# BC MARINE INDUSTRY

# EMPLOYEE HEALTH BENEFIT PLAN

**www.bcmarinebenefits.org**

Address all inquiries to:
**THE ADMINISTRATOR**

convyta

**BC MARINE INDUSTRY EMPLOYEE HEALTH BENEFIT PLAN**

501 - 4445 Lougheed Hwy
Burnaby BC V5C 0E4
**Email: BCMarine@convyta.com**
**1-877-627-4630 or 1-877-MARINE-0**

For Health & Dental Claims Inquiries:
**Toll Free: 1-888-525-7587**
or visit **www.greenshield.ca** to email a question

*Including amendments to June 1, 2025

# 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

# FOREWORD

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*<br><br>*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.<br>Prior Authorization Program applies to Prescription Drugs |
| **Out of Province/ Canada Emergency Medical Travel Insurance** | $5 Million maximum per coverage period to age 80 (does not apply to Retiree Benefits) |
| **TELUS Health Virtual Care** | Online immediate medical support (does not apply to Retiree Benefits) |
| **Dental Plan** | 100% Basic Services<br>50% Major Services<br>50% Orthodontia<br>$2,000 per calendar year maximum for Basic and Major Services Combined<br>$2,500 lifetime maximum for Orthodontia |
| **Retiree Benefits** | As described herein |

# 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. In advance of this covered dependent reaching the maximum age of 21, application must be made to the Plan Administrator to arrange for continued coverage

and the dependent must meet the criteria for such continuation of coverage.

*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. Only one person may qualify as the spouse at any one time.

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. 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.

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

In the event your spouse is an eligible employee under your Benefit Trust Plan, you each may enroll. Only one of you may elect coverage for dependent children. If one spouse does not enroll, they will be the insured spouse by default.

**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 Speech and Hearing
in Both Ears .....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 Speech or Hearing
in Both Ears .....Three-Quarters of The Principal Sum
Loss of Thumb and Index
Finger of Either Hand .....Two-Fifths of The Principal Sum
Loss of Four Fingers of
Either Hand.....Two-Fifths of The Principal Sum
Loss of Hearing in One Ear. .....Two-Fifths of The Principal Sum
Loss of All Toes of One Foot.....One-Third of The Principal Sum

**Paralysis Benefits**

Quadriplegia (complete paralysis of both
upper and lower limbs) .....Two Times the Principal Sum
Paraplegia (complete paralysis of both
lower limbs).....Two Times the Principal Sum
Hemiplegia (complete paralysis of upper and lower
limbs of one side of body).....Two Times the Principal Sum

Indemnity provided under this part for all losses sustained by an Insured Person as the result of any one Accident will not exceed the following:

(a) With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum;

(b) With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum or the

Principal Sum if loss of life occurs within 90 days after the date of the Accident.

In no event will indemnity payable for all losses under this part exceed, in the aggregate, two times the Principal Sum as the result of the same Accident.

"Accident" whenever used in the policy means a sudden, unforeseen and unexpected event which arises from a source external to an Insured Person and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease or treatment for the illness or disease. This event must occur while the policy is in force and be the basis of claim.

"Injury" whenever used in the policy means bodily injury caused by an Accident occurring while the policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease.

"Loss" whenever used in the policy with reference to hand or foot means complete severance at 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 at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

"Loss of Use" whenever used in the policy means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the Accident.

**Bereavement Benefit** (Employees Only)

If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually

incurred by your spouse and dependent children for up to six sessions of grief counseling, by a professional counselor, subject to a maximum of $2,500.00.

**Brain Damage Benefit**

If you sustain an Injury which results in Brain Damage, the insurer will pay the Principal Sum, less any amount paid or payable under "Accidental Death, Dismemberment and Specific Loss Indemnity" of the policy as the result of the same Accident, provided that:

(a) you incur Brain Damage within 120 days from the date of the Accident; and

(b) you are hospitalized as a result of Brain Damage at least seven of the first 120 days of the Injury;

and

(c) a physician determines and the insurer is satisfied that you have evidence of Brain Damage for at least six consecutive months.

"Brain Damage" whenever used in the policy means irreversible physical damage to the brain causing complete incapacity of performing all the substantial and material functions and activities normal to everyday life.

**Continuation of AD&D Coverage** (Employees Only)

Your coverage under the policy may be continued during any approved leave of absence, temporary lay-off, maternity or parental leave or disability leave, provided payment of premium is continued.

**Conversion Option** (Employees Only)

Upon termination of active employment with your Benefit Trust Plan, you may, if under age 70 and within 31 days following the date of such termination, make written application to convert to an individual Accident insurance plan with no evidence of insurability required, at the individual rates in force with the insurer at the time of your termination. You may elect an amount of Principal Sum equal to or lower than the amount of Principal Sum in force under all policies issued to your employer by the insurer to a maximum of $500,000.00. This benefit is restricted to Canadian residents only.

**Day Care Benefit** (Employees Only)

If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $5,000.00, for each of your dependent children under 13 years of age who (a) are enrolled in a legally licensed day care centre on the date of your death; or (b) enroll in a legally licensed day care centre within 12 months after the date of your death.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled in a legally licensed day care centre, but not to exceed four consecutive annual payments with respect to any one dependent child.

