Joint Electrical Industry's

WELFARE PLAN

Address all inquiries to:

THE ADMINISTRATOR
JOINT ELECTRICAL INDUSTRY'S
WELFARE PLAN

4250 Canada Way
Burnaby, British Columbia V5G 4W6
Phone (604) 299-7482
Facsimile (604) 299-8136
Toll Free 1- 800-663-1356
Email: admin@datownley.com (Administration Inquiries)
Email: health@datownley.com (Claims Inquiries)

*Including amendments to July 1, 2022

PRIVACY POLICY

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

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

— The Trustees

The following is an outline of the Joint Electrical Industry's Welfare Plan. The information in this benefits booklet is important to you. It provides the information you need about the group benefits available through the Joint Electrical Industry's Welfare Plan.

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

The trustees are constantly attempting to provide benefits under the Plan to the Members in the most cost-effective manner. For some benefits, such as Dental, Weekly Indemnity and some portions of the Extended Health Benefits, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act.

SCHEDULE OF BENEFITS

Medical Services Plan of BC (MSP)	Group No. 4821427
Life Insurance	$100,000 $70,000 (age 65+)
Optional Life	as described herein
AD&D	Same as Life Insurance
Weekly Indemnity	Equal to EI Weekly Max Integrated with EI
Long Term Disability	$1,750 per month
Employee and Family Assistance Plan	
Extended Health Benefits	80%, unless otherwise stated

Prescription Drugs	80%, Generic Substitution $10.00 Dispense Fee Cap
Out of Province/Canada Emergency Medical Travel Insurance	$5,000,000 Maximum Per Coverage Period
Vision Care	100%, $500/24 months
TELUS Health Virtual Care	Online immediate medical support (does not apply to Members self-paying their coverage)
Dental	90% Basic Services 90% Major Services 50% Orthodontia
Transportation Assistance	as described herein

Details of Eligibility

Who is eligible?
Any Member of the International Brotherhood of Electrical Workers (IBEW) who is working under a Collective Agreement with Locals 230, 993 or 1003 and such Collective Agreement requires employer contribution to the Plan.

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

Do any Forms have to be completed?
YES. You must complete a Medical Services Plan application form and an Enrolment and Beneficiary card.

It is most important that EACH Member complete the required forms. These forms should be sent to the Administrators Office without delay.

How does a person qualify for coverage?
A Member in good standing must accumulate 150 hours or more of work within a 12 month period. Coverage will commence on the 1st day of the month following the month (lag) in which sufficient hours are reported and paid to the Plan by the employer(s).

	HOURS REPORTED		
MONTH	**MEMBER A**	**MEMBER B**	**MEMBER C**
January	50 hours	50 hours	150 hours
February	50 hours	125 hours	lag
March	30 hours	lag	qualified
April	50 hours	qualified	–
May	lag	–	–
June	qualified	–	–

Once coverage starts, you will continue to be covered as long as your Hour Bank contains sufficient hours. Upon qualifying for coverage for the very first time, you will be issued a pay-direct card. You will be issued one card if you have single coverage and two cards (both in the Member's name) if you have dependent coverage. You can use the pay-direct card when you visit your dentist, your ophthalmologist or optometrist, participating paramedical practitioners, when you fill a prescription or make a vision care purchase. Using

your card eliminates the requirement to file a claim – your claim is paid directly at point of sale.

As a Member 100 hours will be withdrawn each month from the Hour Bank. As an Owner/Operator 115 hours will be withdrawn each month from the Hour Bank. A maximum of twelve hundred (1200) hours can be accumulated in a Member's or Owner/Operators Hour Bank which will be drawn upon during a period of poor employment, lengthy illness or extended vacation.

When does coverage end?
Coverage will terminate when there are insufficient hours in the Member's Hour Bank to allow for a deduction of 100 hours or 115 hours if an Owner/Operator.

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

Disability Credits
When a Member is collecting benefits under the Weekly Indemnity Plan, EI Sick Benefits, Long Term Disability benefits or under Workers' Compensation, Members will receive assistance with their Hour Bank. For each day that the Member is disabled and on a claim that has been accepted for payment, the Member's Hour Bank will be credited with contributions of 8 hours, 7 days per week, subject to a maximum of 100 hours per month for Members and 115 hours for Owner/Operators for up to 12 months. The Member or Owner/Operator must request the appropriate form from the Administration Office and return the completed form to apply for Disability Credits. To qualify for these Disability Credits, the Member or Owner/Operator must be eligible for benefits when the disability commences.

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

Self-Pay
Members in good standing will be entitled to the following coverage on a self-pay basis

i) Those Members who have a residue of employer hours in their Hour Bank or who, although working regularly, do not have sufficient work to maintain the Hour Bank charge will qualify under **"shortage hours"** and will receive a billing showing the balance of hours required to make up the 100 hours needed each month to give a Member coverage under **"Plan A" or "Plan G" if the Member is 65 years of age or older. Shortage notices do not reduce the maximum months under self-payment.**

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

Plan A **(up to Age 65)**	**Plan B** **(up to Age 65)**
MSP	MSP
Life Insurance	Life Insurance
AD&D	AD&D
Weekly Indemnity*	Weekly Indemnity*
Extended Health Benefits	Extended Health Benefits
Supplemental Travel	Supplemental Travel
Vision	
Dental	

Plan G **(Age 65+)**	**Plan H** **(Age 65+)**
MSP	MSP
Life Insurance (reduced)	Life Insurance (reduced)
AD&D (reduced)	AD&D (reduced)
Weekly Indemnity*	Weekly Indemnity*
Extended Health Benefits	Extended Health Benefits
Supplemental Travel	Supplemental Travel
Vision	
Dental	

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

The first month in which a Member's Hour Bank falls below 100 employer hours, the Fund will absorb the difference out of general revenue. The following month, a Self-Payment or Shortage Hours Notice will

be sent to the Member's last known address and self-payment must be returned to the Plan Administrator within one month of the Member's Hour Bank falling below 100 hours. Members are required to sign a statement confirming that they are not working within the Trade except as authorized by their IBEW Business Manager.

The first 24 months of self-payments are subsidized by the Plan at 50% of the cost of such benefits. After 24 months of self-payments, the Plan will subsidize 30% of the cost of such benefits. As such, the cost of self-payments will be adjusted from time to time as deemed appropriate by the Board of Trustees. **Owner/Operators, whose company is active in the Electrical Contracting business, are not permitted to self-pay.**

The coverage available under self-payment is determined based on the Member's age and the cost is determined by the length of time since self-payments commenced.

In order to re-qualify for full benefits under the regular Plan, a Member must return to work and accumulate a minimum of 150 hours in his/her Hour Bank within a 12-month period.

Please Note: During the months that a Member is self-paying for coverage, the pay-direct card will not be activated/re-activated until payment is received by the Administrator and processed. If a prescription or other eligible benefit that would normally be claimed using the pay-direct card, is required prior to that, the Member or dependent will be required to pay for the expense and submit the claim to the Administrator for reimbursement.

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

Medical Services Plan of British Columbia
P.O. Box 9678 Stn. Prov Govt
Victoria, BC V8W 9P7

Do Not Ignore the Self-Payment or Shortage Hours Notice

If you receive a Self-Payment or Shortage Hours Notice and you think it is incorrect, contact the Administrator – D.A. Townley:

by telephone: (604) 299-7482
or toll-free: 1-800-663-1356

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

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

Can hours be suspended while working for another Local?

Hours can be "frozen" while you are covered with another IBEW Local.

Are there any reciprocity agreements with other Locals?

