BC MARINE INDUSTRY

EMPLOYEE HEALTH BENEFIT PLAN

www.bcmarinebenefits.org

Address all inquiries to:

THE ADMINISTRATOR

D.A. Townley

BC MARINE INDUSTRY EMPLOYEE HEALTH BENEFIT PLAN
4250 Canada Way
Burnaby, BC V5G 4W6

Email: admin@datownley.com
(Administration Inquiries)
Email: health@datownley.com
(Claims Inquiries)

Telephone 604-299-7482
Fax 604-299-8136
Toll Free 1-800-663-1356

*Including amendments to April 1, 2024 (V-2)

PRIVACY POLICY

We, the Trustees of the BC Marine Industry Employee Health Benefit Plan have adopted the following Privacy Principles, which reflect our commitment to safeguarding our employee's personal information:

- Information about you and your communications with the Plan are kept confidential.
- Neither the Administrator, nor the Plan will sell your personal information.
- Information about you is gathered lawfully and fairly.
- Information about you is gathered, used, or disclosed only to provide you with benefits and services as outlined in your plan documents.
- We maintain appropriate procedures to ensure that personal information in our possession is accurate and, where necessary, kept up to date. You are entitled to seek a correction of your personal information if you believe that the information held by the Plan is not accurate.
- You may access your personal information, subject to limited exceptions and conditions.
- Personal information is not disclosed without employee's permission except in limited circumstances as permitted or required by law. However, the Administrator may share personal information with the Plan's actuaries, agents, consultants or service providers in connection with providing, administering, adjudicating, costing, financially managing and servicing employee's Plans and benefit programs.
- Where we choose to have certain services, such as actuarial valuation, provided by third parties, we take all reasonable precautions regarding the practices employed by the service provider to protect your personal information. We ask that they, in turn, undertake to honour the Plan's privacy policy and applicable legislation.
- To protect your personal information against unauthorized access, disclosure, copying, use or modification, theft or accidental loss, the Plan will maintain appropriate security mechanisms.

The Trustees

FORWARD

This booklet describes the BC MARINE INDUSTRY EMPLOYEE HEALTH BENEFIT PLAN. The Plan is the result of collective bargaining between the Unions and Employers. However, it does not create or confer any rights. These benefits may be amended from time to time by the Trustees or in response to changes through collective bargaining. The exact terms of the Plan are stated in the Master Policies and Contract as governed by the Board of Trustees of the BC Marine Industry Employee Health Benefit Plan.

The Plan operates under the jurisdiction of a Board of Trustees composed of Union Trustees from the International Longshore and Warehouse Union Local 400 Marine Section, the Seafarers' International Union of Canada and Employer Trustees appointed by the Council of Marine Carriers.

Both British Columbia and Alberta have passed legislation affecting the use of self-insured funding for providing benefit plans. In each case, the legislation allows for the use of self-insured funding, subject to disclosing this information to the covered employees in writing.

The Trustees are constantly attempting to provide benefits under the Plan to the employees in the most cost-effective manner. For some benefits, such as Dental, Weekly Indemnity and some portions of the Extended Health Benefits, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act.

The details of the Plan are outlined in this booklet. Please read it carefully and retain it for future reference. It replaces any previous booklet you were given.

BOARD OF TRUSTEES

The following is an outline of the BC Marine Industry Employee Health Benefit Plan. The information in this benefits booklet is important to you. It provides the information you need about the group benefits available through the BC Marine Industry Employee Health Benefit Plan.

SUMMARY OF BENEFITS

Life Insurance	Refer to your Collective Agreement for your benefit amount* *coverage for all working employees reduces to a flat $25,000 at age 65 and terminates at age 70.
Accidental Death & Dismemberment	Equal to the Life Insurance
Uninsured Life and Accidental Death & Dismemberment	Flat $10,000 per benefit
Weekly Indemnity	Refer to your Collective Agreement for your benefit amount
Long Term Disability	Refer to your Collective Agreement for your benefit amount
Extended Health Benefits	As described herein. Prior Authorization Program applies to Prescription Drugs
Out of Province/ Canada Emergency Medical Travel Insurance	$5 Million maximum per coverage period to age 80.
TELUS Health Virtual Care	Online immediate medical support (does not apply to Retiree Benefits)
Dental Plan	100% Basic Services 50% Major Services 50% Orthodontia $2,000 per calendar year maximum for Basic and Major Services Combined $2,500 lifetime maximum for Orthodontia

ELIGIBILITY AND GENERAL INFORMATION

COMMENCEMENT OF COVERAGE

All eligible employees will be covered immediately following 90 days of continuous employment with a participating Employer, provided a Group Insurance Enrolment Card has been completed and submitted to the Administrator.

Employees absent due to disability, temporary lay-off or leave of absence on the date they would normally become eligible will be covered from their date of return to active full-time employment.

Eligible dependents will be covered on the employee's effective date, provided dependent coverage is requested. Newly acquired dependents must be enrolled within 31 days of becoming eligible.

No Medical Examination

No medical examination or other evidence of insurability will be required in order to join the Plan. Evidence of insurability may be required for Long Term Disability coverage for NEW units with less than 10 employees NOT under the jurisdiction of a labor agreement with the I.L.W.U. or S.I.U.

Dependent Coverage

The Plan will provide Dental, Extended Health Benefits and Vision Care for:

a) The spouse* of a covered employee;
b) Any unmarried child of a covered employee to age 21, provided such person is mainly dependent on and living with the covered employee;
c) Any unmarried child of a covered employee to age 25 provided the child is in full-time attendance at a recognized school, college, or university;
d) Any unmarried mentally or physically handicapped child of a covered employee to any age, provided such person is mainly dependent on and living with the covered employee or the spouse of the covered employee.

*Spouse means the employee's legal spouse, or a person who has been residing with the employee continuously for a period of at least 12 consecutive months and has been publicly represented as the Member's spouse in the community in which they reside.

When completing your application forms for coverage, please include all dependents to be covered. To add, delete or change the dependents covered, obtain an Enrolment and Beneficiary card from the Administrator or your Union office, and forward it to the Administrator's office.

Termination of Coverage

Coverage will be terminated on the last day of the calendar month in which employment terminates. However, "lay-days", shall constitute continuation of employment. For example, if employment is terminated and the employee has "lay-days" to their credit, coverage will terminate on the last day of the calendar month in which such credit is exhausted.

Dependent coverage will terminate on the same day as that of the employee or upon ceasing to be a dependent as defined.

Eligibility for Long Term Disability coverage will terminate on the last day of the calendar month in which the employee attains age 64, even if the employee remains employed thereafter.

Eligibility for Weekly Indemnity coverage will terminate on the day in which the employee attains age 68*, even if the employee remains employed thereafter.

*Effective January 1, 2024, previously age 65.

Reinstatement

Coverage will be reinstated immediately for any eligible employee who returns to active full-time employment with any participating employer within 12 months of the date their coverage terminated. If the employee does not return to active full-time employment within the 12 month period, they will be considered a new employee and will be covered upon completion of 90 days continuous employment with any one participating employer.

Temporary Lay-off and Leave of Absence

Coverage will terminate on the last day of the month in which employment terminates. Lay-days shall constitute continuation of employment. For example, if you are laid-off in September with no lay-day entitlement, coverage will terminate on the last day of September. If you have lay-day entitlement and such entitlement carries your employment into October, coverage will terminate the last day of October.

At the employee's option, arrangements may be made for coverage to be continued for up to 2 months from the end of the month in which lay-off or leave of absence commences, except in the case of an employee who is absent from work during any period of formal maternity leave taken by the employee pursuant to provincial or federal law or pursuant to mutual agreement between the employee and the employer, such time limit shall be extended to the end of such maternity leave, subject to payment of premiums. The employer must notify the Administrator within 5 calendar days of the end of the calendar month during which coverage terminates, that an extension of coverage is desired, at which time payment for the required premium must be received by the Administrator in full.

During a short-term lay-off, an employee may make arrangements to keep the benefits in force for up to two months from the end of the month in which the lay-off commences. The employee must notify their employer, within 5 calendar days of the end of the calendar month during which coverage terminated, that an extension of coverage is desired. At the same time, the employee must make arrangements with their employer for full payment of the premium.

