SHEET METAL WORKERS (L 280)

HEALTH BENEFIT PLAN

SUMMARY OF BENEFITS

UPDATED APRIL 2025

BENEFITS ADMINISTRATION OFFICE CONTACT INFORMATION

Address **6192 KINGSWAY, BURNABY, BC V5J 1H5**

Phone	**604-430-3015**
Toll-Free	**1-888-892-1168**
Fax	**604-430-4691**
Text	**604-219-2594**
Email	**info@smw280benefits.ca**
Website	**www.smw280benefits.ca**

PRESCRIPTION DRUGS / MEDICAL SUPPLIES / PARAMEDICAL

Pacific Blue Cross
Policy #1661
Drug card that can be used at pharmacies
and some paramedical practitioners

VISION CARE / HEARING AID / EMERGENCY TRAVEL COVERAGE

Sheet Metal Workers (Local 280) Admin Office

DENTAL COVERAGE

Pacific Blue Cross
Policy 1661

LIFE INSURANCE / AD&D

BC Life & Casualty (a subsidiary of Pacific Blue Cross)

WAGE INDEMNITY (Short Term Disability) (MEMBER ONLY)

Sheet Metal Workers (Local 280) Admin Office

LONG TERM DISABILITY (MEMBER ONLY)

BC Life & Casualty (a subsidiary of Pacific Blue Cross)

Contents

PLAN INFORMATION

DISCLAIMER – This booklet summarizes Active members benefits. The latter will prevail if this document contains information that is not the same as the Plan's contracts and provisions.

ELIGIBILITY

Your coverage will start on the 1st day of the month after the Benefits Administration Office (the "Office") has received the required minimum number of hours worked, together with a completed SMW Local 280 Health Benefit application form as long as (except for Associates) you are a member "in good standing" with Local 280.

Eligibility for coverage example: if you have worked the required minimum number of hours (typically, two consecutive months of full-time employment) by the end of March then the Office would receive your March hours in mid-April and your eligibility for coverage would be effective May 1.

The month of April in the above example is known as the "lag month".

Employers must submit their hours by the 15th of each month (March hours are due April 15).

To be eligible for full Health Benefit coverage, you must have a valid BC Medical Services card that includes a Personal Health Number. If you do not have current BC Medical or fail to complete this section of the Health Benefit application, you will only qualify for partial coverage when the required minimum hours are submitted. Partial coverage includes Life Insurance, Accidental Death and Dismemberment (AD&D), and Wage Indemnity ONLY.

Dependents

For the Health Benefit Plan, "dependent" means:

1. Your legal spouse whom you live with or a person with whom you have lived in a marriage-like relationship for at least 12 months
2. Any unmarried child, step-child, legally adopted child, or legal ward (but not a foster child) who is under age 19 and is financially dependent on the member or spouse, and
3. Under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute, and
4. Any unmarried disabled child under age 25 who is living with and financially dependent on the member or spouse and is incapable of self-sustaining employment. Disabled status must be approved by the insurance carrier and the dependent must become disabled while covered as a dependent under the Health Benefit Plan

You must be prepared to prove that an individual claimed as a dependent meets these requirements.

It is your responsibility to inform the Office when anyone covered on your Health Benefit Plan no longer meets the definition of dependent.

HOUR BANK

An hour bank is maintained by the Office on behalf of every member, and each hour worked for which we receive a contribution is recorded in your hour bank.

If you have not worked for 12 months, all hours worked will be discarded from the hour bank.

For each month that coverage is granted, your hour bank balance will be reduced by the required minimum number of hours worked in that month – known as the "monthly charge".

You can store up to a maximum of 12 months of coverage in your hour bank at any one time. Any excess of that amount is credited to the Plan's General Reserve Fund.

MAINTAINING COVERAGE

Your coverage will continue as long as you have the minimum number of hours worked per month in your hour bank to pay for the following month's coverage AND (except for Associates) you remain a member "in good standing" with Local 280.

Self-payments

(not available to Associates)

If your hour bank balance is less than the required minimum number of hours worked per month, you may be eligible to make a self-payment to cover the shortage to bring your balance up to the required level.

For example, if the required minimum was 120 hours worked, and your hour bank at the end of August was 75 hours you may be eligible to make an optional self-payment for the other 45 hours by the 19th of September to ensure that you are eligible for coverage on October 1st.

