Getting to Know

Your Health Care Benefits

LiUNA! Local 1611
BC & YUKON

CSW Medical and Benefit Plan of BC

January 2026

Welcome to your health care benefits guide

All about the guide

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

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

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

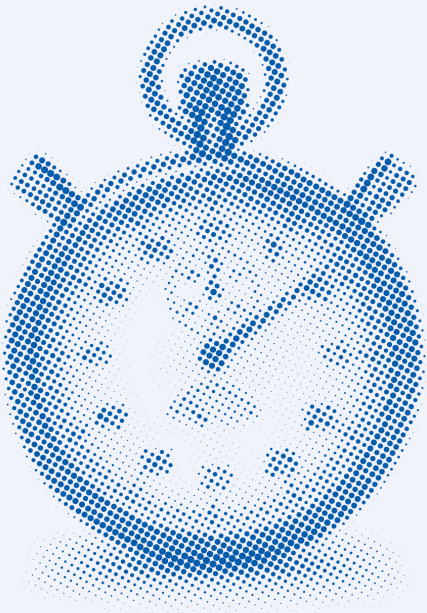
Keep your guide handy

This guide contains information about your Group Benefits. Please keep it in a safe place. It summarizes the principal features of your plan. All rights to benefits are governed by the group policies/contracts for the Plan.

Questions?

If you still have questions after reading this guide, contact the plan office at 604-538-6640 or toll-free at 1-800-964-3666. Or email us at benefits@liuna1611.org. Our staff will be pleased to assist you.

This edition of your health care benefits guide was produced in January 2026 and replaces any previous editions.



Starting your plan coverage

Who's eligible?

You are eligible to enroll for benefits if:

1. **You are a member in good standing of the Construction and Specialized Workers' Union Local 1611 with your union dues fully paid; and**
2. **You have worked at least 250 hours for a contributory employer within six continuous months. Note that hours drop from your hourbank after six months if you do not start coverage through the plan.**

If you are unsure if you are eligible, please call the plan office.

When does my coverage begin?

You are automatically enrolled for the life insurance & accidental death & dismemberment coverage and wage indemnity once you are a member in good standing with LiUNA 1611, and have 250 hours in your hour bank.

How do I enroll?

Once you are eligible for benefits, you will be sent a letter confirming the start date for Life Insurance & AD&D benefits. You will also be sent application forms to enroll for the Extended Health and Dental benefits. These forms must be returned to the Plan office in order for coverage for Extended Health and Dental to begin.

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

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

How does the hour bank work?

By the 15th of each month, your employer reports the previous month's hours you worked. Once 250 hours are reported, you and your dependents are eligible for coverage if you are a member in good standing..

An example of how the hour bank works:

Hours	Month worked	Month reported
120	January	February
100	February	March
120	March	April

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

This example assumes the following:

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

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

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

The effective date of enrollment would be May 1 for benefits.

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

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

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

Is my family covered?

Your family, or "dependents," are covered under the extended health and dental care portions of the CSW plan. A dependent includes:

- Your spouse means the person:
  - Legally married to the member or;
  - A person who has been residing with the member in a common-law or marriage-like relationship for at least 1 year;
  - Only one spouse is eligible for coverage under the Plan at any one time.
- Your unmarried children (including legally adopted children or stepchildren, as well as legal wards). A child may be covered as long as they are dependent on you and are:
  - 21 years of age or under and unmarried;
  - A full-time student at a recognized/accredited school, up to the age of 25 and unmarried; or
  - An unmarried disabled child of any age who is living with and is financially dependent on you and is incapable of self-sustaining employment.

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

What if I need to change my list of dependents?

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

ENROLLMENT CHECKLIST

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

- **Your personal information and a list of your dependents; and**
- **The BC Services MSP CareCard number for everyone listed.**

If you and your dependents are not BC residents, please provide the provincial medical plan numbers, for you and each of your named dependents:

- **You and your eligible dependents must be covered by a provincial medical plan in order to be covered for benefits.**

What if I'm laid off?

If you are laid off, you are still eligible for benefits. Your eligibility for benefits will continue for as long as your hour bank has enough hours and you remain a member in good standing with the local union. Once you run out of hours, self-payment options are available. See section Maintaining your coverage starting on page 42.

