Victoria Mechanical Industry

Health and Welfare Plan

Reference Book

Amendments to January 1, 2018

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UNION MEMBERS' ELIGIBILITY

and

MAINTENANCE of MEMBERSHIP

Who is eligible for benefits?

Any Member in good standing of Local Union 324, United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry (UA Local 324), who is active at the trade working for a signatory employer of UA Local 324 and has sufficient hours for coverage.

Union Members or Associate Members who are owner/operators of a non-signatory contracting business, are not eligible for benefits.

Upon retirement, once a Member's Hour Bank balance is depleted, the Member will be given the opportunity to continue his/her coverage through self-payment of benefits. The Retired package will consist of Extended Health Benefits (limited to $12,000 per insured person per calendar year for prescriptions drugs, and $5,000 per insured person per calendar year maximum for non-drug EHB expenses), Dental Benefits and optional partial reimbursement of MSP premium (see MSP section of booklet for details.)

How does a Union Member qualify for benefits and when does coverage begin?

A Member in good standing of UA Local 324 must accumulate 240 hours or more of work within a consecutive 6-month period. Coverage will commence on the 1st day of the month following the month in which sufficient hours are reported and paid to the Plan Administrator at the Union office.

You will be issued enrolment forms soon after sufficient hours are reported. These should be completed and returned to the Plan Administrator as soon as possible. You will then be issued an Identification Card.

Exception: Those governed by Reciprocal Agreements.

Once qualified, additional hours reported for a Member will be added to his/her "Hour Bank". Each month, the required hours will be withdrawn from the Member's Hour Bank for coverage. See Schedule A below for options. The Member may accumulate up to nine (9) month's coverage (1080 hours) which can be used during a period of poor employment, illness or vacation. Any hours in excess of 1080 will go into the general fund.

SCHEDULE "A"

Description	**Single**	**Couple**	**Family**
Full package	120	120	120
Retired package with MSP	55	90	N/A
Retired package without MSP	35	55	N/A
Retiree package (Retiring on or after June 2016 with or without MSP)	120	120	N/A
Surviving Spouses of Deceased Members	120	N/A	N/A
Non-working Members –self-payment	$396	$396	$396

Regular increases as per the Collective Agreement x 120 hrs ie: 3.30 x120 hrs = 396

When does coverage end for a Union Member?

Coverage for a Union Member will end when his/her Hour Bank falls below 120 hours and he/she fails to make the self-payment to bring his/her Hour Bank up to the minimum of 120 hours (or Schedule A if applicable) The Plan is only required to notify the Member one time upon depletion of his/her Hour Bank to request self-payments. If payment is not received, benefits may be cancelled without further notice. Once cancelled, a Member's benefits may only be reinstated upon the completion of 240 new worked hours.

Coverage will also end on the last day of the month in which a person loses his/her Union Membership.

A Member taking an Honorable Withdrawal (as per the UA Constitution) from the Union may have coverage for as long as his/her banked hours will allow at 120 hours per month, or as per Schedule A. The remaining hours that do not make up a full month's coverage will be forfeited to the general fund when coverage ends.

A Member taking a travel card may have coverage for as long as his/her banked hours will allow at 120 hours per month. He/she may maintain coverage after that period by making self-payments equal to 120 hours for a period of 12 months, providing the Member is available for employment and is not working at any other position. (or Schedule A if applicable) *Long Term Disability benefit is not provided after nine months of self-payment.*

For additional travel card information, please see Reciprocal Agreement

What shall I do if I am a self-employed Union Member?

You must report your own hours on a special remittance form, which can be obtained from the UA Local 324 office. You must qualify in the same manner as an employed Union Member. To maintain coverage, you must continue to report a minimum average of 120 hours per month.

Union Members or Associate Members, who are owner/operators of a non-signatory contracting business, are not eligible for benefits.

What happens when a Union Member is not working due to layoff or leave of absence?

He/she will be covered for the full benefits of the Plan at the regular monthly charge of 120 hours (or Schedule A if Applicable) for the number of complete months of coverage he/she has accumulated. When his/her Hour Bank falls below 120 hours he/she will be notified as to the balance remaining in his/her Hour Bank and will be given the opportunity to make up the difference by self-payment to the Administrator. If self-payment is not received, the benefits will be terminated.