Joint Electrical Industry's Welfare Plan has Reciprocal Agreements with other IBEW Locals across Canada and the USA. If a Member is working in another Local with whom there is a Reciprocal Agreement in place, the contribution made on their behalf will be transferred to Joint Electrical Industry's Welfare Plan.

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

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

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

Are Dependents Covered under the Plan?

YES. The Plan will provide MSP, Dental, Extended Health Benefits and Vision Care for:

a) The spouse* of a covered Member;

b) Any unmarried child of a covered Member to age 21, (age 19 for MSP) provided such person is mainly dependent on and living with the covered Member;

c) Any unmarried child of a covered Member to age 25 can be covered provided the child is in full-time attendance at a recognized school, college, or university;

d) Any unmarried mentally or physically handicapped child of a covered Member to any age, provided such person is mainly dependent on and living with the covered Member or the spouse of the covered Member.

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

"Employee" means an individual who meets the eligibility requirements of the Plan.

When completing your application forms for coverage, please include all dependents to be covered. To add, delete or change the dependents covered, obtain a MSP Group Change Form and an Enrolment and Beneficiary card from the Administrator or your Union Office, and forward it to the Administrator's Office.

If I die do my Dependents remain covered?

If at the time of your death, you were an active Member, your surviving spouse and dependent children will be permitted to continue their coverage for twelve months on a self-paying basis once your Hour Bank has been exhausted.

If you were self-paying coverage will be continued for your surviving spouse and dependent children up to twelve months on a self-paying basis.

Bereavement

Employees will receive three (3) days leave at no cost to the Employer in the event of a death in their immediate family. Immediate family will be recognized as the employee's spouse (including common-law spouse), mother, father, sister, brother, son, daughter (including adopted son or daughter), grandfather, or grandmother. Additional unpaid bereavement leave may be granted upon request. NOTE: Contact your local union office for lost wages reimbursement forms.

Details of Coverage Provided by the Plan

MEDICAL SERVICES PLAN OF BC (MSP)

When you qualify for coverage, you will be covered by the Medical Services Plan of BC, provided you have completed the required MSP application form. If you do not apply for MSP coverage through the Plan at the time you become eligible to do so, the Plan will only make retroactive payments on your behalf back 6 months for MSP coverage. No premium will be required after December 31, 2019. If you are already covered for MSP, it is your responsibility to keep MSP updated on your dependent coverage and if your personal information changes.

LIFE INSURANCE

All eligible Active Members and Owner/Operators will be covered for $100,000 of Life Insurance. This coverage will reduce to $70,000 at age 65.

This amount of insurance is payable to the beneficiary designated by you should your death occur from any cause while you are insured under the group policy.

If you do not designate a beneficiary, the insurance will be payable to your estate.

Continuation of Life Insurance on Termination of Coverage

Your life would continue to be insured, at the conversion rate, under the group policy during the 31 day conversion period, whether or not you apply for an individual policy.

Only one such converted policy may be in force on a Member's life at any time.

If you Become Totally Disabled
Subject to satisfactory proof, submitted within 12 months from the date the insured person becomes Totally Disabled, an insured person who is under age 60 and who becomes Totally Disabled and continues to be disabled for 6 months, as a result of accident, injury or disease may, on written application, be eligible for the total amount of the Life Insurance to remain in force providing the person remains Totally Disabled, subject to termination at age 65. Proof of Total Disability will be required from time to time.

Living Assistance Benefit
The Living Assistance Benefit is available as an advance payment of a portion of the Life Insurance to help meet the medical or other health and welfare expenses of terminally ill Members. Please contact the Administrator.

OPTIONAL LIFE INSURANCE

Personal Life Insurance through Manulife Financial is available to you and your spouse. You can choose the amount of coverage that is right for you.

- Units of $25,000 are available for you and your spouse, up to a maximum of $500,000 each*
- A flat $20,000 is available for each child

*for amounts over $100,000 for you and $50,000 for your spouse, you'll need to answer medical questions on your application.

Paying for Personal Life Insurance is handled directly to Manulife Financial through pre-authorized monthly banking or credit card payments.

Please contact the Plan Administrator for a brochure, application and rates.

Applying is easy. Simply decide how much insurance you would like to purchase, check the cost, complete the application form and send it directly to Manulife.

Your Optional Life coverage will continue, provided premium payments are made, and does not terminate if your benefits under Joint Electrical Industry's Welfare Plan end. If you have any questions, call

1-800-268-6195 and provide policy number 888889.

ACCIDENTAL DEATH & DISMEMBERMENT

The Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed below in the Schedule of Losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is Covered?	**Amount of Coverage**
All eligible Members under age 65	$100,000
All eligible Members age 65+	$ 70,000
All spouses under age 70	$ 20,000
All eligible dependent children	$ 5,000

Schedule of Losses

Loss of Life ..... The Principal Sum
Loss of Both Hands ..... The Principal Sum
Loss of Both Feet ..... The Principal Sum
Loss of Entire Sight of Both Eyes ..... The Principal Sum
Loss of One Hand and One Foot ..... The Principal Sum
Loss of One Hand and the Entire
Sight of One Eye ..... The Principal Sum
Loss of One Foot and the Entire
Sight of One Eye ..... The Principal Sum
Loss of One Arm ..... Four-Fifths of the Principal Sum
Loss of One Leg ..... Four-Fifths of the Principal Sum
Loss of One Hand ..... Three-Quarters of The Principal Sum
Loss of One Foot..... Three-Quarters of The Principal Sum
Loss of the Entire Sight
of One Eye ..... Three-Quarters of The Principal Sum
Loss of Thumb and Index Finger
of the Same Hand ..... One-Third of The Principal Sum
Loss of Speech or
Hearing ..... Three-Quarters of The Principal Sum
Loss of Speech and Hearing ..... The Principal Sum
Loss of Hearing in
One Ear ..... Two-Thirds of The Principal Sum
Quadriplegia (total paralysis of both
upper and lower limbs) ..... Two Times The Principal Sum
Paraplegia (total paralysis of
both lower limbs) ..... Two Times The Principal Sum

Hemiplegia (total paralysis of upper and lower limbs of one side of the body) ..... Two Times The Principal Sum

Loss of Use of Both Arms or Both Hands ..... The Principal Sum

Loss of Use of One Hand or One Foot ..... Three-Quarters of The Principal Sum

Loss of Use of One Arm or One Leg ..... Four-Fifths of The Principal Sum

Loss of Four Fingers of One Hand ..... One-Third of The Principal Sum

Loss of All Toes of One Foot ..... One-Quarter of The Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye.

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

Loss of the Entire Sight of Both Eyes means the total and irrecoverable Loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty (20) degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing. Loss of Hearing in One (1) Ear means the diagnosis of permanent Loss of Hearing in one (1) ear, with an auditory threshold of more than ninety (90) decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing. Loss of Hearing

means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than ninety (90) decibels an ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing.

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

All claims submitted under this policy for Loss of Use must be verified by agreement between a licensed practicing physician appointed by the Administrator "the Plan" and a licensed practicing physician appointed by Blue Cross Life "the Company", or in the event that the two physicians so appointed cannot arrive at an agreement, a third licensed practicing physician shall be selected by the first two physicians and the majority decision of the three physicians shall be binding on the Plan and the Company. This procedure may be waived by the Company at its sole discretion.

Disappearance

If the body of an Insured Member has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that such Insured Member shall have suffered loss of life within the meaning of the policy.

Beneficiary Designation

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

All other benefits shall be payable to the Insured Member.

Repatriation Benefit

When Injuries covered by this policy result in loss of life of an Insured Member outside 50 Km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased

for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of $15,000.00.