Coordinating benefits with a spouse

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

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

For example, our plan provides you with 60% reimbursement on major dental costs, but by also submitting your claim to your spouse's plan, you may be reimbursed for the remaining 40%.

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

Plan benefits for your family

How does it work?

The plan covers the following benefits:

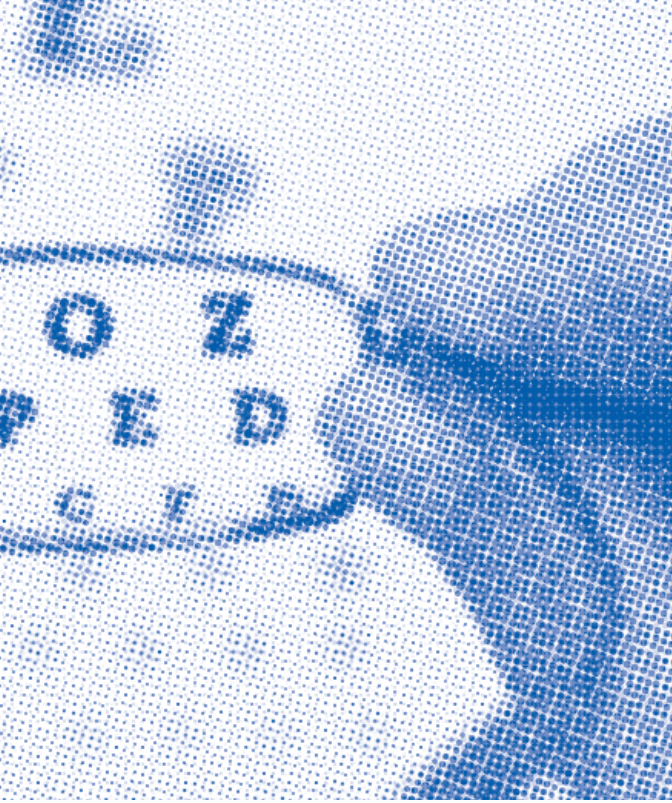
1. **Extended health care coverage** for things such as:
   - Prescription drugs
   - Private hospital room
   - Paramedical/Healthcare services
   - Vision care
   - Medical equipment
   - Emergency medical coverage while you are out of the province (LIMITED COVERAGE)
2. **Dental care coverage**
3. **Life insurance coverage & Accidental Death & Dismemberment**
4. **Dependent life insurance**
5. **Wage indemnity coverage** you maybe eligible to receive a portion of your wages while you are unable to work due to illness or injury.

If you have accumulated enough hours for coverage and completed enrollment forms, you will have coverage for all of the items listed above.

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

CHECK YOUR COVERED DEPENDENTS

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



Benefits at a glance

Throughout this guide, you will find the specifics of the benefits available through the Construction and Specialized Workers' Medical and Benefit Plan of BC. To give you a general overview of your available benefits, a brief summary has been provided for reference. For more detailed descriptions of your coverage, simply go to the designated section in this booklet.

Benefit	Coverage
Extended health All Benefits Plan	• 100% reimbursement (up to certain limits for some services or products) • **Pharmaceutical drug costs:** 100% reimbursement for eligible prescription medications (subject to limitations). See page 15 for details. • Your maximum covered costs during the lifetime of each plan member is $200,000 under the Full & Partial Plan, $100,000 under the Retire Plan.
Dental Full Benefits Plan Partial Benefits Plan	• **Basic services:** 100% reimbursement • **Major services:** 70% reimbursement All Basic and Major services have a combined annual limit of $4,000 per person • **Orthodontic services:** 60% reimbursement to a lifetime limit of $6,000 per person • (Pacific Blue Cross fee schedule)
Life insurance	**Full Benefits life insurance:** • Member – $100,000 **Partial Benefits life insurance:** • Member – $100,000 **Full/Partial Benefits life insurance:** • Spouse – $10,000 **Retiree Benefits life insurance:** • Member under age 65 – $100,000 • Member age 65 to 69 – $12,500 • Member age 70 to 74 – $6,250 • Member age 75 and over – $2,500 **Retiree Spouse's life insurance:** • Member under age 65 – $10,000 • Member age 65 to 69 – $10,000 • Member age 70 to 74 – $6,250 • Member age 75 and over – $2,500 **Life insurance for covered dependent children:** $5,000