For Example:

Monthly coverage requires ..... 120 hours

Your Hour Bank shows a balance of ..... 80 hours

Therefore you are short ..... 40 hours

You must self-pay for that particular month's coverage 40 hours at the unemployed Member's rate.

If you send future self-payments in addition to the current self-payment that is due, they will be recorded in your Hour Bank. This will save you time and reduce administrative costs for your Plan.

In the event that late hours are reported or other adjustments are found later, the hours will be credited to your Hour Bank.

Union Members in good standing may maintain coverage on a self-payment basis while unemployed or while working for employers who are not a party to the UA Local 324 IMIRA or any UA Local 324 signatory Collective Agreement.

However, Members working outside UA Local 324 Collective Agreements, in any position, will self-pay an increased monthly premium based on the current Collective Agreement's Health and Welfare hourly rate at the regular monthly charge of 120 hours (See Schedule A).

Self-payments will only provide coverage for Long Term Disability (LTD) and Life Insurance for a maximum of 9-consecutive months. The self-payment rate will not be reduced upon the discontinuation of the Life and LTD benefit.

Send your self-payment to the Plan Administrator at the union office:

VICTORIA MECHANICAL INDUSTRY
HEALTH AND WELFARE PLAN
919 Esquimalt Road
Victoria, BC V9A 3M7

Make cheques or money orders payable to the Victoria Mechanical Industry Health and Welfare Plan.

SPECIFIC INFORMATION for UA LOCAL 324 MEMBERS

How will I know when sufficient hours and contributions have been reported by my employer to qualify me?

You will be notified soon after sufficient hours are reported and you will be required to complete the enrolment forms.

How will I know from month to month if I have sufficient hours to maintain coverage?

You will be notified when your hours fall below the required 120 minimum (or Schedule A if applicable) You may also check your record at the office of the Administrator.

If my signatory employer, with offices in British Columbia, sends me to work outside the Province and continues to contribute on my behalf to my Plan, will I be eligible for benefits?

Yes, as long as you maintain your Membership in UA Local 324, and your permanent address is still in BC.

Where are the records of my eligibility kept?

In the office of the Administrator.

Will it affect my eligibility if I change my employer?

No, provided your new employer is a signatory contractor of Local Union 324 and contributes to the Plan on your behalf.

IMPORTANT

Keep your own pay slips as errors may occur in reporting and tabulating. To check this, you should keep a record of:

1. Your employer
2. His/her address
3. The hours employed each month.

Remember these three qualifications:

1. You must be a Member in good standing of UA Local 324, who is active at the trade.
2. You must be **enrolled** in the Plan. (failure to return the enrolment cards will result in no coverage).
3. Your hours and contributions must be reported. Your employer must report by the 15th of each month following the last pay period for the preceding month or your hours may not be credited to your Hour Bank until the following month.

ASSOCIATE MEMBER'S ELIGIBILITY

and

MAINTENANCE of MEMBERSHIP

Note: Permit Members are persons who are not Members of the Union but who work under a Collective Agreement which requires them to be a Member of the Plan.

The eligibility and maintenance of Membership rules for Permit Members are similar to the rules of Members of UA Local 324 except that Permit Members are not entitled to self-pay coverage or to make up short hours.

Who is eligible for benefits as an Associate Member?

An Associate Member is an Employer who employs Members of UA Local 324 for whom contributions are being made to the Plan.

Associate Members may enroll personnel who are not Members of UA Local 324, subject to payment of full contributions at a rate determined by the Trustees, and subject to change from time to time.

Employees of Associate Members are not considered Associate Members.

An Associate Member wishing to enroll personnel who are not Members of UA Local 324 must enroll a minimum of 50% of the eligible personnel and must maintain this minimum enrolment going forward.

No person who has attained the age of 65 may apply to join the Plan as an Associate Member or as an employee of an Associate Member.

How does an Associate Member (or employee of an Associate Member) qualify for benefits and when will his/her coverage begin?

A person wishing to join the Plan as an Associate Member (or employee of an Associate Member) must make application and remit the required premium to the Plan Administrator within 30 days of becoming eligible. Coverage for an Associate Member or employee of an Associate Member will commence on the first day of the month following a waiting period of 30 days after his/her date of application. Thereafter, they must remit the required monthly premium to the Plan Administrator in order to maintain coverage.

Note: If the person does not make application within the required time and at a later date desires the coverage, he/she may make application but will be required at that time, at his/her own expense, to submit evidence of insurability satisfactory to the insurers before benefits will become effective.

