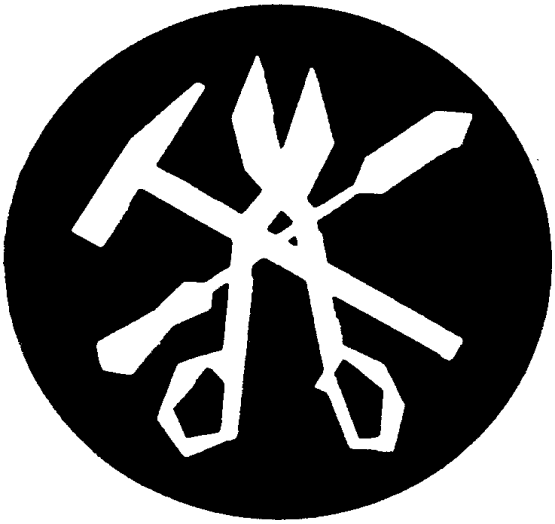

SHEET METAL WORKERS (LOCAL 280)

HEALTH BENEFIT PLAN ["HBP"] POLICY # 1664

RETIRED / LONG TERM DISABILITY MEMBERS

SHEET METAL WORKERS (LOCAL 280) HEALTH BENEFIT PLAN
BENEFITS ADMINISTRATION OFFICE
6192 KINGSWAY, BC V5J 1H5
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INTRODUCTION

Pacific Blue Cross – EXTENDED HEALTH [PART 1] GROUP # 1664
Pacific Blue Cross – LIFE / SPOUSAL INSURANCE POLICY # 30149
Health Benefit Plan ["Office"] – DENTAL & EXTENDED HEALTH [PART 2] GROUP # 1664

THERE ARE SEVEN (7) BENEFITS' PLANS AVAILABLE, AS FOLLOWS –

☐	**PLAN**	**A**	**Group Life & Spousal Insurance only**
☐	**PLAN**	**B**	**Dental and Extended Health**
☐	**PLAN**	**C**	**Group Life Insurance & Spousal Insurance / Dental / Extended Health**
☐	**PLAN**	**D**	**PLAN C – with Group Life Insurance premiums waived [only available to LTD Members]**
☐	**PLAN**	**E**	**Group Life /& Spousal Insurance / Dental**
☐	**PLAN**	**F**	**Extended Health only**
☐	**PLAN**	**G**	**Group Life & Spousal Insurance / Extended Health**

THE PLAN YOU SELECTED IS PLAN _____ (HIGHLIGHTED ABOVE). You may convert to a lesser Plan at any time, but you may not add benefits later.

➔ **PLEASE READ THE FOLLOWING PAGES CAREFULLY – TO MAKE YOURSELF AWARE OF WHAT BENEFITS ARE AVAILABLE TO YOU AND YOUR DEPENDENTS.**

CONTENTS

The Trustees cannot guarantee that the current coverages and/or subsidized premiums in effect at this time will continue unchanged.

This Booklet is intended only to communicate a "user-friendly" summary of Benefits presently provided by your Plan, and does not establish any legal rights or entitlements. Thus, in the event of any difference(s) between this Booklet and the underlying Agreements and/or Contracts – the latter will always prevail.

IF YOU HAVE ANY QUESTIONS, OR NEED MORE INFORMATION, PLEASE CONTACT THE BENEFITS ADMINISTRATION OFFICE [the "OFFICE"].

This icon will appear beside a provision, paragraph and/or section that we suggest you note.

GENERAL PLAN INFORMATION

ELIGIBILITY

The current criterion is that you must have had at least five [5] years of continuous Plan Membership immediately prior to your Pension commencement [or your "retirement" after age 55 if you were never a Member of the Pension Plan and you have retired from your employment with your Contributing Employer].

Once this has been satisfied, you will be able to enroll in this Plan in one of three ways -- (A) by direct transfer from your Active Group (i.e., 1661, 1662, 1663 or 32640), (B) by direct transfer from Group 1164 when your Hour Bank runs out **and** if you have not returned to work for a Contributing Employer or (C) by receiving LTD Benefits.

MAINTAINING COVERAGE

Your coverage is in force as long as you continue to pay the required premium(s) before the due date.

You will receive a Billing Notice from the **Office**; which will be sent to the most recent address that we have in our database for you. **However**, it is **your responsibility** to make sure that we have your most up-to-date address.