Rehabilitation Benefit

If an Insured Member suffers an Injury which results in a payment being made by the Company under the Accidental Death and Dismemberment Indemnity section of this policy, the Company shall pay in addition:

The reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of the Insured Member provided:

a) Such training is required because of such Injuries and in order for the Insured Member to be qualified to engage in an occupation in which he would not have been engaged except for such Injuries,

b) Expenses be incurred within three years from the date of the accident,

c) No payment shall be made for ordinary living, travelling or clothing expenses.

Family Transportation

When Injuries covered by the policy result in an Insured Member being confined to a hospital, outside 100 Km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the reasonable and necessary expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Member but not to exceed the amount $15,000.00

Conversion Privilege

On the date of termination of coverage or during the 90-day period following termination of coverage, you may change your insurance to Blue Cross Life individual insurance policy. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the plan ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at

that time. Application for an individual policy may be made at any office of Blue Cross Life. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

Continuance of Coverage

In the case Members who are (1) laid-off on a temporary basis (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of twelve (12) months, subject to payment of premium. If a Member assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Waiver of Premium

In the event an Insured Member becomes totally and permanently disabled and his/her waiver of premium claim is accepted and approved under the Plan's current Group Life policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier:

a) The date the Insured Member attains age 65.

b) The date of the death or recovery of the Insured Member.

c) The date the Insured Member is no longer eligible for total disability waiver of premium under the Policyholder's group life policy; and

d) The date the Master Policy is terminated

Seat Belt Rider

Benefits under the policy shall be increased by 10% if the Insured Member's Injury or death results while he/she is a passenger or driver of a private passenger type automobile and his/her seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Home Alteration and Vehicle Modification

If an Insured Member receives a payment under The Schedule of Losses herein and was subsequently required (due to the cause for which payment under The Schedule of Losses was made) to use a wheel-

chair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

a) The one-time cost of alterations to the Insured Member's residence to make it wheel-chair accessible and habitable; and

b) The lesser of:

   i) the one-time cost of modifications necessary to a motor vehicle, owned by the Injured Insured Member, to make the vehicle accessible or drivable for the Insured Member; and

   ii) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Company.

Benefit payments herein will not be paid unless:

i) Home alterations are made on behalf of the Insured Member and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

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

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

Dependent Child Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will reimburse the annual tuition, not including room and board, charged by an Institution of Higher Learning per school year for each Dependent Child of such Insured Member up to the lesser of the following amounts:

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

b) 5% of such Insured Member's Principal Sum.

This benefit is payable annually up to a maximum of four (4) consecutive payments per Dependent Child:

a) only for such Dependent Child who is, at the time of such Insured Member's Loss of Life, enrolled as

a full-time student in an Institution of Higher Learning beyond the twelfth (12th) grade level; and

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

The Company will reimburse the person who incurred the actual tuition expenses.

Spousal Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the Insured Member's Spouse the actual cost incurred for a professional or trades training program in which such Spouse enrolls for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than thirty (30) months after the Insured Member's Loss of Life.

The maximum amount payable for this benefit is fifteen thousand dollars ($15,000.00) per Insured Member.

"Dependent Child" as used herein means any unmarried child under 26 years of age who was dependent upon the Insured Member for at least 50% of his maintenance and support.

"Institution of Higher Learning" as used herein includes, but is not limited to, any university, private post secondary college or trade school, and any College of General and Vocational Education/ Collège d'enseignement général et professionnel (CÉGEP).

Day Care Benefit

If an Insured Member suffers Injury resulting in Loss of Life for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the legal guardian of any surviving Dependent Child of the Insured Member, an amount equal to the lesser of the following:

a) the actual annual cost charged by a commercial and licenced day care centre; or

b) 5% of the Insured Member's Principal Sum; or

c) five thousand dollars ($5,000.00) per year.

This benefit is payable annually for a maximum of four (4) consecutive payments per Dependent Child:

a) and only for such Dependent Child who at the

date of the Insured Member's Loss of Life is under age thirteen (13);

b) provided such Dependent Child is enrolled in commercial and licenced day care centre no later than ninety (90) days following the Insured Member's Loss of Life; and

c) provided that the Dependent Child continues his or her enrollment in a commercial and licenced day care centre.

In-Hospital Benefit

If an Insured Member suffers injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses, and as a consequence of such Loss the Insured Member is, pursuant to the instructions of a Physician, confined to a Hospital for more than five (5) consecutive overnight stays, the Company will pay:

a) for a period of confinement in Hospital of more than thirty (30) consecutive overnight stays, 1% of the Insured Member's Principal Sum; or

b) for a period of confinement of thirty (30) consecutive overnight stays or less, one thirtieth (1/30) of the amount determined for each overnight stay in Hospital.

The Company will pay this benefit monthly, retroactive to the first (1st) overnight stay of confinement in Hospital.

The maximum amount payable for this benefit for all injuries resulting from any one (1) accident per insured is two thousand five hundred dollars ($2,500.00) per month.

Benefits are not payable for more than a total of twelve (12) months of confinement for any one (1) accident causing Injury.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than three (3) months, are considered one (1) period of confinement to Hospital for the purposes of calculating this benefit.

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

(1) holds a license as a hospital (if licensing is required in the province);

(2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

(3) provides 24-hour a day nursing service by registered or graduate nurses;

(4) has a staff of one or more licensed physicians available at all times;

(5) provides organized facilities for diagnosis, and major medical surgical facilities; and

(6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

If an Insured Member suffers Injury causing Permanent and Total Disability, the Company shall pay the amount which is 100% of the Principal Sum for the Insured Member less any amounts under the Table of Losses which have been paid or which are payable by the Company for Losses of the Insured Member.

EXCLUSIONS

No coverage shall be provided under this contract and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

a) suicide or any attempt thereat by the Insured Member while sane;

b) self inflicted Injury or any attempt thereat by the Insured Member while sane or insane;

c) declared or undeclared war or any act thereof;

d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

f) Injury sustained while the Insured Member is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

g) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;

h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Member is:

   i) riding as a passenger in any aircraft not intended or licenced for the transportation of passengers; or

   ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

   iii) riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder.

i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

j) Injury or Loss sustained while the Insured Member is on full-time duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Member is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

k) Injury or Loss sustained while the Insured Member is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while his or her blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;

l) Injury or Loss sustained while the Insured Member is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licenced Physician;

m) the commission or attempted commission by an Insured Member or Injury incurred while an Insured Member is in the course of committing or attempting to commit any act which if adjudicated

by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

n) an act, attempted act or omission taken or made by the Insured Member, or an act, attempted act or omission taken or made with the Insured Member's consent, for the purposes of interrupting the blood flow to the Insured Member's brain or to cause asphyxiation to the Insured Member whether with intent to cause harm or not; and

o) natural causes.

WEEKLY INDEMNITY BENEFIT

Weekly Indemnity Benefits will be paid to each Active Member and Owner/Operator who is disabled and unable to work as the result of a non-occupational accident or sickness. Benefit payment commences on the 15th day of a non-occupational accident or sickness if you are not entitled to EI sick pay. The maximum benefit period is 26 weeks for Weekly Indemnity and EI medical payments combined. Rejection by EI must accompany any Weekly Indemnity claim.

Note: Benefits will not commence prior to the day you are seen and treated by a physician. Members or Owner/Operators whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Member or Owner/Operator qualifies for coverage under the Plan.

The maximum number of weeks includes weeks the Member or Owner/Operator is receiving EI medical payments.

