Operating Engineers' Benefits Plan 000115

PACIFIC BLUE CROSS™

OPERATING ENGINEERS' BENEFITS PLAN

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Group Name and Benefit Providers

Operating Engineers' Benefits Plan

Effective: January 1, 2013

Pacific Blue Cross: 000115
Extended Health Care
Dental Care

Great-West Life: 165806 & 165807
Member Basic Life Insurance
Spousal Basic Life Insurance
Optional Life Insurance
Accidental Death, Dismemberment and Specific Loss (AD&D)
Long Term Disability (LTD) Income Benefits Policy
(604) 331-2430 (Life and AD&D)
(604) 455-2700 (LTD)

Operating Engineers' Benefits Plan
Weekly Disability Benefits
(604) 299-8341

Homewood Human Solutions
Member & Family Assistance Program

Vancouver/Lower Mainland	**604-689-1717**
British Columbia or anywhere in North America	**1-800-663-1142**
International (call collect)	**604-689-1717**

Medical: 3131158 and 32698
Medical Services Plan of British Columbia
Alberta Health and Wellness

Introduction

This booklet contains information about your group benefits provided through the Operating Engineers' Benefits Plan. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Operating Engineers' Benefits Plan Document and the group contracts with Pacific Blue Cross (PBC) and Great-West Life (GWL).

This plan does not permit a Member or Dependent to designate a personal representative or a beneficiary to receive Extended Health Care or Dental benefits.

Defined terms are capitalized (e.g. Dependent). We will refer to you, the Member, as "you" or "your" in this booklet.

Pacific Blue Cross, the registered trade-name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

Coverage is provided through:

Pacific Blue Cross	**Great-West Life**
Extended Health Care (EHC) Dental Care	Member Basic Life Insurance Spousal Basic Life Insurance Optional Life Insurance Accidental Death, Dismemberment & Specific Loss (AD&D) Long Term Disability Income Benefits
Operating Engineers' Benefits Plan	**Homewood Human Solutions**
Weekly Disability	Member & Family Assistance

Please refer to the Table of Contents to help you locate the appropriate section in this booklet. If you require additional information, please contact your Plan Administrator.

Privacy Policy for Pacific Blue Cross

PBC has a Privacy Policy which governs our collection, use, and disclosure of personal information (including personal health information) about individuals who are Members or Dependents. This Privacy Policy is compliant with the Personal Information Protection Act (BC). The Privacy Policy requires PBC to keep such personal information confidential, but does permit use and disclosure of personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of our current Privacy Policy can be obtained from PBC on request and is also available on our website: www.pac.bluecross.ca.

Great-West Life Benefit Details

Great-West Life is a leading Canadian life and health insurer. Great-West Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Great-West Life Online

Information and details on Great-West Life's corporate profile, our products and services, investor information, news releases and contact information can all be found at our website **www.greatwestlife.com**.

This booklet describes the principal features of Member Basic Life Insurance, Spousal Basic Life Insurance, Optional Life Insurance, Accidental Death, Dismemberment and Specific Loss Insurance and Long Term Disability Income Benefits which are part of the group benefit plan sponsored by the Trustees of the Operating Engineers' Benefits Plan ("the Benefits Plan") as provided in **Group Policy Nos. 165806 and 165807** issued by Great-West Life. **Group Policy Nos. 165806 and 165807** are the governing documents. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail.

This booklet contains important information and should be kept in a safe place known to you and your family.

This booklet outlines all benefits offered under the Operating Engineers' Benefits Plan. Members may not be covered for all benefits. The table below indicates which benefits are offered to each plan category. Members not sure which category they fall under should contact the Operating Engineers' Benefits Plan Administrator.

OEBP	MSP	EHC	Dental	Life	AD&D[1]	Opt Life[2]	WD	LTD
Full Plan Working	✓	✓	✓	✓	✓	✓	✓	✓
Full Plan Working-Self Pay	✓	✓	✓	✓	✓	✓	✓	✓
Limited Plan	✓	✓	✓	✓	✓	✓		
Subsidy Limited Plan	✓	✓	✓	✓	✓	✓		
Mini Plan	✓	✓		✓	✓	✓		
Subsidized Mini Plan	✓	✓		✓	✓	✓		
Disabled Members Plan				✓	✓	✓		
Retirees		✓		✓	✓	✓		

[1] AD&D to age 70 only.

[2] Optional Life is available under all plans. Members must apply for this insurance and be approved by the insurance company. Members are responsible for the premiums.

Table of Contents

Schedule of Benefits

The Schedule of Benefits contains a brief summary of all benefits offered through the Operating Engineers' Benefits Plan. Please refer to the appropriate page in this booklet for a more detailed benefit description.

Extended Health Care		
Deductible	Medical Travel Benefits: $50 per family, per Calendar year	
	All Other Eligible Expenses: None	
Reimbursement	***In-Province/Territory Eligible Expenses:**	
	Vision Care	100%
	Medical Travel Benefits Room & Board	100%
	All Other Eligible Expenses	80%
	* subject to plan limits	
	Out-of-Province/Territory Eligible Expenses:	
	Emergency	
	Without the purchase of travel insurance	80%
	With the purchase of non-Pacific Blue Cross travel insurance	50%
	With the purchase of Pacific Blue Cross travel insurance	0% (PBC travel insurance 100%)
	Non-Emergency	Same as In-Province

	Prescription Drugs and Medicines: After $1,500 has been paid per family in a calendar year, further eligible expenses within that year will be reimbursed at 30%, subject to the contract maximums for this benefit. **All Other Eligible Expenses:** After $1,000 has been paid per person in a calendar year (for all eligible expenses) , further eligible expenses (excluding prescription drugs) within that year will be reimbursed at 100%, subject to the contract maximums for this benefit.
Plan Maximum	**In-Province Eligible Expenses:** The maximum amount of benefits payable for a Member or Dependent in a 24 month period is $20,000. **Out-of-Province Eligible Expenses:** The maximum amount of benefits payable for a Member or Dependent in a 24 month period is $15,000.

Dental Care				
Deductible	No Deductible			
Reimbursement	**Plan A** Basic Services	**Plan B** Major Restorative Services	**Plan B** Dentures	**Plan C** Ortho–dontics
	90%	50%	80%	50%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**	**Each Calendar Year**	**Lifetime**
Financial Limit Per Dependent Child	Not Applicable	Not Applicable	Not Applicable	$2,000
Financial Limit Per Member or Spouse	Not Applicable	Not Applicable	Not Applicable	$2,000

Employee Basic Life Insurance	
Active Members	$60,000
Reirees	$60,000, once partial or full self payment options are elected, reducing to $12,500 at age 65, then to $6,250 at age 70 and then to $3,125 at age 75

Spousal Basic Life Insurance	
Active Members	$5,000
Retirees	$5,000, reducing to $2,500 at age 65, then to $1,250 at age 70, and then to $625 at age 75 (The reduction is based on your age, not your spouse's age)

Optional Life Insurance	
	Available in $20,000 units to a maximum of $300,000, for you or your spouse, subject to approval of evidence of insurability If you are covered under this plan as both a member and a spouse, you are limited to the $300,000 maximum

Employee Accidental Death, Dismemberment and Specific Loss (Principal Sum)	
	An amount equal to your Basic Life Insurance

Long Term Disability Income Benefits (Not Applicable to Retirees)	
Waiting Period	12 month
Amount	$2,000 per month

Weekly Disability Benefits			
Weekly Benefit Amount	The current Employment Insurance (EI) maximum.		
Elimination Period	**Injury**	**Hospital**	**Sickness**
	0 days	3 days	3 days
Maximum Benefit Period	52 weeks		
Termination	On retirement		
Tax Status	Taxable		

Definitions

Benefits Plan
means the Operating Engineers' Benefits Plan

Coverage effective date
means the date coverage becomes effective for a Member or Dependent based on the eligibility criteria of the Benefits Plan and the date of enrolment with the Plan Administrator

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, denturist, or dental hygienist, depending on the services each may provide.

