Welcome to your health care benefits guide

All about the guide

This booklet takes you through your medical and benefit plan. It’s a summary of the benefits available to qualifying members of the Construction and Specialized Workers’ Medical and Benefit Plan of BC and their dependents – and how to access those benefits.

Inside, you will be provided with information on topics such as:

- Who is eligible and covered
- When coverage begins
- How to apply
- Maintaining your coverage
- Calculating your benefit amount
- Basic medical coverage (MSP)
- Extended health care coverage
- Dental care coverage
- Life insurance coverage
- Accidental death and dismemberment insurance coverage and
- Wage indemnity benefits

Keep your guide handy

Make sure you keep this guide in a safe place year-round so that you can easily refer to it when you have questions about your health or insurance benefits.

Questions?

If you still have questions after reading this guide, contact the plan office at 604-538-6640 in the Vancouver area or toll-free at 1-800-964-3666. Our staff will be pleased to assist you.

This edition of your health care benefits guide was produced in January 2015 and replaces any previous editions.
Starting your plan coverage

Who’s eligible?

You are eligible to enroll for benefits if:

1. You are a member in good standing of the Construction and Specialized Workers’ Union Local 1611 with your union dues fully paid; and

2. You have worked at least 250 hours for a contributory employer within six continuous months. Note that hours age after six months.
If you are unsure if you are eligible, please call the plan office.

How do I enroll?
Once you meet the two eligibility conditions, we will send you a plan enrollment form. Simply complete it and return it to us in order to be covered under this plan. Enrollment forms are also available from the plan office, your business agent and Local 1611.

When you enroll, remember to provide information on your dependents and name a beneficiary for your life and accidental death and dismemberment insurance.

If you are new to British Columbia, please include a photocopy of a birth certificate and/or a valid Canadian passport, Canadian citizenship papers or landed immigrant papers for you and each of your named dependents.

When does my coverage begin?
Your Full Benefits Plan coverage begins once you have 250 hours in your hour bank and the plan office receives your completed enrollment form.

You should send in your enrollment form as soon as you are eligible. You never know when you or your family might need medical treatment, and your coverage can't begin until we receive your completed enrollment form.

If you get your enrollment form in to us quickly, you and your dependents can be covered beginning on the first day of the month following the month in which 250 accumulated plan hours are reported to the plan office by your employer.

How does the hour bank work?
By the 15th of each month, your employer reports the previous month's hours you worked. Once 250 hours are reported, you and your dependents are eligible for coverage.
Starting your plan coverage

An example of how the hour bank works:

<table>
<thead>
<tr>
<th>Hours</th>
<th>Month worked</th>
<th>Month reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>120</td>
<td>January</td>
<td>February</td>
</tr>
<tr>
<td>100</td>
<td>February</td>
<td>March</td>
</tr>
<tr>
<td>120</td>
<td>March</td>
<td>April</td>
</tr>
</tbody>
</table>

250+ hours will have been reported by April 15, so you will be eligible for coverage as of May 1.

This example assumes the following:

a) You have completed the required 250 hours within a six-month period ending on April 30;

b) Your employer has paid the appropriate hourly rate for this period; and

c) You complete your plan enrollment forms, and they are received and processed by the plan office by May 18.

The effective date of enrollment would be May 1.

**NOTE:** January worked hours are not payable to the plan office until February 15.

The lag period of one month in reported hours is to allow employers time to calculate the total number of hours you have worked. Once you are covered, any hours you work above 125 hours per month are credited to your hour bank.

Once you have qualified and completed your application, 125 hours are withdrawn from your hour bank each month. You can accumulate extra hours reported in your bank to provide coverage for up to 12 months. These hours can be used during periods of unemployment or illness.
Is my family covered?

Your family, or “dependents,” are covered under the Medical Services Plan (MSP) of BC, as well as the extended health and dental care portions of the CSW plan. A dependent includes:

- Your spouse, including:
  - Legal;
  - Common-law; or
  - Same-sex.

- Your unmarried children (including legally adopted children or stepchildren, as well as legal wards). A child may be covered as long as he or she is dependent on you and is:
  - 19 years of age or under and unmarried;
  - A full-time student at a recognized/accredited school, up to the age of 25 and unmarried; or
  - An unmarried disabled child of any age who is living with and is financially dependent on you and is incapable of self-sustaining employment.

You and your dependents will be able to receive benefits as long as you continue to meet the required conditions for membership in the plan.

What if I need to change my list of dependents?

If you would like to add or delete a dependent from your coverage, please contact the plan office and we will send you the form to complete. Return the form to the plan office, and we will make sure the change is made.
Starting your plan coverage

ENROLLMENT CHECKLIST

When you apply for your benefits, it’s important you include:

• Your personal information and a list of your dependents; and
• The MSP CareCard number for everyone listed.

If you are new to BC, be sure to also include, for you and each of your named dependents:

• A photocopy of a birth certificate; and/or
• A valid Canadian passport, Canadian citizenship papers or landed immigrant papers.

What if I’m laid off?

If you are laid off, you are still eligible for benefits. Your eligibility for benefits will continue for as long as your hour bank has enough hours and you remain a member in good standing with the local union. Once you run out of hours, self-payment options are available. See page 45.

Coordinating benefits with a spouse

Do you and your spouse both work for companies that offer benefits?

If your spouse has extended health care and dental coverage through an employer, you can maximize your coverage by coordinating your benefits.

For example, our plan provides you with 80% reimbursement on pharmaceutical drug costs, but by also submitting your claim to your spouse’s plan, you may be reimbursed for the remaining 20%.

Want to learn more about coordinating benefits? Contact Pacific Blue Cross or the plan office at 604-538-6640 in the Vancouver area or toll-free at 1-800-964-3666.
Plan benefits for your family

How does it work?
The plan covers the following benefits:

1. **Basic medical coverage** through the provincial health plan – Medical Services Plan of BC (MSP)
2. **Extended health care coverage** for things such as:
   - Prescription drugs
   - Private hospital room
   - Paramedical services
   - Vision care
   - Medical equipment
   - Emergency medical coverage while you are out of the province (LIMITED COVERAGE)
3. **Dental care coverage**
4. **Life insurance coverage**
5. **Dependent life insurance**
6. **Wage indemnity coverage** to continue receiving a portion of your wages while you are unable to work due to illness or injury.

If you have accumulated **enough hours for coverage**, you would have coverage for all of the items listed above, unless you are already covered by the Medical Services Plan of BC (MSP) through your spouse and let us know you do not need MSP coverage.