Benefit	Coverage
Accidental death and dismemberment benefits	• **Full Benefits coverage:** Member is under age 70 – $100,000 **Note:** Members over age 70 who are still working are not eligible for accidental death and dismemberment benefits. • **Partial Benefits coverage:** $100,000 • **Retiree Benefits coverage:** Member is under 65 years of age – $100,000 Retirees over age 65 are not covered for accidental death and dismemberment benefits.
Wage indemnity coverage Full Benefits Plan	Your wage indemnity coverage works with the federal Employment Insurance (EI) benefits to provide an ongoing income for up to 46 weeks. • The plan pays wage indemnity during the first week of disability, which usually equates to the one week Employment Insurance waiting period (if one is applied). • Employment Insurance then pays benefits for up to the next 26 weeks (as long as the member continues to qualify for benefits). • The plan continues to pay 19 weeks of wage indemnity benefits from the date Employment Insurance Sickness Benefits end (as long as the plan receives proof of continued disability).

Your pay-direct drug card

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

How to use your card

Using your new Pacific Blue Cross Indentification card is easy.

1. Prior to paying for your prescription, provide your pharmacist with your drug card. They will enter your patient information, along with the prescription and carrier information, to transmit your claim directly to Pacific Blue Cross.
2. The system will check that the drug is eligible for coverage and that the your coverage is active.
3. The system will then check on any applicable plan limits to determine the amount covered by your plan. The pharmacist will inform you of the out-of-pocket total.
4. Along with your prescription, the pharmacist will provide you with a detailed prescription receipt. This will further outline the out-of-pocket and covered amounts. Keep this for your records.

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

Where can I use my Healthcare card?

Your Healthcare card can be presented at your dental office, and for other healthcare/paramedical expenses. Other expenses can be claimed online or by submitting a paper claim form. Details on how to claim online can be found on the Pacific Blue Cross website @ pac.bluecross.ca

What do I do if I lose my card?

For replacement drug cards, you can contact the plan office at 604-538-6640 or toll-free at 1-800-964-3666. Or log onto your Pacific Blue Cross account and request a replacement card.

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

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

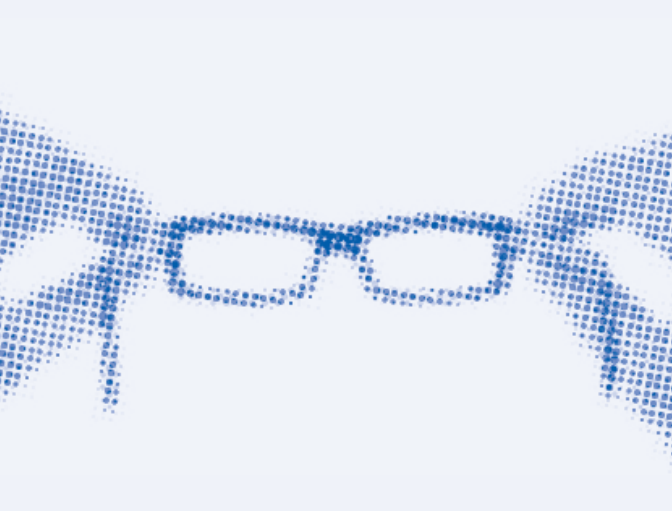
Basic medical coverage

Full Benefits Plan

Your basic medical coverage, provided by British Columbia Medical Services Plan (MSP) program, is not included in your coverage.

If you are a BC resident, you must be enrolled in BC MSP, or a resident in another province must have current provincial medical, in order to be covered for the extended health and dental benefits. This is the basic health plan available to all BC residents. If you are a BC resident and not enrolled in MSP, you should enroll.

Details on how to enroll for BC MSP are available on the BC MSP website @ www2.gov.gc.ca



Extended health care coverage – all plans

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

Here's how your coverage works:

- All services are reimbursed to you at 100%, up to certain limits for some services or products.
- Your pharmaceutical drug costs are reimbursed at a rate of 100% for eligible prescriptons.
- The plan limits pharmacy mark-ups to 8%.
- Reimbursement of eligible drugs will be subject to the BC provincial plan's prices, including the provincial plan's low cost alternative price, reference drug programs price and maximum allowable price.

If Pacific Blue Cross receives written confirmation from the prescribing Practioner that there is a specific adverse effect that prevents the Member from taking the generic, the full ingredient cost of the multi-source brand drug plus markup will be eligible.

