards the $2,000 per year family limit on non-PHC drugs.
- PHC medications, including ones with Special Authority, count towards your PHC deductible. If your family exceeds the PHC deductible in a year, PharmaCare pays 70% to 100% of your drug costs, protecting your overall Plan limit.

IDENTIFICATION (ID) CARDS

The insurer will issue identification (ID) cards for distribution by your employer.

Only you and your enrolled Dependents are entitled to use this card. Should you (or your Dependent) allow an ineligible person to use this card, your coverage may be suspended without notice.

You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent for your group.

CLAIMS

- All claims must be submitted to the insurer in English.
- The insurer will pay eligible claims when we receive all the required information **within the required time limits.** We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.

- Your claim may be rejected if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled.
- The necessary claim forms are available from your employer.
- The exchange rate on foreign currency is payable at the rate quoted by selected financial institutions in Vancouver, British Columbia, for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

DUPLICATE COVERAGE

If you and your Spouse work for different employers and you are both enrolled for similar benefits, Duplicate coverage is allowed, except Duplicate coverage is **not** allowed when you and your Spouse are both working for employers who **participate in the Southern Interior Health & Welfare Plan.** In this situation, if your Spouse also works for your employer or another employer participating in this Plan (and is eligible for coverage), each of you should enroll under your own ID number. Only one of you may enroll Dependent children.

If you are eligible for Duplicate coverage, you and your family should discuss both plans (and what portion of the benefits you pay) to determine whether it is to your advantage to enroll under more than one plan.

Your employer will advise you if you are eligible to waive certain benefits under this group plan.

COORDINATION OF BENEFITS

If Duplicate coverage is allowed, the insurer pays claims based on the Canadian Life and Health Insurance Association guidelines. They are:

The member is always the primary claimant. The Spouse is always the secondary claimant.

Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).

In situations of separation or divorce, the following order applies:

1. the plan of the parent with custody of the child
2. the plan of the Spouse of the parent with custody of the child
3. the plan of the parent not having custody of the child
4. the plan of the Spouse of the parent in c) above

Total reimbursement shall never exceed 100% of the Eligible expenses.

EXTENDED HEALTH CARE (EHC)

(For Employees and Dependents)

The Extended Health Care Plan assists you in paying for many of your medical costs that are not covered by Basic Medical. You must submit proper receipts in order to be paid.

DEDUCTIBLE, REIMBURSEMENT AND MAXIMUM

Deductible*	$75 per person or family each calendar year (eff. Jan 1/07)
Reimbursement	
• In-Province Eligible Expenses	80%**
• Out-of-Province Non Emergency Eligible Expenses	80%**
• In-Province Medical Travel Allowance Eligible Expenses	100%
• Out-of-Province Emergency Eligible Expenses	100%
Lifetime Maximum***	$300,000 per person (eff. Jul 1/17)

* The Deductible does not apply to In-Province Medical Travel Allowance Eligible expenses. If in any calendar year the Eligible expenses do not exceed the Deductible, the Eligible expenses incurred during the last 3 months of the calendar year may be applied against the Deductible for the next year.

** Effective January 1, 2023, after $1,000 has been paid for an individual in a calendar year, further Eligible expenses for that individual within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.

*** This maximum may be reinstated after each two calendar year period of continuous membership, if satisfactory evidence of complete recovery and return to good health is provided to the Plan.

IN PROVINCE ELIGIBLE EXPENSES

Note: If you live in the vicinity of the Alberta border and you receive treatment in Alberta your claim will be processed the same way as if the expenses had been incurred in British Columbia.

The Plan pays for the following eligible expenses, **subject to the deductible, reimbursement percentage and lifetime maximum as noted above**, when medically required and ordered by your attending physician:

- vision care expenses including lenses, frames, contact lenses, laser eye surgery, and/or eye exams to a maximum of $400 per person in any 24 consecutive month period, when prescribed by a person legally qualified to make such prescription.
- charges made by a hospital in British Columbia, including the normal daily hospital charge for a private or semi-private room if a ward room is not available or if required by a physician.
- charges for the differential from standard ward to semi-private or private room accommodation in extended care units of acute care general hospitals.
- daily rate of $18.00 for confinement due to the treatment of alcohol or drug abuse providing that the treatment is provided by a recognized treatment program.
- fees of a private nurse registered with the Registered Nurses Association of British Columbia who is not related to or resident with the member, and when ordered by the attending physician or surgeon for acute care (i.e. up to 30 days), provided the fees are not covered by the Medical Services Plan of BC or other Provincial Programs.

- charges for drugs and medicines prescribed by a physician and purchased from a pharmacy. Normally there is a maximum of 34 days supply per prescription, except when a larger supply is necessary and more economical, in which case a maximum of 100 days supply is allowed.

