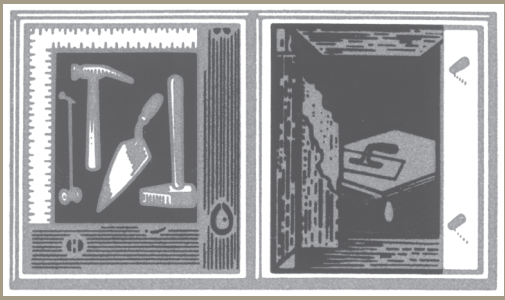
BRICKLAYERS & MASONS WELFARE PLAN



INTERNATIONAL UNION OF BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL #2 BC

Address all inquiries to:

THE ADMINISTRATOR
BRICKLAYERS & MASONS WELFARE PLAN

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)

Effective August 1994
*Including amendments to April 1, 2022

PRIVACY POLICY

We, the Trustees of the Bricklayers & Masons 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 Bricklayers & Masons 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 Bricklayers & Masons 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

Life Insurance	$45,000 (to age 65) $20,000 (to age 80)
Dependent Life	$5,000 - Spouse $2,000 - Dep Child 15 days+ $ 500 - Dep Child <15 days
AD&D	$45,000 (Members to age 65) $20,000 (Members to age 80) $20,000 (Spouse to age 70) $5,000 (Dep Child)
Weekly Indemnity	Equal to EI Weekly Max Integrated with EI
Long Term Disability	As described herein
Extended Health Benefits	80%, as described herein
Prescription Drugs	As described herein
Out of Province/ Canada Emergency Protection	$5,000,000 Maximum Per Coverage Period
TELUS Health Virtual Care	Online immediate medical support
Vision Care	100%, $300/24 months
Dental	80% Basic Services 50% Major Services 50% Orthodontia (Dep Child)

Details of Eligibility

Who is eligible? Any Member in good standing who has sufficient hours for coverage and is under age 80.

Do any Forms have to be completed?

YES. Within one month of becoming eligible you must complete an Enrolment Card and Beneficiary Designation form.

It is most important that EACH Member complete this required form whether or not he/she is eligible. This form should be sent to the Administrator without delay. Each Member must complete this form as soon as he/she commences working under the Agreement.

How does a person qualify for coverage?

A member in good standing must accumulate 360 hours of work within 12 months. The hours reported are credited to the Member's Hour Bank.

When will coverage commence?

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).

Upon qualifying for coverage, the Member will receive a pay-direct card (one for single coverage or 2 cards if the Member has dependent coverage – both will be in the Member's name).

EXAMPLE:

Your employer(s) report that you have accumulated in excess of 360 hours in the last 12 months. Hours are reported and tabulated as illustrated below:

	HOURS REPORTED		
MONTH	**MEMBER A**	**MEMBER B**	**MEMBER C**
January	90 hours	160 hours	185 hours
February	108 hours	160 hours	180 hours
March	50 hours	160 hours	lag
April	160 hours	lag	qualified
May	lag	qualified	–
June	qualified	–	–

Each month 120 hours will be deducted from your Hour Bank to provide coverage. Any excess hours will accumulate in your Hour Bank for future coverage.

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

If you are a member of the Bricklayers & Allied Craftworkers Union Local #2 BC, you may accumulate 9 months' coverage (1080 hours), which will be drawn upon during a period of poor employment, lengthy illness or extended vacation.

A person who is not a member of the Bricklayers & Allied Craftworkers Union Local #2 BC but who is working under the Bricklayers & Allied Craftworkers Union Local #2 BC Collective Agreement (permit worker) will be permitted to accumulate hours for 12 months, at which time all hours would be forfeited if not made a member of the Bricklayers & Allied Craftworkers Union Local #2 BC.

Please note that non-union members (permit workers) will not be notified at the end of the 12 month period.

What happens if the Hour Bank falls short for coverage?

If your Hour Bank drops below 120 hours, you will receive a notice as to the balance in your Hour Bank and the amount required to maintain coverage. If you make payment of the amount requested by the deadline specified on the notice, your coverage will be continuous.

Self-Payment is only available to a union member who was covered under the Bricklayers & Masons Welfare Plan.

