Marine Workers Welfare Plan Trust Fund

Plan Booklet

With amendments up to and including January 1, 2025

Administered by:

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INTRODUCTION

The Marine Workers Welfare Plan is the result of Collective Agreements between the Marine Workers & Boilermakers Industrial Union, Local No 1, and employers who contribute to this Plan. **Each Collective Agreement is unique; you will only be eligible for the benefits outlined in this booklet if your employer contributes to the Plan on your behalf.**

The Plan is administered by a Board of Trustees appointed by the Union who may enter into arrangements with outside providers for some of the benefits. The Trustees are responsible for the administration and operation of the Plan, including the receipt and investment of all contributions and maintenance of the funds. In order to carry out these responsibilities, the Trustees may hire any or all the following professionals:

- an administrator to maintain Member records and process benefits;
- actuaries to value the Plan's liabilities and advise on the design and benefits of the Plan;
- an auditor to verify the financial transactions of the Plan;
- investment counsellors;
- legal advisors; and
- any other professionals as may be deemed necessary by the Trustees from time to time.

The Trustees may amend the Plan's terms and conditions to meet changing conditions, appoint new advisors, and change fiduciaries as circumstances dictate.

This booklet gives only a brief outline of the benefits, rules covering eligibility, and the procedures to follow when making claims. It is intended to explain the Plan in everyday language. It is not a legal document; it does not create or confer any rights to any benefits that are not specifically granted by the Plan

documents, Trust Agreements, or the minutes of the Trustees' meetings.

The Plan is not a contract of insurance but rather an employee life and health trust, which holds employer contributions in order to provide certain benefits as determined by the Board of Trustees. The exact terms of the Plan are contained in the Plan documents, insurance policies issued by the insurance carrier(s), and rules adopted by the Trustees in accordance with the Trust Agreements.

Benefits, eligibility rules and procedures may change from time to time as the Trustees deem necessary. In the event of any discrepancy, disagreement, misunderstanding, or conflict between this booklet and the Plan texts, the formal texts will govern, and benefits will be administered according to the official Plan documents and applicable legislation.

Be sure to read this booklet carefully so you will be acquainted with all the various benefit provisions. Should any question arise as to the exact nature of your coverage, please contact the benefits office for a definite determination.

Your Board of Trustees

BENEFITS PROVIDED BY

Benefit	Provider
Member Life	Insured by The Manufacturers Life Insurance Company, Policy #31606
Dependent Life	
Accidental Death & Dismemberment	
Long Term Disability	
Accidental Death & Dismemberment	Insured by Blue Cross Life, Policy #793960014
Weekly Indemnity	Self-Insured by the Plan and paid by D.A. Townley, Policy #5019
Extended Health	
Vision Care	
Dental	
Emergency Out-of-Province Medical	Manulife Group Travel & Global Excel, Policy #DAT00013350
Employee and Family Assistance Program	TELUS Health (formerly Morneau Shepell / LifeWorks)
Basic Medical	BC MSP, Group #3135019

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.

ELIGIBILTY

WHO MAY BE COVERED

This Plan is for:

- Members of the Marine Workers & Boilermakers Industrial Union, Local No. 1 who work for contributing employers, and who are in good standing with the Union. A Member in good standing is a Member whose Union Dues are paid to date; or
- any employees for whom coverage under this Plan has been approved by the Trustees.

WHEN YOU BECOME COVERED INITIALLY

If you are not a Member of the Union but you are working under the jurisdiction of the Union (i.e. on permit), you will only become eligible for coverage under the Marine Workers Welfare Plan upon becoming a Member of the Union.

An account is kept by the Administrator of the Fund for each Member which shows the hours they have worked for a contributing employer for which contributions have been made to the Plan. This account is called an Hour Bank Account.

In order for a Member of the Marine Workers & Boilermakers Industrial Union, Local No. 1 to qualify for full benefit coverage under the Plan, 280 hours must be reported to the Plan by a contributing employer within a six (6) consecutive-month period. Non-Members (permit) are not eligible until they become a Member of the Marine Workers & Boilermakers Industrial Union, Local No. 1 (the Union).

A Member will have been deemed to qualify for coverage on the 1st day of the month following the month (lag) in which sufficient hours are reported and paid to the Plan by the employer(s).

<u>NOTE</u>: Coverage will not commence until such time as the Member has completed their enrolment forms in full and returned such forms to the Plan Administrator.

Hours reported

MONTH	MEMBER A	MEMBER B	MEMBER C
January	80 hours	60 hours	115 hours
February	80 hours	120 hours	70 hours
March	85 hours	90 hours	100 hours
April	30 hours	60 hours	lag
May	40 hours	Lag	Qualified
June	Lag	Qualified	—
July	Qualified	—	—

Once coverage starts, you will continue to be covered as long as your Hour Bank contains sufficient hours to provide coverage.

Once qualified for coverage, 140 hours will be deducted each month from your Hour Bank Account. The number of hours in your Hour Bank Account may never exceed 700 hours (enough to provide five (5) months of coverage even though you may not acquire new hours during that period). Excess hours over this amount will be credited to the general reserves of the Plan.

EXTENSION OF COVERAGE BY SELF-PAYMENT (UNION MEMBERS ONLY)

If your Hour Bank falls below 140 hours, you will be sent a Self-Payment or Shortage Notice to advise you of the payment you must make to maintain coverage for one month. If you wish to maintain your coverage for that month, you must make a Self-Payment for the number of hours that you are short. Payment must be made by the date shown on the Self-Payment or Shortage Notice.

THE ONLY WAY TO GUARANTEE CONTINUOUS COVERAGE IS TO SELF-PAY BY THE DATE SPECIFIED ON THE SELF-PAYMENT OR SHORTAGE NOTICE.

Sometimes shortages occur because your employer did not report your hours on time. Also, remember that there is a lag month; for example, the January hours that your employer remits go towards your March coverage.

You may Self-Pay your coverage for yourself and your family from month to month provided that you are available for work within the jurisdiction of the Union. If you are working outside of the jurisdiction of the Union, you will not be allowed to Self-Pay and the length of your coverage will be limited to the hours in your Hour Bank.

You may Self-Pay for all benefits except Weekly Indemnity and Long Term Disability.

Self-Payment is limited to a maximum of twelve (12) continuous months unless you have been approved for Long Term Disability benefits or are in receipt of WCB/WorkSafe BC wage loss benefits and have been approved for Life Insurance Waiver of Premium through Manulife Financial.

Self-Payment for Extended Health and Vision Care Benefits is subsidized by the Plan for Members who are receiving Long Term Disability benefits. Union membership must be maintained in order to qualify for Self-Payment.

If you take out a withdrawal or transfer card, your coverage will continue until the end of the month in which you withdraw. If you have not paid Union Dues to the Union for more than three (3) months, you will lose your Union membership and your coverage will be terminated as of the last day of the month in which your Union membership is terminated.

Do Not Ignore the Self-Payment or Shortage Notice

If you receive a Self-Payment or Shortage Notice and you think it is incorrect, contact the Plan Administrator – D.A. Townley:

- by telephone: (604) 299-7482
- or toll-free: 1-800-663-1356
- or by email: marineworkersadmin@datownley.com

The only sure way to provide yourself with coverage for a specified month is to pay the Self-Payment or Shortage Notice by the date specified on the Notice.

In the event that late hours are reported or other adjustments are found later, the hours will be credited to your Hour Bank for future use.

REQUALIFICATION FOR BENEFITS

If your coverage lapses due to insufficient hours in your Hour Bank Account or you have reached the maximum number of Self-Payments, in order to re-qualify for coverage, you will again be required to accumulate 280 hours or more of work with a contributing employer within a six (6) consecutive month period.

If, upon termination of your Group Life Insurance, you converted it in accordance with the section "Conversion Privilege", it will be necessary for you to submit evidence of insurability satisfactory to the Insurer before again becoming insured for Group Life Insurance.

TERMINATION OF COVERAGE

The coverage for you and your Eligible Dependents will terminate:

- the date you fail to have the required monthly Coverage Cost (currently 140 hours) in your Hour Bank Account;
- if you cease to be a Member in good standing of the Union;

- if you enter Military Service;
- if the Group Policy terminates;
- if you discontinue any required contributions; or
- the date you become eligible for other Group Insurance benefits similar to those for which you are covered under this Plan.

A Plan Member must be an active Member in good standing of the Union to receive any benefit coverage under the Plan. If a Member becomes inactive (four (4) months without remitting Union Dues), all benefit coverage will terminate, including disability payments, on the first day of the fourth (4th) month of unpaid Union Dues, and the Member must requalify for benefits by reporting a minimum of 280 hours through a contributing employer within a six (6) consecutive month period.

A Dependent's coverage will also terminate when they are no longer an Eligible Dependent.

ELIGIBLE DEPENDENTS

Eligible Dependents under this Plan shall include:

- your Spouse, as the result of a valid civil or religious ceremony, or a person whose common-law relationship with you has existed for a minimum period of twelve consecutive months immediately prior to the date on which a claim arose. Divorced or separated Spouses (with or without a court order or separation agreement) are not eligible for Dependent Life Insurance coverage. Separated Spouses with a court order stating that benefits are to be maintained will be eligible for Extended Health and Dental benefits.
- unmarried children who are under age nineteen (19), or under age twenty-five (25) if attending an accredited school, college, or university as a full-time student. Dependent Children must be dependent on you for support

and not employed at a regular full-time job. With respect to Dependent Life Insurance, Dependent Children must be at least fifteen (15) days of age.

- functionally impaired children who are totally dependent upon you for support. For the purposes of this Plan, functionally impaired shall mean an unmarried person who was insured as a Dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.
- a child of your Spouse provided,
  - they are also your Spouse's biological child; and
  - your Spouse is living with you and has custody of the child.

In order to be eligible, a child must be dependent on you for support and living with you or your Spouse. If your Spouse is working and has equivalent benefits through employment, you should be enrolled as a family unit both with the Marine Workers Welfare Plan and through your Spouse's group plan for Extended Health and Dental benefits. No one will be eligible as a Dependent while in military service.