  Charges for oral contraceptives, vaccines, erectile dysfunction drugs, drugs for suppression of an addiction (e.g. to nicotine) and drugs not requiring a prescription are not included.

  See "Integration with Government Plans" in this booklet.

- fees for professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances, tray fees and X-rays. *Only the services of a private duty nurse require referral by a Physician except where noted*. (X-rays excluded);

  - Chiropractic treatment rendered by a Registered Chiropractor and Naturpoathic treatment rendered by a Registered Naturopath, to a combined annual maximum of $550 payable for each per member or dependent.
  - Physiotherapy treatment rendered by a Registered Physiotherapist, to an annual maximum of $550 for each member or dependent, with extended coverage with referral from a qualified Medical Practitioner*
  - Massage therapy treatments rendered by a Registered Massage Therapist, to an annual maximum of $550 for each member or dependent, with extended coverage with referral from a qualified Medical Practitioner*.
  - Podiatry treatments rendred by a Registered Podiatrist.
  - Acupuncture treatments rendered by a Registered Acupucturist and Speech Therapy, to an annual maximum of $100 benefit payable per person for each type of practitioner service, when services are provided in B.C.
  - Psychology rendered by a Registered Psychologist and Counselling rendered by a Registered Counsellor, to a

combined annual maximum of $1,000 for each member or depedent.

* As the $550 limit is reached for Massage or Physiotherapy, you should submit a doctor's note to PBC explaining the medical need for additional treatment. If the limit is reached before you submit the doctor's note, PBC will not pay beyond the $550. In that case, we suggest you resubmit the unpaid expenses by mail together with the doctor's note. Once PBC has the doctor's note on file, later claims can be submitted either electronically or on paper.

- charges for oxygen, ostomy or ileostomy supplies, catheters, gloves for persons who use wheelchairs, bath bench suction cups, prosthetic appliances (artificial limbs, eyes), crutches, splints, casts, trusses or braces when required by a physician.
- charges for continuous glucose monitor and supplies, flash gluose monitors and supplies, subject to specifici claiming criteria.
- rental fee (not to exceed the total purchase price) of a wheelchair, hospital type bed, ventilator, respirator, hydraulic lifts for getting in and out of bathtubs or necessary equipment for therapeutic treatment required by a physician. If more economical, these items may be purchased, and as necessary, replaced, subject to pre-approval by the insurance carrier.
- cost of repairs to durable specialty equipment such as wheelchairs and hospital beds, including replacement parts and new tires for wheelchairs.
- return fare for transportation of a patient in an emergency by ambulance, railroad, boat or airplane, or in an acute emergency by air ambulance, from the place where the Sickness or Injury occurs to the nearest Hospital, where such transportation is advised by a Physician, including the return fare of one attending Physician, nurse or first aid attendant when necessary in the opinion of the attending Physician to care for the patient during transportation. In an acute

emergency, the advice of a Physician is not required for transportation by ambulance. Expenses for the following are not eligible:

- transportation arranged at the patient's convenience;
- transportation arranged after waiting for hospital accommodation for a condition not requiring immediate transportation to the hospital; and
- transportation for the removal of a patient from one hospital to another except in cases where the hospital from which the patient is removed has inadequate facilities to provide the required treatment.
- fees of a dentist for repairs to natural teeth (not dentures) when injury is sustained to such natural teeth by extra oral accidental means and while the person is covered by this Plan and when such treatment occurs within one year of the date of accidental injury.
- cost of orthotics, modifications to stock footwear, or orthopedic shoes (in that order) as medically required
  - when prescribed by a Physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, custom made orthopedic shoes (including repairs) and modifications to stock item footwear. A custom made orthopedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg
  - when prescribed by a Physician, podiatrist, chiropractor, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotic. A custom made orthotic is one fabricated from raw materials using a three dimensional volumetric model of the patient's feet
- charges for hearing aids when prescribed by the attending certified ear, nose and throat Specialist. The maximum benefit during a five year period is $550 payable per member

or dependent and includes payment for repairs and maintenance, subject to the financial limit. Batteries, recharging devices or other such accessories are not eligible expenses.

- charges made by a physician for medical examination required by Government statute or regulation for employment purposes, provided such charges are not covered by the employer under a collective agreement and provided no claim has been made under the Basic Medical Plan.

OUT-OF-PROVINCE EMERGENCY ELIGIBLE EXPENSES

The Plan pays for the following eligible expenses, subject to the deductible, reimbursement percentage and lifetime maximum as noted above, when medically required and ordered by your attending physician:

- hospital room charges and/or supplies for confinement, in the event of an emergency while travelling or on vacation, in an acute care general hospital over and above the charges covered by any other underwriter or the Medical Services Plan of BC.
- reasonable charges for physicians or surgeons services in an emergency while travelling or on vacation outside B.C. over and above the amount allowed under the British Columbia Medical Association Schedule of Fees in effect at the time.

