BOILERMAKERS LODGE NO. 191 BENEFIT PLAN

Address all inquiries to:

THE ADMINISTRATOR
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Effective September 1, 2016*

*Including amendments to May 1, 2018

PRIVACY POLICY

We, the Trustees of The Boilermakers Lodge No. 191 Benefit Plan have adopted the following *Privacy Principles,* which reflect our commitment to safeguarding our Members' personal information:

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

The Trustees

The following is an outline of The Boilermakers Lodge No. 191 Benefit Plan benefits. The information in this benefit booklet is important to you. It provides the information you need about the group benefits available through The Boilermakers Lodge No. 191 Benefit Plan.

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

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

SCHEDULE OF BENEFITS

Medical Plan (Medical Services Plan of British Columbia – Group No. 3131919)	As provided by MSP
Life Insurance	$60,000
Accidental Death & Dismemberment	$60,000
Spousal Life Insurance	$10,000
Weekly Indemnity Benefit	EI Maximum (integrated with EI)
Dental Plan	100% Basic, 75% Major – unlimited 50% Orthodontic to a maximum of $2,000 per lifetime
Extended Health Benefits	100% eligible expenses, no deductible, maximum $1,000,000 per policy period
Out of Canada Emergency Coverage	$5 Million maximum per coverage period
Vision Care (Eye glasses/contacts)	100% to a maximum of $500 every 24 months (12 months for dependent children under age 19)
MFAP	As provided by Shepell

PART I
Details of Eligibility

Who is eligible?
Any Member in good standing who has sufficient hours for coverage and is working under a collective agreement requiring employer contributions to this Plan.

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

How does a person qualify for coverage?
Permit Members, Travel Card Members, or Lodge 191 Members who have been suspended or have taken a withdrawal card, must first become Members in good standing of Lodge 191 and then must accumulate 1,000 hours of work reported to the Plan in order to qualify for full benefits under the Plan. Hours reported to the Plan prior to becoming a Lodge 191 Member do not count. Coverage will commence on the 1st day of the second month following the accumulation of 1,000 hours worked and reported to the Plan as a Lodge 191 Member in good standing.

EXAMPLE:
Your employer(s) report your hours on a monthly basis. In the example below, it is on the November report when you reach the 1,000 hour level. November hours are reported in December (the lag month) and coverage becomes effective on the 1st day of January.

Month	**Hours Reported**
February	Permit Member
March	Permit Member
April	Permit Member (became a Lodge 191 Member)
May	150 hours
June	150 hours
July	200 hours
August	75 hours
September	150 hours
October	150 hours
November	200 hours
December	(Lag Month)
January	Coverage Starts

Each month 125 hours will be deducted from the Hour Bank to provide coverage. Any excess hours will accumulate in your Hour Bank for future coverage.

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

A maximum of 8 months' coverage can be accumulated in a Member's Hour Bank.

When does coverage end?

a) Coverage will terminate when there are insufficient hours in the Hour Bank to allow for a deduction of 125 hours.

b) Coverage will be terminated immediately and the Hour Bank will be forfeited for any Member who is suspended or issued a withdrawal card.

Self-Pay:

A Member in good standing of Lodge 191 (dues paying) may continue full coverage through self-payment.

A self-pay notice will be sent to the last known address.

The maximum number of self-pays allowable is 12 consecutive months.

Reminder: If full coverage lapses for a Member who has continually been a Member in good standing, then that Member will be required to accumulate 250 new hours reported to the Plan in order to re-qualify for full benefits.

PLEASE NOTE: During the months that a Member is self-paying for coverage, the Pay Direct Drug Card will not be activated/re-activated until payment is received by the Administrator and processed. If a prescription is required prior to that, the Member or dependent will be required to pay for the prescription and submit the claim to the Administrator for reimbursement.

Can hours be suspended while working for another Lodge 191 employer who does not contribute to this Plan?

YES. On notification from the Union office, hours can be "frozen" while you are covered with another employer under Lodge 191's jurisdiction, who does not contribute to this Plan. Hours can be frozen up to 12 months, at which time they will be forfeited.