When will coverage end for an Associate Member?

Coverage for an Associate Member will end on the last day of the month prior to a month for which no payment has been made.

When will coverage end for an Employee of an Associate Member?

Coverage for an employee of an Associate Member will end on the last day of the month prior to a month for which no payment has been made or when the employee ceases to work for the Associate Member.

RECIPROCITY

UA Local 324 has entered into an Agreement with various sister Locals to promote welfare plans, whereby contributions may be transferred to your home Local. When taking a travel card check with the jurisdiction's welfare office.

DESCRIPTION of PLAN BENEFITS

EXTENDED HEALTH BENEFIT

Self-Insured Policy #011264

The Plan will cover:

- All eligible Members;
- Their Spouse or Common Law Spouse (6 month cohabitation required);
- Any unmarried dependent child of a covered Member to age 21, provided such person is mainly dependent on and living with the covered Member or the Spouse;
- Any unmarried dependent child of a covered Member to age 25 provided the child is in full-time attendance at a recognized school, college or university;
- 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.

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

Benefits

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

1. Prescription Drugs (Generic Substitution Always) – Pay Direct Drug Card – 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 an only be obtained with a written prescription of a licensed physician or Dentist if provincial law permits. Reimbursement of prescription drugs is based on the cost of the lowest priced generic equivalent drug. Drugs and medicines may be dispensed up to a 90-day supply at time of filling the prescription. 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 of 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.

   Smoking cessation products will be covered up to a maximum of $500 per lifetime. Fertility drugs are limited to a lifetime maximum of $5,000. Extemporaneous compounds prescribed by a physician or licensed Dentist and prepared by a pharmacist are considered an eligible expense, as well as injectable insulin, serums, vitamin B12 for the treatment of pernicious anemia, needles, syringes, diagnostic test supplies (excluding swabs and rubbing alcohol) and vaccines for Shingles and Hepatitis.

Drugs and medicines that can normally be purchased "over the counter" are excluded regardless of a prescription having been issued. Vitamins, preventative drugs and vaccines (other than listed as eligible), dietary foods and supplements are also excluded.

Fair PharmaCare Program - If you have not already registered please do so as soon as possible. To register call toll-free1-800-663-7100. You may also register online at:

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

Once you have registered please contact DA Townley to provide your Registration Number. You can mail a copy of the top part of the registration letter to D.A. Townley or fax to 604.299.8136. Alternatively you can email it to pharmacare@datownley.com Be sure to include your name and Social Insurance Number, your Registration Number and your phone number in case there are any difficulties.

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

There are a number of prescription drugs which are not eligible under the Provincial Fair PharmaCare drug formulary, but may be eligible under the 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 Fair PharmaCare approve the application for Special Authority, such drugs will be applied to your annual Fair PharmaCare deductible.

2. Charges in excess of the amount payable under the Insured Person's Provincial 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 $10,000 in any 12-consecutive month period.
4. Fees of a Member of the Association of Physiotherapists and Massage Practitioners of British Columbia to a maximum of $600 per service, per person per year.
5. Fees of podiatrist up to $600 per year. X-rays taken by a podiatrist will not be covered.
6. Fees of a chiropractor up to $600 per year. X-rays taken by a chiropractor will not be covered.
7. Acupuncture to a maximum reimbursement of $600 per year.
8. Fees of a naturopathic physician up to $600 per person per year. X-rays taken by a naturopathic physician will not be covered.
9. Charges for oxygen, blood or blood plasma, artificial limbs or eyes, crutches, splints, casts, trusses, braces, or orthopedic shoes. Orthopedic shoes are limited to one pair per person; replacements are covered only when necessary due to normal wear (must be prescribed by a licensed medical practitioner).
10. Custom made Orthotics (one pair only) prescribed by a podiatrist or General Practitioner. $600 maximum per calendar year.
11. 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).

