

#### ADDRESS ALL BENEFIT PLAN INQUIRIES TO:

The Administrator I The CMAW Benefit Plan

#### D.A. Townley

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# The CMAW Benefit Plan

## **PRIVACY POLICY**

We, the Trustees of the CMAW Benefit Plan, have adopted the following Privacy Principals, which reflect our commitment to safeguarding our Member's 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 the Member's 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.

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# **Summary of Benefits**

## WHAT DOES THE CMAW BENEFIT PLAN COVER?

Group Life Insurance \$100,000 Uninsured Life Benefit : \$5,000

Dependent Life \$25,000/spouse and \$5,000 Insurance each child

Accidental Death \$100,000 and Dismemberment

Insurance

Dependent \$20,000/spouse and \$5,000 each child

Accidental Death and Dismemberment Insurance

Wage Indemnity sick benefit, integrated with E.I. sick benefits El weekly maximum

Long-term Disability

\$2,000 monthly

Extended Health Care :

80% percent of the first \$1,250 of eligible expenses / 100%

percent thereafter to a lifetime

max of \$1 million

Travel Assistance

8 claims per illness

Vision Care Benefits

80% to a maximum reimbursement of \$480 (80% of

\$600) every 12 months

Dental Plan

85% of Basic and Major and orthodontic services to maximum reimbursement of \$5,100 (85% of \$6,000) per family per calendar year.

# PART 1 General Information

#### How do you establish coverage in the plan?

- You must be a Member in good standing of the Construction Maintenance and Allied Workers.
- (2) You must have a minimum of two hundred twenty (220) hours, within a period of twelve (12) consecutive months, reported and paid into the Plan by your employer(s).

#### Do any forms have to be completed?

Yes, you must complete an Enrollment and Beneficiary card.

#### When does coverage commence?

Union Members who have completed an application card will have coverage commencing on the first day of the month following the month in which sufficient hours are reported to the Plan by your employer(s).

#### Example:

Your employer(s) report that you have accumulated in excess of two hundred twenty (220) hours in the last twelve (12) months. March hours are reported and tabulated in April, which makes April the Lag Month; your coverage becomes effective May 1.

Month	Hours Reported
January	
February	110
March	110
April	Lag Month
May	Coverage Starts

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

# How does the Hour Bank build for future coverage?

Once a Member is qualified, additional hours reported will be added to your Hour Bank. Each month one hundred ten (110) hours will be withdrawn from the Hour Bank for coverage. You may accumulate up to twelve (12) months' coverage—one thousand three hundred and twenty (1320 hours) in advance which will be drawn upon during a period of unemployment, illness or extended vacation, providing you remain a Member in good standing of the Union.

# What happens if the Hour Bank falls short for coverage?

If your Hour Bank drops below one hundred ten (110) hours, you will receive a Self-Payment Notice indicating the number of hours you are short 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.

#### Example:

10 hours
) hours
) hours

You must contribute twenty (20) hours at the current self-payment rate.

#### Self-Payment option

In order to assist you in maintaining coverage with the Plan, the following option is available to those Members receiving a Self-Payment Notice.

Full coverage for Group Life, AD&D, Extended Health Care, Vision, Dental, Travel Assistance and EAP.

**NOTE:** there is no Wage Indemnity or Long-term Disability benefits during self paid months.

#### Maximum Self-Pay

When you have no hours left in your Hour Bank, you may continue to self-pay for up to eighteen (18) months.

#### **Disability credits**

Should you go on claim for Wage Indemnity, Worker's Compensation or El sickness benefits, you will receive eight (8) hours for each day you are in receipt of disability benefits, to a maximum of one hundred ten (110) hours per month for a maximum of six (6) months. Disability credits will be given automatically for Wage Indemnity benefits, however, in order to obtain Disability Credits while receiving Worker's Compensation or El sickness benefits, you must submit a competed Disability Credit form to the Administrator.

### Extension of coverage while receiving Long-term Disability Benefits

Members receiving Long-term Disability benefits through the Plan will be provided with continued coverage for Extended Health Care, Vision Care and Dental benefits at no cost for up to 2 years.

#### Right to recover

- Where a member becomes Totally Disabled as a result of an injury or sickness in respect of which;
  - a third party may be, directly or indirectly, either in whole or in part, liable to the member or;
  - (ii) the member has a claim for benefits under Workers Compensation legislation; the Plan will not pay benefits to the member.
- (2) In the circumstances described in (1) above, 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 written Loan Agreement.

#### When does coverage end?

Coverage is always provided on a whole-month basis only, and will be terminated for the Member and their dependents, when:

- your Hour Bank falls below one hundred ten (110) hours and you fail to make a self-payment by the specified date, to bring your Hour Bank up to the required one hundred ten (110) hours, or;
- (2) you cease to be a Member of the Union.

#### 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

604.299.7482 or toll-free at: 1.800.663.1356

By mail:

Suite 160 - 4400 Dominion Street,

Burnaby, BC V5G 4G3

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.



# If coverage terminates, when will coverage re-commence?

When two hundred twenty (220) hours have been worked and reported to the Plan. See "How Do You Establish Coverage in the Plan?" for details. You may not re-qualify by self-payment.

#### Dependent coverage

A Member's registered eligible dependents will be included in the coverage for Dependent Life, Extended Health Care, Vision, Dental Care, Travel Assistance, EAP and the spouse and dependent AD&D benefits.

Dependents eligible for benefits are:

- (1) the Member's spouse\* and
- (2) unmarried dependent children mainly supported by the Member up to twenty-one (21) years of age, and up to the age of twenty-five (25), provided they are attending school, university or college on a full-time basis. Also, dependent children who are physically or mentally disabled and rely upon the Member for support for whom the Member is entitled to an income tax exemption, provided such child was insured under the Plan immediately prior to his/her twenty-first (21) birthday.

