Teamsters Local 213

Health and Welfare Plan

November 2007

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To Our Members From The Trustees

The Teamsters Local 213 Health and Welfare Plan was created on March 1, 1966. It was established by the Board of Trustees to provide health and welfare benefits for all eligible members and their covered dependents.

The Board of Trustees is responsible for the administration of the plan. The Board can increase or decrease benefits depending on the financial position of the plan, and since 1966, the Board of Trustees has made many benefit improvements to the plan.

This booklet provides you with a summary description of the benefits to which you and your dependents may be entitled from the plan, the rules covering eligibility for benefits, and the procedures to follow in applying for benefits.

The Teamsters Local 213 Health and Welfare Plan is governed by the Consolidation Trust Agreement dated December 2, 1988 which consolidated the original Trust Agreement establishing the health and welfare trust and all subsequent amendments, the Plan Text adopted by the Trustees under the Trust Agreement, and applicable Federal and Provincial laws and regulations. Any issues concerning eligibility for, or the amount of, or entitlement to health and welfare benefits under the plan will be resolved by reference to the Trust Agreement, the Plan Text, the insurance contracts, and applicable legislation.

This booklet is explanatory only and while it is believed to be accurate in those explanations, the provisions of the Consolidation Trust Agreement, the Plan Text, the insurance contracts, and applicable legislation will govern exclusively any disputes concerning particular rights or entitlements.

The Trustees for the
Teamsters Local 213 Health and Welfare Plan
(Effective January 1, 2012)

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This page revised 2012

PART 1 - ELIGIBILITY

1. Who is eligible to be covered under the plan?

Any person who is a member in good standing with Teamsters Local Union No. 213 is eligible to participate in the plan.

In addition, the Union member must be employed by an employer signatory to a Collective Agreement requiring contributions to be made to the Teamsters Local 213 Health and Welfare Plan.

2. Am I automatically covered for benefits if I meet the eligibility criteria?

No. Your coverage will only be implemented after the Plan Administrator has received both of the following:

- The required enrollment documentation completed in full by you; and
- The required contributions from your employer.

3. My employer participates in the Hour Bank division. When does my coverage become effective?

You qualify after employer contributions for a minimum of 300 hours are credited to your bank by the Plan Administrator. Coverage is effective on the following first of the month provided the required enrollment forms have been received by the Plan Administrator.

4. How will I know when I'm covered under the Hour Bank?

Call the Plan Administrator to verify that your first 300 hours has been received and the effective date of your coverage. Claims such as dental expenses incurred before you are covered are your responsibility.

For example, assume that you started working on January 2nd and worked 165 hours in January and 140 in February. The January hours are submitted to the Plan Administrator in February. Your hour bank balance at the end of February is 165, which is not enough to activate your coverage. The February hours are submitted in March resulting in your hour bank balance being 305 at the end of March.

In this example, your hour bank coverage would be implemented April 1st assuming the Plan Administrator had also received the required enrollment forms. If the enrollment forms were not received until April 15th, for example, the coverage would not be effective until May 1st.

5. How does the Hour Bank work?

Your employer submits monthly contributions to the Plan Administrator based on the number of hours you have worked in the previous month. Those hours are accumulated in your hour bank account and the Plan Administrator withdraws 150 hours each month entitling you to coverage for that month.

Hours are accumulated in your bank to a maximum of 1,875 hours. These hours can then be used during periods of reduced employment or illness. They can also be used when you quit work and retire.

6. My employer participates in the Dry Fund division. When does my coverage become effective?

It becomes effective on the first of the month following the date the required enrollment forms have been received by the Plan Administrator.

7. How do I find out which division my employer is participating in?

You can either ask your employer, or call the Plan Administrator, to find out if you are covered under the Hour Bank division or the Dry Fund division.

PART 2 - DEPENDENTS

1. Are my dependents also entitled to be covered?

Yes. You can enroll your spouse and children for coverage under the provincial medicare plan called the Medical Services Plan of BC (MSP), and for Extended Health Care (EHC) and Dental benefits.

A spouse can be a legally married husband or wife, or a person to whom you are not married but with whom you live and publicly represent as your husband or wife.

Any natural child, stepchild, legally adopted child, or legal ward (including a sister, brother, niece or nephew if you stand in place of a parent) that is:

a) unmarried,

b) mainly supported by you, and

c) under the age of 19 for MSP, or under the age of 21 for EHC and Dental.

Children over the age of 19 for MSP, or over the age of 21 for EHC and Dental, who become employed on a full-time basis, are no longer eligible for coverage.

2. Can I continue to have my children covered if they are still in school after age 19?

Yes, provided they are in full time attendance at an accredited school or university, are unmarried, and mainly supported by you. MSP will continue up to age 25.

3. Can I continue to cover my divorced spouse?

No.

PART 3 - CONTRIBUTIONS

1. Is my employer required to contribute to the plan?

Yes, if you are in a position covered by a Collective Agreement that requires your employer to contribute to the plan. The Plan Administrator must receive contributions from your employer by the 15th of every month.

2. Am I required to contribute to the plan?

That depends on the provisions of your Collective Agreement. Most employers contribute 100% of the cost as required by the Collective Agreement. This cost is part of the total compensation package obtained through bargaining and, therefore, is not deducted from your wages.

3. Are the contributions made by my employer taxable?

Yes, but only the portion of your employer's contribution for MSP and Group Life insurance is considered taxable income under the Income Tax Act. Therefore, the Plan Administrator will issue a T4A showing the amount allocated for MSP and Group Life coverage. You must include the amount indicated in box 28 of your T4A as income on your tax return.

PART 4 - TERMINATION OF COVERAGE

1. When does my coverage terminate?

Your coverage terminates when:

- You cease to be eligible for coverage, which also includes being suspended from the Union or taking out a withdrawal card;
- Your employer stops remitting contributions or is late in submitting them to the Plan Administrator;
- For Hour Bank members, your hour bank balance is less than 150 hours;
- You attain the maximum age that you can continue to be covered under each of the benefit plans.