12. 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 90 days of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 90 day period.
13. Hospital charges made by an approved acute general hospital in BC for co-insurance and short stay charges and, when actually occupied, the additional charge for private or semi-private room (not including rental of telephone, TV, etc.).
14. Charges made by a physician for a medical examination required by a government statute or regulation for employment purposes, provided such charges are not covered by the employer under a Collective Agreement and provided no claim has been made under the Basic Medical Plan.
15. Prescribed lenses, frames and contact lenses when required to correct vision, up to the amount of $600 per covered person per 24-month period. This includes prescription sunglasses.
16. Cost of hearing aids when prescribed by a certified Ear, Nose and Throat Specialist to a maximum of $600 in a 4-year period, with WorkSafe BC being the first insurer. Repairs, maintenance, batteries or other accessories will not be covered.
17. Reimbursement for Eye Exams up to a maximum of $120 per covered person per 24 month period.
18. Laser Eye Surgery, Lifetime maximum $1500.
19. Surgical Brassieres - 4 per calendar year and surgical hose 4 per calendar year.
20. Wigs or hairpieces required as a result of medical treatment or injury, up to a lifetime maximum of $500.

REIMBURSEMENT

There is no calendar year deductible. Members will be reimbursed at the rate of 80% of eligible expenses to the lifetime maximum of $1,000,000.

Reimbursement for retirees is limited to $12,000 per insured person per calendar year for prescriptions drugs, and $5,000 per insured person per calendar year maximum for non-drug EHB expenses.

HOW A CLAIM IS MADE

You may submit claims at any time during the year.

You have until June 30 to finalize claims for expenses incurred the previous year.

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

Do not include the same receipts more than once. Attempts to pad claims will result in your claim being refused. It is recommended that you retain a photocopy of your claim and receipts for your personal records.

EXCLUSIONS AND LIMITATIONS

The Plan's Extended Health Benefit does not cover:

a. expenses for benefits, care or services payable by or under the Basic Medical Plan, Fair PharmaCare, any Hospital Program or WorkSafe BC, whether or not a claim is made there under 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 of dental services or care or dentures except as specifically provided in Item 12.

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

d. there is no coverage for expenses incurred outside of Canada so it is important that you obtain individual coverage in the event of a claim. Expenses incurred outside the Province of British Columbia may be eligible under your MSP coverage but only if it is an expense covered in BC and only to the maximum that MSP would pay.

e. expenses for services and supplies deemed to be 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-inflicted, 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, eye refractions or for the fitting or cost of eyeglasses, contact lenses or hearing aids (or repairs/maintenance thereof or batteries).

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 Medical Services 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.

MEDICAL SERVICES PLAN (MSP) PREMIUM REIMBURSEMENT

Partial reimbursement (approximately 80%) of Medical Services Plan premium payments is provided twice a year. Reimbursement for the six-month period of October – March commences in April and the six-month period of April – September commences in October. **12 Months maximum reimbursement**

Proof of payments are to be submitted to the Union Office.

EMPLOYEE and FAMILY ASSISTANCE PROGRAM (EFAP)

Shepell Policy #7015

The EFAP provides immediate professional assistance for any work, health or life concern, including;

Personal and work related stress; couple and marital relationships; childcare and parenting issues; eldercare concerns; depression and anxiety; alcohol and drug misuse; family matters; bereavement; legal issues; financial concerns; career issues; crisis counseling/trauma; other concerns.

These services are provided by Shepell and there is no cost to you or your family. Services can be accessed 24 hours a day, 7 days a week, by phone, in person, email, or live chat. The toll free number to call is 1-800-387-4765 or go online to www.workhealthlife.com

DENTAL BENEFIT

Self-Insured Policy #011264

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 80% of the amount charged or 80% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment.

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 one in any 6 month period; however complete oral examinations are limited to one in any 24 month period
- Reasonable and Customary charges for specific examinations
- 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
- Diagnostic models: limited to 1 set per calendar year.

Preventative Services

All necessary procedures to prevent the occurrence of oral disease, including:

- Cleaning (limited to once every 6 months)
- Scaling and root planing (combined maximum of 12 units per calendar year)
- Topical application of fluoride (limited to once every 6 months)
- 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.

Surgical Services

All necessary procedures for extractions and other routine oral surgical procedures normally performed by a Dentist.

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
- Gold Foil only when used to repair existing gold restorations.

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.

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.

Periodontia

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

Anesthesia

General anesthesia required in relation to oral surgery

Part II- Major Services

Prosthetic Appliances, 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:

- In-lays, on-lays 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.
- 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 and their replacement if at least 5 years has lapsed.
- Replacement of an existing full or partial dentures or fixed bridgework, if the existing denture or fixed bridgework was installed 5 years prior to its replacement and cannot be made serviceable. Such extraction(s) must have occurred after the effective date of the covered person's coverage. Partials may only be provided by a Dentist.
- 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)

For Orthodontia services performed by an Orthodontist, payment will be made at 75% to a maximum lifetime limit of $3,500.00. 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 will be considered.

