

COLLECTIVE AGREEMENT

between

**DOUGLAS COLLEGE FACULTY ASSOCIATION
(the “Employer”)**



and

**CANADIAN UNION OF PUBLIC EMPLOYEES,
LOCAL 1004
(the “Union”)**



Effective from April 1st, 2025 to March 31st, 2030

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COLLECTIVE AGREEMENT

BETWEEN:

**DOUGLAS COLLEGE FACULTY ASSOCIATION
(Hereinafter referred to as the "Employer")**

AND:

**CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1004
(Hereinafter referred to as the "Union")**

ARTICLE 1 - RECOGNITION

1.1 Bargaining Agent

The Employer recognizes the Union as the sole collective bargaining agent for all Employees of the Employer.

1.2 Definition - President

Within this Collective Agreement, "President" means President of the Douglas College Faculty Association or another person designated by the Association.

ARTICLE 2 - DUES CHECK-OFF AND UNION SECURITY

2.1 Monthly Union Dues

All Employees shall, as a condition of employment, acquire and maintain Union membership, and all Employees shall pay monthly dues to CUPE 1004. Such payment will be made by payroll deduction in accordance with the provisions of Section 16 of the *Labour Relations Code*.

2.2 Collected Dues

The Employer shall forward the collected dues by cheque to the Secretary-Treasurer of the Union within one (1) month of such deduction. **The Employer shall also include a list detailing the following for each member of the bargaining unit:**

- **Total number of regular hours worked;**
- **Regular rate of pay;**
- **Total number of overtime hours worked;**
- **Overtime rate(s) of pay;**
- **Name, job title, and current working status (i.e. regular (R1, R2, R3), temporary, casual or on leave, and type of leave).**

2.3 No Contracting Out

No work regularly performed by an Employee in the bargaining unit shall be contracted out or be performed by anyone other than an Employee. Persons excluded from this Agreement shall not perform work that is normally performed by Employees covered by this Agreement, except:

- (a) in the case of emergency;
- (b) work that has traditionally been performed by members of DCFA with regard to strikes, Association committees, and internal and external Association political activities; or
- (c) any work traditionally done by the Association officers, provided that such work does not result in the layoff of bargaining unit members.

ARTICLE 3 - PICKET LINES

3.1 Picket Lines

Employees shall not be required to cross picket lines or to perform struck work.

ARTICLE 4 - EMPLOYER/UNION RELATIONS

4.1 Labour Management Meetings

The Parties agree to meet no less than once in each of the Fall and Winter semesters in order to maintain good relations and discuss any workplace issues which may arise. Either party may ask for additional meetings as needed.

4.2 Leave with Pay for Union Activities

Union members shall be allowed reasonable time during working hours without loss of pay for the purposes of attending meetings with CUPE Local 1004 representatives and/or processing grievances, and meeting with the Employer with respect to negotiation of a Collective Agreement, administration of the Collective Agreement, and other collective bargaining matters.

4.3 Leave without Pay for Union Activities

A Union member may request leave of absence without pay for purposes relating to Union activities. Such leave shall not be unreasonably withheld.

4.4 No Loss of Seniority for Union Leave

The Employer agrees that any Employee who is on leave of absence for the purpose of performing their duties as an officer of the Union, or any affiliated body, shall not lose seniority in the service of the Employer and shall continue to accumulate seniority and vacation entitlement while performing such duties. Paid vacation taken for the year in which the leave of absence is taken will be prorated by the ratio of days actually worked divided by the days the participant would have worked but for the leave of absence. Upon retirement from duties as an officer of the Union, such former Union officer shall be entitled to return to their former position.

4.5 Reimbursement for Union Leave

With respect to any leave of absence granted without pay for the purpose of performing duties as an officer of the Union or any affiliated body, the Employer shall maintain the Employee's salary and benefits for the period of the leave of absence and shall invoice the Union for the cost of salary and benefits. The Union shall reimburse the Employer within thirty (30) days for the cost of salary and benefits assigned to the leave. Where the leave of absence is for a duration of five (5) or fewer continuous days, the Employer shall bill the Union for wages only.

4.6 Workplace Technology

1. Notice

When the Employer intends to introduce new workplace technologies, change the use of workplace technologies or implement a change that may affect the digital privacy of Employees (i.e. how Employees' data is collected, processed or used), the Employer will notify the Union in writing no later than one hundred and twenty (120) days prior to the proposed introduction or change.

2. Consultation

When the Employer has notified the Union as to the above, the parties shall meet within thirty (30) days of the notice. Consultation will include:

- (a) the nature of the change;
- (b) the date that the Employer intends to effect the change;
- (c) the effects the change may be expected to have on working conditions.

ARTICLE 5 - OTHER EMPLOYEE RIGHTS

5.1 No Discrimination

- (a) There shall be no discrimination for any reason, nor any violations of the *BC Human Rights Code*.
- (b) **Workplace technologies used for hiring or training, and/or to determine wage rates, upgrading, promotion, transfer, layoff, recall, discipline or discharge and more can create discriminatory outcomes. It is the Employer's responsibility to ensure all workplace technology is free from bias and discrimination. The Employer will prevent and eliminate discrimination perpetuated by workplace technologies on the basis of any of the prohibited grounds.**

5.2 Sexual and Personal Harassment

(a) *Sexual Harassment*

All Employees have the right to work in an environment free from sexual and personal harassment. For the purposes of this clause and without limiting the foregoing, sexual harassment includes:

- (1) Unwanted sexual attention made by a person who knows or ought reasonably to know that such attention is unwanted;
- (2) Unwanted physical contact such as touching, patting, pinching or punching;
- (3) Implied or expressed promise of reward for complying with a sexually oriented request;
- (4) Implied or expressed threat of reprisal, in the form either of actual reprisal or the denial of opportunity, for refusal to comply with a sexually oriented request;
- (5) The inappropriate display of sexually oriented literature, pornographic or offensive material; or

- (6) Remarks or behaviour which may reasonably be perceived to create a negative psychological and emotional environment for work.
- (b) *Personal Harassment*
- For the purposes of this article and without limiting the foregoing, personal harassment includes:
- (1) Physical threat, intimidation, or assault or unwelcome physical contact such as touching, patting, pinching and punching;
 - (2) Unwelcome behaviour or comment that is directed at or offensive to any Employee that demeans, belittles, causes personal humiliation or embarrassment to the Employee, or any other Employees;
 - (3) Implied or expressed promise of reward or threat of reprisal, or the denial of opportunity for refusal to comply with a request which is unrelated to an Employee's assigned duties; or
 - (4) The improper use of power and authority inherent in the position held, so as to endanger an Employee's position, threaten the economic livelihood of the Employee, or in any way interfere with or influence the career of such an Employee.
- (c) Employees may process complaints about harassment through the grievance procedure (Article 7) subject to the following changes.
- (1) Where a person who is the subject of the complaint is the Employer representative or designate, at any state of the grievance procedure the Union may bypass that stage of the procedure or present the grievance to another appropriate Employer representative;
 - (2) In the course of investigating a complaint of harassment, Employer and Union representatives shall have due regard for the privacy and confidentiality of any and all persons involved in the complaint;
 - (3) In determining procedural and evidentiary matters in a harassment complaint, an arbitrator shall take reasonable steps to protect the interest of all parties in privacy and confidentiality, subject to the requirement of fairness to all parties;
 - (4) Where the complainant and the person who is the subject of the complaint are both members of the bargaining unit, then the arbitrator seized with a grievance of harassment shall also have jurisdiction in respect of any grievance arising from related discipline of the subject of the complaint;
 - (5) An arbitrator has the authority to fashion a settlement which can include instructions designed to accommodate the needs of the complainant. Where such action causes detriment, the detriment shall fall upon the harasser and not other bargaining unit Employees; or
 - (6) No information relating to the grievor or alleged harasser's personal background or lifestyle shall be admissible during the grievance or arbitration process.
- (d) Employees against whom a grievance or complaint has been filed pursuant to this Article shall have the right to know what allegations have been made against them, and shall have the right to Union representation at all meetings, interviews, and hearings where the Employee's presence is requested.

- (e) Complainants have the right to Union representation at all meetings, interviews and hearings where the complainant's presence is requested.
- (f) Time limits shall be waived for filing grievances under this Article; however, grievances filed beyond six (6) months after the last incident may be denied on the grounds of unreasonable delay.
- (g) If the complainant chooses to file a simultaneous complaint with the Human Rights Tribunal, the grievance procedure shall be exhausted before the Human Rights complaint proceeds to hearing. However, a grievance cannot be denied solely on the grounds that the complaint has been lodged with the Human Rights Tribunal and the Tribunal chooses to act on the complaint.

5.3 Employee Indemnification

- (a) The Employer shall indemnify and save harmless its Employee(s) against damages and reasonable legal costs related to actions or claims against the Employee arising out of the proper performance of their employment activities or responsibilities.
- (b) This Article shall not be construed to mean that the Employer shall pay costs, expenses, or fees (or be responsible for financial losses) for such Employee incurred during or as a result of the Employer's internal disciplinary proceedings against the Employee. Nor shall it be construed to mean that the Employer shall bear any liability for the Employee's disregard or wilful neglect of their employment activities and responsibilities.

ARTICLE 6 - EMPLOYER RIGHTS

6.1 Management Rights

Except as this Agreement otherwise specifies and subject to the job description(s) appended to this Agreement, the Employer retains the right to assign duties and to manage and direct Employees, provided such rights are exercised fairly and reasonably.