Coverage for your covered dependents also terminates when your coverage terminates. However, coverage will cease earlier if they become ineligible, such as due to age or divorce.

If you are an Hour Bank member, MSP, EHC and Dental benefits will continue after your death for your covered dependents until your Hour Bank is depleted.

2. What is the maximum age that I can be covered?

Up to age 65 for LTD and up to age 70 for Group Life and AD&D. There is no age limit for MSP, STD, EHC and Dental.

However, your Group Life coverage terminates at age 65 if you are disabled and in receipt of STD or LTD.

3. Is there any way I can continue to be covered for benefits after my coverage under the Teamsters Local 213 Health and Welfare Plan is terminated?

Yes. You can convert your Group Life insurance to an individual policy without evidence of good health. Great-West Life must receive the application and required premium within 31 days of the date your group coverage terminates.

Your AD&D coverage can also be converted to a standard individual policy (without 'critical disease' and other special benefits) provided you are under age 65. Co-operators must receive your application and the first year's premium within 31 days of the date your group coverage terminates. The minimum amount that can be converted is $25,000.

You can also apply for an individual EHC and/or Dental policy with Pacific Blue Cross. You must apply within 60 days of termination of your group coverage or Pacific Blue Cross will not cover pre-existing conditions.

PART 5 - SELF-PAY RULES

1. Can I continue to be covered under the Teamsters Local 213 Health and Welfare Plan after my employer stops remitting contributions?

Yes, provided you continue to meet the eligibility requirements under the plan and pay the required cost. The options vary depending on whether you are covered under the Hour Bank or Dry Fund divisions.

2. What if I am covered under the Hour Bank division?

If your hour bank balance drops below 150 hours, the Plan Administrator will forward to you an Application for Continuing Benefits. This will

be sent a month before your coverage is about to expire.

The application will indicate the coverage options available to you and the cost for each option.

You must complete and return each application to the Plan Administrator prior to the 15th of the month if you want coverage for that month.

The length of time that you can make self-payments vary depending on the option you chose.

3. What if I am covered under the Dry Fund division?

The Plan Administrator will forward to you an Application for Continuing Benefits. If you wish to continue being covered for MSP, Group Life and AD&D benefits, forward the monthly application with your cheque to the Plan Administrator prior to the 15th of the month if you want coverage for that month.

Self-payments can be made for a maximum of six months.

PART 6 - DENTAL

1. What dental coverage is provided?

The Dental plan will reimburse you for:

- Plan A - Basic Services, which include most routine dental services.
- Plan B - Major Restorative services, such as bridges, crowns and dentures.
- Plan C - Orthodontic services for correction of improper bite.

All expenses are reimbursed at the percentages indicated on your Pacific Blue Cross Dental ID card, and up to the current Pacific Blue Cross

Dental Fee Schedule. **You are responsible for charges in excess of the amounts shown in the Pacific Blue Cross Dental Fee Schedule.**

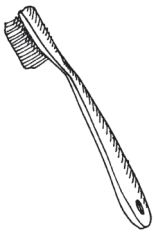
2. Should I get an estimate of dental costs before treatment?

Yes. You should ask your dentist for a verbal estimate of the cost of your proposed treatment. If the estimate is over $500, ask your dentist to determine the portion Pacific Blue Cross will cover before beginning the treatment. You can then decide if you wish to proceed with the treatment knowing your share of the cost, if any.

3. Are there any exclusions?

Yes. The Dental plan does not provide for:

- A course of treatment started prior to the effective date of coverage (excluding Orthodontia) or completed after the termination date of coverage.
- Expenses which are eligible for payment under your provincial government medical/hospital plans, any other government authority such as Workers' Compensation, or any other group or individual insurance policy.



- Charges for completion of claim forms or written reports, broken appointments, oral hygiene or nutritional instruction.
- Travel expenses for treatment.
- Additional charges made as a result of changing dentists.
- Extra charges for procedures which would normally be included in the basic service.
- Services and supplies for a full mouth reconstruction for a vertical dimension

correction, or for correction of a temporal mandibular joint dysfunction (jaw structure).

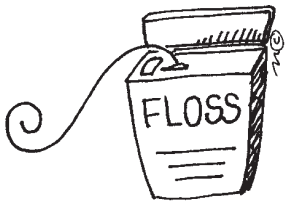
- Procedures to correct congenital malformations or for purely cosmetic reasons.
- Incomplete, unsuccessful or temporary procedures; recent duplication of services by the same or different dentists; drugs or medicines; pantographic tracings; osseous or tissue grafts; implants for dentures and bridgework.
- Intentional self-inflicted injuries while sane or insane.
- Expenses for which a third party is liable.
- Expenses relating to or as a result of war, riot or insurrection, or as a result of participating in active service of any armed forces.
- Expenses arising from a direct or indirect attempt at or commission of an indictable offense under the Criminal Code of Canada or under similar law of any other country.