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, oral hygiene 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 coordinated 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 is $3500.00 per lifetime per covered eligible dependent.

TO MAKE A CLAIM

Your Dentist can file a claim directly on your behalf to the Plan or, if payment is required by your Dentist at time of service, standard BC Dental claim forms are usually available from your Dentist, but if required, Dental claim forms can also be provided by the Administrator's office.

All Dental claims must be filed and received by D.A. Townley no later than June 30th of the year following the year the expense was incurred, to be considered for payment.

When submitting eligible claims, please be sure to include:

- Your Name (please print)
- Your Address
- Your Group Policy Number (011264) and Certificate Number/ID Number (SIN)

Completed claim forms including receipts can be mailed, faxed, dropped off or emailed to:

D.A. Townley
160-4400 Dominion Street
Burnaby, BC V5G 4G3
By Fax: (604) 299-8136 or By Email: health@datownley.com

COORDINATION OF BENEFITS:

1. When coordinating 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 coordinated 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. 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 explanation of benefits statement or cheque stub when making further claim under this provision.

WEEKLY INDEMNITY

Self-Insured Policy #011264

This is a benefit which provides a weekly payment equal to the Employment Insurance (EI) Sickness benefit for up to a maximum of twenty-six (26) weeks for each eligible Member who becomes Disabled and is unable to work as a result of a non-occupational accident or illness and remains under the care and treatment of his/her physician for such disability. Benefits will start on the first day of absence due to a Disability resulting from an accident or, if hospitalized for at least 24 hours, payment shall commence from the first day of hospitalization for a non-occupational accident or illness. Benefits will commence on the fourth day if the Disability is due to an illness.

NOTE: The elimination period is a period of time, when a Member is continuously Disabled, which must be completed before a claim for benefits will be considered. Benefits will begin on the day after the elimination period expires or on the first day the Member is seen and treated by a physician or a licensed chiropractor – whichever is later – and will be paid only during periods of disability when the Member is under regular care and following the treatment prescribed. When certification is made by a chiropractor, any periods beyond six (6) weeks must be made by a physician. 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 Plan.

If the Member is eligible for EI Sickness benefits, benefits from the Plan will cease during the period the Member is eligible to collect EI. If the Member is still disabled after reaching the maximum duration of EI Sickness benefit payments or if the Member is not eligible for EI Sickness benefits or only partially eligible, the Plan will continue benefits up to the maximum twenty-six (26) weeks including EI Sickness benefits. If the Member is not eligible for EI Sickness benefits, the Plan will pay the full twenty-six (26) weeks, provided the rejection from EI accompanies the Weekly Indemnity claim, and there is sufficient medical evidence to support the Disability being claimed.

The Plan will be responsible for the portion of the first week, during the EI Sickness benefit elimination period. EI will pay the next fifteen (15) weeks and the Plan will pay for the balance, for up to a total of twenty-six (26) weeks maximum for Weekly Indemnity and EI Sickness benefit payments combined.

Benefits will be paid pro-rated on the basis of a seven (7) day work week.

HOW TO CLAIM FOR BENEFITS

Take the following steps as soon as possible after you have become Disabled.

1. Contact your physician immediately upon becoming Disabled.
2. Obtain a claim form from the Plan Administrator.
3. You must complete the front of the claim form and sign it on both sides.
4. Your physician must complete the Physician's Statement on the back of the same form.
5. It is your responsibility to have the claim form, once completed, sent to the Plan Administrator.
6. The Administrator of the Victoria Mechanical Industry Health & Welfare Plan must complete the Employer Authorization at the very bottom of the form.
7. Claims will be assessed by D.A. Townley and once reviewed, if approved, you will receive your benefit cheque by mail at your home address.

8. Claims should always be submitted within 30 days of commencement of Disability, unless special circumstances prevent you from doing so.

9. Benefits will only be paid when a Member is under the full-time care of a physician and/or surgeon. Where there is any doubt as to the validity of the claim, D.A. Townley reserves the right to obtain a second medical opinion from a physician and/or surgeon of its choice.

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

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

   2. the Member has a claim for benefits under WorkSafe BC or similar 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 the written and signed Loan & Replacement Agreement.

RECURRENCE OF FORMER AILMENTS

You will not receive benefits for more than 26 weeks as a result of Disability due to any one ailment.