MEDICAL TRAVEL ALLOWANCE ELIGIBLE EXPENSES

This benefit is intended to provide a medical travel allowance for **necessary medical travel** from remote areas when members or their dependents are referred by their attending physician to Medical Specialists in B.C. or, where applicable, in Alberta to the nearest site of available service and where the round trip travel is in excess of 500 km from the site of their employment.

"Medical Specialists" as defined in the Plan are persons duly licensed and registered as specialists in the practice of medicine. For instance, an oncologist or orthopedic surgeon is considered a "Medical Specialist", but not dentists, nurses, chiropractors, physiotherapists and so on, no matter how "specialized" their work is.

Maximum Allowance

The maximum allowance payable on behalf of any member or dependent is $1,000 in any calendar year.

Expenses Covered

Eligible Expenses include the following:

- regularly scheduled economy class air fare
- reasonable hotel accommodation (based on the reasonableness of the member or dependent being unable to return home on the day of the referral). Due to Canada Revenue Agency regulations, accommodation expense can only be reimbursed on submission of a hotel receipt. No "per diem" in lieu of hotel receipt can be recognized.
- taxi fares, bus fare or other public transportation
- travel by private automobile at 30¢ per kilometer including ferry fares and highway tolls if applicable; OR travel by public transport (e.g. inter-city bus); NEITHER of which may exceed the equivalent regularly-scheduled economy air fare
- transportation of an attendant for the patient being transported when ordered by the physician.

Some Conditions That Apply To Medical Travel Allowance

- All medical referrals must be in writing on the Plan's **Medical Travel Allowance Referral And Claim Form**, and the completed form must be submitted to the insurer at the address shown on the form.
- The travel (subject to this benefit) must take place within two months of the physician's referral unless the earliest possible date of availability of the Specialist is beyond two months from the date of the referral.
- A claim form (with the original medical referral) together with the original receipts must be filed by the member within 90 days of the date eligible expenses are incurred.
- Expenses which are payable under WorkSafeBC or by the Medical Services Plan of B.C., the Insurance Corporation of B.C. or any other government agency or insurance plan will not be eligible for reimbursement from this Plan.
- Medical Travel is applicable for travel in excess of 500 kilometers on a round trip basis **to the closest location where the specialist medical service is available.** However, if the required Medical Specialist service is available within the 500 kilometer round trip area but the same service is available outside the area at an earlier date and it is proven to the satisfaction of the Trustees that the service was necessary medically at the earlier date, eligible expenses of such referral may be payable under this Plan.

Other Assistance

Other assistance may be available to you in the form of travel cost discounts through the **Medical Services Plan Travel Assistance Program (TAP).** Further information about TAP may be obtained by calling 1-800-661-2668.

ITEMS NOT PAID FOR BY YOUR EHC PLAN

Items not covered include:

- Any expenses for which the Medical Services Plan of British Columbia, or Fair PharmaCare is liable.
- Dental treatment (except as outlined above under “eligible expenses”)
- Rest cures, travel for health or health examinations of any kind.
- Any illness or accident provided for by the Workers' Compensation Act or any government authority.
- Expenses related to, or as a result of war, riot or insurrection of any kind.
- Expenses incurred if the person is hospitalized at the time of enrollment in this Plan.
- Services or supplies where it is established that a third party is liable at law.
- Any portion of the fee of a medical or dental practitioner not allowable under the Provincial Medical Plan as a result of non-referral.
- Any amount of fees in excess of the usual or recognized fees for the service performed.
- Expenses incurred outside the Province of British Columbia or Alberta (where applicable) unless resulting from an unexpected sickness or injury occurring while temporarily travelling outside the Province and then only to the extent provided under “Eligible Expenses”
- Expenses for services and supplies for wholly cosmetic purposes.

- Expenses caused, contributed to or necessitated as a result of:
  - sickness or injury which was intentionally self-inflicted, whether sustained or suffered while sane or insane; or
  - the commission by the person of any unlawful act including an offence under the Criminal Code of Canada.
- Expenses incurred for orthopaedic treatment, eyeglasses, contact lenses, hearing aids, or prescriptions for any of them except as specifically provided under "eligible expenses".
- Any amount exceeding the fee under the schedule of costs prescribed by the MSP-BC, except as specifically provided under " eligible expenses ".
- The cost for medical services which exceed the amount payable under the MSP-BC, whether or not the medical practitioner is a participant in the MSP-BC, except as specifically provided under “Out-of-Province”.
- Any expense which does not arise as a result of sickness or injury except for expenses arising out of loss or impairment of faculties, as specifically provided under " eligible expenses”.