Dependent
means any of the following persons for whom coverage is provided under this Plan:

1) one Spouse of the Member
2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
3) any unmarried child who is also in full-time attendance at a recognized educational institute

a) **Extended Health Care:** under age 25
b) **Dental Care:** of any age

4) 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 PBC. The Dependent must become handicapped while covered as a Dependent under clause 2 and 3 above.

The Member must be prepared to prove that an individual claimed as a Dependent falls within these requirements.

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 1 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 a union member enrolled by the Plan Administrator for benefit coverage.

Plan Administrator
means the person appointed by the International Union of Operating Engineers, Local 115 as the administrator of the Benefits Plan.

Spouse
means your legal Spouse (Spouse may include a common-law Spouse who lives with you publicly as your wife/husband provided you have no other Spouse listed on the plans records as your Dependent).

Member Information/Access to Records

1) Each Member who becomes insured under the PBC group contract must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when our booklet is altered in any way.
2) Only the Member and Dependent(s) are entitled to the benefits. A Member's coverage may be suspended or terminated immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to PBC. Any other misrepresentation or fraudulent action by a Member or Dependent to claim or obtain or attempt to claim or obtain benefits will have similar consequences.
3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.
4) The terms of the PBC group contract govern if they conflict with the information in a booklet.
5) Upon request, and at no charge to the Member, we will provide the Member with one copy of:
   a) the current contract
   b) any written statement or other record provided to PBC as evidence of insurability of the Member.
6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the PBC group contract or denial of such a claim.
7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

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. Your failure to enroll for and maintain coverage under the Medical Services Plan of British Columbia, or its provincial equivalent, shall result in termination of your coverage. PBC will also make payment only where permitted by provincial/territorial legislation or other applicable law.

Effective Date of Coverage and Enrolment

The effective date of coverage for Members and Dependents will be the first day of the month following the date on which the Member or Dependent as the case may be is enrolled by the Pan Administrator.

Refer to the appendix at the end of this booklet for a full description of eligibility requirements..

Identification (ID) Cards

PBC will issue identification (ID) cards for distribution to the Members.

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

Claims

1) All claims must be submitted to PBC in English or French.
2) We 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.
3) We may reject your claim 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.
4) The necessary claim forms are available from your Plan Administrator or on our website at www.pac.bluecross.ca/caresnet
5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

Duplicate Coverage

Duplicate coverage is allowed, subject to Coordination of Benefits.

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 enrol under more than one plan.

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

Coordination of Benefits

PBC pays claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

1) Dependent 00 is always the primary claimant. Dependent 01 (or 90 to 99) is always the secondary claimant.
2) Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).
3) In situations of separation or divorce, the following order applies:
   a) the plan of the parent with custody of the child
   b) the plan of the Spouse of the parent with custody of the child
   c) the plan of the parent not having custody of the child
   d) the plan of the Spouse of the parent in c) above.
4) Total reimbursement shall never exceed 100% of the eligible expenses.

Third Party Liability

Benefits will be paid for illness or injury due to an incident in which a third party is liable or for which you are eligible for Insurance Corporation of British Columbia or any other automobile insurer's wage-loss benefits provided that the Operating Engineers' Benefits Plan shall be subrogated to the claim of the Member to the extent of benefits paid and on the condition that the Member provide an assignment and agreement in the form prescribed by the Operating Engineers' Benefits Plan providing for the direct reimbursement of benefits paid and an indemnification for all legal fees and disbursements actually incurred by the Operating Engineers' Benefits Plan on a solicitor and own client basis in enforcing the said assignment or the Member's obligation to so reimburse the Operating Engineers' Benefits Plan.

General Exclusions

1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
   a) under any other group or individual benefit plan or insurance policy, or
   b) due to the legal liability of any other party.

2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
   a) intentional self-inflicted injury while sane or insane, war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
   b) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
   c) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
   d) false pretences or fraudulent misrepresentation
   e) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Legal Action

Every action or proceeding against PBC for the recovery of benefits payable under the group contract is absolutely barred unless commenced within one year from the date satisfactory written proof of loss is filed with PBC, or within the time set out in other applicable legislation as may apply to a claim, action or proceeding for benefits..

Termination of Coverage

Please refer to the appendix at the end of this booklet for a full description of the Termination of Benefits provisions.

Survivor Benefit

If you die while covered under this plan, coverage for your Dependents will continue until the earliest of the following occurs:

1) 12 months after your death
2) the date your Dependent ceases to be a Dependent other than as a result of your death
3) the date the contract is terminated
4) the date your Dependent becomes eligible for coverage under a similar group plan.

Please contact your Plan Administrator for details and application process.

Conversion to an Individual Plan

Should your group coverage terminate for any reason, you may purchase an individual plan from Pacific Blue Cross if you live in British Columbia, or an individual plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by PBC or Blue Cross within 60 days of the date your group plan terminates. To be eligible to convert, you must have had coverage under the PBC group plan for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for one of our individual plans under the conversion option, we will waive the Pre-existing condition contained in the individual plan.

Pre-existing condition
means any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12 month period before you apply for the individual plan.

Call our Individual Products Department at 604 419-2200 for an application form.

If you are converting to an individual plan offered by Blue Cross, contact your local Blue Cross organization for full details before your group coverage terminates.

Individual Travel Benefits

Individual coverage is also available from PBC. Call 604 419-2200 or 1 800 USE-BLUE (873-2583) outside the Lower Mainland for information.

CARESnet

CARESnet is an online service from Pacific Blue Cross that offers you convenient and secure access to your benefit information 24 hours a day. Information about benefit coverage, claim status, and easy access to claim forms are the enhanced services CARESnet provides. To access CARESnet, visit our website: **www.pac.bluecross.ca/caresnet**

Extended Health Care

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

All dollar limits included in the benefit descriptions are claimable.

To determine the benefit amount claimable, PBC assesses the claim as follows:

- calculates the total eligible expense
- applies the claimable limits
- subtracts the Deductible, when applicable
- applies the reimbursement percentage
- applies the EHC plan maximum.

Definitions

Eligible expense
means a charge for any service and/or supply included in this booklet as a benefit that:

1) in our assessment is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician or Dentist, unless otherwise specified in the benefit description, and
3) is not a cost normally paid (in whole or part) or provided by a government plan or any other provider of health coverage, and
4) is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received.

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing, or extra charging), which represents an amount in excess of the schedule of costs prescribed by the government plan. PharmaCare's low cost alternative and reference drug program will not be applied unless specified in this booklet.

Out-of-Province/Territory
Out-of-Province/Territory includes travel outside the Members province/territory of residence, including Canada.

Physician
means an individual who is duly qualified and licensed to practice medicine or surgery, or both, in the area where the service is provided, but excludes a Physician residing with or related to you or your Dependent.

Practitioner
means an individual who is currently licensed, certified, or registered to practice a profession in the area where the care or service is provided.

In-Province/Territory Eligible Expenses

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician. Unless otherwise indicated, the maximums included here are on a per person basis.

1) Hospital
   The additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

2) Emergency ambulance
   a) charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient

b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport
c) emergency transport from one hospital to another, only when the original hospital has inadequate facilities
d) charges for an attendant when medically necessary.