Using the most current information in our database, we will contact you by mail to inform you that your coverage may lapse due to a shortage of hours. We strongly advise you NOT to ignore these notices, because a lapse in coverage will result in your having to re-qualify (like a new member) for entitlement to benefits.

Please be advised that although we will contact you by mail (as noted above) we are ultimately not responsible for keeping you informed of the number of hours worked in your hour bank. This information is available to you by contacting the Office.

The Office does not email or call you about these shortages.

Important Notes

Wage Indemnity and Long-Term Disability coverages are excluded from these self-payment premiums.

If the shortage of hours represents a full month, then you are restricted to making self-payments for a maximum of 6 consecutive months while remaining a member "in good standing" with Local 280.

If your membership is suspended from Local 280 and/or if you resign, take a withdrawal or transfer card, and/or a part-paid initiation fee is forfeited, you will not be able to make any self-payments.

Should you receive a shortage of hours notice and feel that it is not correct you should contact the Office immediately.

Self-payments must be received by the due date stated on the notice otherwise your coverage will be terminated.

Instead of paying the self-payment notice, you may choose to purchase just Life Insurance and Accidental Death and Dismemberment coverage. If you choose this option, no monthly notices will be sent to remind you to pay the required premiums, and the rules are outlined on the application form which is included with the shortage of hours notice.

If you lose hours worked because you are:

- receiving Wage Indemnity payments
- receiving WorkSafe BC ["WSBC"] payments **(you MUST advise us ASAP when on a claim)**
- receiving Employment Insurance Sickness benefits
- attending an Apprenticeship Course (at a facility approved by the SMW Training Centre)

This Plan will credit your hour bank accordingly, subject to the following criteria:

(1). You must have completed and filed an application form

(2). You must be covered on the Plan at the time the Disability commenced [except for the situation per the NOTE below].

Hour bank credits will not be granted if you have resigned, taken a withdrawal or transfer card, and/or have been suspended from Local 280.

In the case of Associate Members, no credits will be granted if you have terminated employment with your Contributory Employer.

(3). No credits will be granted for claims that occur while working for a non-contributory Employer.

(4). An application for credits for Wage Indemnity, due to a WSBC claim, must be made within 3 months of the Disability [injury or illness] and is subject to the restrictions of the Wage Indemnity Plan [See "Wage Indemnity"].

NOTE - credits will be granted in the case of a WSBC injury or illness that occurs within 1 calendar month before the commencement of your Plan coverage -- provided that this coverage has been earned through actual hours worked AND that the application has been received by the Office within 30 days of the event.

Generally, credits will be based on the required minimum amount of the monthly charge. For example, if you are off work for the entire month, you will be credited with the minimum number of hours worked per month. However, if you were off work for only 7 days of the month you will be credited with 56 hours (i.e., 8 multiplied by the number of days).

Credits for apprenticeship courses will be similarly granted by the length of the course reduced by the

number of days you were absent from classes. Credits will be processed in the same manner as regular working hours — there is a “lag month”, as explained under “Eligibility”.

WSBC credits will be given for a maximum of 43 weeks (see also “LTD”).

Notices of credit granted will be mailed to your address on file with the Office.

TERMINATION

Your coverage will terminate at the end of a calendar month because (1) your hour bank total is less than the required minimum number of hours worked per month for eligibility or (2) you have not made a self-payment to cover the difference OR (3) because you are no longer a member "in good standing" with Local 280 or (4) because you no longer reside in BC.

Note - #2 and #3 do not apply to Associate members.

When your coverage terminates, you have a right to convert your Group Life Insurance benefit into an Individual Insurance Policy (for the same or lesser amount) with PBC, and there are also Conversion privileges with Pacific Blue Cross (PBC) regarding Dental & Extended Health benefits. For more details, please refer to the relevant sections of the PBC Booklet which is available from the Office and/or our website.

REINSTATEMENT

If your coverage has terminated, you must re-enroll in the same way as if you were a new entrant [see "Eligibility"]. You must again accumulate the required minimum number of new hours worked in your hour bank and have re-established your "in good standing" (except for Associates) status with Local 280.

RECIPROCAL AGREEMENTS

(not available to Associates)

The Plan has established many formal arrangements with other Sheet Metal and related Construction Trades Locals in both BC and throughout the rest of Canada.

It may be possible for you to transfer your hour bank to or from this Plan.