During periods of extended lay-off, 3-6 months, and provided the employee is available for work and not actively working outside the Industry, the employee may make arrangements for continuation of Life Insurance, Accidental Death & Dismemberment and Weekly Indemnity coverage, subject to full premium payment. Extended Health Care, Dental and Long Term Disability are not available during this period. The Weekly Indemnity would be payable from the first day of disability due to a non-occupational accident and the 30th day of disability due to a non-occupational illness. Benefits would be paid for a maximum period of 15 weeks.

Where an employee undertakes a course of study to upgrade or attain a recognized seagoing certificate, coverage may be continued for up to one year subject to payment of premiums.

Beneficiary

Upon enrolment in the Plan, an employee must designate the beneficiary to whom the death benefits will be payable. Subject to any legal restrictions they may change their beneficiary by completing the necessary change of beneficiary forms.

Survivor Benefits

Upon the death of a covered employee, the Plan will continue Dental and Extended Health Care coverage for surviving eligible dependents for 24 months from the date of death of the covered employee, with no premium charge.

Employee Pay-Direct Card

Upon becoming eligible for Plan benefit coverage, every eligible employee will receive a pay-direct card. Two cards will be issued, both in the employee's name, if the employee has dependent coverage. This card is to be presented each time the employee or dependent fills a prescription, visits the dentist, purchases prescription eyewear or has an eye examination or visits a participating paramedical practitioner such as a chiropractor, registered massage therapist, physiotherapist etc. The card will permit the submission of your claim for these benefits, to be done directly to the Plan by the provider. You will only be charged the balance that the Plan would not cover. Using your pay-direct card eliminates the requirement for you to pay for your prescription and wait for reimbursement from the Plan.

MEDICAL SERVICES PLAN OF BC (MSP)

The Medical Services Plan of BC (MSP) provides for payment of costs for required medical, surgical, obstetrical and diagnostic services of medical practitioners.

Personal Health Care Cards (BC Care Cards) are issued by MSP and will not be replaced or reissued when eligibility is re-established through employment. New cards may be ordered directly through MSP.

When an employee is eligible for or is currently covered through a spousal, native or alternate group plan for MSP, they may elect to “opt out” of the MSP through their employer. MSP may be reinstated at any time, provided the employee remains eligible for benefits through their employer.

If an employee becomes Totally Disabled and has applied for and is approved for Long Term Disability (LTD) benefits, including MSP, through the BC Marine Industry Employee Health Benefit Plan, while they collect LTD benefits, MSP coverage will continue while and for

as long as they continue to collect LTD benefits through the Plan.

LIFE INSURANCE

Refer to your Collective Agreement for the benefit amount or contact the Plan Administrator.

Any change to the amount of an employee's Life Insurance Benefit due to an earnings adjustment, negotiated benefits or a change in classification shall be effective on the date of that change, except if an employee is absent due to sickness or injury on the date that any increase in benefits would normally take effect, in which case the increased coverage will be effective from the date of return to active full-time employment.

In the event of your death while insured, the amount of your Life Insurance is payable to your beneficiary should your death occur from any cause while you are insured under the group policy.

You may change your beneficiary at any time by providing written notice to the Administrator. If you do not designate a beneficiary, the insurance will be payable to your estate.

For working employees, the Life Insurance benefit reduces to $25,000 the 1st of the month following attainment of age 65 and terminates at age 70. For Seaspan Shore Members, the Life Insurance benefit reduces to $25,000 the 1st of the month following attainment of age 65, to $5,000 following attainment of age 70 and terminates at retirement. Employees must work an average of at least 20 hours per week to be eligible for coverage.

Waiver of Premium for Disability

If while insured for this coverage an employee becomes totally disabled for 12 consecutive months before age 70, the Insurer may waive the payment of the Life Insurance premiums. Satisfactory proof must be given to Canada Life within 3 months of the date of notice and thereafter when and as required by Canada Life once each year.

The amount of coverage continued is the amount for which the employee was covered for at the commencement of total disability. If the coverage would normally reduce when the employee attains a certain age or for any other reason, the amount of coverage will reduce accordingly.

This extension of coverage will immediately terminate if the employee:

1) ceases to be totally disabled;
2) reaches age 70;
3) retires;
4) fails to furnish any required proof that the total disability continues; or
5) fails to submit to a medical exam by physicians named by Canada Life when and as often as Canada Life requires.

Continuation of Life Insurance on Termination of Coverage

When your coverage with the Plan terminates prior to age 65, you may convert your Life Insurance to an individual policy without a medical examination or health questionnaire. The individual policy would be for an amount not greater than the amount under the group policy and would be available at any time within 31 days after termination of the group insurance. Contact the Administrator for details.

Your life would continue to be insured, under the group policy during the 31 day conversion period, whether or not you apply for an individual policy.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed below in the Schedule of Losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is Covered? Amount of Coverage

All eligible Members	Same as Life Insurance
All spouses under age 70	$20,000
All eligible dependent children	$ 5,000

Schedule of Losses

Loss of Life ..... The Principal Sum

Loss of Both Hands ..... The Principal Sum

Loss of Both Feet ..... The Principal Sum

Loss of Entire Sight of Both Eyes ..... The Principal Sum

Loss of One Hand and One Foot ..... The Principal Sum

Loss of One Hand and the Entire Sight of One Eye ..... The Principal Sum

Loss of One Foot and the Entire Sight of One Eye ..... The Principal Sum

Loss of One Arm ..... Four-Fifths of the Principal Sum

Loss of One Leg ..... Four-Fifths of the Principal Sum

Loss of One Hand ... Three-Quarters of The Principal Sum

Loss of One Foot .....Three-Quarters of The Principal Sum

Loss of the Entire Sight of One Eye .....Three-Quarters of The Principal Sum

Loss of Thumb and Index Finger of the Same Hand .....One-Third of The Principal Sum

Loss of Speech or Hearing ..... Three-Quarters of The Principal Sum

Loss of Speech and Hearing ..... The Principal Sum

Loss of Hearing in One Ear ..... Two-Thirds of The Principal Sum

Quadriplegia (total paralysis of both upper and lower limbs) ... Two Times The Principal Sum

Paraplegia (total paralysis of both lower limbs) ..... Two Times The Principal Sum

Hemiplegia (total paralysis of upper and lower limbs of one side of the body)..... Two Times The Principal Sum

Loss of Use of Both Arms or Both Hands ..... The Principal Sum

Loss of Use of One Hand or One Foot .....Three-Quarters of The Principal Sum

Loss of Use of One Arm or One Leg..... Four-Fifths of The Principal Sum

Loss of Four Fingers of One Hand ..... One-Third of The Principal Sum

Loss of All Toes of One Foot ..... One-Quarter of The Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the

elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds.

Loss of the Entire Sight of Both Eyes means the total and irrecoverable Loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty (20) degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing. Loss of Hearing in One (1) Ear means the diagnosis of permanent Loss of Hearing in one (1) ear, with an auditory threshold of more than ninety (90) decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing. Loss of Hearing means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than ninety (90) decibels an ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing.

"Loss" as used with reference to "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

All claims submitted under this policy for Loss of Use must be verified by agreement between a licensed practicing physician appointed by the Administrator "the Plan" and a licensed practicing physician appointed by Blue Cross Life "the Company", or in the event that the two physicians so appointed cannot arrive at an agreement, a third licensed practicing physician shall be selected by the first two physicians and the majority decision of the three physicians shall be binding on the Plan and the Company. This procedure may be waived by the Company at its sole discretion.

Disappearance

If the body of an Insured Member has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that such Insured Member shall have suffered loss of life within the meaning of the policy.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Member under the Plan's current basic group life insurance policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Member.

All other benefits shall be payable to the Insured Member.

Repatriation Benefit

When Injuries covered by this policy result in loss of life of an Insured Member outside 50 Km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of $15,000.00.

Rehabilitation Benefit

If an Insured Member suffers an Injury which results in a payment being made by the Company under the Accidental Death and Dismemberment Indemnity section of this policy, the Company shall pay in addition:

The reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of the Insured Member provided:

a) Such training is required because of such Injuries and in order for the Insured Member to be qualified to engage in an occupation in which they would not have been engaged except for such Injuries,

b) Expenses be incurred within three years from the date of the accident,

c) No payment shall be made for ordinary living, travelling or clothing expenses.