If your hour bank falls below **125 hours**, you can choose to pay for the Partial or Retiree coverage (if eligible). You do this by paying into the plan yourself. These self-payment options are described on page 45.

CHECK YOUR LIST OF DEPENDENTS

Call the plan office to be sure your dependents are on file: 604-538-6640 in the Vancouver area or toll-free at 1-800-964-3666.
Benefits at a glance

Throughout this guide, you will find the specifics of the benefits available through the Construction and Specialized Workers’ Medical and Benefit Plan of BC. To give you a general overview of your available benefits, a brief summary has been provided for reference. For more detailed descriptions of your coverage, simply go to the designated section in this booklet.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
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<tbody>
<tr>
<td><strong>MSP</strong></td>
<td>Basic medical coverage (MSP of BC)</td>
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<tr>
<td></td>
<td>The Medical Services Plan of BC covers the costs for required medical,</td>
</tr>
<tr>
<td></td>
<td>surgical, obstetrical and diagnostic services of medical practitioners.</td>
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<tr>
<td><strong>Extended health</strong></td>
<td><strong>All services (except pharmaceutical drug costs):</strong> 100% reimbursement</td>
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<tr>
<td></td>
<td>(up to certain limits for some services or products)</td>
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<tr>
<td></td>
<td><strong>Pharmaceutical drug costs:</strong></td>
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<tr>
<td></td>
<td>80% reimbursement to $1,000, 100% after that</td>
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<td></td>
<td><strong>Your maximum covered costs during the lifetime of each plan member is</strong></td>
</tr>
<tr>
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<td>$200,000 under the Full &amp; Partial Plan, $100,000 under the Retire Plan.</td>
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<tr>
<td><strong>Dental</strong></td>
<td><strong>Basic services:</strong> 100% reimbursement</td>
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<tr>
<td></td>
<td><strong>Major services:</strong> 60% reimbursement</td>
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<tr>
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<td>All Basic and Major services have a combined annual limit of $3,000</td>
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<tr>
<td></td>
<td>per person.</td>
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<td></td>
<td><strong>Orthodontic services:</strong></td>
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<td>50% reimbursement to a lifetime limit of $3,000 per person</td>
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<tr>
<td></td>
<td><strong>(Pacific Blue Cross fee schedule)</strong></td>
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<tr>
<td><strong>Life insurance</strong></td>
<td><strong>Full Benefits life insurance:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Member – $75,000</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Partial Benefits life insurance:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Member – $75,000</strong></td>
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<td></td>
<td><strong>Retiree Benefits life insurance:</strong></td>
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<tr>
<td></td>
<td><strong>Member under age 65 – $75,000</strong></td>
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<td></td>
<td><strong>Member age 65 to 69 – $12,500</strong></td>
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<td><strong>Member age 70 to 74 – $6,250</strong></td>
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<tr>
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<td><strong>Member age 75 and over – $2,500</strong></td>
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<tr>
<td></td>
<td><strong>Spouse’s life insurance:</strong></td>
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<tr>
<td></td>
<td><strong>Member under age 65 – $10,000</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Member age 65 to 69 – $10,000</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Member age 70 to 74 – $6,250</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Member age 75 and over – $2,500</strong></td>
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<tr>
<td></td>
<td><strong>Life insurance for covered dependent children:</strong> $5,000</td>
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</table>
Benefits at a glance

<table>
<thead>
<tr>
<th>Benefit Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accidental death and dismemberment benefits</strong></td>
</tr>
</tbody>
</table>
| • Full Benefits coverage: Member is under age 70 – $75,000  
  *Note:* Members over age 70 who are still working are not eligible for accidental death and dismemberment benefits.  
  • Partial Benefits coverage: $75,000  
  • Retiree Benefits coverage: Member is under 65 years of age – $75,000  
  Retirees over age 65 are not covered for accidental death and dismemberment benefits. |

<table>
<thead>
<tr>
<th>Wage indemnity coverage</th>
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</thead>
</table>
| Your wage indemnity coverage works with the federal Employment Insurance (EI) benefits to provide an ongoing income for up to 35 weeks.  
  • The plan pays wage indemnity during the first week of disability, which usually equates to the one week Employment Insurance waiting period (if one is applied).  
  • Employment Insurance then pays benefits for up to the next 15 weeks (as long as the member continues to qualify for benefits).  
  • The plan continues to pay 19 weeks of wage indemnity benefits from the date Employment Insurance Sickness Benefits end (as long as the plan receives proof of continued disability). |

**Your pay-direct drug card**

In 2012, we introduced a pay-direct drug card to eliminate the need for any paper-based prescription claims. When you present your card to your pharmacist, the covered amount is automatically deducted from your total and you will immediately know what portion of your prescription is covered. No hassle, no paperwork and no stamp required.
How to use your card

Using your new drug card is easy.

1. Prior to paying for your prescription, provide your pharmacist with your drug card. He or she will enter your patient information, along with the prescription and carrier information, to transmit your claim directly to Pacific Blue Cross.

2. The pharmacist enters your patient information, along with prescription and carrier details, into the system. The system will check that the drug is eligible for coverage and that the plan member is active.

3. The system will then check on any applicable plan limits to determine the amount covered by your plan. The pharmacist will inform you of the out-of-pocket total.

4. Along with your prescription, the pharmacist will provide you with a detailed prescription receipt. This will further outline the out-of-pocket and covered amounts. Keep this for your records.

Our system is secure, accurate and immediate – no more waiting for refunds.

What does my drug card cover?

Your pay-direct drug card covers prescriptions only and does not cover dental, emergency and paramedical expenses. All other claims will continue to require you to submit the relevant form. There has been no change in the process for submitting non-prescription claims.

What do I do if I lose my card?

For replacement drug cards, you can contact the plan office at 604-538-6640 or toll-free at 1-800-964-3666.

How do I get an additional drug card for my dependents?

For dependents covered by the plan, you may request additional copies of your drug card. Contact the plan office at 604-538-6640 or toll-free at 1-800-964-3666 for more information.
Benefits at a glance

Basic medical coverage

Full Benefits Plan

Your basic medical coverage, provided by the province’s Medical Services Plan (MSP) program, is included in your coverage unless you tell us that your spouse has MSP coverage for you and your dependents through a separate health care plan.
MSP PREMIUMS ARE TAXABLE

Don’t pay more than you have to on your taxes by making sure you and your family are covered only once for MSP in BC.

Does your spouse have MSP coverage?

If your spouse has MSP coverage, you may want to opt out of the CSW plan coverage to avoid duplication of benefits.

Please contact the plan office if you wish to exercise this option.