RETIREE BENEFIT PLAN ELIGIBILITY REQUIREMENTS

Members in good standing, who retire under the Marine Workers Pension Plan on or after January 1, 2013, with active coverage under the Marine Workers Welfare Plan at the time of retirement, will be presented with the option to enrol in the Retiree Benefit Plan once the hours run out in their Hour Bank Account. To qualify for eligibility for this coverage, the Member must:

- be at least 60 years of age at the time of retirement;
- have a minimum of 15 years of continuous Union Membership immediately prior to retirement from a contributing employer with a minimum of nine years' (108 months) employer contributions to the Plan;

- cease to work for a contributing employer;
- cease to work within the shipbuilding, boilermaker and related industries; and
- remain a Member in good standing of the Union.

Those Members retiring between the age of 60 and 65 and those with less than nine years' employer contributions to the Plan, will be required to Self-Pay the Retiree Benefit Plan at the full cost of benefits. It is important that you respond by the deadline indicated on the notice, as you will not be permitted to enrol at a later date. Eligible Retirees will only have one opportunity to apply for the Retiree Benefit Plan coverage. This benefit is only available to Members of the Marine Workers Pension Plan. The Trustees reserve the absolute right to change and/or reduce the benefits offered, change the pricing of such benefits or outright cancel the Retiree Benefit Plan at their discretion. Please contact the Administrator prior to retirement for further details and confirmation of any coverage that may be available upon retirement.

DECEASED MEMBERS - LENGTH OF DEPENDENT COVERAGE

In the event of your death while covered under the Plan, benefits will continue for your Eligible Dependents until your Hour Bank runs out.

CHANGES IN ELIGIBILITY RULES

These rules may be altered by the Trustees from time to time without the necessity of prior notice being made to those affected thereby.

CHANGE OF ADDRESS OR BENEFICIARY

If you have a change of address or beneficiary, please notify the Plan Administrator immediately.

NOTE: Failure to comply with the above requirements may result in a delay or loss of benefits.

GENERAL PROVISIONS

DEFINITIONS

Earnings shall be your normal earnings which exclude overtime, bonus, commissions, shift differentials, incentive pay and automobile allowance.

Member means a person who conforms to the definition of Member as defined in the Marine Workers and Boilermakers Industrial Union Trust Agreement, meets the eligibility requirements as set out in this booklet, and is resident in Canada.

Collective Agreement means an agreement between an employer, group of employers or employers' organization and the Union requiring contributions to be made to the applicable trust fund, whether or not such agreement also contains conditions of employment; it may also include any special arrangement between an employer contributing to the Plan and the Trustees, and includes all extensions, renewals or amendments made from time to time.

Union means the Marine Workers & Boilermakers Industrial Union Local No 1 (MWBIU).

Year except where the context clearly implies otherwise shall mean a fiscal year or a Plan year and in either case it shall mean the calendar year ending December 31.

Leave of Absence shall mean a period of time away from work mutually agreed to by you and your employer. In the case of maternity leave of absence, the leave shall begin and finish on dates agreed to by you and your employer or as required by Provincial or Federal law.

SUMMARY OF BENEFITS

Life Insurance (Active Members only)

- $75,000 reducing to $25,000 when you attain age 65
- Coverage terminates on the date you attain age 70 or retirement, whichever is earlier, as outlined in the General Provisions section

Dependent Life Insurance (Active Members only)

- Spouse: $ 10,000
- Each Child over 14 days old: $ 5,000
- Coverage terminates on the date your Life Insurance terminates, and as outlined in the General Provisions section

Accidental Death & Dismemberment (Active Members only)

- An amount equal to the Group Life Insurance amount
- Coverage terminates on the date you attain age 70 or retirement, whichever is earlier, and as outlined in the General Provisions section

Long Term Disability (LTD) (Active Members only)*

- Monthly Benefits: $2,500**
- Qualifying Disability Period: The expiration of Weekly Indemnity benefits (up to 26 weeks) and the expiration of Employment Insurance Sickness Benefits (up to 26 weeks)
- Maximum Disability Period: to age 65
- Coverage terminates on the date you attain age 65, and as outlined under General Provisions

* Not all Members are eligible for the LTD benefit. You are only eligible for LTD coverage if your employer participates in this benefit.

** applies to claims incurred on or after January 1, 2025, otherwise $2,000

Weekly Indemnity (Active and Employed Members only)

- 70% of gross weekly Earnings up to a maximum of $725* per week *WI claims incurred on/after January 1, 2025, otherwise $670
- Benefits payable from:
  - 1st day accident
  - 1st day hospitalized
  - 5th day illness
- 26 weeks maximum

Extended Health

Active Members:

- Prescription Drugs (pay-direct), Mandatory Generic Substitution, Prior Authorization Program
- 100% reimbursement
- No deductible
- $5 Million lifetime maximum
- $5 Million Out of Canada/Province Emergency Travel protection

Retired Members:

- Prescription Drugs (pay-direct)
- Drug Coverage: 100% for all BC Fair PharmaCare eligible drugs, 60% for all other eligible prescription drugs, $25,000 per calendar year maximum per person
- $50 calendar year deductible (does not apply to drugs)
- 80% reimbursement
- $25,000 per calendar year non-drug maximum per person
- No Out of Canada/Province Emergency Travel protection

Vision Care

Active Members:

- 100% reimbursement
- $425 every 24 months
- $425 every 12 months for Dependent Children under age 16
- Vision Care maximum includes eye exams up to $75

Vision Care

Retired Members:

- 75% reimbursement
- $350 every 24 months
- $350 every 12 months for Dependent Children under age 16
- Vision Care maximum includes eye exams up to $75

Dental

Active Members:

- No deductible
- 100% reimbursement of Basic and Major Services
- 100% reimbursement of Orthodontia for Dependent Children
- 50% reimbursement of Orthodontia for adults
- $5,000 maximum for all services combined per family per calendar year

Retired Members:

- No deductible
- 50% reimbursement of Basic and Major Services
- No Orthodontia
- $5,000 maximum for all services combined per family per calendar year

Employee and Family Assistance Program (EFAP) (Active Members only)

As provided by TELUS Health (previously referred to as Morneau Shepell/Lifeworks)

Medical Services Plan (Active Members only)

As provided by Medical Services Plan of BC

MEMBER LIFE INSURANCE

In the event of your death while insured, the amount of your Life Insurance is payable to your beneficiary. You may change your beneficiary at any time by written notice to the Plan Administrator, subject to any Policy or legal limitations.

WAIVER OF PREMIUM FOR DISABILITY

If you become totally disabled for six (6) consecutive months before age 65, your Life Insurance will be continued free of charge until you cease to be totally disabled or you reach age 65, whichever occurs first. To qualify, you must, for the first 24 months following the qualifying period of six (6) months, be unable to perform any and every duty of your own business or occupation. Thereafter, you must be unable to work for compensation or profit or to engage in any business or occupation. You must submit proof of your continuing disability as may be required by the Insurer.

NOTE: In order to qualify for the Waiver of Premium benefit you must notify Manulife Financial of your disability within one (1) year of your last active day at work and must furnish proof of your disability satisfactory to the Insurer within 18 months of that last active working day.

A claim for a Waiver of Premium benefit must be submitted within 18 months of the date disabled.

CONVERSION PRIVILEGE

If your Group Benefits terminate or reduce, you may be eligible to convert your Employee Life Insurance coverage to an individual Policy, without medical evidence. Your application for the individual Policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Employee Life Insurance. If you die during this 31-day period, the amount of Employee Life

Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

NAMING A BENEFICIARY

The Member may name a beneficiary, subject to governing law, while applying for Group Insurance under this Policy or by filing notice in accordance with instructions provided by Manulife Financial. An existing beneficiary may be changed by the Member, subject to governing law, by filing notice in accordance with instructions provided by Manulife Financial. Once notice has been filed, it takes effect as of the date it was signed with respect to any payment made after the time it was filed.

If there is no designated beneficiary living at the time of death of the Member, then Manulife Financial shall pay the benefit to the Estate of the Member.

You should review your beneficiary designation to be sure that if reflects your current intent.

CLAIMS

Your beneficiary should contact the Plan Administrator, D.A. Townley, as soon as possible to obtain the necessary claim forms so that the Group Life Insurance benefit can be paid on a timely basis.

DEPENDENT LIFE INSURANCE

In the event of the death of your Spouse and/or Dependent Children while insured, the amount of Dependent Life Insurance is payable to you.

CONVERSION PRIVILEGE

If your Spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual Policy, without medical evidence.

Your Spouse application for the individual Policy, along with the first monthly premium, must be received by Manulife Financial, within 31 days of the termination date. If your Spouse dies during this 31-day period, the amount of Spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion.

If you reside in the province of Quebec and if your Dependent Child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for Spousal coverage.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

WAIVER OF PREMIUM BENEFIT

If while insured for this coverage, you become disabled and qualify for the Waiver of Premium Benefit under your Life Insurance coverage, the Insurer will also waive the payment of your Dependent Life Insurance premiums. Your entitlement to Waiver of Premium Benefit ceases on the earlier of a) the date your Waiver of Premium for Life Insurance ceases, or b) the date the Policy or this coverage terminates.

CLAIMS

Contact the benefits office as soon as possible to obtain the necessary claim forms so that the Dependent Group Life benefit can be paid on a timely basis.

ACCIDENTAL DEATH & DISMEMBERMENT

The Basic 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 (Principal Sum)**
All eligible Members	Equal to the Life Insurance
All Spouses under 70	$20,000
All eligible Dependent Children	$5,000

SCHEDULE OF LOSSES

Description of Loss	***Benefit as portion of the Principal Sum***
Life	100%
Both Hands or Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing	100%
Use of Both Arms or Both Hands	100%

Description of Loss	***Benefit as portion of the Principal Sum***
One Arm or One Leg	80%
Use of One Arm or One Leg	80%
One Hand or One Foot	75%
Use of One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing	75%
Thumb and Index Finger of the Same Hand	33.3%
Four Fingers of the Same Hand	33.3%
Hearing in One Ear	66.7%
All Toes of the Same Foot	25%
Quadriplegia (complete paralysis of both upper and lower limbs)	200%
Paraplegia (complete paralysis of both lower limbs)	200%
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	200%

"Loss" as above used with reference to Quadriplegia, Paraplegia, and Hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to Hand or Foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to Arm or Leg means complete severance through or above the elbow or knee joint; as used with reference to Thumb and Index Finger means complete severance through or above the first phalange; as used with reference to Fingers means complete severance through or above the first phalange of all four (4) Fingers of one hand; as used with reference to Toes means complete severance of both phalanges of all the Toes of one foot and as used with reference to Eye means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such Eye.