**Education Benefit** (Employees Only)

If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $10,000.00, for each of your dependent children who (a) are enrolled as full-time students in a school for higher learning above the secondary school level; or (b) were enrolled as fulltime students at the secondary school level but enroll as full-time students in a school for higher learning within 12 months after the date of your death.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in a school for higher learning, but not to exceed four consecutive annual payments with respect to any one dependent child. If, at the time of loss, none of your dependent children are eligible for the Education Benefit, the insurer shall pay an additional amount of $2,500.00 to your designated beneficiary.

**Family Transportation Benefit**

If, following an Injury which results in a Loss covered by the policy, you are confined as an inpatient in a hospital located from a point of not less than 150 kilometers from your normal place of residence, the insurer will pay the reasonable and necessary expenses actually incurred by any one member of your immediate family for hotel accommodation and

transportation by the most direct route to you, subject to a maximum of $210,000.00 for all such expenses.

**Funeral Expense Benefit**

If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred for your funeral, subject to a maximum of $5,000.00.

**Home Alteration and Vehicle Modification Benefit**

If, following an Injury which results in a Loss covered by the policy, you are required to use a wheelchair to be ambulatory, the insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the Accident causing such Loss for (a) the cost of alterations to your principal residence; and/or (b) the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by the provincial vehicle licensing authorities where required for the purpose of making them wheelchair accessible, subject to a maximum of $50,000.00 as the result of any one Accident.

**Hospital Indemnity Expense**

A daily benefit of one-thirtieth of one percent of your Principal Sum, to a maximum monthly benefit of $2,500.00 will be payable when you are in a hospital and under the regular care and attendance of a physician, but only if such period of hospitalization is necessary for the treatment of an Injury which results in a Loss covered by the policy.

Such daily benefit will be paid from the first day of a necessary period of hospitalization as an inpatient, for which a full day's room and board is charged, but in no event for more than 12 months per Accident. A period of hospitalization which becomes necessary for the treatment of any Injury other than for a Loss covered by the policy will be covered in accordance with the above terms, and the daily benefit will be paid from the first day of hospitalization of at least a four day period of hospitalization. If a particular condition causes more than one period of hospitalization due to the same or related causes, then the maximum benefit (12 months in a hospital)

will be reinstated, provided a period of six months has elapsed between periods of hospitalization.

**Identification Benefit**

If Injury results in your loss of life and indemnity becomes payable under the policy, and provided identification of your body is required by the police or similar law enforcement agency, the insurer will pay the reasonable and necessary expenses actually incurred by a member of your immediate family for lodging and board (not to exceed a maximum duration of three consecutive nights) and transportation by the most direct route to and from the location of your body, subject to a maximum of $20,000.00. The body's location must not be less than 150 kilometers from the family member's normal place of residence.

**Permanent Total Disability** (Employees Only)

If, following an Injury and within 12 months of the date of the Accident, you are totally and permanently disabled while under age 65 and prevented from engaging in any and every occupation or employment for compensation or profit, the insurer will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any amount paid or payable under "Accidental Death, Dismemberment and Specific Loss Indemnity" as the result of the same Accident.

**Psychological Therapy Benefit**

If Injury results in a Loss covered by the policy and you require psychological therapy as prescribed by a physician, the insurer will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $5,000.00, until the full maximum has been paid, two years have elapsed from the date of Injury, or you die, whichever occurs first.

**Rehabilitation Benefit** (Employees Only)

If, following an Injury which results in a Loss covered by the policy, you require special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such Injury, the insurer will pay the reasonable and necessary expense incurred for such training within two years of

the date of the Accident, subject to a maximum of $20,000.00 as the result of any one Accident.

**Repatriation Benefit**

If Injury results in loss of life for you, your insured spouse or insured dependent child and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred for preparation and transport of the body to the city of residence, subject to a maximum of $20,000.00.

**Seat Belt Benefit**

If, due to a vehicular Accident, Injury results in a loss covered by the policy, the Principal Sum applicable to you, your insured spouse or insured dependent child will be increased by 10% if, at the time of the Accident, you, your insured spouse or insured dependent child were driving or riding in a vehicle and wearing a properly fastened seat belt. The driver of the vehicle must hold a current and valid driver's license authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs at the time of the Accident. Due proof of seat belt use must be provided as part of the written proof of loss.

**Spousal Retraining Benefit** (Employees Only)

If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such Accident by your spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications, subject to a maximum of $20,000.00 for all such expenses.

**Waiver of Premium** (Employees Only)

In the event you become totally disabled and your waiver of premium claim is accepted and approved under your Benefit Trust Plan's current Group Life policy, premiums payable under the Basic A.D.&D. policy will be waived as of the same date the claim is accepted and approved by the Group Life policy Underwriter.

**Workplace Modification and Accommodation Benefit** (Employees Only)

If, following an Injury which results in a Loss covered by the policy, you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active full-time employment with the Benefit Trust Plan providing this benefit, the insurer will pay the reasonable and necessary expenses actually incurred by your Benefit Trust Plan subject to a maximum of $5,000.00 as the result of any one Accident, provided your Benefit Trust Plan (a) agrees to provide the required equipment and/or make modifications to your workplace; and (b) acknowledges performance of the essential duties of your occupation may be altered. All required equipment and/or workplace modification must have prior approval by the insurer.