Please check with the Office to determine if a Reciprocal Agreement exists. We will also provide you with information regarding BC's Provincial Medical coverage – if necessary.

DENTAL

The following types of benefits are available through PBC:

Plan 'A' – 90% Claims Reimbursements for approved Basic Restorative services; including Diagnostic, Endodontic, Periodontic, Preventive, Prosthetic, Restorative, and Surgical procedures to restore your teeth to their normal functions.

NOTE - Recall exam, polishing, and fluoride treatments are eligible once every 9 months or, for dependents under age 19, twice per calendar year.

Plan 'B' – 70% Claims Reimbursements for approved Major Restorative services; including replacement &/or reconstruction, when Basic Restorative services are ineffective; usually including Crowns, Dentures, Fixed Bridges, Inlays, and Veneers.

Plan 'C' – 50% Claims Reimbursements for approved Orthodontic services – subject to a lifetime maximum limit of $3,500 i.e., 50% of $7,000.

Notwithstanding the above reimbursement percentages (and the $ Limit in Plan "C") – the actual amounts to be reimbursed will be based on PBC's "fee guide" for the current year. However, if the dentist charges fees greater than those in the Fee Guide, only the fee guide amount is considered for reimbursement.

We strongly advise you to always check with the dentist before the commencement of any treatment to clarify their fees for such services. Dentists are NOT obligated to adhere to the amounts in the current fee guide.

No annual financial limit exists for claims under Plans 'A' and/or 'B'.

Should your dentist require that you pay them directly, rather than direct billing to PBC, you will be required to obtain the following from the dentist:

(a) a Standard Dental Claim Form with the details of the work performed, and

(b) a paid receipt

EXTENDED HEALTH CARE [PBC]

When a Member or covered dependent requires treatment, the following benefits are available through PBC. A separate PBC booklet with more details is available on our website.

80% to $1,250 in claims and 100% after that.

$3,000,000 Lifetime Maximum Limit – reduced on an ongoing basis for the claims submitted.

The main benefits under the Plan for each Member and covered dependent are as follows:

- ✓ Prescription Drugs – 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, Podiatrist, and more. Note -- all must be "Registered" with their BC Professional Associations

- ✓ Psychologist/Counsellor/Dietician – $2,000 annual limit – refunded at 100%

- ✓ Medical Aids/Supplies – Oxygen, (ile)ostomy supplies, walkers/canes, Orthopedic shoes/Orthotics etc.

- ✓ Standard Durable Medical Equipment – Wheelchair, Glucose Monitors, Breathing 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, and 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 Member if there are no Dependents.

Benefits for paramedical services adhere to a Schedule of "Reasonable and Customary Limits" – which may lead to your owing, for example, $40 to a Physiotherapist whose fee is $120, if the PBC Fee Guide limit is only $80.

You may use the PBC app to submit almost all paramedical claims.

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 Group Plan number [1661] and your ID number from your PBC '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.

Notwithstanding the disclaimers above, there is no annual maximum limit to prescription drugs.

EXTENDED HEALTH CARE [SMW Admin Office]

Reimbursements for Vision Care, Hearing Aids, and Emergency Medical Travel will be processed by the Office. Direct billing is not available.

Before any purchase, you should contact the Office to clarify your eligibility.

The back of the application form, which is available from the office or our website, provides more comprehensive explanations of the information required to process your claim.

VISION CARE

The reimbursement for each Member and covered dependent 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

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.

HEARING AIDS

Forms are available by contacting the Office or our website. 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 protection” is not included in this coverage.

There is an agreement between SMART Canada and the Hear Canada Company [please visit their website at https://www.hearcanada.com] that may offer discounts for certain items and/or services.

EMERGENCY MEDICAL TRAVEL

NOTE – This is NOT in any way related to PBC’s “Out-Of-Province/Territory Emergency Eligible Expenses” benefits or to what is commonly referred to as “Individual Travel Medical Insurance”.

This Benefit relates to reimbursements, to certain limits, for transportation, meals, and accommodation expenses for a Member or covered dependent 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 Member or covered dependent'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 will be reimbursed at the maximum rate of $40 for the day of arrival and $40 for the day of departure.

Meals
The total daily reimbursement will be up to $50 for an individual or $100 for a family for a maximum of 7 days.

Accommodation
The total daily reimbursement is $80 for a maximum of 7 days.