Are there any reciprocity agreements with other Boilermaker Locals?

YES. If a Member is working under another local of the International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers, he/she may be entitled to have his/her contributions remitted to The Boilermakers Lodge 191 Benefit Plan. The Union office must be contacted to ensure there is a reciprocity agreement in place with the local you are working in and you must advise the local in which you are working that you are a Member of Lodge 191 and wish your contributions transferred to this Plan.

Are Dependents Covered under the Plan?

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

a) The spouse* of a covered Member;

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

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

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

*Spouse means the Member's legal spouse, or a person who has been residing with the Member continuously for a period of at least one year and has been publicly represented as the Member's spouse in the community in which they reside.

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

PART II

Details of Coverage Provided by the Plan

BASIC MEDICAL (MSP)

When you qualify for coverage, you will be covered by the Medical Services Plan of B.C., provided you have completed the required MSP application form. If you do not apply for MSP coverage through the Plan at the time you become eligible to do so, the Plan will only make retroactive payments on your behalf back 3 months for MSP coverage.

LIFE INSURANCE

Each eligible Member is insured for Life Insurance as specified on Page 2.

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

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

SPOUSAL LIFE INSURANCE

If your spouse should die while insured for this benefit, the $10,000 Spousal Life Insurance will be paid to you, if living, otherwise to your estate.

Continuation of Life Insurance on Termination of Coverage
When your coverage with the Plan terminates, you may convert your Life Insurance to an individual policy without a medical examination or health questionnaire. The individual policy would be for an amount not greater than the amount under the group policy and would be available at any time within 31 days after termination of the group insurance. Contact the Administrator for details.

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

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

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

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

Who is covered?	**Amount of Coverage**
All eligible members	$60,000
All spouses under age 70	$20,000
All eligible dependent children	$ 5,000

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm	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 Su
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 or Hearing . . . . . .Two-Thirds of The Principal Sum
Loss of Speech and Hearing . . . . . .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 of the body) . . . . . .Two Times The Principal Sum
Loss of Use of Both Arms or Both Hands . . . . . .The Principal Sum
Loss of Use of One Hand or One Foot . . . . . .
. . . . . .Two-Thirds of The Principal Sum
Loss of Use of One Arm or One Leg . . . . . .
. . . . . .Three-Quarters of The Principal Sum
Loss of Four Fingers of One Hand . . . . . .
. . . . . .One-Third of The Principal Sum
Loss of All Toes of One Foot . . . . . .
. . . . . .One-Quarter of The Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the 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 12 consecutive months and such loss of use is determined to be permanent.

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

Exposure & 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 of 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.

Beneficiary Designation
In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Person under the Pch 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 50 Km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of $15,000.00.

Rehabilitation Benefit
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 $15,000.00 for special training of the Insured Person provided:

a) 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,

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

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

Family Transportation
When injuries covered by the policy result in an Insured Person being confined to a hospital, outside 100Km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the 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 $15,000.00.

The term "member of the immediate family" means the spouse (or common-law spouse) parents, grandparents, children age 18 and over, brother or sister of the Insured Person.

Conversion Privilege
On the date of termination of coverage or during the 60-day period following termination of coverage, you may change your insurance to the AIG 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 plan ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of the AIG Insurance Company. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

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

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

a) The date the Insured Person attains age 65.

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

c) The date the Master Policy is terminated.

Seat Belt Rider
Benefits under the policy shall be increased by 10% 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 receives a payment under The Schedule of Losses herein and was subsequently required (due to the cause for which payment under The Schedule of Losses was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

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

b) The one-time cost of modifications necessary to a motor vehicle, owned by the Insured Person, to make the vehicle accessible or drivable for the Insured Person.

Benefit payments herein will not be paid unless:

i) 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 (a) and (b) combined will not exceed $15,000.00.