ARTICLE 7 - GRIEVANCE AND ARBITRATION

7.1 Step One

- (a) All grievances concerning the operation or application of this Agreement will first be discussed with the President.
- (b) If no agreement is reached, the Union may submit the grievance in writing to the President, who will meet with the designated Union representative and the grievor to discuss the grievance in an attempt to obtain a satisfactory resolution. The President will give the Union a formal written response within fifteen (15) working days following the meeting. A grievance must be filed in writing within forty (40) working days of the alleged violation of the Agreement. Timelines may be extended by mutual agreement of the Parties.

7.2 Step Two

If the grievance is not resolved at Step One, the Union may submit the grievance to the DCFA Table Officers Committee, which will meet with the Union and attempt to obtain a satisfactory resolution. The Table Officers Committee will give a formal written response within fifteen (15) working days following the meeting. Timelines may be extended by mutual agreement of the parties.

7.3 Step Three

If the grievance is not resolved at Step Two, the Union may submit the grievance to the DCFA Executive Council, which will meet with the Union and attempt to obtain a satisfactory resolution. The Executive Council will give a formal written response within fifteen (15) working days following the meeting. Timelines may be extended by mutual agreement of the Parties. In cases of termination or policy grievances, the Union may file the grievance directly to Step Three.

7.4 Arbitration

If a grievance is not resolved satisfactorily, it may be referred by either party to arbitration. The parties shall determine by mutual agreement whether to send the grievance to formal or expedited arbitration.

7.5 Formal Arbitration

- (a) When a grievance is referred to formal arbitration, the parties will agree on the single arbitrator. Failing agreement, either party may request the Labour Relations Board to make the appointment.
- (b) The arbitrator will hear the dispute within thirty (30) days of being appointed and will render decision as soon as possible thereafter. The arbitrator's decision will be binding on both parties.
- (c) The arbitrator has jurisdiction to hear and determine the real issue in dispute and to decide the matter in accordance with law and equity, to extend time limits, and to relieve against technical irregularities.

7.6 Expedited Arbitration

- (a) Hearing dates shall be scheduled as expeditiously as possible.
- (b) The location of the hearings will be mutually agreed to by the parties.
- (c) All presentations are to be short and concise and are to include a comprehensive opening statement. The parties agree to make limited use of authorities during their presentations.
- (d) Prior to rendering a decision, with the parties' agreement, the arbitrator may assist the parties in mediating a resolution to the grievance.
- (e) Where mediation fails, or is not appropriate, a decision shall be rendered as contemplated herein.
- (f) The decision of the arbitrator is to be completed and mailed to the parties within ten (10) working days of the hearing.
- (g) The arbitrator for the expedited arbitration shall be mutually agreed upon by the parties.
- (h) The arbitrator shall have the power and authority to conclusively settle the dispute and this decision shall be binding on both parties. Arbitration awards shall be of no precedential value and shall not thereafter be referred to by the parties in respect of any other matter or proceeding.

7.7 Arbitrator Fees and Expenses

The arbitrator's fees and expenses will be shared by the parties, the Employer paying fifty percent (50%) and the Union paying fifty percent (50%). The Union and the Employer are each responsible for their own costs of representation.

ARTICLE 8 - APPOINTMENT OF EMPLOYEES

8.1 Definition of Employees

(a) *Regular Full-Time (R1)*

A **R1** Employee is any person employed on a full-time permanent basis whose duties fall within the bargaining unit as defined in Article 1.1 of this Agreement and who has completed the probationary period. Full-time hours of work are as defined in Article 14.

(b) *Regular Part-Time (R2, R3)*

i) A **R2** Employee is any person employed on a continuing basis for a **minimum of 20 hours of work per week, but fewer than the full-time hours of work as defined in Article 14**, whose duties fall within the bargaining unit as defined in Article 1.1, and who has completed the probationary period.

ii) A **R3** Employee is any person employed on a continuing basis for **fewer than 20 hours of work per week, whose duties fall within the bargaining unit as defined in Article 1.1, and who has completed the probationary period. A R3 Employee may receive 20 hours per week or more to replace Regular Employees who are absent or on leave.**

(c) *Temporary*

A Temporary Employee is one so informed by the Employer at the start of employment. A Temporary Employee may be hired to replace a Regular Employee on paid or unpaid leave pursuant to the terms of the Collective Agreement, or for an extended project of more than thirty (30) days and up to twelve (12) months.

(d) *Casual*

Casual Employees shall be those Employees hired for extra or relief work for periods of up to one (1) month. The Employer may also hire Casual Employees to replace Regular Employees who are absent or on leave under the provisions of this Agreement. An extension of the time period may be arranged by mutual agreement between the parties.

8.2 Appointment of Employees

(a) The appointment of Employees shall indicate whether the appointment is Regular (**under one of the following categories: R1, R2 or R3**), Temporary or Casual.

(b) A Temporary Employee shall not attain Regular status during the period of their Temporary appointment.

8.3 Probation - Regular Employees

(a) Every new Regular Employee shall be on probation for the first **four hundred and twenty (420) hours or 6 months** of employment **whichever comes first**.

(b) The President or designate shall appraise new Regular Employees during their probationary periods. If no appraisal is carried out, an Employee's performance shall be deemed to be satisfactory.

(c) Upon the successful completion of the probationary period, a Regular Employee shall be placed on the seniority list in order of their date of appointment.

- (d) In the event that a Regular Employee's appointment is not confirmed at the end of the probationary period, the Employer shall give the Employee at least two (2) weeks notice (or pay in lieu of notice) of the termination.

8.4 Probation - Temporary and Casual Employees

- (a) There shall be no probation period for Temporary or Casual Employees.
- (b) In the event that a Temporary Employee becomes Regular, the time worked as a Temporary Employee for any continuous period of four (4) months or more with a satisfactory appraisal in accordance with Article 10.2, may be considered as part or all of the probationary period.

ARTICLE 9 - NEW CLASSIFICATIONS

9.1 New Classifications

Should a new classification be created during the life of this Collective Agreement, in addition to those positions described in the job descriptions appended to this Agreement, the parties will negotiate a rate of pay and other terms relevant to that position. In the event the parties cannot agree, these matters may be referred to arbitration as provided in Article 7. Such new terms will be effective from the first (1st) day of the new classification.

ARTICLE 10 - EMPLOYEE APPRAISALS

10.1 Employee Appraisals – Regular Employees

The Employer may conduct formal appraisals of a Regular Employee's performance at any time following the probationary period. The procedures for such appraisal shall be worked out in consultation with the Employee and the Union.

10.2 Employee Appraisals – Temporary Employees

The Employer shall conduct formal appraisals of every Temporary Employee upon the completion of their appointment. The appraisal should follow closely the criteria for formal appraisal for Regular Employees.

ARTICLE 11 - JOB VACANCIES AND OTHER APPOINTMENTS

11.1 Job Postings

When a job vacancy occurs, the job shall be posted for five (5) working days. First consideration shall be given to the existing Regular Employees, then to Temporary Employees, then to new hires (external candidates).

11.2 Awarding Positions – Regular Employees

In filling vacant positions or in making promotions, transfers, and demotions, the Employer shall award the position to the senior qualified Regular Employee applicant.

11.3 Awarding Positions – Temporary Employees

In filling vacant positions where there are no Regular Employee applicants for the position, the Employer shall award the position to the qualified Temporary Employee applicant who has exhibited satisfactory performance, and with the greatest total accumulated service.

11.4 Available Work

Any available work shall be offered to **qualified R2 and R3 Employees, in order of seniority** prior to the appointment of or the assignment of the available work to a Temporary and/or Casual Employee.

ARTICLE 12 - SENIORITY, LAYOFF AND RECALL

12.1 Seniority Defined

Seniority for a Regular Employee is defined as the length of the Employee's continuous employment (Full or Part-Time) from the date of commencement of regular employment, plus time worked as a Temporary Employee.

12.2 Seniority During Leaves of Absence

During all leaves of absence from work as defined in Articles 21, 22, 23 and 24, a Regular Employee's seniority shall be maintained (continue to accrue).

12.3 Order of Layoffs

- (a) The Employer shall layoff Employees only for lack of work or shortage of funds.
- (b) Casual and Temporary Employees will be laid off first in reverse order of hire before any Regular Employees.
- (c) Layoffs of Regular Employees shall occur in reverse order of seniority (see Appendix A) within the appropriate job classification subject to the ability of the remaining Regular Employee(s) to perform the work available. Disputes on the issue of such ability may be referred directly to arbitration.

12.4 Notice of Layoff

Regular Employees with over five (5) years service shall receive at least three (3) months notice of layoff or pay in lieu of notice. Other Regular Employees shall receive at least two (2) months notice of layoff or pay in lieu of such notice. Temporary Employees shall receive at least one (1) month notice, or pay in lieu of notice, if layoff occurs prior to the end of the Employee's term of employment.

12.5 Right of Recall

- (a) For a period of two (2) years following the date of layoff, laid-off Regular Employees shall have the right of recall to any position for which they are qualified, except where the Employer, in consultation with the Union, determines that the Employee no longer has the capabilities and qualifications to perform the work. Recall will be in the order of seniority.
- (b) For a period of two (2) years following the end of their employment term, Temporary Employees shall have the right of recall on a "last off, first on" basis to fill any Temporary or Casual position for which they are qualified, subject to Article 12.5(a). A Casual position shall count as time worked as a Temporary Employee.
- (c) A Casual Employee has no right of recall.

12.6 Severance

Upon layoff, a Regular Employee shall receive severance pay of one (1) month's salary for each year of service to a maximum of ten (10) months.

ARTICLE 13 - DISCIPLINE

13.1 Just Cause

The Employer shall not dismiss, suspend, demote, or discipline an Employee bound by the Collective Agreement except for just and reasonable cause. In case of a dismissal, suspension, demotion, or reprimand, the Employer shall give written notification of and reasons for the action taken.