The benefit has a maximum limit of 6 separate trips per calendar year.

We must receive all paperwork within 60 days of the occurrence of the medical appointment.

GROUP LIFE INSURANCE

Your Group Life Insurance coverage up to age 65, is $75,000. At age 65, this coverage reduces to $30,000 and it will reduce by $5,000 annually thereafter until it reaches $10,000 (age 69) where it will remain as long as you are a covered Member.

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) and surname(s), the percentage(s) applicable to each, as well as the relationship(s) to you.

Conversion of Your Group Life Insurance Policy

Upon termination from the Plan before age 65 you may apply directly to BC Life & Casualty 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. 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.

Total Disability/Waiver of Premium

If you become Totally and Permanently Disabled AND you qualify for LTD benefits, your Group Life Insurance coverage may remain in force as long as you continue to receive those LTD benefits.

Spousal Life Insurance Coverage

If you have enrolled your Spouse as a dependent – then in the event of their death, you will receive a tax-free lump sum payout of $10,000. There is no conversion option for spousal insurance.

Exclusions

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

Claim Procedures [applicable to Group Life and Spousal Insurance Coverage]

We must receive notification of the death within 30 days, and a completed claim form and the official death certificate must be provided to the Office within 90 days.

No payment will be made on any claim submitted later than 1 year from the date of death.

ACCIDENTAL DEATH & DISMEMBERMENT

In the case of an accident, the amount(s) payable to you and/or to your beneficiary/(ies) are determined by the TABLE OF LOSSES listed below. From now on, Accidental Death & Dismemberment will be shortened to AD&D.

All calculations of the payable tax-free amounts are based on specific percentages of the in-force Life Insurance coverage (the "Principal Sum"), which is $75,000 for Members under 65.

This coverage ceases at age 70 – or retirement if earlier.

TABLE OF LOSSES	Payable to	% times "Principal Sum"
Life	Your Beneficiary	100
Both Hands or Feet	You	100
Entire Sight of Both Eyes	You	100
One Hand and One Foot	You	100
One Hand and Entire Sight of One Eye	You	100
One Foot and Entire Sight of One Eye	You	100
Speech and Hearing	You	100
One Arm or One Leg	You	75
One Hand or One Foot	You	75
Entire Sight of One Eye	You	75
Thumb and Index Finger of the Same hand	You	33.33
Four Fingers of the Same Hand	You	33.33
Hearing in One Ear	You	25
All Toes of the Same Foot	You	25
Quadriplegia, Paraplegia, Hemiplegia	You	200

Loss of Use

Notwithstanding the appropriate amount payable upon your death, the Policy will compensate you for "Loss of Use" benefits payable if such a Loss is deemed total, permanent, and has been continuous for 365 days from the date of the accident and/or the onset of the illness.

Total Disability/Waiver of Premium

If you become Disabled AND if you qualify for LTD benefits, your AD&D coverage may remain in force as long as you receive the LTD benefits.

WAGE INDEMNITY

THIS COVERAGE IS NOT AVAILABLE IF YOU ARE:
SELF-PAYING FOR COVERAGE OR
COLLECTING YOUR SMW L280 PENSION

This benefit is adjudicated and administered by the Office. You must be covered on the Plan at the time of the Disability.

It is the policy of this Plan to maintain the same criteria for benefits as are in effect under the Employment Insurance Sickness benefits program AND to incorporate the same age limitations and regulations used in that program to determine the benefits payable from this Plan. Any payments may be reduced after age 60 by the amount of any Canada Pension Plan ["CPP"] payments received.

Illness

Benefits will be paid from the 4th day of an illness, provided you have seen a Physician.

Non-occupational accident/day surgery/overnight hospital admittance

Benefits will be paid from the 1st day, provided you have seen a Physician and/or Surgeon.

If you have not seen a Physician as required above, payments will begin from the date you first see a Physician, Surgeon, or Chiropractor regarding the specific Disability.

Benefit payments can be made for up to 17 weeks of Disability while under the continuing care of a Physician and/or Surgeon; or for 6 weeks if solely under the care of a Chiropractor.

Medical updates will be required and the costs for these are NOT covered by the Plan.

Bereavement Leave

Will be paid for up to 5 days in the event of the death of a spouse/common-law spouse, child, or step-child and up to 3 days in the event of the death of a parent, step-parent, sibling, or step-sibling, grandparent, or grandchild.