HOW TO MAKE AN EHC CLAIM

The following notes may help you avoid delays in claims payment.

Pay Direct

1. Provided your pharmacy is connected to the insurer's electronic processing system, the insurer will pay them directly for prescription drugs and testing supplies for diabetics covered under your EHC plan. Simply show the pharmacist your EHC ID card.

   Only prescription drugs **on the PharmaCare formulary** will be directly paid at the pharmacy. See the "Integration with Government Plans" section of this booklet.

2. The pharmacist will charge you only for amounts not covered by the Plan. If your pharmacy does not have access to this system, or for other types of expenses, please follow the instructions below.

Paper Claims

1. Because the insurer does not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit for your records, or in case your claim is lost in the mail. The insurer will send you an Explanation of Benefits (EOB) statement for your records each time you submit a claim.

2. If you have duplicate coverage, please review the *Coordination of Benefits* section of this booklet. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The EOB statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on this Plan's files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.

3. Certain medical expenses are covered under the government plan. If you submit your claim to the insurer before you submit your claim to the government plan, we will deduct what the government plan would normally pay (e.g. Fair PharmaCare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan coverage. You will find information on registering for Fair PharmaCare in the "Integration with Government Plans" section of this booklet.

4. Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:

    a. Obtain a claim form from your employer or the Plan Office.

    b. Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).

    c. We suggest you submit claims within **90 days** from the date the expense was incurred. However, **we must receive the claim form by December 31st** of the year following the calendar year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.

    Example: **We must receive your receipts for 2021 before December 31, 2022.**

DENTAL PLAN

(For Employees and Dependents)

DEDUCTIBLE, REIMBURSEMENT AND MAXIMUM

Deductible	Nil
Reimbursement	
• Plan A	80%
• Plan B	60%
• Plan C	60%
Plan C Lifetime Maximum	$4,000 per person

PAYMENT OF BENEFITS

The services covered by the Plan are those services that are routinely performed in the offices of general practising dentists. Covered services are only those services listed in the Fee schedule.

The amount paid will be based on th Fee schecule, or the dentists' usual and customary fee, whichever is less. The Plan pays for services performed by a specialist, in accordance with The Fee Schedule, providing you have been referred by a general practitioner.

The Plan pays benefits based on dental services, financial limits, and treatment frequencies in the Fee schedule.

The Plan applies the reimbursement percentage shown in the Schedule of Benefits to the fees shown in the Fee schedule/Fee guide as follows:

- for services performed in British Columbia or outside Canada, if your province of residence is British Columbia - the fees in the Fee schedule.

- for services performed in Canada but outside British Columbia - the fees in the Fee guide in the province/territory of service.
- for services performed outside Canada if your province of residence is not British Columbia - the fees in the Fee guide in your province/territory of residence.

Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

When the dentist has completed the work, they will complete a claim on your behalf and forward it to PBC for payment. If your dentist does not wish to forward the claim directly to PBC, you can arrange to pay the dentist yourself and be reimbursed by PBC.

PLAN A – BASIC PREVENTIVE & RESTORATIVE SERVICES

The benefits under this section are those services that are routinely performed in the offices of a general practitioner and are required to maintain teeth in good order as well as normal restoration services to restore them to good order.

Diagnostic Services

- examinations:
  - complete - 1 per lifetime by a general practitioner and 1 per lifetime by a specialist
  - recall - 2 per calendar year for persons under age 17 and 1 every 9 months for persons age 17 or older
  - specific - 2 per calendar year
  - consultations (as a separate appointment)
- x-rays
  - diagnostic ("bite-wing") - 1 every 18 months for the same teeth
  - panoramic - 1 per 5 year period
  - complete mouth series - 1 per 3 year period
  - All x-rays combined shall not exceed the dollar limit for a complete mouth series.

- diagnostic models - 1 set per calendar year.

Preventive Services

- scaling, root planing, and gingival curettage - a combined limit shown in our Fee Schedule
- polishing - 2 per calendar year for persons under age 17 and 1 every 9 months for persons age 17 or older
- topical application of fluoride - 2 per calendar year for persons under age 17 and 1 every 9 months for persons age 17 or older
- fixed space maintainers
- preventive restorative resins and pit and fissure sealants - combined limit of 1 per tooth in a 2 year period. No age limit.

Surgical Services

All necessary procedures for extractions and other surgical procedures normally performed by a general practising dentist.

Endodontic Services (Root Canals)

Treatment of disease of the pulp chamber and pulp canal.

Periodontic Services (Gums & Bones)

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

Restorative Services

All necessary procedures for filling teeth with amalgam silicate (synthetic porcelain), acrylic (plastic), and composite resin restorations for restoring of tooth surfaces which have been broken down as a result of decay process, including stainless steel crowns. The tooth surface is covered only once, regardless of the number of restorations placed thereon or therein.