13.2 Right to Union Representation

An Employee shall have a Union Representative present at any discussion with supervisory personnel which could form the basis of disciplinary action. Where a supervisor intends to interview an Employee for disciplinary purposes, the supervisor shall notify the Employee in advance of the purpose of the interview.

13.3 Personnel File

An Employee, or their steward or CUPE 1004 Staff Representative with the written authority of the Employee, shall have the right of access to their personnel record at the Employer's premises.

Any disciplinary document, as well as any non-disciplinary letters of expectation, shall be removed from the Employee's personnel file after the expiration of eighteen (18) calendar months from the date it was placed on the file, provided there has not been a further infraction of a similar nature.

The Employer agrees not to introduce as evidence in any hearing any document from the file of an Employee, the existence of which the Employee was not aware of at the time of filing.

ARTICLE 14 - HOURS OF WORK AND OVERTIME

14.1 Hours of Work – R1 Employee

The hours of work for a R1 Employee shall total thirty-five (35) hours per week. These hours will be scheduled in consultation with the President or designate.

14.2 Daily Hours of Work

Regular hours worked in any one (1) day shall not exceed seven (7) hours unless mutually agreed to for the sole purpose of reducing the number of days in the work week.

14.3 Overtime

For the purpose of computing overtime for an Employee, all time worked after seven (7) hours per day (unless mutually agreed to under Article 14.2) or thirty-five (35) hours per week shall be considered as overtime and paid at the rate of one hundred and fifty percent (150%) of an Employee's hourly rate up to a maximum of two (2) hours per day and a maximum of eight (8) hours per week. All overtime worked beyond two (2) hours per day or eight (8) hours per week shall be paid at the rate of two hundred percent (200%).

14.4 Overtime on a Weekend or Statutory Holiday

All time worked on Saturdays shall be considered as overtime and paid at the rate of one hundred and fifty percent (150%) of an Employee's hourly rate. All time worked on Sundays, or on a statutory holiday, or on a day granted in lieu thereof, shall be considered as overtime and paid at the rate of two hundred percent (200%) of the Employee's hourly rate.

14.5 Overtime Pay or Time off in Lieu of Pay Options

Overtime must be authorized by the Employer. For all overtime worked, an Employee will have the option of overtime pay, or time off in lieu of pay, by mutual agreement of the Employer and Employee. Overtime for a Regular Employee is voluntary and the Employee has the right to refuse overtime.

14.6 Paid Breaks

An Employee working more than five (5) hours per day shall receive two (2) fifteen minute paid breaks. An Employee working five (5) hours or fewer per day shall receive one (1) fifteen (15) minute paid break per day.

14.7 Family Flex Time

An Employee may request their start time to be adjusted. The regular hours worked shall not change. Approval shall not be unreasonably withheld.

14.8 Unforeseen Worksite Closure

In the event of a worksite closure during a period of time in which Employees would normally be working, the Employer will continue to pay the Employees for up to five (5) consecutive working days. Should the closure be expected to last more than five (5) consecutive working days, the Employer shall meet and consult with the Union about how to proceed.

ARTICLE 15 - SALARIES

15.1 Hourly Rates

The hourly rate shall be as follows:

Administrative Officer/Financial Coordinator	April 1, 2024	April 1, 2025 2% Increase + 0.6% COLA	April 1, 2026 2% Increase + ___ COLA	April 1, 2027 2% Increase + ___ COLA	April 1, 2028 2% Increase + ___ COLA	April 1, 2029 2% Increase + ___ COLA
At Start	\$36.42	\$ 37.37	\$	\$	\$	\$
After 6 months	\$38.05	\$ 39.04	\$	\$	\$	\$
After 12 months	\$39.63	\$ 40.66	\$	\$	\$	\$
After 24 months	\$42.91	\$ 44.03	\$	\$	\$	\$

“COLA” or “Cost of Living Adjustment” means a percentage-based general wage increase adjustment provided in accordance with the collective agreement.

The “Annualized average BC CPI over twelve months” (AABC CPI) means the *Latest 12-month Average Index % Change* reported by BC Stats in March for British Columbia for the twelve months starting at the beginning of March in the preceding year and concluding at the end of the following February.

The “Latest 12-month Average Index”, as defined by BC Stats, is a 12-month moving average of the BC consumer price indexes of the most recent 12 months. This figure is calculated by averaging index levels of the applicable 12 months.

The “Latest 12-month Average Index % Change” is reported publicly by BC Stats in the monthly BC Stats Consumer Price Index Highlights report. The BC Stats *Consumer Price Index Highlights* report released in mid-March will contain the applicable figure for the 12 months concluding at the end of February. The percentage change reported by BC Stats that will form the basis for determining any COLA increase is calculated to one decimal point. For reference purposes only, the annualized average of BC CPI over twelve months from March 1, 2021, to February 28, 2022, was 3.4%.

The COLA will be applied as applicable to the GWI effective on April 1 in each year of the collective agreement. The COLA will be calculated by determining the difference between the AABC CPI and the annual general wage increase to the maximum of 4%.

15.2 Pay in Lieu of Benefits – R3 Employees

A R3 Employee shall be paid at the salary rates provided in this Agreement plus 5 percent (5%) in lieu of extended health benefits, 0.42% in lieu for each statutory holiday (6.3% for 15 statutory days), and the percentage in lieu of vacation as stipulated in article 16.1.

For example, an entry level R3 would receive 17.3% in addition to their hourly rate, and a nine (9) year Employee would receive 25.3% in addition to their hourly rate.

15.3 Pay in Lieu of Benefits - Temporary Employees

A Temporary Employee shall be paid at the salary rates provided in this Agreement plus fourteen percent (14%) in lieu of benefits, inclusive of vacation and statutory holidays, unless Article 19.4 applies.

15.4 Pay in Lieu of Benefits – Casual Employees

A Casual Employee shall be paid at the salary rates provided in this Agreement plus fourteen percent (14%) in lieu of benefits, inclusive of vacation and statutory holidays.

15.5 Pay Periods

Wages shall be paid biweekly. Compensation for all CUPE Employees will be deposited to the personal account they have established with a Canadian Registered Financial Institution (Bank or Credit Union).

ARTICLE 16 - ANNUAL VACATION

16.1 Vacation Entitlement

Vacation entitlement for a **R1 or R2 Employee** shall be based on the anniversary date of hire. A **R1 or R2** Employee shall receive vacation with pay and accumulate vacation as follows:

In the Year of Service	Weeks of Vacation	Percentage Accrual on Gross Earnings
1 st	3 weeks	6%
2 nd	3 weeks	6%
3 rd	4 weeks	8%
4 th	4 weeks	8%
5 th	5 weeks	10%
6 th	5 weeks	10%
7 th	6 weeks	12%
8 th	6 weeks	12%
9 th	7 weeks	14%

16.2 Vacation – Partial Years of Service

For partial years of service, vacation shall be prorated on the basis of the entitlement for the current year.

16.3 Vacation Anniversary Year

Vacation entitlement is accrued in each anniversary year. An anniversary year is the year beginning with the date first hired to the day prior to one (1) year from that date for the first anniversary and from the anniversary date to each day prior to the next anniversary date for each subsequent year.

- (a) Annual vacation is taken within the year in which it is accrued and shall be deducted from the total entitlement for that year. With the Employer’s approval, up to twenty percent (20%) of a year’s vacation entitlement may be carried over to the following year. Additional carryover may be requested. Approval of such requests shall not be unreasonably withheld.

- (b) If a serious illness or injury prevents an Employee from taking their vacation entitlement, they will attempt to reschedule the unused vacation entitlement within the anniversary year. No Employee's request to reschedule this vacation shall be unreasonably denied. If such rescheduling proves untenable, the unused vacation entitlement shall be paid out by the Employer.
- (c) Employee(s) unable to take their vacation entitlement due to a Workers' Compensation Board (WCB) Claim(s) as per the current provincial WCB legislation shall have the unused vacation entitlements carried over to the following anniversary year.
- (d) In the event that the Employer determines that operational requirements prevent an Employee from taking their vacation entitlement, attempts will be made to reschedule the unused vacation entitlement within the anniversary year. No Employee's request to reschedule unused vacation shall be unreasonably denied. If the Employee and the Employer cannot agree on an appropriate rescheduling, any unused vacation entitlement beyond that which can be carried over according to Article 16.4(a) shall be paid out by the Employer at the end of the anniversary year in which the vacation ought to have been taken.

16.4 Vacation Approval and Scheduling

- (a) Vacation shall be taken at a time approved by the Employer; such approval shall not be unreasonably withheld and shall reasonably accommodate the choice of the Employee. In scheduling the vacations of Employees, the Employer shall make reasonable effort to arrive at an equitable arrangement of vacation schedules for all Employees. Each employee shall submit a vacation plan for the following 12 months by September 21 of each year.
- (b) Changes to an Employee's approved vacation may occur only with the mutual consent of the Employer and the Employee. Requests for changes must be in writing and will not be unreasonably denied.

ARTICLE 17 - PAID HOLIDAYS

17.1 Statutory Holidays

- (a) Employees will receive the following holidays off with pay:
- New Year's Day
 - Family Day
 - Good Friday
 - Easter Monday
 - Victoria Day
 - Canada Day
 - British Columbia Day
 - Labour Day National
 - National Day of Truth and Reconciliation
 - Thanksgiving Day
 - Remembrance Day
 - Christmas Eve Day
 - Christmas Day
 - Boxing Day
 - New Year's Eve Day

- (b) Employees will also receive any other day declared a holiday by the Federal, Provincial, or Municipal governments.