If you are a BC resident, you must be enrolled in MSP. This is the basic health plan available to all BC residents, and your benefits include payment for this coverage. If you are a BC resident and not enrolled in MSP, you should enroll.

You can get a brochure on the MSP system directly from MSP. The brochure explains how to enroll and what medical services are provided by MSP.
Extended health care coverage – all plans

As you know, some medical expenses are not covered by MSP. Your extended health care plan provides benefits to cover those costs for you and your dependents through our provider, Pacific Blue Cross. This plan reimburses you for a number of medical expenses such as prescription drugs, health services (e.g., physiotherapy), medical aids, nursing services, supplies and equipment, as well as vision care expenses.
Here's how your coverage works:

• All services – except pharmaceutical drug costs – are reimbursed to you at 100%, up to certain limits for some services or products.

• Your pharmaceutical drug costs are reimbursed at a rate of 80% up to $1,000, and 100% after that. The plan limits pharmacy mark-ups to 8%.

Coverage maximums:

• **Full and Partial Plan** – Your maximum covered costs during the lifetime of each covered person is $200,000

• **Retiree Plan** – Your maximum covered costs during the lifetime of each covered person is $100,000

**Is there a health plan deductible?**

There is no deductible

**Pacific Blue Cross (our carrier)**

Group number: E902779 Div 1 class 1
for Full Benefits Plan coverage

Group number: E902779 Div 2 class 2
for Partial Plan coverage

Group number: E902780
for Retiree coverage

**What’s covered?**

Let’s look closer at the benefits you’re entitled to. They are divided into two groups:

**Health care services**

• Complementary and alternative health services

• Emergency services

• Nursing services

• Prostate testing

• Psychology

• Vision care

**Health care drugs, equipment and supplies**

• Drugs and medicines

• Hearing aids

• Medical supplies and equipment

• Orthotics and orthopedic shoes
Health care services
All practitioners must be registered in the province where the service is provided.

<table>
<thead>
<tr>
<th>What’s covered</th>
<th>Coverage and conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complementary and alternative health services</td>
<td></td>
</tr>
<tr>
<td>The following practitioner services are covered according to the limits noted:</td>
<td>100% claimable</td>
</tr>
<tr>
<td>- Acupuncturist</td>
<td>For each type of service listed, your maximum coverage is $500 per calendar year.</td>
</tr>
<tr>
<td>- Chiropractor</td>
<td>Note: X-rays are not covered.</td>
</tr>
<tr>
<td>- Massage therapist</td>
<td></td>
</tr>
<tr>
<td>- Naturopath</td>
<td></td>
</tr>
<tr>
<td>- Physiotherapist</td>
<td></td>
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<tr>
<td>- Podiatrist</td>
<td></td>
</tr>
<tr>
<td>- Speech therapist</td>
<td></td>
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</tbody>
</table>

Emergency services

Emergency ambulance
• 100% claimable
• Restrictions may apply.
• Contact the Pacific Blue Cross Call Centre.

Nursing services

Registered nurse in a hospital or home
• Covered
• Contact the Pacific Blue Cross Call Centre for details and restrictions.
• Doctor’s note required

Prostate testing

Testing
• 100% claimable

Psychology

Registered psychologist
• 100% claimable
• Maximum $500 per calendar year
### What’s covered

#### Coverage and conditions

**Psychology (continued)**

| Registered counsellor | - 100% claimable
| | - Maximum $500 per calendar year

#### Vision care

The following items are covered according to the limits noted in the right-hand column:
- Eye exams
- Prescriptions
- Frames
- Prescription sunglasses
- Prescription lenses, frames
- Prescription safety goggles
- Vision care repairs
- Laser eye surgery

- 100% claimable
- Combined maximum of $500 per person every 24 months from date of service

**Lens implant**

- Two items per person per lifetime with a maximum of $500 per person per item
- Doctor’s note required

### Fair PharmaCare program

The Fair PharmaCare program is another part of BC’s basic medical coverage. If your family has high prescription drug costs and if those costs exceed the maximum allowable coverage under the extended health care benefits of this plan, we recommend you enroll in Fair PharmaCare.

You must register directly with Fair PharmaCare to get this benefit.

- **By phone:** 1-800-387-4977
- **Online:** www.gov.bc.ca
- **By mail:** You must complete, sign and return a registration and consent form.
## Health care drugs, equipment and supplies

<table>
<thead>
<tr>
<th>What’s covered</th>
<th>Coverage and conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drugs and medicines</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Prescription medication (PharmaCare or non-PharmaCare) | • 80% reimbursed to $1,000; 100% after that  
• 8% pharmacy mark-up limitation  
• Must be dispensed by a licensed pharmacist |
| Erectile dysfunction drugs             | • 80% reimbursed  
• Must be dispensed by a licensed pharmacist |
| Fertility drugs                        | • 80% reimbursed  
• Lifetime maximum of $3,000  
• Must be dispensed by a licensed pharmacist |
| Insulin preparations for diabetics     | • 100% covered  
• Must be dispensed by a licensed pharmacist |
| Obesity drugs                          | • 80% reimbursed  
• Must be dispensed by a licensed pharmacist |
| Oral contraceptives                    | • 80% reimbursed  
• Must be dispensed by a licensed pharmacist |
| Smoking cessation drugs                | • 80% reimbursed  
• Lifetime maximum of $300  
• Must be dispensed by a licensed pharmacist |
## What’s covered

<table>
<thead>
<tr>
<th>Hearing aids</th>
<th>Coverage and conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aids and hearing aid repairs</td>
<td>• 100% claimable</td>
</tr>
<tr>
<td>Adult</td>
<td>• Combined maximum of $2,000 per adult every five years</td>
</tr>
<tr>
<td>Child</td>
<td>• Combined lifetime maximum of $1,000 per child with an additional benefit of $1,000 in a five-year period per child</td>
</tr>
</tbody>
</table>

## Orthotics and orthopedic shoes

<table>
<thead>
<tr>
<th>Orthotics</th>
<th>Coverage and conditions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• 100% claimable if custom-made</td>
</tr>
<tr>
<td></td>
<td>• Annual maximum of $300 per person; doctor’s note required</td>
</tr>
<tr>
<td>Note: A custom-made orthotic or orthopedic shoe is one made from raw materials and specially designed for the patient using a three-dimensional volumetric model of the patient’s foot and lower leg.</td>
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</tbody>
</table>

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<tr>
<th>Orthopedic shoes</th>
<th>Coverage and conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 100% claimable if custom-made</td>
</tr>
<tr>
<td></td>
<td>• Combined lifetime limit of one pair per person and shoe repairs; doctor’s note required</td>
</tr>
</tbody>
</table>

## Denturist coverage

For Plan members, the plan provides for coverage for complete dentures when provided by a denturist or dental mechanic every five years from date of service. Check with Pacific Blue Cross at 604-419-2000 or 1-877-722-2538 for details regarding coverage.
Out of province/Out of country
Out-of-province expenses are subject to the plan limit. If travelling outside of Canada, you should obtain extra medical insurance.