Payment(s) may be made in cash, by having set up, with the Office, a pre-authorized debit plan, using debit / credit cards, by cheque delivered to the **Office or** mailed with a postmark no later than the due date shown on the Billing Notice.

You may pay up to 1 year in advance, but such a payment must be made in one lump-sum amount. This option is not available if you are collecting LTD payments.
NOTE – individual postdated cheques are **not** acceptable and will be returned to you.

Because of the possibility that you may **not** receive a Billing Notice and/or that you may forget to contact us to pay your premium on time, we strongly encourage you to sign up for our **Automatic [Direct Debit] Withdrawal Plan** so that you will never have to worry about **NOT** paying the premium by the 19th of every month.

RETURNING TO WORK

If you return to work for an Employer that contributes to the Plan, at any time; this Plan 1664's coverages will not change, although you may accumulate sufficient **Hours Worked** in your Hour Bank to cover the monthly premium. If you are on the Automatic Withdrawal Plan, you should contact the Office to suspend monthly premium payments.

TERMINATION

You may voluntarily terminate your coverage [and you may be permitted to purchase individual Health and Life Insurance coverage through PBC] at the end of any month for which you have paid the required premium. You will be required to sign a letter acknowledging that your coverage will never be re-instated.

However, if you cease to be a BC resident, you will be eligible to continue under Plan A coverage only. Your other coverages will be automatically terminated at the end of the 3rd month including your date of departure. You must contact the Office to make arrangements to switch to Plan A (life insurance only).

Moreover, you may decide to cease your coverage in any of Plans 'B' to 'G' and move to Plan 'A' for Life Insurance and Spousal Insurance only. You may opt into a lesser plan at any time, but you may not opt back into a plan with more coverage later.

Automatic termination will occur if you return to work for an Employer in the same Trade / Industry but which is **in competition with any Contributing Employers of the Plan**.

If your Plan Membership terminates, for whatever reason, and you are under age 65, you have the right to convert – within 30 days – (i) your Extended Health Benefits with PBC and/or (ii) your Group life insurance only into an Individual Insurance Policy with BC Life for the same or lesser amount.

REINSTATEMENT

If your coverage is terminated -- it can never be re-instated.

DENTAL [PLANS B / C / D / E ONLY]

This Benefit is administered and adjudicated by the Office. When an eligible Covered Person requires treatment, the following Benefits are available for Claim Reimbursements of 90% [although see ** below for exceptions] ---

Approved Basic Restorative services are -- Diagnostic, Endodontic, Periodontic, Preventive, Prosthetic, Restorative and Surgical procedures to restore your teeth to their normal functions. Recall exams, polishing and fluoride treatments are eligible at 1 per 9-month period (and 2 per calendar year for Dependents under age 19);

****Crowns/Bridges** – covered at 50% [of the relevant PBC Fee Guide amount(s)], 1 per tooth in a 5 year period.

Notwithstanding the above, the actual amounts to be reimbursed will be based on the current **PBC Fee Guide**.

However, if the dentist charges fees that are greater than those in that Fee Guide, then these latter amounts will be used to calculate the appropriate Reimbursement.

Because of the constraints of the Fee Guide, we strongly advise you to always check with the Dentist prior to commencement of any treatment to determine their fees for the services that you require – as Dentists are NOT obligated to adhere to the amounts in the current Fee Guide (and, indeed, some don't).

The Plan will NOT cover the difference between their fees and the maximum Reimbursement amounts payable per that Fee Guide. ALSO, you must pay the fees first – and seek reimbursement from the Office.

In order to be reimbursed, we require:

a. The paid receipt for the work done
b. A detailed standard Dental Claim form, which must include the itemized PBC Fee Guide Codes and also that the relevant dates of the procedures

➔ Notwithstanding the above remarks, there are no annual maximum limits for your Plan.

NOT COVERED
Orthodontic Procedures; Implants

** DENTURIST

- **70% Reimbursements** [of the relevant PBC Fee Guide amount(s)] will be paid by the **Office**.
- You must pay the fees yourself and submit the receipt(s) to the **Office**. Please ensure that these receipt(s) state the date(s) when the work was done and the service(s) performed**.**

Note: new dentures are reimbursed once every 5 years, and relines will be reimbursed once every 2 years.