Inlays and Onlays
Inlays, onlays and gold foils will be covered only when other materials cannot be used satisfactorily. Patients choosing gold where other materials would suffice will be responsible for the difference in cost. In any event, prior approval of such work is suggested.

Prosthetic Repair Services & Relines
The Plan covers the repair of a fixed appliance and the repair or reline of removable appliances. Repair or reline of a removable appliance may be done by a dentist or licensed dental mechanic. Relines will not be covered more often than once in any 24 month period. Services of a temporary nature pending fabrication of a new denture are not covered.

PLAN B – MAJOR RESTORATIVE SERVICES

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 five years.

Crowns
For rebuilding natural teeth where other restorative material cannot be used satisfactorily. Certain materials will not be authorized for use on back teeth. Prior approval of such work before proceeding is suggested.

Prosthetics
- Removable Prosthetics - Full upper and lower dentures or partial dentures. These will not be provided more often than once every five years. Full upper and lower dentures may be provided by a dentist or a duly licensed dental mechanic. Partials may only be provided by a dentist.
- Crowns and Bridges - To artificially replace missing teeth with a fixed prosthesis. These will not be provided more than once every five years.

PLAN C – ORTHODONTICS

The benefits under this section are orthodontic services performed by an Orthodontist. **Appliances lost or stolen will not be replaced.** Before commencing treatment a complete Orthodontic Treatment plan form must be submitted to PBC for approval.

SERVICES NOT COVERED

Dental benefits do not cover payment for:

- Treatment covered by WorkSafeBC or publicly supported plans.
- Services required as a result of an accident for which a third party is liable.
- Services purely cosmetic in nature or with respect to congenital malformations, temporary dentistry, oral hygiene instruction or tissue grafts.
- Anaesthetics.
- Implants for dentures and bridgework.
- Charges for completing forms.
- The cost of replacing lost or stolen orthodontic appliances.
- Services performed after Date of Termination even if an approved treatment plan is in progress. However, completion of procedures for endodontic treatment, Dentures, or crown and bridge work, commenced prior to the Date of Termination, will be considered work in progress and will be reviewed for payment if completed within 30 days of the Date of Termination.
- Charges for services commencing prior to date of coverage.
- recent duplication of services by the same or different Dentist.

Where a covered employee or dependant is entitled to coverage under more than one plan, benefit payment will be

coordinated so that the total payment received does not exceed 100% of dental expenses actually incurred.

EMERGENCY TREATMENT

Emergency dental care will be provided anywhere in the world. If while you are travelling or on vacation outside of British Columbia, you require dental care as a result of an emergency, you are entitled to services of a fully qualified dentist in the event of such emergency, and will be reimbursed up to the amount that the Plan would have paid had the services been rendered in British Columbia. Itemized statements must be provided with claims.

HOW TO MAKE A DENTAL CLAIM

Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us before you start treatment. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.

We suggest that you submit claims within 90 days of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, we must receive the claim form within 12 months from the date the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.

Example: We must receive your receipts for dental work done on March 15th, 2021, no later than March 14th, 2022.

We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:

- name of the Dentist
- name and birthdate of the person receiving the dental care
- your policy and identification numbers (this information is on your ID card)
- your home mailing address
- whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms

(one for each plan). Incomplete claims will be returned for clarification.

Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:

- We will pay the Dentist directly for services provided under this dental plan when we receive a claim form signed by the Dentist, certifying these services were performed and the fee charged.
- If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive a claim form or receipts signed by your Dentist. We will send you a cheque when the claim is processed.

Orthodontic Claims Procedures

Receipts

Because we do not return original receipts, we will accept photocopies. Do not hold receipts until the completion of treatment.

Treatment plan

Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts. If the payment schedule or treatment changes, we require a revised treatment plan for review.

We will retain your treatment plan on file. If we do not have your treatment plan on file we are unable to pay your initial fee/down payment, your monthly/quarterly fees, or one time appliance fees.

Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

Monthly or quarterly fees

Submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses.

The amount paid will be prorated 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 your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

DEATH BENEFITS

(For Employees)

GROUP LIFE INSURANCE

The amount shown in the Summary of Benefits, will be paid on your death to your named beneficiary.

ACCIDENTAL DEATH

If you die because of an accident, your beneficiary will receive an additional sum as shown in the Summary of Benefits. Your accidental death must occur within 365 days from the date of the accident.

"Accidental" refers to a death or loss as a direct result of bodily injuries occasioned solely through external, violent and accidental means, without negligence on your part. The death or loss must occur before your 80th birthday and within 365 days of the date of the accident. There are special provisions for accidental exposure to the elements or disappearance.