Medical equipment and supplies
The following items are covered by your plan, as long as the cost is reasonable and customary. Reasonable and customary pricing means the cost of the item or service must fit within the range of pricing deemed normal and fair within the province of BC. Contact the plan office if you have questions regarding the reasonable and customary costs for your health care needs.

Important: You must get Pacific Blue Cross’ authorization before purchasing any equipment costing more than $5,000.

- AeroChamber devices
- Blood glucose monitors
- Canes, casts, crutches, splints and walkers
- CPAP machine and supplies (doctor’s note required)
- Manual hospital beds: purchase, rental and repairs (doctor’s note required for purchase and rental)
- Mastectomy brassieres (limited to one mastectomy brassiere per breast prosthesis to a maximum of two per lifetime)
- Mastectomy forms
- Ostomy supplies
- Oxygen and oxygen supplies (doctor’s note required)
- Prosthetics
- Stump socks
- Surgical stockings (limited to two items per person per calendar year; doctor’s note required)
- Wheelchairs: rental, purchase or repairs of electric, manual or scooter (doctor’s note required for purchase and rental)
- Wigs (lifetime limit of $500; doctor’s note required)
How do I make an extended health care claim?

Making a health care claim

A claim form may be obtained from the plan office or directly from Pacific Blue Cross’ website www.pac.bluecross.ca. When complete, the claim form should be sent along with the receipts directly to Pacific Blue Cross at the following address:

PACIFIC BLUE CROSS

Mailing address: P.O. Box 7000
Vancouver, BC
V6B 4E1

Street address: 4250 Canada Way
Burnaby, BC
V5G 4W6

PACIFIC BLUE CROSS CALL CENTRE

Extended health: 604-419-2000
Dental: 604-419-2000
Toll-free: 1-877-722-2583
Fax: 604-419-2990
Website: www.pac.bluecross.ca

How to submit a health care claim

- Complete the claim form.
- Include original receipts.
- Provide an explanation or proof to support the claim, such as itemized bills, an attending physician’s statement or any other information related to the expense.

You will have to pay any expense incurred in arranging or obtaining proof of claim (such as a doctor’s note) yourself.

Don’t forget to submit your claims within six months of the calendar year end. Under no circumstances will a claim be processed if Pacific Blue Cross receives it later than June 30 of the calendar year following the year in which the expense was incurred.

Payment of the claim will be sent to you unless Pacific Blue Cross agrees to your request to assign payment directly to a third party. You can make a request to divert your payments by contacting the plan office.
If you’re travelling, make sure to buy additional travel insurance

If you are travelling outside of BC, you are covered for emergency medical care. However, restrictions apply that could limit your coverage. Contact the Pacific Blue Cross Call Centre before leaving on a trip for more information on your out-of-province coverage.

You could be stuck with a large bill if you travel outside of BC and experience a medical emergency that you are not covered for. To avoid this, you can purchase individual travel insurance, so it won’t count against your extended health care maximum in your plan.

Make sure you’ve got the coverage you need; do your research before you travel.

How is my benefit amount calculated?

Benefits are calculated and totalled separately for you and each of your dependents when you provide satisfactory written proof for each expense submitted for payment.

To determine the benefit amount payable, follow these steps:

- Calculate the total expense.
- Apply any deductible.
- Apply the reimbursement percentage.
- Apply the payment limits.
- Apply the extended health care plan maximum.

Note: No coverage is available for expenses billed before you are enrolled in the plan or after you have left the plan.

What’s not covered?

We are proud to offer you and your dependents comprehensive coverage under your health care benefits plan, but there are a number of items that may not be covered. It’s important to check to be sure.
Below is a sample of some of the items not covered under your extended health care plan:

- Medical laboratory services and x-rays
- Vitamins and/or minerals
- Drugs used to treat or replace an addiction or habituation
- Arch supports
- General anaesthetic, medications used to prevent baldness or promote hair growth, food replacement or supplements, HCG injections, drugs not approved for sale and distribution in Canada and medications available without a prescription
- Allergy testing unless rendered by a naturopath
- Charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-shareable or capital costs levied by local hospitals, or charges for translating documents into English
- Out-of-province expenses incurred due to elective treatment and/or diagnostic procedures or complications related to such treatment
- Any drug, vaccine item or service classified as preventative treatment or administered for preventative purposes
- Orthodontic repair that is required as a result of a dental accident

Before you pay, check to make sure the expense is covered. Call Pacific Blue Cross at 604-419-2000 or 1-877-722-2583.

DEADLINES FOR YOUR CLAIMS

Remember, you have until June 30 to submit receipts for all extended health care expenses and claims from the previous calendar year.

A claim submitted after June 30 of the calendar year following the year in which the expense was incurred will not be considered and you will not be compensated.
Your dental plan provides coverage for services that help restore and maintain healthy teeth and gums. Your coverage is based on Pacific Blue Cross’ dental fee schedule, which limits the frequency of some services, the types of services and the fees covered for the service.
Services must be provided by general practising dentists, dental hygienists, denturists or dental specialists.

Your dental care coverage is divided into three different reimbursement rates:

1. **Basic services** such as exams, x-rays and fillings are reimbursed at a rate of 100%;

2. **Major services** such as crowns and bridges are reimbursed at a rate of 60%; and

3. **Orthodontic services** are reimbursed at a rate of 50%.

**GET THE DETAILS BEFORE YOU PAY**

It’s a good idea to discuss recommended treatment with your dentist before you have the services. Consider asking the following questions before routine dental work:

- Why is the treatment required?
- What’s the cost and how much will be covered by my plan?
- Are there alternative procedures available and what do they cost?

Once you select your treatment, ask your dentist to submit a pre-treatment plan to Pacific Blue Cross for any large expenses, especially major restorative and orthodontic services.