Dependent children must be added within sixty (60) days from the date of birth or from the date the child became a dependent. A spouse must be added within sixty (60) days of the date of marriage.

Newborn children are NOT automatically registered. You must notify the Administrator and provide the child's name and date of birth in order to have him/her included in your coverage.

Dependents not added as above will be covered from the first day of the calendar month following the date of application or if specifically requested, from the first day of the month in which application is made.

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\* 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 with 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 six (6) months.

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

#### Termination of dependent student coverage

A dependent student will automatically be terminated when they reach the maximum dependent age for the benefit.

**NOTE:** If your dependent's coverage is terminated and he or she is still a student (and within the maximum age), contact the Administrator's office to arrange for reinstatement.

#### Co-ordination of benefits

- (1) When co-ordinating benefit payments, Green Shield 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 one hundred (100) percent 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:
  - the amount that would have been payable had it been the primary carrier, or
  - one hundred (100) percent 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 coordination 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.

# PART 2 Group Life Insurance

#### AMOUNT OF BENEFIT

All Members who are under age 70 \$100,000 (\$50,000 for mini plan) reduced 50% at age 65 and each year after up to age 69.



The Group Life Insurance Benefits is payable to the beneficiary designated by you on your Group Enrollment card, should your death occur from any cause while you are insured under the group policy. If any beneficiary dies before you, the interest of such beneficiary shall, unless otherwise provided, vest in your estate. If you do not designate a beneficiary, the insurance will be payable to your estate.

If you wish to change your beneficiary, proper forms are available from the Administrator's office.

#### Conversion privilege

In the event of cancellation of coverage due to termination of your coverage, you have the right to convert your Group Life Insurance to an individual Life Insurance policy at the insurance company's rates for such policy, without medical evidence, provided application is made within thirty-one (31) days of such termination.

In the event of your death, within thirty-one (31) days following termination of coverage, the death benefit would be payable.

#### Waiver of Premium - Total Disability

While covered, should you qualify to receive Long-term Disability benefits under this plan or become totally disabled for more than nine (9) months prior to age sixty-five (65), the amount of your life insurance will continue without payment



of premiums while you remain totally Disabled. Satisfactory proof of Total Disability must be submitted to the insurance company within twelve (12) months from the date of Total Disability and thereafter, upon requests by the insurance company. Your life insurance coverage and waiver will terminate when you reach age sixty-five (65) or recover, whichever occurs first.

#### Submitting a claim

The time limit within which a group life insurance claim must be made is one hundred eighty (180) days from the date of loss.

## PART 3 Uninsured Life Benefit

## AMOUNT OF COVERAGE

All Uninsured Members

\$5,000

The CMAW Benefit Plan provides a Life Benefit of \$5,000 should you die before becoming eligible for coverage under the plan providing you have completed your union membership card.

Payment of this benefit will be made to your Estate.

# PART 4 Dependent Life Insurance

This benefit provides life insurance coverage for your spouse and dependent children. The amount of the benefit is:

Spouse	\$25,000	
Child (from birth)	\$5,000	

#### Total disability waiver of premium

If you are totally disabled and the premiums for your basic life insurance coverage are being waived, then premiums for the dependent insurance will also be waived, but only so long as the policy remains in force.

# PART 5 Accidental Death & Dismemberment

The Basic Accidental Death and Dismemberment benefit 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 a result of an accidental injury which results directly and independently of all other causes and the loss occurs with three hundred sixty five (365) days of the date of the accident, the benefits indicated below will be paid.

#### Who is Covered? Amount of Coverage

All Members who are under age 70 \$100,000 reduced 50% at age 65 and each year after up to age 69.

All Spouses

\$20,000

All eligible dependent children \$5,000

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## SCHEDULE OF LOSSES

SCHEDULE OF LOSSE	5
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 Entire Sight of One Eye	The Principal Sum
Loss of One Foot and Entire Sight of One Eye	The Principal Sum
Loss of One Arm	Three-Quarters of the Principal Sum
Loss of One Leg	Three-Quarters of the Principal Sum
Loss of One Hand	Two-Thirds of the Principal Sum
Loss of One Foot	Two-Thirds of the Principal Sum
Loss of the Entire Sight of One Eye	Two-Thirds of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One -Third of the Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Speech or Hearing	Two-Thirds of the Principal Sum
Loss of Hearing in One Ear	One -Third 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	Two Times the Principal Sum

of the body)

#### SCHEDULE OF LOSSES Continued

Loss of Use of Both The Principal Sum Arms or Both Hands Loss of Use of One Two-Thirds of the Principal Hand or One Foot Sum Loss of Use of One Arm: Three-Quarters of the or One Leg Principal Sum Loss of Four Fingers of One -Third of the Principal One Hand Sum One-Quarter of the Loss of All Toes on One Principal Sum Foot

"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 irrecoverable loss of the entire sight thereof.

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

"Loss" as used with reference to "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for twelve (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 Health & Welfare Plan "the Plan" and a licensed practicing physician appointed by the insurance 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 to 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.



#### Exposure and disappearance

If by reason of an accident covered by the policy an insured person is unavoidably exposed to the elements and, as a result of such exposure suffers a loss for which indemnity is otherwise payable hereunder, such loss will be covered under the terms of the policy.

If the body of an insured person 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 person shall have suffered loss of life within the meaning of the policy.

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#### Beneficiary designation

In the event of accidental loss of life, benefits shall be payable as designated in writing by the insured person 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 person. All other benefits shall be payable to the insured person.

#### Repatriation benefit

When injuries covered by this policy result in loss of life of an insured person outside fifty (50) km from their permanent city of residence and within three hundred sixty five (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.