“Loss” as above used with reference to Speech means complete and irrecoverable Loss of the ability to utter intelligible sounds. Loss of the Entire Sight of Both Eyes means the total and irrecoverable Loss of Sight of Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty (20) degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing. Loss of Hearing in One (1) Ear means the diagnosis of permanent Loss of Hearing in One (1) Ear, with an auditory threshold of more than ninety (90) decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing. Loss of Hearing means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than ninety (90) decibels in the ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing.

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

All claims submitted under this Policy for Loss of Use must be verified by agreement between a Licensed Practicing Physician appointed by the Administrator “the Plan” and a Licensed Practicing Physician appointed by Blue Cross Life “the Company”, or in the event that the two (2) Physicians so appointed cannot arrive at an agreement, a third Licensed Practicing Physician shall be selected by the first two (2) Physicians and the majority decision of the three (3) Physicians shall be binding on the Plan and the Company. This procedure may be waived by the Company at its sole discretion.

Disappearance

If the body of an Insured Member has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an

occupant, then it shall be deemed subject to all other terms and provisions of the Policy, that such Insured Member shall have suffered Loss of Life within the meaning of the Policy.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Member under the Plan's current Basic Group Life Insurance Policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Member. All other benefits shall be payable to the Insured Member.

Repatriation Benefit

When Injuries covered by this Policy result in Loss of Life of an Insured Member outside fifty (50) Km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of $15,000.

Rehabilitation Benefit

If an Insured Member suffers an Injury which results in a payment being made by the Company under the Accidental Death and Dismemberment Indemnity section of this Policy, the Company shall pay in addition, the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of the Insured Member provided:

- such training is required because of such Injuries and in order for the Insured Member to be qualified to engage in an occupation in which they would not have been engaged except for such Injuries;
- expenses be incurred within three (3) years from the date of the accident; and

- no payment shall be made for ordinary living, travelling or clothing expenses.

Family Transportation

When Injuries covered by the Policy result in an Insured Member being confined to a Hospital, outside 100 Km from their permanent city of residence, within 365 days of the accident and the Attending Physician recommends the personal attendance of a member of the immediate family, the Company shall pay the reasonable and necessary expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Member but not to exceed the amount $15,000.

Conversion Privilege

On the date of termination of coverage or during the ninety (90)-day period following termination of coverage, you may change your insurance to the Blue Cross Life's individual insurance Policy. The individual Policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the Plan ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual Policy at that time.

Application for an individual Policy may be made at any office of the Blue Cross Life. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

Continuance of Coverage

In the case Members who are:

- laid-off on a temporary basis;
- temporarily absent from work due to short-term disability;
- on leave of absence; or
- on maternity leave.

coverage shall be extended for a period of twelve (12) months, subject to payment of premium. If a Member assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a Loss occurring during the performance of this occupation.

Waiver of Premium

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

- the date the Insured Member attains age 65;
- the date of the death or recovery of the Insured Member;
- the date the Insured Member is no longer eligible for total disability waiver of premium under the Policyholder's Group Life Policy; and
- the date the Master Policy is terminated.

Seat Belt Rider

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

Home Alteration and Vehicle Modification

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

- the one-time cost of alterations to the Insured Member's residence to make it wheelchair accessible and habitable; and
- the lesser of:
  - the one-time cost of modifications necessary to a motor vehicle, owned by the Injured Insured Member, to make the vehicle accessible or drivable for the Insured Member; and
  - the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Company.

Benefit payments herein will not be paid unless:

- home alterations are made on behalf of the Insured Member and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
- vehicle modifications are made on behalf of the Insured Member and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items combined will not exceed $15,000.

Dependent Child Educational Benefit

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

- ten thousand dollars ($10,000) per school year; or

- 5% of such Insured Member’s Principal Sum.

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

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

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

Spousal Educational Benefit

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

The maximum amount payable for this benefit is fifteen thousand dollars ($15,000) per Insured Member.

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

“Institution of Higher Learning” as used herein includes, but is not limited to, any university, private post-secondary college or trade school, and any College of General and Vocational Education.

Day Care Benefit

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

- the actual annual cost charged by a commercial and licensed day care centre;
- 5% of the Insured Member’s Principal Sum; or
- five thousand dollars ($5,000.00) per year.

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

- and only for such Dependent Child who at the date of the Insured Member’s Loss of Life is under age thirteen (13);
- provided such Dependent Child is enrolled in commercial and licensed day care centre no later than ninety (90) days following the Insured Member’s Loss of Life; and
- provided that the Dependent Child continues their enrolment in a commercial and licensed day care centre.

In-Hospital Benefit

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

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

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

The Company will pay this benefit monthly, retroactive to the first (1st) overnight stay of confinement in Hospital. The maximum amount payable for this benefit for all Injuries resulting from any one (1) accident per insured is $2,500 per month. Benefits are not payable for more than a total of twelve (12) months of confinement for any one (1) accident causing Injury.

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

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

- holds a license as a Hospital (if licensing is required in the province);
- operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- provides 24-hour a day nursing service by registered or graduate nurses;
- has a staff of one or more Licensed Physicians available at all times;
- provides organized facilities for diagnosis, and major medical surgical facilities; and
- is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

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

Exclusions

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

- suicide or self-inflicted injury;
- declared or undeclared war or any act thereof;
- sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
- mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
- Injury sustained while the Insured Member is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
- stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;
- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Member is:
  - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

  - riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder.
- infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
- Injury or Loss sustained while the Insured Member is on fulltime duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Member is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
- Injury or Loss sustained while the Insured Member is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while their blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;
- Injury or Loss sustained while the Insured Member is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly Licensed Physician;
- the commission or attempted commission by an Insured Member or injury incurred while an Insured Member is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed;
- an act, attempted act or omission taken or made by the Insured Member, or an act, attempted act or omission taken or made with the Insured Member’s consent, for the purposes of interrupting the blood flow to the Insured Member’s brain or to cause asphyxiation to the Insured Member whether with intent to cause harm or not; and

- natural causes.

LONG TERM DISABILITY

In the event that you become totally disabled from a non-occupational disease or injury for the required period of time known as the Qualifying Disability Period and you are under the continual treatment of a legally qualified Physician deemed appropriate by the Insurer, you will receive a monthly income benefit.

Qualifying Disability Period	The expiration of Weekly Indemnity benefits (up to 26 weeks) and the expiration of Employment Insurance Sickness Benefits (up to 26 weeks).
Monthly Benefits	$2,500* *Claims incurred on/after January 1, 2025 otherwise $2,000
Maximum Disability Period	To age 65

Benefits will not be payable beyond age 65, unless you satisfy the Qualifying Disability Period while age 64, in which case benefits will be payable for a maximum of twelve (12) months. In no event shall benefits be payable after your death, recovery, or attainment of age 66.

If you receive an increase to a prior government disability income benefit (including partial disability pensions payable under a WCB/WorkSafe BC Act) because of a current disability, then only the initial amount of such increase in the government benefit will be used to offset this benefit.

Application for whatever WCB/WorkSafe BC and/or Canada Pension disability benefits to which you may be entitled must be made prior to claiming under this Plan.

If you have a claim for benefits under WCB/WorkSafe BC and/or Canada Pension that is under dispute, you will be required to complete an irrevocable assignment of the WCB/WorkSafe BC and/or Canada Pension disability benefit, if and when received, in favour of the Plan. The Plan may withhold from the Long Term Disability benefits an amount equal to the WCB/WorkSafe BC or Canada Pension disability benefit until the dispute is resolved one way or the other.

TAXABILITY OF BENEFITS

The benefit is fully taxable.

TOTAL DISABILITY

You are considered totally disabled, during the first 24 months in which you receive benefits, if you are unable to perform any and every duty of your occupation. After this period, you are considered totally disabled if you are unable to perform any and every duty of any occupation for which you are reasonably qualified by training, education or experience. In order to determine eligibility for benefits during the first 24 months, you may be required to be examined by a medical doctor chosen by the Plan or the insurance company. In order for benefits to continue beyond the first 24-month period, you may again be required to be examined by a medical doctor chosen by the Plan or the insurance company.

To remain qualified for benefits, you must be under the regular care and personal attendance of a licensed Doctor of Medicine. Statements of continuing disability signed by your Attending Physician will be required on a regular basis.

RECURRENT DISABILITY

If a disability recurs and it is due to the same or related causes, it will be considered as one continuous disability and will not be subject to the Qualifying Disability Period unless you have returned to active, full-time employment for a period of six (6) consecutive months or longer. If your new disability is due to causes unrelated to your prior disability you may be eligible for a new disability period, subject to the Qualifying Disability Period, if you have returned to active work for at least one full day.

OFFSETS

The Amount of Disability Benefit payable to you is the Benefit Amount shown in the Summary of Benefits page, reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

- Canada or Quebec Pension Plans, excluding dependent benefits;
- WCB/WorkSafe BC;
- any group, association or franchise plan;
- any retirement or pension plan;
- Earnings or payments from any employer, including severance payments and vacation pay;
- any government plan, excluding Employment Insurance Benefits; and
- any government motor vehicle automobile insurance plan or Policy unless prohibited by law.

ALL SOURCE MAXIMUM:

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 85% of your pre-disability gross Earnings. All sources include those sources stated above and any benefit you are entitled to receive from:

- Long Term Disability benefits under this Plan;
- Canada or Quebec Pension Plans' dependent benefits; and
- if you are participating in a Program of Rehabilitation, income from the Program of Rehabilitation.

If you are participating in a Program of Rehabilitation, total monthly income while disabled cannot exceed 100% of your pre-disability Earnings as of the date disability commences. If total income exceeds 100%, the Long Term Disability Income benefit will be reduced by the amount of such excess.

Reduced Monthly Benefit: If you are disabled and eligible for full benefits and elect a different and lesser paid occupation not related to the Program of Rehabilitation, the gross benefit less reductions shall be further reduced by 50% of the Earnings from the lesser paid occupation elected, subject to the All Source Maximum described in this section.