Periods of Disability, due to the same or related causes, will be considered one continuous period of Disability except where the Member returns to work and the same Disability recurs. It must be separated from the original Disability by more than two weeks of continuous active employment for it to be considered a new period of Disability. If a Disability arises from a different and unrelated cause, it will be considered a new Disability, provided it commences following the Member's return to full-time work.

LIMITATION AND EXCLUSIONS

No benefit will be paid for any period for which the Member has or will receive vacation pay for an annual vacation, or any paid statutory holidays.

A Member who is Disabled by an event prior to the effective date of coverage may only be entitled to receive benefits from the effective date of coverage.

No benefit will be paid for a period of Disability arising from:

- an occupational accident or illness, as these are covered by Worksafe BC or similar legislation;
- your commission of or attempt to commit an assault or criminal offense;
- self-inflicted injuries or sickness;
- substance abuse, including but not limited to alcoholism or drug addiction, unless you are receiving continuing treatment for substance abuse from your physician;
- injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service;

- 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;
- an automobile accidence except as a fully repayable loan;
- if you become Disabled during a strike or lockout at your place of employment. However, your rights to benefits will be reinstated when the strike or lockout ends.

DISABILITY CREDITS

When a Member is collecting benefits under the Weekly Indemnity Plan, EI Sickness Benefits, or under WorkSafe BC, Members will receive assistance with their Hour Bank. For each day that he/she is Disabled and a claim for Weekly Indemnity Plan, EI Sickness Benefits or WorkSafe BC has been accepted for payment, the Member's Hour Bank will be credited with contributions of 8 hours per day, subject to a maximum of 120 hours per month up to a maximum of nine months. Proof of acceptance for Weekly Indemnity, EI Sickness benefits or WorkSafe BC must be provided to the Administration Office by the Member in order to apply for Disability Credits.

To qualify for these Disability Credits, the Member must be eligible for benefits when the Disability commences. If the Member is Disabled for longer than the maximum Weekly Indemnity claim of 26 weeks, he/she should apply to the Administration Office for further Disability Credits to be applied to his/her Hour Bank.

GROUP LIFE INSURANCE

Sun Life Policy #022807

What are the Life Insurance Benefits?

Life Insurance in the amount of $80,000* is payable to the beneficiary designated by you should your death occur from any cause while you are insured under the group policy, with the exception of Plan Members who have attained the age of 65. Group Life Insurance coverage will cease at age 65 or at earlier retirement.

*Effective January 1, 2018

What happens to my Life Insurance if my Membership terminates?

If you are no longer eligible for coverage under the Plan, you may take out an individual policy without evidence of insurability, on certain types of policies offered by the insurance company, at the insurance company's rates then in effect at your attained age.

The individual policy will be for an amount not greater than the group policy and will be available at any time within 31 days after cancellation of the group insurance. Your group insurance will remain in force during the 31-day conversion period whether or not you apply for conversion. Only one such converted policy may be in force on your life at any time.

What happens if I become Totally Disabled?

If you become Totally Disabled, as defined in the policy, before your 65th birthday, your insurance will be kept in force without charge as long as your Disability prevents you from working, but not beyond age 65, and proof of Total Disability will be required.

If I die, to whom are the benefits paid?

You may designate either a named person or your estate as beneficiary and may change your beneficiary at any time. If you wish to change your beneficiary, proper forms are available from the Plan Administrator. If any beneficiary dies before you, the interest of such beneficiary shall be payable equally to the remaining designated beneficiaries or, if there is no remaining beneficiary, to your estate.

Are my dependents covered?

Your dependents are covered for Life Insurance in the following amounts:

Spouse.....$2,500.00

Unmarried Dependent Child (age 14 days to 21 years).....$1,000.00

Insurance on any of your dependents will terminate when Membership terminates for any reason, when the benefit is cancelled, or when the dependent ceases to be eligible.

LONG TERM DISABILITY

Sun Life Policy #022807

If an eligible Member becomes Totally Disabled (by definition under this policy) while covered under the Long Term Disability Benefit for the required period of time known as the Qualifying Disability Period and is under the continual treatment and care of a legally qualified and appropriate physician, you will receive a monthly income benefit.

Total Disability

A Member will be considered to be Totally Disabled:

- while the Member is continuously unable, due to an illness or injury, to do the essential duties of the Member's own occupation during the Qualifying Disability Period and the following 24 months, and
- afterward, if the Member is continuously unable, due to an illness or injury, to do any occupation for which the Member is or may become reasonably qualified for by education, training or experience.