4. What Basic Services are reimbursed under Plan A?

Most routine dental services are covered, including:

- Oral examinations (two per calendar year); cleaning and routine scaling (twice per calendar year); fluoride treatment (twice per calendar year); routine X-rays (limited to the equivalent of one full mouth series per calendar year);
- Consultations (as a separate appointment - twice per calendar year);
- Complete mouth X-rays (once every three calendar years);
- Fixed band and loop space maintainers to maintain space;

- Basic procedures necessary for the extraction of teeth, and other basic surgical procedures normally performed by a dentist;
- Fillings of amalgam, silicate, resin or composite materials;
- Stainless steel crowns (limited to once per tooth per two-year period);
- Gold inlays or onlays (once per tooth per five-year period) but only when there are three or more surfaces of the tooth to be restored, decay is evident on pre-treatment X-rays and one or more cusps are involved. The maximum benefit that will be paid per tooth is the dollar equivalent of a five surface filling per two year period. If less than three surfaces are treated, the amalgam equivalent for the restoration will be paid. X- rays and study models are required for approval by Pacific Blue Cross prior to start of treatment when an onlay or inlay, or a series of onlays or inlays, is planned;
- Gold foil, but only in cases of repair to existing gold restorations;
- Relining or repairing, but not remaking, of bridgework and dentures;
- Endodontic treatment, including root canal therapy (once per tooth per lifetime);
- Periodontic treatment of gums;
- Anesthesia used during oral and periodontal surgery (limited to a combined maximum payable of $170 per calendar year);
- Emergency Basic Services treatment which is incurred while traveling or on vacation outside the province, or Canada.



5. What Major Restorative services are reimbursed under Plan B?

The following Major Restorative services are covered:

- Crowns (for rebuilding natural teeth when other restorative material cannot be used);
- Bridges, onlays and/or inlays involved in bridgework;
- Partial dentures:
- Complete upper and lower dentures.

These items will only be replaced if they are at least five years old and cannot be repaired. Lost, stolen or broken dentures will not be replaced.

6. What Orthodontic services are reimbursed under Plan C?

Corrections for malocclusions (improper bite) are covered, with a maximum lifetime benefit of $2,000 per person. Lost, stolen or broken appliances will not be replaced.

Before the start of orthodontia work, ask the orthodontist to complete and submit a treatment plan to Pacific Blue Cross for approval. Orthodontic claims will not be processed until Pacific Blue Cross has approved the treatment plan.

7. How do I submit a claim?

Present your Dental identification card and ask the dentist to bill Pacific Blue Cross directly. You are responsible for any portion not covered by the Dental plan. If you pay the dentist directly, you will be reimbursed for your eligible portion of the cost. Claims must be submitted within one year of treatment and will not be paid if submitted after that time.

PART 7 - EXTENDED HEALTH CARE

1. What does the Extended Health Care (EHC) plan provide?

The Extended Health Care plan will reimburse you for the cost of many medical expenses not covered by provincial medicare. The percentage you will be reimbursed is indicated on your Pacific Blue Cross EHC ID card.

2. Is there a deductible?

Yes. The deductible is $25 per calendar year.

3. Is there an overall financial limit on claims?

No. However, certain types of coverage also have individual limits as noted below.

4. What expenses are eligible for reimbursement?

- Prescription drugs and medicines up to a maximum of 34 days supply per prescription. If you can satisfy Pacific Blue Cross that a larger supply is necessary and more economical, a larger supply may be prescribed up to 100 days per prescription. (Excluded are drugs or supplies used to suppress an addiction including those for smoking cessation, or for contraceptive or fertility purposes, vitamin injections or preparations, food and mineral supplements, preventative vaccines, drugs which do not by law require a prescription or drugs which are not approved under the Food and Drug Act for sale and distribution in Canada, and drugs which have not been authorized for payment under Pharmacare).

- You will be reimbursed the percentage shown on your EHC ID card for the cost of approved prescription drugs, up to BC Pharmacare's annual deductible. Pharmacare will reimburse 70% of the cost in excess of their deductible. The balance left after Pharmacare's payment will be reimbursed at 80% by the EHC plan.
- Corrective lenses and frames, and contact lenses (excluding eye examinations and non-prescription sun glasses or safety goggles). The maximum benefit is $200 per person per 24 month period.
- For dependent children under age 16, expenses incurred for special problems of visual acuity recommended by a registered ophthalmologist. The maximum benefit is $300 per child per 36 month period.
- Additional costs for semi-private or private accommodation in an approved hospital or its extended care unit. Rental charges for telephones, televisions, radios and other similar equipment are not covered.
- Services of licensed or registered chiropractors. The maximum benefit is $200 per person per calendar year.
- Services of licensed or registered naturopaths. The maximum benefit is $200 per person per calendar year.
- Services of licensed or registered podiatrists (including X-rays but excluding appliances). The maximum benefit is $200 per person per calendar year.
- Services of licensed or registered massage practitioners when recommended by the attending physician. The maximum benefit is $250 per person per calendar year.
- Services of licensed or registered physiotherapists (including X-rays). The maximum benefit is $250 per person per calendar year.

- Services of licensed clinical psychologists when recommended by the attending physician. The maximum benefit is $200 per person per calendar year.
- Services of registered speech language pathologists when recommended by the attending physician. The maximum benefit is $100 per person per calendar year.
- Services of a registered private duty nurse for acutely ill patients when recommended by the attending physician. The maximum benefit is $10,000 per person per calendar year. The maximum lifetime benefit is $25,000 per person.
- Services of a Christian Science Practitioner if listed in the Christian Science Journal.
- Reasonable and customary fees for acupuncture treatments.
- Diabetic supplies such as insulin, syringes, needles, litmus-type testing material, electronic blood glucose monitors and insulin infusion pumps, when prescribed by an attending physician. Pump supplies are not covered. The maximum lifetime benefit for a glucometer is $250 per person.
- Reasonable and customary charges for the purchase or rental (up to the purchase price) of a manual or electric wheelchair, scooter, hospital bed (manual type), iron lung, respirator or cardiac screener, when ordered by the attending physician. Expenses in excess of $5,000 must be approved in advance by Pacific Blue Cross.

- Reasonable and customary charges for oxygen, oxygen equipment, blood and blood plasma, crutches, splints, casts, trusses, ostomy and

ileostomy supplies, braces and permanent prostheses (artificial limbs and eyes, and mastectomy forms) when ordered by the attending physician. The plan will also pay for the repair or replacement of worn prostheses and braces.