The markup is eligible up to 8% of the manufacturer's list price.

Coverage maximums:

- **Full and Partial Plan** – Your maximum covered costs during the lifetime of each covered person is $200,000
- **Retiree Plan** – Your maximum covered costs during the lifetime of each covered person is $100,000

Is there a health plan deductible?

There is no deductible

Pacific Blue Cross (our carrier)

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

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

Group number: E902780
for Retiree coverage

What's covered?

Your benefits are divided into two groups:

Health care services

- Complementary and alternative health services
- Emergency services
- Nursing services
- Prostate testing
- Psychology
- Vision care

Health care drugs, equipment and supplies

- Drugs and medicines
- Hearing aids
- Medical supplies and equipment
- Orthotics and orthopedic shoes

Health care services

All practitioners must be registered in the province where the service is provided.

What's covered	Coverage and conditions
Complementary and alternative health services	
The following practitioner services are covered according to the limits noted: • Acupuncturist • Chiropractor • Massage therapist • Naturopath • Physiotherapist • Podiatrist • Speech therapist	• 100% claimable • For each type of service listed, your maximum coverage is $1,200 per calendar year. • **Note:** X-rays are not covered. • Reasonable and Customary Limits apply.
Emergency services	
Private or semi-private hospital rooms (acute or extended care)	• 100% claimable • A doctor must require you to be in a hospital or an extended care unit.
Emergency ambulance	• 100% claimable • Restrictions may apply. • Contact the Pacific Blue Cross Call Centre for details & restrictions.
Nursing services	
In home registered nursing services	• Contact the Pacific Blue Cross Call Centre for details and restrictions. • Doctor's note required
Prostate testing	
Testing	• 100% claimable
Psychology	
Registered psychologist Registered counsellor	• 100% claimable • Maximum $4,000 per calendar year

What's covered	Coverage and conditions
Vision care	
The following items are covered according to the limits noted in the right-hand column: • Frames • Prescription sunglasses • Prescription lenses, frames • Prescription safety goggles • Vision care repairs • Laser eye surgery	• 100% claimable • Combined maximum of $800 per person every 24 months from date of service
• Eye exams	• $100 for a routine eye exam per person every 24 months from date of service
Lens implant	• Two items per person per lifetime with a maximum of $500 per person per item • Doctor's note required

Fair PharmaCare program

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

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

- **By phone:** 604-683-7151 or 1-800-663-7100
- **Online:** www2.gov.bc.ca
- **By mail:** You must complete, sign and return a registration and consent form.

Health care drugs, equipment and supplies

What's covered	Coverage and conditions
Drugs and medicines	
Eligible Prescription medication (PharmaCare or non-PharmaCare)	• 100% reimbursed • 8% pharmacy mark-up limitation • Must be dispensed by a licensed pharmacist
Erectile dysfunction drugs	• 100% reimbursed • Must be dispensed by a licensed pharmacist
Fertility drugs	• 100% reimbursed • Lifetime maximum of $10,000 • Must be dispensed by a licensed pharmacist
Insulin preparations for diabetics	• 100% covered • Must be dispensed by a licensed pharmacist
Obesity drugs	• 100% reimbursed • Must be dispensed by a licensed pharmacist
Oral contraceptives	• 100% reimbursed • Must be dispensed by a licensed pharmacist
Smoking cessation drugs	• 100% reimbursed • Lifetime maximum of $300 • Must be dispensed by a licensed pharmacist
Drugs used to treat or replace an addiction or habituation	• 100% reimbursed • Must be dispensed by a licensed pharmacist
Shingrix vaccine and other shingles vaccines	• 100% reimbursed • Must be dispensed by a licensed pharmacist

What's covered	Coverage and conditions
Hearing aids	
Hearing aids and hearing aid repairs	• 100% claimable
Adult	• Combined maximum of $4,000 per adult every five years
Child	• Combined lifetime maximum of $1,000 per child with an additional benefit of $1,000 in a five-year period per child
Orthotics and orthopedic shoes	
Orthotics	• 100% claimable if custom-made • Annual maximum of $700 per person; doctor's note required **Note:** A custom-made orthotic or orthopedic shoe is one made from raw materials and specially designed for the patient using a three-dimensional volumetric model of the patient's foot and lower leg.
Orthopedic shoes	• 100% claimable if custom-made • Combined lifetime limit of one pair per person and shoe repairs; doctor's note required

Out of province/Out of country

Out-of-province expenses are subject to the Plan limit. If travelling outside of Canada, you should obtain extra medical insurance.