Educational Benefit Rider
If indemnity becomes payable for the accidental loss of life of an Insured Employee the Holder, under the policy, the Company shall:

1) Pay the lesser of the following amounts to or on behalf of any dependent children who, at the date of the accident, was enrolled as a full time student in any institution of higher learning beyond the 12th grade level:

   a) The actual annual tuition, exclusive of room and board, charged by such institution per school year.

   b) $10,000.00 per school year.

c) 5% of the Insured Employee's Principal Sum.

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

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

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

2) Pay to or on behalf of the surviving spouse the actual cost incurred within 30 month from the date of death of the Insured Member as payment for any professional or trades training program in 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 $10,000.00.

Day Care Benefit
If indemnity becomes payable under the policy for Accidental Loss of Life of an Insured Employee, the Company will pay an amount equal to the lessor of the following amounts:

1) The actual cost charged by such day care center per year, or
2) 3% of the Insured's Principal Sum, or
3) $5,000.00 per year,

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

The benefit is payable annually for a maximum of four 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 a 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) a monthly benefit of one (1) percent of the Insured's applicable Principal Sum; or
b) 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:

a) a monthly amount not to exceed $1,000.00; and

b) a total of twelve (12) months for any covered accident.

Successive periods 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:

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

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

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

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

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

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

Permanent Total Disability Indemnity
When, as the result of injury and commencing within 365 days of the date of the accident, an Insured Person is totally and permanently disabled and prevented from engaging in each and every occupation or 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 the 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.

WEEKLY INDEMNITY BENEFIT

A benefit of the Employment Insurance (EI) weekly maximum benefit rate will be paid to each eligible Member who is disabled and unable to work as the result of a non-occupational accident or sickness. Benefit payment commences on the 1st day of a non-occupational accident, and the 4th day of a non-occupational sickness. If you are hospitalized prior to the 4th day of sickness, benefits commence on the 1st day of hospitalization. If a surgical procedure is performed on an out-patient basis, in a general hospital, benefits will commence on the date the surgery was performed.

Note: A Member who makes a claim for Weekly Indemnity benefits must be seen and treated by a physician within 3 days (excluding weekends) of disability, unless there are extenuating circumstances. Otherwise, the determination of eligibility for benefit commencement date will be as of the first day of treatment.

Members whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Plan Member qualifies for full coverage under The Boilermakers Lodge No. 191 Benefit Plan.

If you are eligible for EI sick benefits, benefits from the Plan will cease during the period you are eligible to collect EI. If you are still disabled after reaching the maximum duration of EI sick benefit payments, or if you are not eligible for EI, or only partially eligible, the Plan will continue benefits for up to a maximum of 26 weeks including the EI sick benefit payments.

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

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

b) Obtain a claim form from the Union office or the Administrator's office and note instructions concerning an EI sick claim.

c) Complete the form where indicated and have your doctor complete the physician's portion of the form.

d) Your Union must complete the Authorization at the bottom of the form.

e) Send the completed form to the Administrator without delay.

f) Claim cheques will be sent directly to your home address.

g) Claims for disability must be submitted no later than 30 days after your total disability begins.

Third Party Liability
If you receive benefit payments under this Plan for loss of income for which there may be a cause of action against a third party, you will be required to complete a Loan & Replacement Agreement. This will entitle the Plan to be reimbursed for any benefits paid, which have been recovered from a third party.

Right to Recover
(a) Where a Member becomes Totally Disabled as a result of an injury or sickness in respect of which

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

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

  the Plan will not pay benefits to the Member.

(b) In the circumstances described in (a) 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.

Recurrence of Former Ailments
You will not receive benefits for more than 34 weeks as a result of disability due to any one ailment. However, a new waiting period and benefit duration period will start if you return to active full-time work for:

a) A period of 2 weeks before you again become disabled because of the same or related cause, or

b) One full day before you again become disabled because of a different or unrelated cause.

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

- arising from occupational accident or illness, as these are covered by WorkSafe BC.
- arising from self-inflicted injuries or disease with the exception of alcoholism and drug addiction. A person is not considered totally disabled due to the use of drugs or alcohol unless the person is being actively supervised by and receiving continuous treatment for that disability from a rehabilitation centre, a physician or an institution provincially designated for that treatment.
- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service.
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits

from EI, or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence.