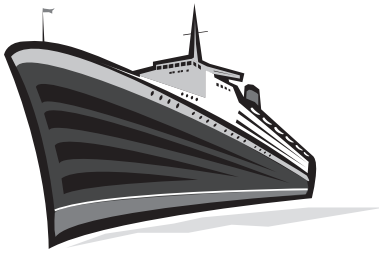
- Wigs or hairpieces needed as a result of medical treatment or injury when ordered by the attending physician. The maximum lifetime benefit is $500 per person.
- Charges for two pairs of surgical stockings per person per calendar year, and two mastectomy brassieres per person per lifetime, when required as a result of medical treatment for injury or illness.
- Charges for one pair of custom fitted orthopedic shoes per calendar year (including repairs), and one pair of custom made foot orthotics per calendar year (and replacements when necessitated by normal wear and tear). The combined maximum benefit for shoes and orthotics is $750 per adult and $500 per dependent child per calendar year. The order of a physician, podiatrist, or chiropractor is required plus written confirmation from the provider indicating the shoe or orthotic was specially designed and made from a 3-D volumetric model of the lower leg and/or foot using raw materials. **Contact Pacific Blue Cross or the Plan Administrator for an orthopedic shoe or custom foot orthotics claiming checklist before incurring any expenses and to obtain a copy of the required Orthopedic Shoe Fabrication Form, or Orthotic Fabrication and Casting Form which must be submitted with the claim.**
- Dental treatment for accidental injuries. The treatment must be performed by a registered dentist and must be completed within 52 weeks of the accident. For an injury to be defined as accidental, it must be the result of a direct blow to the external mouth or face

resulting in damage to the prosthetic or natural teeth. An injury caused by putting an object wittingly or unwittingly in the mouth does not qualify for coverage. Payments will not be made for temporary, duplicate or incomplete procedures, or for correcting unsuccessful procedures. Payment is based on the Pacific Blue Cross Dental Fee Schedule.

- Hearing aids when prescribed by certified ear, nose and throat specialists or supplied by recognized audiologists on the recommendation of a physician. Repairs, maintenance, batteries and recharging devices are not covered. The maximum benefit is $400 per person per four-year period.

5. What does the plan cover for emergencies that come up while traveling?

- Emergency medical care while traveling or on vacation outside BC or outside Canada.
- For a medical emergency in BC, transportation by licensed ambulance service to the nearest Canadian hospital equipped to provide the required treatment. In an acute emergency, air transport will also be covered. If an attendant is required, his/her transportation expenses will be covered as well.
- For a medical emergency outside of BC, air ambulance from the out-of-province hospital to the hospital nearest your residence. The service must be requested by the attending physician. Expenses in excess



of $1,000 must be approved in advance by Pacific Blue Cross.

- Charges incurred outside of BC as a result of a medical emergency are reimbursed at 100%.

6. If I or one of my dependents has to travel to another location for medical treatment or tests, does the plan reimburse me for my lost wages, and for hotel, food, gas, and other expenses?

No, unfortunately the coverage provided by the plan does not include those types of expenses.

7. What else does the plan not cover?

- Dentures or dental treatment (except as specified).
- Professional services of physicians and surgeons in BC or any person who renders a professional health service (except as specified).
- Expenses which are eligible for payment under your provincial government Pharmacare/medical/hospital plans, any other government authority such as Workers' Compensation, or any other group or individual insurance policy.
- Expenses incurred prior to the effective date of coverage or incurred by an employee or dependent (other then a newborn infant) hospitalized on their effective date of coverage.
- Charges for completion of claim forms or written reports.
- Drugs and medicines not eligible for reimbursement under the BC Pharmacare Plan, or those that can be bought without a written prescription.
- Remedies prescribed by a naturopath or a podiatrist, HCG injections, services of

Victorian Order of Nurses or Graduate or Licensed Practical Nurses, services of religious or spiritual healers, occupational therapy and rest cures.

- Elastic stockings, air humidifiers and purifiers.
- Transportation charges incurred for health reasons (except as outlined on pages 16 and 17), health examinations of any kind, elective treatment and/or diagnostic procedures and charges incurred for purely preventative purposes.
- Charges incurred while outside your province of residence for: 1) pre-existing conditions requiring continuous or routine medical care; and 2) expenses due to therapeutic abortion, childbirth, or complications related to pregnancy occurring within two months of the expected delivery date.
- Services and supplies for cosmetic purposes.
- Expenses resulting from intentional self-inflicted injuries while sane or insane.
- Expenses resulting from suicide or attempted suicide.
- Expenses in which a third party is liable.
- Expenses relating to or as a result of war, riot or insurrection, or as a result of participating in active service of any armed forces.
- Expenses arising from a direct or indirect attempt at or commission of an indictable offence under the Criminal Code of Canada or under similar law of any other country.

8. How do I submit a claim?

Obtain an Extended Health Care claim form from the Plan Administrator. Complete and sign the form and attach all original receipts and required

documentation. As Pacific Blue Cross does not return the original receipts, you should keep a photocopy of them before submitting your claim to Pacific Blue Cross for reimbursement. Claims should be submitted within three months of the expense. Expenses incurred during a calendar year must be submitted by June 30 of the next year and will not be paid if submitted after that time.

Save the Remittance Statement and attachments returned to you with your reimbursement cheque. You may need them for reimbursement from BC Pharmacare or for Income Tax purposes. If your family's eligible Pharmacare expenses are more than the Pharmacare deductible, you must claim reimbursement from BC Pharmacare.

9. How do I submit a claim for emergency medical expenses incurred while traveling outside of BC or outside of Canada?

The provincial Medical Services Plan (MSP) and the Extended Health Care plan (through Pacific Blue Cross) share most of the cost of such medical expenses. Pacific Blue Cross has been authorized to pay claims for MSP. Therefore, you only need to submit your claim once through Pacific Blue Cross.