How to claim for Weekly Indemnity:
Take the following steps as soon as possible after you have become disabled:

a) Contact your doctor immediately upon becoming disabled. You must be seen and treated during the time of your disability.

b) Obtain an EI Claims Kit from the Employment Office. The physician's report must be completed and a copy sent to the Administration Office in order that they may provide the Member with Disability Credits.

c) If the Member is not eligible for EI sick benefits, he/she must obtain a claim form from the Administration Office as he/she is entitled to submit a claim to the Joint Electrical Industry's Weekly Income Plan, provided a copy of the EI rejection letter accompanies the claim. **Claimants must be under the care of a physician and be treated in person during the period claimed for.**

d) Complete the front of the claim form.

e) The attending physician must complete the Physician's Statement on the back of the same form. If there is any charge for completing this form, it is the claimant's responsibility.

f) Claim for disability must be submitted no later than 30 days after your total disability begins unless special circumstances prevent such.

On what basis are the Weekly Indemnity Benefits paid?
Claim cheques are mailed to your home address at the end of each 7 day period on the basis of a 7 day work week up to a maximum of the current EI maximum provided that the Member is not eligible for EI sick benefits, including Saturdays and Sundays.

All substance abuse claims will be paid a maximum Weekly Indemnity benefit of 5 weeks provided that you are in a rehabilitation centre and remain there for the full course of treatment.

Is it necessary to consult a physician in person before making a claim for Weekly Indemnity Benefits?
Yes. The physician's report is required to establish the record of your inability to work and regular medical attendance will be required for the duration of the claim.

Will further medical reports be required?
Yes, depending on the nature of the illness and in addition, you may be required to provide additional medical evidence.

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

a) a third party may be, directly or indirectly, either in whole or in part, liable to the Member or

b) the Member has a claim for benefits under workers compensation legislation;

the Plan will not pay benefits to the Member.

EXCLUSIONS and LIMITATIONS:
No benefit will be paid for periods of disability:

- arising from occupational accident or illness, as these are covered by the WorkSafe BC/WBC Act;
- arising from your commission of or attempt to commit an assault or criminal offense;
- arising from self-inflicted injuries or sickness;
- substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician;
- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service;
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from EI, or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence;
- during which the insured is receiving or eligible to receive EI benefits;
- if you become disabled during a strike or lockout at your place of employment; however, your rights to benefits will be reinstated when the strike or lockout ends;
- arising from an automobile accident where a third party may be, directly or indirectly, either in whole or in part, liable to the Member.

TERMINATION OF BENEFIT

Your benefit payments will cease on the earliest date one or more of the following occurs:

- you are no longer disabled;
- your are no longer receiving continuing medical care or treatment from your physician;

- you fail to submit satisfactory proof of continuing disability as required by the Plan;
- you refuse a medical examination by a physician chosen by the Plan;
- you are no longer following the treatment recommended for your disability;
- you leave the province, state or country where you normally work and live, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by the Plan;
- you perform any work for compensation or profit;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire; or
- you die.

LONG TERM DISABILITY

If a Member or Owner/Operator becomes Totally Disabled while covered under the Long Term Disability Benefit, the Plan will pay the benefits for which that Member is eligible in accordance with the following Benefit Schedule:

All eligible Members under age 65:	Flat $1,750*
Benefit Waiting Period:	180 days of total disability
Duration Period:	to age 65
Definition of Disability:	2 year own occupation, any occupation thereafter
All Source Maximum:	85% of your inflation-indexed, pre-disability earnings.
Taxable Status:	Taxable

*The benefit amount cannot exceed 85% of the Eligible Member's average gross monthly earnings. If the benefit exceeds 85% the benefit will be reduced by the amount that the benefit exceeds the 85% threshold.

Benefit increased from $1,500 to $1,750 for claims incurred on or after June 1, 2021.

Benefit Payment Waiting Period
A Member must be Totally Disabled for a period of 28 weeks or for the duration of the Weekly Indemnity benefit period, whichever is greater.

Total Disability Benefit
If you become Totally Disabled while insured for this benefits, incur a loss of time from work and a loss of earnings, and remain disabled for longer than the Benefit Payment Waiting Period, you will be eligible for the monthly disability income payments described below and no premium will be required for this benefit.

Your disability, due to sickness or bodily injury, must require the regular and ongoing care of a legally qualified physician appropriate to the sickness or injury and must prevent you:

- for the first 24 months of benefit payments, from performing the substantial duties of your own occupation, and
- thereafter, from performing any gainful occupation for which you are or may reasonably become qualified by training, education, or experience.

The benefit provider will monitor the quality and appropriateness of medical care and also reserves the right to refer you to a specialist for proper ongoing treatment.

Integration of Benefits
Your Monthly Integrated Benefit will be your Monthly Benefit reduced by an amount equal to the amount by which your Income from All Sources exceeds the All Source Maximum shown in the Benefit Schedule.

Rehabilitation Programme
While you are receiving Long Term Disability benefits, if you participate in an approved rehabilitation programme which is supervised by a physician, you may still be considered Totally Disabled, subject to the continued approval of the benefit provider.

Benefit payments under the plan will be reduced by 50% of your monthly net (after tax) earnings from the rehabilitation programme.

Your total amount of income from “all sources”

including remuneration from the rehabilitation programme, must not exceed 100% of your inflation-indexed, pre-disability earnings.

Benefit Payment Termination
You will stop receiving benefits on the earliest of:

1. attainment of the maximum age as specified under Age Termination in the Benefit Schedule;
2. failure to satisfy any of the following:
    a. furnish written proof satisfactory to the Insurer of your disability,
    b. submit to a medical examination by an independent physician of the Insurer's choice,
    c. accept medical treatment by a specialist covering your disability when requested by the Insurer,
    d. receive medical supervision and treatment,
    e. enter into a rehabilitation programme considered appropriate by the Insurer and its medical advisors,
    f. agree in writing to reimburse the Insurer, following written request to do so, for any amounts paid by the Insurer that are recoverable from a third party;
3. end of disability as outlined in the group policy;
4. death; or
5. commencement of any occupation for wage or profit other than as specifically described in the group policy.

Extension
If your insurance terminates while you are Totally Disabled, the Insurer will pay the same amount as if insurance had not terminated if:

1. you are receiving monthly benefits or are completing the Benefit Payment Waiting Period,
2. a physician certifies that you were Totally Disabled when insurance terminated, and
3. you continue to be Totally Disabled.

However, there is no extension if the Insurer receives "late notice" of disability. "Late notice" means more than 6 months from either: termination of insurance (provinces other than Quebec) or commencement of

disability (Quebec).

Recurrent Disability

1. If you have satisfied some but not all of the Benefit Payment Waiting Period, return to work for up to a maximum of 2 weeks, and subsequently become disabled as a result of the same or related disability, then the Insurer shall consider the subsequent period of disability as a continuation for the purpose of satisfying the Waiting Period. Only one period of continuation will be allowed per disability.
2. If you have satisfied the Benefit Payment Waiting Period and received Monthly Integrated Benefits, return to work for up to a maximum period of 6 months, and subsequently become disabled as a result of the same or related disability, then the Insurer shall consider the subsequent period of disability as a continuation, and no new waiting period shall be required.

Benefit Offsets

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

- as a Long Term Disability Benefit;
- from any job for pay or profit (except under an approved rehabilitation or partial disability program); or
- because the Member is disabled or retired under any plan required or provided by a government or pursuant to a statute, such as, but not limited to, Workers' Compensation and any Automobile Insurance Act; and
- because the Member is disabled or retired under any other group insurance, benefit, or other arrangement for members of a group (whether on an insured basis or not.

to 85% if pre-disability earnings.