Medical equipment and supplies

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

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

- AeroChamber devices
- Blood glucose monitors
- Canes, casts, crutches, splints and walkers
- CPAP machine and supplies (doctor's note required)
- Manual hospital beds: purchase, rental and repairs (doctor's note required for purchase and rental)
- Mastectomy brassieres (limited to one mastectomy brassiere per breast prosthesis to a maximum of two per lifetime)
- Mastectomy forms
- Ostomy supplies
- Oxygen and oxygen supplies (doctor's note required)
- Prosthetics
- Stump socks - $250.00 per calendar year
- Surgical stockings (limited to two items per person per calendar year; doctor's note required)
- Wheelchairs: rental, purchase or repairs of electric, manual or scooter (doctor's note required for purchase and rental)
- Wigs (lifetime limit of $500; doctor's note required)

How do I make an extended health care claim?

Making a health care claim

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

PACIFIC BLUE CROSS

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

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

PACIFIC BLUE CROSS CALL CENTRE

Extended health: 604-419-2000

Dental: 604-419-2000

Toll-free: 1-877-722-2583

Fax: 604-419-2990

Website: www.pac.bluecross.ca

How to submit a health care claim

- Complete the claim form.
- Include original receipts.
- Provide an explanation or proof to support the claim, such as itemized bills, an attending physician's statement or any other information related to the expense.
- **Create an online account with Pacific Blue Cross at www.pac.bluecross.ca**
- **You can also claim some expenses online.**

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

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

Payment of the claim will be sent to you unless Pacific Blue Cross agrees to your request to assign payment directly to a third party.

Out-of-province limit

If you're travelling, make sure to buy additional travel insurance

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

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

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

How is my benefit amount calculated?

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

To determine the benefit amount payable, follow these steps:

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

Note: No coverage is available for expenses billed before you are enrolled in the plan or after your coverage has been cancelled.

What's not covered?

We are proud to offer you and your dependents comprehensive coverage under your health care benefits plan, but there are a number of items

that may not be covered. It's important to check to be sure.

Below is a sample of some of the items not covered under your extended health care plan:

- Medical laboratory services and x-rays
- Vitamins and/or minerals
- Arch supports
- General anaesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada and medications available without a prescription
- Allergy testing unless rendered by a naturopath
- Charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-shareable or capital costs levied by local hospitals, or charges for translating documents into English
- Out-of-province expenses incurred due to elective treatment and/or diagnostic procedures or complications related to such treatment
- Any drug, vaccine item or service classified as preventative treatment or administered for preventative purposes. With the exception of the shingles vaccine (see page 18).
- Orthodontic repair that is required as a result of a dental accident

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

DEADLINES FOR YOUR CLAIMS

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

A claim claim received by Pacific Blue Cross after June 30 of the calendar year following the year in which the expense was incurred will not be considered and you will not be compensated.

Dental care coverage

Full Benefits Plan

Partial Benefits Plan

Your dental plan provides coverage for services that help restore and maintain healthy teeth and gums. Your coverage is based on Pacific Blue Cross' dental fee schedule, which limits the frequency of some services, the types of services and the fees covered for the service.

Services must be provided by general practising dentists, dental hygienists, denturists or dental specialists.

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

1. **Basic services** such as exams, x-rays and fillings are reimbursed at a rate of 100%;
2. **Major services** such as crowns and bridges are reimbursed at a rate of 70%; and
3. **Orthodontic services** are reimbursed at a rate of 60%.

GET THE DETAILS BEFORE YOU PAY

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

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

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

Pacific Blue Cross (our carrier)

Group number: D902779 - Div 1 Class 1
for Full Benefits Plan coverage

Group number D902779 - Class 2 Div 2
for Partial Benefits Plan coverage

Important: All of the basic and major services listed have a combined annual limit of $4,000 per person. Orthodontics has a lifetime limit of $6,000 per person.

What's covered?