Call the Plan Administrator for the Pacific Blue Cross and MSP claim forms used for claiming these expenses. Complete and sign both forms. and attach all original receipts and required documentation. Then submit them to Pacific Blue Cross for reimbursement.

10. Is there any help available if a medical emergency happens outside of Canada?

Yes. You and your dependents are covered for "Worldwide Emergency Medical Assistance" under Medi-Assist Group No. 549 issued to Pacific Blue Cross covered members.

In emergencies which occur while traveling, Medi-Assist will coordinate the following services:

a) locate the nearest appropriate medical care;

b) obtain consultative and advisory services and supervision of medical care by qualified licensed physicians;

c) investigate, arrange and coordinate medical evacuations and related transportation needs;

d) arrange and coordinate the repatriation of remains;

e) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your dependents may require when in distress.

Before you leave Canada, make sure you have your "Worldwide Emergency Medical Assistance" ID card with you. The back of the card provides the telephone numbers to contact Medi-Assist.

If you need help in an emergency:

a) Call the nearest number listed on the back of the card;

b) If necessary, call collect or contact the local telephone operator for help in placing your call to Medi-Assist;

c) Have your EHC ID number and Medi-Assist group number ready for personal identification as both numbers are required.

Charges for the above referral services are 100% covered under the Plan and are not subject to a deductible.

PART 8 - SHORT TERM DISABILITY

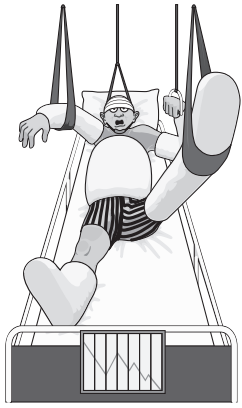
1. What does Short Term Disability (STD) provide?

Short Term Disability provides you with a bi-weekly income if you are unable to work due to a disabling non-work related illness or injury. Contact the Plan Administrator if you are covered under the Dry Fund division to find out if your company is covered for STD.

2. When do these benefits begin?

STD payments will be paid from the latest of the following dates:

- The fourth day of disability due to an illness;
- The first day of disability due to an accident;
- The day you were first seen by a physician after becoming disabled.



The STD benefit is calculated on a seven-day workweek basis, which includes Saturday and Sunday. Benefit cheques are issued every two weeks.

3. How much are my STD benefits?

Contact the Plan Administrator for your weekly benefit amount and to find out if you are covered.

STD benefit payments will be reduced to 75% of your basic earnings, if your STD weekly benefit amount exceeds that percentage.

4. Are my STD payments tax-free?

No. Your STD payments are considered taxable income. You can either pay the Income Tax owing on your disability income when you file your Income Tax return, or you can have Co-operators withhold Income Tax from your monthly payments. Contact your claims examiner if you wish to have tax deducted each month.

5. How long will STD be paid?

STD payments will be made for a maximum of 52 weeks as long as you are under the care of a physician, continue to be medically unable to return to work, and do not start to receive a retirement pension.

If you are under a chiropractor's care, STD payments will be made for a maximum of four weeks.

STD will also be paid for a maximum of two weeks if you are prevented from working due to a dental problem and are being treated by the appropriate dental practitioner.

6. Will the plan allow me to return to work gradually?

Yes, provided there is full agreement from you, your attending physician, your employer, and the claims adjudicator, Co-operators. This is referred to as Rehabilitative Employment or graduated return to work.

The benefits paid to you by Co-operators will be reduced by 50% of your income earned during this rehabilitative or graduated work period. The combined total of your income cannot exceed 100% of your average weekly wage prior to the start of your disability.

7. If Workers' Compensation terminates my claim, can I apply for STD?

No. The Plan does not cover occupational accidents or any condition which entitled you to Workers' Compensation benefits.

8. What if I am injured by a third party, such as in a car accident and ICBC is involved?

This is referred to as a third party claim. No STD benefits are payable under the plan. However, if you have the right to recover money from a third party, as compensation for sickness or injury, but the liability of the third party has not yet been determined, you may apply for STD benefits. Before STD benefits will be paid, you must agree in writing to do the following:

a) Take all steps necessary to recover from the third party the total of the benefits paid in STD benefits, including directing your lawyer to repay to the plan the full amount of the benefit directly from any monies received pursuant to any judgment or settlement;

b) Pay all legal fees incurred in pursuing the action against the third party;

c) Repay to the plan the full amount of the benefits advanced to you in the event the claim against the third party is abandoned or settled without the written consent of the plan;

d) Satisfy all of the terms and conditions of the plan for eligibility and payment of STD as if you were totally disabled;

e) Enter into a Reimbursement Agreement with the plan setting out the terms and conditions for repayment of the benefits;

f) Consent to the release by the third party, or ICBC, of all information in their possession relating to your claim. In the event any of the above parties decline to provide the required information, you must provide such information that is in your possession as requested by the plan.

If you fail to comply with sub-paragraphs a) to f) above, then the plan may terminate STD benefits.

9. What if I am traveling outside of Canada and become disabled, can I apply for STD benefits?

Yes, after you return to Canada.

10. Are there any limitations under the STD plan?

Yes, your STD benefit will be reduced by other income you receive, or are entitled to receive from the following sources:

- Group insurance or wage continuation plans;
- Any employer in the form of salary or other payments due to employment termination (excluding benefits or income received from Rehabilitative Employment, vacation pay received from an employer, and banked overtime earned prior to the date you were disabled);
- Any other source, other than from CPP or a personal insurance policy.

Co-operators must be advised of all income received or payable from the above sources. You are required to provide either a statement of income received or payable, or proof your application for benefits has been declined.