HOW TO MAKE A LONG TERM DISABILITY CLAIM

Contact the benefits office to obtain the appropriate forms. You must file your claim for Long Term Disability benefits within six (6) months from the date of your disability.

FALSE CLAIMS

Benefits will be discontinued if you have intentionally failed to disclose or misrepresented a material fact in applying for a claim. All monies received by you or paid on your behalf must be returned to the Plan.

EXCLUSIONS AND LIMITATIONS

No benefits are payable to an insured Member for any total disability commencing within twelve months of the insured Member's effective date of insurance if the disability is caused or contributed to by a sickness or accidental injury for which the Member has received medical treatment services or has taken a

prescribed drug at any time within ninety days before their effective date of insurance.

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 a period of disability during which you do not participate 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 addiction, unless you are participating in a recognized substance withdrawal program;
- disabilities resulting from self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;
- disabilities as a result of participation in a war, riot, insurrection or criminal act;
- 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 General Provisions section of this booklet;
- for a disability which commences on or after the date a strike begins, except as outlined in the Master Policy; however, a Member can fulfil their Qualifying Disability Period during a strike;

- 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; or
- to an insured individual who is receiving any WCB/WorkSafe BC benefits or benefits from similar law.

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 be subrogated to all your 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 that 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 payments which you receive or are entitled to receive on account of past, present or future loss of income.

DISABILITY CASE MANAGEMENT PROGRAM

Manulife Financial has developed a disability case management program. The purpose of this program is to assist you, in the event that you become totally disabled and qualify for benefits, to return to productive employment. Our disability case management team includes medical consultants, claim

adjudicators and a field coordinator. This team will work with you, your employer and your Physician to assist you to recover and return to the workplace.

REHABILITATIVE EMPLOYMENT

If you are disabled, the Insurer may recommend that you undergo some suitable rehabilitative training program which would take into account the nature and limitations of your disability. Further details on this aspect will be provided in the event that you become disabled. Participation in an approved Rehabilitation Program early in your disability may improve your chances of recovery. Expert vocational and physical rehabilitation counsellors assess the level of disability and set goals. Help may include:

- coordinating return to work;
- suggesting workplace devices and modifications;
- negotiating a slow return to modified duties;
- developing alternative income sources;
- helping with vocational testing;
- job training or work-related activity;
- education; and
- physical therapy.

The Monthly Integrated Benefit will be calculated, using the Rehabilitation Reduction, to reflect participation in the Rehabilitation Program.

A claim for disability income benefits must be submitted within six (6) months of the end of the qualifying disability period.

WEEKLY INDEMNITY

If, while you are covered under the Marine Workers Welfare Plan, you become totally disabled while you are employed as a result of a non-occupational injury or a non-occupational

disease and are unable to work, the Weekly Indemnity benefit will provide you with an income of 70% of your gross Earnings up to a maximum of $670 per seven (7)-day week, for as long as you remain totally disabled and unable to work, or up to the maximum benefit of 26 weeks (180 days), whichever is the lesser. No benefit is paid for any day for which you are compensated including but not restricted to EI, employer pay or for work of any kind for remuneration or profit.

The Weekly Indemnity benefit commences from the fifth day of disability due to sickness or the first day of disability due to an accident. Should sickness result in overnight hospitalization, benefits will commence on the first day of hospitalization if it is prior to the fifth day of disability. If the disability is due to an accident, benefits will commence from the day of the accident, unless the disability commenced more than four (4) days from the date of the accident.

Where Weekly Indemnity benefits are paid for four (4) weeks or longer, the benefit will become retroactive to the first day of disability (i.e. you will receive payment for the first four (4) days that was withheld when the claim started).

NOTE: Benefits will not be paid for any period of time prior to seeing a doctor.

Chiropractors are allowed to sign Weekly Indemnity claim forms for claims of up to a maximum of six (6) weeks. Dental Surgeons are allowed to sign Weekly Indemnity claim forms for claims of up to a maximum of two (2) weeks.

Benefits will not be paid for more than one month at a time as you must be under the regular care of your doctor and following a treatment plan. Supplementary reports will be required to substantiate on-going disability.

BENEFITS WHILE IN RECEIPT OF TREATMENT FOR SUBSTANCE ADDICTION

Following a medical diagnosis from an appropriate specialist for diagnosis of addiction, resulting in a recommendation for the Member to participate in a residential treatment program or a pre-approved recommended alternate treatment program, provided the Member is eligible for Weekly Indemnity benefits, Weekly Indemnity benefits are available while the Member is unavailable for work due to receiving such treatment, up to a maximum of ninety (90) days per lifetime, provided the Member is not receiving compensation elsewhere.

RECURRENT DISABILITY

Successive periods of total disability separated by less than two (2) weeks of active work or availability for active work shall be considered as one period of disability and will be paid from the first day of disability, unless the subsequent disability is due to injury or sickness entirely unrelated to the causes of the previous disability and commences after return to work or availability for work. The maximum Weekly Indemnity benefit period for all disabilities related to the same cause is 26 weeks unless you return to work for more than two (2) consecutive months and become subsequently disabled for the same cause. In this case, the second period of disability will be treated as a new claim.

NOTE: Members on self-pay or lay-off are not eligible for this benefit. Weekly Indemnity benefits are payable only to Members in good standing of the Union who are covered under full Plan benefits at the date of disability. Dependents are not eligible for this benefit.

EXTENSION OF BENEFITS

If you are disabled and in receipt of Weekly Indemnity benefits on the date your Plan coverage terminates, Weekly Indemnity benefits will continue until the end of the benefit period under

the Plan (26 weeks), or until you recover, whichever occurs first, provided you remain a Member in good standing of the Union.

REPORTING OF CLAIM

You must file your completed claim for Weekly Indemnity benefits with the Plan Administrator within thirty (30) days of the initial assessment of the Attending Physician or within thirty (30) days from the date you received notification from WCB/WorkSafe BC that your claim has been denied or terminated because it has been deemed to be non-occupational.

LIMITATIONS

No benefit will be paid during a period:

- of disability in which you fail to submit satisfactory medical evidence if requested to do so by the Plan;
- you are entitled to Long Term Disability benefits;
- you are not under full time treatment by a duly qualified Physician;
- you refuse a medical examination by a Physician chosen by the Plan;
- you are no longer following the treatment recommended for your disability;
- of disability in which you have a right to claim wage loss or rehabilitation benefits from WCB/WorkSafe BC;
- you are outside of Canada for more than two (2) weeks unless the Plan has approved that benefits will be continued prior to your leaving BC;
- you do any kind of work for pay or profit;
- you fail to execute a Loan & Replacement Agreement when requested;
- of disability in which you have the right to recover any wage loss from a third party;
- you will be receiving EI/Employment Insurance benefits; or

- you are confined to a prison or similar institution.

EXCLUSIONS

No amount will be payable under this benefit for any disabilities which arise from the following causes:

- commission of or attempt to commit an assault or criminal offence;
- medical or surgical care which is cosmetic, unless such care is rendered as a result of reconstructive cosmetic surgery and you submit satisfactory proof that such care is medically necessary and is performed to restore tissue damaged by disease or accidental bodily injury;
- occupational injury or illness;
- self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness.
- routine pregnancy;
- Injury or illness resulting from willful participation in war, riot or insurrection or in disorderly conduct or in an unlawful assembly or from the commission of an unlawful act, including an offence under the Criminal Code of Canada; or
- Injuries sustained as the result of a motor vehicle-related accident in which ICBC or similar Insurance (Vehicle) Act is associated, or an ICBC/similar Insurance (Vehicle) Act-insured third party is liable.

TERMINATION OF BENEFIT

Your benefit payments will cease on the earliest date one or more of the following occurs:

- you are no longer disabled;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire; or
- you die.

FALSE CLAIMS

Benefits will be discontinued if you have intentionally failed to disclose or misrepresented a material fact to the Welfare Plan in applying for a claim. All monies received by you or paid on your behalf must be returned to the Plan.

No benefits will be paid for any period for which you have received or will receive regular wages or Employment Insurance or holiday pay or for any paid statutory holidays or any other incomes accruing from employment, or for any period of disability that commenced prior to the effective date of your coverage under the Welfare Plan.

When you are maintaining your Welfare Plan coverage on a full Self-Pay basis, Weekly Indemnity benefits coverage will not be available, but this restriction does not apply where coverage is maintained by partial Self-Payments plus some hours arising from employment, unless laid off or terminated from a contributing employer.

HOW TO MAKE A WEEKLY INDEMNITY CLAIM

1. Contact your doctor immediately upon becoming disabled.

2. Obtain a Weekly Indemnity claim form from the Plan Administrator’s office.

3. You must complete all the questions on the front of the claim form and sign it on both sides.

4. Ask your doctor to complete the Physician's Statement on the back of the same claim form.

5. Take or send the form back to the Plan Administrator for processing.

6. When your claim is assessed and approved, you will receive your benefit payments either by EFT (Electronic Funds Transfer) or by mail sent to your home address. You should receive your first payment within a week after receipt of your properly completed claim form unless there are complications regarding your claim or more information is required.

NOTE: The charges made by your Attending Physician for the completion of the Weekly Indemnity form and any supplementary forms are your responsibility.

THIRD PARTY LIABILITY

Weekly Indemnity Benefits may be payable to you if you would otherwise be working but are totally disabled and therefore experience wage loss. It is not intended to apply to work-related absences, which are covered by WCB/WorkSafe BC, or disabilities which are the result of the act or omission of a third party.

However, Weekly Indemnity benefits may be loaned to you for disabilities due to an accident in which a third party is liable provided that you enter into and sign a Loan & Replacement Agreement with the Plan and undertake to endeavour to collect the amount of benefits paid by the Marine Workers Welfare Plan and refund same to the Plan. Please refer to the section of this booklet entitled BENEFITS PAYABLE WHERE A THIRD PARTY IS INVOLVED for details.

In the event of an overpayment of benefits, you will be required to reimburse the Plan the full overpayment on your claim.

BENEFITS PAYABLE WHERE A THIRD PARTY IS INVOLVED

Where a Member suffers a disability as a result of a work related incident covered by WCB/WorkSafe BC, or an injury or sickness for which a third party is, or may be, directly or

indirectly, either in whole or in part legally liable, no Extended Health, Weekly Indemnity, or Long Term Disability Benefits are payable under the Marine Workers Welfare Plan.

