

BCHA – UNITE HERE Local 40 Health Care Plan
The Barclay Hotel
Effective March 15, 2010

Group One Benefits

To Qualify - 360 hours or more over each three (3) consecutive month period to qualify the first day of the fourth (4) month and 360 hours to continue Health Care Plan eligibility.

(A) MEDICAL SERVICES PLAN OF B.C.

This coverage is available to all who qualify but as this is a **taxable benefit** members already covered under the Medical Services Plan of B.C. through their spouse or family, need not take out duplicate Medical Services Plan of B.C. coverage. The medical coverage is not required for Dental and/or other Health Care Plan Benefits.

Eligibility for MSP coverage is determined by the Medical Services Plan of B.C. You will be required to provide proof of Canadian citizenship or up-to-date immigration documents for yourself and each of your family members. You will be required to provide on-going proof of an overage dependent's attendance at school.

If your total family income is less than \$30,000 in a year, you may be eligible for a premium reduction. [Applications for this premium reduction](#) are available from the Office of the Administrator or our website www.armmanagement.ca.

The Medical Services Plan of B.C. is mandatory for all residents of British Columbia so please be certain to [complete an application](#) and apply for this coverage should you not be eligible for the coverage as a dependent with your spouse or family.

(B) ACCIDENT AND SICKNESS (WAGE LOSS) BENEFIT

An eligible participant will receive 75% of earnings, based upon the earnings of the 3 consecutive month period immediately prior to the month their claim commenced to a **weekly maximum of \$448.00**.

Duration/Claims Procedure:

1. All eligible persons should apply for Accident & Sickness Benefits by [completing a claim form](#) for both the BCHA - Union Local 40 Health care Plan as well as from Human Resources Development (EI) Canada as soon as possible,
2. During the initial two (2) week Human Resources Development (EI) Canada waiting period, all eligible persons will receive accident & sickness benefits from the Health Care Plan for the period of time they qualify (maximum initial payment = 14 days less any applicable waiting period),
3. All insured and eligible persons who continue to be disabled for a period greater than 14 days will apply to Human Resources Development (EI) Canada for accident & sickness benefit payable for their entire EI benefit entitlement period or a maximum period of fifteen (15) weeks, which ever is less, and
4. Those eligible persons who continue to be disabled, who have qualified for Human Resources Development (EI) Canada sickness benefits and who provide documentation satisfactory to the Board of Trustees and/or the Plan Administrator may apply for additional accident & sickness benefits from the Health Care Plan, payable for a maximum period of 28 weeks.

Under the terms of this Health Care Plan payment for any one ailment is limited to a maximum of 30 weeks. Claims will not commence until the claimant has been seen by a physician.

- In order to avoid any delays in processing your claim or commencement of your claim, **see your physician immediately, and promptly return the completed claim form to the Office of the Administrator.**
- If you are disabled because of an accident, benefits begin on the **first day** you are absent from work.
- If you are disabled because of illness, benefit payments begin on the **fourth day** you are absent from work.
- If you are admitted to hospital, benefits begin immediately.
- In all cases, benefits are not paid on days that would have been your A day off.
- In all cases, you must be under the care of a physician. The calculation of the benefit period does not begin until you have been seen by a physician.

(C) DENTAL CARE BENEFIT

Plan A (Basic) 90%, Plan B (Major) 80%, Plan C (Orthodontics) 50%

Coverage is based upon the Association of Dental Surgeons of BC 2010 Fee Guide for General Practitioners.

Benefit Year Maximum - \$2,100 per eligible plan member to a maximum of \$2,400 per family for Basic (Plan A) and/or Major (Plan B) Dental services.

Plan C (Orthodontics) Financial Limit - \$1,500 Lifetime maximum per eligible plan member for Plan C (Orthodontics). From December 16, 2009 forward Plan C Orthodontic services are payable to the Plan Participant regardless of age and Dependents who incur such expenses while under 19 years of age.