Self-Payment Options

	Plan A	**Plan B**	
	Life Insurance	Life Insurance	
	Dependent Life	Dependent Life	
	Weekly Indemnity	Extended Health	
	Extended Health	Vision	
	Vision	Dental	
	Dental		
	Plan C	**Plan D**	
	Extended Health	Life Insurance	
	Vision	Dependent Life	
	Dental	Extended Health	
		Vision	

You may change from a more comprehensive plan to a lesser plan during the same period of Self-Payment, but you cannot upgrade your coverage. You will only become eligible for the full benefit package (Plan A) when you have had 120 hours reported in one month by your employer.

If you select Plan A, you are encouraged to keep track of the number of months such self-payments are made. If you file a WI claim in the future, and are approved and receive WI benefits, you may be eligible to deduct $19 for each month of self-payment made under Plan A in the past, from the taxable income reported on your Income Tax return for the year you were in receipt of such WI benefits. Such past self-payments can only be deducted once. Consult with your accountant or CRA (IT-428) for details.

Self-Payment is not available to a person who is not a member of the union, nor to union members working non-union.

When does coverage end?

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

a) Your Hour Bank falls below 120 hours and you fail to make a payment by the date specified on the Self-Payment Notice (Union Members Only) to bring your Hour Bank up to the required hours; or
b) You are no longer a member in good standing with the union, at which time coverage terminates immediately, any hours in your Hour Bank are forfeited and Self-Payment will no longer be permitted.

Self-Payment:

A Member in good standing may continue full coverage through Self-Payment.

A Self-Payment notice will be sent to the last known address.

The maximum number of Self-Payments allowable is 18 consecutive months. Retired and Disabled Members can Self-Pay indefinitely at a subsidized rate however you cannot Self-Pay for Plan A coverage.

Do Not Ignore the Self-Payment Notice

If you receive a Self-Payment 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
or email: admin@datownley.com

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

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

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.

Disability Credits

When a Member is collecting benefits under the Weekly Indemnity Plan, EI Sick Benefits or under WorkSafe BC/WCB, 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 6 hours per day, to a maximum of 120 hours per month for up to 24 months.

If the claim is for Weekly Indemnity, your Hour Bank will be credited automatically, but for EI Sick Benefits or WorkSafe BC, the Member must forward cheque stubs to the Administrator. To qualify for these disability credits, the Member must be eligible for benefits when the disability commences.

If the Member is disabled for longer than the maximum Weekly Indemnity claim of 15 weeks the Member should contact the Administrator for a form so that further disability credits may be applied to their Hour Bank until such time as recovery or the 24 month maximum has been reached, whichever occurs earliest.

If coverage terminates when will coverage recommence?

When 360 hours have been worked and reported to the Plan; the same as commencement for a new person. You may not re-qualify by Self-Payment.

Working for another Local?

From time to time the Trustees may enter into reciprocity agreements with other Locals. Please check with the Administrator to ask if there is a reciprocity agreement in place with the local you are working in. If there is, you must advise the local in which you are working that you are a Member of Bricklayers and

Allied Craftworkers Local #2 BC and wish your contributions be transferred to this Plan.

Are Dependents Covered under the Plan?

YES. The Plan will provide 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, provided such person is mainly dependent on and living with the covered Member;
c) Any unmarried child of a covered Member to any age 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.
e) 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 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.

The co-habitation period for a common-law spouse is a continuous period of one year.

“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 an Enrolment and Beneficiary card from the Administrator or your Union Office, and forward it to the Administrator's office.

PLEASE NOTE:

- **Quote your Client ID from your pay-direct card on all correspondence to the Plan.** Your Client ID is your identity number.
- You must notify the Administrator if you wish to add or delete a dependent under you coverage.
- Self-Payment Notices or any other material mailed by or under authority of the Administrator to the person's last known address is deemed to have been duly received by the addressee. Notification of the change of address is the duty and responsibility of the Member.

LIFE INSURANCE

Each eligible Member is insured for $45,000 of Life Insurance. This amount reduces to $20,000 at age 65 and terminates at age 80.

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

When your coverage with the Plan terminates, provided it ends before your 65th birthday, you may convert your Life Insurance to an individual

policy without a medical examination or health questionnaire. The individual policy would be for an amount not greater than the amount under the group policy and would be available at any time within 31 days after termination of the group insurance coverage. Please note, Life Insurance conversion is not available to Members 65 or older. Contact the Administrator for details.

Your life would be continued 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.

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 will, on written application, be eligible for the total amount of the Life Insurance to remain in force without further charge providing the person remains totally disabled. Proof of total disability will be required from time to time.