17.2 Holiday Falling on Vacation Period Weekend

When a holiday referred to in Article 17.1 falls in an Employee's vacation period or on a weekend, the Employee will be given an additional day off with pay.

17.3 Paid Time between Boxing Day and New Years Day

Employees shall receive time off with pay on the working days between Boxing Day and New Year's Day.

17.4 Paid Holidays During Unscheduled Hours of Work

Paid holidays on which a R2 Employee is not scheduled to work shall be prorated based on the number of hours worked in the four (4) week period immediately preceding the statutory holiday. However, the Employee shall be entitled to take a day in lieu of the paid holiday at the regularly scheduled hours.

17.5 Floating Wellness Days

R1 and R2 Employees shall receive **four (4)** floating wellness days per year. R3 Employees shall receive **two (2)** floating wellness days per year.

ARTICLE 18 - PROFESSIONAL DEVELOPMENT AND STAFF TRAINING

18.1 Definitions

- (a) *"Professional Development"* refers to Employee initiated and directed activities that enhance Employees' abilities to perform their duties or improve their career development or for work-related equipment (such as computer hardware and software).
- (b) *"Staff Training"* refers to Employer initiated and directed activities or activities that the Employer designates as required for the job. Such designation will take place in consultation with the Employee. Employees who disagree with the Employer's designation of the activity as training, or believe that it is not required for the performance of their duties, shall have the right to grieve that decision in accordance with the provisions of Article 7.

18.2 Eligibility

A R1 or R2 Employee shall be eligible for a minimum of five (5) paid days per year for Professional Development activities.

18.3 Funding

- (a) In any year a R1 or R2 Employee is guaranteed a minimum allocation of five hundred dollars (\$500) in approved Professional Development funds. An Employee may carry forward their unused minimum allocation from year to year, but any accumulated funds shall not be paid upon the Employee's termination, resignation, layoff, retirement or death. Funds shall not be unreasonably withheld.
- (b) The Employer may provide funds, in addition to those listed in Article 18.3(a) that it deems beneficial to Professional Development activities.
- (c) The Employer shall pay wages, fees, and reasonable expenses for the Employee to participate in Staff Training activities.

- (d) The Employer shall implement Article 18.3(a) by allocating a sum equivalent to five-hundred dollars (\$500.00) per **R1 or R2 employee** to the Professional Development Fund on April 1st of each year.

18.4 Scheduling

- (a) The Employer and **R1 or R2 Employees** shall meet at least once a year to determine and document appropriate Professional Development and Staff Training activities and funds.
- (b) Where possible, a **R2 Employee** will use days when the employee is not regularly scheduled to work for Professional Development and Staff Training.

18.5 Reporting

Each **R1 or R2 Employee** will submit an annual Professional Development and Staff Training report by August 31 of each year. The report will account for and reflect on the activities pursued and funds spent.

18.6 Restrictions

- (a) Professional Development entitlements do not apply to **R3, Temporary or Casual Employees**.
- (b) Professional Development days not used in one (1) year shall not carry forward to the following year.

ARTICLE 19 - BENEFITS AND PENSIONS

19.1 Benefit Plans

The Employer will provide each **R1, R2** and qualified Temporary Employee (see Article 19.4) access to the following benefit plans: Medical, Extended Health, Dental, Long Term Disability, Group Life Insurance and Accidental Death and Dismemberment Insurance.

19.2 Benefit Premiums – Regular Employees

The Employer will pay for a **R1 or R2 Employee** one hundred percent (100%) of the premiums for Medical, Extended Health, Dental, Long Term Disability Plan, Group Life Insurance and Accidental Death and Dismemberment Insurance Plans.

19.3 Continuation of Benefits on Layoff

- (a) In the event of a layoff, the Employer agrees to pay the premiums for the Employee benefit plans for a period of up to two (2) months. After that period, Employees so affected will be given the right to continue this coverage through direct payment until such time as their recall rights expire, or the insurance carrier no longer permits continuation of coverage, whichever occurs first.
- (b) The Employee must pay their share of the cost of the premiums to the Employer prior to the date that the Employer makes premium payments to the insurance carrier.

19.4 Eligibility – Temporary Employees

A Temporary Employee who is employed for more than six (6) months and up to twelve (12) months shall be eligible for access to the benefit plans.

19.5 Benefit Premiums – Eligible Temporary Employees

The Employer will pay for an eligible Temporary Employee one hundred percent (100%) of the premiums for Medical, Extended Health, Dental, Group Life Insurance and Accidental Death and Dismemberment Insurance Plans.

19.6 Pay in Lieu of Benefits – Temporary Employees

A Temporary Employee who is employed for less than six (6) months shall be paid fourteen percent (14%) in lieu of benefits, inclusive of vacation and statutory holidays.

19.7 Pension Plan

- (a) Upon commencement of employment, a new **R1 or R2** Employee may enrol in the Municipal Pension Plan.
- (b) For any **R1 or R2** Employee who does not qualify for Pension under the Municipal Pension Plan or who chooses not to participate in the Municipal Pension Plan, the Employer shall pay each year, in quarterly instalments, an amount equal to nine point three one percent (9.31%) of the Employee's gross annual salary, into a Registered Retirement Savings Plan. Any Employee on whose behalf the Employer makes contributions to a Registered Retirement Savings Plan shall not be eligible for participation in the Municipal Pension Plan.
- (c) A new **R1 or R2** Employee shall, for the purposes of enrolment in the Municipal Pension Plan only, have their probation waived.
- (d) Upon retirement of an Employee, the Employer will continue the coverage and continue to pay its share of premiums for Medical, Extended Health and Dental for the month in which the retirement occurred and for one (1) calendar month thereafter.

19.8 Weekly Indemnity Benefit

- (a) The Employer shall provide a short-term income protection policy (weekly indemnity benefit) insuring seventy percent (70%) of an Employee's regular salary, in the event of illness or accident, to cover the period from the thirty-first (31st) calendar day of an incapacity to the six (6) month anniversary of the illness or accident. The Employer will pay one hundred percent (100%) of the premiums for such insurance.

19.9 Benefit Provisions

The benefits provided for in this Article shall not, at the date of signing of this Agreement, fall below the level in existence as described in Appendix C, save and except as they are reduced or altered through circumstances beyond the control of the Employer.

ARTICLE 20 - EXPENSES**20.1 Expense Policies**

Work and travel expense policies adopted by the Employer for its members shall be applied to all Employees under this Agreement, provided they are consistent with this Agreement.

20.2 Expense Reimbursement

An Employee will be reimbursed for any reasonable expense incurred while engaged in the business of the Employer. Additional expenses shall not be reimbursed unless they are authorized in advance by the President or their designate.

20.3 Expense Rates

Expense rates shall be amended in accordance with any increases in the Employer's expense rates for its members during the term of this Agreement. The expense rate for Employees during this term of the Agreement shall not fall below those rates in effect at the time the Agreement was signed.

20.4 Receipts Required

Receipts are required for all expenses.

20.5 Other Expenses

An Employee who is on the Employer's business while away from the Association Office, or who is requested to work outside regularly scheduled working hours, shall be reimbursed for expenses. The Employer will reimburse an Employee who is required to work after their regularly scheduled hours of work for taxi fare, if required.

20.6 Meal Reimbursement

The Employer will reimburse an Employee who is required to work up to two (2) or more hours after their regularly scheduled hours of work for meals at a rate of twenty-three dollars (\$23.00) per day.

20.7 Automobile Transportation

Employees required to use their personal vehicle in the performance of their duties shall be reimbursed for kilometres traveled at a rate of eighty cents (80¢) per kilometre.

20.8 Parking Fees

The Employer shall pay the fees for parking. For Employees who do not opt for parking, the Employer shall pay the equivalent of parking fees to cover the Employee's transportation cost.

ARTICLE 21 - SICK LEAVE**21.1 Entitlement – R1 Employee**

A R1 Employee absent from work on account of illness shall continue to receive their full salary and benefits for up to thirty (30) calendar days for each illness or debilitating treatment. Following two (2) weeks of such absence, a Employee may, at the Employer's discretion, be required to provide a certificate from a medical practitioner.

21.2 Entitlement – R2 Employee

A R2 Employee on sick leave shall receive a prorated salary based on the number of hours normally worked in a week for up to thirty (30) calendar days, after which time they shall receive salary continuance benefits, pursuant to Article 19.8.

21.3 Sick Leave during Vacation

Sick leave days will be substituted for vacation time where an Employee can demonstrate that they were ill during scheduled vacation time.

21.4 Workers' Compensation Benefits

(a) Where a Regular or Temporary Employee suffers from a disease or illness or incurs personal injury (which disease, illness, or injury is hereinafter called the "disability") and the Employee is entitled to time loss compensation under the *Workers' Compensation Act*, they shall not be entitled to receive sick leave benefits as described in Article 21.1.

(b) *Regular Employees*

Up to a maximum period of one (1) year, all monies received by a Regular Employee by way of compensation for loss of wages under the said Act shall be paid to the Employer. In return for such payment and up to a maximum period of one (1) year, the Employer shall pay the Regular Employee the amount of their salary (up to the maximum reference salary specified in the WCB Regulations) to which they would have been entitled but for the disability.

(c) *Temporary Employees*

Up to the maximum period of their employment, all monies received by a Temporary Employee by way of compensation for loss of wages under the said Act shall be paid to the Employer. In return for such payment and up to the maximum period of their employment, the Employer shall pay the Temporary Employee the amount of their salary (up to the maximum reference salary specified in the WCB regulations) to which they would have been entitled but for the disability.

21.5 Family Illness

In the case of illness of a member of the immediate family of a **R1, R2** or Temporary Employee, when no one other than the Employee can provide for the needs of the ill person, the Employee is entitled to use sick leave entitlement for this purpose up to a maximum of ten (10) working days per year.