3) Drugs and medicines
Charges for drugs and medicines in a quantity we consider reasonable, and
   a) which are dispensed by a pharmacist, Physician, or a Dentist, including:
      i) insulin preparations, testing supplies, needles, and syringes for diabetics
      ii) allergy serums when administered by a Physician, or
   b) which legally require a prescription from a medical provider legally authorized to do so, including
      i) contraceptives
      ii) fertility drugs
      iii) hepatitis vaccines
      iv) erectile dysfunction

4) Practitioners

Professional services of the following Practitioners to the maximum amounts indicated per visit, but excluding x-rays (unless indicated below), appliances and tray fees. Only the services of a private duty nurse require referral by a Physician.

a) acupuncturist ..... $45 per visit
b) chiropractor ..... $45 per visit
c) massage practitioner ..... $45 per visit
d) naturopath ..... $45 per visit
e) physiotherapist ..... $45 per visit
f) podiatrist/chiropodist combined ..... $45 per visit
g) private duty care by a licensed practical or registered nurse for a person with an acute condition in the person's home or in a hospital in the patient's province/territory of residence, limited to a maximum of $5,000 per calendar year.

5) Dental Accident

Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental

means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth.

We pay benefits based on eligible dental services and financial limits in our current Fee schedule, and we pay the fees in our current Fee schedule or, if applicable, the Fee guide in the province/territory of service.

6) Medical aids and supplies provided by a medical supplier (as approved by PBC)

Charges for the following services and supplies:

a) oxygen, blood, and blood plasma
b) ostomy and ileostomy supplies
c) intrauterine contraceptive devices (IUD's)

d) walkers, canes and cane tips, crutches, splints, casts, collars, and trusses, but not elastic or foam supports
e) rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms). Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis
f) charges for the following items:
    i) mastectomy brassieres
    ii) stump socks
    iii) surgical stockings
g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $300
h) orthopaedic shoes and orthotics
    i) when prescribed by a Physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear. A custom made orthopaedic 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
    ii) when prescribed by a Physician, podiatrist or chiropractor as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet
i) hearing aids to a lifetime maximum of $1,000. Batteries, repairs, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

7) Standard durable medical equipment
   a) Preauthorization is required from PBC for expenses in excess of $5,000
   b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.
   c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.
   d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
   e) Standard durable equipment includes:
      i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating the manual equivalent, otherwise we will pay the manual equivalent
      ii) lift chairs, to a maximum of $700, per lifetime
      iii) medical heart and blood glucose monitors, and cardiac screeners
      iv) speech processors and headsets when prescribed for profound deafness subject to a 5 calendar year period
      v) bi-osteogen systems (when recommended by an orthopaedic surgeon) and growth guidance systems
      vi) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
      vii) insulin infusion pumps for diabetics – when basic methods are not feasible
      viii) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
      ix) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

8) Vision Care and Eye Examinations
Charges for the purchase and/or repair of eyewear, contact lens fittings, and routine eye examinations when prescribed and/or performed by a Physician or legally authorized optical provider to a combined maximum of:
a) $350 in a 24 month period for adults, and
b) $350 in a 12 month period for Dependent Children.
Charges for non-prescription eyewear are not covered.

9) Lens Implants
Charges for lens implants to a maximum of $500 per lens when performed by a Physician or legally authorized optical provider.

10) Psoralens Ultra Violet Application (PUVA)
Charges for psoralens ultra violet application (PUVA) to a maximum of $1,000 per treatment year when performed by a Dermatologist. Treatment period not to exceed 2 years

11) Uvuloplasty
Charges for laser assisted uvuloplasty to a lifetime maximum of $2,000.

12) Medical Examinations
Charges of a Physician for medical examinations required by government statute or regulation for employment purposes provided such charges are not payable by You under a collective agreement.

In-Province/Territory Medical Travel Eligible Expenses

When ordered by the attending Physician because, in his or her opinion, adequate medical treatment is not available locally (in excess of 100 kilometres on a round trip basis), the following are included as eligible expenses:

1) Transportation for a patient and attendant if medically required, to and from the nearest locale, within the province/territory of residence or border province/territory, equipped to provide the required treatment by:
    a) scheduled economy air (including Airport Improvement fee where applicable), rail, ferry, or bus
    b) private automobile, reimbursement:
        i) 100-299 kms round trip, $50 per day, for a maximum of 3 days
        ii) 300+ kms round trip, $70 per day, for a maximum of 3 days
    c) local limousine and taxi service:
        i) to and from the airport, rail station, ferry terminal, or bus station
        ii) to and from the treatment facility and accommodation
    d) parking:
        i) at the airport of departure
        ii) hospital, accommodation, and doctor's office parking at the destination of the referral for the patient
        iii) receipts are required.
2) Where transportation has been provided under 1) above, room and board in a commercial facility for the patient and attendant, before and after medical treatment, to a combined maximum of $50 per day, for a maximum of 3 days.
3) Transportation must take place within a reasonable time period of the Physician's referral.

Out-of-Province/Territory Non-Emergency Eligible Expenses

We will reimburse you (and your Dependents) for non-emergency eligible expenses incurred while travelling outside your province/territory of residence subject to the Deductible, in-province/territory reimbursement percentage, and maximums. We will not reimburse any expenses payable or provided under a government plan.

Out-of-Province/Territory Emergency Eligible Expenses

While travelling outside your province/territory of residence, benefits are payable for the following eligible expenses incurred IN AN EMERGENCY ONLY and when ordered by the attending Physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are not eligible.

1) Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
2) The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days.
   If reasonably possible, we should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit may be extended with our expressed written consent.
3) Services of a Physician and laboratory and x-ray services.
4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.

5) Other emergency services and/or supplies, if we would have covered them inside your province/territory of residence.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, medi-assist will coordinate the following services:

1) locate the nearest appropriate medical care
2) obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians
3) investigate, arrange and coordinate medical evacuations and related transportation needs
4) arrange and coordinate the repatriation of remains
5) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

Your Pacific Blue Cross worldwide emergency medi-assist card provides instant information on how to contact medi-assist. Call the nearest medi-assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to medi-assist. Have your EHC ID number and medi-assist group number ready for personal identification – both numbers are required.

Extended Health Care Exclusions

The following are not included as eligible expenses under your EHC plan:

1) dentures or dental treatments, x-rays, hospital coinsurance, vitamins and/or minerals (including vitamin B12), medications used to treat or replace an addiction or habituation, drugs and supplies for smoking cessation, obesity drugs and any drug, vaccine (excluding hepatitis), item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury, transportation charges incurred for elective treatment and professional services of Physicians or any person who renders a professional health service in the patient's province/territory of residence
2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription
3) allergy testing
4) long term hospital care (i.e. intermediate or extended care, nursing home etc.)
5) sclerosing agents for varicose veins
6) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate, services of religious or spiritual healers, occupational therapy, speech therapy, shiatsu massage, services and supplies for cosmetic purposes, public ward accommodation, rest cures, and medical laboratory tests
7) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English
8) any payment to a pharmacy, a Practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan
9) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits

10) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
11) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
12) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the government plan in your province/territory of residence
13) services performed by a Physician who is related to or resident with you or your Spouse
14) fees for ambulance services when an ambulance is called but not used
15) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility
16) retroactive coverage and payment of any expense, including drugs that receive special authorization from PharmaCare
17) any other item not specifically included as a benefit.

Claims

Electronic Claims

1) When submitting an electronic claim you must:
   a) complete the claim form online and submit it electronically to PBC
   b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to PBC
   c) if the claim is selected for review by PBC, you must submit the original receipts and supporting documentation to within 21 calendar days. If we do not receive this information within this time, your claim will be refused.
2) We reserve the right to remove your ability to submit electronic claims if you provide false, incomplete or misleading claims information. In such circumstances you will have to submit paper claims with supporting receipts and documentation.
3) You must provide explanation or proof to support the claim or any other information we consider necessary.