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

- as a retroactive award, benefit payments will be adjusted to reflect any overpayment that may have been made

- other than monthly, such income will be converted to a monthly basis; or
- in a lump sum payment for loss of future income, no further benefits will be paid until such time as the sum of the benefit payments otherwise payable equals the amount of each sum.

This benefit will not be reduced by income payable from:

a) the Canada or Quebec Pension Plan (CPP/QPP);

b) disability or retirement benefits at the level that the Member was receiving them prior to the date of becoming Totally Disabled under this Benefit; or

c) any individual disability insurance, exclusive of accident benefits payable under an automotive policy;

unless the total amount of disability related income, including benefits described in a) (CPP/QPP) exceeds 85% of the disabled employees pre-disability gross monthly income.

Limitations

1. No benefit will be paid for any disability which directly or indirectly results from:
   a. intentionally self-inflicted sickness or injury;
   b. any act of insurrection or war, or participation in a riot;
   c. your commission or attempted commission of any criminal offence (including an offence related to driving a vehicle while under the influence of alcohol).
2. No amount will be payable for any period:
   a. during which you are in prison;
   b. during a leave of absence for any reason if you had arranged the leave with your Employer prior to commencement of disability; or
   c. during which you are absent from Canada.
3. For a period of disability due to the chronic use of alcohol or drugs (prescribed or otherwise) or the use of any hallucinogen, benefits will be payable for a maximum of 12 months and only if you are actively participating in a medically supervised rehabilitation programme approved by the Insurer.

The Insurer will also pay your cost for such a programme.

4. No amount is payable for a total disability due to a condition for which you were treated or attended by a physician, or for which prescription drugs were taken, within 3 months prior to the effective date of your insurance. This limitation will not apply after you have performed all the duties of your regular occupation on a full-time basis for 3 months after the applicable effective date.

Right to Recover
If the Insurer makes any payment of benefits to you which you have the right to recover from any other person, the Insurer reserves the right to recover the amount of such payments. You will be expected to do everything necessary within your power to secure such rights of recovery.

For a **Long Term Disability claim,** submit written proof of loss (completed claim form) 6 weeks before the end of the waiting period.

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

The EFAP is a voluntary, confidential, short-term counseling and advisory service that connects you and your eligible family members to a network of dedicated professionals who are available to give you assistance 24 hours a day, 7 days a week, 365 days a year.

This benefit provides professional assistance for a wide range of issues such as:

- Personal and work-related stress;
- Couple and marital relationships;
- Childcare and parenting issues;
- Family matters;
- Eldercare concerns;
- Depression and anxiety;
- Alcohol and drug abuse;
- Legal matters and financial concerns.

Please refer to the website: www.workhealthlife.com or call 1-844-880-9137.

Note: When contacting Shepell be sure to advise

them that you are covered under the Joint Electrical Industry's Welfare Plan.

EXTENDED HEALTH BENEFITS

There is a $100 annual deductible per Member or family per calendar year applied to eligible prescription drugs only. In-Canada expenses are reimbursed at 80% unless otherwise indicated and all In-Canada eligible expenses will be reimbursed up to a lifetime maximum of $1,000,000 if under age 65, to a lifetime maximum of $100,000 if aged 65 to 79 inclusive and from age 80 to a lifetime maximum of $20,000. Benefits in excess of $25,000 provided by Joint Electrical Industry's Welfare Plan self-insured Extended Health Care program will be limited to those expenses incurred within 52 weeks of the date of the covered injury or sickness

Out of Province/Canada Emergency Medical Travel Insurance coverage is provided to eligible Members and their dependents up to a maximum of $5,000,000 per coverage period. For those who are the age of 80 through to 98, there is a pre-existing condition limitation wherein any such condition must be stable for a minimum of 90 days prior to travel. Full details and restrictions are outlined in the full Emergency Medical Travel Insurance Booklet available from the Administrator.

The Extended Health Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

Benefits:
The Extended Health Benefit is designed to help you pay for specified services and supplies incurred by you and your dependents, when not provided under a government health plan or by a tax supported agency.

The following are classed as eligible expenses when incurred as the result of necessary treatment of illness or injury and where applicable when ordered by a physician.

1) Prescription Drugs – present your pay-direct card, along with your prescription, to your pharmacist and your prescription drug claim will be adjudicated right at the pharmacy. Using your pay-direct card eliminates the need to send in

your prescription receipt and wait for reimbursement. Your Plan provides coverage for prescription drugs and medicines (including oral contraceptives) which require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits. Coverage of prescription drugs is based on the cost of the lowest priced generic equivalent drug. Dispensing fees are covered to a maximum of $10.00 per prescription filled and dispensing fee charges over $10.00 will be your responsibility. Drugs and medicines are limited to a 90 day supply. Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Vacation supplies of your medications, which are outside the regular days supply limits must be pre-authorized by the Plan and must be paid for in full by the Member and submitted to the Plan for reimbursement. Drugs and medicines that can normally be purchased "over the counter" are excluded regardless of a prescription having been issued. Vitamins, preventative drugs, dietary foods and supplements are also excluded. Smoking cessation products will be covered up to a lifetime maximum of $500 per person. Fertility drugs are covered up to a lifetime maximum of $5,000.

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

PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for Fair PharmaCare call 1-800-663-7100 or from the Lower Mainland call 604-683-7151 or visit the BC Fair PharmaCare website:
https://my.gov.bc.ca/fpcare/registration/requirements

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

2) Charges in excess of the amount payable under the Insured Person's Basic Medical Plan for professional licensed ambulance service in an emergency including transportation by railroad, boat or airplane, or in acute emergency by air ambulance, from the place where the injury or sickness occurs to the nearest acute general hospital and return fare, including round trip fare for one attending person (doctor, nurse, first aid attendant), where necessary. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation arranged at the patient's convenience are not eligible expenses.

3) Charges for out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. These services are covered up to a maximum of $25,000 per 52-week period.

4) Convalescent Home or Physical Rehabilitation Facility room and board charges, excluding charges for chronic care, if the Insured Person's residence in the institution:

   1. is certified as medically necessary by a Physician,
   2. occurs after a Hospital stay, and
   3. is due to the same sickness or accidental bodily injury which was the reason for the Hospital stay.

   Charges are limited to reasonable and customary Room and Board charges, and the institution's charge, up to a maximum of 120 days. All confinements in a convalescent hospital will be considered as one period of disability unless confinements are separated by at least 90 days.

5) You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, speech therapist, acupuncturist, podiatrist, chiropractor, naturopath or physiotherapist, who is registered and legally practicing within the scope of his/her license. These charges will be covered at 100% up to a calendar year combined maximum of $1,000 per insured person.

6) You can use your pay-direct card for the charges of a registered psychologist. Coverage is provided at 100% up to a maximum of ten (10) visits per calendar year per person. Charges for the services of a registered clinical counselor or a licensed social worker or Valentus Clinics are included in this combined calendar year maximum.

   Coverage for 100% confidential counseling is also available under the Plan's EFAP benefit provided by Morneau Shepell at no charge to Members and their eligible dependents.
   www.workhealthlife.com or 1-844-880-9137.

7) Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies.

8) Charges for walkers, canes and cane tips, crutches, splints, casts, collars and trusses but not elastic or foam supports.

9) Charges for testing supplies, needles and syringes for diabetics.

10) Charges for surgical stockings to a maximum of 3 pair per calendar year.

11) Charges for stump socks.

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

13) Cataract surgery foldable lens.