**Pacific Blue Cross (our carrier)**

**Group number: D902779 - Div 1 Class 1**

for Full Benefits Plan coverage

**Group number D902779 - Class 2 Div 2**

for Partial Benefits Plan coverage

**Important:** All of the basic and major services listed below have a combined annual limit of $3,000 per person. Orthodontics has a lifetime limit of $3,000 per person.
**What’s covered?**

**Dental care services**

<table>
<thead>
<tr>
<th>What's covered</th>
<th>Coverage and conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exams</strong></td>
<td></td>
</tr>
<tr>
<td>New patient exams</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td>Recall exams</td>
<td>• Combined annual limit of two per person</td>
</tr>
<tr>
<td>Specific exams</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td>Complete exams (periodontist)</td>
<td>• Limit of one per person every three years from date of service</td>
</tr>
<tr>
<td>Complete exams (general practitioner or specialist)</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td></td>
<td>• Combined limit of one per person every three years from date of service</td>
</tr>
<tr>
<td><strong>X-rays</strong></td>
<td></td>
</tr>
<tr>
<td>Bitewing</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td>Periapical</td>
<td>• Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre.</td>
</tr>
<tr>
<td>Panoramic film</td>
<td>• Additional limit: Panoramic film x-rays once every two years per person from date of service</td>
</tr>
<tr>
<td>Complete series</td>
<td>• Additional limit: Complete series x-rays once every three years per person from date of service</td>
</tr>
<tr>
<td><strong>Preventative care</strong></td>
<td></td>
</tr>
<tr>
<td>Polishing and fluoride treatment</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td></td>
<td>• Annual limit of two each per person</td>
</tr>
<tr>
<td>Scaling and root planing</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td>What’s covered</td>
<td>Coverage and conditions</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Night guards</td>
<td>• 60% reimbursed</td>
</tr>
<tr>
<td></td>
<td>• Limit of two per person every five years</td>
</tr>
<tr>
<td>Gingival curettage</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td>Gingivectomy</td>
<td>• Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre.</td>
</tr>
<tr>
<td>Occlusal adjustment/ equilibration</td>
<td></td>
</tr>
<tr>
<td>Recontouring of teeth</td>
<td></td>
</tr>
<tr>
<td>Space maintainers</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td>Pit and fissure sealants</td>
<td>• Combined limit of one per tooth per person every two years from date of service</td>
</tr>
<tr>
<td>Preventative restorative resins</td>
<td></td>
</tr>
<tr>
<td>Fillings: Silver fillings for primary teeth</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td>Silver fillings for permanent teeth</td>
<td>• Per-person dollar limits subject to change. Contact the Blue Cross Call Centre.</td>
</tr>
<tr>
<td>White fillings for permanent teeth</td>
<td></td>
</tr>
<tr>
<td>Crowns and bridges: Crowns (gold)</td>
<td>• 60% reimbursed, except inlays and onlays, which are reimbursed at 100%</td>
</tr>
<tr>
<td>Inlays</td>
<td>• Combined limit of one per tooth per person every five years from date of service</td>
</tr>
<tr>
<td>Onlays</td>
<td></td>
</tr>
<tr>
<td>Abutments</td>
<td></td>
</tr>
<tr>
<td>Pontics</td>
<td></td>
</tr>
<tr>
<td>Veneers</td>
<td></td>
</tr>
<tr>
<td>Stainless steel crowns</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td></td>
<td>• Limit of one per tooth per person every two years from date of service</td>
</tr>
<tr>
<td>What’s covered</td>
<td>Coverage and conditions</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Buildups</td>
<td>• 60% reimbursed</td>
</tr>
<tr>
<td>Posts</td>
<td>• Limit of one per tooth per person every five years</td>
</tr>
<tr>
<td>Repairs of inlays, onlays, crowns or veneers</td>
<td>• 100% reimbursed</td>
</tr>
<tr>
<td>Repairs of bridges</td>
<td>• Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre.</td>
</tr>
</tbody>
</table>

**Dentures**

| Complete or partial dentures          | • 60% reimbursed                                                                        |
|                                       | • Combined limit of one per arch per person every five years                            |
| Repairs or additions                  | • 100% reimbursed                                                                        |
| Adjustments                           | • 100% reimbursed                                                                        |
| Tissue conditioning                   | • Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre.|
| Rebases                               | • 100% reimbursed                                                                        |
| Relines                               | • Combined limit of one per arch per person every two years                              |

**Dental surgery**

| Root canals                           | • 100% reimbursed                                                                        |
|                                       | • Limit of one per tooth per person every five years                                    |
| Extractions                           | • 100% reimbursed                                                                        |
| Complicated extractions               | • Lifetime limit of one per tooth per person                                             |
| Crown lengthening                     | • 100% reimbursed                                                                        |
| Osseous surgery                       | • Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre.|

Contact the Pacific Blue Cross Call Centre.
What’s covered | Coverage and conditions
---|---
Dental surgery (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
</table>
| Anaesthesia | - 100% reimbursed  
- Annual limit of $190 per person |

**Orthodontics**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
</table>
| Orthodontic services | - 50% reimbursed  
- Lifetime limit of $3,000 per person |

**Emergency dental coverage**

Under this plan, emergency dental care will be provided anywhere in the world. If you require emergency dental treatment while travelling outside your home province, you will be reimbursed up to the amount the plan would have paid had the treatment been completed at home.

In order to receive your reimbursement, you **must** obtain a fully completed claim card or a fully itemized statement marked “paid in full” that provides the following information:

- The dates of service;
- Tooth numbers;
- Details of the service; and
- The fee for each service.

**How do I make a dental claim?**

**Making a dental claim**

You will be issued a Pacific Blue Cross identification card, which is your identification for coverage with the plan. When you visit the dentist, show the card and discuss the proposed services, the amount to be charged and the amount to be covered by your plan.

Note that this card is also your pay-direct drug card.

When the dental service is completed, the dentist will send the claim form directly to Pacific Blue Cross for payment. You will be required to pay the dentist the portion not covered by the plan.
Certain dentists may require you to pay the full amount of the claim up front and then claim directly from Pacific Blue Cross. All dental claims must be submitted to Pacific Blue Cross within 12 months of paying for services, or the claim will not be paid.

**If your dentist doesn’t submit claims on your behalf, then you must send them.**

**How to submit a dental claim**

- Claims must be submitted within 12 months of the date of service. If you do not submit your claim within 12 months of the date of service, Pacific Blue Cross will not pay for the claim.

- If you pay the dentist, Pacific Blue Cross will reimburse you with the amount once they receive the claim form or receipts signed by the dentist.

- If you do not pay the dentist directly, Pacific Blue Cross will pay the dentist directly for services provided once they receive a claim form signed by the dentist certifying these services were performed and the fee charged.

- To claim orthodontic benefits, Pacific Blue Cross must receive:
  - A treatment plan (completed by the dentist) before treatment starts; and
  - Photocopies of receipts monthly, as treatment progresses.