#### Rehabilitation benefit

When injuries shall result 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 person provided:

- such training is required because of such injuries and in order for the insured person to be qualified to engage in an occupation in which he would not have been engaged except for such injuries,
- (2) expenses be incurred within three years from the date of the accident,
- no payment shall be made for ordinary living, travelling or clothing expenses.



#### Family transportation

When injuries covered by the policy result in an insured person being confined to a hospital, outside one hundred (100) km from his/her permanent city of residence, within three hundred sixty five (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 actual expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined insured person but not to exceed the amount of \$15,000.

The term "member of the immediate family" means the spouse (or common-law spouse), parents, grandparents, children under eighteen (18), brother or sister of the insured person.

#### Conversion privilege

On the date of termination of employment or during the sixty (60) day period following termination of employment, you may change your insurance to the insurance company'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 policy 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 the insurance company. The amount of insurance benefit converted to shall not exceed that amount issued during coverage.

#### Waiver of premium

In the event an insured person becomes totally and permanently disabled and his/her Waiver of Premium claim is accepted and approved under the Plan's current Group Life Insurance policy, then the

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premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Insurance Plan Underwriter until one of the following occurs, whichever is earlier.

- The date the insured person attains age sixtyfive (65).
- The date of the death or recovery of the insured person.
- (3) The date the Master Policy is terminated.

#### Seat belt rider

Benefits under the policy shall be increased by ten (10) percent if the insured person'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 person received payment under Part 5 – Schedule of Losses herein, and was subsequently required (due to the cause for which payment under Part 5 – Schedule of Losses was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

- The one-time cost of alterations to the injured person's residence to make it wheel-chair accessible and habitable; and
- (2) The one-time cost of modifications necessary to a motor vehicle, owned by the injured person, to make the vehicle accessible or drivable for the insured person.

Benefit payments herein will not be paid unless:

 Home alterations are made on behalf of the insured person and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and



(ii) Vehicle modifications are made on behalf of the insured person 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 1 and 2 combined will not exceed \$15,000.

#### Educational benefit rider

If Indemnity becomes payable for the accidental loss of life of an insured Member of the Plan, under the policy, the Company shall:

- (1) Pay the lesser of the following amounts to or on behalf of any dependent child who, at the date of accident, was enrolled as a full time student in any institution of higher learning beyond the 12th grade level:
  - the actual annual tuition, exclusive of room and board, charged by such institution per school year.
  - (ii) \$10,000 per school year.
  - (iii) five (5) percent of the insured Member's Principal Sum.

Such amount will be payable annually for a maximum of four (4) consecutive annual payments, only if the dependent child continues his education.

"Dependent Child" as used herein means any unmarried child under twenty-six (26) years of age who was dependent upon the insured Member for at least fifty (50) percent of his maintenance and support.

"Institution of higher learning" as used herein includes, but is not limited to, any University, Private College, or Trade School.

(2) Pay to or on behalf of the surviving spouse the actual cost incurred within thirty (30) months from the date of death of the insured Member as

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payment for any professional or trades training program which such spouse has enrolled for the purpose of obtaining an independent source of support and maintenance, but not to exceed a maximum total payment of \$10,000.

#### Day care benefit

If indemnity becomes payable under the policy for accidental loss of life of an insured Member, the Company will pay an amount equal to the lessor of the following amounts:

- the actual cost charged by such day care center per year, or
- three (3) percent of the insured's Principal Sum, or
- (3) \$5,000 per year,

On behalf of any child who was an insured's dependent at the time of such loss and is under age thirteen (13) and is currently enrolled or subsequently enrolled in an accredited day care center with ninety (90) days following such loss.

The benefit is payable annually for a maximum of four (4) consecutive payments but only if the dependent child continues his or her enrollment in an accredited day care center.

#### In-hospital indemnity benefit

If an insured suffers loss under the Schedule of Losses as a result of a covered accident and requires that an insured be confined to a hospital for more than five (5) consecutive days, the Company will pay:

- a monthly benefit of one (1) percent of the insured's applicable Principal sum; or
- (2) for periods of less than one (1) month, one thirtieth (1/30) of the above monthly benefit per day.

Benefits are retroactive to the first (1st) day of hospital confinement.



This benefit is limited to:

- (i) a monthly amount not to exceed \$1,000 and
- (ii) a total of twelve (12) months for any covered accident.

Successive period of hospital confinement for loss from the same covered accident separated by a period of less than three (3) months will be considered as one (1) period of hospital confinement.

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

- 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;
- 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

When, as a result of injury and commencing within three hundred sixty five (365) days of the accident, an insured person is totally and permanently disabled and prevented from engaging in each and every occupation for employment for compensation or profit for which he is reasonably qualified by reason of his education, training or experience, the Company shall pay, provided such disability has continued for a period of twelve consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any other amount paid or payable under the Accidental Death and





Dismemberment Indemnity Coverage of the policy as a result of the same accident.

#### Exclusions

The accident insurance plan does not cover any loss resulting from:

- Suicide or self-inflicted injuries
- Full-time service in the Armed Forces:
- · Declared or undeclared war or any act thereof;
- Injuries received during aircraft travel except for the purposes of transportation where the Member is travelling as a passenger.

# PART 6 Wage Indemnity

The El maximum benefit will be paid to you when you are unable to work because of either an accident or sickness that is not covered by Workers' Compensation or similar legislation.

The benefits commence from the first day of disability if resulting from an accident, or on the fourth day of disability if resulting from an illness. Payments continue as long as you are unable to work, up to a maximum of twenty-six (26) weeks. Benefits are pro-rated on the basis of a seven (7) day week.