**Aggregate Limit of Indemnity**

The policy is subject to an Aggregate Limit of Indemnity of $2,500,000.00 for all losses resulting from any one Accident. This means that in the event of an Accident that results in an accumulation of losses exceeding $2,500,000.00, the amount payable with respect to each Insured Person will be reduced proportionately.

**Exclusions**

Coverage does not apply to any loss, fatal or nonfatal, caused by or contributed to, directly or indirectly resulting from:

- declared or undeclared war or any act of war;
- active full-time service in the armed forces of any country;
- suicide or self-destruction, regardless of any impairment, illness or state of mind;
- flying as a pilot or crew member in any aircraft;
- flying in owned, operated, leased or chartered aircraft of your Benefit Trust Plan;
- physical or mental illness or disease or treatment for the illness or disease;
- Injury sustained while operating a motor vehicle while either under the influence of any intoxicant, or with blood alcohol content in excess of the

lower of: the then-current legal limit for operating a motor vehicle in the jurisdiction in which the Accident took place, or 80 milligrams of alcohol per 100 millilitres of blood;

- the commission or the attempt to commit a criminal act by the Insured Person;
- an act, attempted act or omission taken or made by the Insured Person, or an act, attempted act or omission taken or made with the Insured Person's consent, for the purposes of interrupting the blood flow to the Insured Person's brain or to cause asphyxiation to the Insured Person whether with intent to cause harm or not;
- taking any drug other than as prescribed by a licensed Physician.

**Exposure and Disappearance**

If due to Accident you are unavoidably exposed to the elements and such exposure, within 12 months of the date of the Accident, results in a Loss for which indemnity would otherwise have been payable under the policy, such Loss will be deemed to be the result of Injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and if your body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you suffered loss of life as a result of Injury.

**Beneficiary**

The beneficiary or beneficiaries of an employee shall be that person or persons designated in writing by the employee and on file with your Benefit Trust Plan. If no such beneficiary designation has been filed, the beneficiary in respect of loss of life of an employee shall be the estate of the employee. All other indemnities payable, including those payable for the insured spouse and/or insured dependent children, are payable to the employee, with the exception of indemnities payable under "Bereavement Benefit", "Day Care Benefit", "Education Benefit", "Family Transportation Benefit", "Identification Benefit", "Spousal Retraining Benefit" and "Workplace Modification and Accommodation Benefit".

**Termination of AD&D Insurance**

Your AD&D insurance will immediately terminate on the earliest of the following dates:

(a) the date the policy is terminated;

(b) the premium due date if your Benefit Trust Plan fails to remit your premium to the insurer, except as the result of an inadvertent error;

(c) the date you reach 65 years of age with respect to the "Permanent Total Disability" benefit, and with respect to other benefits, the premium due date coinciding with or immediately following the date you reach 80 years of age;

(d) the premium due date coinciding with or immediately following the date you cease to be associated with your Benefit Trust Plan in a capacity making you eligible for insurance, except as provided under the part titled "Continuation of Coverage".

Your insured spouse's and/or insured dependent children's AD&D insurance will terminate on the earliest of the following dates:

(a) the date such person ceases to be an eligible person;

(b) the date your insurance is terminated.

**A.D.&D. Claims Procedures**

Written notice of claim is to be given to the insurer within a period of 30 days from the date of the Accident. Claim forms are available from your plan administrator. The insurer reserves the right to request additional information when processing the claim. Completed claim forms must be filed with the insurer within 90 days after the date of the Injury and no later than one year regardless of whether the full extent of loss is known.

## 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.

No period will be considered prior to the first day the employee was seen and treated by a physician.

***Example:*** the employee 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).

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.

**How to claim for Weekly Indemnity:**

In the event you become disabled, take the following steps as soon as possible:

a) Contact your doctor immediately upon becoming disabled. You must be seen and treated during the time of your disability.

b) Contact your employer and advise that you have become disabled and wish to file a claim for Weekly Indemnity.

c) Obtain the claim forms from your employer or from the Plan Administrator. You must complete the Plan Member Statement and your physician must complete the Attending Physician's Statement in full.

d) Once completed in full, these forms must be sent directly to Cooperators, no later than 30 days

after total disability begins, unless special circumstances prevent such.

e) Your employer will complete the Plan Sponsor Statement and send it directly to the Plan Administrator (Convyta Partners) and the Plan Administrator will review it, save a copy, create the claim and send the Plan Sponsor Statement on to Cooperators to commence the review process.

f) Once all documentation is received by Cooperators in full, if there is no outstanding information, a disabilty case manager will be assigned to the claim and a decision will be communicated to you within approximately five business days.

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 – Present your pay-direct card to your pharmacist each time you fill a prescription. Reimbursement will be made for the cost of the lowest priced generic equivalent drug based on specific provincial regulations, unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine.