Your death will not be considered an accident if it is caused by:

- Suicide while sane or insane;
- Intentionally self-inflicted injury while sane or insane;
- Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed;
- Any drug, poison, gas or intoxicant, taken, administered, absorbed or inhaled, voluntarily or otherwise with the exception of occupational related accidents;
- Disease or infirmity;
- Medical or surgical treatment;
- Service, including part-time or temporary service, in the armed forces of any country;

- War, insurrection, or voluntary participation in a riot;
- Air travel, ascent, or descent, except in a licensed aircraft flown by a pilot certified to fly the aircraft. Under no circumstances will benefits be paid where the person who suffers the loss is acting as a crew member unless the aircraft is owned, leased, or rented by the employer.

YOUR BENEFICIARY

When you enroll in the Plan you must indicate who you wish to receive your life insurance and/or accidental death insurance in the event of your death.

You may change your beneficiary at any time by completing a form that is available at your local union or from your employer.

If no beneficiary is designated the benefit will be paid to your estate, which may cause delays and the payment of probate fees and taxes. Also, if you have creditors, they could "attach" your estate, but not payments made to a beneficiary.

CLAIMS

On your death, your beneficiary or the administrator of your estate may obtain the necessary forms from your local union or from your employer. After completion by your beneficiary, employer and attending physician, they should be sent to the Plan Office.

OTHER BENEFITS

Your survivors should also contact the Canada Pension Plan to claim the lump sum death benefit and, if applicable, monthly pension (payable to spouses) and dependent children benefits.

If your death is as a result of an on-the-job accident or illness, benefits may also be payable to your survivors from WorkSafeBC.

Your beneficiary may also be entitled to a pension benefit from the IWA - Forest Industry Pension Plan.

DISABILITY BENEFITS

(For Employees)

For absences from work as a result of a non-occupational accident or illness the Weekly Indemnity (WI) Plan provides a payment in the amount shown in the Summary of Benefits for a maximum of 26 weeks.

If you receive Workers' Compensation Board wage loss or income continuity benefits for the same disability, any Weekly Indemnity Plan benefit payments for which you may become eligible (WI benefits are not payable during a WCB wage loss or income continuity benefit payment period) will be limited to a benefit payment period that, when combined with the Workers' Compensation Board benefit payment period, does not exceed 26 weeks.

CLAIM DEADLINE

- You must notify your employer of your absence due to injury or illness. Failure to do so may disqualify you from eligibility to have your claim processed as you may be classified as absent without leave.
- See your doctor promptly when you become disabled by illness. If you do not see your doctor **within six days,** benefits cannot start until the day you see you doctor
- Notice of claim must be given to the Plan Administrator within thirty (30) days of your injury or illness and proof of disability submitted within ninety (90) days.

If you fail to submit your claim on time, YOUR CLAIM MAY BE DENIED!!

This is required for ALL CLAIMS, including claims for WI benefits while your WorkSafeBC claim is held up (see following pages).

CLAIMS

Claim forms for WI benefits are available at your local union, from your employer, and on the Plan's web page.

The WI Claim Form has four parts:

1. EMPLOYEE'S STATEMENT to be completed by you.

2. REIMBURSEMENT AGREEMENT AND DIRECTION to be completed by you if your disability resulted from an accident where a third party is involved.

3. EMPLOYER'S STATEMENT to be completed by your employer.

4. ATTENDING PHYSICIAN'S STATEMENT to be completed by your doctor, with all clinical notes, consultation reports and test/investigation reports from the date disability started to the current date.

You must complete the "Employee's Statement." *If you wish, you can complete it online, then print the form and sign it, or your employer or local union can supply the blank form.* Your employer must complete the "Employer's Statement" and your doctor must complete the "Attending Physician's Statement". *ALL NINE PAGES* of the completed claim form is to be sent to:

Southern Interior Health and Welfare Plan
c/o Blue Cross Life
PO Box 7000
Vancouver, BC V6B 4E1

Alternatively, you may return the claim form to your employer who will send it to Blue Cross Life on your behalf.

SOME CONDITIONS OF THE WEEKLY INDEMNITY PLAN

- You must remain under the care of a doctor of medicine or a chiropractor throughout your period of disability and the attending physician must support your inability to work.
  - A physiotherapist's certification of your disability is not acceptable unless you have been referred for treatment by your doctor and your doctor continues to support your absence from work.
  - If you are treated only by a dentist or a dental surgeon, the maximum payment period is 2 weeks.
- The claims office at Blue Cross Life may request that you have an independent medical examination. Blue Cross Life arranges for the appointment and the Plan pays for any charges made by the physician (examination fees, etc.).
- If your disability results from sickness, payments from the WI Plan start from the earliest of:
  - date surgery is performed
  - date you are hospitalized
  - your sixth day of absence from work. In this case, **you MUST see your doctor within six days**. Otherwise, benefits cannot start until the day you see you doctor.