- during which the insured is receiving or eligible to receive EI benefits.
- any day you perform any form of work for wage or profit.
- arising from your commission of or attempt to commit an assault or criminal offense.
- if you become disabled during a strike or lockout at your place of employment, your rights to benefits will be reinstated when the strike or lockout ends.

TERMINATION OF BENEFIT

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

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

DENTAL PLAN

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

Part I – Basic Services
The following services are eligible for reimbursement of the lesser of 100% of the amount charged or 100% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment.

1) Diagnostic Services
   All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:
   - Oral examinations: limited to two in any calendar year; however, complete oral examinations are limited to one in any 36 month period.
   - Dental x-rays: bite-wing x-rays are limited to one set in any 6 month period, full mouth x-rays are limited to one set in any 36 month period, and panoramic film is limited to one x-ray in any 36 month period.

2) Preventative Services
   All necessary procedures to prevent the occurrence of oral disease, including:
   - Cleaning (limited to twice in any calendar year)
   - Scaling and root planing (combined maximum of 15 units per calendar year)
   - Topical application of fluoride (limited to two applications in any calendar year)
   - Pit and fissure adhesive sealants limited to once per tooth every 24 months for children under 18
   - Fixed space maintainers on primary teeth for dependent children under 18
   - Oral hygiene instruction allowed once in any 36 month period.

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

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

5) Prosthetic Repairs and Maintenance
   Repair if a 6-month period has elapsed since the last date on which the dentures were provided.

Denture maintenance, after the 3 month post insertion care period, including:

- denture relines for dentures at least 6 months old, once every 36 months
- denture rebases for dentures at least 2 years old, once every 36 months
- resilient liner in relined or rebased dentures, once every 36 months.

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

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

8) Major Restorative Services
   - Inlays, onlays and gold foils will be covered only when other material cannot be used satisfactorily. Patients choosing gold where other materials would suffice will be responsible for the cost difference. A pre-authorization is suggested.

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

Part II – Major Services
Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for reimbursement of the lesser of 75% of the amount charged, or 75% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment:

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

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

Part III – Orthodontia (dependent children under 21 and adults)
For orthodontia services performed by an orthodontist payment will be made at 50% to a maximum lifetime limit of $2,000. Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced at the Plan's expense.

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

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

Emergency Dental Care Anywhere in the World
In an EMERGENCY, while you are travelling or on vacation outside of your Province of residence, you are entitled to the services of a duly qualified dentist and will be reimbursed at the lower of the actual cost or the amount that would have been paid had the service been rendered in Province of residence.

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

- items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- charges for broken appointments or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- dental care which is cosmetic;
- dental care provided under a medical plan provided by an employer or government.
- which, in the absence of coverage, there would be no charge;
- stainless steel crowns on permanent teeth;
- protective athletic appliances;
- anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- replacement of a lost or stolen prosthesis;

- incomplete and temporary procedures;
- implants;
- any dental charge for services which were started prior to the date of coverage; or
- dental treatment which was ordered while covered, (which included lab work and impressions), but was not installed or delivered until more than 31 days after the dental benefit terminated.

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

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

There is no limit for Part I and II coverage. The maximum amount that will be paid for Part III (Orthodontia) is $2,000 per lifetime per covered Member or dependent.

EXTENDED HEALTH BENEFITS

There is no annual deductible and 100% of eligible expenses will be reimbursed up to a maximum of $1,000,000 per benefit period. Out of province emergency medical coverage is provided to eligible Members and their dependents up to a maximum of $5,000,000 per coverage period.