Family Transportation

When Injuries covered by the policy result in an Insured Member being confined to a hospital, outside 100 Km from their permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the reasonable and necessary expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Member but not to exceed the amount $15,000.00

Conversion Privilege

On the date of termination of coverage or during the 90-day period following termination of coverage, you may change your insurance to Blue Cross Life's individual insurance policy. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the plan ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of Blue Cross Life. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

Continuance of Coverage

In the case Members who are (1) laid-off on a temporary basis (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of twelve (12) months, subject to payment of premium. If a Member assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Waiver of Premium

In the event an Insured Member becomes totally and permanently disabled and their waiver of premium claim is accepted and approved under the Plan’s current Group Life policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier:

a) The date the Insured Member attains age 65.

b) The date of the death or recovery of the Insured Member.

c) The date the Insured Member is no longer eligible for total disability waiver of premium under the Policyholder's group life policy; and

d) The date the Master Policy is terminated

Seat Belt Rider

Benefits under the policy shall be increased by 10% if the Insured Member's Injury or death results while they are a passenger or driver of a private passenger type automobile and their seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Home Alteration And Vehicle Modification

If an Insured Member receives a payment under The Schedule of Losses herein and was subsequently required (due to the cause for which payment under The Schedule of Losses was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

a) The one-time cost of alterations to the Insured Member's residence to make it wheel-chair accessible and habitable; and

b) The lesser of:

   i) the one-time cost of modifications necessary to a motor vehicle, owned by the Injured Insured Member, to make the vehicle accessible or drivable for the Insured Member; and

   ii) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Company.

Benefit payments herein will not be paid unless:

i) Home alterations are made on behalf of the Insured Member and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and

ii) Vehicle modifications are made on behalf of the Insured Member and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items (a) and (b) combined will not exceed $15,000.00

Dependent Child Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will reimburse the annual tuition, not including room and board, charged by an Institution of Higher Learning per school year for each Dependent Child of such Insured Member up to the lesser of the following amounts:

a) ten thousand dollars ($10,000.00) per school year; or

b) 5% of such Insured Member's Principal Sum.

This benefit is payable annually up to a maximum of four (4) consecutive payments per Dependent Child:

a) only for such Dependent Child who is, at the time of such Insured Member's Loss of Life, enrolled as a full-time student in an Institution of Higher Learning beyond the twelfth (12th) grade level; and

b) only while such Dependent Child continues their continuous enrollment in an Institution of Higher Learning.

The Company will reimburse the person who incurred the actual tuition expenses.

Spousal Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the Insured Member's Spouse the actual cost incurred for a professional or trades training program in which such Spouse enrolls for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than thirty (30) months after the Insured Member's Loss of Life.

The maximum amount payable for this benefit is fifteen thousand dollars ($15,000.00) per Insured Member.

"Dependent Child" as used herein means any unmarried child under 26 years of age who was dependent upon the Insured Member for at least 50% of their maintenance and support.

"Institution of Higher Learning" as used herein includes, but is not limited to, any university, private post secondary college or trade school, and any College of General and

Vocational Education/ Collège d'enseignement général et professionnel (CÉGEP).

Day Care Benefit

If an Insured Member suffers Injury resulting in Loss of Life for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the legal guardian of any surviving Dependent Child of the Insured Member, an amount equal to the lesser of the following:

a) the actual annual cost charged by a commercial and licenced day care centre; or

b) 5% of the Insured Member's Principal Sum; or

c) five thousand dollars ($5,000.00) per year.

This benefit is payable annually for a maximum of four (4) consecutive payments per Dependent Child:

a) and only for such Dependent Child who at the date of the Insured Member's Loss of Life is under age thirteen (13);

b) provided such Dependent Child is enrolled in commercial and licenced day care centre no later than ninety (90) days following the Insured Member's Loss of Life; and

c) provided that the Dependent Child continues their enrollment in a commercial and licenced day care centre.

In-Hospital Benefit

If an Insured Member suffers injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses, and as a consequence of such Loss the Insured Member is, pursuant to the instructions of a Physician, confined to a Hospital for more than five (5) consecutive overnight stays, the Company will pay:

a) for a period of confinement in Hospital of more than thirty (30) consecutive overnight stays, 1% of the Insured Member's Principal Sum; or

b) for a period of confinement of thirty (30) consecutive overnight stays or less, one thirtieth (1/30) of the amount determined for each overnight stay in Hospital.

The Company will pay this benefit monthly, retroactive to the first (1st) overnight stay of confinement in Hospital.

The maximum amount payable for this benefit for all injuries resulting from any one (1) accident per insured is two thousand five hundred dollars ($2,500.00) per month.

Benefits are not payable for more than a total of twelve (12) months of confinement for any one (1) accident causing Injury.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than three (3) months, are considered one (1) period of confinement to Hospital for the purposes of calculating this benefit.

The term **"Hospital"** is defined as an establishment which meets all of the following requirements:

(1) holds a license as a hospital (if licensing is required in the province);

(2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

(3) provides 24-hour a day nursing service by registered or graduate nurses;

(4) has a staff of one or more licensed physicians available at all times;

(5) provides organized facilities for diagnosis, and major medical surgical facilities; and

(6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

If an Insured Member suffers Injury causing Permanent and Total Disability, the Company shall pay the amount which is 100% of the Principal Sum for the Insured Member less any amounts under the Table of Losses which have been paid or which are payable by the Company for Losses of the Insured Member.

EXCLUSIONS

No coverage shall be provided under this contract and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

a) suicide or any attempt thereat by the Insured Member while sane;

b) self inflicted Injury or any attempt thereat by the Insured Member while sane or insane;

c) declared or undeclared war or any act thereof;

d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

f) Injury sustained while the Insured Member is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

g) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;

h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Member is:

   i) riding as a passenger in any aircraft not intended or licenced for the transportation of passengers; or

   ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

   iii) riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder.

i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

j) Injury or Loss sustained while the Insured Member is on full-time duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Member is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

k) Injury or Loss sustained while the Insured Member is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while their blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;

l) Injury or Loss sustained while the Insured Member is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licenced Physician;

m) the commission or attempted commission by an Insured Member or Injury incurred while an Insured Member is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

n) an act, attempted act or omission taken or made by the Insured Member, or an act, attempted act or omission taken or made with the Insured Member's consent, for the purposes of interrupting the blood flow to the Insured Member's brain or to cause asphyxiation to the Insured Member whether with intent to cause harm or not; and

o) natural causes.

WEEKLY INDEMNITY BENEFIT

Refer to your Collective Agreement for the benefit amount or contact the Plan Administrator.

A percentage of the basic monthly wage or weekly equivalent will be paid to an employee when they are necessarily absent from work because of either an accident or sickness not covered by WorkSafe BC or similar legislation. The benefit commences from the 1st day of disability due to an accident and the 7th day of disability due to sickness, except that if, during the period of disability, an employee is confined in a hospital for at least 24 consecutive hours prior to the 7th day of disability, the payment shall commence from the 1st day of hospitalization. Payments will continue as long as the employee is disabled and unable to work, provided they are following the prescribed treatment plan of their medical advisors, up to a maximum of 52 weeks for any continuous period of disability or upon attaining age 68 (applicable to disabilities incurred on or after January 1, 2024, otherwise age 65), whichever is sooner. There is no limit to the number of separate periods of disability, as long as they are not due to the failure to follow recommended treatment programs. If an employee is on a union pension the Weekly Indemnity Benefit terminates.

Periods of disability, due to the same or related causes, will be considered one continuous period of disability except where the employee returns to work and works at least 30 days between periods of disability.

The disabled employee must be under the care of a Physician, Surgeon, Chiropractor or other qualified Practitioner, and be compliant with the treatment prescribed by that Practitioner. Failure to comply with the prescribed treatment may result in discontinuation of benefits.Weekly Indemnity claimants, whose claims are stress-related, must be directed to WORKHEALTH. Participation in the WORKHEALTH program is mandatory for stress-related claims.

This benefit is not payable during any period for which the employee is paid Employment Insurance Maternity benefits; for intentionally self-inflicted injury, while sane or insane; insurrection or war or participation in any riot.

This benefit does not cover any period of disability which is due to any bodily injury or sickness for which payment is made by WorkSafe BC or similar legislation, including ICBC and ICBC equivalent insurance.

At the discretion of the Trustees, benefits may be payable to a disabled employee who has a right to recover damages or benefits from any person or organization due to the same cause. Subject to approval by the Trustees, such employee must enter into a Loan Agreement with the Plan, which states that they will reimburse the Plan in the amount of benefits paid out of damages recovered. The term “damages” will include, but are not limited to, any lump sum or periodic payments received on account of past, present or future loss of income. The Plan shall be first payee of any outstanding monies owed following settlement from WorkSafe BC or equivalent insurance claims and any outstanding monies can be drawn from Long Term Disability payments, if any.