  Surgery includes laser surgery, except where such surgery is for cosmetic purposes rather than for a medical reason. Payment also begins on the first day of disability due to radiation or chemotherapy treatment for cancer.
- If your disability is a result of an accident (an unexpected occurrence over which you have no control), or injury caused by domestic violence, benefit payments start from the first day of disability. Disabilities caused by overexertion are subject to the waiting period.
- Payments are made for a maximum of 26 weeks for any one absence (regardless of the number of disabilities).
- Absences due to the same or related causes will be considered one continuous absence unless you return to

work on a regular full-time basis for at least four continuous weeks between absences.

If you do return to work for at least four continuous weeks and you are again disabled, there may be another waiting period before benefit payments start.

- Benefits shall be payable with respect to absences due to disability resulting from pregnancy related illnesses or injuries, except that such benefits shall not be payable during a period when pregnancy benefits are payable under the Employment Insurance Act or during a period of maternity leave taken in accordance with the British Columbia Southern Interior Master Agreement.
- No WI benefits will be paid during your period of regular holidays with pay which you take in accordance with the Employment Standards Act and the Southern Interior Master Agreement. Regular paid vacation days while you are disabled may however count toward your waiting period for WI benefits.
- If your injury or illness is job related, wage loss benefits must be claimed from the WCB. If you are having a problem with a WCB appeal or there is a delay in the processing of your WCB claim, contact your local union or employer. If WI benefits are paid, you must be under the care and treatment of a qualified practitioner and you must sign an agreement promising to pay back the WI benefits if your WCB claim is settled in your favour.
- If you are receiving permanent partial disability benefits from WCB for the same or related disability, your WI benefit will be reduced by the amount your permanent partial disability benefit exceeds $50 per week.
- If your disability is wholly or partially attributable to a third party you will be required to sign a reimbursement agreement before receiving WI benefits. Under the terms of this reimbursement agreement you will be required to pursue a settlement from the third party. If you are

successful with your third party claim you will be required to reimburse the Plan in accordance with the Plan Text.

- No WI benefits will be paid while you are working for any employer and receiving remuneration except if you are working in rehabilitative employment approved by your doctor and the Trustees of the Southern Interior Health and Welfare Plan under the graduated return to work program or by your Doctor and Trustees of the IWA - Forest Industry LTD Plan.
- While you are on leave of absence for compassionate reasons or educational or training purposes (other than for apprenticeship under a provincial apprenticeship program), or extended vacation, WI coverage is not provided.
- No WI benefits will be paid while in receipt of a benefit from the IWA-Forest Industry Pension Plan.
- No WI benefits will be paid for any period during which you are an inmate in a penitentiary or jail.
- No WI benefits will be paid for disabilities resulting from
  - insurrection, war, participation in a riot, or service in the armed forces of any country;
  - the commission of an unlawful act;
  - intentionally self-inflicted injury or illness while sane.
- No WI benefits will be paid for a disability resulting from the use, consumption, or ingestion of any addictive or intoxicating substances including but not limited to drugs and alcohol, unless the covered person is participating in a treatment program approved by BC Life on the following criteria:
  - there must be an assessment, a treatment plan, and monitoring and follow up as determined by a Substance Abuse Professional (SAP). A SAP is firstly qualified as a licensed physician, licensed or certified social worker, psychologist, employee assistance professional, marriage and family therapist, or an alcohol and drug abuse

counselor. These professionals are also required to have specialized training and certification by examination to qualify as a SAP.

- there must be participation in early rehabiliataion services offered by Evergreen Management Society.

IF YOU HAVE A PROBLEM WITH YOUR CLAIM:

In the event of a claim problem, you should call your employer or local union office.

Some problem claims are brought to the attention of the Trustees of the Plan for discussion.

WAGE INDEMNITY CHEQUES:

Payments are processed every two weeks. On the claim form you may choose to have your weekly indemnity cheque sent directly to your mailing address. If you do not make this selection on the form, your cheque will be sent to your employer, who will make arrangements for the delivery of your cheque.

There is now a provision that allows you to choose direct deposit to your bank account. The form required to choose direct deposit is available to you at your local union office, from your employer, or on the Plan Office website.

CASE MANAGEMENT

A new case management service of the Plan gives you more than just financial help. It can help speed your recovery. It can help lessen the stress and confusion of dealing with the medical system and it can help you return more quickly to your job and to the life you enjoy.

For more information, see the Plan's brochure "When illness or injury puts your life on hold …". You can get a copy from your Local Union, Employer, or from the Plan Office.