21.6 R3 Employees

R3 Employees are entitled to five (5) days of paid sick leave, which may be used in the case of illness of the immediate family of the R3 Employee, when no other than the Employee can provide for the needs of the ill person. A R3 Employee will receive their regular day's pay for each day of sickness, up to a maximum of five (5) days per year. The R3 Employee must provide reasonably sufficient proof of illness if requested after utilization of three (3) consecutive paid sick days.

21.7 Casual Employees

The provisions of Article 21.1, 21.2, 21.3, 21.4, 21.5, **21.6** do not apply to a Casual Employee.

Casual Employees are entitled to five (5) days of paid sick leave. Casual Employees will receive their regular day's pay for each day of sickness, up to a maximum of five (5) days per year. The employee must have worked with the employer for at least 90 days to be eligible for the paid sick days. The Casual Employee must provide reasonably sufficient proof of illness if requested after utilization of three (3) consecutive paid sick days.

ARTICLE 22 - MATERNITY/PARENTAL LEAVE**Preamble**

The terms and conditions for Maternity, Parental and Adoption leaves for Auxiliary Employees shall be in accordance with the *Employment Standards Act*.

While Article 22 applies to all Employees, it is understood that where specific entitlements provided in this Collective Agreement are cross-referenced to provisions other than those listed in Article 22, these specific entitlements only apply to applicable employee categories.

22.1 Maternity Leave

- (a) A pregnant Employee is entitled to up to eighteen (18) consecutive weeks of unpaid maternity leave.
- (b) A pregnant Employee will provide the DCFA with a written request for leave at least four (4) weeks prior to the start of the leave and a medical certificate in support of the request for leave.
- (c) The maternity leave may start no earlier than eleven (11) weeks before the expected birth date, and must end no earlier than six (6) weeks after the birth date unless the Employee produces a Doctor's certificate, which supports a request for a shorter period. The leave period may be extended up to six (6) weeks if a Doctor certifies that it is required.
- (d) A birth parent must request parental leave, as set out in Clause 22.2 and the *Employment Standards Act*, at least four (4) weeks before beginning parental leave. To take parental leave, the birth parent must begin that leave immediately after their maternity leave.
- (e) Where an Employee who is at work becomes ill or injured following the commencement of the eleven (11) week period in (c) above, such illness or injury shall be covered by application of the sick leave provision as follows:
 - (1) where the illness or injury is not directly related to the condition of pregnancy, sick leave coverage may extend to the scheduled date of commencement of maternity leave, or birth of the child(ren), whichever occurs first.
 - (2) where the illness is caused through an abnormal condition of pregnancy as verified in writing by a qualified medical practitioner and the Employee returns to work before the scheduled commencement date of maternity leave, the period of absence will be covered by the provisions of Article 19.8.
- (f) On return from maternity leave, an Employee shall be placed in their former position.
- (g) When an Employee is on maternity leave, employment is considered continuous for the purposes of calculating annual vacations, seniority and termination entitlement, as well as for pension, medical or other plans of benefits to the Employee. The DCFA will also continue to make payments to any such plans unless the Employee chooses not to continue with their share of the cost of a plan. The Employee is also entitled to all increases in wages and benefits which the Employee would have received if not on leave.
- (h) An Employee on maternity leave shall notify the DCFA of the date when the Employee shall be returning to work, four (4) weeks prior to the expiration of the maternity leave.

22.2 Parental and Adoption Leave

- (a) The purpose of these unpaid leaves is for the primary care and custody of the newborn or newly adopted child(ren).
- (b) The Employee shall notify the DCFA in writing, a minimum of four (4) weeks prior to the anticipated commencement (and in the case of adoption leave as much notice as is practical) of the start date of the leave and whether they are taking the standard parental leave or the extended parental leave.
- (c) Eligible Employees shall be granted parental leave without pay for a period of up to thirty-five (35) weeks for standard parental leave, or sixty-one (61) weeks for extended parental leave following the birth or adoption of the child(ren). The birth parent must begin that leave immediately after their maternity leave. The non-birth parent must begin the leave within seventy-eight (78) weeks after the birth of the child(ren). Likewise, an adopting parent must take the leave within seventy-eight (78) weeks after the child is placed with the parent.
- (d) Where both parents are Employees of the DCFA, the Employees shall determine the apportionment of parental leave between them which will not exceed a combined total of sixty-nine (69) weeks. The leave shall only be granted to one (1) Employee parent at a time. Neither parent's parental leave shall exceed sixty-one (61) weeks.
- (e) When a birth parent requests unpaid parental leave in combination with unpaid maternity leave, the combined leaves will not exceed seventy-nine (79) weeks.
- (f) The Employee shall, upon request, furnish proof of the birth or adoption of the child(ren).
- (g) When an Employee is on parental or adoption leave, employment is considered continuous for the purposes of calculating annual vacations, seniority and termination entitlement, as well as for pension, medical or other plans of benefits to the Employee. The DCFA will also continue to make payments to any such plans unless the Employee chooses not to continue with their share of the cost of a plan. The Employee is also entitled to all increases in wages and benefits which the Employee would have received if not on leave.

22.3 Supplemental Employment Benefit for Maternity and Parental Leave

- (a) When on maternity or parental leave, an Employee will receive a supplemental payment added to Employment Insurance benefits as follows:
 - (1) For the first two (2) weeks of maternity/parental leave an Employee shall receive one hundred percent (100%) of their salary calculated on their average base salary.
 - (2) For up to eighteen (18) weeks of maternity leave, the birth parent shall receive an amount equal to the difference between EI benefits and ninety-five percent (95%) of their salary calculated on their average base salary.
 - (3) For up to thirty-five (35) weeks of standard parental leave, an Employee who is the birth parent shall receive an amount equal to the difference between the Employment Insurance benefits and ninety-five percent (95%) of their salary calculated on their average base salary. For up to a maximum of sixty-one (61) weeks of extended parental leave the birth parent shall receive an amount equal to the difference between the Employment Insurance benefits and seventy-three percent (73%) of their salary calculated on their average base salary.

- (4) For up to a maximum of thirty-seven (37) weeks of standard parental leave, the spouse, the biological father, the common-law partner or adoptive parent who is caring for the child (i.e., the non-birth parent) shall receive an amount equal to the difference between the Employment Insurance benefits and ninety-five percent (95%) of the Employee's salary calculated on their average base salary. For up to a maximum of sixty-one (61) weeks of extended parental leave the birth parent shall receive an amount equal to the difference between the Employment Insurance benefits and seventy-three (73%) of their salary calculated on their average base salary.
- (5) The average base salary for the purpose of Clauses 22.3(a)(1), 22.3(a)(2), and 22.3(a)(3) is the Employee's average base salary for the twenty-six (26) weeks preceding the maternity or parental leave. If the Employee has been on unpaid leave for part of the preceding twenty-six (26) weeks, then up to four (4) weeks of that unpaid leave will be subtracted from the twenty-six (26) weeks for the purpose of calculating the average base salary.
- (b) An Employee is not entitled to receive Supplemental Employment Benefits and Disability Benefits concurrently. To receive Supplemental Employment Benefits, the Employee shall provide the Employer with proof of application for and receipt of Employment Insurance benefits.
- (c) If an Employee is disentitled or disqualified from Employment Insurance maternity or parental benefits, the Employee shall receive the supplemental payment or the appropriate percentage less the amount of Employment Insurance benefits the Employee would have received if qualified for Employment Insurance benefits.

22.4 Employment Protection

- (a) The DCFA may not terminate an Employee on maternity, parental or adoption leave or change a condition of employment, without the Employee's and Union's written consent.
- (b) As soon as the maternity, parental or adoption leave ends, the Employee must be returned to their former position.

22.5 Extension of Parental or Adoption Leave

Parental leave or adoption leave for Regular Employees when granted for less than thirty-four (34) weeks may be extended for an additional period, so long as the combined time of the original leave and the extension does not exceed thirty-four (34) weeks. Such an extension must be for health reasons for the newborn child(ren) and will be without pay. A doctor's certificate is required. Benefit provisions under Article 22.1(g) shall apply.

22.6 Return to Work

- (a) Notwithstanding Article 16.3 vacation entitlements and vacation pay for **R1 or R2** Employees shall continue to accrue while the birth mother is on maternity leave for the duration of the leave, or during the first twenty-six (26) weeks parental leave.
- (b) In the case of maternity leave, vacation earned pursuant to Article 22.6(a) may be carried over to the following year, notwithstanding Article 16.4(a).
- (c) Where the birth mother combines Clause 22.1 and 22.2 leaves, the maximum vacation entitlement will not exceed a total of twenty-six (26) weeks.

ARTICLE 23 - POLITICAL LEAVE

23.1 Notice of Leave

Written notice of taking political leave of absence shall be given by a Regular Employee at least one (1) month prior to the commencement of the leave.

23.2 Campaign Leave

If nominated as a candidate for election at the Federal, Provincial, or Municipal level, or for election to an Indigenous government, leave of absence without pay shall be provided to take part in the election campaign. During the period of leave provided for the election campaign, the Employer will maintain, at the written request of a **R1 or R2** Employee, all health and welfare and statutory benefits. The Employee shall reimburse the Employer for the cost of the benefits maintained.

23.3 Leave Upon Election

If elected to full-time office, leave of absence without pay and benefits shall be provided for the term of the office. Leave under this Article shall be limited to one (1) term of office unless further leave is granted, at the Employer's discretion. The Regular Employee shall give the Employer two (2) months written notice prior to resuming their position with the Employer.