A government-issued Death Certificate or Statement of Death issued by the funeral home must be submitted with your claim form.

Jury Duty

The Plan will pay for the day you are absent from work to attend the courthouse for jury selection. The summons letter from the BC Sheriff Service must be submitted with your claim form.

If you are selected for jury duty, the Plan will pay for the day(s) you are absent from work. The fee receipt showing the dates served from the BC Sheriff Service must be submitted with your claim form.

Substance Abuse/Addiction

Payments may be made only when you actively participate in an appropriate Rehabilitation Program or process

under the guidance of counsellors with the Construction Industry Rehabilitation Plan.

To make a claim

NOTE *- This Plan must be your first payer BEFORE any EI Sickness benefit claim is filed.*

1. You must be totally disabled and prevented from working for wage or profit because of your injury or illness.
2. Request the application forms from the Office. Application must be made within 30 days of the date the disability occurred. Failure to file a claim within such time shall not necessarily invalidate nor reduce any claim if it is proven to the Administrator that you gave notice as soon as was reasonably possible. However, no benefits will be paid for claims submitted 6 months or longer after the date of disability.
3. The Disability must be supported by documented evidence that you are under the care of a Physician and/or Surgeon (or Chiropractor.)
4. Return the completed forms to the Office.

Incomplete forms could result in a delay in the assessment and/or payment of any benefits.

Payments

Payments will be made on a bi-weekly basis for as long as you continue to qualify.

If your claim is approved, payments will be deposited directly into your bank account to reduce administration time and costs AND to ensure that you receive your benefit without having to worry over undelivered/lost mail.

Because the payments are considered to be "taxable income" (although the Office does not tax them at source) you will receive a T4A form in February of each year showing the amount of income received that you must include in your tax return for the prior year.

Involvement of a 3rd Party

At the discretion of the Trustees to provide you with "income" for the period while you wait to settle your 3rd Party claim, upon your completion of the required Assignment Form(s), benefits may be "advanced" to you if your Disability occurred due to an accident (for example, a 'slip-and-Fall' situation in a store) for which a 3rd Party could be considered liable for damages.

HOWEVER – for the amounts of benefits that may be "advanced" by the Plan to you (excluding ICBC-related claims), you must strive to recover all such advances including the cost of maintaining your hour bank for up to 17 weeks. Once your 3rd Party claim is settled, you must refund the total amount of payments and the value of the hour bank credits to the Plan.

It is an established principle of Trust [but NOT Insurance] Law that legal fees may not be deducted from any Claim Settlement amount owed to the Plan.

PLEASE NOTE

(a) No benefits will be advanced to you for a 3rd Party Claim if you still owe the Plan a reimbursement from a previous 3rd Party Claim Settlement.

(b) At the sole discretion of the Trustees, your Dental and/or Extended Health benefit coverage may be suspended (and potential claims reimbursements may be temporarily withheld) until any/all outstanding 3rd Party Claim repayment amounts have been settled.

Exclusions

No benefits (neither payments nor hour bank credits) will be granted if the Member:

(a) Is Disabled due to occupational injuries or illnesses

(b) Is Disabled due to self-inflicted injuries or illnesses (with the exception of alcohol or drug addiction)

(c) Is Disabled due to their willful participation in war, riot, insurrection, disorderly conduct, or unlawful assembly

(d) Is Disabled due to their commission of any unlawful act, including an offence under the Criminal Code of Canada

(e) Is absent from work due to a pregnancy-related illness
   i. If the Member is absent from work because they are taking a period of formal maternity leave pursuant to provincial or federal law, or pursuant to mutual agreement between the Member and her Employer; and/or
   ii. If the Member is in receipt of Employment Insurance Maternity Benefits

(f) Is absent from work due to being institutionalized in a penitentiary, jail, or mental facility pursuant to a court order

(g) Is Disabled leading to a claim for benefits commenced prior to the date the Member was covered under the Plan or commenced during a period for which the Member is not eligible for benefits for any reason unless the Trustees otherwise agree in writing

(h) Is in receipt of any salary or wages from any occupation, including without limitation, the Member's Normal Occupation

(i) Is Disabled due to an Illness or Injury sustained while in the Armed Forces of any country

(j) Is Disabled and in receipt of WorkSafe BC payments in respect of the Disability that led to a claim for benefits being made under the Plan