14) Custom built orthopedic shoes will be reimbursed at 50% to a maximum of $250 per calendar year when prescribed by a physician or podiatrist and replacements when necessary due to normal wear and tear. Modifications to stock items are not a covered expense.

15) Custom fitted orthotics when prescribed by a physician or podiatrist and replacements when necessary due to normal wear and tear to a maximum of $400 per calendar year. Reimbursed at 50%.

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

17) Cost of rental or where more economical, purchase of durable equipment for therapeutic treatment including wheelchairs and hospital beds. CPAP Machines / Mandibular Repositioning Appliances for Respiratory Dysrhythmia / Sleep Apnea. Prior authorization and physician's referral are required. Electric wheelchairs are covered only when a doctor certifies the patient is incapable of operating a manual wheelchair (e.g. Paraplegic).

18) Charges made by a dentist for the repair or replacement of sound, vital, natural teeth or the setting of a fractured or dislocated jaw if:

- those services are required as a result of a direct accidental blow to the month and not as a result of an object placed in the mouth;
- the accident occurred while the person is covered under this benefit; and
- the charges are incurred within 60 days of the date of the accident.

19) Hospital charges made by an approved acute general hospital in B.C. for the difference between ward cost and semi-private room, or if required as medically necessary by a physician, private accommodation (not including rental of telephone, T.V. etc.).

20) Costs of hearing aids to a maximum of $700 in a 5 year period for adults and dependent children. In addition to traditional hearing aids, wireless Bluetooth hearing aids are also eligible. Maintenance, batteries or other accessories will not be covered.

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

22) You can use your pay-direct card when you visit a Licensed Optometrist or Ophthalmologist for an eye examination, up to a maximum of $65 every 24 months.

23) Prostate Screening Assessments (PSA Tests)

24) Vaccines for Shingles.

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

a) expenses for benefits, care or services payable by or under the Basic Medical Plan, Pharmacare, any Hospital Program or the Worker's Compensation Act, whether or not a claim is made thereunder or provided without cost or at nominal cost by any public or tax-supported authority or agency or for which the Member or dependent can recover from another party.

b) expenses of dental services or care or dentures except as specifically provided in Item 18.

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

d) expenses incurred outside the Province of British Columbia unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out of Province/Canada Emergency Medical Travel Insurance or if pre-approved under the Medical Referral Benefit as described herein.

e) expenses of services and supplies for cosmetic purposes.

f) expenses caused, contributed to or necessitated as a result of:
   - war or any act of war or participation in a riot or civil insurrection;
   - injury or sickness which was intentionally self-inflected, whether sustained or suffered while sane or insane;
   - occupational illness or injury; or
   - the commission by the person of any unlawful act including an offense under the Criminal Code of Canada.

g) any expenses that a covered person may obtain as a benefit under any government plan or law.

h) any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging

which represents an amount in excess of the schedule of costs prescribed by the Medical Services Plan.

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

Medical Referral Benefit

The Medical Referral Benefit provides coverage for reasonable and customary charges for medical and transportation expenses in excess of those expenses covered by the insured person's government health insurance plan, Health Insurance Plan or EHC plan, for the insured person and an approved escort, up to a lifetime maximum of $75,000 per person, as a result of a pre-approved medical referral for treatment, subject to the following conditions:

a) the treatment must not be available within 500 kilometres from your residence; and

b) the medical referral service must be obtained in Canada, if available, regardless of any waiting lists; and

c) your attending Canadian physician and a qualified Canadian medical specialist from an appropriately related medical field must recommend the treatment; and

d) the referral service must be eligible for reimbursement and paid in whole or in part by your government health insurance plan or Health Insurance Plan (a written pre-authorization from your government health insurance plan or Health Insurance Plan outlining their liability is required); and

e) if your government health insurance plan, Health Insurance Plan or EHC plan covers and reimburses the full medical referral expenses, no benefits are payable; and

f) the treatment must not be experimental or investigative in nature; and

g) medical services and travel must take place within 30 days of receiving approval from your government health insurance plan or Health Insurance Plan, unless the earliest possible treatment date exceeds 30 days from the date of approval; and

h) the medical referral must be pre-approved, following submission of a request for pre-approval in writing to Global Excel, along with supporting documentation.

Out of Province/Canada Emergency Medical Travel Insurance

Emergency Medical Travel Insurance provides coverage for eligible Members under the age of 99 and their eligible dependents for certain expenses incurred as a result of an emergency while travelling outside your province. This travel insurance is underwritten by the Manufacturers Life Insurance Company (Manulife). Manulife has appointed Global Excel Management (Global Excel) as the provider of all assistance and claims services under this policy.

While you are travelling outside your province of residence carry the wallet card that has been provided to you. For those who are the age of 80 through 98, there is a pre-existing conditions limitation, wherein any such condition must be stable for a minimum of 90 days prior to travel. Refer to the full Emergency Medical Travel Insurance Booklet for full details and restrictions.

Coverage Period: 60 days per trip

Policy Number: DAT00013343

Out of Province/Canada Emergency Medical Travel Insurance coverage has a maximum of $5 Million per coverage period, provided you are under the age of 99.

IF YOU HAVE AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY BEFORE SEEKING TREATMENT. THEY ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK AND CAN BE CONTACTED BY CALLING:

From Canada and the United States,
call TOLL FREE 1-833-685-2790

From anywhere else in the world,
call COLLECT + 519-735-9448

You must notify Global Excel before obtaining emergency treatment, so that they may:

- confirm coverage
- provide pre-approval of treatment

If it is medically impossible for you to call prior to obtaining emergency treatment, call or have someone call on your behalf as soon as possible. If you fail to notify Global Excel, the Insurer reserves the right to limit your benefits as follows:

- The Insurer will not pay expenses for benefits that are not approved by Global Excel, if pre-approval is required; and
- In the event of hospitalization, 80% of eligible expenses, based on reasonable and customary charges, to a maximum of $25,000; and
- In the event of an outpatient medical consultation, a maximum of one visit per sickness or injury.

You will be responsible for payment of any remaining charges.

Some treatments require pre-approval in order to be covered. For more details refer to the full Emergency Medical Travel Insurance Booklet, available upon request from the Plan Administrator.

If you do not contact Global Excel prior to seeking treatment, the medical treatment you receive may not be covered by this insurance. Global Excel can direct you to a medical facility or doctor in your area of travel. If you contact Global Excel at the time of your emergency, they will ensure that your covered expenses are paid directly to the hospital or medical facility, where possible.

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your coverage before you travel, as your coverage is subject to certain limitations and exclusions.

Pre-existing medical condition exclusions may apply to medical conditions and/or symptoms that existed before your trip. Refer to your Schedule of Benefits outlined above your Manulife/Global Excel Assistance Wallet Card to determine how these exclusions affect your coverage and how they relate to your departure date. In the event of a claim, your medical history will be reviewed after a claim has been reported.

Your insurance provides travel assistance. You are required to contact Global Excel prior to treatment. Failure to do so limits benefits.

Coverage is for an unlimited number of trips up to the coverage period for each trip (60 days per trip); however, each trip must be separated by a return to your province.

Coverage must be in effect before you leave your province. You do not need to provide advance notice of your departure date and return date for each trip. However, you will be required to provide evidence of these dates when filing a claim, for example, an airline ticket or boarding pass.

A Manulife/Global Excel Assistance Wallet Card, with worldwide contact numbers, for the Emergency Medical Travel Insurance coverage should be carried by the Insured when travelling. These cards, along with the Schedule of Benefits and the full Emergency Medical Travel Insurance booklet can be obtained from the Plan Administrator.

Members working outside of Canada must independently arrange for additional coverage.