Funds owed to the Plan are expected to be repaid immediately upon the employee’s receipt of their WorkSafe BC, ICBC or equivalent payment. If an employee does not co-operate in repaying the funds owed, the file will be referred to the Plan’s legal counsel for the appropriate handling. Should the Plan be required to pursue the employee for collection of any outstanding monies, the employee will be responsible for any legal costs and administrative charges incurred by the Plan in doing so.

In the event an employee's injury or resulting disability arises from an incident to which the BC Insurance (Vehicle) Act applies, the employee will be given the option to: (a) decline an advance/loan of benefits from the Plan, in which case ICBC can be so advised via a rejection letter, with the result that the employee's claim against the party responsible for the employee's injury or disability is unaffected by Plan benefits, or (b) accept from the Plan an advance (or advances) on account of benefits – which will limit recovery of equivalent compensation in the claim against the party responsible for the employee's injury or disability – on the employee's written agreement to reimburse the Plan for such advance(s) out of any recovery in the claim against the party responsible for the employee's injury or disability.

If the employee returns to work with an employer participating in the BC Marine Industry Employee Health Benefit Plan (the Plan) and the employee owes money to the Plan, the Trustees may force an assignment of wages to the Plan until such time as the total debt is repaid. For amounts of indebtedness up to $1,000, the Plan may take 100% of the employee's wage. For amounts of indebtedness greater than $1,000, the Plan may take 25% of the total indebtedness, in each of four consecutive pay periods. Where the wages are insufficient to cover the total indebtedness in four installments, the Trustees, at their sole discretion, may agree to extend the period of repayment.

Integration with Federal and Provincial Plans

Any disability income benefits which an employee becomes eligible to receive under the Canada Pension Plan or Quebec Pension Plan (primary only and not secondary) or any other disability income benefits which an employee becomes eligible to receive under any other Federal or Provincial Plan, shall reduce the amount payable under this benefit to the extent that the total amount which the employee is eligible to receive from all such sources shall not exceed 85% of gross earnings at the date of commencement of their disability.

Substance Abuse Claims

An employee is normally entitled to receive benefits only once for substance abuse-related claims under the Plan for Weekly Indemnity and Treatment Centre costs, unless satisfactory medical evidence is provided that the employee was unable to successfully complete the treatment program

due to circumstances beyond their control and which are not the result of failure to follow treatment.

When the Plan receives a substance abuse claim, payment will be initiated and the employee will be referred to the mandatory WORKHEALTH program through Homewood Health Solutions or a similar program, if recommended by the employee's treating physician. An assessment will be completed and a treatment coordinator will be assigned by the applicable program.

With a medical referral and the assistance of the treatment coordinator, the employee may enter a residential treatment centre or engage in other recommended treatment. Weekly Indemnity benefits will be paid for up to 7 days while an employee waits for entry into the facility, unless a longer period is necessary due to lack of available treatment places.

The employee will receive Weekly Indemnity benefits for the period they are resident in the treatment facility or otherwise unavailable for work due to receiving treatment for substance abuse. In the normal course, this period shall not exceed 56 days unless satisfactory medical evidence is provided that a lengthier period of confinement is necessary for treatment purposes. Benefits will be paid at the regular Weekly Indemnity benefit rate. Additionally, facility charges of the lesser of the actual daily charge or $150 per day (prior to January 1, 2021 $75.00 per day) will be paid through the Extended Health Care benefit.

Upon completion of the Residential Treatment Program (RTP), or other recommended treatment program, the employee is required to continue to participate in the WORKHEALTH or other applicable treatment program in order to ensure continued and successful rehabilitation. The employee may be eligible for up to 30* days of Weekly Indemnity benefits during a transition period to accommodate work re-entry following the completion of the RTP.
*Effective April 1, 2024

Guide to Obtain Benefits for Substance Abuse Treatment

The procedure for obtaining benefit coverage for treatment for substance abuse is as follows:

An employee sees their physician, who diagnoses a substance abuse problem and/or refers them to an appropriate specialist for diagnosis and treatment of such a problem. The physician provides medical information on the WI claim form stating that the employee is currently

unavailable for work due to seeking treatment for a substance abuse problem, and provides information as to the nature of the program to which the employee has been referred. If the treatment program is other than a residential treatment program, the physician or treatment specialist must provide a satisfactory medical rationale for selecting a different treatment method.

In the normal course, the Plan will only pay Weekly Indemnity benefits for the waiting period to enter the facility for up to 7 days, plus 56 days in-house treatment, unless provided with medical verification that appropriate treatment cannot be completed within this time frame.

Maintenance of benefits for absence from work due to substance abuse problems requires medical verification that the employee is actively pursuing treatment and is compliant with the prescribed treatment program. Benefits will normally be provided for only one period of absence from work due to substance abuse problems and treatment unless medical evidence is provided which demonstrates that the unsuccessful treatment or relapse is due to circumstances beyond the employee's control and is not the result of gross non-compliance with the treatment program, in which case Weekly Indemnity benefits may be provided for an additional period, as prescribed by the attending physician, up to a maximum of 4 weeks.

Negotiated Benefit Changes

If the employee is on active claim for a disability which commenced prior to a negotiated change in benefits, they will be eligible for the changed Weekly Indemnity benefit on the effective date of the negotiated change for their employer.

Weekly Indemnity Claim Procedure

In the event of a claim, the disabled employee can obtain the necessary forms from their employer or the Administrator.
It is important that the employee promptly reports to their employer any disability which may result in a Weekly Indemnity claim in order that the appropriate forms can be completed.

Example: Claimant misses 4 days of work and sees a Physician on the 5th day for an illness. Determination of eligibility commences day 5. As the waiting period for illness is 6 days with benefits payable only if still disabled

on the 7th day, benefits in this example would not commence until the 11th day (day 5 plus 6 days).

Send the completed form to the Administrator without delay.

Claim cheques will be sent directly to your home address.

Claims for disability must be submitted no later than 30 days after your total disability begins.

Third Party Liability

If you receive benefit payments under this Plan for loss of income for which there may be a cause of action against a third party, you will be required to complete a Loan Reimbursement Agreement. This will entitle the Plan to be reimbursed for any benefits paid, which have been recovered from a third party.

Right to Recover

(a) When an employee becomes Totally Disabled as a result of an injury or sickness in which:

  a) a third party may be, directly or indirectly, either in whole or in part, liable to the employee; or

  b) the employee has a claim for benefits under workers compensation legislation;

  the Plan will not pay benefits to the employee.

(b) In the circumstances described in (a) above, the Plan may, not must, provide financial relief on a periodic (usually bi-weekly) basis to alleviate income loss. The total of all advances made to the employee is fully repayable to the Plan on terms to be settled between the employee and the Plan and incorporated into a written Loan Reimbursement Agreement.

LONG TERM DISABILITY

Refer to your Collective Agreement for the benefit amount or contact the Plan Administrator.

Elimination Period

Benefits will be payable for each period of total disability after 52 weeks of continuous disability, or a period equal to the duration of the benefit period under the employee's Weekly Indemnity Benefit Plan, whichever is greater.

If total disability is not continuous, the days an employee is disabled will be accumulated to satisfy the elimination period so long as no interruption is longer than 30 days and total disability arises from the same accidental bodily injury or sickness.

Maximum Benefit Period

Benefits are payable up to your 65th birthday or, if earlier, to the date which you elect to receive early retirement benefits. If you satisfy the elimination period while you are age 64, benefits are payable for 12 months.

Long Term Disability benefits are taxable for all employees except for Seaspan Log Loaders as the premiums are paid by the employee.

Total Disability

Means that because of accidental bodily injury or sickness an employee (a) is not able to engage in any and every gainful occupation for which an employee is reasonably fitted by education, training or experience to earn at least 60% of their inflation-indexed earnings as of the commencement of Total Disability; and (b) at any time, not working for wage or profit (other than rehabilitative employment).

Recurrent Disability

If you return to work on a full-time basis with the employer after a period of total disability for which benefits have been paid, successive periods of total disability due to the same or related causes which are separated by less than 6 consecutive months of active work on a full-time basis with the employer will be considered as one continuous period of total disability. Payments will commence one month from the date the total disability recurs.