If a Member has the right to recover money from WCB/WorkSafe BC or a third party as compensation for, sickness or injury but the liability of WCB/WorkSafe BC or the third party has not yet been determined, then the Member may apply to the Plan(s) for an advance payment of any benefit which the Member may be ultimately entitled to receive under the Plan. No advance payment/loan of benefits shall be made unless the Member is otherwise eligible to receive benefits and the Member agrees in writing to do the following:

- take all steps necessary to recover from WCB/WorkSafe BC or the third party, the total of the benefits advanced or to be advanced under this Provision, including without limitation, directing the Member's lawyer to repay to the Plan the full amount of the Benefits loaned directly from any monies received pursuant to any judgment or settlement;
- pay all legal fees incurred in pursuing the action against WCB/WorkSafe BC or the third party;
- repay to the Plan(s) the full amount of the benefits advanced to the Member under this Provision in the event the claim against WCB/WorkSafe BC or the third party is abandoned or settled without the written consent of the Plan;
- satisfy all of the terms and conditions of the Plan(s) for eligibility and payment of Weekly Indemnity or Long Term Disability benefits as if the Member was totally disabled;
- enter into a Loan & Replacement Agreement with the Plan(s) setting out the terms and conditions for repayment of the benefits; and
- consent to the release by WCB/WorkSafe BC, the third party or the insurance company of all information in their

possession relating to the Member's claim. In the event that any of the above parties decline to provide the required information, the Member must provide such information which is in their possession if requested by the Plan.

If a Member has the right to recover money from ICBC or a third party as a result of a motor vehicle-related accident/injury, for compensation for sickness or injury but the liability of ICBC or such third party has not yet been determined, then the Member may apply to the Plan(s) for a loan of such benefit.

NOTE: By accepting such loan, ICBC may deem such loan to be a payment from a first payer of such benefits and reduce the amount they allocate in the settlement/judgment by such amounts. Such reduced settlement does not reduce the amount to be repaid to the Plan and the loaned amount must be repaid to the Plan from whatever monies are recovered from ICBC or such third party.

If the Member decides to proceed in requesting such loaned amounts from the Plan, the Member must agree in writing to do the following:

- take all steps necessary to recover from ICBC or the third party, the total of the benefits loaned under this Provision, including without limitation, directing the Member's lawyer to repay to the Plan the full amount of the Benefits loaned directly from ANY monies received pursuant to any judgment or settlement;
- pay all legal fees incurred in pursuing the action against ICBC or the third party;
- repay to the Plan(s) the full amount of the benefits loaned to the Member under this Provision in the event the claim against ICBC or the third party is abandoned or settled without the written consent of the Plan;

- satisfy all of the terms and conditions of the Plan(s) for eligibility and payment of Weekly Indemnity or Long Term Disability benefits as if the Member was totally disabled;
- enter into a Loan & Replacement Agreement with the Plan(s) setting out and acknowledging the terms and conditions for repayment of the benefits; and
- consent to the release by ICBC, the third party or the insurance company of all information in their possession relating to the Member's claim. In the event that any of the above parties decline to provide the required information, the Member must provide such information which is in their possession if requested by the Plan.

EXTENDED HEALTH

Deductible*	**Active Members**: $0 **Retired Members**: $50/calendar year*
Reimbursement	**Active Members:** 100% **Retired Members:** 80%
Prescription Drugs (pay-direct card included)	**Active Members**: 100%, Mandatory Generic Substitution Prior Authorization Program **Retired Members**: 100% for BC Fair PharmaCare eligible drugs, 60% for all other eligible drugs, $25,000/yr. maximum
Maximum	**Active Members**: $5,000,000 lifetime

	Retired Members: $25,000/calendar yr.
Dependent Children	Covered from birth to age 19, or to age 25 if in full-time attendance at a school or university, or to any age if permanently disabled.

*Deductible does not apply to prescription drugs

Upon qualifying for coverage, you will receive a pay-direct card (one if you have single coverage or two (2) cards if you have Dependent coverage – both will be in your name).

The Extended Health Benefits are designed to help you pay for specified services and supplies. If you incur reasonable and customary charges for medically necessary care, services, or supplies as described here-under, when incurred as the result of necessary treatment of illness or injury and, where applicable, when ordered by a Physician, the Plan will pay benefits for such charges, subject to certain terms and conditions. However, benefits covering such charges are provided only to the extent that:

- such charges are not provided for under the Medical Services Plan of BC under which you are required to be covered; and
- the benefit is not in contravention of the terms of the legislation creating the Medical Services Plan of BC. A charge is considered to be incurred on the date the medical care, service, or supply to which the charge applies is rendered or provided.

Benefits will only be paid for charges incurred for medical care, services, or supplies described hereunder, provided they are:

- incurred as a result of sickness or accidental bodily injury;

- medically necessary; and
- given by or ordered by a Physician.

IN-PROVINCE EXPENSES

Your Extended Health covers reasonable and customary charges for the following services and supplies where medically necessary, and prescribed, ordered or referred by a Physician. Unless otherwise indicated, the maximums indicated are on a per person basis.

Hospital

This benefit will help you meet bills which are not paid for by the Provincial Hospital Plan when a sickness or accident occurs while you are covered for this benefit that requires you or your Dependent(s) to be confined to a hospital.

The following charges made by a hospital:

- hospital out-patient charges which are not eligible under MSP;
- daily room and board charges, excluding charges for chronic care, limited to the difference between the Provincial Medical Allowance for room and board charges and the Hospital's Semi- Private or Private charge; and
- room and board charges excluding charges for chronic care, made by a Convalescent Home or a Physical Rehabilitation Facility, provided that the patient's residence in the institution:
  - is certified as medically necessary by a Physician;
  - occurs within 48 hours after a hospital stay of at least five (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 Semi Private Charge, for up to a maximum benefit payment period of 180 days.

A new maximum benefit period of 180 days will apply if you incur room and board charges as described above

- for a sickness or injury unrelated to the sickness or injury which was the reason for the prior stay; or
- if at least fourteen (14) consecutive days have passed since the prior stay during which you were not a patient in a hospital, convalescent home or physical rehabilitation facility.

- room and board charges from a Substance Abuse rehabilitation program pre-approved by the Marine Workers Welfare Plan. The Member must be in good standing of the Union for the last continuous twelve (12)-month period and must remain in good standing while completing the program. The Member must complete the program.

  Charges are limited to:

  - the difference between the amount provided under the Provincial Medical Allowance for Room and Board charges and the institution's Semi Private Charge up to a maximum of $160 per day; and
  - a cumulative lifetime maximum payment of $14,400 per person. Charges for rental of a telephone, television, or similar equipment are not covered

  up to ninety (90) days of treatment.

Emergency Ambulance Services

Charges made by a local licensed ambulance service, or scheduled airline, railroad, ship or boat, or air ambulance service (including the services of a medical attendant if certified as necessary by the Attending Physician) for transporting you or your Eligible Dependent(s) for medically necessary emergency

care to the nearest hospital qualified to render such care. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation arranged at the patient's convenience is not eligible for reimbursement.

Charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient.

Air transport will be covered when time is critical, and the patient's physical condition prevents the use of another means of transport.

Emergency transport from one hospital to another will be covered only when the original hospital has inadequate facilities.

Prescription Drugs

Present your pay-direct card, along with your prescription, to your Pharmacist and your prescription drug claim will be adjudicated right at the pharmacy. Using your pay-direct card eliminates the need to send in your prescription receipt and wait for reimbursement. Your Plan provides coverage for prescription drugs (including oral contraceptives) which require and can only be obtained with the written prescription of a Licensed Physician, Dentist, or Pharmacist if provincial law permits.

Drugs are limited to a 100 day supply. Refills are not permitted to be dispensed earlier than is deemed to be reasonable and customary. Vacation supplies of your medications, which are outside of the regular days' supply limit, must be pre-authorized by the Plan Administrator and must be paid in full by the Member and submitted to the Plan for reimbursement.

Drugs that can normally be purchased ‘over the counter’ are excluded regardless of a prescription having been issued. Vitamins, smoking cessation products, drugs to treat erectile dysfunction, fertility drugs, preventive drugs, dietary foods and supplements are also excluded. Medical cannabis in any and all of its forms is excluded from coverage under the Plan.

No amount will be payable for any drug or medicine which is experimental, or which has not been approved for use by the Ministry of Health and Welfare Canada (Food & Drugs) for the sickness or injury for which it was prescribed.

NOTE: No amount will be payable for drugs or medicines that can be purchased without a prescription.

Prescription Drug Prior Authorization Program*

***Does not apply to Retired Members**

There are a number of prescription drugs which will now require prior authorization before they can be determined eligible under the Plan.

The complete Prior Authorization Listing of these drugs can be found online at:
https://www.telus.com/en/health/prior-authorization-forms

If your doctor prescribes a drug for you or one of your Eligible Dependents, that is on the Prior Authorization Listing, when you take your prescription to the pharmacy, your Pharmacist will be advised that you must obtain prior authorization first. You will then need to download the applicable Prior Authorization (PA) form for that drug from
https://www.telus.com/en/health/prior-authorization-forms
and complete the patient section, have the prescribing Physician complete their section of the form, and then send the completed form to where indicated. This information will be reviewed, and it will be determined whether the required eligibility criteria is met.

The decision will be communicated directly with the patient or individual indicated by the patient on the form. If deemed to be eligible, an exception will be added to that patient's Plan record so that the pay-direct card will accept that drug going forward according to the terms of the approval.

NOTE: do not purchase your medication in advance of the completion of the Prior Authorization Process. Claims are not covered retroactively. Please wait to confirm criteria has been met before returning to your pharmacy to fill your prescription.

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

For Active Members, reimbursement of prescription drugs is based on the cost of the lowest priced generic equivalent drug. If there is a medical reason for which you are unable to be dispensed the generic equivalent drug, your doctor will be required to complete an application for coverage of the cost of the brand name medication. This form can be obtained from the Plan Administrator.