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

Benefits:

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

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

1) Prescription Drugs – Pay Direct Drug Card Benefit- present your drug card, along with your prescription, to your pharmacist and your prescription drug claim will be adjudicated right at the pharmacy. Using your drug card eliminates the need to send in your prescription receipt and wait for reimbursement. Your Plan provides coverage for prescription drugs and medicines (including oral contraceptives) which require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits. Drugs and medicines are limited to a 100 day supply. Refills are not permitted to be dispensed earlier than

what is deemed to be reasonable and customary. Vacation supplies of your medications, which are outside the regular days supply limits must be pre-authorized by the Plan and must be paid for in full by the Member and submitted to the Plan for reimbursement. Drugs and medicines that can normally be purchased "over the counter" are excluded regardless of a prescription having been issued. Fertility drugs, vitamins, preventative drugs, dietary foods and supplements are also excluded. Smoking cessation products will be covered up to a lifetime maximum of $500 per person.

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

PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for the Fair PharmaCare Program, call 604 683-7175 from Vancouver or toll-free 1-800-663-7100 from the rest of BC. If you prefer to go online to the Fair PharmaCare website, the address is https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/who-we-cover/fair-pharmacare-plan/register-for-fair-pharmacare

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

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

3) Charges for out-of-hospital private duty nurse services when medically necessary. Services must be for nursing

care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. The maximum for these services will be limited to $25,000 per person during any 3 consecutive benefit years.

4) Charges from a massage therapist, osteopath (including x-rays), speech therapist, acupuncturist, psychologist, podiatrist (including x-rays),, chiropractor (including x-rays), naturopath (including x-rays), or physiotherapist, who is registered and legally practicing within the scope of his/her license. These charges will be 100% reimbursed up to a calendar year maximum of $500 per insured person for all practitioners.
5) Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies.
6) Charges for walkers, canes and cane tips, crutches, splints, casts, collars and trusses but not elastic or foam supports.
7) Charges for testing supplies, needles and syringes for diabetics.
8) Charges for surgical stockings to a maximum of 2 pair per calendar year.
9) Charges for stump socks.
10) Charges for surgical brassieres up to two per calendar year.
11) One pair of custom fitted orthopedic shoes when prescribed by a physician or podiatrist and replacements when necessitated by normal wear and tear.
12) One pair of custom made orthotics (including molds and arch supports) when prescribed by a physician or podiatrist to a maximum of $200 per calendar year.
13) Charges for rigid support braces and permanent prosthesis (artificial eyes, limbs, larynxes and mastectomy forms). Myoelectrical limbs are excluded but the Plan will pay the equivalent of a standard prosthesis.
14) Cost of rental or where more economical, purchase of durable equipment for therapeutic treatment including wheelchairs and hospital beds. Electric wheelchairs are covered only when a doctor certifies the patient is incapable of operating a manual wheelchair (e.g. Paraplegic).
15) Charges made by a dentist for the repair or replacement of sound, vital, natural teeth or the setting of a fractured or dislocated jaw if:

- those services are required as a result of a direct accidental blow to the month and not as a result of an object placed in the mouth;
- the accident occurred while the person is covered under this benefit; and
- the charges are incurred within 6 months of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 6 month period.

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

17) Costs of hearing aids to a maximum of $400 in a 5 year period for dependent children to the age of 16 when prescribed by a certified Ear, Nose and Throat Specialist. Repairs, maintenance, batteries or other accessories will not be covered.

18) Wigs and hairpieces required as a result of chemo-therapy up to a maximum of $300 per benefit year.

19) The cost of eye exams performed by a Licensed Optometrist or Ophthalmologist to a maximum or $85 every 24 months.

20) Convalescent Hospital to a maximum of $20 per day for a maximum of 180 days for treatment of an illness due to the same or related causes.

Reimbursement:
Extended Health Claim forms can be obtained from the Administrator. Follow the instructions on the form. When properly completed, return the EHC claim form, together with your receipts to:

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

By Fax: (604) 299-8136 or
By Email: health@datownley.com

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

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

b) expenses for dental services except as specifically provided in Item 15.

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

d) expenses incurred outside the Province of British Columbia unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out–of-Province Emergency Eligible Expenses.

e) expenses of services and supplies for cosmetic purposes.

f) expenses caused, contributed to or necessitated as a result of:

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

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

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

i) any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging which represents an amount in excess of the schedule of costs prescribed by the Medical Services Plan.

j) Medical Marijuana, in any and all of its forms, regardless of whether or not having been prescribed by an attending physician.