Offsets

The amount payable under this benefit for total disability is calculated by deducting from your benefit any other sources of income. These are specified in the Master Policy and include the following:

a) wages or retirement benefits payable from the employer or employer's pension or retirement plans;

b) any payments on account of your disability from any WCB/ Work Safe BC Act or similar law;

c) payments received from the Canada or Quebec Pension Plan, excluding payments made in respect of dependent children;

d) any income or benefit payable under any other plan or program of any government or of any subdivision or agency of the government, including any plan or program established pursuant to a provincial automobile insurance act.

All Source Maximum

The total monthly income while disabled (Long Term Disability benefit plus any income listed above and Canada or Quebec Pension family benefits) cannot exceed 85% of your net monthly earnings if nontaxable or 85% of your gross monthly earnings if taxable. Earnings are determined as of the date your Long Term Disability claim is approved.

EXCLUSIONS AND LIMITATIONS

If an employee has been absent from work due to sickness or bodily injury at any time during the 4 week period immediately preceding the effective date of their insurance under this benefit, such insurance shall not cover any disability which is due to the same or related sickness or bodily injury until they have completed, subject to their last day of absence, a period of 4 consecutive weeks of employment without absence from work due to the same or related sickness or bodily injury.

If an employee becomes totally disabled as a result of sickness or injury for which they were under the care of a physician or received medical care or services within the 12 month period immediately preceding the effective date of becoming eligible:

a) benefits will not be payable until they have completed a waiting period of 365 days, and

b) such benefits will be payable for a maximum of 12 months for that sickness or injury.

Benefits are not payable for the following:

- for any portion of a period of disability unless you are receiving ongoing supervision/treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of disability during which you are not participating in the treatment program recommended by said physician;

- for any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;
- for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addition, unless you are participating in a recognized substance withdrawal program;
- disabilities resulting from self-inflicted injuries or attempted suicide;
- disabilities as a result of participation in a war, riot, insurrection or criminal act;
- an automobile accident except as a fully repayable loan;
- for the portion of a period of disability during which you are:
  - imprisoned in a penal institution; or
  - confined in a hospital, or similar institution, as a result of criminal proceedings;
- any period of disability, or portion thereof, during any leave of absence (including maternity leave) as defined in the Benefit Plan Provisions section of the Contract;
- for a disability which commences on or after the date a strike begins, except as outlined in the Master Policy; however, an employee, may commence to fulfill their qualifying disability period from the date of disability;
- to an insured individual who refuses to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending physician or on the advice of independent medical opinion;

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will subrogate to all the rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You shall execute such documents as required by the Insurer.

In the event you provide proof to the Insurer that you have not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the Insurer's right of subrogation will apply.

The term compensation shall include any lump sum or periodic payment which you receive or are entitled to receive on account of past, present or future loss of income.

Rehabilitative Employment

The Insurer may recommend that a disabled employee undergo some suitable rehabilitation training program which would take into account the nature and limitations of their disability. Additional details would be provided to the employee in the event of such a recommendation is made.

Canadian Residency Requirement

No benefits are payable if the employee resides outside Canada for any period exceeding 90 consecutive days or a total of 180 days in any 365 day period unless:

- the employee has previously notified and received approval in writing from the Insured, and;
- the employee remains under the regular care of a licensed physician deemed appropriate by the Insurer, and;
- proof of ongoing disability can be determined on evidence satisfactory to the Insurer in English or French.

EXTENDED HEALTH BENEFITS

Deductible

$100 per person or family each calendar year.

Employees on Long Term Disability are exempt from the Deductible.

Eligible expenses which are incurred during the last 3 months of a calendar year and which are used to satisfy all or part of the deductible, will also be applied to the deductible for the next year.

Reimbursement

In-Canada Eligible Expenses (except smoking cessation)	100%
Out of Province/Canada Emergency Medical Travel Insurance Eligible Expenses	100% $5,000,000 per coverage period

Smoking Cessation Drugs	75%
Medical Referral Benefit	100% $75,000 per lifetime

Plan Maximum

The lifetime maximum amount of benefits payable for an Employee or dependent is $1,000,000.

Benefits

The Extended Health Benefit is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax supported agency.

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

1. Prescription Drugs – Upon becoming eligible for benefit coverage, you will receive a pay-direct card. Present this card to your pharmacist each time you fill a prescription. Your Plan provides coverage up to the "generic equivalent" (unless your physician has expressed in writing "no alternative") for prescription drugs and medicines which require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits. Drugs and medicines are limited to a 90 day supply. Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Drugs and medicines that can normally be purchased "over the counter" are excluded regardless of a prescription having been issued and products such as vitamins, preventative drugs, dietary foods and supplements are excluded. Prescribed treatments to cure Hepatitis C, if eligible, are limited to a lifetime maximum reimbursement of $90,000.

   Vitamin B12 for the treatment of pernicious anemia only, insulin preparations for diabetics and allergy extracts and serums with a DIN # and that are administered by a physician are covered. Smoking cessation drugs may be covered (75%) to a lifetime maximum of $250. Coverage for fertility drugs, where deemed eligible, have a lifetime maximum of $5,000. Coverage for drugs to treat erectile dysfunction, if eligible, are limited to a maximum of $500 per calendar year.

Prescription Drug Prior Authorization Program*

**Does not apply to Retiree Benefits*

There are a number of prescription drugs which will now require prior authorization before they can be determined eligible under the Plan. The complete Prior Authorization Listing of these drugs can be found online at:

https://www.telus.com/en/health/prior-authorization-forms

If your doctor prescribes a drug for you or one of your Eligible Dependents, that is on the Prior Authorization Listing, when you take your prescription to the pharmacy, your Pharmacist will be advised that you must obtain prior authorization first. You will then need to download the applicable Prior Authorization (PA) form for that drug from:

https://www.telus.com/en/health/prior-authorization-forms

and complete the patient section, have the prescribing Physician complete their section of the form, and then send the completed form to where indicated. This information will be reviewed, and it will be determined whether the required eligibility criteria is met.

The decision will be communicated directly with the patient or individual indicated by the patient on the form. If deemed to be eligible, an exception will be added to that patient's Plan record so that the pay-direct card will accept that drug going forward according to the terms of the approval. *NOTE: do not purchase your medication in advance of the completion of the Prior Authorization Process. Claims are not covered retroactively. Please wait to confirm criteria has been met before returning to your pharmacy to fill your prescription.*

It's recommended that you refer to the Prior Authorization Listing while you are with your doctor, so that if a drug they intend to prescribe is on the Listing, the applicable Prior Authorization form can be downloaded, printed, and completed before you leave your doctor's office. If you need assistance accessing a Prior Authorization form, you can contact the claims customer service department at D.A. Townley.

PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for Fair PharmaCare call 604-683-7151 from

Vancouver and 1-800-663-7100 from anywhere else in BC or visit the BC Fair PharmaCare website: **http://www2.gov.bc.ca/gov/content/health/health-drug-coverge/pharmacare-for-bc-residents**

2. Charges in excess of the amount payable under the Insured Person's Basic Medical Plan for professional licensed ambulance service in an emergency including transportation by railroad, boat or airplane, or in acute emergency by air ambulance, from the place where the injury or sickness occurs to the nearest acute general hospital and return fare, including round trip fare for one attending person (doctor, nurse, first aid attendant), where necessary. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation arranged at the patient's convenience are not eligible expenses.

3. Charges for out-of-hospital private duty nursing services up to a maximum of $5,000 per policy period to a lifetime maximum of $25,000, when medically necessary and with a physician's referral. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties.

4. Charges from a Licensed, Certified or Registered:

   You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a Licensed, Certified or Registered:

   - Chiropractor and Massage Therapist - $500 per calendar year per practitioner (plus $20 per calendar year combined for x-rays)
   - Naturopath – unlimited
   - Speech Therapist – unlimited
   - Acupuncture – unlimited
   - Osteopath – unlimited
   - Physiotherapist – unlimited
   - Podiatrist – unlimited
   - Audiologist – unlimited
   - Occupational Therapist – unlimited

- Orthoptic Technician (with physician's letter) – unlimited
- Inhalation Therapist (with physician's letter) – unlimited
- Psychologist / Licensed Social Worker / Registered Clinical Counsellor – unlimited ***Please note:*** *If the employer participates in an Employee Assistance Program, psychological services should be sought from that program first, to the maximum allowed. Benefits in excess of such maximum may then be claimed through this Plan.*

5. Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies.
6. Charges for walkers, canes and cane tips, crutches, splints, casts, collars and trusses but not elastic or foam supports.
7. Charges for testing supplies, needles and syringes for diabetics.
8. Charges for surgical stockings to a maximum of 2 pair per calendar year.
9. Charges for stump socks.
10. Charges for surgical brassieres up to 4 per calendar year.
11. Cataract surgery foldable lens.
12. Custom built orthopaedic shoes when prescribed by an orthopedic surgeon, physician or podiatrist to a maximum of $600 per calendar year. Modifications to stock items are not a covered expense.
13. Custom fitted orthotics when prescribed by a physician or podiatrist to a maximum of $200 per calendar year.
14. Charges for rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes and mastectomy forms). Myoelectrical limbs are excluded but the Plan will pay the equivalent of a standard prostheses.
15. Cost of rental or where more economical, purchase of durable equipment for therapeutic treatment including wheelchairs and hospital beds. Electric wheelchairs are covered only when a doctor certifies the patient is incapable of operating a manual wheelchair (e.g. Paraplegic).