Living Death Benefit

In the event you have a terminal illness, it may be possible to receive a portion of your Life Insurance in a lump sum. Please contact the Administrator.

DEPENDENT LIFE INSURANCE

An eligible spouse is insured for $5,000 of Life Insurance and each eligible dependent child is insured for $2,000 if 15 days or older and for $500 if under 15 days of age.

A dependent becomes eligible for insurance when the Member becomes Eligible or, if acquired later, upon becoming the Member's dependent.

The Member must be insured in order for the dependents to be insured.

Insurance, or any increase in insurance, for a dependent (other than a newborn child who becomes insured within 31 days of becoming eligible) who is confined in a hospital because of illness or injury on the date such insurance would become effective, will not become effective until the date such dependent is no longer confined.

If a dependent dies while insured, Dependent Life Insurance will be paid to the Member, if living, otherwise to the Member's estate.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

The Basic 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 to age 65	$45,000
All eligible members age 65 to 80	$20,000
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 in 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's individual insurance policy. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the 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 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

A benefit of the Employment Insurance (E.I.) weekly maximum benefit rate will be paid to each eligible Member who is disabled and unable to work as the result of a non-occupational accident or sickness. Benefit payment commences on the 1st day of a non-occupational accident, and the 8th day of a non-occupational sickness. The Plan will pay benefits for a maximum of 15 weeks.

Note: The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for benefits will be considered. Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a physician – whichever is later – and will be paid only during periods of disability when you are under his or her regular care and following the treatment prescribed.

Members whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Plan Member qualifies for full coverage under the Plan.

Jury Duty will be considered as Illness for the purpose of this benefit.

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 a claim form from the Union office or the Administrator's office.
c) Complete the form where indicated and have your doctor complete the physician's portion of the form.
d) Send the completed form to the Administrator without delay.
e) Claim cheques will be sent directly to your home address.
f) Claims for disability must be submitted no later than 30 days after your total disability begins.
g) With the exception of Jury Duty, benefits will only be paid when you are under the full-time care of a physician and/or surgeon. Where there is any doubt as to the validity of the claim, the Claims Adjudicator reserves the right to arrange an independent medical examination.

Occupational Accidents or Illnesses

When a Member becomes Totally Disabled as a result of an occupational injury or illness for which the Member may claim benefits under workers compensation legislation, the Plan will not

pay benefits to the Member. The Plan *may*, not must, provide financial relief on a periodic (usually bi-weekly) basis to alleviate income loss. The total of all advances made to the Member is fully repayable to the Plan on terms to be settled between the Member and the Plan and incorporated into a signed Loan & Replacement Agreement.

Recurrence of Former Ailments

You will not receive benefits for more than 15 weeks as a result of disability due to any one ailment. However, a new waiting period and benefit duration period will start if you return to active full-time work for:

a) A period of 2 weeks before you again become disabled because of the same or related cause, or
b) One full day before you again become disabled because of a different or unrelated cause.

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 a motor vehicle accident;
- arising from an occupational accident or illness, as these are covered by WorkSafe BC/workers compensation legislation; except as a fully repayable loan upon receipt of a signed Loan &

Replacement Agreement between the Member and the Plan;

- 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 E.I., 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 E.I. benefits;
- if you become disabled during a strike or lockout at your place of employment, your rights to benefits will be reinstated when the strike or lockout ends.

A Member in receipt of a pension from the Bricklayers & Masons Pension Plan will not be entitled to receive Weekly Indemnity benefits.

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 BENEFIT

Eligibility

The purpose of this benefit is to provide disability income for eligible Members who become totally disabled on or after January 1, 1992. Such disabled Members must be approved by Canada Pension Plan for disability benefits. The effective date fixed by Canada Pension Plan shall be the effective date of the Long Term Disability benefit, provided at that date such disabled Member has at least

3,200 covered hours or employment under the Bricklayers and Masons Pension Plan, and has not retired or terminated Membership in that Plan.

A member is not entitled to an annual disability payment hereunder if, at the date of disability:

a) he/she was paying union dues as a self-employed union member; or
b) the Trustees determine the Member was not employed by a Participating Employer, the Union or an employer contractor.