Benefits will also be paid up to a maximum of six (6) weeks when you are under the full-time care of a chiropractor for disabilities that are normally treated by a chiropractor. For benefits beyond the six (6) week duration, you must be under the full-time care of a physician and/or surgeon.

Benefits are integrated with El sick benefits, and will be paid as follows:

- The first four (4) weeks will be paid by the Plan at the El maximum.
- The weeks from 5 to 19 (15 weeks) inclusive, will be paid by EI at a rate determined by EI.
- The balance of the weeks from 20 to 26 will be paid by the Plan, if you are still disabled, at a rate of the El maximum.

Benefits received under this benefit are taxable.

### The maximum period payable from both the plan and EI is 26 weeks

NOTE: In order to qualify for EI sick benefits you must have worked twenty (20) weeks in the past twenty-six (26) weeks. Claims must be filed for EI sick benefits at the same time you apply for Wage Indemnity benefits with the Plan. If you are rejected by EI, the Plan will cover you for the period not covered by EI, providing you are still disabled under the terms of the Wage Indemnity Plan.

#### How to claim for wage indemnity

Take the following steps as soon as possible after you have become disabled:

- Contact your medical doctor immediately on becoming disabled. No benefits are payable prior to the date you are first seen and treated by your doctor.
- (2) Obtain a claim form from the Administrator or from your participating Local Union office or your shop steward.

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- (3) You must complete the front of the claim form and sign it on both sides.
- (4) Ask your doctor to complete the Physician's Statement on the back of the same form.
- (5) It is your responsibility to have the claim form sent to the Administrator.
- (6) Claims will be assessed by the Plan, and once approved, you will receive your benefit cheques by mail at your home address.
- (7) Claims should always be sent in within thirty (30) days of commencement of disability, unless special circumstances prevent you from doing so.
- (8) Benefits will only be paid when a Member is under the full-time care of a physician and/ or surgeon. Where there is any doubt as to the validity of the claim, the Plan reserves the right to obtain a second medical opinion from a physician and/or surgeon of their choice.

#### Third party liability

Benefits will be paid for disabilities due to an accident in which a third party is liable only when the person undertakes to endeavor to collect, at least the amount of benefits paid, and refund the amount paid to the Plan. The Trustees may, at their discretion, allow a Member to discontinue action to collect from a third party when, in their opinion, there is little or no hope of collection.

#### Recurrence of former ailments

You will not receive benefits for more than twentysix (26) weeks as a result of disability due to any one ailment. However, if you return to work and are



at work for two (2) consecutive weeks and again become disabled, it will be considered a new ailment.

#### Limitations and exclusions

No benefit will be paid for periods of disability arising from:

- Occupational accidents or illness as these are covered by the WCB Act.
- Self-inflicted injuries or diseases, excluding alcoholism and drug addiction.
- Injuries or diseases resulting from war or participation in a riot, or arising while serving as a member of any armed service.
- Routine pregnancy.
- No benefit will be paid for any period for which the person has or will receive vacation pay for an annual vacation.
- Arising from an automobile accident except as a fully repayable loan.

## PART 7

#### **Long-term Disability**

The purpose of this benefit is to provide coverage should you become totally disabled as a result of an accidental injury or illness and are unable to work at your own occupation for wage or profit.

YOUR TAXABLE BENEFIT	
Each Member	Flat \$2,000

Benefits will commence on the one hundred eighty third (183rd) day of continuous/consecutive disability.

You are eligible for benefits for a twenty-four (24) month period from the date disability payments are eligible to begin if you are unable to perform the usual and customary duties of your occupation.

Thereafter, benefits will continue only if you are unable to perform the duties of any occupation.

In no case shall a benefit be paid beyond:

- the date of your sixty-fifth (65th) birthday, or
- · the date you are no longer totally disabled,
- or retirement.
- or the date you engage in any work or occupation other than rehabilitative employment, or
- the date you fail to furnish satisfactory evidence of total disability or refuse to submit to a medical examination by a physician chosen by the Insurance Company, or
- the date you refuse to participate in any rehabilitation program approved by the Insurance Company, whichever occurs first.

Successive periods of disability arising from the same or related cause and separated by less than six (6) months will be treated as one (1) period of continuous total disability.

#### Benefit adjustment

At the time of a claim, your Long-term Disability benefit will be reduced by any disability benefit you are entitled to receive from any Worker's Compensation act or similar statute, Canada/ Quebec Pension Plan, any criminal injuries compensation legislation and any automobile insurance act. The reduction will also include any CPP/QPP retirement benefits, however, will not include any additional amounts payable for dependents or cost of living increases.

If necessary, your Long-term Disability benefit will

be further adjusted so that your total income will not exceed eighty-five (85) percent of your predisability gross salary (net salary if your benefit is non-taxable). This applies to disability benefits from any other source including: pension plan, employer funded salary replacement, other insurance plan whether group or association, damages for loss of



income which are payable from any legal action, employment income other than from an approved rehabilitation program and severance.

#### Rehabilitation program

Based on a determination made by the Insurance Company, a rehabilitation program may be provided to you which could include: assessment (medical, psychological, vocational evaluation), treatment (medical, psychological, vocational intervention, including various programs of therapy), employment (work trial, modified/full or part-time work), services (training strategies and work related activities expected to enhance your ability to return to work or secure employment) and a rehabilitation benefit.

The Insurance Company will have the sole right and discretion in determining whether a rehabilitation program will be provided to you and the services provided as part of that program. If you do not participate in rehabilitation program provided either by the Insurance Company or by another party and approved by the Insurance Company (i.e. Worker's Compensation act or similar statute, auto plan benefits, Canada/Quebec Pension Plan) or the Insurance Company withdraws approval of your program, then your disability/rehabilitation benefits under this policy will cease.