(k) Is Disabled and in receipt of pension payments from the Sheet Metal Workers (Local 280) Pension Plan or self-paying for benefit coverage

Interrupted WorkSafe BC (WSBC) Claims

Notwithstanding Exclusion (j) above, this Plan will consider payment of benefits while you are Disabled during periods of delay, interruption, or suspension of WSBC payments after at least 45 days have elapsed since –

(1) You have filed a WSBC Claim, which has neither been accepted nor rejected
or
(2) Payments of WSBC benefits were suspended during an interrupted claim
or
(3) You have filed a formal appeal to continue receiving WSBC benefits

Wage Indemnity benefits can only be paid while WSBC payments are **not** being paid, and the maximum payment period for benefits is the standard 17 weeks.

Any benefit payments made to you in the above-stated circumstances MUST BE REIMBURSED to the Plan within 10 days of receipt of the relevant WSBC payments -- once your claim for these WSBC benefits has been reinstated and/or payments have been made for the time in question.

Recurrent Disability

If you are Disabled and return to work on a "full-time full-pay" basis for less than 2 full consecutive weeks and again become Disabled as a result of the same or related cause, it shall be considered a continuation of the first period of Disability.

If, however, you return to work for 2 full consecutive weeks on a "full-time full-pay" basis or more and again become Disabled as a result of the same or a related cause, it shall be considered a new period of Disability with new waiting periods, if any, and subject to a new maximum period of benefits.

Potential Extension of Benefits

If the illness or injury continues beyond the 17-week maximum payout period, you should apply for EI Sickness benefits so your income may continue.

If you are approved for payments under EI Sickness benefits, the Office will send you an application for Long Term Disability benefits at around week 18 of your EI Sickness claim.

If, however, **through no fault of your own**, EI Sickness benefits will not be paid, then before the end of your WI benefits, you may appeal to the Trustees to request an extension of those benefits for a maximum of 26 weeks on a discretionary basis.

Termination of Benefits

A Disabled Member who receives benefits from the Plan will cease to receive these benefits upon the earliest of the following events occurring:

1. The Member ceases to be Disabled

2. The Member reaches the end of the Maximum Benefit Period

3. The Member fails to comply with the terms of the Plan

4. The member fails to complete and return a Reimbursement and Assignment Agreement or refuses or fails to comply with the terms of the Reimbursement and Assignment Agreement

5. The Member fails to see a Practitioner as frequently as is appropriate given the cause and nature of the Disability, in which case Benefits will cease as of the date the Member fails to see the Practitioner as required

6. The Member fails to see a Practitioner for more than 30 consecutive days within the Member's Period of Disability without the Administrator's written approval - in which case the benefits will cease as of the last day of the 30-day period referred to above

7. The Member commences a SMW Local 280 pension

8. The Member dies

9. The Plan is terminated

LONG TERM DISABILITY ["LTD"]

This is a summary only. For further details, please see the Pacific Blue Cross booklet.

Disability means that during the Elimination period and the subsequent 12 months of disability, you are prevented, by injury or sickness, from performing each of the essential duties of your own occupation.

Thereafter, you must be prevented from performing each of the essential duties of any occupation for which you are or may become reasonably qualified by education, training, or experience.

Elimination ("Waiting") Period – is calculated as 43 weeks being the sum of:

- 17 weeks maximum duration of approved Wage Indemnity benefits – payable by the Office

  plus

- 26 weeks of EI Sickness benefits

  OR

- 43 weeks of WorkSafe BC benefits (even if payments continue, you are strongly advised to apply for LTD in case your claim ends, and you are unable to return to work. Please contact the Office for further details as other benefits may also be available)

Basic Monthly Benefit Amount – $1,750

The cessation date for receiving benefits is the last day of the month when you reach the age of 60.

If you have been covered under the Plan for less than 24 months, your entitlement to the full benefit of $1,750 per month will be reduced, as per the following table.

Pre-Disability Coverage	**Reduction**
From 0 to 6 months	40%
From 7 to 12 months	30%
From 13 to 18 months	20%
From 19 to 23 months	10%
24 months or more	none

Coordination with other Income Sources
Your monthly LTD benefit may be reduced by any amount of disability and/or retirement benefit that you are eligible to receive from other income sources. The maximum amount payable from all sources of income is 85% of your monthly basic earnings.

Third Party Liability
Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse BC Life when you receive payment from the third party.