4) We must receive an electronic claim by June 30th of the calendar year following the year in which the expense was incurred. If your electronic claim is selected for review by PBC, we will accept the original receipts and supporting documentation after the June 30th deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission. We will not accept a faxed or scanned claim form and/or receipts.
5) Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Pay Direct

Provided your pharmacy is connected to our electronic processing system, we 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.

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

Please Note: If your Spouse and/or children have coverage through another plan, your Pay Direct card cannot be used for their prescription expenses. Please refer to item 2 below for further information.

Paper Claims

1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to PBC. We will send you a remittance statement for your records each time you submit a claim.
2) If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our 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 PBC before you submit your claim to the government plan, we will deduct what the government plan would normally pay (e.g. PharmaCare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer. Information for claiming PharmaCare expenses may be obtained from your pharmacist.
4) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
   a) Obtain a claim form from your Plan Administrator or on our website at www.pac.bluecross.ca/caresnet
   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 your claim by **June 30th** of the calendar year following the year in which the expense being claimed was incurred. .
   Example: We must receive your receipts for 2013 before June 30, 2014.
   d) We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

Late Claims

For claims received by PBC after the June 30th claiming deadline, we will only pay a maximum of $25 or the eligible paid amount, whichever is less.

Payment of Benefits

1) We pay benefits based on dental services, financial limits and treatment frequencies in the Fee schedule. We apply reasonable and customary limits to fee items as applicable.
2) We apply the reimbursement percentage shown in the *Schedule of Benefits* to the fees shown in the Fee schedule/Fee guide as follows:
   a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia — the fees in the Fee schedule
   b) for services performed in Canada but outside British Columbia —the fees in the Fee guide in the province/territory of service
   c) for services performed outside Canada if your province/territory of residence is not British Columbia—the fees in the Fee guide in your province/territory of residence.
3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

Plan A – Basic Preventive & Restorative Services

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible expenses per person include, but are not limited to, the basic services shown below.

1) Diagnostic services
   a) examinations:
      i) complete – provided we have not paid for any other exam by the same Dentist in the past 6 months –1 per 3 year period
      ii) recall – 2 per calendar year
      iii) specific – 2 per calendar year
      iv) consultations (as a separate appointment)
   b) x-rays
      i) diagnostic
      ii) panoramic – 1 per 3 year period
      iii) complete mouth series – 1 per 3 year period

      All x-rays combined shall not exceed the dollar limit for a complete mouth series.
   c) diagnostic models – 1 set per calendar year.

2) Preventive services
   a) scaling
   b) polishing – 2 per calendar year
   c) topical application of fluoride – 2 per calendar year
   d) fixed space maintainers
   e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.

3) Restorative services
   a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:
      i) amalgam (silver coloured) fillings
      ii) composite (tooth coloured) fillings on permanent (anterior, bicuspid and molar) teeth

      On all primary teeth, we pay the bonded amalgam rate for composite fillings.
   b) stainless steel crowns on primary and permanent teeth – once per tooth in a 2 year period.

4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals.

5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
   a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
   b) root planing
   c) gingival curettage – 1 per sextant in a 5 year period
   d) osseous surgery – 1 per sextant in a 5 year period
   e) bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

6) Prosthetic repairs
   a) removal, repairs, and recementation of fixed appliances
   b) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
   c) gold foil – only when used to repair existing gold restorations.
   Excludes relines and rebases

7) Surgical services
   a) extractions
   b) other routine oral surgical procedures

Plan B – Major Restorative Services

You are eligible for Plan B services when your Dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

Mounted x-rays and/or diagnostic casts may be required for our approval.

Plan B services include, but are not limited to, the following:

1) Prosthodontic Services
   a) removable
      i) complete upper and lower dentures
      ii) partial upper and lower dentures

b) fixed bridges.

2) Restorative Services
   a) inlays and onlays
   b) veneers
   c) crowns and related services.

Limitations
1) Only 1 major restorative service involving the same tooth will be covered in a 5 year period.
2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.
3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our Fee schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

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

Limitations
1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
2) No benefit is payable for the replacement of appliances which are lost or stolen.
3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
4) Treatment performed solely for splinting is not covered.

Emergency Treatment Outside Your Province/Territory of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province/territory of residence, you require emergency dental care. You will be reimbursed according to our Fee schedule. This will not apply to the services of a dental hygienist.

Dental Exclusions

The following are not eligible expenses under your dental plan:

1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule
2) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
3) procedures performed for congenital malformations or for purely cosmetic reasons
4) charges for drugs, pantographic tracings, and grafts
5) charges for relines and rebases
6) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule
7) anesthesia and charges for facilities, equipment and supplies
8) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
9) incomplete or temporary procedures
10) recent duplication of services by the same or different Dentist
11) any extra procedure which would normally be included in the basic service performed
12) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
13) any item not specifically included as a benefit
14) travel expenses incurred to obtain dental treatment.

Claims

1) 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 PBC **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.
2) 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, in no event will we pay any claim or adjustment received later than **1 year** from the date the service is performed.
3) 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:
    a) name of the Dentist
    b) name and birthdate of the person receiving the dental care
    c) your group, ID, and Dependent(s) numbers (this information is on your ID card)
    d) your home mailing address
    e) 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.
4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:
    a) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive:
        i) a claim form signed by the patient that is either submitted with a receipt or is signed by the dental provider showing the services performed and the fee charged, or
        ii) an electronic claim showing the services performed and the fee charged. The dental provider must have the

consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

b) For pay direct claims, We will pay the benefit amount to the Dentist directly for services provided under this benefit plan when We receive:
   i) a claim form showing the services performed and the fee charged, signed by the patient and the dental provider, or
   ii) an electronic claim showing the services performed and the fee charged. The dental provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Pacific Blue Cross.

5) Orthodontic Claims Procedures
   a) Receipts
   Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.
   b) Claiming deadlines
      i) We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
      ii) Reimbursement is made if the complete and correct claims information is received within 1 year of the due date. However, no benefit is payable for claims not received within **1 year** of the due date.
   c) Treatment plan
      i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.
      ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.
      iii) 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
         - one time appliance fees

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

d) Monthly or quarterly fees

i) If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by PBC which are over 1 year old will not be reimbursed.

ii) If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.

iii) 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.

Great-West Life General Information

Access to Documents

You have the right, upon request, to obtain a copy of the policy from Great-West Life, your application and any written statements or other records you have provided to Great-West 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 after Great-West Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Great-West 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 Great-West Life's right to use other legal means to recover the overpayment.

Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

1) determining your eligibility for coverage under the plan
2) enrolling you for coverage
3) investigating and assessing your claims and providing you with payment
4) managing your claims
5) verifying and auditing eligibility and claims
6) creating and maintaining records concerning our relationship
7) underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
8) preparing regulatory reports, such as tax slips

We may exchange personal information with your health care providers, your Plan Administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Great-West Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Commencement and Termination of Coverage

You are eligible to participate in the Benefits Plan for:

- Life Insurance benefits and Accidental Death, Dismemberment and Specific Loss benefits on the first day of the month coinciding with or next following the date on which you complete a minimum of 250 hours of work within a 12-consecutive-month period.

- Long Term Disability benefits on the first day of the month coinciding with or next following the date on which you complete a minimum of 375 hours of work within a 12-consecutive-month period.