For Retired Members, those drugs which are eligible under the BC Fair PharmaCare Program will be covered by the Plan at 100%. When you use your pay-direct card at the pharmacy for these medications, you will not have to pay your pharmacy anything at all. All remaining otherwise eligible drugs will be covered at 60%. When you use your pay-direct card at the pharmacy, you will be asked to pay 40% of the cost to your pharmacy. This is your share of the cost and no further amount is payable by the Plan. There are many medications that are not

eligible under Fair PharmaCare's standard drug formulary. Please discuss with your doctor whether a Fair PharmaCare eligible drug is suitable for you. If it is not suitable for you, you can request your doctor apply to Fair PharmaCare to have the drug covered under Special Authority. If your doctor receives approval from Fair PharmaCare, a copy of the approval must be sent to the Plan Administrator and an exception can be made on your behalf so that the medication can be covered at 100% as a Special Authority drug. To determine if a drug is eligible under Fair PharmaCare's drug formulary, perform a search online at:

https://pharmacareformularysearch.gov.bc.ca/Search.xhtml then select Fair PharmaCare from the PharmaCare Plan drop down menu.

Paramedical Practitioner Services

Fees for the following paramedical practitioners are eligible, provided they are from a licensed, certified, or registered practitioner in the province of treatment, up to the maximum amounts indicated per calendar year. X-rays, appliances and tray fees are not covered. Present your pay-direct card to your practitioner's office at the time of your appointment to determine whether they are able to submit your claim to the Plan online at point of sale.

Registered Acupuncturist	$600 per calendar year
Chiropractor	$600 per calendar year
Massage Practitioner	$600 per calendar year
Naturopath	$600 per calendar year
Physiotherapist	$600 per calendar year
Podiatrist or Chiropodist	$600 per calendar year
Clinical Psychologist	$600 per calendar year
Speech Pathologist	$600 per calendar year

Private Duty Nursing

Charges made by a Registered nurse (RN) or a Registered nursing assistant (RNA) for medically necessary nursing care when certified by a duly qualified Physician for special duty nursing in acute cases, excluding charges for nursing care rendered:

- up to a maximum of $10,000 per twelve (12) months;
- in a hospital;
- by a person who is related to the patient, or who lives in your home; or
- which does not require the specific skills of a Registered nurse or a Registered nursing assistant.

"Acute cases" means conditions having a sudden onset with a sharp rise and a course of less than 60 days but does not include conditions due mainly to chronic illness, alcoholism, mental illness, drug addiction, tuberculosis or infirmity.

Accidental Dental

Charges made by a Dentist, for the repair or replacement of sound, vital, natural teeth, up to the maximum stated in the current Dental Fee Schedule (less any amounts paid or payable by a Dental Care Plan) provided that:

Accidental Dental treatment must commence within ninety (90) days of the accident, unless a treatment plan has been submitted within ninety (90) days of the accident and treatment must be completed within fifty-two (52) weeks of the accident. No payment will be made for temporary, duplicate or incomplete procedures or for correcting unsuccessful procedures. Orthodontia services are not covered under this provision. To be eligible the accident must have occurred while the Member is covered under the Plan.

Medical / Surgical Supplies

- testing supplies, needles and syringes for diabetics - Oxygen and the rental of equipment for its use - Blood and blood plasma;
- ostomy and ileostomy supplies;
- surgical stockings to a maximum of $250 per calendar year;
- walkers, canes, crutches, splints, casts, collars, trusses, braces, but not elastic or foam supports;
- rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, mastectomy forms);
- stump socks to a maximum of $250 per calendar year;
- mastectomy brassieres to a maximum of $250 per calendar year;
- wigs and hairpieces required as a result of medical treatment or injury to a lifetime maximum of $500;
- the cost of purchasing and fitting a hearing aid, when prescribed by a doctor to a maximum of 50% of the cost of the purchase and fitting of the hearing aids up to a max of $2,000 every five (5) years. WorkSafe is to be the first payer for all hearing aid claims. The cost of necessary repairs, routine maintenance, batteries, recharging devices and other such accessories are not covered;
- reasonable and customary charges for contact lenses, when required as a result of cataract surgery or keratoconus;
- diagnostic procedures when recommended by a Physician or Surgeon;
- x-ray and diagnostic laboratory procedures and x-ray or radium therapy. Such procedures do not include services received during confinement in hospital.
- CPAP Machines, masks, hoses, and related equipment to a maximum of $1,500 per 60-month period. Repairs and replacements will be limited to reasonable charges once over the life of the machine.
- custom built orthopaedic shoes (including repairs) and modifications to stock item footwear (but not the footwear

itself) when prescribed by a Physician or Podiatrist as medically necessary, to a maximum of $600 in a calendar year period for an adult and $400 for a Dependent Child in a calendar year period; and

- custom built foot orthotics, including foot braces, when prescribed by a Physician or Podiatrist as medically necessary to a maximum of $600 in a calendar year. Replacements are covered only when necessary due to normal wear and tear.

Standard Durable Equipment
(pre-authorization is required for expenses in excess of $5,000)

Charges for standard durable equipment are eligible when rented from a medical supplier. If unavailable on a rental basis, or are required for a long term, purchase of these items from a provider may be considered on a pre-authorized basis and will include repairs to purchased items (excluding routine maintenance and batteries):

- manual wheelchairs, manual type hospital beds and necessary accessories (electric wheelchairs and hospital beds will be covered only when a doctor certifies that the patient is incapable of operating a manual wheelchair or hospital bed);
- medical monitors including heart and blood glucose monitors and cardiac screeners;
- bi-osteogen systems (when recommended by an Orthopaedic Surgeon) and growth guidance systems;
- breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks and regulators;
- insulin infusion pumps for diabetics when basic methods are not feasible;
- transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain; and

- transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.

MEDICAL REFERRAL BENEFIT

(Eligible Active Members and their Eligible Dependents only)

The Medical Referral Benefit provides coverage for eligible Active Members under the age of 80 and their Eligible Dependents for reasonable and customary charges for medical and transportation expenses in excess of those expenses covered by the insured person's Government Health Insurance Plan, Health Insurance Plan or EHC Plan, for the insured person (provided they are under the age of 80) and an approved escort, up to a lifetime maximum of $75,000 per person, as a result of a pre-approved medical referral for treatment, subject to the following conditions:

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

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

c) your attending Canadian Physician and a qualified Canadian medical specialist from an appropriately related medical field must recommend the treatment; and

d) the referral service must be eligible for reimbursement and paid in whole or in part by your Government Health Insurance Plan or Health Insurance Plan (a written pre-authorization from your Government Health Insurance Plan

or Health Insurance Plan outlining their liability is required); and

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

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

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

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

OUT-OF-PROVINCE /CANADA EMERGENCY ELIGIBLE EXPENSES

(Eligible Active Members and their Eligible Dependents only)

Emergency Medical Travel Insurance provides coverage for eligible Members under the age of 80 and their Eligible Dependents for certain expenses incurred as a result of an emergency while travelling outside your province. This travel insurance is underwritten by the Manufacturers Life Insurance Company (Manulife). Manulife has appointed Global Excel Management (Global Excel) as the provider of all assistance and claims services under this Policy.

Coverage Period: 60 days per trip

Policy Number: DAT00013350

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

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

- **from Canada and the United States, call TOLL FREE: 1-833-685-2790**
- **from anywhere else in the world, call COLLECT: + 519-735-9448**

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

- confirm coverage; and
- provide pre-approval of treatment.

If it is medically impossible for you to call prior to obtaining emergency treatment, call or have someone call on your behalf as soon as possible. If you fail to notify Global Excel, the Insurer reserves the right to limit your benefits as follows:

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

You will be responsible for payment of any remaining charges.

Some treatments require pre-approval in order to be covered (for more details Out of Province/Canada Emergency Medical

Travel Insurance Emergency Medical Travel Insurance Booklet). Ask the Plan Administrator for a copy.

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

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

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

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

In the event of a claim, your medical history will be reviewed after a claim has been reported. Your insurance provides travel assistance. You are required to contact Global Excel prior to treatment. Failure to do so limits benefits.

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

Coverage must be in effect before you leave your province. You do not need to provide advance notice of your departure date and return date for each trip. However, you will be required to

provide evidence of these dates when filing a claim, for example, an airline ticket or boarding pass.

A Manulife/Global Excel Assistance Wallet Card, with worldwide contact numbers, for the Emergency Medical Travel Insurance coverage should be carried by the Insured when travelling. These cards, along with the Schedule of Benefits and the full Emergency Medical Travel Insurance booklet can be obtained from the Plan Administrator. Members working outside of Canada must independently arrange for additional coverage.

Claims Procedures
Emergency Out of Province/Canada Expenses

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

- **if in Canada and the United States, call TOLL FREE: 1-833-685-2790**
- **from anywhere else in the world, call COLLECT: + 519-735-9448**

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

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

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

- complete original unused transportation tickets and vouchers if the Emergency Air Transportation or Return of Travel Companion benefit is used;
- all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all relevant dates and type of treatment, and the name of the hospital or medical facility and/or Physician;
- all original prescription drug receipts (not cash receipts) from the Pharmacist, Physician, hospital or medical facility showing the name of the prescribing Physician, prescription number, name of preparation, date, quantity and total cost;
- proof of your departure date and return date. While boarding passes are preferred, airline tickets or other proof of departure date from your province, may be accepted, provided it contains your name and the location and date of your purchase; or
- any other additional documents pertinent to your claim, as may be required by Global Excel. Failure to complete the required Claim & Authorization Form in full may delay the assessment of your claim.

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

All pertinent documents should be sent to:

Global Excel Management Inc.
73 Queen St. Sherbrooke, Quebec J1M 0C9

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

Exclusions

The following are not included as eligible expenses under your Extended Health Benefits:

- any item not specifically mentioned in this booklet as a benefit;
- except as specifically included in this booklet: eyeglasses, contact lenses, surgical lens implants, x-rays, hospital co-insurance, vitamin preparations, contraceptives, fertility drugs, smoking cessation treatments, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, arch supports, professional services of Physicians or any person who renders a professional health service in your province of residence;
- charges for completion of forms or written reports, communication costs, delivery or mailing or handling charges, interest on late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English;
- any payment to a pharmacy, a practitioner, or a Physician (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the Government Plan;
- that portion of a claim normally covered by the Government Plan which has been refused on the basis that the claim was not submitted within the Government Plan's time limits;
- expenses incurred outside BC due to elective treatment and/or diagnostic procedures, or complications related to such treatment;

- expenses incurred outside BC due to therapeutic abortion, childbirth, or complications of pregnancy occurring within two (2) months of the expected delivery date;
- charges incurred outside BC for continuous or routine medical care normally covered by the Government Plan in BC;
- transportation costs incurred for elective treatment and/or diagnostic procedures or for health examinations of any kind;
- expenses of a Dependent hospitalized at time of enrolment in the Plan;
- services performed by a Physician who is related to or resident with you or your Spouse;
- fees for ambulance services when an ambulance is called but not used;
- ambulance charges for work related illness or injury assessed by the WCB/WorkSafe BC Board to be your employer's responsibility; or
- medical cannabis in any and all of its forms.