- Routine exams, cleaning and fluoride once per year per insured member and twice per year (at least 6 months apart) for dependent=s age 18 or less.
- A treatment plan & supporting x-rays should be submitted to the Administrator to determine benefit eligibility prior to the treatment being performed when the treatment is expected to exceed \$400.00.

Note Re: Dental Eligibility

To become eligible for the Dental Plan for the first time you must have worked at least three (3) months and A come on the Plan as a Group One or Group Two participant as described throughout; THEN, you must remain covered as a Group One or Group Two participant for four (4) consecutive months. Your coverage then begins the first day of the month following this qualifying period. Once you have met this four (4) month qualification, you will not have to serve an additional four (4) month waiting period should your hours fall below the 240 minimum required.

(D) EXTENDED HEALTH CARE (MAJOR MEDICAL) BENEFIT

90% co-insurance, No deductible, Generic Drug Policy - \$2,000 Annual Maximum for Prescription Drugs

Lifetime maximum of \$25,000 for each participant and dependent and \$50,000 in the aggregate for the participant and all of his/her dependents.

British Columbia Fair Pharmacare Plan – Adopted May 1, 2003

This government-sponsored plan assists with the cost of prescription drugs. After satisfying an annual deductible, Fair Pharmacare pays 70% of eligible prescription drugs which may include the lowest cost alternative to the drug your doctor prescribes. Your pharmacist will advise you of the low cost alternative and you will have the choice of the low cost alternative or the higher cost brand name drug. If you select the higher priced drug, you will be required to pay the full cost and submit the claim to the Office of the Administrator for reimbursement, if you qualify.

- i. Annual BC Fair Pharmacare Deductible – assigned annually by BC Fair Pharmacare
- ii. Co-insurance Paid by BC Fair Pharmacare 70% (After you exceed the BC Fair Pharmacare Family or Individual

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maximum assigned annually by BC Fair Pharmacare, BC Fair Pharmacare pays at 100%)

iii. Amount paid by your Health Care Plan - 90% of BC Fair Pharmacare Deductible - 90% of Co- insurance not paid by B.C. Fair Pharmacare.

All members are required to register with the BC Fair Pharmacare Program and secure confirmation of their BC Fair Pharmacare deductible and provide a copy of their "Confirmation of BC Fair Pharmacare Deductible" to the Administrator before the Trustees will be in a position to consider a claim for prescription receipts

Paramedical services of the following health care practitioners up to the maximum specified below are covered by this Plan, commencing with the thirteenth (13th) visit:

Chiropractor - \$200 per person to a maximum of \$500 per family per calendar year.

Naturopath - \$200 per person to a maximum of \$500 per family per calendar year (visit costs only, no tests, no vitamins, etc.).

Massage Therapist - \$200 per person to a maximum of \$500 per family per calendar year.

Podiatrist - \$200 per person to a maximum of \$500 per family per calendar year.

Physiotherapist - \$200 per person to a maximum of \$500 per family per calendar year. (Physiotherapist visits are eligible commencing with the first visit provided you have been referred by a physician and you submit a copy of your physician referral for the physiotherapy treatment).

Acupuncturist - \$200 per person to a maximum of \$500 per family per calendar year. (**Coverage starts with the first visit provided you have been referred by a physician and only if the acupuncturist is a registered practitioner)

Orthopaedic supplies:

- Custom made Orthotic insole/insert prescribed by a medical doctor
- Orthopaedic shoes prescribed by a medical doctor are covered at 50% (Off-the-shelf orthopaedic shoes are not covered and casting charges are not covered)
- Orthopaedic shoes prescribed by a medical doctor attached to a brace.
- the plan will reimburse the eligible member and dependent for 1 pair of orthotics every 24 months to a maximum of \$400

Hearing aids for eligible plan members and their eligible dependents, who qualify for Group One coverage with a minimum of 12 consecutive months of Health Care Plan eligibility on or after August 1, 1999 (providing NO form of hearing aid for either ear was worn prior to becoming eligible for coverage under this plan) purchased on the written recommendation of a doctor certified as an otolaryngologist.