   Maintenance drugs required to treat lifelong chronic conditions may be required to be purchased in a 90-day supply of a prescription at any one time. Non-maintenance drugs may be purchased in a supply not exceeding 3-months (90-day) supply of a prescription at any one time. However, for all drugs, 6 months for a vacation supply may be purchased and not more than a 13-month supply in any 12 consecutive months. Prescribed treatments to cure Hepatitis C, if eligible, are limited to a lifetime maximum reimbursement of $90,000. Prescribed anti-obesity drugs and medicines are eligible under the Plan provided the patient meets the specific criteria as outlined on the applicable medical questionnaire completed by the prescribing physician.

   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 with a limit of 36 tablets per 90-day period.

   The following are excluded and no amount will be paid for:

   - vitamins that do not legally require a prescription;

   - vaccines;

   - ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage.

Before your drug claim can be reimbursed, GreenShield, on behalf of the Plan, may require prior authorization. You can find out if your drug requires prior authorization by using the online drug search tool available to you through the member portal or by contacting GreenShield's Customer Service Centre. Further, reimbursement of reference drugs (including biologics) that have an approved biosimilar may not be reimbursed or may be limited to the lower cost drug unless medical evidence is provided.

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 GreenShield 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: **https://my.gov.bc.ca/ahdc/msp-eligibility**

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. Reimbursement for the services of a Registered Nurse (R.N.) or Reågistered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) in the home on a visit or shift basis, up to $5,000 every calendar year to a maximum of $25,000 per lifetime. No amount will be paid for services which are custodial and/or services that do not require the skill level of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.). A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GreenShield.

4. 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 type (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
    - Registered Psychologist / Licensed Social Worker / Registered Clinical Counsellor / Registered Therapeutic 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. Diabetic equipment and supplies, such as:

    - blood glucose meters;
    - insulin infusion pumps, limited to one every 5 calendar years;

- glucose monitoring systems (GMS) such as continuous and flash type monitors including sensors and transmitters;

8. Compression stockings with a pressure measurement of 15 mmhg or higher, limited to 2 pairs every 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 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 and eligible dependents.* Charges for non-prescription eyewear are not covered. *starting June 1, 2025

22. Reasonable and Customary charges for Optometric eye examinations (not covered for Retirees who retired prior to October 1, 2006), for visual acuity performed by a licensed optometrist, ophthalmologist or physician, limited to a maximum of one exam every 24 months (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.

24. Accommodation Expenses for Medical Reasons: Reimbursement for lodging for the Plan Member only (not covered for a companion) are covered at 50% copay, limited to $50 per day up to $1,000 per disability, however:

    - the required treatment must be for a serious medical condition;

- the necessity to stay overnight in a nearby treatment facility must be certified as medically necessary by your physician.
- 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.

## TRAVEL

(Applies to Active Plan Members and their eligible dependents only)

Important: This Travel benefit includes requirements, limitations, and exclusions that can affect eligibility and/or reimbursement of incurred expenses. You must be accurate and complete in your dealings with GreenShield at all times. Please take the time to read through this benefit before you travel to ensure you are aware of the terms and conditions, making note of the following:

- With the exception of the **"Referral Services"**, this Travel benefit is an **emergency** medical benefit only and provides coverage while you are temporarily outside of your regular province/territory of residence for vacation, education, or business reasons. It does not cover any non-emergency, elective, cosmetic, or experimental treatment, surgery, procedure, or any other service a covered person chooses to have performed outside of their home province/territory – whether pre-planned or not.

- GreenShield reserves the right to review your medical information at the time of claim. Any invasive or investigative procedures must be pre-approved by GreenShield Travel Assistance. If the covered person is the patient and it is medically impossible for the covered person to call prior to obtaining emergency treatment, it is extremely important to have someone call GreenShield Travel Assistance on the covered person's behalf within 48 hours. If GreenShield Travel Assistance is not notified within the first 48 hours, reimbursement of incurred expenses may be limited to **the lesser of** the amount of only those expenses incurred within the first 48

hours of any and each treatment/incident **or** the plan maximum. This means the covered person will be responsible for all expenses thereafter.

**Emergency** means a sudden and unforeseen Medical Condition that requires Treatment. An emergency no longer exists when the evidence reviewed by GreenShield Travel Assistance indicates that no further Treatment is required at your destination or you are able to return to your province/territory of residence for further Treatment. If GreenShield Travel Assistance determines that you transfer to another facility or return to your home province/territory of residence, and you choose not to, the benefits will not be paid for further medical treatment and coverage will be limited for unrelated events.

Emergency excludes Treatment of a **Pre-existing Condition** that was not completely **Stable** for the 90-day period immediately preceding the covered person's departure.