No amounts will be paid by the Plan under Extended Health for charges:

- in excess of the specific limitations and maximum amounts described under eligible expenses;
- in connection with general health examinations;
- for which you obtain or are entitled to obtain benefits under any Government Plan;
- for which you are entitled to obtain benefits without charge;
- for Out-of-Province or Out-of-Canada and Emergency Travel Assistance only, self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;

- which result from insurrection or war, whether or not war is declared, any act incident to such insurrection or war, or participation in any riot;
- which result from the commission by the person of any unlawful act including an offence under the Criminal Code of Canada;
- which result from any sickness or bodily injury arising out of or in the course of any employment;
- for orthoptic treatment, eye refractions or for the cost or fitting of eyeglasses or contact lenses;
- for the cost or fitting of contraceptive devices;
- for "in vitro" or "in vivo" procedures, or any other infertility procedures;
- made by a Physician in Canada;
- for medical care or services deemed cosmetic unless it is reconstructive surgery to restore tissue damaged by sickness or bodily injury;
- for Dental Care or services or dentures, except as specifically described under eligible expenses;
- incurred for personal comfort items;
- incurred for a change in gender;
- for treatment which is experimental;
- for services or supplies rendered to facilitate participation in any sport or recreational activity if not required for other daily living activities;
- for myoelectric and electric prostheses;
- for time spent travelling; broken appointments, transportation costs or advice given by telephone or by any other means of communication;
- for any portion of the fee of a medical or Dental practitioner not allowable under the Basic Medical Plan due to non-referral;
- for any payment to a medical practitioner whether or not the practitioner is 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 scheduled costs prescribed by the Basic Medical Plan; or

- that are in excess of reasonable and customary charges for the least expensive treatment that is medically appropriate in the opinion of the Trustees of the Marine Workers Welfare Plan and their medical advisors.

VISION CARE

Deductible	$0
Reimbursement	**Active Members**: 100% **Retired Members:** 75%
Maximum	**Active Members**: $425 / 24 months $425 / 12 months for Dependent Children under the age of 16 **Retired Members:** $350 / 24 months $350 / 12 months for Dependent Children under the age of 16
Dependent Children	Covered from birth to age 19, or to age 25 if in full-time attendance at a school or university, or to any age if permanently disabled.

Vision Care Benefits (glasses and contact lenses when required to correct vision only) are payable when provided by a legally qualified licensed ophthalmologist, optometrist or optician.

Eye examinations are eligible for reimbursement up to a maximum of $75 per 24 months for adults or twelve (12) months for children under the age of sixteen (16). (Eye examinations are part of the Vision Care maximum).

This benefit has no deductible or lifetime maximum, and paid claims do not reduce your lifetime maximum under the

Extended Health Benefit. Present your pay-direct card to your Vision Care provider to determine whether they are able to submit your claim directly to the Plan.

Exclusions

No allowances are provided for non-corrective lenses and repairs to glasses.

Limitations

No benefits will be paid for:

- services or supplies the person is entitled to without charge by law;
- services or supplies that do not represent reasonable treatment;
- services or supplies associated with recreation or sports rather than with other regular daily living activities;
- services or supplies associated with covered items, unless specifically listed as an eligible expense;
- services or supplies received out of your province of residence, unless the person is covered by the Provincial Medical Plan and benefits would have been paid for the same services or supplies if they had been received in your province of residence;
- expenses arising from war, insurrection or voluntary participation in a riot; or
- laser surgery or other treatment.

DENTAL CARE

Deductible	$0
Reimbursement	**Active Members:** • 100% of the standard BC Dental Fee Guide for Basic, Major and

	Dependent Children's Orthodontia treatment. • 50% of the standard BC Dental Fee Guide for adult Orthodontia treatment **Retired Members:** • 50% of the standard BC Dental Fee Guide for Basic and Major Services. • No Orthodontia
Maximum	The annual family maximum amount of benefits payable for you and your Dependents is $5,000
Dependent Children	Covered from birth to age 19, or to age 25 if in full-time attendance at a school or university, or to any age if permanently disabled.
Waiting Period	**Basic Dental** – no waiting period **Major Dental** – six (6) consecutive months of coverage **Orthodontia** – twelve (12) consecutive months of coverage

The Plan provides pay-direct claims processing using your pay-direct card – present your pay-direct card to the receptionist when you arrive at your Dentist's office for your appointment.

If you or your Dependent(s) incur(s) eligible expenses as described below for medically necessary Dental Care to maintain teeth in good order or to restore them to good order, the Marine Workers Welfare Plan will pay benefits up to an annual family maximum of $5,000 per calendar year, subject to all the provisions of this Plan. Eligible expenses may contain specific annual or lifetime limits.

A charge for Dental Care is considered to be incurred on the date the Dental procedure is performed, except that if two (2) or more appointments are required to complete a Dental procedure, then the charges for such procedure are considered to be incurred on the date such treatment ends.

The maximum amount of the eligible expense with respect to any Dental procedure shall be in accordance with the current General Practitioner's Fee Guide in the province where the service is rendered or, with respect to eligible Denturist charges, the current Denturist Schedule in the province where the service is rendered. Any charges in excess of the current General Practitioner's Fee Guide, e.g. for specialist fees or for an Oral Surgeon, will be your responsibility.

The total amount payable by the Marine Workers Welfare Plan for all eligible expenses incurred by you and your Dependent(s) during a calendar year shall not exceed the annual maximum amount per calendar year for this benefit ($5,000). Any charges in excess of $5,000 per calendar year are your responsibility.

BASIC PREVENTIVE AND RESTORATIVE SERVICES

Dental services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible basic services include:

Diagnostic Services

- Oral examinations, limited to:
  - one complete oral examination in any 36 month period by a general practitioner and one complete oral examination in any 36 month period by a periodontist, provided the Plan has not paid for any other exam, by the same Dentist in the previous six (6) months;
  - one recall examination in any six (6)-month period; and
  - specific/emergency examinations provided the Plan has not paid for any other exam by the same Dentist within

60 days. If a specific exam is provided 60 days prior to a recall exam, the recall exam will not be eligible for reimbursement.

- Dental x-rays, limited to:
  - panoramic - one per 36 months;
  - complete mouth series - one per 36 months; and
  - bitewing x-rays are limited to one set in any six (6)-month period.

NOTE: All x-rays combined shall not exceed the dollar limit for a complete mouth series per calendar year.

Preventive Services

Other preventive services including:

- cleaning of teeth – prophylaxis, but not more than once in any six (6)-month period; scaling and root planing services are limited to 12 units (combined) per calendar year);
- topical application of fluoride, but not more than once in any six (6)-month period;
- initial provision and installation of fixed space maintainers, for primary teeth only (to maintain space not to obtain more space); and
- pit and fissure sealants - combined limit of one per tooth per 24 months. Covered to age 16.

Restorative Services

- fillings to restore tooth surfaces broken down as a result of decay limited to a dollar amount equal to a five (5)-surface filling per tooth in a 24-month period;
- amalgam (silver coloured) fillings;
- composite (tooth coloured) fillings on permanent teeth only; and
- stainless steel crowns on primary or permanent teeth - once per tooth in a 24-month period.

Endodontics

For the treatment of diseases of the pulp chamber and pulp canal including, but not limited to:

- root canals - once per tooth in a five (5)-year period (60 months)

Periodontics

For the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:

- scaling/root planing - limited to twelve (12) units of time in any twelve (12)-month period;
- gingival curettage - one per sextant in a five (5)-year period (60 months);
- osseous surgery - one per sextant in a five (5)-year period (60 months); and
- bruxing guards – one upper and one lower per 24 months. No benefit is payable for the replacement of lost, broken or stolen bruxing guards.

Prosthetic Repairs

- removal, repairs and re-cementation of fixed appliances;
- rebase and reline of removable appliances - a combined limit of one per upper and one per lower prosthesis in a 24-month period; and
- tissue conditioning - one per upper and one per lower in a 24-month period.

Surgical Services

- extractions;
- other routine oral surgical procedures; and
- anesthetics administered in conjunction with oral surgery or other restorative Dental services.

MAJOR RESTORATIVE SERVICES

All Major Restorative services must be pre-approved in order to be eligible for reimbursement under the Plan. Major services that are not pre-approved are not eligible under the Plan.

To replace missing teeth or to reconstruct teeth only when Basic Restorative methods cannot be used. Mounted x-rays will be required for pre-approval.

Major Restorative services include:

Prosthodontic Services

- initial installation of full dentures, partial dentures, or fixed bridgework;
- addition of teeth to existing dentures or fixed bridgework; and
- replacement of an existing full denture with a new full denture, or an existing partial denture with a new partial denture, or an existing fixed bridgework with a new fixed bridgework, only if the existing denture or fixed bridgework was installed five (5) years prior to its replacement and cannot be made serviceable.

Restorative Services

- initial provision of crowns, only if the tooth is broken down by decay or traumatic injury so that the tooth structure cannot be restored with an amalgam silicate, acrylic or composite resin restoration; and
- replacement of crowns **only** if the existing crown was provided five (5) years prior to its replacement.

NOTE: You must obtain a pre-treatment estimate prior to proceeding with these services.

Exclusions for Major Restorative Services

No amount shall be payable for charges for:

- replacement of dentures, which are lost, stolen or broken;
- any crown, bridge, or denture ordered prior to the effective date of coverage under this benefit;
- tissue grafts; or
- onlays, Inlays.

Limitations on Major Restorative Services

Only one eligible Major Restorative service on the same tooth will be covered in a five (5)-year period (60 consecutive months);

Only one upper and lower denture (complete or partial) is eligible in a five (5)-year period (60 consecutive months).