Amount of Long Term Disability

This benefit pays an annual disability benefit in monthly installments of 50% of your basic hourly rate of compensation at the date of disability times 1600, less:

a) any payment which the Member may receive or be entitled to receive at the date of disability as a result of being totally and permanently disabled under any Pension Plan, Weekly Indemnity plan or Long Term Disability plan of a Participating Employer, the Union, an employer contractor or any other employer to which such Participating Employer, the Union, employer contractor or other employer contributed; and
b) any payment which the Member receives as a result of being totally and permanently disabled under any Provincial or Federal program to which a Participating Employer, the Union, an employer contractor or other employer directly contributes excluding, Employment Insurance benefits.

In determining the deduction to be made with respect to payments under paragraphs (a) and (b) above, the following shall be excluded:

a) payments made to or on account of dependent children under the Canada or Quebec Pension Plans;

b) increases in payments made to the Member under the Canada or Quebec Pension Plan after such payments have commenced;
c) payments made to the Member from a personal insurance policy or any other income or benefit the Member was receiving prior to becoming disabled as defined hereunder.

Any payment or benefit described in paragraphs (a) and (b) which the Member is entitled to receive will be included in the deduction to be made regardless of whether the Member has applied to receive it.

Cessation of Long Term Disability Benefits

A Member's disability benefits shall cease with the payment made at the earliest of the following dates:

a) the first day of the month prior to the date of death of the Member;
b) the first day of the month prior to the date that the Member ceases to be entitled to disability benefits under the Canada Pension Plan;
c) the first day of the month prior to the date upon which the Trustees decide that the Member is not totally and permanently disabled.

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 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 E.I., 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 E.I. 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 a motor vehicle accident incurred on or after November 9, 2018.

How to Claim Long Term Disability Benefits

If you have been accepted by the Canada Pension Plan for a disability pension, obtain a Notice of Disability form from the Bricklayers and Masons Welfare Plan Administrator. Complete the top section of the form and return it to the Plan Administrator with evidence of your disability. You will be advised of any additional information required by the Administrator.

EXTENDED HEALTH 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.

With the exception of Prescription Drugs, the Plan provides coverage at 80% for all eligible expenses incurred by the Member or covered dependent up to a maximum (including drugs) of $1,000,000 per lifetime for Members under age 65. For Members aged 65-79 inclusive, benefits will be limited to $100,000.00 per lifetime.

Out of province emergency medical coverage is provided to eligible Members and their dependents, who are under the age of 80, up to a maximum of $5,000,000 per coverage period.

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. Upon qualifying for coverage, you will receive a pay-direct card (one if you have single coverage or 2 cards if you have dependent coverage – both will be in the Member's name).

Benefits:

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

1) Prescription Drugs: Present your pay-direct card to your pharmacist each time you fill a prescription.

   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.

   If the medication you are being prescribed is considered an eligible drug by BC PharmaCare, the Plan will provide 100% coverage. When you

use your pay-direct card at the pharmacy for these medications, you will not have to pay your pharmacy anything at all.

If the otherwise eligible medication you are prescribed is not considered eligible under PharmaCare, the Plan will provide 60% coverage for the cost of the medication(s). When you use your pay-direct card at the pharmacy, you will be asked to pay 40% of the cost to your pharmacy. This is your share of the cost and no further amount is payable by your Plan.

There are many medications that are not eligible under PharmaCare's standard drug formulary. Please discuss with your doctor whether a PharmaCare eligible drug is suitable for you. If it is not suitable for you, you can request that your doctor apply to PharmaCare to have the drug covered under Special Authority. If your doctor receives approval from PharmaCare, a copy of the approval must be sent to the Plan Administrator and an exception can be made on your behalf so that the medication can be covered at 100% as a Special Authority drug.

Drugs and medicines are limited to a 34-day supply (100 days for maintenance drugs). 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 supply limits 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. Fertility drugs, 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.

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 visit the BC Fair PharmaCare website: https://pharmacare.moh.hnet.bc.ca

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. The maximum for these services will be $25,000 per year

4) You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, speech therapist, acupuncturist, psychologist, clinical counselor, social worker, 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 maximum of $1,000 per insured person for all practitioners combined.

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

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

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

8) Charges for surgical stockings to a maximum of 4 pair per calendar year.

9) Charges for stump socks.

10) Charges for surgical brassieres up to four per calendar year.

11) One pair of custom fitted orthopaedic shoes or orthotics when prescribed by a physician or podiatrist and replacements when necessitated by normal wear and tear. Orthotics are limited to a maximum of $200 per calendar year.

12) Charges for rigid support braces and permanent prosthesis (artificial eyes, limbs, larynxes and mastectomy forms). Myoelectrical limbs are

excluded but the Plan will pay the equivalent of a standard prosthesis.