23.4 Exceptions

The provisions of Article 23 do not apply to a Temporary or Casual Employee.

ARTICLE 24 - OTHER LEAVES

24.1 Serious Illness or Bereavement Leave

A Regular or Temporary Employee is entitled to five (5) days paid leave in the event of serious illness or the death of a person(s) as listed and defined in the expanded definition of "Family Member" identified by the current Employment Insurance legislation and as per the attached Appendix, or any other person with the approval of the Employer. With the Employer's approval this leave may be extended by using vacation days, accumulated time off in lieu, and/or up to one (1) month's leave of absence without pay.

24.2 Leave without Pay

After two (2) years employment, a Regular Employee may apply for and receive up to six (6) months leave of absence without pay. Approval for such leave must be obtained from the Employer in writing and shall not be unreasonably withheld. Unless the Employer and the Employee mutually agree otherwise, an Employee, upon completing such a leave of absence without pay, shall return to regular employment for at least another two (2) years before becoming eligible for another leave of absence without pay under this Article. **R1 and R2** Employees shall pay full benefit premiums to the Employer where the Employee chooses to remain on the benefits as listed in Article 19 - Benefits and Pensions.

24.3 Other Unpaid Leave

Unpaid leave of absence not otherwise provided for in this Agreement may be granted at the discretion of the Employer. Such leave shall not be unreasonably withheld. The Employer shall continue to pay benefit premiums for a period of up to two (2) months when the leave of absence is based on compassionate grounds **for an R1 or R2 employee**. Otherwise, the **R1 and R2** Employee shall pay full benefit premiums to the Employer where the Employee chooses to remain on the benefits, as listed in Article 19 – Benefits and Pensions.

24.4 Jury or Witness Leave

A Regular or Temporary Employee is entitled to paid leave as required in the event that the Employee is summoned as a juror or witness in any court or tribunal empowered by law to compel attendance of witnesses. The Employee shall remit to the Employer all monies paid to the Employee by the court, except for the traveling and meal allowances not reimbursed by the Employer.

24.5 Medical or Dental Leave

A **R1 or R2** or Temporary Employee shall receive time off with pay in the event of doctor and dentist appointments which cannot reasonably be made outside normal working hours. Such time off must have prior approval of the Employer and shall not be unreasonably withheld.

ARTICLE 25 - GENERAL

25.1 No Smoking

Smoking is not permitted inside the Association office.

25.2 Union Label

All typewritten and/or word processed work in the office of the Employer shall bear the Local 1004 CUPE Union label if such work is performed by a member of the Union.

25.3 Minimum Benefits

Notwithstanding any other provision of this Agreement, or any provisions of the *Employment Standards Act*, the benefits set out in the *Employment Standards Act* shall be deemed to be the minimum standards of employment under this Agreement, and will apply except where a provision more beneficial to the Employees is set out in this Agreement.

25.4 Health and Safety

The parties agree to abide by the requirements included in the *Workers' Compensation Act* and the *WCB Occupational Health & Safety Regulation*.

25.5 Physical Fitness

With the knowledge that a program of physical fitness will improve the well being of the Employees and improve productivity, the Employer shall endorse the joining of a **R1 or R2** Employee to a fitness club or community centre and/or fitness classes. The Employer shall reimburse the Employee for the fees associated with the membership in the club or community centre, and/or fitness/sports equipment, to a maximum of four hundred dollars (\$400) yearly.

Where an Employee makes a single purchase in excess of their annual allotment, the Employer will reimburse the Employee in two (2) or more equal payments over a maximum of three (3) years. At no time will the amount paid out to the Employee exceed four hundred dollars (\$400) in any one (1) year.

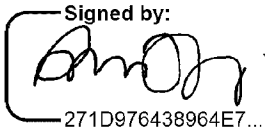
25.6 Data Security

The Employer will ensure that any data pertaining to its employees is secured on Canadian servers, and will provide proof of this to the Union upon request.

ARTICLE 26 - TERM OF AGREEMENT

The Agreement shall be in full force and effect from April 1, **2025** to March 31, **2030** and shall continue from year to year unless written notice is given by either party of their intent to negotiate changes within a four (4) month period preceding the expiry date of the Agreement. During the period of negotiation, the Agreement shall remain in full force and effect.

**FOR THE UNION,
CUPE LOCAL 1004:**

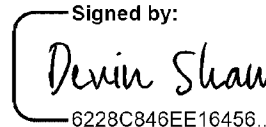
Signed by:


271D976438964E7...

Robert Limongelli, Administrator

Dorina Jeske, Bargaining Committee

**FOR THE EMPLOYER, DOUGLAS
COLLEGE FACULTY ASSOCIATION:**

Signed by:


6228C846EE16456...

Devin Shaw, Interim President
(Vice President Negotiations)

Signed by:

D486D93B40D643A...
Jennifer Kirkey, Secretary-Treasurer

Dated at Burnaby B.C., this 31st day of July, 2025

MR/mlp
COPE*491

LETTER OF UNDERSTANDING #1

LETTER OF UNDERSTANDING

BETWEEN:

**DOUGLAS COLLEGE FACULTY ASSOCIATION
(Hereinafter referred to as the "Employer")**

AND:

**CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1004
(Hereinafter referred to as the "Union")**

RE: Creation of New Positions, Lil Mairs Work Agreement

This Agreement is made without prejudice and without precedent to the interpretation or application of the Collective Agreement, or any other agreements between the Parties, or to any similar dispute between the Parties.

WHEREAS: the Parties agreed in Bargaining for the Collective Agreement dated April 1, 2021 to March 31, 2025 to split the position of 'Office Manager/Financial Coordinator' into two positions: (1) Administration Officer, and (2) Financial Coordinator. The Job Descriptions for these positions form part of the Collective Agreement; and,

WHEREAS: the Job Descriptions for the two positions allow for an employee in one classification to perform limited work in the other classification without being responsible for all the tasks and duties of the other Job Description; and,

WHEREAS: Lil Mairs is capable and qualified to perform both roles of the Administrative Officer and Financial Coordinator to the full extent; and,

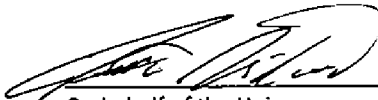
WHEREAS: the Parties have a mutual interest in having Lil's experience with the Employer be utilized to its fullest extent possible.

Now, therefore, the Parties agree as follows:

1. Lil Mairs will be assigned work from both Job Descriptions to their full extent;
2. Lil will be scheduled as a permanent regular employee for 20 hours of work per week;
3. When Lil is performing work in either classification she will be paid at the same hourly rate and will not lose any prerequisites; and

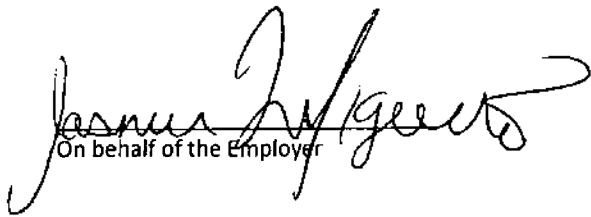
- 4. This arrangement is made exclusively for Lil Mairs. If Lil should leave the DCFA, no future employee will be required to perform all duties and tasks in both classifications without the agreement of the parties. All future employees will be employed in one classification and only be required to perform minimal tasks as needed in the other classification, as explained in the job descriptions.

The Employer and Union agree that these terms represent the full and final resolution of all matters addressed in this Letter of Understanding.



 On behalf of the Union

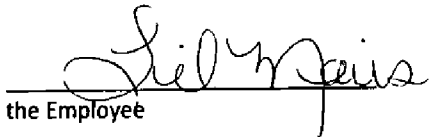
Date 14 / 10 / 2022
 DD / MM / YY



 On behalf of the Employer

Date 25 / 10 / 2022
 DD / MM / YY

I have read and considered the contents of this Agreement and agree to its terms. I acknowledge that the Union has fully and fairly represented my interests in these matters.



 the Employee

Date 17 / 10 / 2022
 DD / MM / YY

LETTER OF UNDERSTANDING #2

BETWEEN:

DOUGLAS COLLEGE FACULTY ASSOCIATION
(Hereinafter referred to as the "Employer")

AND:

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1004
(Hereinafter referred to as the "Union")

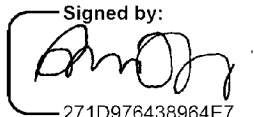
Re: Legacy Benefits of Employee Dorina Jeske

During the period covered by the 2021-2025 DCFA – CUPE 1004 Collective Agreement, the Parties agreed to categorize Dorina Jeske as a type of Employee not yet defined in the Collective Agreement, and agreed to clarify the type of Employee during the subsequent round of bargaining.

Now, therefore, the Parties agree as follows:

1. That Dorina Jeske is employed as a R3 Employee as per Article 8.1.
2. That as long as Dorina Jeske maintains continuous employment as a R3 Employee, she shall be paid 35% in lieu of Extended Health Benefits, Vacation and Statutory Holidays according to the following:
 - 8% in lieu of vacation; plus
 - 0.42% per each of the 15 statutory holidays for a total of 6.3%; plus
 - 20.7% in lieu of extended health and welfare benefits.
3. A R3 Employee hired after the ratification of this agreement shall receive pay in lieu of benefits, inclusive of vacation and statutory holidays, as per 15.2 Pay in Lieu of Benefits – R3 Employees.
4. Dorina Jeske is entitled to severance as per 12.6 from the date that the tentative settlement is ratified.

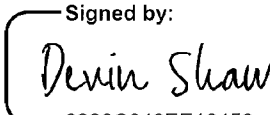
The Employer and Union agree that these terms represent the full and final resolution of all matters addressed in this Letter of Understanding.