While you participate in the rehabilitation program your disability benefit will continue, but will be



The CMAW Benefit Plan

reduced by fifty (50) percent of any rehabilitative earnings (total earnings from your rehabilitation employment if your benefit is taxable, total earnings less income tax, EI, CPP/QPP if your benefit is non-taxable). Your benefit may be further reduced so that your rehabilitative earnings plus your disability benefit do not exceed one hundred (100) percent of your pre-disability (gross if your benefit is taxable, net if your benefit is non-taxable).

Any rehabilitation program will not extend beyond the end of your own occupation period. Nothing in the rehabilitation program or provision will create any basis for any extension of the own occupation period unless an extension of the duration is recommended and approved in writing by the Insurance Company.

#### Third party liability

If you become totally disabled due to an injury or disease for which a third party is or may be legally liable, benefits will be paid when you sign (and submit to the Insurance Company) a Reimbursement Agreement.

You will be required to reimburse the Insurance Company for benefits received in accordance with the terms and conditions stated in the Reimbursement Agreement.

You must obtain the written consent of the Insurance Company before compromising or settling the action or cause of action with the third (3rd) party. Failure to do so may disentitle you to any further benefits under this policy.

#### Exclusions

- No benefit will be payable for any disability resulting from or caused by:
  - intentionally self-inflicted injury, while sane or insane, or;



- insurrection, war or hostilities of any kind, or riot or civil commotion regardless of whether you were participating, or;
- injury occurring while committing or attempting to commit a criminal offense including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 milliliters of blood. A "vehicle means, a vehicle that is drawn, propelled or driven by any means other than muscular power, or;
- use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment from a rehabilitation centre or an institution provincially recognized for that treatment, or;
- medical or surgical care which is cosmetic in nature or medical care or surgery that is not medically necessary. However, periods of disability due to the donation or an organ or tissue will be covered, or;
- injury or sickness for which a third party is liable, except as provided for in the third party liability section, or;
- an automobile accident except as a fully repayable loan.
- (2) No benefit will be payable for any disability if you are imprisoned or if you are not under continuous care and treatment of a physician who is certified by the Royal College of Physicians and Surgeons in a specialty appropriate to your sickness or injury.
- (3) No benefits will be payable during any period that you are on maternity leave, parental leave or any other leave of absence.
- (4) No further benefits will be payable from the date you refuse to participate in any rehabilitation program approved by the Insurance Company.

#### Pre-existing condition limitation

A pre-existing condition is any injury or sickness for which you received medication, treatment or medical advice or for which there were symptoms which would have caused an ordinary person to seek diagnosis, care or treatment within the ninety (90) days immediately prior to becoming insured under the Policy.

No monthly benefit shall be payable for any period of total disability which was caused by or resulting directly or indirectly from a pre-existing condition, unless you have not required treatment, medication or medical advice for a period of ninety (90) days while insured under the Policy or unless you have been insured under the policy for at least twelve (12) months and have not been absent from work due to the pre-existing condition for at least twelve (12) months. Time away from work up to ten (10) cumulative working days during the twelve (12) month period will be interpreted as not being absent from work.

#### Submitting a claim

The time limit within which a Long-term Disability claim must be made is ninety (90) days from the date the Insurance Company is liable.

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## PART 8 Extended Health Care

Extended Health Care is an extension of your coverage through the Provincial Medical Services Plan and is designed to protect you and your dependents against unusually large expenses incurred during a serious accident or illness. The benefits hereunder do not cover any benefits for which provision is made under or pursuant to the Medical Services Act in your province of residence or any amendment to those provisions from time to time (hereinafter referred to as MSP, or the BC PharmaCare Plan).



The following are eligible expenses when incurred as a result of necessary treatment for illness or injury and, where applicable, when ordered by a physician. Eligible expenses are reimbursed at eighty (80) percent.

(1) Charges for drugs and medicines requiring a physician's prescription and which are dispensed by a licensed pharmacist (maximum ninety (90) day supply). Anti-Obesity, fertility drugs, erectile dysfunction agents and smoking cessation drugs (including gum, patches and inhalation) have a combined maximum of \$1,000 per calendar year per person. Fertility drugs have a lifetime overall maximum of \$3,000, and smoking cessation products have a \$300 maximum per twenty-four (24) months.

Your plan provides for Mandatory Generic Drug Substitution - this means that reimbursement will be made for the cost of the lowest priced equivalent drug, unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine. Some drugs may require Prior Authorization from Green Shield before they can be reimbursed. Prior authorization drugs tend to be expensive. For each prior authorization drug, Green Shield establishes medical criteria that you must meet before approval for coverage is granted. Check the status of the prescribed drug by asking your physician what drug is being prescribed. Then you can find the status of that drug in one of three ways: use the drug search feature on Plan Member Online Services (via greenshield.ca) or on the Green Shield on the Go mobile app, call GSC at 1.888.711.1119, or ask your pharmacist to submit the drug claim electronically using your GSC ID card.

Members who are BC residents, MUST register for Fair PharmaCare and provide their registration number to Green Shield Canada in order to ensure continued coverage for benefits under this Plan.

- (2) Services of a Registered Nurse when ordered by the attending physician in the management of an acutely ill patient to a maximum \$10,000 per calendar year. Acutely ill refers to conditions having a sudden onset with a sharp rise and a course less than sixty (60) days. This does not include conditions due mainly to chronic illness, alcoholism, mental illness, drug addiction, tuberculosis or infirmity. Lifetime maximum for services of a Registered Nurse is \$25,000.
- (3) Emergency transportation to and from a hospital, provided the trip is in a professional ambulance or on a scheduled airline or railroad, ship or boat, or in an acute emergency by air ambulance to the nearest hospital qualified to provide the necessary treatment. 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.
- (4) The following expenses are covered when you or your eligible dependents receive services rendered by a "Licensed, Certified, or Registered" practitioner.
  - Fees of a massage therapist up to a maximum of \$1,200 per person per calendar year.
  - (ii) Fees of a physiotherapist up to a maximum of \$1,200 per person.