- Pacific Blue Cross will pay benefits on diagnostic services, initial fees and monthly or quarterly treatment fees. If you pay any amount to the dentist in advance of completed treatment, Pacific Blue Cross will allow an initial payment amount and then pro-rate the balance into monthly payments throughout the treatment period.
CHECKING IN BEFORE MAJOR TREATMENTS

Your dentist is not required to obtain prior approval from Pacific Blue Cross, but if you are planning major treatment, it is a good idea to seek authorization from Pacific Blue Cross to ensure your benefit payments will be what you expect.

What’s not covered?

Just as with your extended health care benefits, there are items that might not be covered under your dental coverage. It’s important to check your coverage before undergoing any major dental treatment. Below are a few services not covered under your dental care plan:

- Charges for missed appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents into English
- Charges for drugs, pantographic tracings or graphics
- Charges for services related to the functioning or structure of the jaw, jaw muscles or temporomandibular joint
- Incomplete or temporary services
- Recent duplication of services by the same or different dentist
- Travel expenses incurred to obtain dental treatment

Before you proceed, check to make sure the expense is covered.

Call Pacific Blue Cross at 604-419-2000 or 1-877-722-2583.
Insurance coverage

Your life and accidental death and dismemberment coverage

Your plan provides the following insurance protection to you and your family, regardless of whether you have Full Benefits, Partial Benefits or Retiree Benefits Plan coverage.
Your life coverage

<table>
<thead>
<tr>
<th></th>
<th>Member life Insurance</th>
<th>Spouse life insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Benefits Plan</strong></td>
<td>$75,000</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Partial Plan and Retiree Plan</strong></td>
<td>$75,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>member under age 65</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retiree Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>member age 65 to 69</td>
<td>$12,500</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Retiree Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>member age 70 to 74</td>
<td>$6,250</td>
<td>$6,250</td>
</tr>
<tr>
<td><strong>Retiree Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>member age 75 and over</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

Life insurance for covered dependent child: $5,000
The Co-operators (our carrier) Group number: G-83

**Accidental death and dismemberment**

The plan provides members with a principal sum of $75,000 in coverage for accidental death and dismemberment (AD&D) claims. Plan members are eligible for this coverage if they are either:

1. Full Benefits coverage members under age 70; or
2. Partial and Retiree Benefits coverage members under age 65.

All eligible claims must be submitted within 365 days of the accident. The accident must occur prior to your termination age birthday and while you are still insured under this benefit.

**Accidental death benefit**

Should an accidental injury be shown to directly result in death, your beneficiary will be paid the full $75,000 benefit.

**Accidental dismemberment benefit**

Should accidental bodily injuries or critical disease be shown to result in the following losses, your beneficiary will receive a percentage of the $75,000 benefit, as outlined on the following page:
## Insurance coverage

<table>
<thead>
<tr>
<th>Injury</th>
<th>% of principal sum paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraplegia, hemiplegia, quadriplegia</td>
<td>200%</td>
</tr>
<tr>
<td>Loss of use of both arms</td>
<td></td>
</tr>
<tr>
<td>Loss of use of both legs</td>
<td></td>
</tr>
<tr>
<td>Loss of use of one arm and one leg on same side of body</td>
<td></td>
</tr>
<tr>
<td>Loss of both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of both arms or both legs</td>
<td></td>
</tr>
<tr>
<td>Loss of sight in both eyes</td>
<td></td>
</tr>
<tr>
<td>Loss of one hand and one foot</td>
<td></td>
</tr>
<tr>
<td>Loss of use of both hands</td>
<td></td>
</tr>
<tr>
<td>Loss of use of both feet</td>
<td></td>
</tr>
<tr>
<td>Loss of speech and hearing in both ears</td>
<td></td>
</tr>
<tr>
<td>Loss of use of one hand or arm and one leg</td>
<td></td>
</tr>
<tr>
<td>Loss of sight in one eye and of one hand</td>
<td></td>
</tr>
<tr>
<td>Loss of sight in one eye and of one foot</td>
<td></td>
</tr>
<tr>
<td>Loss of one arm</td>
<td>75%</td>
</tr>
<tr>
<td>Loss of use of one arm</td>
<td></td>
</tr>
<tr>
<td>Loss of one leg</td>
<td></td>
</tr>
<tr>
<td>Loss of use of one leg</td>
<td></td>
</tr>
<tr>
<td>Loss of one hand</td>
<td>66.66%</td>
</tr>
<tr>
<td>Loss of one foot</td>
<td></td>
</tr>
<tr>
<td>Loss of speech</td>
<td></td>
</tr>
<tr>
<td>Loss of hearing in both ears</td>
<td></td>
</tr>
<tr>
<td>Loss of sight in one eye</td>
<td></td>
</tr>
<tr>
<td>Loss of use of one hand</td>
<td></td>
</tr>
<tr>
<td>Loss of use of one foot</td>
<td></td>
</tr>
<tr>
<td>Loss of thumb and index finger on same hand</td>
<td>33.33%</td>
</tr>
<tr>
<td>Loss of four fingers of one hand</td>
<td></td>
</tr>
<tr>
<td>Loss of hearing in one ear</td>
<td></td>
</tr>
<tr>
<td>All toes on one foot</td>
<td>25%</td>
</tr>
</tbody>
</table>

## Surgical reattachment

In the event of a loss of a limb or thumb or index finger that is surgically reattached, you will be eligible for 50% of the benefit amount shown in the chart above. The balance will be available should the reattachment fail within one year of the surgery date.
Other eligible claims

Members may also be eligible for additional benefits to assist with costs related to the eligible accidental injury, such as rehabilitation services, family transportation, home and vehicle alterations, spousal occupational training and dependent education benefits.

In the event of your death, your beneficiary will also have access to a repatriation benefit should you be more than 150 km from your home at the time, as well as a seat belt benefit, should you be properly buckled in at the time of the accident.

If you need more information on these benefits, please contact the CSW plan office using the contact information on the back cover.

How to make a claim

In case of your death or the death of a dependent, your beneficiary or the administrator of your estate (or the dependent’s estate) must notify the plan office. A form will be sent to the responsible individual that will include all the information necessary to claim this benefit.

CHOOSING YOUR BENEFICIARY

Be sure to complete the beneficiary card included with the enrollment package.

Beneficiary designations must be in writing. If you choose more than one beneficiary, please specify how the benefit is to be divided.

If your beneficiary is underage, you should have a trust agreement drawn up and signed.