EXTENDED HEALTH CARE [PART 1]

PLANS B / C/ D / F / G ONLY

When a Covered Person requires treatment, the following types of benefits [together with the appropriate reimbursement percentages] are available through PBC --

- **80% reimbursement up to $1,000 paid then 100% thereafter.**
- **$ 200,000 Lifetime Maximum Limit – reduced on an ongoing basis for the Claims submitted.**

The main benefits under the Plan <u>for each Covered Person</u> are as follows --

- ✓ **Prescription Drugs –** In the first instance, the Low-Cost Alternative (i.e., the 'generic') or, if supported by medical evidence, the Brand name is the basis for reimbursement;
- ✓ **Paramedical --** $2,000 annual limit for a combination of Acupuncture, Chiropractor, Massage Therapy, Naturopath, Physiotherapy. Note -- all must be "Registered" with their BC Associations;
- ✓ **Psychologist/Counsellor --** $2,000 annual limit – reimbursed at 100%
- ✓ **Medical Aids / Supplies –** Oxygen, (ile)ostomy supplies, walkers / canes, Orthopedic shoes / Orthotics etc.;
- ✓ **Standard Durable Medical Equipment** – Wheelchair, Glucose Monitors, CPAP machines / apparatus, TENS, TEMS, Insulin infusion pumps etc.;
- ✓ **Out-Of-Province / Territory Emergency Eligible Expenses –** refunded at 100%; after being offset by any Government or other Health Insurance benefits – are Ambulance, Hospital room charges, Physician(s), Laboratory, Prescription Drugs.

If such an event occurs more than 60 consecutive days since you departed from Canada, any/all expenses will NOT be covered.

PLEASE NOTE --

- ☐ There is a **$100 annual Deductible** (payable per Family); or per Member if no other Covered Persons;
- ☐ Benefits for Paramedical Services adhere to a Schedule of "Reasonable and Customary Limits";
- ☐ You may **"e-file"** certain paramedical Claims [e.g., Physiotherapy] with PBC**;**

- For **Prescription Drugs**, virtually all Pharmacists can obtain, directly from PBC, the appropriate insured amount (i.e., 80% or 100%) once you provide them with the Policy number [1664] and your ID number – from your 'Pay Direct' card.

  Any balance owing – including the dispensing fee – will have to be paid by you.

- PBC's Prescription Drug program is, by law, **integrated** with Pharmacare.

Note 1 **-- further details of the benefits, limitations, coverages and conditions are contained in the current PBC Booklet; obtainable from the Office or from our website at www.smw280benefits.ca**

Note 2 **-- we strongly advise you to enroll online with PBC's Member Profile, at service.pac.bluecross.ca/member/login/ to view your up-to-date Extended Health Claims histories, check ALL benefits limits, e-file certain Paramedical Claims and set up / change Bank Account information.**

EXTENDED HEALTH CARE [PART 2]

These three benefits are administered and adjudicated by the Office.

EMERGENCY MEDICAL TRAVEL

NOTE – This is NOT in any way related to [a] the Plan's (PBC's) "Out-Of-Province / Territory Emergency Eligible Expenses" benefits or [b] to what is commonly referred to as "Individual Travel Medical Insurance".

The PBC Booklet contains comprehensive details of the former; while details for the latter may be obtained from PBC at (604) 419-2000 and/or through their website **www.pac.bluecross.ca.**

Plan Members have an automatic 10% discount on the individual premiums with PBC for this coverage.

This Benefit relates to reimbursements, to certain limits, for **(1) Transportation, (2) Meals and (3) Accommodation** expenses for a Covered Person, and an attendant [who may or may not be a family member], who must attend at a **non-local** Hospital for consultation and/or special medical and/or surgical treatment.

- **Transportation** -- If a Covered Person's attending physician has certified in writing that adequate treatment is not available locally, the expenses for **transportation beyond a 160-km distance**, by regularly scheduled airline or by automobile to and from the nearest medical facility equipped to provide the required and recommended consultation, diagnosis and/or treatment (by a physician and/or surgeon within 12 months of the referral) may be submitted for review and reimbursement.

  The limit for Airline Transportation is 75% of the cost of an economy class flight, if applicable, or 75% of certain expenses for other modes of transportation.

  In addition, Taxi / Uber expenses paid between the Airport and the medical facility / hotel – with original receipts – will be reimbursed at the maximum rate of $40 each for the days of arrival and departure.

- **Meals** -- the maximum daily reimbursement will be $50 for the Covered Person or $100/couple or family for a maximum of 7 days.

- **Accommodation** -- the maximum total daily reimbursement per Covered Person and/or family member and/or attendant is $80 for a maximum of 7 days.