- (iii) Fees of a chiropractor up to a maximum of \$1,200 per person per calendar year. X-rays taken by a chiropractor will not be covered.
- (iv) Fees of a naturopathic physician up to a maximum of \$600 per person per calendar year. X-rays taken by a naturopathic physician will not be covered.
- Fees of an approved acupuncturist up to a maximum of \$600 per person per calendar year when services are provided in BC.
- (vi) Fees of a speech therapist, when prescribed by a specialist up to a maximum of \$600 per person per calendar year.
- (vii) Fees of a podiatrist up to a maximum of \$600 per person per calendar year. X-rays taken by a podiatrist will not be covered.
- (viii) Fees of a psychologist, refer to the EFAP on page 48.
- (5) Charges for oxygen, blood or blood plasma, charges for ostomy supplies or ileostomy supplies, artificial limbs or eyes, crutches, splints, casts, trusses or braces.
- (6) Orthopaedic shoes are limited to one pair every twelve (12) months for under age nineteen (19). For ages nineteen (19) and older, limited to one pair every five (5) years. Replacements are covered only when necessary due to normal wear and must be prescribed by a licensed medical practitioner.
- (7) 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.

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- (8) Cost of hearing aids, when prescribed by an ear, nose and throat specialist up to a reimbursement maximum of \$800 per person every five (5) years. Maintenance and repairs are covered under the Plan. Replacement hearing aids will be paid for only in those cases where the hearing aid cannot be satisfactorily repaired. Molded Earplugs reimbursed at \$150 every two (2) years.
- (9) Wigs or hairpieces, when required as a result of chemotherapy or radiation treatment, up to a lifetime maximum of \$500 per person.
- (10) Charges made by a physician for a medical examination 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 no claim had been made under the Provincial Medical Services Plan.
- (11) Private or semi-private hospital charges made by an approved acute general hospital in your province of residence for coinsurance and short stay charges, and when actually occupied. Rental of telephone or TV, etc., will not be considered eligible expenses.
- (12) Fees of a dentist (up to a maximum stated in the current dental fee guide) for repairing damage caused to natural teeth due to accident, provided treatment occurs within one (1) year of the date of the accidental injury, and injury occurred while the person was covered under this Plan.

#### **Out-of-Province emergencies**

Emergency medical, surgical, hospital and other similar expenses incurred by a covered member or his/her eligible dependents while travelling on vacation outside of Canada will be eligible under this



Plan just as they are while in Canada (provided it is within sixty (60) days of leaving Canada).

This benefit is provided through GSC Travel Assistance through Allianz. In the event of an emergency the insured must immediately contact Allianz (the company appointed to provide medical assistance and claims services). Allianz will open a claim file, assist in locating proper medical care, verify coverage and assist in co-ordinating payment of the claim with the Provincial Medical Plan and the Plan's policy. A Medical Assistance Card, with worldwide contact numbers, for the Allianz Emergency coverage should be carried by the Insured when travelling.

#### Covered expenses include:

- reasonable and customary charges for hospital services and accommodation up to a standard ward rate in a public general hospital.
- reasonable and customary charges for physician's services required.

Employees working outside of Canada must arrange for additional coverage.

#### Amount of reimbursement

Eligible expenses are reimbursed at one hundred (100) percent to a maximum lifetime of \$1,000,000. This is combined with all other eligible expenses under the EHC benefit.

#### **Exclusions and Limitations**

Your Extended Health Care Plan does not cover:

(1) expenses for benefits, care or services payable by or under your Provincial Medical Plan, PharmaCare, any Hospital Program or the Worker's Compensation Act, whether or not a claim is made thereunder or provided without cost or at normal cost by any public or tax-

- supported authority or agency, or for which the Member or dependent can recover from another party;
- (2) the expenses of a physician, except as described under "Out of Province Emergencies" for emergency treatment while travelling outside your province of residence and as limited thereby;
- (3) expenses caused, contributed to or necessitated as a result of war or any act of war (whether declared or undeclared) invasion, acts of terrorism or acts of foreign enemies, civil war, rebellion, revolutions or civil insurrection;
- (4) expenses incurred due to suicide or any attempt there at:
- expenses incurred due to orthopotic treatment, refractions, eye glasses, contact lenses, hearing aids or prescriptions for any of them (except as expressly provided);
- (6) expenses incurred due to dental services except as set out in item 12;
- (7) any portion of a specialist's fee not allowable under the Provincial Medical Plan due to nonreferral; or any amount of fees charged by any practitioner in excess of the recognized fees for such service;
- (8) expenses incurred due to service and supplies for cosmetic purposes;
- (9) expenses incurred outside the province on an elective basis. Services will only be allowable for an unexpected illness or injury while the insured person is temporarily visiting in other provinces of Canada or other countries, or



(10) expenses contributed to or caused by occupational disabilities.

#### Fair PharmaCare Program

The British Columbia Government introduced the Fair PharmaCare Program in May 2003.

Under this program the annual family deductible was changed from a flat \$1,000 to a percentage of your net family income. All BC residents are required to register for this program. Failure to do so will result not only in your deductible increasing to \$10,000 but may also prevent us from honouring your claims until you register.



To register for the Fair PharmaCare Program call 604.683.7151 from Vancouver and toll-free 1.800.663.7100 from the rest of BC. If you prefer to go on-line to the Fair PharmaCare website the address is https://www.health.gov.bc.ca/pharmacare/plani/planiindex.html.