13) Cost of rental or where more economical, purchase of durable equipment for therapeutic treatment including wheelchairs and hospital beds. Electric wheelchairs are covered only when a doctor certifies the patient is incapable of operating a manual wheelchair (e.g. Paraplegic).

14) 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 90 days of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 90 day period.

15) Hospital charges made by an approved acute general hospital in B.C. for private or semi-private room if ward is not available or if required as medically necessary by a physician (not including rental of telephone, T.V. etc.).

16) Costs of hearing aids to a maximum of $500 in a 5 year period for adults and dependent children when prescribed by a certified Ear, Nose and Throat Specialist. Repairs, maintenance, batteries or other accessories not will be covered.

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

18) Charges made by a physician for a medical examination required by a Government statute or regulation for employment purposes, provided such charges are not covered by the employer under a Collective Agreement and provided no claims have been made under the Basic Medical Plan.

19) Vision Care – You can use your pay-direct card for the purchase of frames, lenses, and contact lenses. These expenses, plus laser eye surgery, are covered by the Plan at 100% up to a maximum of $300 every 24 consecutive months. You can also 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 as part of your $300 maximum.

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

    a) duplicate or spare eye glasses or any lenses or frames thereof;
    b) safety goggles, sun glasses (plain or prescription);
    c) replacement or lost, stolen or broken lenses or frames.

EXCLUSIONS and LIMITATIONS:

The Plan's Extended Health Benefits does not cover:

a) expenses for benefits, care or services that result from a motor vehicle accident incurred on or after November 9, 2018, or which are payable by or under the Basic Medical Program, PharmaCare, any Hospital Program or the Workers Compensation Act, whether or not a claim is made thereunder or provided without cost or at a nominal cost by any public or tax-supported

authority or agency or for which the Member or dependent can recover from a third party.

b) expenses for dental services except as specifically provided in Item 14.

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 Emergency Eligible Expenses.

e) expenses or 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) expenses incurred for orthoptic treatment, eyeglasses, contact lenses, hearing aids, or prescriptions for any of them except as specifically provided; (see Vision Care Plan).

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

i) 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.

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

Out-of-Province/Canada Emergency Eligible Expenses

Charges for services and supplies required as a result of a medical emergency occurring while travelling if:

- you or your Dependent is covered under a provincial medical plan; and
- treatment could not have been delayed until return to Canada.

Emergency Medical Insurance & Travel Assistance

While you are travelling outside your Province of residence carry the wallet card that has been provided to you.

Travel insurance is designed to cover losses arising from sudden or unforeseeable circumstances occurring while you are temporarily travelling outside your province or territory of residence. It is important that you read and understand your Plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provisions of the Policy, the provisions of the Policy shall govern. The Plan has contracted Viator/Global Excel Management Inc. (called Global Excel) to provide medical assistance and claims services under the Policy. This is a summary of benefits. A complete booklet is available from the Plan Administrator.

Coverage Period: 60 days per trip.

IN THE EVENT OF AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY

The emergency telephone numbers are listed on the back of the Medical Assistance Card provided.

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the policy expressly requires the prior approval or authorization of Global Excel, on the basis of the reasonable and customary costs that would have been payable for such expenses by the insurer in accordance with the terms and conditions of the policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the reasonable and customary costs reimbursed by the insurer.

In an emergency the policy covers expenses that are:

- incurred outside the province or territory of residence of the insured person;
- medically necessary;
- reasonable and customary costs;
- incurred as a result of an emergency due to sudden and unforeseen sickness and/or injury occurring during the coverage period;

- in excess of those covered by the Government Health Insurance Plan or other insurance under which you may have coverage; and
- legally insurable;
- subject to the overall maximum of $5,000,000 per coverage period for all eligible Members under age 80. There is no coverage if the Member is 80 or older.

Claims Procedures - Emergency Out of Province/ Canada Expenses

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

a) include the policy number, the patient's name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
b) submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or physician;
c) provide the original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;
d) provide proof of the departure date(s) and return date(s);
e) provide written proof of claim within ninety (90) days of the date of receipt of services covered under the policy;
f) provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;

g) sign and return the authorization form, provided by Global Excel, allowing the insurer to recover payment from the Canadian provincial or territorial Government Health Insurance Plan. The insurer will coordinate and pay your claim to the participating medical providers and where permitted, coordinate claims directly with the Canadian provincial or territorial Government Health Insurance Plan on your behalf; and
h) return the unused portion of your air ticket to Global Excel if the Emergency Air Transportation benefit is used.