Dental care services

What's covered	Coverage and conditions
Exams	
New patient exams Recall exams	• 100% reimbursed • Combined annual limit of two per person
Specific exams	• 100% reimbursed • Annual limit of two per person
Complete exams (periodontist)	• 100% reimbursed • Limit of one per person every three years from date of service
Complete exams (general practitioner or specialist)	• 100% reimbursed • Combined limit of one per person every three years from date of service
X-rays	
Bitewing Periapical Panoramic film Complete series	• 100% reimbursed • Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre. • Additional limit: Panoramic film x-rays once every two years per person from date of service • Additional limit: Complete series x-rays once every three years per person from date of service
Preventative care	
Polishing and fluoride treatment	• 100% reimbursed • Annual limit of two each per person
Scaling and root planing	• 100% reimbursed

What's covered	Coverage and conditions
Night guards	• 60% reimbursed • Limit of two per person every five years
Gingival curettage Gingivectomy Occlusal adjustment/ equilibration Recontouring of teeth	• 100% reimbursed • Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre.
Space maintainers	• 100% reimbursed • Annual limit of one per quadrant per person from date of service
Pit and fissure sealants Preventative restorative resins	• 100% reimbursed • Combined limit of one per tooth per person every two years from date of service
Fillings	
Silver fillings for primary teeth Silver fillings for permanent teeth White fillings for permanent teeth	• 100% reimbursed • Per-person dollar limits subject to change. Contact the Blue Cross Call Centre.
Crowns and bridges	
Crowns (gold) Inlays Onlays Abutments Pontics Veneers	• 60% reimbursed, except inlays and onlays, which are reimbursed at 100% • Combined limit of one per tooth per person every five years from date of service
Stainless steel crowns	• 100% reimbursed • Limit of one per tooth per person every two years from date of service

What's covered	Coverage and conditions
Buildups Posts	• 60% reimbursed • Limit of one per tooth per person every five years
Repairs of inlays, onlays, crowns or veneers Repairs of bridges	• 100% reimbursed • Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre.
Dentures	
Complete or partial dentures	• 60% reimbursed • Combined limit of one per arch per person every five years
Repairs or additions	• 100% reimbursed
Adjustments Tissue conditioning	• 100% reimbursed • Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre.
Rebases Relines	• 100% reimbursed • Combined limit of one per arch per person every two years
Dental surgery	
Root canals	• 100% reimbursed • Limit of one per tooth per person every five years
Extractions Complicated extractions	• 100% reimbursed • Lifetime limit of one per tooth per person
Crown lengthening Osseous surgery	• 100% reimbursed • Per-person dollar limits subject to change. Contact the Pacific Blue Cross Call Centre.

What's covered	Coverage and conditions
Dental surgery *continued*	
Anaesthesia	• 100% reimbursed • Subject to Pacific Blue Cross fee schedule
Orthodontics	
Orthodontic services	• 60% reimbursed • Lifetime limit of $6,000 per person

Emergency dental coverage

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

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

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

How do I make a dental claim?

Making a dental claim

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

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

When the dental service is completed, the dentist will send the claim form directly to Pacific Blue Cross for payment. You will be required to pay the dentist the portion not covered by the plan.

Certain dentists may require you to pay the full amount of the claim up front and then claim directly from Pacific Blue Cross. All dental claims must be submitted to Pacific Blue Cross within 12 months of paying for services, or the claim will not be paid.

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

How to submit a dental claim

- Claims must be submitted within 12 months of the date of service. If you do not submit your claim within 12 months of the date of service, Pacific Blue Cross will not pay for the claim.
- If you pay the dentist, Pacific Blue Cross will reimburse you with the amount once they receive the claim form or receipts signed by the dentist.
- If you do not pay the dentist directly, Pacific Blue Cross will pay the dentist directly for services provided once they receive a claim form signed by the dentist certifying these services were performed and the fee charged.
- To claim orthodontic benefits, Pacific Blue Cross must receive:
    - A treatment plan (completed by the dentist) before treatment starts; and
    - Photocopies of receipts monthly, as treatment progresses.
- Pacific Blue Cross will pay benefits on diagnostic services, initial fees and monthly or quarterly treatment fees. If you pay any amount to the dentist in advance of completed treatment, Pacific Blue Cross will allow an initial payment amount and then pro-rate the balance into monthly payments throughout the treatment period.

CHECKING IN BEFORE MAJOR TREATMENTS

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

What's not covered?