Once you have registered please contact Green Shield Canada to provide them with your registration number. You can contact them as follows:  Customer Service Centre online via www.greenshield.ca or call 1.888.711.1119

If you already provided your PharmaCare
Registration Number on your Group Insurance
Enrolment Card there is no need to submit it again.

#### PART 9 Travel Assistance

This benefit assists members to reach the nearest specialized medical services where such services are not available locally.

- \$25 deducted from the cost of return fare, balance is reimbursed at eighty-five (85) percent. On a doctor's recommendation, the fare of an accompanying member of the family or guardian will be reimbursed.
- Per diem allowance of \$60 per day for meals and expenses to a maximum of eight (8) days.
- Up to \$80 per day additional reimbursement for accommodation expenses (receipts are required).
- The program will reimburse a maximum of eight (8) claims per family member per illness.



#### PART 10 Vision Care Benefit

The following expenses shall be eligible for reimbursement at eighty (80) percent up to a maximum of \$480 (eighty (80) percent of \$600) per person per twelve (12) month period. There is no deductible applied to this benefit.

- Single vision, bifocal or trifocal lenses, prescribed by a person legally qualified to make such a prescription;
- (2) Frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable;
- (3) Contact lenses prescribed by a person legally qualified to make such prescription.

Eye exams which are not covered under any other Plan, up to a maximum reimbursement of \$60 per insured person under seventeen (17) every twelve (12) months, \$100 per person seventeen (17) and over every twenty-four (24) months.

Laser Eye Surgery will be reimbursed at eighty (80) percent to a lifetime maximum of \$900 per person.

#### PART 11 Dental Plan

#### **Basic services**

The benefits under this section are those services that are required to maintain teeth in good order and normal restoration services to restore them to good order.

The following services are eligible for reimbursement on the lesser of eighty-five (85) percent of the amount charged or eighty-five (85) percent of the current College of Dental Surgeons Fee Guide.

# The CMAW Benefit Plan

#### (1) DIAGNOSTIC SERVICES

Necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment. This includes examinations, consultations, pathological reports and other diagnostic aids as may be deemed necessary. The Plan will cover two (2) standard oral examinations each calendar year. The Plan will cover a complete full examination only if the Plan has not paid for a complete full examination during the past three years. The Plan will cover full-mouth x-rays once every twenty-four (24) months. Other x-ray expenses are covered, subject to a calendar year maximum.

#### (2) PREVENTATIVE SERVICES

Necessary procedures to prevent the occurrence of oral disease, including:

- prophylaxis and topical fluoride application twice in one calendar year.
- (ii) space maintainers (to maintain space, not to obtain more space).

#### (3) SURGICAL SERVICES

Necessary procedures for extractions and other surgical procedures normally performed by a general practicing dentist.

#### (4) ENDODONTIC SERVICES

Necessary procedures required for pulpal therapy and root canal filling. Repeat treatment is covered only if the original treatment fails after eighteen (18) months.

#### (5) PERIODONTIC SERVICES

Procedures necessary for the treatment of diseases of the soft tissue (gums) and the bones surrounding and supporting the teeth but not tissue grafts.



- (6) RESTORATIVE SERVICES
  - Necessary procedures for filling teeth with amalgam silicate (synthetic porcelain), acrylic (plastic), and composite resin (anterior only) restorations for restoring tooth surfaces which have been broken down as a result of decay process, including stainless steel crowns.
- (7) PROSTHETIC REPAIR SERVICES AND RELINES Necessary procedures required to repair or reline fixed or removable appliances. Repairs or relines to dentures may be obtained from a dentist or a duly licensed dental mechanic. Relines will not be covered more often than once in a twenty-four (24) month period. Services of a temporary nature, pending fabrication of a new denture, are not covered.



#### Prosthetic appliances and crown and bridge procedures

The benefits under this section are those services required for major reconstruction of teeth that have deteriorated, and for replacement of teeth that are missing, with crowns, bridges and dentures. These services will not be covered more often than once every five (5) years.

The cost of the following services will be eligible for reimbursement on the lesser of eighty-five (85) percent of the amount charged or eighty-five (85) percent of the College of Dental Surgeons Fee Guide.

#### (1) CROWNS, INLAYS & ONLAYS

- Crowns, if at least five (5) years has elapsed since last provided.
- Inlays or onlays, and gold foils are covered only when other restorative materials cannot be used satisfactorily.

### (2) PARTIAL AND/OR COMPLETE DENTURES AND BRIDGEWORK

- (i) Initial installation of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Such extraction(s) must have occurred after the effective date of coverage. Partials may only be provided by a dentist.
- (ii) Replacement of an existing full or partial denture, or fixed bridgework, if the existing denture or fixed bridgework was installed five (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.

A maximum payment of \$5,100 per family, per calendar year is available for Basic Service, Prosthetic Appliances, Crowns and Bridges and Orthodontic Services combined.

The following services are eligible for reimbursement on the lesser of eighty-five (85) percent of the amount charged or the current College of Dental Surgeons Fee Guide. \$5,100 per family per calendar year (eighty-five (85) percent of \$6,000) combined with Basic/Major.

#### Orthodontic

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



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. Treatment performed solely for splinting is not covered.