You and your spouse will be covered as soon as you become eligible. A common-law spouse must have lived with you publicly for at least 12 months.

- In order to maintain your benefits, you must maintain a minimum of 125 hours in your hour bank each month, or you may choose the self-pay option.

  Please refer to the table of benefits offered under each plan category at page 6 of this booklet.

Please refer to the appendix at the end of this booklet for full details of the Benefits Plan eligibility requirements. The appendix also contains important information governing when termination of benefits will occur.

Beneficiary Designation

iv) You may make, alter, or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under the policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from the Plan Administrator.

Member Basic Life Insurance

On your death, Great-West Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. The Plan office will explain the claim requirements to your beneficiary.

1) If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See the Plan office for details.

Spousal Basic Life Insurance

If your spouse dies, Great-West Life will pay you the spousal basic life insurance benefit. The Plan Administrator will explain the claim requirements.

1) If your spouse's insurance terminates on or before his or her 65th birthday, he or she may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. See your Plan Administrator for details.

Optional Life Insurance

Optional Life Insurance allows you to choose additional coverage for yourself and your spouse. Check the **Benefit Summary** for the amount of Optional Life Insurance available. When you apply for Optional Life Insurance, you must provide proof of your insurability, and your application must be approved by Great-West Life. If you or your spouse die within two years after applying for Optional Life Insurance, Great-West Life has the right to verify any medical information you or your spouse provided. If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

On your death, Great-West Life will pay your optional life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your Plan Administrator will explain the claim requirements. If your spouse dies you will be paid the amount for which he or she was insured.

1) If your or your spouse's optional life insurance terminates, you or your spouse may be eligible to apply for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your Plan Administrator for details.
2) Your optional life insurance terminates when you reach age 65. Your spouse's coverage terminates at the same time, or when he or she reaches age 65 or is no longer your spouse, whichever comes first.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Great-West Life refunds the premiums that have been received.

Accidental Death, Dismemberment & Specific Loss (AD&D) Insurance

If you suffer one of the losses listed below as the result of an accident which occurs while you are insured, you will be paid the factor or portion of the Principal Sum shown opposite the loss in the table on the next page. The loss must occur no later than 365 days after the accident. For loss of use, the loss must be continuous for 365 days. If you suffer multiple losses to the same limb as the result of the same accident, only the loss providing the highest amount payable will be paid.

If you die as a result of an accident, Great-West Life will pay the Principal Sum to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your Plan Administrator will explain the claim requirements to your beneficiary.

The Principal Sum is the maximum amount that will be paid for all injuries resulting from the same accident. For paraplegia, hemiplegia, and quadriplegia, the maximum amount that will be paid for all injuries resulting from the same accident is two times the Principal Sum.

Loss	Amount Payable
Life	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
Speech and Hearing in both ears	Principal Sum
One arm or one leg	3/4 Principal Sum
One hand or one foot or sight of one eye	1/2 Principal Sum
Speech	1/2 Principal Sum
Hearing in both ears	1/2 Principal Sum
Thumb and index finger or at least 4 fingers of one hand	1/4 Principal Sum
All toes of one foot	1/8 Principal Sum

Loss of Use

Both arms and both legs (quadriplegia)	2 X Principal Sum
Both legs (paraplegia)	2 X Principal Sum
One arm and one leg on the same side of the body (hemiplegia)	2 X Principal Sum
One arm and one leg on different sides of the body	Principal Sum
Both arms or both hands	Principal Sum
One hand and one leg	Principal Sum
One leg or one arm	3/4 Principal Sum
One hand	1/2 Principal Sum

Your AD&D insurance terminates when you reach age 70.

Surgical Reattachment

If you suffer the loss of a limb that is surgically reattached, Great-West Life will pay 50% of the amount that would have been payable if the loss had been permanent, regardless of the amount of use regained. The balance of the benefit will be payable if the reattachment fails and the reattached part is removed within one year after the reattachment was performed.

Repatriation

If you die as the result of an accident that is at least 150 kilometres away from your home, Great-West Life will pay up to $2,500 for the preparation and transportation of your body to the place of burial or cremation.

Educational Benefit for Dependent Children

If benefits are payable under this benefit provision for your death, Great-West Life will pay the tuition fees for enrolling your dependent children as full-time students at a post-secondary institution. To qualify for an educational benefit, a dependent child must have been enrolled as a full-time student at a post-secondary institution at the time of the accident causing your death, or he must have been enrolled as a full-time student at the secondary school level at the time of the accident causing your death and enrols as a full-time student at a post-secondary institution within 365 days after the accident.

Great-West Life will pay up to 5% of the Principal Sum, or $5,000, whichever is less, for each year of full-time post-secondary school enrolment. Great-West Life will pay the educational benefit each year for a maximum of 4 consecutive years upon receipt of proof of full-time enrolment.

No benefits will be paid for tuition expenses incurred before the accident, or room or board or other ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

If you are hospitalized more than 150 kilometres from your home as a result of an injury for which benefits are payable under this benefit provision, Great-West Life will pay up to $2,000 for transportation and lodging expenses for one family member to join you.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included. Meal expenses are not covered.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $.44 per kilometre travelled.

Occupational Training Benefit for Spouses

If benefits are payable under this benefit provision for your death, Great-West Life will pay for expenses associated with your spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify.

Great-West Life will pay up to 10% of the Principal Sum, or $10,000, whichever is less.

No benefits will be paid for expenses incurred more than 3 years after the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Educational Benefit

If benefits are payable under this benefit provision for an injury that requires you to change occupations, Great-West Life will pay the tuition fees for enrolling you as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, you must enrol at a post-secondary institution within 365 days after the accident. Great-West Life will pay up to $10,000.

No benefits will be paid for tuition expenses incurred before the accident, expenses incurred more than 2 years after the accident causing the injury, or room or board or other ordinary living, travelling, or clothing expenses.

Wheelchair Benefit

If benefits are payable under this benefit provision for an injury that requires the use of a wheelchair for you to be ambulatory, Great-West Life will pay for alterations to your principal residence to make it wheelchair accessible and habitable, and modifications to a motor vehicle you use to make it accessible to and driveable by you.

Benefits for home alterations are payable only if the person or persons making the changes are experienced in home alterations for wheelchairs, and recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if the person or persons making the changes are experienced in vehicle modification for wheelchairs, and the modifications are approved by the provincial vehicle licensing authority.

Great-West Life will pay up to $10,000 for all home and vehicle modifications combined.

No benefits will be paid for expenses incurred more than 365 days after the accident, or for subsequent alterations to your home or vehicle after an initial claim for benefits has been made under this wheelchair benefit provision.

Limitations

No benefits are paid for injury or death resulting from:

1) Intentionally self-inflicted injury or suicide
2) Viral or bacterial infections, except pyogenic infections occurring through the injury for which loss is being claimed
3) Any form of illness or physical or mental infirmity
4) Medical or surgical treatment, except surgical reattachment
5) War, insurrection or voluntary participation in a riot
6) Service in the armed forces of any country
7) Air travel serving as a crew member, or in aircraft owned, leased or rented by your employer, or air travel where the aircraft is not licensed or the pilot is not certified to operate the aircraft

How to Make a Claim

1) To claim benefits for yourself, ask the Plan Administrator for a claim form. Complete it and return it to the Plan office.
2) If you die accidentally, your Plan Administrator will explain the claim requirements to your beneficiary.
3) Claims should be submitted as soon as possible, but no later than 15 months after the loss.

Long Term Disability (LTD) Income Benefits

The Benefits Plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or you reach age 60, whichever comes first. Check the **Benefit Summary** for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.

- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from performing the essential duties of your regular occupation, and, except for any employment under an approved rehabilitation plan, you are not employed in any occupation that is providing you with income equal to or greater than your amount of LTD insurance under this plan, as shown in the Benefit Summary.

- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 50% of your indexed monthly earnings before you became disabled.

- Loss of any license required for work will not be considered in assessing disability.

- After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.

- Because employers contribute to the cost of LTD coverage, benefits are taxable.

- Your LTD insurance terminates when you reach age 60.

- While in receipt of LTD benefits, members of the Operating Engineers' Pension Plan will continue to accrue pension within the Operating Engineers' Pension Plan subject to the provisions of the Operating Engineers' Pension Plan. The eligibility and amount of accrual are set by the Trustees and are subject to change based upon the financial condition of the Pension Plan.

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

1) disability or retirement benefits you are entitled to on your own behalf under the Canada Pension Plan or Quebec Pension Plan
2) benefits under any Workers' Compensation Act or similar law except for:
   a) permanent partial disability awards that were payable for each of the 12 months before a disability period
   b) benefits related to employment with another employer
3) employer sponsored short term disability or sick leave benefits
4) loss of income benefits under an automobile insurance plan, to the extent permitted by law
5) 50% of earnings received from an approved rehabilitation plan

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 80% of your monthly earnings before you

became disabled. If it does, your benefit is reduced by the excess amount.

1) your income under this plan
2) loss of income benefits available through legislation, except for Employment Insurance benefits and automobile insurance benefits, which you or another member of your family is entitled to on the basis of your disability
3) the wage loss portion of any criminal injury award
4) disability benefits under a plan of insurance available through an association
5) employment income, disability benefits, or retirement benefits related to any employment except for income from an approved rehabilitation plan, or employer sponsored short term disability or sick leave benefits (termination pay, severance benefits, and any similar termination of employment benefits, including any salary paid in lieu of notice, are included as employment income under this provision)

The balance of any earnings received from an approved rehabilitation plan is not used to further reduce your LTD benefit unless that balance, together with your income from this plan and the other income listed above, would exceed your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

Cost-of-living increases in the other income listed above, that take effect after the benefit period starts, except for income from an approved rehabilitation plan, are not included.

Vocational Rehabilitation

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to your own job or other gainful employment, and is recommended or approved by Great-West Life. In considering whether to recommend or approve a rehabilitation plan, Great-West Life will assess such factors as the expected duration

of disability, and the level of activity required to facilitate the earliest possible return to work.

Medical Coordination

Medical coordination is a program, recommended or approved by Great-West Life, that is designed to facilitate medical stability and provide you with cost effective, quality care. In considering whether to recommend or approve a medical coordination program, Great-West Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate medical stability.

Limitations

No benefits are paid for:

1) Any period after you fail to participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

   Depending on the severity of the condition, you may be required to be under the care of a specialist.

   If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

2) Any period after you fail to cooperate in applying for other disability benefits, reapplying for such benefits, or appealing decisions regarding such benefits, where considered appropriate by Great-West Life.
3) Any period after you fail to participate or cooperate in an approved rehabilitation plan.
4) Any period after you fail to participate or cooperate in a recommended medical coordination program.
5) Any period after you fail to participate or cooperate in a required medical or vocational assessment.

6) The scheduled duration of a leave of absence.

   This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.

7) Any period in which you are outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Great-West Life pre-authorized the absence prior to your departure.
8) Any period of incarceration, confinement, or imprisonment by authority of law.
9) Disability arising from war, insurrection, or voluntary participation in a riot.

How to Make a Claim

Obtain an Employee Claim Submission Guide (form M4307B) from your Plan Administrator and follow the guide's instructions. **Return the completed form to the Plan office as soon as possible, but no later than 3 months after proof of your claim has been requested.**

Please note - The LTD plan provides both occupational and non-occupational coverage. Although Workers' Compensation benefits may continue to be paid beyond the end of the LTD waiting period, it is the plan member's responsibility to have the completed LTD claim form submitted to the Plan office as soon as possible, but **no later than 3 months after the end of the LTD waiting period**. Failure to submit this information within the prescribed timelines could result in an ineligible LTD claim. Obtain an Employee Claim Submission Guide (form M4307B) from your Plan Administrator and follow the guide's instructions.

Weekly Disability Benefits

Introduction

Weekly Disability Benefits are provided through the Board of Trustees of the Operating Engineers' Benefits Plan.

Benefits

(a) Benefits are paid for periods of time during which you are prevented from working at your regular occupation as result of non-occupational injury or illness.
(b) Benefits commence on the first day for a disability resulting from an accident, and on the fourth day for a disability resulting from illness.

NOTE: Benefits will only be paid while you are under the full-time care of a medical practitioner or registered chiropractor.

(c) When the claim is signed by a medical practitioner, benefits will be paid for a maximum of 52 weeks for any one period during which you are totally disabled.
(d) When the claim is signed by a registered chiropractor, benefits will be paid for a maximum of six weeks for any one period during which you are totally disabled.
(e) Alcoholism and drug addition will be considered as illnesses, only if you are undergoing "In House" treatment in a recognized rehabilitation centre.

(f) Where there is any doubt as to the validity of a claim, the Board of Trustees reserve the right to obtain a second medical opinion from a medical practitioner or other professional of their choice.

(g) The Weekly Disability Benefit is paid for a maximum of 52 weeks at the rate of $501.00 per week. Please note this rate is tied to the Employment Insurance Maximum benefit which is usually increased January 1st of each year.

The benefit is integrated with the Employment Insurance Sick Benefits. For those members who qualify for E.I. Sick Benefits, the first 6 weeks will be paid by the Operating Engineers' Benefits Plan Weekly Disability Benefit. The member will then go on E.I. Sick Benefits for 15 weeks, after which they will continue on the Operating Engineers' Benefits Plan Weekly Disability Benefit for the balance of the claim or until they are able to return to work.

Those members who do note qualify for E.I. Sick Benefits will stay on the Operating Engineers' Weekly Disability until they are able to return to work or for the 52 weeks. Members must provide written confirmation from E.I. that they do not qualify for sick benefits and that this is not the result of any penalties they have been assigned.

NOTE 1: You must be eligible under the plan on the first day of your disability in order to receive benefits.

NOTE 2: All disability benefits are taxable as this Plan is considered an "Employer Contributed" Plan by Canada Customs & Revenue Agency even though you make self-payments.

How to Make a Claim

(a) Contact your medical practitioner or registered chiropractor immediately upon becoming disabled.
(b) Obtain a claim form from the Plan Office.
(c) Complete the Claimant's Statement and sign the form.
(d) Ensure that your doctor or chiropractor completes the Physician's Statement.
(e) Send the claim form to the Plan Office.

This is your responsibility.

(f) Claims are assessed by the Operating Engineers' Benefits Plan. If approved, you will receive your bi-weekly benefit cheques by mail at your home address.

ADDITIONAL INFORMATION REGARDING CLAIMS
Claims should be always be submitted within thirty (30) days of commencement of disability. Should special circumstances prevent you from doing so, a letter of explanation must accompany your claim. Claims submitted late may be disallowed by the Trustees.

Third Party Liability

Benefits will be paid for disabilities due to an accident in which a third party is liable or for which you are eligible for Workers' Compensation, Insurance Corporation of British Columbia or any other automobile insurer's wage-loss benefits provided that the Operating Engineers' Benefits Plan shall be subrogated to the claim of the member to the extent of benefits paid and on the condition that the member provide an assignment and agreement in to form prescribed by the Operating Engineers' Benefits Plan providing for direct reimbursement of benefits paid and an indemnification for all legal fees and disbursements actually incurred by the Operating Engineers' Benefits Plan on a solicitor and own client basis in enforcing the said assignment or the Member's obligation to so reimburse the Operating Engineers' Benefits Plan.