HOW YOUR BENEFITS CONTINUE WHILE YOU ARE DISABLED

While you are disabled and receiving weekly indemnity or WorkSafeBC compensation or income continuity benefits, your coverage under all of the benefits provided by the Southern Interior Health and Welfare Plan continues while your employment continues.

If your employment is terminated for any reason while you are disabled then:

- Dental, Extended Health Care and AD&D end.
- Weekly Indemnity and Group Life insurance continue while you remain disabled and in receipt of temporary wage loss benefits.

When your weekly indemnity or WCB wage loss or income continuity benefits stop, if you are still totally disabled your life insurance will be maintained until you reach age 65 or until you recover, at no cost to you.

Your life insurance is maintained automatically while you are in receipt of benefits from the LTD Plan. When your LTD benefits end, you will be asked to have your doctor complete a physician's statement. If you remain totally disabled, life insurance coverage will continue to age 65. Satisfactory proof of disability must be provided to the Trustees when requested.

This continued coverage is provided for both job related disabilities and disabilities that do not result from your occupation. If you are totally disabled as a result of a work-related accident or illness you must contact your employer or local union when your wage loss benefits stop and apply for continued group life coverage. Satisfactory proof of disability must be provided to the Trustees.

OTHER BENEFITS THAT MAY BE AVAILABLE TO YOU

Long Term Disability Benefits

Your local union and employer have copies of booklets that describe the benefits available under this program. The earliest date LTD benefits are payable is after you have been disabled for 26 weeks. You should apply well in advance of that time to ensure your disability benefits are continuous. If you qualify, coverage for you and your family under the Provincial Medical Plan, Extended Health Care and Dental benefits will be provided by the IWA - Forest Industry Long Term Disability Plan.

Canada Pension Plan

For both occupational and non-occupational disabilities, pensions (and monthly payments on behalf of dependent children), may be available from the Canada Pension Plan, provided you satisfy its requirements.

Accidental Dismemberment

(Including Disabilities resulting in Paralysis, Loss of Hearing, etc.)

Disclaimer: the specific schedule of benefits and ancillary benefits in this section are features of the current contract of insurance, and are subject to change in the future should the contract of insurance change.

If you are injured and within 365 days of the accident date, you suffer any of the following losses, the Principal Sum shown in the Summary of Benefits, or the appropriate fraction of this sum shown below may be payable to you from the Accidental Death and Dismemberment Plan.

Loss	% of Principal Sum
Loss of both hands or both feet	100%
Loss of entire sight of both eyes	100%
Loss of one hand and one foot	100%
Loss of one hand and entire sight of one eye	100%
Loss of one foot and entire sight of one eye	100%

Loss of speech and hearing in both ears	100%
Loss of use of both arms or both hands	100%
Loss or loss of use of one arm or one leg	75%
Loss of one hand or one foot	66 2/3%
Loss of entire sight of one eye	66 2/3%
Loss of use of one hand	66 2/3%
Loss of speech, or of hearing in both ears	66 2/3%
Loss of thumb and index finger of same hand	33 1/3%
Loss of all four fingers of same hand	33 1/3%
Loss of hearing in one ear	25%
Loss of all toes of same foot	12 1/2%
Quadriplegia (complete paralysis of both upper and lower limbs)	100%
Paraplegia (complete paralysis of both lower limbs)	100%
Hemiplegia (complete paralysis of upper and lower limbs of one side of the body)	100%

Maximum Benefit
If one accident results in more than one of the losses above, payment will not exceed 100% of the principal sum.

Definitions
"Loss" means complete severance, as defined in the contract for each listed body part.

"Loss of sight, hearing or speech" means total and irrecoverable loss of that faculty, so that it cannot be recovered or partially recovered by the use of a device or rehabilitative program.

"Loss of use" means total and irrecoverable loss of use for a continuous period of twelve months. The loss must be caused by tendon, nerve or bone damage.

"Paralysis" means complete and irreversible paralysis caused by brain, spine, muscle or nerve damage, which has continued for a continuous period of 12 months.

Additional Benefits
When you receive one of the above payments, or your beneficiary receives the Accidental Death benefit, one of the following additional benefits may be payable. Ask your employer, local union, or the Plan Office for details.

- **Rehabilitation** - payment for special training
- **Repatriation** - transportation of your body to your city of residence
- **Family Transportation** - attendant accompanying the member to treatment
- **Spousal Occupational Training** - to assist your widow(er) returning to work
- Home Alteration or Vehicle Modification - to accommodate the disabled member

Exclusions
Benefits are not payable for any loss which results from or is caused, directly or indirectly by any of the causes excluded under Accidental Death, or from a cause which does not meet the definition of “Accidental” (see Accidental Death).