If you do not designate a beneficiary, then the insurer will pay the benefit to your estate. There may be tax implications for not designating a beneficiary.
Wage indemnity benefits – Full Benefits Plan

Wage indemnity benefits are designed to help replace the wages lost if you suffer an injury or illness that isn’t related to your work and are not able to work for an extended period of time. Your wage indemnity coverage works with the federal Employment Insurance (EI) benefits to provide an ongoing income for up to 35 weeks.
It works like this:

- The plan pays wage indemnity during the first week of disability, which usually equates to the one-week Employment Insurance waiting period (if one is applied).
- Employment Insurance then pays benefits for up to the next 15 weeks (as long as the member continues to qualify for benefits).
- The plan continues to pay 19 weeks of wage indemnity from the date following the cessation of the Employment Insurance Sickness Benefits upon the plan receiving the required proof of disability.

The wage indemnity benefits amount is the same amount you would receive from Employment Insurance to their maximum (currently at $562.00 per week as of 2019) with a minimum weekly benefit of $300.00.

If a member does not qualify for EI Sickness Benefits, once the plan receives written confirmation, the plan will pay up to the maximum 35-week benefit as long as the member continues to be certified as disabled by his or her medical practitioner.

Wage indemnity is a taxable benefit; 10% income tax is deducted from the amount payable. The plan office will issue a T4A in February of the following year for the amount of the benefit received to declare it as taxable income on your income tax return.

**How do I apply for wage indemnity benefits?**

To qualify for benefits from the date of disability, you must be seen by a physician within three calendar days of the date of disability. If you have not seen a physician within the three-calendar-day period immediately following the date of disability, the wage indemnity benefits will commence the date you see a physician.
Disability claims of six days or less have a three-day waiting period applied. If you have seen your physician within three calendar days of the date of disability, wage indemnity benefits will begin on the fourth day of injury or illness as indicated by your physician.

For a disability that is seven calendar days or more in duration, there is no waiting period, and wage indemnity benefits begin the first day of disability provided you were seen by your physician within three calendar days from the date of disability.

**How to make a claim**

- Contact a medical practitioner immediately upon becoming disabled.
- Obtain the wage indemnity claim forms from the plan office.
- Complete all the questions on the Claimant’s Statement.
- Have the Physician’s Statement on the back of the same claim form completed.
- Complete Section 1 of the Medical Certificate for the Employment Insurance Sickness Benefits.
- Have a medical practitioner complete Section 2 of the Medical Certificate for the Employment Insurance Sickness Benefits.
- Obtain a Record of Employment from your employer. The plan office requires a copy of the Record of Employment.
- Hand-deliver or mail the Employment Insurance forms to their office with the Record of Employment. You can also file online at www.servicecanada.gc.ca or by telephone.
- Hand-deliver or mail the claim forms to the plan office for processing.

Claims should always be submitted within 30 days of the commencement of the disability. If claims are submitted after 30 days and there are extenuating circumstances for this late claim submission, a letter of explanation must accompany your claim. Claims submitted late may be disallowed by the Trustees.
Amount of benefit
The full amount of the benefit is a combination of the wage indemnity from the plan and Employment Insurance. This plan pays the same amount you would receive from Employment Insurance with a minimum weekly benefit of $300. This is a taxable benefit, which means income tax of 10% is deducted and paid to the Canada Revenue Agency on your behalf.

The plan can help protect your income when you can’t work due to an illness or injury that isn’t work-related.

Limitations and recurrence of former ailments
Your benefits are capped at 35 weeks for any one ailment. After 35 weeks, you can no longer make claims related to that ailment.

However, if you return to regular full-time work after receiving wage indemnity for any period of time and again become disabled from the same or a related illness, then the subsequent disability will be considered a continuation of the initial claim if the disability recurs before the later of:

• the end of 30 calendar days from the return to work date; or
• the time required to accrue 125 hours in the hour bank after the return to work date.

If the disability recurs:

• More than 30 calendar days after the return to work date
• And after more than 125 hours have been accrued in the hour bank after the return to work date,

then you must file a new claim and may have a waiting period applied as defined above.

If you become disabled from the same or a related illness while participating in a modified return to work program, the subsequent disability is considered a continuation of the initial claim and, thus, the recurrence period defined above does not apply.
Wage indemnity benefits

What happens if I’m injured at work?

Wage indemnity for WorkSafeBC claims

When a disability is due to a workplace accident and you are eligible for Workers’ Compensation wage loss, please notify the plan office to have disability credits added to your hour bank.

If your Workers’ Compensation claim has been denied, you may be entitled to advance payment of the wage indemnity benefits.

The following conditions apply:

- A member is required to sign a Reimbursement Agreement and/or an Assignment Agreement with the plan, which sets out the terms and conditions of the repayment of benefits.
- A member must take all steps necessary to recover from WorkSafeBC the total benefits advanced.
- A member must agree to repay the plan the full amount of the benefits advanced if the claim against WorkSafeBC is abandoned.

DISABILITY CREDITS

While on wage indemnity or receiving wage loss benefits from WorkSafeBC, hour bank credits are granted to members with Full Benefits coverage at a rate of 31.25 hours per week to a maximum of 125 hours per month. This will maintain your coverage for a maximum of six months.
Will the plan always pay lost wages?

There are some circumstances in which the plan will not pay for your lost wages. Your wage indemnity benefits will not be paid under the following circumstances:

- Occupational injury or illness
- Self-inflicted injury or illness, except alcohol or drug addiction
- Drug or alcohol addiction, unless the member is actively participating and co-operating in a medical treatment or an in-patient facility for substance abuse
- Routine pregnancy
- If vacation pay is paid for the same period
- Injury or illness from war or participation in a riot or while serving as a member of any armed service
- Participation in a criminal offence
- While you are incarcerated or in jail
- If there is an outstanding debt with the Plan from a prior claim
- Stress-related claims without a specifically diagnosed medical condition
- If there is a motor vehicle accident claim through ICBC
- Cosmetic or elective surgery unless deemed medically necessary by your treating physician
Maintaining your coverage

Once your coverage starts, you will continue to be covered as long as you remain a union member in good standing and your hour bank contains sufficient hours.

The following questions and answers help explain how your hour bank works and the ways you can maintain your coverage.
Your hour bank

How will my hour bank affect my benefits?
You need to have 250 worked hours within six consecutive months in your hour bank in order to be eligible for coverage. From there, 125 hours will be withdrawn from your hour bank each month. Those hours can be replaced either through reported employer contributions or self-payment (see page 45). Every month, 125 hours are removed from your hour bank. If you work less than that and don’t have extra hours banked, you will need to top up your account with a self-payment to maintain your coverage.

How does my hour bank work?

Hours accumulate in your hour bank on a monthly basis for each hour an employer pays into the plan for time you work.

Some employers may contribute at a higher or lower rate per hour to the hour bank. In this case, the hours are pro-rated according to the plan rate.