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

If in Canada or the United States,
call toll free at: 1-833-685-2790

From anywhere else in the world,
call collect to: + 519-735-9448

During your call, you will be given all the information required to file a claim. You will be asked to substantiate your claim by providing all required documents. Failure to do so may result in non-payment of your claim. The Insurer is not responsible for fees charged in relation to any such documents. Incomplete documentation will be returned to you for completion.

When making a claim, you may be required to complete a Claim & Authorization Form along with providing supporting documentation such as:

- Complete original unused transportation tickets and vouchers if the Emergency Air Transportation or Return of Travel Companion benefit is used.

- All original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all relevant dates and type of treatment, and the name of the hospital or medical facility and/or physician.

- All original prescription drug receipts (not cash receipts) from the pharmacist, physician, hospital or medical facility showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.

- Proof of your departure date and return date. While boarding passes are preferred, airline tickets or other proof of departure date from your province, may be accepted, provided it contains your name and the location and date of your purchase.

- Any other additional documents pertinent to your claim, as may be required by Global Excel.

Failure to complete the required Claim & Authorization Form in full may delay the assessment of your claim.

All sums under this Plan are in Canadian currency unless otherwise indicated. If you paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

All pertinent documents should be sent to:
Global Excel Management Inc.
73 Queen St. Sherbrooke, Quebec J1M 0C9

Online Claim Submission:
Visit **https://manulife.acmtravel.ca** to submit your claim online. For faster and easier submissions, have all your documents available in electronic format, such as a PDF or a JPEG.

VISION CARE

(eyeglasses/contact lenses)

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

Covered Expenses

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

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

b) one set of frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable;

c) contact lenses prescribed by a person legally qualified to make such a prescription;

d) prescription safety glasses.

Payment of Expenses

The maximum amount payable during any period of 24 consecutive months shall be 100% of the actual expense incurred or $500.00, whichever is the lesser for an eligible adult and for dependent children. The Plan will allow you to submit (resubmit) a receipt for Laser Eye Surgery or Intraocular Lens Implant Surgery that occurred while you are covered under the Plan, and while you remain covered under the Plan, a maximum of 5 Vision Care cycles or until paid in full if sooner.

EXCLUSIONS and LIMITATIONS

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

a) duplicate or spare eye glasses or any lenses or frames thereof;

b) non-prescription safety glasses;

c) safety goggles (plain or prescription);

d) sun glasses (plain or prescription);

e) replacement or lost, stolen or broken lenses or frames.

TELUS HEALTH VIRTUAL CARE

Provides eligible Members and their families with confidential online virtual access to doctors, medical practitioners and other health care professionals without having to leave home or the workplace, avoiding travel and wait times that come with traditional medical appointments.

TELUS Health Virtual Care provides immediate, professional support from a desktop/laptop computer, tablet or smart phone. Once registered and logged in to TELUS Health Virtual Care, you will enter your name and the reason for the consult, and a TELUS Health Virtual Care Manager will be accessed to gather the information necessary to connect you with the appropriate medical practitioner. The assigned practitioner can address basic physical and mental medical needs, issue referrals to specialists, issue and renew prescriptions and lab or other diagnostic tests ordered, as appropriate.

To set up an account, visit **virtualcare.telushealth .com/welcome** and you will need your **Client ID number** from your pay-direct card and use **Group number 4239**. You will also need to have government-issued ID handy (Provincial Health Insurance Card, Drivers License or Passport). You will be prompted to enter the email address you would like to use to set up your account, along with your province. Select your eligibility type and select the option to enter your group number (4239) and your personal coverage identifier (your Client ID Number). You will receive an activation link. Follow the link in the email you receive to activate your account. Then sign in with your email address and choose a password.

Now you are set to download the TELUS Health Virtual Care app from the App Store or Google Play. Use your account credentials to sign in to the app and ensure you enable notifications. You can then set up your profile under the Profile tab and add any family members. If you need help, contact **help@vc.telushealth.com**

Now you are ready to start a consult from the home screen as soon as you need care.

This benefit is not available to Members who are self-paying for their coverage.

DENTAL PLAN

The Dental Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you. The Plan provides pay-direct claims processing using your pay-direct card. Present your pay-direct card to the receptionist when you arrive at your dentist's office for your appointment.

Basic and Major Services have an annual combined maximum of $2,500 per person.

Part I – Basic Services

The following services are eligible for coverage at the lesser of 90% of the amount charged or 90% of the Dental Association Fee Guide (General Practitioner) in the Province of residence.

1) Diagnostic Services

   All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:

   - Complete oral examinations are limited to one in any three-year period
   - Recall oral examinations are limited to two in any calendar year
   - Specific examinations
   - Consultations (as a separate appointment)
   - Dental X-Rays: bite-wing x-rays are limited to one set in any six-month period, full mouth x-rays are limited to one set in any three-year period and panoramic film is limited to one x-ray in any three-year period
   - Diagnostic models are limited to reasonable and customary

2) Preventative Services

   All necessary procedures to prevent the occurrence of oral disease, including:

   - Cleaning, prophy and topical application of fluoride – two per calendar year
   - Scaling and root planing – 16 units per calendar year
   - Pit and fissure adhesive sealants
   - Fixed space maintainers on primary teeth

3) Surgical Services
   All necessary procedures for extractions and other routine oral surgical procedures normally preformed by a dentist.

4) Restorative Services
   All necessary procedures for:
   - Filling teeth with amalgam, silicate, acrylic or composite restorations
   - Replacement restorations if at least 12 months has elapsed since initial placement
   - Stainless steel crowns on primary teeth
   - Gold Foil only when used to repair existing gold restorations.

5) Prosthetic Repairs and Maintenance
   Denture maintenance, after the 3 month post insertion care period, including:
   - denture relines for dentures at least 6 months old, once every 36 months
   - denture rebases for dentures at least 2 years old, once every 36 months
   - resilient liner in relined or rebased dentures, once every 36 months

6) Endodontia (Root Canals)
   All necessary procedures required for pulpal therapy and root canal filling. Repeat treatment is covered only if the original treatment fails after the first 18 months.

7) Periodontia
   All necessary procedures for the treatment of tissues supporting the teeth including grafts.

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

Part II – Major Services

Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for coverage at the lesser of 90% of the amount charged, or 90% of the Dental Association Fee Guide (General Practitioner) in the Province of residence.

- Inlays, onlays and gold. A pre-authorization is suggested.

- Initial installations of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Partials may only be provided by a dentist.
- Initial placement of a crown or veneers and their replacement every 5 years
- Replacement of an existing full or partial denture, once every 5 years
- Fixed bridgework and its replacement if the existing bridgework was installed 5 years prior and cannot be made serviceable.
- Dentures misplaced, lost or stolen will not be replaced at the Plan's expense.

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

Part III – Orthodontia (adults and dependent children under 21 years of age or 25 if a student)
For orthodontia services performed by an orthodontist payment will be made at 90% to a maximum lifetime limit of $3,000.00. Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced at the Plan's expense.

Part IV – Implants
Effective June 1, 2021, implants (including implant surgery and implant crowns) will be reimbursed at 50% up to a maximum of $3,000 per person every five years. The implant procedure must be performed in Canada and if the implant fails, the Plan will not allow a second procedure earlier than five years from placement.

Pre-Treatment Estimate of Major Restorative & Orthodontic and Implant Charges
Prior to the commencement of treatment, the dentist should provide a summary of charges for the proposed course of dental care. The Plan will then provide a written estimate of the maximum amount for which payment will be made.