16. Charges made by a dentist for the repair or replacement of sound, vital, natural teeth if the injury results from a direct accidental blow to the mouth. The accident must occur while covered under this plan and treatment must be provided within 60 days unless a detailed treatment plan is approved within 60 days of the accident. Treatment must be completed while covered under the plan.

17. Convalescent Home or Physical Rehabilitation Facility room and board charges, excluding charges for chronic care, if the Insured Person's residence in the institution:
    - is certified as medically necessary by a Physician,
    - occurs within 48 hours after a Hospital stay of at least 5 consecutive days, and
    - is due to the same sickness or accidental bodily injury which was the reason for the Hospital stay.

    Charges are limited to the difference between the Provincial Medical Allowance for Room and Board charges, and the institution's charge, up to maximum of 180 days per lifetime.

18. Hearing aids and repairs will be reimbursed at 50% of the cost up to a maximum of $3,500 every 5 years, provided they are prescribed by a doctor. Maintenance, batteries or other accessories are not covered expenses.

19. Wigs and hairpieces required as a result of medical treatment or injury.

20. Standard durable medical equipment
    Preauthorization is required from us for expenses in excess of $5,000
    - Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a provider may be considered.
    - Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.
    - Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
    - Standard durable equipment includes:
    - manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and

hospital beds will be covered only when the patient is incapable of operating a manual wheelchair, otherwise we will pay the manual equivalent

- medical monitors including heart and blood glucose monitors and cardiac screeners
- breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks and regulators

21. Vision Care
    You can use your pay-direct card to purchase your prescription eyewear. Prescription eyewear includes lenses, frames and contact lenses when prescribed by a physician or optometrist to a maximum of $400 per 24-month period. Prescription sunglasses are covered for employees only. Charges for non-prescription eyewear are not covered.

22. Reasonable and Customary charges for eye exams are allowed once every 24 months; once every 12 months for dependent children. Present your pay-direct card to have the cost of your eye examination submitted to the Plan directly.

23. Hospital charges made by an approved acute general hospital in BC for private or semi-private room (not including rental of telephone, T.V. etc.).

    Accommodation in a residential treatment centre for substance abuse is covered at the lesser of the actual daily charge or $150.00 per day, subject to the following conditions: (a) coverage will normally be limited to 56 days, unless satisfactory medical evidence is provided that a lengthier period of confinement is necessary for treatment purposes, and (b) coverage is limited to one time only per insured employee/dependent, unless satisfactory medical evidence is provided.

Accommodation Policy

Occasionally, it will be necessary for an insured person to travel away from their home for medical treatment. Due to the nature of the treatment, it is sometimes impossible for the insured to return home immediately after their treatment.

The Trustees recognize that there may be a rare but real need for an insured person to stay overnight nearby the treatment facility. Therefore, the Trustees have agreed to implement an Accommodation Policy.

The Accommodation Policy will reimburse the employee 50% of the cost of lodging expenses subject to the following conditions:

- the treatment must be for a serious medical condition;
- the necessity for the insured person to stay overnight nearby the treatment facility must be certified as medically necessary by the insured person's attending physician;
- the Plan will reimburse 50% of the cost of lodging, subject to a $25 per day minimum and a $50 per day maximum;
- the Plan will reimburse an overall maximum of $1,000 per insured person, per medical condition;
- the benefit will apply only to the expenses of the insured person and not a companion;
- lodging expenses must be supported by valid original receipts.

The Plan's Extended Health Benefits do not cover:

a) expenses for benefits, care or services payable by or under the Basic Medical Plan, PharmaCare, any Hospital Program or the Worker's Compensation Act, whether or not a claim is made there under or provided without cost or at nominal cost by any public or tax-supported authority or agency or for which the Member or dependent can recover from another party.

b) any amount of fees in excess of the usual or recognized fees for the service performed.

c) expenses incurred outside the province of residence unless resulting from an unexpected injury or sickness occurring while temporarily traveling outside the province and then only to the extent provided under the section Out of Province/Canada Emergency Medical Travel Insurance or if pre-approved under the Medical Referral Benefit as described herein.

d) expenses of services and supplies for cosmetic purposes.

e) expenses caused, contributed to or necessitated as a result of:
   - war or any act of war or participation in a riot or civil insurrection;
   - injury or sickness which was intentionally self-inflicted, whether sustained or suffered while sane or insane;

- occupational illness or injury; or
- the commission by the person of any unlawful act including an offense under the Criminal Code of Canada.

f) any expenses that a covered person may obtain as a benefit under any government plan or law.

g) any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging which represents an amount in excess of the schedule of costs prescribed by the Medical Services Plan.

h) medical cannabis in any and all of its forms.

Extension of Benefits

Extended Health Benefits for an employee who is Totally Disabled will remain in force while the employee is receiving Long Term Disability Benefits. The premium for this benefit will be paid by the Plan, as long as the employee collects LTD benefits under the Plan.

MEDICAL REFERRAL BENEFIT

The Medical Referral Benefit provides coverage for reasonable and customary charges for medical and transportation expenses in excess of those expenses covered by the insured person's government health insurance plan, Health Insurance Plan or EHC plan, for the insured person and an approved escort, up to a lifetime maximum of $75,000 per person, as a result of a pre-approved medical referral for treatment, subject to the following conditions:

a) the treatment must not be available within 500 kilometres from your residence; and

b) the medical referral service must be obtained in Canada, if available, regardless of any waiting lists; and

c) your attending Canadian physician and a qualified Canadian medical specialist from an appropriatel relate medical field must recommend the treatment; and

d) the referral service must be eligible for reimbursement and paid in whole or in part by your government health insurance plan or Health Insurance Plan (a written pre-authorization from your government health insurance plan or Health Insurance Plan outlining their liability is required); and

e) if your government health insurance plan, Health Insurance Plan or EHC plan covers and reimburses the full medical referral expenses, no benefits are payable; and

f) the treatment must not be experimental or investigative in nature; and

g) medical services and travel must take place within 30 days of receiving approval from your government health insurance plan or Health Insurance Plan, unless the earliest possible treatment date exceeds 30 days from the date of approval; and

h) the medical referral must be pre-approved, following submission of a request for pre-approval in writing to Global Excel, along with supporting documentation.

OUT OF PROVINCE/CANADA EMERGENCY MEDICAL TRAVEL INSURANCE

Emergency Medical Travel Insurance provides coverage for eligible Members and their eligible dependents for certain expenses incurred as a result of an emergency while travelling outside your province. This travel insurance is underwritten by the Manufacturers Life Insurance Company (Manulife). Manulife has appointed Global Excel Management (Global Excel) as the provider of all assistance and claims services under this policy.

Coverage Period: 60 days per trip

Policy Number: DAT00013334

Out of Province/Canada Emergency Medical Travel Insurance coverage has a maximum of $5 Million per coverage period.

IF YOU HAVE AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY BEFORE SEEKING TREATMENT. THEY ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK AND CAN BE CONTACTED BY CALLING:

From Canada and the United States,
call TOLL FREE 1-833-685-2790

From anywhere else in the world,
call COLLECT + 519-735-9448

You must notify Global Excel before obtaining emergency treatment, so that they may:

- confirm coverage
- provide pre-approval of treatment

If it is medically impossible for you to call prior to obtaining emergency treatment, call or have someone call on your behalf as soon as possible.

If you fail to notify Global Excel, the Insurer reserves the right to limit your benefits as follows:

- The Insurer will not pay expenses for benefits that are not approved by Global Excel, if pre-approval is required; and
- In the event of hospitalization, 80% of eligible expenses, based on reasonable and customary charges, to a maximum of $25,000; and
- In the event of an outpatient medical consultation, a maximum of one visit per sickness or injury.