If you work more than 125 hours in a month, the extra hours will be credited to your hour bank. This will allow you to continue coverage during a short layoff.

In total you may accumulate hours for up to 12 months of coverage that can be drawn upon during periods of unemployment or illness. The total number of hours that can be credited is 1,500: 125 for the current month’s coverage and 1,375 for future months’ coverage.

The hour bank may be credited with hours while a covered member is receiving Workers’ Compensation wage loss or wage indemnity benefits. Please refer to the wage indemnity section starting on page 36 of this booklet.

What happens if I leave my employer?
If you leave your employer, hours are held in the hour bank with 125 hours withdrawn for each month’s coverage.
Maintaining your coverage

Eligibility for benefits is provided on a “whole month” basis with benefits terminating on the last day of the month if:

- You are no longer a member in good standing with Union Local 1611 (i.e., you have been suspended).
- Your hour bank falls below 125 hours and you fail to make the required payment by the date specified on your shortage notice.
- Self-payment for Partial Benefits Plan coverage has reached the maximum 60 months or you have reached age 65, whichever is earlier. (Contact the plan office to check for Retiree coverage eligibility.)

What if my hour bank falls below 125?
Do I still get benefits?

If your hour bank falls below 125 hours, the plan office will send a notice to your last address on file. To maintain continuous coverage, you can select one of the self-payment options detailed below. It is very important you make the payment of the amount requested by the deadline specified on the notice or you will lose your options for self-payment. Once you lose those options, you will not be able to rejoin the plan until you resume eligible employment and meet the basic conditions to apply for membership.

What is self-payment?

Once coverage is established, you may pay into the plan yourself to top up reported hours to continue coverage during periods of unemployment or if your hour bank falls below the required 125 hours for the next month’s coverage. Read more about self-payment options on page 45 for information on how you can stay in the plan through self-payment.

What if I have no hours left in my hour bank?

If you have no hours left in your hour bank, you will be sent a shortage notice for the Partial Plan. This notice will advise you of the payment required to maintain coverage for one month. If you wish to maintain your coverage for that month, you must make a self-payment for the number of hours that you are short.
Choosing the right self-payment option

1. Full Benefits coverage

When your hour bank balance falls below 125 hours, you have the option to self-pay up to 125 hours to maintain your Full Benefits coverage with the plan. From there, you can keep your coverage going by buying hours as needed.

This coverage gives you life insurance, accidental death and dismemberment, dependent life, wage indemnity, basic medical coverage, extended health care and dental. A member with Full Benefits is also eligible to accrue disability credits.

2. Partial Benefits coverage

If you have no hours left in your hour bank and are under age 65, you may self-pay to maintain Partial Benefits coverage with the plan. This coverage includes dental, extended health care, life insurance, dependent life insurance and accidental death and dismemberment benefits.

This package does not include wage indemnity, basic medical (MSP) or the application of disability credits. If you are self-paying for partial coverage, you will automatically revert to full coverage on the first month following the month in which worked hours appear in your hour bank.

3. Retiree Benefits coverage

If you have no hours left in your hour bank and meet the definition of retiree under the plan, you may self-pay and receive Retiree coverage. To receive this coverage, you must complete and submit an application form.

The coverage provides you with life insurance, dependent life, extended health care and accidental death and dismemberment (under age 65) but no dental, wage indemnity and basic medical (MSP). A member who has Retiree coverage is not eligible to accrue disability credits.
For further details on self-payment options, including rates and application forms, please contact the plan office using the information at the back of this booklet.

**When does my coverage end?**

Your coverage will end if:

- You are no longer a member in good standing with Union Local 1611 (i.e., you have been suspended); or
- Your hour bank falls below 125 hours and you fail to make the required payment by the end of the date specified on your shortage notice; or
- Self-payment for Partial Benefits coverage has reached the maximum 60 months or you have reached age 65, whichever is earlier, and do not qualify for Retiree Benefits coverage. (Contact the plan office to check for Retiree coverage eligibility.)

Once you lose your coverage, you have to start again and meet the basic conditions for membership, which include the following:

- You must be a member in good standing of the Construction and Specialized Workers’ Union Local 1611 with your union dues fully paid; and
- You must have worked at least 250 hours with a contributory employer within six continuous months.

You will not be able to purchase hours for your hour bank for the purpose of getting back into the plan.

**Will I lose my coverage if I’m injured or sick and can’t work?**

Here is how your disability credits work. While you are on wage indemnity or receiving wage loss benefits WorkSafeBC, hour bank credits are granted to members with Full Benefits coverage at a rate of 31.25 hours per week to a maximum of 125 hours per month to a maximum of 750 hours. This will maintain your coverage for a maximum of six months.
How do I continue coverage if I am widowed?
Covered widows or widowers of deceased plan members may continue to self-pay for coverage under the plan. All benefits remain the same except for life insurance, which will follow the current dependent life schedule. Dependent benefits are paid only for dependents who were covered at the date of the member’s death.
This coverage is offered on a one-time basis only. A separate group application form must be completed for this coverage.

How my spouse or dependents can continue coverage in the event of my death
If you die, your spouse will assume your hour bank, and the hour bank balance will be used to continue benefits. When the hour bank falls below 125 hours, your spouse may self-pay to continue current plan coverage for that month. When the hour bank has gone to zero, your spouse is eligible for the following coverage:

• If you had Full or Partial Benefits coverage and your spouse is under 65, your spouse may be eligible for the Partial Benefits coverage for a maximum of 60 months. After 60 months, your spouse may be eligible for reduced Retiree Benefits coverage if he or she is receiving a survivor’s pension through the BC Labourers’ Pension Plan.

• If you had Full or Partial Benefits coverage and your spouse is 65 or over, your spouse may be eligible for reduced Retiree Benefits coverage.

• If you had Retiree Benefits coverage, your spouse is eligible for reduced Retiree Benefits coverage.

It is important to keep on top of your status in the plan. Once you leave, you will not be able to purchase hours to get back into the plan.
Are my benefits taxable?
Yes. Under existing tax rules, your benefits are taxable. Each February, the plan office will send to you a T4A, which sets out this benefit. This amount must be included when completing your annual income tax return. Any self-payment you make into the plan during the year is deducted from the amount on the T4A, so you pay taxes only on the benefits you did not pay for directly.

NOTES

Disclaimer
Note: This document provides an overview of the CSW Medical and Benefit Plan of BC. A more complete description of the plan may be found in the benefit plan contracts. If there is any difference between this summary and the contracts, the contracts will apply.
Contacts

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CSW Medical and Benefit Plan of BC

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