ORTHODONTIA SERVICES (ACTIVE MEMBERS ONLY)

You and your Eligible Dependent(s) must be covered under the Dental Plan for at least twelve (12) consecutive months before being eligible for Orthodontia Services.

If you or your Eligible Dependent incur(s) charges for medically necessary Orthodontia when you are eligible for this benefit, the Marine Workers Welfare Plan will pay benefits for charges for Orthodontia care administered by or ordered by a Licensed Dentist. The Dentist must submit a treatment plan prior to commencing with these services.

For purposes of benefit payments, a charge for Orthodontia care is considered to have been incurred on the later of:

- the date treatment was rendered; or
- the date the Member is billed for any amount for such treatment by the Dentist.

Under no circumstances shall a benefit be payable for treatment before the date such treatment is rendered.

There will be no run-off of Orthodontia claims after termination of Welfare Plan coverage.

No benefit is payable for the replacement or repair of appliances which are lost, broken or stolen. Services for the correction of temporomandibular joint (TMJ) dysfunction are not covered.

Orthodontia Claims Procedures

Please submit your receipts as soon as possible; do not hold them until treatment is completed. It is recommended that you submit Orthodontia claims within ninety (90) days of the date the payment was made to your orthodontist.

Reimbursement will be made if the complete and correct claims information is received within one year of the date the payment was made to your orthodontist. No benefit is payable for claims not received within one year of the date the payment was made.

Treatment Plan

Please have your orthodontist complete the "Certified Specialist In Orthodontics Standard Information Form" (the treatment plan) before treatment starts. If the payment schedule or treatment changes, the Plan Administrator will require a revised treatment plan.

If the Plan Administrator does not have your treatment plan on file, no payment will be made for:

- your initial fee/down payment;
- your monthly/quarterly fees; or
- one-time appliance fees.

Claims for Orthodontic exams and Orthodontic records (x-rays, study models etc.) may be reimbursed without a treatment plan.

Please submit receipts for the monthly or quarterly fees on a regular basis as treatment progresses.

EMERGENCY TREATMENT OUTSIDE YOUR PROVINCE OF RESIDENCE

If, while travelling or on vacation outside of your province of residence, you require emergency Dental Care, you will be reimbursed according to your province of residence fee schedule.

EXCLUSIONS

The following are not eligible expenses under your Dental Plan:

- any item not specifically included as a benefit;
- charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents into English;
- procedures performed for congenital malformations or for purely cosmetic reasons;
- charges for drugs, pantographic tracings, grafts;
- charges for implants and/or services performed in conjunction with implants;
- charges for services related to the functioning or structure of the jaw, jaw muscles, or TMJ;
- incomplete or temporary procedures;
- recent duplication of services by the same or different Dentist;
- any extra procedure which would normally be included in the basic service performed;

- services or items which would not normally be provided, or for which no charge would be made, in the absence of Dental Benefits;
- travel expenses incurred to obtain Dental treatment; or
- tooth bleaching.

No amount shall be payable under the Dental Benefit for charges:

- in excess of the specific limitations and maximum amounts described under eligible expenses;
- in connection with general health examinations;
- for which you obtain or are entitled to obtain benefits under any Government Plan;
- for which you are entitled to obtain benefits without charge;
- which result from insurrection or war, whether or not war be declared, any act incident to such insurrection or war, or participation in any riot;
- incurred as a result of any Dental disease, defect or injury arising out of or in the course of employment;
- for which you obtain or are entitled to obtain benefits under another benefit of this Plan or under any group plan providing medical benefits;
- for a Dental procedure which requires two (2) or more appointments, which commenced prior to the effective date of your coverage under this benefit;
- for Dental treatment which is not approved by the Canadian/American Dental Association, or which is experimental in nature;
- for full mouth x-rays for a Dependent who has not attained at least twelve (12) years of age when the charges are incurred;
- for education or training in, and supplies used for dietary or nutritional counselling, personal oral hygiene, or Dental plaque control;

- for procedures, appliances and restorations used to increase vertical dimension to restore occlusion or in connection with the treatment of temporomandibular joint dysfunction (TMJ);
- for any Dental treatment which is deemed to be cosmetic, i.e. not medically necessary to maintain teeth in good order or restore them to good order;
- for the replacement of an orthodontic appliance;
- for procedures and appliances in connection with implants;
- for anesthesia, unless provided by a qualified Dentist;
- for drugs;
- for examinations required for use by a third party;
- for time spent travelling, broken appointments, transportation costs or advice given by telephone or by any other means of communication;
- for Dental services of a temporary nature;
- that are in excess of reasonable and customary charges for the least expensive treatment that is consistent with good Dental Care in the opinion of the Trustees of the Marine Workers Welfare Plan and their medical advisors;
- for Dental charges that are incurred prior to the effective date of coverage under this benefit;
- for Dental services required as the result of an accident for which a third party is liable; or
- for any charges for completion of forms.

COORDINATION OF BENEFITS

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

If the Member or Dependent is also covered under the Spouse's Plan or under any other group plan which provides similar benefits, payment will be coordinated and/or reduced to the

extent that benefits payable from all plans will not exceed 100% of the Eligible Expense (for Dental, the Fee Guide applies).

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

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

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

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

Extended Health Benefits with Dental Accident coverage determine benefits before Dental plans.

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

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

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

HOW TO FILE A CLAIM

Extended Health Benefits, Vision Care and Dental Use your pay-direct card when you fill a prescription, when you visit participating paramedical practitioners, when you have an eye examination, for Dental visits and Vision Care purchases. If you do not use your pay-direct card, these expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the D.A. Townley *My Claims* portal or mobile app (see page 80 for details).

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

Standard B.C. Dental claim forms are usually provided by your Dentist, but if required, Dental claim forms can also be provided by the Administrator's Office, your Union Office or also from the Administrator's website: https://www.datownley.com/health-benefits/filing-a-claim/

Both the receipts and the fully completed forms should be sent to the Administrator. All receipts must be received by the Administrator within 18 months of the date the expense is incurred to be considered for payment.

When submitting eligible claims, please be sure to include:

- your Name (please print);
- your Address; and
- your Client ID (found on your pay-direct card).

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

- the D.A. Townley *My Claims* portal or mobile app

- by email to health@datownley.com
- by fax to (604) 299-8136
- drop off or mail to D.A. Townley
  4250 Canada Way
  Burnaby BC V5G 4G3

For Extended Health, Vision Care, and Dental you can now view and print your claim history by using D.A. Townley's *My Claims* Member Website at www.datownley.com. You can also arrange to have your claim reimbursements directly deposited into your bank account by completing the Direct Deposit Registration form, also available on the D.A. Townley website at www.datownley.com.

In the event of termination of coverage, a claim must be submitted within ninety (90) days following the date of termination of your insurance or the date following termination of coverage or the Policy.

With respect to benefits underwritten by Manulife Financial, no legal action against Manulife Financial may commence less than 60 days after proof has been filed in accordance with the above requirements. Every action or proceeding against Manulife Financial for the recovery of benefits payable under this Policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

With respect to all other benefits, every action or proceeding against the Plan for the recovery of benefits payable under the Contract is absolutely barred unless commenced within the time set out in the Insurance Act.

D.A. TOWNLEY MY CLAIMS PORTAL AND MOBILE APP

Go to: www.datownley.com/myclaims/ and look for Online Registration in the resources section on the right side of the page. Click on the link. Complete all the required fields and acknowledge that you have read the terms and conditions. Click on the Submit button and it will automatically direct you to the *My Claims* portal. Set up your account on the *My Claims* portal by clicking on Register Account. Enter your Group number (5019) and your Client ID number from your pay-direct card, along with your postal code and date of birth. Then click Next. Set up your username and password.

NOTE: you can only create one username and password for the same coverage.

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

DIRECT DEPOSIT

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

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM (EFAP)

Facing a challenge? Overwhelmed at work? Struggling with stress or dealing with debt? The Employee and Family Assistance Program (EFAP) provides totally confidential, professional counselling for a broad range of personal and family problems, including:

- emotional or physical problems
- marital or family problems
- pre-retirement planning
- financial and legal difficulties
- sexual harassment or abuse
- alcohol or drug dependencies
- stress
- work-related problems
- child and elder care
- gambling
- bereavement

The Program can be used for crisis intervention, however, the ideal time to use it is before problems get out of hand.

To access the Employee and Family Assistance Program, please contact TELUS Health (formerly LifeWorks/Morneau Shepell):

Phone: **1-844-671-3327**
Website: **one.telushealth.com**
Username: **marineworkers**
Password: **efap**

NOTE: The login credentials above are case-sensitive.

When you call, please state that you are covered through the Marine Workers Welfare Plan. You can also access tools and resources direct from your smart phone. Get the free LifeWorks mobile app for iPhone and Android – just search for LifeWorks in your app store.

MEDICAL SERVICES PLAN OF BC (MSP)

When you qualify for coverage, you will be covered by the Medical Services Plan of BC, provided you have completed the required MSP application form. If you already have MSP coverage in place, you are not required to arrange your coverage through the Plan.

Members who need to obtain their own Medical Services Plan (MSP) coverage need to make arrangements for coverage.

To apply for individual MSP coverage, contact:

MEDICAL SERVICES PLAN OF BC

P.O. BOX 9035 STN PROV GOVT

VICTORIA, BC V8W 9E3

RIGHTS TO INFORMATION

Under insurance standards regulation, such as the *Insurance Act* (BC), Members are entitled to request certain information regarding insured benefits (Life Insurance, Long Term Disability, Accidental Death and Dismemberment, Emergency Medical Travel Insurance), including a copy of the insurance policy.

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

TIME LIMITS

Claims for certain benefits must be filed within the times set out in this Booklet or the relevant insurance policies and contracts. Failure to file a claim within those time limits could result in your claim being denied. Every action or proceeding against the

Plan for payment of benefits must be commenced within the limitation periods provided by relevant insurance policies or contracts, the applicable limitations statute (e.g. Limitations Act (BC)) or the applicable insurance standards legislation (e.g. Insurance Act (BC)). Each Member is responsible for obtaining their own independent legal advice with respect to such limitation periods.

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.

NOTES