- subject to a maximum of \$750 during any continuous five (5) year period, such maximum inclusive of charges for repair or replacement.

How to submit your claims to the Office of the Administrator for payment:

You must complete an [Extended Health Care Plan Claim form](#) and attach all your original receipts to the claim form and forward the claim form and original receipts to the Plan Administrator's office for payment.

When to submit your claims to the Office of the Administrator for payment:

No benefits will be paid for claims exceeding the following time limit:

- (i) on behalf of a Participant, no later than 24 months following the date in which the expense was incurred; or
- (ii) on behalf of a former participant, no later than six months following the date the expense was incurred.

(E) VISION CARE BENEFIT

- i. One set of new lenses, including contact lenses selected in place of spectacle lenses, not more frequently than once in 12 months to the following limits:

single vision lenses or laser eye surgery - \$200.00
bifocal lenses - \$240.00
Trifocal lenses - \$280.00

- ii. Up to \$500 during the lifetime of the Participant and their qualified Dependents for one set of contact lenses or laser eye surgery prescribed by an Ophthalmologist or Optometrist for:
(a) correction of corneal astigmatism, severe corneal scarring keratoconus, conical cornea or aphakia, &
(b) when visual acuity in the better eye cannot be improved to at least the 20/40 level by glasses.

- When submitting your claim you should submit the **ORIGINAL RECEIPT** reflecting a breakdown between the cost of the lenses and the cost of the frames, and also a **copy of the optical prescription**.
- Replacement of lost, stolen or broken glasses or contacts is not covered by the Plan.

(F) DEATH BENEFIT - \$10,000 No benefit will be payable upon the death of a participant after age seventy (70).

(G) ACCIDENTAL DEATH AND DISMEMBERMENT - Principal Sum \$10,000 (No benefit will be payable upon the death of a participant after age seventy (70)).

(H) DEPENDENT LIFE - Spouse - \$1,000; Child - \$500 - Taxable Benefit (Benefit not applicable to children younger than 14 days or children 19 years or older as well as a spouse after age seventy (70)).

GROUP TWO - BENEFITS

To Qualify - 240 hours to 359 hours over each three (3) consecutive month period to qualify the first day of the fourth (4th) month and 240 hours to continue Health Care Plan eligibility.

(A) MEDICAL SERVICES PLAN OF B.C.

This coverage is available to all who qualify but as this is a **taxable benefit** members already covered under the Medical Services Plan of B.C. through their spouse or family, need not take out duplicate Medical Services Plan of B.C. coverage. The medical coverage is not required for Dental and/or other Health Care Plan Benefits.

Eligibility for MSP coverage is determined by the Medical Services Plan of B.C. You will be required to provide proof of Canadian citizenship or up-to-date immigration documents for yourself and each of your family members. You will be required to provide on-going proof of an overage dependent's attendance at school.

If your total family income is less than \$30,000 in a year, you may be eligible for a premium reduction. [Applications for this premium reduction](#) are available from the Office of the Administrator or our website www.armmanagement.ca

The Medical Services Plan of B.C. is mandatory for all residents of British Columbia so please be certain to [complete an application](#) and apply for this coverage should you not be eligible for the coverage as a dependent with your spouse or family.

(B) ACCIDENT AND SICKNESS (WAGE LOSS) BENEFIT

Eligible Health Care Plan participants will be reimbursed 55% of their average weekly earnings, based on the

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earnings of the three consecutive month period immediately prior to the month of claim, to a maximum weekly benefit of \$448

Claims procedure the same as Group One. - Balance of terms and conditions same as describe in Group One

(C) DENTAL CARE BENEFIT

Plan A (Basic) 60%, Plan B (Major) NIL, Plan C (Orthodontics) NIL

Balance of terms and conditions same as described in Group One.