Recurrence of Previous Disabilities

(a) Total disability caused by the recurrence of a previous illness or injury is considered to be a new disability provided that subsequent to the previous illness or injury:
   (i) you were certified by your doctor or registered chiropractor as being fit to return to active employment on a full-time basis, and;
   (ii) you returned to active employment on a full-time basis, or were available for such employment for at least two consecutive weeks.

   In such event, benefits will commence and be paid as if you had not received benefits for that previous illness or injury.

(b) Otherwise, any recurrence of an illness or injury is considered to be a continuation of your previous disability. In such event, benefits will commence immediately and will be made up to the balance of the 52 week benefit period remaining from your previous disability.

Exclusions & Limitations

(a) No benefits will be paid for any period of disability arising from:
   (i) Occupational accident or illness covered by the Workers' Compensation Act.
   (ii) Self-inflicted injuries or diseases.
   (iii) Injuries or diseases resulting from war or participation in a riot, or arising while serving as a member of any armed service.

(b) No benefits will be paid for any period for which the person has, or will receive vacation pay for an annual vacation.

(c) No benefits will be paid if it is determined that the member claiming disability benefits is receiving wages outside his regular occupation.

(d) No reimbursement will be made for any cost incurred by you for the completion of a form.

(e) Retired members or members who are receiving a pension form the Operating Engineers' Pension Plan are not eligible for Weekly Disability Benefits.

Member & Family Assistance Program

Introduction

The Member and Family Assistance Program is provided through an agreement with Human Solutions Canada Inc.

From time to time we all face difficult or stressful events in our lives. Most of the time, we handle these personal challenges fairly well. Other times, our personal problems can become large enough that they begin to interfere with our effectiveness, happiness or safety, both at work and at home.

Your Member and Family Assistance Program (MFAP) provides totally confidential, professional counselling for a broad range of personal and family challenges. While the program can be used for crisis intervention, the ideal time to use the program is before problems get out of hand.

The Member and Family Assistance Program is a pro-active option helping you to manage your personal health and happiness.

Eligibility

All members and dependents of the Operating Engineers' Benefits Plan are eligible for the benefits provided by the Member and Family Assistance Program. Members are eligible for a maximum of 12 hours of therapy, per family, per contract year.

Benefits

Together, you and your dependents can receive short term counselling from a professional counsellor either in person, by phone or through Human Solution's internet site at: www.humansulutions.ca .

The Member and Family Assistance Program offers confidential, professional assessment, guidance, counselling (and referral, when required) for personal difficulties such as:

a) emotional or physical problems
b) marital of family problems
c) stress
d) work-related problems
e) pre-retirement planning
f) financial and legal difficulties
g) child and elder care
h) sexual harassment or abuse
i) alcohol or drug dependencies
j) gambling
k) bereavement

How to Use the Program

When you want to speak with someone, simply call the Human Solutions number. The Human Solutions staff will ask you for some basic registration information (to establish your eligibility for this benefit) and then help set up an initial appointment at a time and office location convenient for you. An experienced psychologist or counsellor will help assess your concerns and aid you in developing practical solutions.

Counselling

Counselling will be provided by a registered psychologist or counsellor in the Human Solutions network. All Human Solutions counsellors have extensive experience helping individuals with their problems.

Should longer-term counselling, hospital treatment or specialized services (such as medical, legal or financial help) be required, your counsellor will arrange a follow-up with you.

Confidentiality

Human Solutions Counsellors are required by law to maintain the strictest confidentiality. No one who inquires about or receives services under this plan will have personal information revealed to anyone without written approval. Eligibility is verified though confidential contact with the Operating Engineers' Benefits Plan Administration.

To speak with someone confidentially, call the Human Solutions number nearest you.

Contact Information

For Emergency Services (24 hours/day) or to book an appointment (during regular office hours) call:

Vancouver Lower Mainland	604-689-1717
British Columbia or anywhere in North America	1-800-663-1142
International (call collect)	604-689-1717

Appendix

This appendix sets out the eligibility requirements and when termination of benefits occurs under the Operating Engineers' Benefits Plan as at January 1, 2013. These provisions are subject to amendment by the trustees of the Benefits Plan. Please check with the Benefits Plan Administrator for the details of any amendments or visit the Benefits Plan web site.

Establishing Eligibility for Benefits under the Plan

(a) To establish eligibility for benefits under the Plan you must fulfill ALL of the following requirements:

(i) You must be a member of Local 115 or one of the various branches of Local 115 of the International Union of Operating Engineers;

OR

You must have applied for membership in the Union and your enrollment on the Plan is approved by the Union;

OR

You must be working under permit issued by the Union and your enrollment on the Plan is approved by the Union, and;

(ii) You must file completed enrollment applications with the Administrator, and;

(iii) A minimum of 250 hours, at the Plan's current contribution rate, must be reported and paid to the Plan by a contributing Employer within the twelve consecutive month period immediately prior to establishing eligibility for all benefits other than Long Term Disability.

(iv) A minimum of 375 hours, at the Plan's current contribution rate, must be reported and paid to the Plan by a contributing Employer within the twelve consecutive month period immediately prior to establishing eligibility for the Long Term Disability Benefits.

(b) Your eligibility for benefits begins on the first day of the month following the month in which ALL of these requirements are met.

The following example illustrates hours worked, hours received and the month of eligibility for commencement of benefits:

NOTE - The hours worked in January are not payable to the Plan Office until February 15th.

Month	Hours Worked by Member	Hours Received by Plan Office
January	100	0
February	50	100 (Jan. hours)
March	100	50 (Feb. hours)
April	125	100 (Mar. hours)
May	Eligibility for all Benefits other than Long Term Disability	
June	Eligibility for Long Term Disability begins	

(c) All hours reported and paid are added to your Hour Bank if they are reported in the twelve consecutive month period before eligibility for benefits is established or in subsequent months.

(d) Once you have qualified, 125 hours are withdrawn each month from your Hour Bank to provide benefits under the Plan. You may

accumulate up to a twelve (12) month Hour Bank (1500 hours) that will be used during periods of reduced employment, illness, or extended vacation.

(e) Your eligibility for benefits will continue for as long as your Hour Bank has sufficient hours, AND you remain in good standing with the Local Union.

(f) No benefit is paid and no reimbursement is provided for expenses incurred by you or your dependents for services or supplies which are provided to you or your dependents for services or supplies which are provided to you or your dependents, or for any disablement or death which occurred to you or to your dependents. either before you became eligible for benefits, or after your eligibility for benefits under the Plan has terminated.

Hour Bank Shortages

(a) If you are a member of the Union, currently covered under the Plan, and the balance in your Hour Bank is less than 125 hours, you will be notified of the options of payment available to maintain eligibility for monthly benefits and the procedures required.

EXAMPLE:

Monthly eligibility for benefits requires	125 hours
Your Hour Bank balance is	85 hours
Therefore, you are short	40 hours

(b) If you wish to maintain eligibility for Full Plan benefits, you must make a self-payment for the number of hours that you are short at the Plan's current contribution rate.

(c) If you receive a Shortage Notice and would like to question the amount or hours, pay the notice within the required time and include an accompanying letter with explanation or contact the

Plan office directly. Include your Social Insurance Number and the name of your employer.

(d) Shortages may occur because you have not worked sufficient hours, your employer did not report within the required time, your name was accidentally left off the report, an error was made in the number of hours reported, or hours were reported under an incorrect Social Insurance Number. It is advisable that you keep your pay slips in the event that any errors do occur.