Signed by:


271D976438964E7

On behalf of the Union

31 / 07 / 2025
Date DD / MM / YY

Signed by:


6228C848EE16456

On behalf of the Employer

31 / 07 / 2025
Date DD / MM / YY

**APPENDIX A
SENIORITY LIST**

NAME	DATE OF INITIAL APPOINTMENT
Lil Mairs	August 21, 2000
Anne Swinton	November 20, 2020
Dorina Jeske	February 10, 2023

**APPENDIX B
JOB DESCRIPTIONS**

Job Title: Administrative Officer

DESCRIPTION

The incumbent performs a variety of administrative tasks such as word processing, database, technical, publishing, and other clerical duties in support of the Association's operations, under the direction of the President, or other authorized DCFA representatives. The Administrative Officer works independently on the day to day responsibilities of the job, reporting unusual problems or concerns to the President.

DUTIES

1. *Word Processing/Correspondence*

- 1.1 General correspondence as needed. Agendas, correspondence, newsletters, announcements, bulletins, and other documents for the Table Officers (President, VP Negotiations VP Stewardship, Member-at-Large, Secretary-Treasurer), Executive Council, or any faculty member involved in DCFA business.
- 1.2 Be proficient with software programs such as Microsoft, Excel, and Adobe Suite.
- 1.3 Create a yearly meeting schedule (AGM, General Meeting, Contract Committee, Executive Council) for distribution in April.
- 1.4 Create fillable forms/templates for office procedures (expenses, committee reports, terms of reference, etc.)
- 1.5 Compile proposed Association By-law changes and update the DCFA Constitution and Bylaws as well as policies, procedures, and guidelines as necessary.
- 1.6 Maintain Policy and Procedures manual.
- 1.7 Compose correspondence as requested.
- 1.8 Use Envoke software, or other similar software, to send faculty wide communications on behalf of the Table Officers.

2. *Minutes*

- 2.1 Take minutes for Executive, General and other Committee meetings, including the AGM, and produce word processed copies of those minutes, as requested.

3. *Membership Lists*

- 3.1 Update and maintain a current database of faculty membership and of each individual faculty.
- 3.2 Update and maintain a current database of all DCFA standing committees, Contract Committee and Executive Council.

4. *Elections & Surveys*

- 4.1 Under the guidance of the Elections Committee, assist with the Table Officer elections.
- 4.2 Under the guidance of the Table Officers, assist with constituency and committee elections.
- 4.3 Welcome the newly elected members to the DCFA and provide the necessary committee resources they require.
- 4.4 Create and manage surveys and election polls as needed.

5. *Website, Technology, and Publications*

- 5.1 Operate and maintain 'as Administrator' the DCFA website and any other social media platforms.

- 5.2 Assist with technology for online meetings such as General Meetings and the AGM.
 - 5.3 Provide minor technical and user support to Table Officers.
 - 5.4 Have knowledge of desktop publishing software such as InDesign to assist with the publication of Faculty Matters.
- 6. *Filing Systems***
- 6.1 Establish and maintain up to date electronic filing systems, including computerized indexing, office records, monthly agendas, meeting minutes, confidential files, policies and procedures and various other documents as directed.
 - 6.2 Establish and maintain a well-organized paper filing system.
 - 6.3 File the updated Constitution and Bylaws and the DCFA policies, procedures, and guidelines.
 - 6.4 Conduct research as requested by the Table Officers.
 - 6.5 Compile and collate statistics as needed.
- 7. *Telephone, Reception and Mail***
- 7.1 Take and relay messages by telephone or in person and check the DCFA emails.
 - 7.2 Answer enquiries relating to the DCFA, or direct enquiries to the appropriate individual.
 - 7.3 Set up voice mail and email lists.
 - 7.4 Maintain mailing lists – internal and external.
 - 7.5 Open and distribute mail daily in accordance with established procedures.
 - 7.6 Arrange specialty mailings by courier or through the post office.
- 8. *DCFA General Meetings, AGM and other Special Events***
- 8.1 Make arrangements for General Membership meetings, special events, workshops etc., including room bookings, catering, tech assistance, material preparation, promotion, and monitoring cost and budget as required.
- 9. *Duplication and Distribution of Materials***
- 9.1 Duplicate and distribute documents such as, meeting packages, minute, bulletins, newsletters, and other documents at the request of the Table Officers.
 - 9.2 Deliver material to the field bases and arrange for material to be distributed at all DC campuses.
- 10. *Office Supplies, Equipment and Continuity***
- 10.1 Purchase office supplies (including kitchen/housekeeping), as needed.
 - 10.3 Maintain an inventory of DCFA Office Equipment.
 - 10.3 Arrange for purchase, maintenance, and repair of office equipment, as needed.
 - 10.4 Maintain record of office keys and ensure office security procedures are in place.
 - 10.5 Provide continuity for office vacation coverage.
 - 10.6 Provide continuity during transfer of authority from outgoing executive to incoming executive by providing information and explaining processes and procedures.
- 11. *Vacation Coverage / Assist the Financial Coordinator***
- 11.1 Assist the Financial Coordinator if requested, in particular to cover as much of their duties as reasonably possible when the Financial Coordinator is unavailable.

Job Title: Financial Coordinator**DESCRIPTION**

The incumbent performs a variety of financial accounting and other administrative tasks in support of the Association's operations. They handle the financial affairs of the DCFA, including dues and accounts receivable, accounts payable, month and year-end financials, monthly and yearly reports, and year-end Audit preparation. Generally, the incumbent will be expected to perform the required tasks based on instructions from the Secretary-Treasurer and/or other authorized DCFA representatives. Unusual problems or concerns will be brought to the Secretary-Treasurer. However, since this is a small office, the employee is also expected to work independently when necessary.

DUTIES

1. Confirm that Faculty dues from the College have been received by the credit union.
2. Verify and prepare monthly payables for signature and mail cheques.
3. Prepare for signature and mail additional cheques as requested by the Secretary-Treasurer.
4. Maintain various Excel spreadsheets as requested by the Secretary-Treasurer.
5. Assist the Secretary-Treasurer with accounting and financial responsibilities using Excel spreadsheets and Sage Business Cloud accounting software or other similar software.
6. Assist in preparation and maintenance of the annual budget.
7. Assist in the annual audit.
8. Ensure maintenance and preparation of payroll records and staff benefits.
9. Complete and submit reports to government agencies as required.
10. Assist the Administrative Officer if requested, in particular to cover as much of their duties as reasonably possible when the Administrative Officer is unavailable.

APPENDIX C

EXPANDED DEFINITION OF “FAMILY MEMBER”

	Family members of your spouse or common-law partner
Brothers or sisters and stepbrothers and stepsisters	
Grandparents and step-grandparents	Grandparents
Grandchildren and their spouse or common-law partner	Grandchildren
Son-in-law and daughter-in-law, either married or common-law, and their step-children	
Father-in-law and mother-in-law, either married or common-law	
Brother-in-law and sister-in-law, either married or common-law	
Uncle and Aunt and their spouse or common-law partner	Uncle and Aunt
Nephew and Niece and their spouse or common-law partner	Nephew and Niece
Current or former foster parents	Current or former foster parents
Current or former foster children and their spouse or common-law partner	
Current or former wards	Current or former wards
Current or former guardians or tutors and their spouse or common-law partner	
A close friend or neighbour	

APPENDIX D

**BENEFITS FOR
DOUGLAS COLLEGE
FACULTY ASSOCIATION
MEMBERS OF
CUPE LOCAL 1004**

Douglas College Faculty Assoc.

All Staff

**GROUP
INSURANCE
BENEFITS**



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This booklet provides a summary of your Johnstone's group benefits plan. The information contained here is important to you and your family and you should keep it in a safe place. Familiarize yourself with the contents of this booklet and refer to it whenever you claim group insurance benefits.

The information in this booklet is designed to help you understand the benefits covered under your plan. **It is not a legal contract, and payment for all claims is based solely on the group master policy or contract issued by the insurer.**

Benefit	Insurer	Policy number
Life	RBC Insurance	82418
Accidental death & disablement	Lloyd's of London	10012/93-511
Short term disability	BC Life	901111
Long term disability	RBC Insurance	82418
Extended health care	Pacific Blue Cross	901111
Dental care	Pacific Blue Cross	901111
Cost Plus	Pacific Blue Cross	901111

Johnstone’s Benefits website

You can find information to better understand your benefits and learn how we can help you at www.jbenefits.com

Claims Submissions

You can find claim forms for any of your benefits at our website: www.jbenefits.com. If you have any questions, call (604) 980-6227 (toll free: 1 800 432-9707).

Extended health care and dental claims

Mail extended health care and dental claims to:

Pacific Blue Cross
P.O.Box 7000
Vancouver, B.C. V6B 4E1

To submit an EHC claim, see “claiming procedures” in the EHC section of this booklet. For dental claims, your dental office will usually submit on your behalf.

To contact Pacific Blue Cross for assistance with your medical and dental claims and coverage, phone:

Metro Vancouver: (604)-419-2000
Toll free: 1-877 PAC-BLUE

Submitting claims online

The Member Profile site is an on-line service from Pacific Blue Cross that offers you convenient and secure access to your benefits and claim information 24 hours a day. Go to www.pac.bluecross.ca to make a claim, track the status of a current claim, check your benefit limits, download forms, and sign up for direct deposit.