Emergency Dental Care Anywhere in the World
In an EMERGENCY, while you are travelling or on vacation outside of your Province of residence, you are entitled to the services of a duly qualified dentist

and will be reimbursed at the lower of the actual cost or the amount that would have been paid had the service been rendered in Province of residence.

EXCLUSIONS and LIMITATIONS

The Plan's Dental benefits do not cover payment for:

- items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- dental care which is cosmetic;
- dental care provided under a medical plan provided by an employer or government.
- which, in the absence of coverage, there would be no charge;
- stainless steel crowns on permanent teeth;
- protective athletic appliances;
- anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- replacement of a lost or stolen prosthesis;
- incomplete and temporary procedures;
- any dental charge for services which were started prior to the date of coverage; or
- dental treatment which was ordered while covered, (which included lab work and impressions), but was not installed or delivered until more than 31 days after the dental benefit terminated.

Expenses recoverable under any other Plan will be co-ordinated with payments from this Plan, so that total payment received will not exceed the expenses actually incurred.

TRANSPORTATION ASSISTANCE

Eligibility

Any person who is covered under the Joint Electrical Industry's Welfare Plan will be entitled to submit transportation expenses for him/herself or for an eligible dependent.

Covered Expenses
The following expenses shall be eligible for reimbursement:

The actual cost of transportation, up to a maximum of 75% of the amount equal to the round trip commercial economy class airfare for transportation within British Columbia or Alberta or the Yukon Territory from the commercial airport nearest to the Member's residence in British Columbia where regularly scheduled airlines depart from to the commercial airport located nearest to the facility recommended by the patient's physician where treatment, diagnostic tests or examination takes place.

Within each calendar year no more than eight (8) trips will be eligible for reimbursement. If, on the physician's recommendation, the patient requires an accompanying person, payment shall be made on the basis of 75% of the airfare subject to the conditions as outlined, but only if air transportation is involved.

Lodging
In conjunction with transportation charges, lodging expenses up to a maximum of 3 days per trip at a rate not to exceed $75.00 per day, for a patient receiving treatment outside their area of residence, on presentation of the appropriate medical documentation and receipts, will be recovered.

EXCLUSIONS
The following are excluded from payments:

a) The cost of transportation from the patient's home to the nearest airport from which regular scheduled airlines depart.

b) The cost of transportation from the airport at the city of destination to the place where treatment, examination or tests take place.

c) Any accident or sickness which is the responsibility of WorkSafe BC, Insurance Corporation of British Columbia or any other third party.

d) Any journey where the round trip is less than 500 km.

   Effective January 1, 2021 the requirement for the journey to be at least 500 km round trip will not apply to those eligible claimants who meet all other eligibility criteria but must travel from or

through Vancouver Island to the mainland for their medical treatment or medical appointment.

e) Treatment for services not medically required.

How a Claim is Made

1) The attending physician must complete a form confirming the diagnosis, the facility or name of the physician who will see the patient and the date and time of the appointment, also if the patient required an accompanying person.
2) The physician who renders the treatment, examination or test will complete a form confirming the visit(s).
3) Payment of expenses will be made directly to the Member, subject to receipt of the applicable forms.
4) Should the patient be transported by car or bus, reimbursement will be 100% of the actual cost.

TO MAKE A CLAIM

Extended Health Benefits, Vision Care and Dental Plan

Use your pay-direct card when you fill a prescription, when you visit participating paramedical practitioners, when you have an eye examination, for dental visits and vision care purchases. If you do not use your pay-direct card, these expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the **D.A. Townley *My Claims*** portal or mobile app (see page 50 for details).

Alternatively, claim forms for Extended Health Benefits and Vision Care can be obtained from the Administrator's Office or your Union Office or from the Administrator's website:
https://www.datownley.com/health-benefits/filing-a-claim/

When submitting eligible claims, please be sure to include:

- Your Name (please print)
- Your Address
- Client ID
- Your Local Union

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

- the **D.A. Townley *My Claims*** portal or mobile app
- by email to health@datownley.com
- by fax to (604) 299-8136
- mail to **Joint Electrical Industry's Welfare Plan**
  4250 Canada Way
  Burnaby BC V5G 4W6

All receipts must be received by the Administrator within 24 months of the date the expense was incurred to be considered for payment.

COORDINATION OF BENEFITS:

1) When co-ordinating benefit payments, D.A. Townley will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the Eligible Expense was incurred.
2) If the Member or Dependent is also covered under the Spouse's plan or under any other group plan which provides similar benefits, payment will be co-ordinated and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the Eligible Expense (for dental, the fee guide applies).
3) The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.
4) The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:
   a) the amount that would have been payable had it been the primary carrier, or
   b) 100% of all Eligible Expenses reduced by all other benefits payable for the same expenses by the primary carrier.
5) If the other plan does not contain a co-ordination of benefits clause, payment under that plan must be made before the Plan will pay under this provision.
6) Extended health care plans with dental accident coverage determine benefits before dental plans.

7) If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.

8) When the Plan has paid benefits to the Member to the limit of the PharmaCare deductible, the Plan will pay their portion of the Eligible Expenses based on the plan's reimbursement percentage.

9) The Member will provide the information required to implement this provision. It is the Member's responsibility to present a copy of the original claim form and the remittance statement or cheque stub when making further claim under this provision.

D.A. TOWNLEY *MY CLAIMS* PORTAL and MOBILE APP

Go to: **www.datownley.com/myclaims/** and look for Online Registration in the resources section on the right side of the page. Click on the link. Complete all the required fields and acknowledge that you have read the terms and conditions.

Click on the Submit button and it will automatically direct you to the My Claims portal. Set up your account on the My Claims portal by clicking on Register Account. Enter your group number and your Client ID number from your pay-direct card, along with your postal code and date of birth. Then click Next. Set up your username and password.

Please note: you can only create one username and password for the same coverage. Then click Sign Up and accept the terms and conditions. Now you can download the free **D.A. Townley *My Claims*** app by visiting the App Store for IOS devices or Google Play for Android devices. Once downloaded, register your account on the portal and app, then you are ready to sign in using your username and password that you assigned.

DIRECT DEPOSIT

If you have not already done so, you can sign up for Direct Deposit for your claims reimbursements. Get your reimbursement faster and have the funds deposited directly into your bank account rather than

waiting for a physical cheque. On the **D.A. Townley *My Claims*** portal or app, click on the Person icon on the top navigation. Go to Update Direct Deposit and enter your banking information (this can be found on the bottom of a personal cheque, from your online banking app or by calling your financial institution directly.)

RIGHTS TO COPIES OF DOCUMENTS

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

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

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

LEGAL ACTION

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

NOTES

Benefits Administered by:Benefits Provided by:

D.A. Townley

MANULIFE FINANCIAL #31317
Life Insurance
Long Term Disability
Optional Life #888889

JOINT ELECTRICAL INDUSTRY'S WELFARE PLAN #2600
Weekly Indemnity
Extended Health Care
Vision
Dental
Transportation Assistance

TELUS HEALTH VIRTUAL CARE #4239
Virtual Health Care/Telemedicine

BLUE CROSS LIFE #79396003
Accidental Death & Dismemberment

MANULIFE GROUP TRAVEL INSURANCE # DAT00013343
Global Excel Management Inc.
Out of Province/Canada Emergency Medical Travel Insurance

MORNEAU SHEPELL #7017
Employee and Family Assistance Plan

MEDICAL SERVICES PLAN OF BC #4821427
Basic Medical Plan

This booklet explains in general terms the Plan of benefits and coverage in effect. It is not to be considered a contract of insurance. The complete terms of the Plan are set forth in the group policies issued to the Trustees.

JULY 2022

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