You will be responsible for payment of any remaining charges.

Some treatments require pre-approval in order to be covered. For more details refer to the full Emergency Medical Travel Insurance Booklet available upon request from the Plan Administrator.

If you do not contact Global Excel prior to seeking treatment, the medical treatment you receive may not be covered by this insurance.

Global Excel can direct you to a medical facility or doctor in your area of travel. If you contact Global Excel at the time of your emergency, they will ensure that your covered expenses are paid directly to the hospital or medical facility, where possible.

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your coverage before you travel, as your coverage is subject to certain limitations and exclusions.

Pre-existing medical condition exclusions may apply to medical conditions and/or symptoms that existed before your trip. Refer to your Schedule of Benefits outlined above your Manulife/Global Excel Assistance Wallet Card to determine how these exclusions affect your coverage and how they relate to your departure date.

In the event of a claim, your medical history will be reviewed after a claim has been reported.

Your insurance provides travel assistance. You are required to contact Global Excel prior to treatment. Failure to do so limits benefits.

Coverage is for an unlimited number of trips up to the coverage period for each trip (60 days per trip); however, each trip must be separated by a return to your province.

Coverage must be in effect before you leave your province. You do not need to provide advance notice of your departure date and return date for each trip. However, you will be required to provide evidence of these dates when filing a claim, for example, an airline ticket or boarding pass.

Claims Procedures

You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim:

If in Canada or the United States,
call toll free at: 1-833-685-2790

From anywhere else in the world,
call collect to: + 519-735-9448

During your call, you will be given all the information required to file a claim.

You will be asked to substantiate your claim by providing all required documents. Failure to do so may result in non□payment of your claim. The Insurer is not responsible for fees charged in relation to any such documents. Incomplete documentation will be returned to you for completion.

When making a claim, you may be required to complete a Claim & Authorization Form along with providing supporting documentation such as:

- Complete original unused transportation tickets and vouchers if the Emergency Air Transportation or Return of Travel Companion benefit is used.
- All original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all relevant dates and type of treatment, and the name of the hospital or medical facility and/or physician.

- All original prescription drug receipts (not cash receipts) from the pharmacist, physician, hospital or medical facility showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.
- Proof of your departure date and return date. While boarding passes are preferred, airline tickets or other proof of departure date from your province, may be accepted, provided it contains your name and the location and date of your purchase.
- Any other additional documents pertinent to your claim, as may be required by Global Excel.

Failure to complete the required Claim & Authorization Form in full may delay the assessment of your claim.

All sums under this Plan are in Canadian currency unless otherwise indicated. If you paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

All pertinent documents should be sent to:
Global Excel Management Inc.
73 Queen St. Sherbrooke, Quebec J1M 0C9

Online Claim Submission:
Visit **https://manulife.acmtravel.ca** to submit your claim online. For faster and easier submissions, have all your documents available in electronic format, such as a PDF or a JPEG.

TELUS HEALTH VIRTUAL CARE

Provides eligible Employees and their families with confidential online virtual access to doctors, medical practitioners and other health care professionals without having to leave home or the workplace, avoiding travel and wait times that come with traditional medical appointments.

TELUS Health Virtual Care provides immediate, professional support from a desktop/laptop computer, tablet or smart phone. Once registered and logged in to TELUS Health Virtual Care, you will enter your name and the reason for the consult, and a TELUS Health Virtual Care Manager will be accessed to gather the information necessary to connect you with the appropriate medical practitioner. The assigned practitioner can address basic

physical and mental medical needs, issue referrals to specialists, issue and renew prescriptions and lab or other diagnostic tests ordered, as appropriate.

To set up an account, visit **virtualcare.telushealth.com/welcome** and you will need your **Client ID number** from your pay-direct card and use **Group number 4240.** You will also need to have government-issued ID handy (Provincial Health Insurance Card, Drivers License or Passport). You will be prompted to enter the email address you would like to use to set up your account, along with your province. Select your eligibility type and select the option to enter your group number (4240) and your personal coverage identifier (your Client ID Number). You will receive an activation link. Follow the link in the email you receive to activate your account. Then sign in with your email address and choose a password. Now you are set to download the TELUS Health Virtual Care app from the App Store or Google Play. Use your account credentials to sign in to the app and ensure you enable notifications. You can then set up your profile under the Profile tab and add any family members. If you need help, contact **help@vc.telushealth.com**

DENTAL PLAN

100% Basic Services
50% Major Services
$2,000 per person per calendar year maximum for both Basic and Major Services Combined
50% Orthodontia
$2,500 lifetime maximum

Calendar Year Deductible: Nil

Present your pay-direct card to your dentist office to have your dental claim submitted directly to the Plan.

Part I – Basic Services

The following services are eligible for payment. The amount payable will be calculated using the lesser of the amount charged or the fee shown in the Dental Association Fee Guide (General Practitioner) in the Province of treatment at the reimbursement level indicated on your Identification Card.

Diagnostic Services
All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:

- Oral examinations: limited to 1 every 6 months; however, complete oral examinations are limited to one in any 36 month period
- Consultations (as a separate appointment) limited to two per calendar year
- Dental x-rays: bite-wing x-rays are limited to one set every 6 months, full mouth x-rays are limited to one set in any 36 month period, and panoramic film is limited to one x-ray in any 36 month period
- Diagnostic models: limited to 1 set per calendar year.

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

- Cleaning (limited to once every 6 months)
- Scaling and root planning (16 units combined per calendar year)
- Topical application of fluoride (limited to one application every 6 months)
- Pit and fissure adhesive sealants limited to once per tooth every 24 months for children and once per tooth every 5 years for adults
- Fixed space maintainers on primary teeth

Surgical Services
All necessary procedures for extractions and other routine oral surgical procedures normally preformed by a dentist.

Restorative Services
All necessary procedures for:

- Filling teeth with amalgam, silicate, acrylic or composite restorations
- Replacement restorations if at least 12 months has elapsed since initial placement.
- Stainless steel crowns on primary teeth

Prosthetic Repairs and Maintenance
- Repair if a 6-month period has elapsed since the last date on which the dentures were provided.
- Denture maintenance, after the 3 month post insertion care period, including:
- relines and rebase- a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period
- tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period

Endodontia (Root Canals)
All necessary procedures required for pulpal therapy and root canal filling. Repeat treatment is covered only if the original treatment fails after the first 18 months.

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

Anesthesia
General anesthesia required in relation to oral surgery.

Part II – Major Services

Prosthetic Appliances, Crowns and Bridge Procedures

- Initial installation of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Partials may only be provided by a dentist/denturist.
- Initial placement of a crown and their replacement if at least 5 years has lapsed.
- Replacement of an existing full or partial denture, or fixed bridgework, if the existing denture or fixed bridgework was installed 5 years prior to its replacement and cannot be made serviceable. Dentures misplaced, lost or stolen will not be replaced at the Plan's expense.

Charges made by a licensed Denturist will be recognized for payment, in accordance with a separate Schedule of Allowances. If the services are provided by a Specialist, the Plan will add a maximum of 10% to the General Practitioners Fee Guide in recognition of the higher charges.

Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.

- Inlays and onlays will be covered only when other material cannot be used satisfactorily. Patients choosing gold where other materials would suffice will be responsible for the cost difference. A pre-authorization is suggested. Covered once in a 5 year period.
- Gold Foil only when used to repair existing gold restorations

Part III – Orthodontia (Adults if they qualify as an employee, dependent children to age 21 or 25 if a student)

Benefits are payable for Orthodontic Services performed after you have been enrolled under this Dental Plan. This benefit is designed to cover Orthodontic Services provided to maintain, restore or establish a functional alignment of the upper and lower teeth. Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced at the Plan's expense.

Pre-Treatment Estimate of Major Restorative & Orthodontic Charges

Prior to the commencement of treatment, the dentist should provide a summary of charges for the proposed course of dental care. The Plan will then provide a written estimate of the maximum amount for which payment will be made.

Alternative Services

If alternative services may be performed for the treatment of a dental condition, the maximum amount shown in the Suggested Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

Emergency Dental Care Anywhere in the World

In an EMERGENCY, while you are travelling or on vacation outside of your Province of residence, you are entitled to the services of a duly qualified dentist and will be reimbursed at the lower of the actual cost or the amount that would have been paid had the service been rendered in your Province of residence.

Extension of Benefits

Dental Benefits for an employee who is Totally Disabled will remain in force while the employee is receiving Long Term Disability Benefits.