(e) There are no limitations on the number of months you may continue to self-pay at the Full Plan rate provided you remain a member of the Union.

NOTE 1: The only way to guarantee continuous eligibility for benefits is to pay your shortage by the date specified on the notice.

NOTE 2: Retired members do not qualify for Weekly Disability and Long Term Disability Benefits provided by the Full Plan.

Limited Plan

You may pay your Shortage Notice at a reduced hourly rate for the following Plan:

Medical
Dental Benefits
Extended Health Care Benefits
Group Life Insurance
Accidental Death & Dismemberment
Member & Family Assistance Program

NOTE 1: If you are not retired, you will re- qualify for the Full Plan on the first day of the second month following the month that the Plan has received some employer contributions and you have paid your Shortage Notice, for that second month, at the Full Plan contribution rate.

NOTE 2: The Limited Plan does not include Weekly or Long Term Disability Benefits.
NOTE 3: The Limited Plan is available to all members paying Shortage Notices.

Mini Plan

You may pay your Shortage Notice at a reduced hourly rate for the following Plan:

Medical
Extended Health Care Benefits
Group Life Insurance
Accidental Death & Dismemberment
Member & Family Assistance Program

NOTE 1: You will re-qualify for the Full Plan the first day of the month following the month that the Plan has received a total of 250 employer- contributed hours, at the current contribution rate, within a twelve (12) consecutive month period.
NOTE 2: the Mini Plan does not include Weekly Disability, Long Term Disability or Dental Benefits.
NOTE 3: The Mini Plan is available to all members paying Shortage Notices.

Plan B

You may pay your Shortage Notice at a reduced hourly rate for the following Plan:

Medical
Extended Health Care Benefits

NOTE 1: If you are on Plan B you cannot, at a later date, obtain the other benefits available to retired members unless, subsequent to that date, you have at least 250 hours reported and paid by a contributing Employer, at the Plan's current contribution rate, within a twelve consecutive month period.

NOTE 2: Plan B ceased to be available for new retirees as of January 31, 1994. Plan B will be maintained for those members enrolled on Plan B as of January 31, 1994 until protection is no longer required. Plan B will cease to exist when there are no longer any members protected under this Plan.

Retiree's Plan

You may pay your Shortage Notice at a reduced hourly rate for the following Plan:

Extended Health Care Benefits Group Life Insurance
Accidental Death & Dismemberment (if you are under age 70)
Member & Family Assistance Program

NOTE 1: Members electing the Retirees' Benefit Plan must apply for and maintain their own medical coverage.

NOTE 2: Retirees' Plan is available only if you are retired and eligible for benefits on the Operating Engineers' Benefits Plan.

NOTE 3: You may maintain the benefits of this Plan by making payments at a reduced hourly rate established by the Trustees.

NOTE 4: If you choose the Retirees' Benefit Plan you cannot, at a later date, obtain the other benefits available to retired members, with the exception of the Medical coverage, unless, subsequent to that date you have at least 250 hours reported and paid by a contributing employer, at the Plan's current contribution rate, within a 12 consecutive month period.

Associate Members – Eligibility for Benefits

(a) Associate Members are:
   (i) Persons who are Employers, contributing to the Plan for members of the Union and who have agreed to participate as Associate Members, and the non- bargaining unit employees of such Employers. All non-bargaining unit employees of such Employers must be Associate Members.

   (ii) Full-time employees of the Union, Benefits Plan, and Training Association.

   (iii) Employer Trustees and their employees.

(b) Associate Members are eligible for all benefits other than Long Term Disability.

(c) Eligibility for benefits begins on the first day of the month following the month in which the Plan Office receives from your employer:

(i) 250 employer contributed hours, at the Plan's current contribution rate;
(ii) Enrollment applications filed with the Plan office.

NOTE 1: Associate Members are not eligible for Long Term Disability.

NOTE 2: Employers of Associate Members are required to remit 125 hours monthly at the current Full Plan contribution rate. Such remittance and report are to be forwarded to the Plan Office not later than the 15th day of the month following the month for which the hours are being reported.

NOTE 3: Benefits for an Associate Member terminate on the last day of the last month for which the required payment has been made by the employer.

NOTE 4: Associate members are not eligible to self-pay for benefits.

Termination of Benefits

Eligibility for benefits is provided on a whole month basis with benefits terminating on the last day of the month if:

a) your Hour Bank falls below 125 hours and you fail to make the required payment by the date specified on your Shortage Notice, or you cease to be a member of the Union.

b) If your eligibility terminates as a result of Suspension of Union membership, your benefits under the Plan will cease until you have corrected your status. Upon receipt of verification of continuous membership, from the Local Union, your benefit eligibility will be reinstated retroactive to the date of cancellation. If you are reinstated from Suspension, with a break in continuous membership, your benefits will re-commence the first of the month following your reinstatement provided there are sufficient hours in your Hour Bank and the re-instatement occurs within a twelve-month period.

   Should you subsequently become Expelled from the Union, all hours then in your Hour Bank will be transferred to the General Fund. **THESE HOURS WILL NOT BE TRANSFERRED BACK TO YOU UNDER ANY CIRCUMSTANCES.**

c) If your eligibility terminates as a result of non-payment of a Shortage Notice, all hours then in your Hour Bank will be retained for a period of not longer than twelve months.

d) If your application for membership in the Union is not accepted or you were working under permit issued by the Union and your eligibility under the Plan was approved by the Union, you will continue to remain eligible for benefits for as long as there are sufficient hours in your Hour Bank.

e) If you take a withdrawal or a travel card from the Union to work elsewhere, you will continue to be eligible for benefits providing you meet the requirements for each benefit, for as long as there are sufficient hours in your Hour Bank.

f) If you die, your dependents will continue to be eligible for benefits for as long as there are sufficient hours in your Hour Bank.

g) You will not be credited with any hours reported and paid by a contributing Employer during the period of time when the Trustees have deemed that you are ineligible to receive benefits under the Plan, or during the period of time that you are inactive with the Union.

h) If you fail to pay a Shortage Notice and your Hour Bank remains below 125 hours, you will receive a Cancellation Notice. Payment of this notice must be made by the required date or benefits will remain cancelled and you will be subject to the eligibility requirements for Re-Qualification.

i) No benefit is paid and no reimbursement is provided for expenses incurred by you or your dependents for services or supplies which are provided to you or your dependents, or for any disablement or death which occurred to you or to your dependents before you became eligible for benefits, or after your eligibility for benefits under the Plan has terminated.

Re-Qualification after Benefits Terminate

If you reinstate your eligibility for benefits, you will be subject to the requirements as if you are a new member of the Plan. You may re-qualify for benefits provided:

a) a minimum of 250 hours are reported and paid to the Plan by a contributing Employer, a the Plan's current contributing rate, within a twelve consecutive month period after your eligibility for benefits terminated, and
b) you are a member of the Union, and
c) you have filed enrollment applications with the Plan office as required.
d) your eligibility for benefits begins on the first day of the month following the month in which **ALL** of these requirements are fulfilled.
e) You may not re-qualify by self-payment except by the payment of a current Cancellation Notice..

Notes

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PACIFIC BLUE CROSS™ BC Life

Dental Claims
604 419-2300

Extended Health Claims
604 419-2600

Toll-free
1 888 275-4672

Short-Term Disability Claims
604 419-8080

Life and Long-Term Disability Claims
604 419-8040

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Street Address
4250 Canada Way
Burnaby, BC

www.pac.bluecross.ca

CARESnet®

Plan details, claim history, direct deposit information and much more. Go to **www.pac.bluecross.ca** and activate your online access.

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