➔ **Lastly – the benefit has a maximum limit of 6 separate trips per calendar year.**

NOTE 1 -- You will find more comprehensive explanations of the information [including the formats of all required receipts that the Office must review and approve] to support your claims -- on the back of the Application Form which is available from the Office or from our website at **www.smw280benefits.ca**

NOTE 2 – We must receive all relevant paperwork within 60 days of the occurrence of the Claim.

HEARING AIDS

Forms are available at the Office or from the website; and the reimbursement rate is 80% with a maximum limit of $1,000 – ***per ear*** – every 48 months.

Reimbursements will NOT be made for maintenance, batteries, recharging devices, or accessories.

Please note that "Hearing protectors" are not included in this coverage.

Lastly, there is an agreement between SMART Canada and the HearCANADA Company [please see their website at https://www.hearcanada.com] that may offer discounts for certain items and/or services.

See NOTE 1 above as it applies here also.

VISION CARE

The reimbursement for each Covered Person is 100% of eligible expenses to a maximum of $600 every 24 months, and the benefits categories are –

- ☐ Eye Exams
- ☐ Prescription Eyeglasses
- ☐ Prescription Sunglasses
- ☐ Prescription Contact Lenses
- ☐ Prescription Safety Glasses
- ☐ Cataract Exam / Surgery
- ☐ Corrective Laser Eye Surgery

NOTE – the availability of coverage for such procedure(s) should not be construed as any kind of recommendation on the part of the Trustees about the effectiveness of this treatment.

See NOTE 1 on the previous page as it applies here also.

Reimbursements for any / all of the above will be processed by the Office. Prior to the purchase, you should contact the Office to clarify the specific criteria.

YOUR NOTES

GROUP LIFE INSURANCE

ALL PLANS EXCEPT B & F

Your Group Life Insurance coverage up to age 65, is $75,000. At age 65, this coverage reduces to $30,000. Thereafter reducing by $5,000/year until a flat amount of $10,000 is reached at age 69.

Note - your Group Life Insurance is pure "Term Insurance" i.e., there is no buildup of any monetary Cash Value and no identity cards or individual policy documents are issued as 'proof' of coverage. All payments are tax-free.

DESIGNATING YOUR BENEFICIARY

You must designate your beneficiary [or group of beneficiaries] when you complete your Application Form; although you may change this designation(s) at any time. If you have **not** named a beneficiary/(ies) or your form is **invalid**, your insurance benefit will, by law, be payable to your Estate.

Note - When naming a beneficiary/(ies), we need to know the person(s) complete given name(s) / surname(s), the percentage(s) applicable to each, as well as the relationship(s) to you. *Also, your signature must be witnessed by someone who is neither a beneficiary nor a member of your immediate family*.

CONVERSION OF YOUR GROUP INSURANCE POLICY

Upon termination from the Plan before age 65 [age 60, effective January 1st 2021, for Long Term Disabled Members whose Date of Disability is on or after the effective date] you may apply directly to PBC to convert the Group Life Insurance amount [not including the Spousal component] to an individual Insurance Policy; without evidence of insurability.

The resulting Policy is issued for the in-force Life Insurance amount – **or less, if you wish** -- not including the Premium Waiver provision; and the conversion must be implemented within 31 days after the termination of your Group Life Insurance [during which month-long period you remain covered under the Plan].

LIVING BENEFIT

If you are suffering from a terminal illness, you may request an advance tax-free payment of up to **50% of the insured amount** subject to providing the required medical evidence AND subject to the Beneficiary's agreement.

SPOUSAL LIFE INSURANCE COVERAGE (ALL PLANS EXCEPT B&F)

If you have enrolled your Spouse as a Covered Person – then in the event of their death, you will receive a tax-free Lump Sum payout of $10,000.

EXCLUSIONS

You are not entitled to receive this benefit if your Spouse dies (a) while not residing in Canada or in the USA or (b) as a result of being a member of the armed forces of any Country.

CONVERSION TO AN INDIVIDUAL POLICY

It is not possible to convert this Insurance to an Individual Insurance Policy with PBC.

CLAIM PROCEDURES [APPLICABLE ALSO TO GROUP LIFE INSURANCE]

For situations involving the Member or the Spouse -- we must receive notification of the death within 30 days. A completed Claim Form and the official death certificate must be provided to the Office within 90 days.

However, no payment will be made on any Claim submitted later than 1 year from the date of death.