**Pre-existing Condition** means any Medical Condition that exists prior to the date of the covered person's departure.

**Medical Condition** means any disease, illness or injury (including symptoms of undiagnosed conditions).

A Medical Condition is considered Stable when all of the following statements are true during the 90-day period immediately preceding the date of the covered person's departure.

a) There has not been any new Treatment prescribed or recommended, or change(s) to existing Treatment (including stoppage in Treatment), and

b) The Medical Condition has not become worse, and

c) There has not been any new, more frequent, or more severe symptoms, and

d) There has been no hospitalization or referral to a specialist, and

e) There have not been any tests, investigation or Treatment recommended, but not yet complete, nor any outstanding test results, and

f) There is no planned or pending treatment, and

g) There has not been any change to an existing prescribed drug (including an increase, decrease, or stoppage to prescribed dosage), or any recommendation or starting of a new prescription drug. The following are not considered changes to existing prescribed drug Treatment:

   i. Routine dosage adjustments of Coumadin, Warfarin, or insulin, as long as these medications have not been newly prescribed or stopped;

   ii. A change from a brand name to a generic equivalent product as long as the dosage is the same – including a transition from a biologic to a biosimilar product;

   iii. A decrease in the dosage of a medication due to the improvement of a condition.

**All of the above conditions must be met during the 90-day period prior to the covered person's departure in order for a Medical Condition to be considered Stable.**

**Travelling Companion** means any person who has prepaid accommodation and/or transportation with the Covered Person for the same covered trip.

**Treat, Treated, Treatment** means a procedure prescribed, performed, or recommended by a Physician for a Medical Condition. This includes but is not limited to prescribed medication, investigative testing, and surgery.

- To qualify for benefits, the claimants must be covered by their respective provincial/territorial government health plan or equivalent at the time the expenses are incurred; otherwise, there is no coverage under this benefit.

- Eligible travel benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial/territorial health insurance plan, if your province/territory provides such coverage.

- All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, based on the country of the payee. For payments that require currency

conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.

- Eligible benefits are limited to a maximum of 60 days per trip commencing with the date of departure from your province/territory of residence. If you are hospitalized on the 60th day, your benefits will be extended until the date of discharge.

Eligible travel expenses include the following:

**Hospital services and accommodation**

- up to a standard ward rate in a public general hospital;

- up to $350 for out-of-pocket expenses such as telephone, television rental, and parking.

**Medical/surgical services** rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;

**Emergency Transportation**

- **Land ambulance** to the nearest qualified medical facility;

- **Air ambulance** – the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial/territorial health insurance plan or to the nearest qualified medical facility.

**Referral services** – Reasonable and customary hospital, medical, surgical, and transportation expenses in excess of those expenses covered by your provincial/territorial health insurance plan for you and an approved escort;

- **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial/territorial health insurance plan and GreenShield must be obtained. Your provincial/territorial health insurance plan may cover this referral benefit entirely. You must provide GreenShield with a letter from your attending physician stating the reason for the referral, and a letter from your provincial/territorial health insurance plan outlining their liability. **Failure to obtain pre-authorization will result in non-payment.**

**Services of a registered private nurse** up to a maximum of $10,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse registered and licensed in the jurisdiction in which treatment is provided. You must contact GreenShield Travel Assistance for pre-approval;

**Diagnostic laboratory tests and X-rays** when prescribed by the attending physician. Except in emergency situations, GreenShield Travel Assistance must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery);

**Reimbursement of prescriptions** for drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded). Submit to GreenShield Travel Assistance the original paid receipt from the pharmacist, physician or hospital outside your province/territory of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

**Medical appliances** including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province/territory of residence;

**Treatment by a dentist** only when required on an emergency basis for:

- Services and treatment of a direct accidental blow to the mouth up to a maximum of $2,500. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GreenShield Travel Assistance along with dental X-rays;

- Treatment to relieve dental pain up to a maximum of $500 per trip.

**Coming Home** – when your emergency illness or injury is such that:

- GreenShield Travel Assistance specifies in writing that you should immediately return to your province/territory of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a

one-way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you and a Travelling Companion by the most direct route to the major air terminal nearest the departure point in your province/territory of residence.

This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, or cancellation penalties are not included.

- GreenShield Travel Assistance or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant.

**Cost of returning your personal use motor vehicle** to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $10,000 per trip. GreenShield Travel Assistance requires original receipts for costs incurred, i.e. gasoline, accommodation and airfares;

**Meals and accommodation** up to a maximum of $250 per day to a maximum of $5,000 per family per trip will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you or a covered dependent when the trip is delayed or interrupted due to an illness, accidental injury to or death of a Travelling Companion and the covered person remains until they or their Travelling Companion is fit to travel. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from commercial organization;

**Transportation to the bedside** including round trip economy airfare by the most direct route from your province/territory of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of 5 days for meals and accommodation at a commercial establishment will be paid for that family member to:

- be with you or your covered dependent when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least 7 days outside your province/territory of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit;

- identify a deceased prior to release of the body.

**Return airfare** if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you and your covered dependents travelling with you, or a Travelling Companion by the most direct route to the major airport nearest your departure point in your province/territory of residence. An official report of the loss or accident is required;

**Return of deceased** up to a maximum of $15,000 toward the cost of preparation and transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province/territory of residence. In the case of cremation and/or burial at the place of death, this benefit is limited to $5,000. The benefit excludes the cost of a burial coffin, urn, or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc.;

**Paramedical Practitioners** up to a maximum of $500 per practitioner per Emergency (including x-rays) for the services of a licensed chiropractor, physiotherapist, podiatrist/chiropodist, or osteopath in conjunction with treatment for an Emergency;

**Child Care** when pre-approved by GreenShield Travel Assistance, up to $5,000 for one of the following benefits for dependent children under the age of 16 in the event of an Emergency involving you or your spouse while travelling:

- Additional cost of one-way economy airfare for the return home of accompanying dependent children when you or your spouse are hospitalized, plus the cost of an escort if required;

- The cost of services of a caregiver (who is not a relative) in the location where you or your spouse is hospitalized;

- The cost of services of a caregiver (who is not a relative) in your home province/territory when the children are left unattended due to the delayed return of you or your spouse.