All sums 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.

Any information not provided may result in a delay in processing your claim.

All pertinent documents should be sent to:

Global Excel Management Inc.
73 Queen St. Sherbrooke, Quebec J1M 0C9
Tel.: 1-866-870-1898 (toll free) or
(819) 566-1898 (collect) during business hours (EST)

Policy Number: 1059209 (previously 32445235)

Emergency Out of Country coverage has a maximum of $5 Million per coverage period

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 4241**. 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 (4241) 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.

DENTAL

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. Dental is not provided under Self-Pay Plan D.

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.

Part I – Basic Services

The following services are eligible for coverage at the lesser of 80% of the amount charged or 80% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment.

1) Diagnostic Services
   All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:
   - Oral examinations: limited to two in any calendar year; however, complete oral examinations are limited to one in any 3 year period
   - Specific examinations provided the Plan has not paid for any other exam by the same dentist in the past 60 days
   - Consultations (as a separate appointment)

limited to two per calendar year.
- Dental x-rays: bite-wing x-rays are limited to one set in any 6 month period, full mouth x-rays are limited to one set in any 3 year period, and panoramic film is limited to one x-ray in any 3 year period
- Diagnostic models: limited to 1 set per calendar year.

2) Preventative Services
All necessary procedures to prevent the occurrence of oral disease, including:
- Cleaning (limited to twice in any calendar year)
- Scaling and root planning (combined maximum of 16 units per calendar year)
- Topical application of fluoride (limited to two applications in any calendar year)
- Pit and fissure adhesive sealants limited to once per tooth every 24 months
- Fixed space maintainers on primary teeth for dependent children under 18.

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
Repair if a 6-month period has elapsed since the last date on which the dentures were provided.

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 to a maximum of $175 per calendar year.

Part II – Major Services

Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for coverage at the lesser of 50% of the amount charged, or 50% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment:

- Inlays, onlays and gold foils will be covered only when other material cannot be used satisfactorily. Patients choosing gold where other materials

would suffice will be responsible for the cost difference. 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 if at least 5 years has lapsed.
- Replacement of an existing full or partial denture, or fixed bridgework, if the existing denture or fixed bridgework was installed 5 years prior to its replacement and cannot be made serviceable. Dentures misplaced, lost or stolen will not be replaced at the Plan's expense. If the open space limitation is included, such extraction(s) must have occurred after the effective date of the Covered Person's coverage. Charges made by a licensed Denturist will be recognized for payment, in accordance with a separate Schedule of Allowances.

Part III – Orthodontia (dependent children to age 21, to age 25 if a student)

For orthodontia services performed by an orthodontist payment will be made at 50% to a maximum lifetime limit of $1,000.00. 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.

Pre-Treatment Estimate of Major Restorative & Orthodontic 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.

Alternative Services:

If alternative services may be performed for the treatment of a dental condition, the maximum amount shown in the Suggested Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

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;
- implants;
- 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.

What is the maximum amount that will be paid for any one person?

There is a combined maximum of $2,000 per calendar year for Basic (I) and Major (II) services combined. The maximum amount that will be paid for Part III (Orthodontia) is $1,000 per lifetime per covered dependent.

TO MAKE A CLAIM

Extended Health Benefits and Dental

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 53 for details).

Alternatively, claim forms for Extended Health Benefits can be obtained from the Administrator's

Office, your Union Office or from the Administrator's website: https://www.datownley.com/health-benefits/filing-a-claim/

Both the receipts and the fully completed forms should be sent to the Administrator. All receipts must be received by the Administrator before the end of the year following the year the expenses were incurred to be considered for payment.

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
*drop off or mail to **D.A. Townley**
4250 Canada Way
Burnaby BC V5G 4W6

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 (10943) 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.

Benefits Provided by:

Canada Life Assurance Company #157452
Life Insurance

The Bricklayers & Masons Welfare Plan #10943
Weekly Indemnity
Long Term Disability
Extended Health Care
Vision
Dental

TELUS Health Virtual Care
#4241
Virtual Health Care / Telemedicine

Blue Cross Life
#79396-005
Accidental Death & Dismemberment

RSA Travel Insurance Inc.
#1059209
VIATOR Out of Province Emergency
Excess Medical and Hospital
Travel Insurance

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

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