11. What disabilities are not covered by this plan?

Benefits are not payable for disabilites:

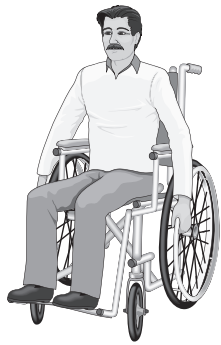
- to which the Workers' Compensation Act applies;
- which occur before you are insured or after you are terminated or laid off;
- if you are not under the care of a legally qualified physician, including a specialist where considered appropriate;

- caused by self-inflicted injuries while sane or insane;
- resulting from committing or attempting to commit a criminal offence, insurrection, war or participating in a riot;
- as a result of cosmetic medical or surgical care unless required as a result of an accidental injury;
- which occurred during full- or part-time service in any armed forces.

PART 9 - LONG TERM DISABILITY

1. What does Long Term Disability (LTD) provide?

Long Term Disability provides you with a monthly income if you are unable to work due to a disabling non-work related sickness or injury. Contact the Plan Administrator if you are covered under the Dry Fund division to find out if your company is covered for LTD.



2. When do these benefits begin?

LTD payments begin after expiry of Short Term Disability benefits.

3. How long will my payments continue?

Your payments will continue until you recover, start to receive a retirement pension, or reach age 65, whichever occurs first. You must also be under the supervision of a physician who is acceptable to the claims adjudicator, Co-operators, and following the treatment prescribed by your attending physician or specialist.

4. How do I qualify for LTD benefits?

You qualify for LTD benefits if, as a result of a disability caused by illness or injury, you are unable to do any work for which you are reasonably suited by education, training or experience.

5. Do I have to requalify for benefits if I return to work and then suffer a relapse?

You will not have to requalify if your disability reoccurs within 28 days of your return to work. However, if you suffer a different disability during this 28 day period, you will have to requalify for LTD benefits.

6. How much are my monthly LTD benefits?

Contact the Plan Administrator for the monthly amount and to find out if you are covered. Your LTD payments are co-ordinated with other income or disability benefits for which you may qualify.

7. Are my LTD payments tax-free?

No. Your LTD payments are considered taxable income. You can either pay the Income Tax owing on your disability income when you file your Income Tax return, or you can have Co-operators withhold Income Tax from your monthly payments. Contact your claims examiner if you wish to have tax deducted each month.

8. What happens if I qualify for other income or disability benefits?

Your LTD benefit will be reduced by other income you receive, or are entitled to receive, from the following sources:

- Group insurance or wage continuation plans;
- Any employer in the form of salary or other

payments due to employment termination (excluding benefits or income received from Rehabilitative Employment, vacation pay received from an employer, and banked overtime earned prior to the date you were disabled);

- Any other source, other than from CPP or a personal insurance policy.

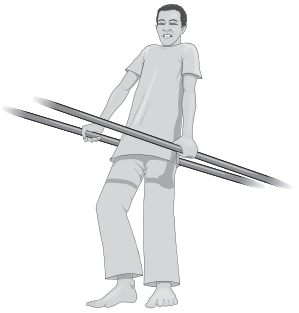
Co-operators must be advised of all income received or payable from the above sources. You are required to provide either a statement of income received or payable, or proof your application for benefits has been declined.

9. Will I continue to receive LTD benefits if I participate in a Rehabilitation Program?

Yes, if you receive advance approval from Co-operators and continue to participate in the approved Rehabilitation Program, or a similar program through another source. The program may include rehabilitate employment on a full-time, part-time or modified work basis, or rehabilitate assessment, treatment or other services such as training strategies.

10. What happens if I receive income from Rehabilitation Employment?

Your LTD benefit will be further adjusted so that your gross income from all sources does not exceed 100% of your pre-disability average gross monthly earnings.



11. Do any benefits continue when I'm receiving LTD payments?

MSP, EHC, Dental (50% of Plan A-Basic Services only), and your Group Life insurance will continue as long as you are receiving LTD.

12. If Workers' Compensation terminates my claim, can I apply for LTD?

No. The Plan does not cover occupational accidents or any condition which entitled you to Workers' Compensation benefits.

13. What if I am injured by a third party, such as in a car accident and ICBC is involved?

This is referred to as a third party claim. No LTD benefits are payable under the plan. However, if you have the right to recover money from a third party, as compensation for sickness or injury, but the liability of the third party has not yet been determined, you may apply for LTD benefits. Before LTD benefits will be paid, you must agree in writing to the following:

a) Take all steps necessary to recover from the third party the total of the benefits paid in LTD benefits, including directing your lawyer to repay to the plan the full amount of the benefit directly from any monies received pursuant to any judgment or settlement;

b) Pay all legal fees incurred in pursuing the action against the third party;

c) Repay to the plan the full amount of the benefits advanced to you in the event the claim against the third party is abandoned or settled without the written consent of the plan;

d) Satisfy all of the terms and conditions of the plan for liability and payment of LTD as if you were totally disabled;

e) Enter into a Reimbursement Agreement with the plan setting out the terms and conditions or repayment of the benefits;

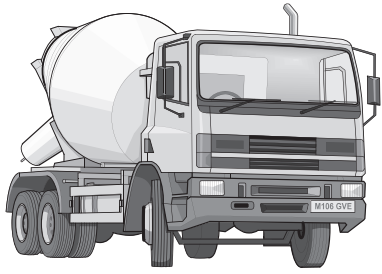
f) Consent to the release by the third party, or ICBC, of all information in their possession relating to your claim. In the event any of the above parties decline to provide the required information, you must provide such information that is in your possession as requested by the plan.

If you fail to comply with sub-paragraphs a) to f) above, then the plan may terminate LTD benefits.

14. What disabilities are not covered by this plan?

Benefits are not payable for disabilites:

- to which the Workers' Compensation Act applies;
- which occur before you are insured or after you are terminated or laid off;
- if you are not under the care of a legally qualified physician, including a specialist where considered appropriate;
- caused by self-inflicted injuries while sane or insane;
- resulting from committing or attempting to commit a criminal offence, insurrection, war or participating in a riot;
- as a result of cosmetic medical or surgical care unless required as a result of an accidental injury;
- which occurred during full- or part-time service in any armed forces.