**Pet Return** up to a maximum of $500 for the return of your accompanying pet(s) in the event you are hospitalized or repatriated during an Emergency.

## GREENSHIELD TRAVEL ASSISTANCE SERVICE

The following services are available 24 hours per day, 7 days per week through GreenShield's international medical service organization.

**These services include:**

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination;
- Multilingual assistance;
- Assistance in locating the nearest, most appropriate medical care;
- International preferred provider networks;
- Medical consultation and monitoring to review appropriateness and quality of medical care;
- Assistance in establishing contact with family, personal physician and employer as appropriate;
- Monitoring of progress during treatment and recovery and confirming when the patient is medically fit for transportation when a transfer or repatriation is necessary;
- Emergency message transmittal services;
- Translation services and referrals to local interpreters as necessary, pertaining to the medical emergency;
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers;
- Special assistance regarding the co-ordination of direct claims payment;
- Co-ordination of embassy and consular services;

- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary;
- Management, arrangement and co-ordination of repatriation of remains;
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
  - the return of unaccompanied travel companions;
  - travel to the bedside of a stranded person;
  - rearrangement of ticketing due to accident or illness and other travel related emergencies;
  - the return of a stranded personal use motor vehicle and related personal items.
- Knowledgeable legal referral assistance;
- Co-ordination of securing bail bonds and other legal instruments;
- Guidance in replacing lost or stolen travel documents including passports;
- Courtesy assistance in securing incidental aid and other travel related services.

**How Travel Assistance Service Works**

For assistance dial **1.800.936.6226** within Canada and the United States or call collect **519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GreenShield Identification Card.

Quote your GreenShield Identification Number, found on your GreenShield Identification Card, and explain your medical emergency. **You must always be able to provide your GreenShield Identification Number and your provincial/territorial health insurance plan number.**

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major

emergency treatment, GreenShield Travel Assistance will guarantee the provider (hospital, clinic or physician), that you have the required provincial/territorial health insurance plan coverage and GreenShield travel benefits as detailed above.

GreenShield Travel Assistance will follow your progress to ensure that you are receiving the best available medical treatment. GreenShield Travel Assistance also keeps in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GreenShield Travel Assistance and submit them for reimbursement upon your return to Canada.

**Travel Limitations**

1. Coverage becomes effective at the time you or your dependent crosses the provincial/territorial border departing from their province/territory of residence and terminates upon crossing the border returning to their province/territory of residence on the return home. If traveling by air, coverage becomes effective at the time the aircraft takes off in the province/territory of residence and terminates when the aircraft lands in the province/territory of residence on the return home.

2. GreenShield Travel Assistance must be notified **before** obtaining Emergency Treatment in order for GreenShield Travel Assistance to:

   - confirm coverage; and

   - provide pre-approval of treatment.

   If it is medically impossible for the covered person to call prior to obtaining Emergency Treatment, GreenShield Travel Assistance requires either the covered person or someone on behalf of the covered person to call GreenShield Travel assistance within 48 hours of commencement of treatment.

   If GreenShield Travel Assistance is not notified before the Emergency Treatment was received, benefits will be limited to **the lesser of** the amount of only those expenses incurred within

the first 48 hours of any and each treatment/incident or the plan maximum. This mean you will be responsible for all expenses hereafter.

3. After your medical emergency treatment has started, GreenShield Travel Assistance must assess and pre-approve additional medical treatment. If you undergo tests as part of a medical investigation, treatment or surgery, obtain treatment or undergo surgery that is not pre-approved, your claim will not be paid. This includes invasive testing, surgery, cardiac catheterization, other cardiac procedures, transplants, MRI.

4. Repatriation is mandatory when GreenShield Travel Assistance determines that the covered person should transfer to another facility or return to the home province/territory of residence for treatment, or at the end of the emergency. If you choose not to return:

   - no benefits will be paid for any further medical treatment;

   - no benefits will be paid for any recurrence or complications related directly or indirectly to the Medical Condition that caused the emergency; and

   - for the remainder of the trip, coverage will be limited to Medical Conditions completely unrelated to the Medical Condition that caused the emergency.

5. Air ambulance services will only be eligible if:

   - they are pre-approved by GreenShield Travel Assistance;

   - there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey;

   - you or your dependent are admitted directly to a hospital in your province/territory of residence, and;

   - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GreenShield Travel Assistance;

- proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GreenShield Travel Assistance.

6. If planning to travel in areas of political or civil unrest, or in areas where the Canadian government has issued a formal travel warning regarding non-essential travel, contact GreenShield Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services.