EXCLUSIONS and LIMITATIONS

The Plan's Dental benefits do not cover payment for:

- items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- dental care which is cosmetic;

- dental care provided under a medical plan provided by an employer or government;
- services or items which would not normally be provided, or for which no charge would be made, in the absence of dental coverage;
- stainless steel crowns on permanent teeth;
- protective athletic appliances;
- anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporo-mandibular joint dysfunction;
- replacement of a lost or stolen prosthesis;
- incomplete and temporary procedures;
- implants;
- veneers;
- any dental charge for services incurred after the date coverage terminates; or
- travel expenses incurred to obtain Dental treatment.

Expenses recoverable under any other Plan will be coordinated with payments from this Plan, so that total payment received will not exceed the expenses actually incurred.

TO MAKE A CLAIM

Use your pay-direct card when you fill a prescription, when you visit participating paramedical practitioners, when you have an eye examination, for dental visits and vision care purchases. If you do not use your pay-direct card, these expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the **D.A. Townley *My Claims*** portal or mobile app (see page 47 for details).

Alternatively, claim forms for Extended Health Benefits and Vision Care can be obtained from the Administrator's Office or your Union Office or from the Administrator's website: **https://www.datownley.com/health-benefits/filing-a-claim/**

When submitting eligible claims, please be sure to include:

- Your Name (please print)
- Your Address
- Client ID
- Group Number 903037

All claims for reimbursement should be forwarded, along with applicable receipts, to the Administrator via:

- the **D.A. Townley *My Claims*** portal or mobile app
- by email to health@datownley.com
- by fax to (604) 299-8136
- mail to

  BC Marine Industry Employee Health Benefit Plan
  4250 Canada Way
  Burnaby BC V5G 4W6

COORDINATION OF BENEFITS

When coordinating benefit payments, D.A. Townley will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the Eligible expense was incurred.

If the Member or Dependent is also covered under the Spouse's plan or under any other group plan which provides similar benefits, payment will be coordinated and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the Eligible Expense (for dental, the fee guide applies).

The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.

The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:

the amount that would have been payable had it been the primary carrier, or 100% of all Eligible expenses reduced by all other benefits payable for the same expenses by the primary carrier.

If the other plan does not contain a coordination of benefits clause, payment under that plan must be made before the Plan will pay under this provision.

Extended health care plans with dental accident coverage determine benefits before dental plans.

If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.

When the Plan has paid benefits to the Member to the limit of the PharmaCare deductible, the Plan will pay their portion of the Eligible expenses based on the plan's reimbursement percentage.

The Member will provide the information required to implement this provision. It is the Member's responsibility to present a copy of the original claim form and the remittance statement or cheque stub when making further claim under this provision.

All receipts must be received by the Administrator within 15 months of the date the expense was incurred to be considered for payment.

D.A. TOWNLEY *MY CLAIMS* PORTAL and MOBILE APP

Go to: **www.datownley.com/myclaims/** and look for Online Registration in the resources section on the right side of the page. Click on the link. Complete all the required fields and acknowledge that you have read the terms and conditions.

Click on the Submit button and it will automatically direct you to the My Claims portal. Set up your account on the My Claims portal by clicking on Register Account. Enter your group number and your Client ID number from your pay-direct card, along with your postal code and date of birth. Then click Next. Set up your username and password.

Please note: you can only create one username and password for the same coverage. Then click Sign Up and accept the terms and conditions. Now you can download the free **D.A. Townley *My Claims*** app by visiting the App Store for IOS devices or Google Play for Android devices. Once downloaded, register your account on the portal and app, then you are ready to sign in using your username and password that you assigned.

DIRECT DEPOSIT

If you have not already done so, you can sign up for Direct Deposit for your claims reimbursements. Get your reimbursement faster and have the funds deposited directly into your bank account rather than waiting for a physical cheque. On the **D.A. Townley *My Claims*** portal or app, click on the Person icon on the top navigation. Go to Update Direct Deposit and enter your banking information (this can be found on the bottom of a personal cheque, from your online banking app or by calling your financial institution directly.)

RIGHTS TO COPIES OF DOCUMENTS

Effective July 1, 2012, if an employee/member lives in British Columbia or Alberta, they have the right to request, with reasonable notice, copies of documents that relate to the Plan. Legislation allows for them to obtain copies of the following documents:

Their enrollment form or application for insurance

Any written statement or other record, not otherwise part of the application, provided to the insurer as evidence of insurability

A copy of the contract/policy

The first copy will be provided at no cost to the employee/member and a fee may be charged for subsequent copies. All requests for copies of documents should be directed in writing to D.A. Townley.

LEGAL ACTION

Every action or proceeding against the Plan for the recovery of benefits payable under the Contract is absolutely barred unless commenced within the time set out in the Insurance Act.

BC MARINE INDUSTRY RETIREE BENEFITS

The BC Marine Industry Employee Health Benefit Plan does not include retiree benefits however some benefits may be available through one of two separate plans. The two plans that are available are referred to as either the 1% Plan or the $5 Plan. The names are derived from the required employer contribution rate stipulated in the respective Collective Agreements. Most employees are covered by the 1% Plan. The required employer contribution rate is subject to change as negotiated at Collective Bargaining. Despite any changes to the contribution rate, the reference will remain the 1% Plan and the $5 Plan.

As soon as you intend to retire, you must contact the Plan Administrator for the BC Marine Industry Employee Health Benefit Plan and indicate that you wish to apply for the Retiree Benefit Plan. It's important that you apply before your active employee benefit plan coverage terminates and you must also make an election to retire under your pension plan.

In order to qualify for retiree benefits, you must meet the following criteria:

- You must cease working for a contributing employer and make a pension selection to officially retire. You are not permitted to work within the Industry once you retire;
- You must have had contributions to the BC Marine Retiree Benefit Plan made on your behalf. Employees retiring on or after January 1, 2020 must have 10 years contributions into either the $5 Plan or the 1% Plan (or a combination of both and not necessarily 10 consecutive years);
- You must have been a participant in either the BC Marine Industry Employee Health Benefit Plan or the Towboat Seamen Retirement Plan or an equivalent plan at the discretion of the Trustees, for a minimum of two consecutive years immediately preceding retirement; and
- There cannot be a break in coverage when your benefits under the BC Marine Industry Employee Health Benefit Plan (or an equivalent plan at the discretion of the Trustees) ends as an active employee and when your coverage commences under the Retiree Benefit Plan.

It is important to understand that the retiree benefits will be provided as long as the Plans are financially able to do so, but are not guaranteed. The Trustees reserve the absolute right to make changes to the Plans, at any time, including cancellation of the benefits in their entirety.

The benefits available through the Plans are:

$5 Plan

- Medical Services Plan of BC (MSP)
- Extended Health: Annual deductible of $100 Single or Family,100% reimbursement of most eligible expenses, $200 per year maximum, no out of country coverage

1% Plan

- Medical Services Plan of BC (MSP)
- Dental: 50% reimbursement, $1,000 combined Family maximum per calendar year
- Vision: 100% reimbursement, $400 maximum every 24 months
- Extended Health: Annual deductible of $100 Single or Family,100% reimbursement of most eligible expenses, $1 Million lifetime maximum, no out of country coverage
- Prescription drug coverage is limited to $10,000 per person per calendar year.

Currently, there is no premium payment required from the retired employees.

If you have any questions regarding these Plans, please contact the Plan Administrator.

Benefits Provided by:

Canada Life #329027
Life Insurance
Long Term Disability

Blue Cross Life #79396008
Accidental Death & Dismemberment

BC Marine Industry Employee Benefit Plan #903037
Uninsured Life Insurance
Uninsured Accidental Death & Dismemberment
Weekly Indemnity
Extended Health Care
Dental

TELUS Health Virtual Care #4240
Virtual Health Care / Telemedicine

Manulife Group Travel Insurance
 # DAT00013334
Global Excel Management Inc.
Out of Province/Canada Emergency
Medical Travel Insurance

Address all inquiries to:

THE ADMINISTRATOR

D.A. Townley

BC MARINE INDUSTRY EMPLOYEE HEALTH BENEFIT PLAN
4250 Canada Way
Burnaby, BC V5G 4W6

This booklet explains in general terms the Plan of benefits and coverage in effect. It is not to be considered a contract of insurance. The complete terms of the Plan are set forth in the group policies issued to the Trustees.

APR 2024 (V-2)

2000 210