At the end of the 24 month own-occupation period, if the job that the employer would expect the Member to take does not pay 75% of the Member's gross or net if taxable earnings, the Member would still be considered Totally Disabled.

Qualifying Disability Period

180 consecutive days prior to age 65.

Monthly Benefit

This benefit is equal of $1,750.00 per month.

Maximum Disability Period

The Maximum Disability Period is to age 65 providing the Member became Totally Disabled while covered, the Total Disability continued beyond the Qualifying Disability Period and the Member has been following appropriate treatment since the onset of the condition.

The Member is entitled to benefits while the Total Disability continues.

- Nervous or mental or emotional sickness or disorder - to age 65, but you must be under the care of a psychiatrist and receiving treatment;
- Drug addiction or alcoholism - to age 65, but you must be participating in a rehabilitation program specializing in treatment of such sickness;
- Other Sickness - to age 65
- Accidental Injury - to age 65

Benefits will not be payable beyond age 65 or upon earlier age retirement.

Recurrent Disability

If a Disability recurs and it is due to the same or related causes, it will be considered as one continuous Disability and will not be subject to the Qualifying Disability Period unless the Member has returned to active, full-time employment for a period of six consecutive months or longer.

If the new Disability is due to causes unrelated to the prior Disability, the Member may be eligible for a new Disability period, subject to the Qualifying Disability Period, if the Member returned to active work for at least one full day.

Reductions of Coverage

If the Member is Disabled and eligible for full benefits, and elects a different and lesser-paid occupation not related to the program of rehabilitation, the gross benefit shall be reduced by 50% of the earnings from the lesser-paid occupation elected.

All Source Maximum

The Member's Total monthly income while disabled (Long Term Disability benefit plus any income from an employer, retirement Plan, WorkSafe BC or similar legislation, Canada Pension Plan or any other government Plan, including automobile insurance) cannot exceed 85% of the Member's gross pre-Disability monthly earnings (100% if participating in a rehabilitation program).

If total income exceeds 85% (100% with rehabilitation), the Long Term Disability benefit will be reduced accordingly.

Rehabilitative Employment

If a Member is Disabled, the Insurer may recommend that he/she undergo some suitable rehabilitative training program that would take into account the nature and limitations of the Disability. Further details on this aspect will be provided in the event that the Member becomes Disabled.

EXCLUSIONS AND LIMITATIONS

No benefits are payable to an insured Member for any Total Disability commencing within 6 months of the insured Member's effective date of insurance, if the Disability is caused by or contributed to or is a consequence of, a sickness or injury for which the Member has received medical treatment or services or has taken a prescribed drug or drugs or medicine at any time or times within 90 days before the Member's effective date of insurance.

Benefits are not payable for the following:

- Disability resulting from self-inflicted injuries or attempted suicide.

- Disability as a result of participation in a war, riot, insurrection or criminal act.
- Disability resulting from an accident, which occurs while the Member is operating a motor vehicle and the Member's blood contains more than 80 milligrams of alcohol in 100 litres of blood (.08%).
- Any period of Disability, or portion thereof, during the Member is not under the care of a legally qualified physician and no such period of time shall be counted towards the Qualifying Disability Period.
- Any period of Disability (including maternity leave) as defined in the General Provisions section.
- Disability that commences on or after the date a strike or layoff begins, except as outlined in the Master Policy.

ACCIDENTAL DEATH and DISMEMBERMENT

AIG Policy #28472044

The Basic Accidental Death and Dismemberment benefit covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job.

If you suffer any of the losses listed below in the Schedule of Losses as 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 under age 65	$80,000 (effective January 1, 2018)
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 Sum
Loss of One Foot	Two-Thirds of The Principal Sum
Loss of the Entire Sight of One Eye	Two-Thirds of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Third of The Principal Sum
Loss of Speech 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 Plan's current basic group life insurance policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Person.

All other benefits shall be payable to the Insured Person.

Repatriation Benefit

When injuries covered by this policy result in loss of life of an Insured Person outside 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 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.

Termination of Coverage

Group AD&D coverage will cease when the Member reaches age 65 or at earlier retirement.

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 Members 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 a Member 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 Member 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 Member'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 25 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 Member, the Company will pay an amount equal to the lesser 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.