7. GreenShield Travel Assistance reserves the right, without notice, to suspend, curtail or limit its services in any area if any of the following occur:

   - political or civil unrest, rebellion, riot, or military uprising;

   - labour disturbance or strike;

   - act of God; or

   - refusal of authorities in a foreign country to permit GreenShield Travel Assistance to provide service.

   This includes travel if when you booked your trip (including delay of travel), or before your departure date, the Canadian government issued a formal travel warning advising Canadians to avoid either all travel or all non-essential travel regarding the country, region, city, or other key components of your travel arrangements (e.g., cruise ship) due to a likely or actual epidemic or pandemic.

In this limitation, non-essential travel means anything other than a significant medical or family emergency, such as the death of a family member.

**Travel Exclusions**

In addition to the Health Exclusions, Travel claims will not be paid for the following.

1. Any expenses incurred for the treatment related directly or indirectly to a Pre-existing Medical Condition that, at the time of your departure from your province/territory of residence and the 90-day period immediately preceding your departure from your province/territory of residence:

a) was not completely Stable in the professional opinion of GreenShield Travel Assistance Team;

b) where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling; or

c) a physician advised the covered person not to travel.

GreenShield Travel Assistance reserves the right to review the covered person's medical information at the time of claim. A physician's opinion that the covered person was fit to travel does not override or eliminate the requirement for the covered person to satisfy all the conditions of Stable.

2. Any expenses submitted if the covered person or anyone acting on behalf of a covered person attempts to deceive GreenShield Travel Assistance, or makes a fraudulent, false, or exaggerated statement or claim.

3. Any expenses incurred for any services received that:

   a) were not required to treat an Emergency;

   b) were not recommended by a legally qualified physician or surgeon;

   c) are not covered under your provincial/territorial health insurance plan;

   d) are normally covered under the out-of-Canada benefits of your provincial/territorial health insurance plan's out-of-Canada coverage (where applicable), when the provincial/territorial plan has declined payment; or

   e) are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined 3.a), b), c), or d) above.

4. Any expenses incurred for services received after GreenShield Travel Assistance determined:

   a) the covered person was to return to the province/territory of residence for treatment, but the covered person chose not to return to the province/territory of residence;

b) the services could be reasonably delayed until the covered person returned to the province/territory of residence;

c) the emergency had ended; or

d) the services are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined 4.a), b), or c) above.

5. Any expenses incurred for services to treat a medical condition or complications of a medical condition directly or indirectly related to an epidemic or pandemic if, when the trip was booked, or before the departure date, an official travel advisory was issued by the Canadian government advising Canadians to avoid either all travel or all non-essential travel regarding any country, region, city, or other key components of your travel arrangements (e.g., cruise ship). To view the travel advisories, visit the Government of Canada Travel site.

6. Any expenses incurred for services to treat:

   a) any medical condition, including symptoms of withdrawal, arising from or in any way related to the chronic use of alcohol, drugs, or other intoxicants whether prior or during the trip;

   b) any medical condition arising during the trip resulting from, or in any way related to, the abuse of alcohol that results in a blood alcohol level of more than 80 milligrams in 100 millilitres of blood, drugs or other intoxicants; or

   c) any medical condition resulting from not following Treatment as prescribed, including prescribed or over-the-counter medication.

7. Any expenses related to pregnancy, delivery, or complications of either, arising during the 8-week period before and after the expected date of delivery.

8. Any expenses incurred for a child born during the trip within the 8-week period before and after the expected date of delivery.

9. Any expenses incurred during any trip made for the purpose of obtaining a diagnosis, Treatment, surgery, palliative care, or any alternative therapy,

as well as any directly or indirectly related complication.

**GreenShield does not assume responsibility for, nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other healthcare provider or facility recommended by GreenShield Travel Assistance.**

## 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 temporomandibular 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.

## CLAIM INFORMATION

**Inquiries**

For detailed inquiries, contact GreenShield:

- Call the Customer Service Centre at 1-888-525-7587 to determine eligibility for a specific item or service and GreenShield's pre-authorization requirements, or
- Visit their website at greenshield.ca to e-mail your question.

**Submitting Claims**

Claim forms, including Pre-Authorization forms, and valuable claims submission information, is available at greenshield.ca.

Please note that in addition to a completed claim form, claims reimbursement requires the original itemized paid receipt **(cash receipts or credit card receipts alone are not acceptable).** GreenShield reserves the right to request supplementary claims information. Failure to respond to such requests may result in the denial of the claim. The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud. Submission of a fraudulent claim is a criminal offence and will be reported to the applicable law enforcement and/or regulatory agencies and your plan sponsor. This could result in termination of your coverage under this benefit plan.

**Emergency Travel**

GreenShield Travel Assistance must be contacted by phone within 48 hours of commencement of treatment. For assistance and to obtain the proper claim form, dial **1.800.936.6226** within Canada and the United States or call collect **519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GreenShield Identification Card.

If you have incurred out of pocket expenses, make sure you tell GreenShield Travel Assistance about all the travel coverage you have when submitting claims. Claims must be submitted together with supporting original receipts to GreenShield Travel Assistance who will then co-ordinate reimbursement of those approved, eligible expenses from all sources (e.g., provincial plans that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.).