PART 10 - GROUP LIFE INSURANCE

1. What is the amount of my Group Life insurance?

If you are covered under the Hour Bank division, the amount of your Group Life insurance is $61,000. Under the Dry Fund division, the amounts of insurance vary. Call the Plan Administrator to find out the amount of your Group Life insurance.

2. When is the insurance paid?

It is paid if you die from any cause while insured.

3. Who receives the benefit if I die?

The person you have indicated as your beneficiary on your enrolment card will be paid the insurance benefit provided they are at least 18 years old.

4. Can I designate my children as a beneficiary if they are under age 18?

Yes. However, as the children are minors, the insurance company cannot pay the insurance benefit directly to your children.

If you wish to designate your minor children, you can appoint a trustee to receive and disburse the Group Life insurance benefit. The advantage in naming a trustee is that the Group Life amount does not become part of your estate. Contact the Plan Administrator for the trustee appointment form, which must be completed and returned.

5. Can I designate my estate as my beneficiary?

Yes. A notarized copy of Probate will be required before payment can be made.

6. How do I change my beneficiary?

You may change your beneficiary at any time. If you wish to do so, it is your responsibility to obtain the required form from the Plan Administrator. Then return the completed form to the Plan Administrator.

7. What happens to my Group Life insurance if I am disabled and receiving LTD?

MSP, Group Life, EHC and Dental coverage will continue for as long as you are receiving LTD benefits. Under the Dental plan, only Plan A coverage is continued with reimbursement at 50%.

8. If I continue working past age 65, does my Group Life insurance continue?

Yes. You are covered for Group Life insurance until your 70th birthday.

PART 11 - ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

1. How much coverage does my AD&D insurance provide?

If you are covered under the Hour Bank division, your beneficiary will receive $25,000 in addition to the amount of your Group Life insurance, if you die accidentally. For example, your Hour Bank Group Life amount is $61,000 and, if you die accidentally, your beneficiary will receive $86,000 ($61,000 Group Life and $25,000 AD&D).

The amounts of AD&D insurance vary under the Dry Fund division. Call the Plan Administrator to find out the amount of your AD&D insurance.

If you die, suffer a dismemberment or permanently lose the use of a designated part of your body within one year of the date of the accident, the following benefit amounts are payable:

Loss	**% of Insured Amount Payable**
Life	100%
Both arms or both legs	100%
Both hands or both feet	100%
One hand and one foot	100%
One hand and sight in one eye	100%
One foot and sight in one eye	100%
Sight of both eyes	100%
One arm or one leg	75%
One hand or one foot	66-2/3%
Sight of one eye	66-2/3%
Thumb and index finger of one hand	33-1/3%
Speech and hearing in both ears	100%
Speech or hearing in both ears	66-2/3%
Hearing in one ear	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of both legs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Call the Plan Administrator if you have suffered a dismembering loss, or loss of use, to learn what defines a specific loss before claiming a dismemberment benefit.

If you are diagnosed after April 1, 1998 with a 'critical disease' while insured and prior to age 65, 10% of your AD&D insurance amount or 10% of $50,000, whichever amount is less, will be paid to you. You must be totally disabled from performing all occupations for at least nine months as a result of the 'critical disease'.

'Critical disease' includes:

- Alzheimers Disease,
- Amyotrophic Lateral Sclerosis (ALS),
- Huntington's Chorea,
- Multiple Sclerosis,
- Necrotizing Fasciitis,
- Parkinson's Disease,
- Peripheral Vascular Disease,
- Poliomyelitis, and
- Type I Diabetes (Insulin Dependent).

2. What happens if I suffer multiple losses in a single accident? Will I receive benefits for each loss?

You will receive benefits for one loss only (the most serious) resulting from a single accident.

3. Are there any other limitations on coverage?

Yes. If your employment continues after age 65, coverage ceases at age 70.

In addition, coverage applies only to bodily injury caused by an accident, and not as a result of medical care or treatment including surgery. It does not apply when the loss is caused by suicide, intentionally self-inflicted injury, participating in a riot, committing/attempting/provoking an assault or criminal offence, insurrection or declared or undeclared war or act of war, an air crash when you are the pilot or a member of the crew, or active service in the armed forces.

4. Who receives the benefit?

If you die accidentally, the beneficiary you select to receive your Group Life insurance will also receive your AD&D insurance. You are the beneficiary of all other benefits.

5. Does the plan provide other benefits in addition to those listed above?

Yes. Under specific circumstances, the plan may also cover some expenses related to rehabilitation, family transportation, home/vehicle modifications, spousal occupational training, continuation of a dependent child's education, or repatriation of remains. Contact the Plan Administrator for more details.

PART 12 - ADMINISTRATION

1. How is the plan administered?

The Union has appointed Trustees who have complete authority in operating the health and welfare plan. Only the Trustees can make changes to the plan coverage as they may deem necessary from time to time.

The Trustees are responsible for the design, administration and operation of the health and welfare plan, including the receipt of contributions, payment of benefits, and the investment and maintenance of the health and welfare fund.

In order to carry out these responsibilities, the Trustees have appointed a trust company which has custody of the health and welfare fund assets, an investment manager who directs investments, an actuary to advise on the design and operation of the health and welfare plan, a Plan Administrator to accept and record all information on contributions and hours and to maintain clerical records pertaining to each member, and auditors to audit and prepare the financial statements.

The Trustees may appoint other professionals such as legal advisors whose services may be

required. The Trustees may amend the plan terms, appoint new advisors, and change the custodian of the plan assets.

All contributions will be paid into the fund, and all benefits and expenses of operating the plan will be paid from the fund.