Just as with your extended health care benefits, there are items that might not be covered under your dental coverage. It's important to check your coverage before undergoing any major dental treatment.

Below are a few services not covered under your dental care plan:

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

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

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

Insurance coverage

Your life and accidental death and dismemberment coverage

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

Your life coverage

	Member life Insurance	Spouse life insurance
Full Benefits Plan	$100,000	$10,000
Partial Plan and Retiree Plan member under age 65	$100,000	$10,000
Retiree Plan member age 65 to 69	$12,500	$10,000
Retiree Plan member age 70 to 74	$6,250	$6,250
Retiree Plan member age 75 and over	$2,500	$2,500

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

Accidental death and dismemberment

The plan provides members with a principal sum of $100,000 in coverage for accidental death and dismemberment (AD&D) claims. Plan members are eligible for this coverage if they are either:

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

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

Accidental death benefit

Should an accidental injury be shown to directly result in death, your beneficiary will be paid the full $100,000 benefit.

Accidental dismemberment benefit

Should accidental bodily injuries or critical disease be shown to result in the following losses, your beneficiary will receive a percentage of the $100,000 benefit, as outlined on the following page:

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

Surgical reattachment

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

Other eligible claims

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

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

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

How to make a claim

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

CHOOSING YOUR BENEFICIARY

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

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

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

If you do not designate a beneficiary, then the insurer will pay the benefit to your estate. There may be tax implications for not designating a beneficiary.

Wage indemnity benefits – Full Benefits Plan

Wage indemnity benefits are designed to help replace the wages lost if you suffer an injury or illness that isn't related to your work and are not able to work for an extended period of time. Your wage indemnity coverage works with the federal Employment Insurance (EI) sickness benefits to provide an ongoing income for up to 46 weeks.

Benefits are paid as follows:

- The plan pays wage indemnity during the first week of disability, which usually equates to the one-week Employment Insurance waiting period (if one is applied).
- Employment Insurance then pays benefits for up to the next 26 weeks (as long as the member continues to qualify for benefits).
- The plan continues to pay 19 weeks of wage indemnity from the date following the cessation of the Employment Insurance Sickness Benefits upon the plan receiving the required proof of disability.

The wage indemnity benefits amount is the same amount you would receive from Employment Insurance to their maximum (currently at $729.00 per week as of 2026) with a minimum weekly benefit of $300.00.

If a member does not qualify for EI Sickness Benefits, once the plan receives written confirmation, the plan will pay up to a maximum 38-week benefit as long as the member continues to be certified as disabled by his or her medical practitioner.

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

How do I apply for wage indemnity benefits?

To qualify for benefits from the date of disability, you must be seen by a physician within three calendar days of the date of disability. If you have not seen a physician within the three-calendar-day period immediately following the date of disability, the wage indemnity benefits will commence the date you see a physician.

Disability claims of six days or less have a three-day waiting period applied. If you have seen your physician within three calendar days of the date of disability, wage indemnity benefits will begin on the fourth day of injury or illness as indicated by your physician.

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

How to make a claim

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

Claims should always be submitted within 30 days of the commencement of the disability. If claims are submitted after 30 days and there are extenuating circumstances for this late claim submission, a letter of explanation must accompany your claim. Claims submitted late may be disallowed by the Trustees.

Amount of benefit

The full amount of the benefit is a combination of the wage indemnity from the plan and Employment Insurance. This plan pays the same amount you would receive from Employment Insurance with a minimum weekly benefit of $300. This is a taxable benefit, which means income tax of 10% is deducted and paid to the Canada Revenue Agency on your behalf.

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

Limitations and recurrence of former ailments

Your benefits are capped at a maximum 46 weeks (if you qualify for EI sickness benefits) for any one ailment. After 46 weeks, you can no longer make claims related to that ailment.

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

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

If the disability recurs:

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

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

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

What happens if I'm injured at work?

Wage indemnity for WorkSafeBC claims

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

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

The following conditions apply:

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

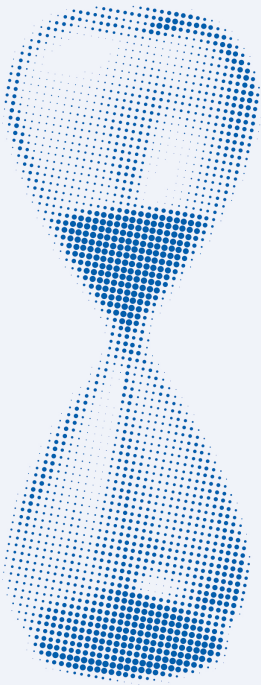
DISABILITY CREDITS

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

Will the plan always pay lost wages?