When submitting your Emergency Medical claim, please include:

- Completed and signed claim form provided to you by GreenShield Travel Assistance when notice of claim has been given, which you must complete and sign for the purpose of allowing GreenShield Travel Assistance to recover payment from any other insurance contract or health plan (group, individual or government).

- A fully completed and signed claim form with all original bills and receipts from commercial organizations for any claims you paid out of pocket.

- Medical records including an emergency room report and diagnosis from the medical facility, or a Medical Certificate completed by the treating physician. Any fee for completion of the certificate is not a benefit under this insurance.

- Completed appropriate Government Health Insurance Plan forms; see claim form for details.

- Proof of date of departure from your province or territory of residence.

- Any other documentation that may be required and/or requested by GreenShield Travel Assistance.

**Claims Submission Period**

All Health, Travel and Dental claims must be received by GreenShield no later than 12 months from the date the eligible benefit was incurred.

**Reimbursement**

Reimbursement will be made by one of the following methods:

- Direct deposit to your personal bank account, when requested;

- A reimbursement cheque, or

- Direct payment to the provider of services, where applicable.

All dollar maximums and limitations stated are expressed in Canadian dollars. Reimbursement will be made in Canadian or U.S. funds for both providers and plan members, based on the country of the payee.

**Overpayments**

GreenShield reserves the right to recover all amounts resulting from overpaid or unsupported claims for benefits by deducting such amounts from future claims and/or by any other legal means.

**Limitation on Legal Action**

In Ontario, every action or proceeding against GreenShield for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the Limitations Act, 2002.

In British Columbia, Alberta and Manitoba, every action or proceeding against GreenShield for

recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the Insurance Act.

**Subrogation**

GreenShield retains the right of subrogation of benefits. This means if GreenShield paid benefits on behalf of you or your dependent, but the benefits either should have been paid or are subsequently paid or provided, in whole or in part, by a third party liability or other coverage(s), GreenShield has the right to recover such payment or reimbursement. In cases of third party liability, you must advise your lawyer of our subrogation rights.

## CO-ORDINATION OF BENEFITS (COB)

If you are covered for extended health and dental benefits under more than one plan, your benefits under this plan will be coordinated with the other plan so that you may be reimbursed up to 100% of the eligible expense incurred.

Claims must be submitted to the primary payer first. Any unpaid balances should then be submitted to the secondary plan(s). When GreenShield is identified as a secondary carrier, submit the original Explanation of Benefits statement from the primary carrier and a copy of the claim form in order to receive any balances owing.

Use the following guidelines to identify the primary and secondary plans:

**BC Marine Plan Member**

GreenShield coverage for you is always primary. If you are the plan member under two group plans, priority goes in the following order:

- The plan where you are a full-time plan member;
- The plan where you are a part-time plan member;
- The plan where you are a retiree.

**Spouse**

If your spouse is a plan member under another benefit plan, this GreenShield coverage is always secondary. Your spouse must first submit claims to his/her benefit plan.

**Children**

When dependent children are covered under both your GreenShield plan and your spouse's benefit plan, use the following order to determine where to submit the claims:

- The plan of the parent whose birth date (month and day) occurs earliest in the calendar year;
- The plan of the parent whose first name begins with the earlier letter of the alphabet, if the parents have the same birth date;
- In cases of separation or divorce with multiple benefit plans for the children, the following order applies:
    - The benefit plan of the parent who has custody of the dependent child;
    - The plan of the spouse of the parent who has custody of the dependent child;
    - The plan of the parent who does not have custody of the dependent child;
    - The plan of the spouse of the parent who does not have custody of the dependent child.

If the parents have joint custody and both have the children listed as dependents under their plans, claims should first be submitted to the plan of the parent whose birth date (month and day) occurs earliest in the calendar year. Balances can then be submitted to the other parent's plan.

**Travel Benefits**

In the event of a travel claim, all plans equally share the cost of the claim.

## ACCESS TO INFORMATION

If you live in a province where the law permits you to request copies of your records, GreenShield will provide one copy of the following at no charge:

a) any enrollment form you completed for coverage under this plan that was submitted to GreenShield;

b) any written statements or other record about your health that you submitted to GreenShield

during the course of applying for coverage under this plan;

c) one copy of the group contract.

GreenShield may charge you to provide any additional copies.

## CONFLICT

To the extent that there is any conflict between the content of this Booklet and a provision of the Trust Agreement, an applicable insurance policy or benefit contract, or applicable legislation, the provision of the Trust Agreement, insurance policy, benefit contract or applicable legislation (as the case may be) will prevail.

## NOT A CONTRACT OF INSURANCE

This booklet is not to be considered a contract or policy of insurance. The complete terms of any insured benefit are set forth in the group policies of insurance issued to the Trustees.

## 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

**Industrial Alliance #100013339**
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

**GreenShield**
Out of Province/Canada Emergency Medical Travel Insurance

Address all inquiries to:
**THE ADMINISTRATOR**

convyta

**BC MARINE INDUSTRY EMPLOYEE HEALTH BENEFIT PLAN**

501 - 4445 Lougheed Hwy
Burnaby BC V5C 0E4

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.

JUN 2025

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