(D) EXTENDED HEALTH CARE (MAJOR MEDICAL) BENEFIT

80% Co-insurance, No Deductible, Generic Drug Policy - Balance of terms and conditions same as described in Group One.

(E) DEATH BENEFIT - \$7,000 - No benefit will be payable upon the death of a participant after age seventy (70).

(F) ACCIDENTAL DEATH AND DISMEMBERMENT - Principal Sum \$7,000 - No benefit will be payable upon the death of a participant after age seventy (70).

(G) DEPENDENT LIFE - Spouse \$500; Child \$250 - Taxable Benefit - Balance of terms and conditions same as described in Group One.

GROUP THREE - BENEFITS

To Qualify - 150 hours to 239 hours over each three (3) consecutive month period to qualify the first day of the fourth (4th) month and 150 hours to continue Health Care Plan eligibility.

(A) DEATH BENEFIT - \$5,000 - No benefit will be payable upon the death of a participant after age seventy (70)

IMPORTANT ITEMS TO REMEMBER

(A) Should you have any questions regarding your Health Care Plan eligibility or the eligibility of a specific claim, please contact the Administrator **PRIOR TO** receiving the treatment or purchase of the item.

(B) Should you be injured on the job and be receiving Workers' Compensation Board of B.C. benefits, you must forward your W.C.B. cheque stubs to the Administrator, so that the Health Care Plan Board of Trustees may credit your file with the hours necessary to maintain your Health Care Plan eligibility (maximum 30 weeks). Please be certain to include your name, social insurance number and address on the cheque stubs, so the Administrator may return the cheque stubs to you.

(C) It is your responsibility to see that the Administrator receives completed applications to effect your coverage. Therefore, in order to avoid any unnecessary delays with the commencement of your Health Care Plan

coverage you should contact the Office of the Administrator to determine that all the applications necessary to commence your coverage have been fully completed and received by the Administrator (Immigration Documents may be necessary). You should also contact Local 40 by phoning (604) 291-8211 or 1-800-663-1728 to verify that all your union fees (i.e. initiation, dues etc.) have been paid, and you are a member in good standing of Local 40.

(D) If you wish to include a Common-Law Spouse (Including same sex spouse), on your coverage, the coverage is **NOT** automatic. You must provide the Administrator with a **NOTARIZED STATEMENT** outlining your full names, birth dates, social insurance numbers, and length of time you have resided together, and this statement must be signed by at least two independent parties known to both you and your common-law spouse. Upon receipt of this notarized statement the Health Care Plan Board of Trustees will give your request its full consideration.

(E) Notify the Administrator **in writing** as to any change in your mailing address, marital status, addition to or deletion from your family, so that we may keep your records current to ensure you will receive all correspondence from this office.

(F) Notify the Administrator **in writing** as to the dates of your **annual paid vacation** in order that the Health Care Plan Board of Trustees may credit your files with the necessary hours to maintain your Health Care Plan eligibility during your vacation.

(G) Your Identification number under this plan is your Social Insurance Number.

Contact the Administrator:

A.R.M. Management Ltd.,
#201 - 4853 Hastings Street, Burnaby, BC, V5C 2L1
Telephone: 604-294-4441,
Toll free: 1-800-661-2766
Facsimile: 604-294-0476

E-mail linda_benka@armmanagement.ca
Website www.armmanagement.ca

Contact your Union:

UNITE HERE Local 40
#100 - 4853 Hastings Street, Burnaby, BC, V5C 2L1
Telephone 604-291-8211,
Toll free: 1-800-663-1728
Facsimile 604-291-1187

E-mail duesadmin@local40union.com
Website www.uniteherelocal40.org

Should there be a disagreement as between the wording in this summary and the Plan Document and Group Insurance Contracts, the Plan Document and Group Insurance Contracts will prevail.