Out-of-Province/Canada Emergency Eligible Expenses

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

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

Emergency Medical Insurance & Travel Assistance

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

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

Coverage Period: 180 days per trip.

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

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

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

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

In an emergency the policy covers expenses that are:

- incurred outside the province or territory of residence of the insured person;
- medically necessary;
- reasonable and customary costs;
- incurred as a result of an emergency due to sudden and unforeseen sickness and/or injury occurring during the coverage period;
- in excess of those covered by the Government Health Insurance Plan or other insurance under which you may have coverage; and

- legally insurable;
- subject to the overall maximum per insured person of $5,000,000 per coverage period.

Claims Procedures

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

a) include the policy number, the patient's name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);

b) submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or physician;

c) provide the original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

d) provide proof of the departure date(s) and return date(s);

e) provide written proof of claim within ninety (90) days of the date of receipt of services covered under the policy;

f) provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;

g) sign and return the authorization form, provided by Global Excel, allowing the insurer to recover payment from the Canadian provincial or territorial Government Health Insurance Plan. The insurer will coordinate and pay your claim to the participating medical providers and where permitted, coordinate claims directly with the Canadian provincial or territorial Government Health Insurance Plan on your behalf; and

h) return the unused portion of your air ticket to Global Excel if the Emergency Air Transportation benefit is used.

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

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

All pertinent documents should be sent to:

Global Excel®

®The logo is a registered trademark of Global Excel Management Inc., a member of the ETFS Financial Group.

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

Policy Number: 1059208

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

VISION CARE
(eyeglasses/contact lenses)

The Vision Care Plan will cover you and your eligible dependents.

You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

Covered Expenses
The following expenses shall be eligible for reimbursement:

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

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

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

Payment of Expenses
The maximum amount payable for an eligible Member or for an eligible dependent (regardless of consecutive months of coverage) shall be 100% of the actual expenses incurred or $500.00, whichever is the lesser, during any period of 24 consecutive months (12 consecutive months for dependent children under age 19).

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

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

b) safety goggles, sun glasses (plain or prescription);

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

TO MAKE A CLAIM

Extended Health Benefits, Vision Care and Dental Plan:
Claim forms for Extended Health Benefits and Vision Care can be obtained from the Administrator's office or your Union Office. Standard B.C. Dental claim forms are usually provided by your dentist, but if required, Dental claim forms can also be provided by the Administrator's office or your Union office.

When properly completed, return the claim form, together with your receipts to:

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

By Fax: (604) 299-8136 or
By Email: health@datownley.com

All receipts must be received by the Administrator within 12 months of the date of service to be considered for payment.

COORDINATION OF BENEFITS:

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

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

8) When the Plan has paid benefits to the Member to the limit of the Fair 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.

When submitting eligible claims, please be sure to include:

- Your Name (please print)
- Your Address
- Your Certificate Number/ID Number (SIN)
- Your Local Union

All claims should be forwarded to the Administrator's office

BOILERMAKERS LODGE NO. 191 BENEFIT PLAN

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

MEMBER WEBSITE & DIRECT DEPOSIT

For Extended Health, Vision and Dental you can now view and print your claim history by using D.A. Townley's Member Website at www.datownley.com. You can also arrange to have your claim reimbursements directly deposited into you bank account by completing the Direct Deposit Registration form, also available on the D.A. Townley website at www.datownley.com.

Benefits Provided by:

Sun Life Financial Canada #G56709

Life Insurance
Spousal Life Insurance

AIG Insurance Company of Canada #28472016

Accidental Death & Dismemberment

The Boilermakers Lodge No. 191 Benefit Plan #56709

Weekly Indemnity
Extended Health Care
Vision
Dental

RSA Travel Insurance Inc.#1059208

VIATOR Out of Province Emergency Excess Medical and Hospital Travel Insurance

Medical Services Plan of BC #3131919

Basic Medical Coverage

Shepell #1004465

Member and Family Assistance Program

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.