PART 13 - CLAIMS INFORMATION

Information can be obtained from your employer or from the Plan Administrator. The claim forms must be fully completed and submitted within the relevant time limits to ensure payment. If the forms have to be returned due to incomplete data, the claim cannot be processed quickly. Please ensure that all questions are answered on the forms and they have been properly signed by all parties.

Group Life and Accidental Death and Dismemberment

Contact the Plan Administrator to obtain the required claim forms.

Short Term Disability

All of the items set out below must be completed, and all forms submitted to Co-operators within 90 days of the date you became disabled or your claim will be denied.

Therefore as soon as possible after you become disable you should:

- See your doctor immediately (if you have not already done so);
- Obtain a claim form from the Plan Administrator;
- Complete the Employee Statement on the claim form and ensure that you have fully completed and signed the form;
- Have your employer complete the Employer Statement;

- Have your doctor complete the Physician Statement;
- Have all three completed statements sent to Co-operators as soon as possible.

Claims must be submitted within 90 days of your date of disability. **Claims submitted after this 90-day period will be declined.**

Long Term Disability

Claim forms and specific instructions will be provided by Co-operators.

Written proof of a claim must be submitted within three months from:

a) the expiration of your STD payments, or

b) the date you become eligible for LTD benefits, whichever is sooner.

No action or proceeding at law claiming LTD benefits may be brought against the Trustees unless commenced within two years from the expiration of the time within which written proof of claim is required.

Extended Health Care

You must attach your receipts to the claim form and complete all of the information that will identify you as a member. Receipts for small amounts should be accumulated and submitted at your convenience. All receipts for the previous calendar year must be sent in by June 30th of the following year.

Complete a claim form in accordance with the directions on the reverse side of the EHC claim form and submit it to Pacific Blue Cross along with your original receipts. The receipts should have sufficient information to identify the member of your family, the date on which the expense was incurred and the services provided, or the type of medication prescribed. Claims should be submitted as soon as you have accumulated eligible receipts in excess of the $25 calendar year deductible. Claim forms can be obtained from the Plan Administrator.

Pharmacare

BC Pharmacare provides for reimbursement to all BC residents for prescription drugs purchased in BC that are supported by an official BC Pharmacare receipt, and certain prosthetic appliances. BC Pharmacare reimburses 70% of prescribed drug expenses after their required deductible. Your Extended Health Care benefit is co-ordinated with BC Pharmacare so that there is not a duplication of payment.

Dental

Refer to page 11 of this booklet for instructions. Claims must be submitted 12 months from the date the claim was incurred.

Taxable Benefits

The premium paid on your behalf by the plan for the following benefits is considered taxable income by Canada Revenue Agency. Therefore, you will receive a T4A showing the premium amount paid for:

- Group Life insurance; and
- Medical Services Plan of BC (MSP).

Canada Revenue Agency will treat disability benefits paid to you from the claims adjudicator as taxable income and you will receive a T4A.

Time Limits

Claims for certain benefits must be brought within the times prescribed in this booklet or the relevant contracts. Failure to bring a claim within those time limits could result in your claim being denied.

Where claims have been denied and you wish to dispute that decision, it may be necessary for you to commence legal proceedings. Those legal proceedings must be commenced within the limitation periods provided by relevant contracts, the *Limitation Act* or the *Insurance Act*.

PART 14 - INSURANCE/BENEFIT FRAUD

Insurance or benefit fraud is defined as an intentional act or omission with a view to illegally obtaining a benefit.

Insurance/benefit fraud or abuse is a crime that directly affects all members covered under the Teamsters Local 213 Health and Welfare Plan. Not only does the plan pay the price for fraud - all members pay if the Trustees have to reduce benefits due to an increase in costs.

Fraud or abuse may be committed by:

1. Billing or claiming for procedures or services not provided.
2. Forging receipts or altering information on actual receipts.
3. Submitting claims for services or products not required or not received.
4. Falsifying claim information or a medical diagnosis to receive benefits.
5. Over-billing by service providers for procedures or services rendered.
6. Receiving disability benefits from more than one source for the same period.
7. Falsely stating that a person is unable to work.

Exclusion From Coverage

It is a criminal offense to represent a matter of fact that is known by the person making it to be false and that is made with a fraudulent intent to induce the person to whom it is made to act upon it.

Members of the Teamsters Local 213 Health and Welfare Plan who obtain, or attempt to obtain, a benefit under the plan to which they are not entitled (including a benefit which is greater than the benefit to which they are entitled), by submitting false, misleading or inaccurate information may, at the discretion of the Trustees be:

a) Refused payment of every such benefit;

b) Denied coverage under the plan:

c) Declared ineligible for any further benefits under the plan;

unless the member can establish that any discrepancy in the information submitted was due solely to a bona fide error on their part.

PART 15 - CONFIDENTIALITY OF YOUR PERSONAL INFORMATION

Your Social Insurance Number and other personal information will only be used for the purpose of managing and administering your health and welfare benefits.

When writing to the Plan Administrator include the following information:

1. Your name in full
2. Your Social Insurance Number
3. Your address
4. Your telephone number

When phoning:

1. Your name in full
2. Your Social Insurance Number
3. The name of your employer

FOR FURTHER INFORMATION

PLAN ADMINISTRATOR

Teamsters Local 213 Members Benefit Plans
490 East Broadway
Vancouver BC
V5T 1X3

Fax: (604) 872-4725

Vancouver and Lower Mainland

Telephone: (604) 879-8627

Other areas in BC and the Yukon

Toll Free 1-800-972-6241

Email: inquiries@teamsters213benefits.com

ADVISE THE PLAN ADMINISTRATOR IMMEDIATELY IF YOU CHANGE YOUR ADDRESS

CLAIMS ADJUDICATORS

Pacific Blue Cross

Dental
Extended Health Care

Co-operators Life Insurance Company

Short Term Disability
Long Term Disability
Accidental Death & Dismemberment

Great-West Life Assurance Company

Group Life