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

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



Maintaining your coverage

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

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

Your hour bank

How will my hour bank affect my benefits?

You need to have 250 worked hours within six consecutive months in your hour bank in order to be eligible for coverage. Once you are covered on the Plan, 125 hours will be withdrawn from your hour bank each month. Those hours can be replaced either through reported employer contributions or self-payment (see page 45).

Every month, 125 hours are removed from your hour bank. If you work less than that and don't have extra hours banked, you will need to top up your account with a self-payment in order to maintain your coverage.

How does my hour bank work?

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

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

If you work more than 125 hours in a month, the extra hours will be credited to your hour bank. This will allow you to continue coverage during periods where you are not working or are working less that 125 hours per month.

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

The hour bank may be credited with hours while a covered member is receiving Workers' Compensation wage loss or wage indemnity benefits. Please refer to the wage indemnity section starting on page 40 of this booklet.

What happens if I leave my employer?

If you leave your employer, hours are held in the

hour bank with 125 hours withdrawn for each month's coverage.

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

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

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

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

What is self-payment?

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

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

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

Choosing the right self-payment option

1. Full Benefits coverage

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

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

2. Partial Benefits coverage

If you have no hours left in your hour bank and are under age 65, you may self-pay to maintain Partial Benefits coverage with the plan. This coverage includes dental, extended health care, life insurance, dependent life insurance and accidental death and dismemberment benefits. This package does not include wage indemnity, or the application of disability credits. If you are self-paying for partial coverage, you will automatically revert to full coverage on the first month following the month in which worked hours appear in your hour bank.

3. Retiree Benefits coverage

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

The coverage provides you with life insurance, dependent life, extended health care and accidental death and dismemberment (under age 65) but no dental, wage indemnity.
A member who has Retiree coverage is not eligible to accrue disability credits.

For further details on self-payment options, including rates and application forms, please contact the plan office using the information at the back of this booklet.

When does my coverage end?

Your coverage will end if:

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

Once your coverage is cancelled, you have to start again and meet the basic conditions in order to re-join the plan.

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

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

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

While you are on wage indemnity or receiving wage loss benefits WorkSafeBC, hour bank credits are granted to members with Full Benefits coverage at a rate of 31.25 hours per week to a maximum of 125 hours per month to a maximum of 750 hours. This will maintain coverage for a maximum of six months.

How do I continue coverage if I am widowed?

Covered widows or widowers of deceased plan members may continue to self-pay for coverage. All benefits remain the same except for life insurance, which will follow the current dependent life schedule. Dependent benefits are paid only for dependents who were covered at the date of the member's death.

This coverage is offered on a one-time basis only. A separate group application form must be completed for this coverage.

How my spouse or dependents can continue coverage in the event of my death

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

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

It is important to be aware of your status in the plan. Once your coverage ends you will not be able to purchase hours to get back into the plan.

Are my benefits taxable?

Yes. Under existing tax rules, premiums for group life insurance, dependent life insurance and accidental death and dismemberment insurance are taxable benefits.

Each February, the plan office will send to you a T4A, which sets out this benefit. This amount must be included when completing your annual income tax return. Any self-payment you make into the plan during the year is deducted from the amount on the T4A, so you pay taxes only on the benefits you did not pay for directly.

NOTES

Disclaimer

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

Contacts

CONSTRUCTION AND SPECIALIZED WORKERS' MEDICAL AND BENEFIT PLAN OF BC

Mailing address:
Suite 100
19092 - 26th Avenue
Surrey, BC
V3Z 3V7

Telephone: 604-538-6640

Toll-free: 1-800-964-3666

Fax: 604-538-6680

Email: benefits@liuna1611.org

PACIFIC BLUE CROSS

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

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

BLUE CROSS CALL CENTRE

Extended health and Dental: 604-419-2000

Toll-free: 1-877-722-2583

Website: www.pac.bluecross.ca

Caresnet Account for online submission of claims: www.pac.bluecross.ca

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