New Plan Members: the \$6,000 plan maximum is prorated based on Plan Member's coverage effective date, as follows:

Coverage Date	Prorated Maximum	
January 1st	\$6,000 per family per calendar year (paid at 85%, maximum \$5,100)	
February 1st	\$5,500 per family per calendar year (paid at 85%, maximum \$4,675)	
March 1st	\$5,000 per family per calendar year (paid at 85%, maximum \$4,250)	
April 1st	\$4,500 per family per calendar year (paid at 85%, maximum \$3,825)	
May 1st	\$4,000 per family per calendar year (paid at 85%, maximum \$3,400)	
June 1st	\$3,500 per family per calendar year (paid at 85%, maximum \$2,975)	
July 1st	\$3,000 per family per calendar year (paid at 85%, maximum \$2,550)	
August 1st	\$2,500 per family per calendar year (paid at 85%, maximum \$2,125)	
September 1st	\$2,000 per family per calendar year (paid at 85%, maximum \$1,700)	
October 1st	\$1,500 per family per calendar year (paid at 85%, maximum \$1,275)	
November 1st	\$1,000 per family per calendar year (paid at 85%, maximum \$850)	
December 1st	\$500 per family per calendar year (paid at 85%, maximum \$425)	

#### Services not covered

- cosmetic dentistry, temporary dentistry, oral hygiene instruction, tissue grafts, drugs and medicines;
- (2) treatment covered by Worker's Compensation Board or publicly supported plans;
- (3) services required as a result of an accident for which a third party is liable;
- charges for services commencing prior to date of coverage or provided after termination of coverage;
- (5) charges for completing forms;



#### **Emergency treatment**

Emergency Dental Care will be provided anywhere in the world. If, while you are traveling or on vacation outside your province of residence, you require Dental Care as a result of an emergency, you are entitled to services of a duly qualified dentist in the event of such emergency, and will be reimbursed up to the amount that the Plan would have paid had the services been rendered in your province of residence. Itemized statements must be provided with claims.

#### Change of dentist

If you find it necessary to change your dentist after a course of treatment has commenced, please tell both dentists concerned and notify the Administrator. Provided there is no duplication of services, payment can be made.

#### To make a claim

#### Dental, extended health and vision care

Claim forms can be obtained by visiting the Green Shield Website at http://www.greenshield.ca/sites/ corporate/en/what-you-need/forms/Pages/default. aspx or,

Call the Green Shield Customer Service Centre at 1.888.711.1119.

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Attn:	Drug	Department

P.O. Box 1652

Windsor, ON N9A 7G5

Attn: Medical Items

P.O. Box 1623 Windsor, ON

N9A 7B3

Attn: Professional

Services

P.O. Box 1699

Windsor, ON N9A 7G6

N9A 6W1

Attn: Dental Department

Attn: Hospital/ Vision

Attn: Out-of-Country

Department

P.O. Box 1615

Windsor, ON

Department P.O. Box 1606

Windsor, ON

N9A 7J3

P.O. Box 1608

Windsor, ON

N9A 7G1

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Both the original receipts and the forms can be sent to Green Shield Canada at:

All claims must be received by GSC no later than twelve (12) months from the date the eligible benefit was incurred.

#### PART 12

#### Employee assistance plan

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

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

#### Member website & direct deposit

You can arrange to have your claim reimbursements for Extended Health, Vision and Dental directly deposited into your bank account by completing the Direct Deposit Registration form, also available on the Green Shield Canada website at www.greenshield.ca

#### 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 enrolment 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.

#### Insurance Benefits Provided by: Co-operators, #8931

Life Insurance Dependent Life Insurance Long-term Disability

#### **CMAW Benefit Plan**

Uninsured Life Insurance Wage Indemnity Travel Assistance

#### **Green Shield Canada**

Extended Health Benefits
Vision Care
Dental Plan
Emergency Out of Country Travel
Call the Green Shield Customer Service Centre at
1.888.711.1119

## The CMAW Benefit Plan

#### AIG, #25721154

Accidental Death and Dismemberment

#### Shepell, #1004154

1-800-387-4765. Employee Assistance Program

- Please quote Identity or Social Insurance Number on all correspondence to the Plan.
- Always be sure to notify the Plan of any change of address.

## For additional information or assistance, please contact the Plan Administrator:

D.A. Townley 160 - 4400 Dominion Street, Burnaby, BC V5G 4G3

Tel: 604.299.7482 Fax: 604.299.8136

Toll Free: 1.800.663.1356 Email: admin@datownley.com

www.datownley.com

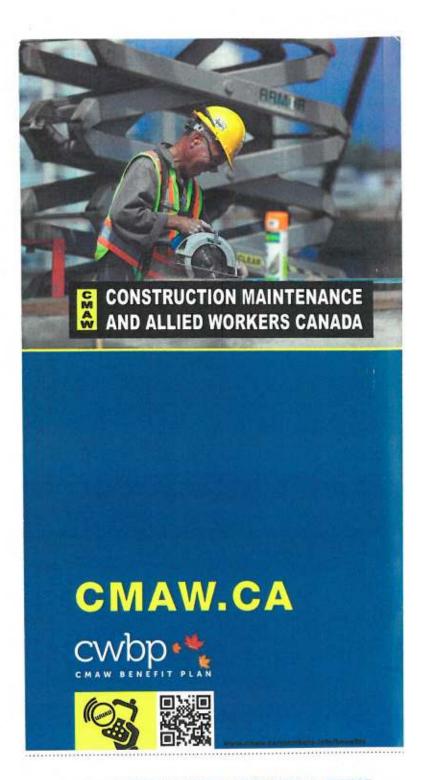
Assistance can also be obtained through your local union office.

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.

The pictures enclosed in this booklet are of CMAW members working. We would like to thank everyone for their participation.







FOR ADDITIONAL INFO OR ASSISTANCE, PLEASE CONTACT THE PLAN ADMINISTRATOR:

D.A. Townley

#160 - 4400 Dominion Street | Burnaby, BC V5G 4G3 T: 604.299.7482 | F: 604.299.8136 | Toll Free: 1.800.663.1356