All other claims

Send Life, AD&D, STD, LTD and Cost Plus claims to:

Johnstone's Benefits
3095 Woodbine Drive
North Vancouver, B.C. V7R 2S3
admin@jbenefits.com

Written notice of Life, AD&D, STD and LTD claims must be filed with the insurer as soon as reasonably possible, after the occurrence or start of any loss. See the summary of benefits for each benefit for specific limitations.

life insurance

This is a summary of your life insurance benefits. For details see the life insurance section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee only.
Benefit formula	Three times your annual income (rounded to the next highest \$1,000)
Maximum benefit	\$300,000
Living benefit	Yes. You may elect to receive a portion of the life insurance benefit while living. See Accelerated benefit on page <u>18</u> for details.
Non-evidence amount	<p>\$150,000</p> <p>This is the maximum amount of coverage available before evidence of insurability will be requested.</p> <p>NOTE: the non-evidence amount is subject to change without notice and will be determined at the time of your application or salary change.</p>
Termination	At the earlier of termination of employment, retirement or age 70
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 31 days of termination. For details, see Conversion privilege on page <u>19</u> .
Beneficiary	<p>Payment of this benefit will be made to the persons you have designated.</p> <p>NOTE: if no beneficiary is designated, proceeds will go to your estate.</p>
Claiming deadline	Notify the insurer within 30 days, submit claim within 90 days

accidental death & disablement

This is a summary of your accidental death & disablement benefits (AD&D). For details see the AD&D section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee only.
Benefit formula	Accidental death benefit: Three times your annual income (rounded to the next highest \$1,000) Loss of use: see Specific Loss Benefits Schedule on page <u>22</u>
Maximum benefit	\$300,000
Aggregate	\$21,000,000
Non-evidence amount	Accidental death coverage matches the life insurance, above. See life benefit non-evidence amount for details. This is the maximum amount of coverage available before evidence of insurability will be requested.
Termination	At the earlier of termination of employment, retirement or age 70
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 60 days of termination. For details, see Conversion Privilege on page <u>25</u> .
Beneficiary	Payment of the death benefit will be made to the persons you have designated. Note: if no beneficiary is designated, proceeds will go to your estate.
Claiming deadline	Notify the insurer within 30 days, submit claim within 90 days

short term disability

This is a summary of your short term disability benefits (STD). For details see the STD section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee only.
Benefit formula	Weekly benefit is calculated as 70% of gross weekly earnings
Maximum weekly benefit	\$1,500
Non-evidence amount	\$1,500 This is the maximum amount of coverage available before evidence of insurability will be requested.
Benefit starts after	30 days in the event of accident 30 days in the event of sickness 30 days in the event of hospitalization (in-patient only)
Benefit period	Benefits are paid for 26 weeks
Termination	At the earlier of termination of employment or retirement or age <u>28</u>
Taxation	Benefits paid are taxable.
Claiming Deadline	The insurer must receive notice of any claim for a short-term disability benefit within 31 days of the date of the commencement of the employee's disability.

long term disability

This is a summary of your long term disability benefits (LTD). For details see the LTD section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee only.
Benefit formula	Monthly benefit calculated as 70% of gross monthly earnings
Definition of earnings	For the insurer’s definition, see What are your monthly earnings? on page 31
Maximum monthly benefit	\$6,000 The individual's income from all sources, while disabled, cannot exceed 85% of indexed pre-disability monthly income.
Non-evidence amount	\$6,000 This is the maximum amount of coverage available before evidence of insurability will be requested.
Benefit starts after	The later of 180 days or the date your accumulated sick leave or salary continuation payments end, if applicable
Partial disability	Employees may satisfy the elimination period while partially disabled, provided the definition of disability is met. After the elimination period, see How much will RBC insurance pay you if you are disabled and working? on page 31 .
Pre-existing limitation	Exclusions apply. See page 35 for details.
Benefit period	To age 65
Definition of disability	You are unable to perform the regular duties of your occupation due to your sickness or injury. After 24 months, you are unable to perform any gainful occupation for which you are reasonably fitted by education, training or experience. For the insurer’s definition, see page 30
Termination	At the earlier of termination of employment, retirement or age 65
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 31 days of termination. For details, see What insurance is available if you end employment? on page 37 .
Taxation	Benefits paid are taxable.
Claiming deadline	Notify the insurer within 30 days, submit claim within 90 days

extended health care

This is a summary of your extended health care benefits (EHC). For details see the EHC section of this booklet.

NOTE: frequency limitations and financial maximums apply to specific benefits covered under this EHC plan. See details under the extended health care section in this booklet. Reimbursement amounts for EHC procedures, supplies, and services are always based on reasonable and customary fees as determined by your insurer.

Plan Design	Details
Eligibility	Coverage is for the employee, the spouse, and dependent children. Dependent children are covered to age 21, or 25 if a full-time student, to any age if disabled.
Reimbursement schedule (unless otherwise indicated)	Out of province emergency care: 100% All other eligible expenses: 80% After \$1,000 has been paid for a person in a calendar year, further eligible expenses for that person within that year will be reimbursed at 100%, subject to the contract maximums.
Plan maximums	Out of province and out of country emergencies: Unlimited lifetime maximum All other eligible expenses: Unlimited lifetime maximum
Annual deductible	There is no deductible
Termination	At the earlier of termination of employment or retirement
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 60 days of termination. For details, see Conversion to Individual Plan on page 51 .
Claiming deadline	The insurer must receive the claim by December 31 of the year following the calendar year in which the expense was incurred (i.e. 2022 claims must be received before December 31, 2023).
Survivor benefit	Dependent coverage may continue without further payment of premiums for up to 24 months after the date of the employee's death.

extended health care

Covered Items	Reimbursement Percentage	Details
PRESCRIPTION DRUGS	80%	No annual maximum dollar amount but reimbursement will be based on the reasonable and customary fees in the pricing file set by the insurer.
Pay direct drug card		Yes. Present the card to the pharmacist and pay only the portion not covered under your plan.
Eligible drugs		Lowest-cost alternative, usually the generic prescription equivalent when available. For details see Drugs and Medicines on page 44
Dispensing fee		Dispensing fees are covered
PARAMEDICAL SERVICES		
Speech Therapist Naturopath Podiatrist	80%	\$500 per practitioner per calendar year limit
Acupuncture Chiropractor	80%	\$600 per practitioner per calendar year limit
Clinical psychologist (combined w/registered clinical counsellors)	80%	\$1,000 per calendar year limit
Massage Therapist Physiotherapist	80%	Unlimited – subject to Reasonable and customary charges
VISION CARE		
Prescription eye glasses, laser surgery and contact lenses	80%	\$850 every two calendar years
Eye exams	80%	\$100 every two calendar years

extended health care

Covered Items	Reimbursement Percentage	Details
AMBULANCE AND HOSPITAL Ambulance Hospital	80%	Emergency only, includes air transport Private or semi-private
MEDICAL EQUIPMENT AND SUPPLIES	80%	Limits apply. See the EHC section of this booklet for details. Pre-authorization is required for large dollar amounts.
HEARING AIDS	80%	\$1,000 every 3 years Adults and dependent children
DENTAL ACCIDENTS	80%	Yes, within 52 weeks of the accident. For claims submission instructions, see Dental Accidents on page 45.
ORTHOPEDIC SHOES	80%	Adult-\$500 each calendar year Child-\$300 each calendar year
ORTHOTICS	80%	\$250 each calendar year
EMERGENCY TRAVEL Out of province and out of country emergency coverage	100%	Unlimited For details see Out-Of-Province Emergency Expenses on page 48.
International medical assistance		24-hour multilingual assistance to help identify the appropriate medical care, assist in emergency medical payments, arrange medical transportation, assist travel companions. Refer to your travel assist card for the phone numbers. Call within 48 hours after your medical emergency.

This is a summary of your dental care benefits. For details see the dental care section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee, the spouse, and dependent children. Dependent children are covered to age 21, or 25 if a full-time student, to any age if disabled.
Annual deductible	There is no deductible
Termination	At the earlier of termination of employment or retirement
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 60 days of termination. For details, see Conversion to Individual Plan on page 59.
Fee guide	Pacific Blue Cross Fee Schedule. All fees in excess of this fee schedule are the patient's responsibility. Your dentist has a copy of this fee schedule.
Claiming deadline	Claims submitted later than one year after the date of service will not be paid.
Survivor benefit	Dependent coverage may continue without further payment of premiums for up to 24 months after the date of the employee's death.
Dental accidents	Covered under the EHC plan

dental care

Type of Coverage	Reimbursement Percentage	Maximums
Plan A: basic services	100%	No annual dollar maximum
Recall exam limit		Two in a calendar year
Scaling (periodontal cleaning) limit		Based on the contract percentage of the combined dollar maximum outlined in the current years <i>PBC Fee Guide</i> . See your dentist for the current dollar maximum.
Plan B: major restorative services including crowns, bridges, partial and full dentures	80%	No annual dollar maximum.
Plan C: orthodontics Coverage for employee, spouse and dependent children	50%	\$3,000 lifetime maximum for each insured person. Coverage for dependent children ends when the dependent reaches age 21, 25 if a full-time student, or to any age if disabled.

cost plus benefit

This is a summary of your health spending account (HSA). For details see the HSA section of this booklet.

Eligibility	Coverage is for all employees, their spouse and/or dependents.
Maximum benefit	\$1,000 per insured person, per lifetime
Termination	At the earlier of termination of employment or retirement
Covered items	laser eye treatment, hearing aids, or dental implants
Claiming instructions	<p>Cost plus claims are for items not covered under your insured plan. All claims must be submitted through the regular health and dental plans prior to submitting an extra-contractual claim.</p> <p>To submit a cost-plus claim, complete the extra-contractual cost-plus claim form and send to Johnstone’s Benefits along with your receipts and /or explanation of benefits. Johnstone’s Benefits will coordinate the payment from Pacific Blue Cross and invoicing to your employer accordingly.</p>

Who is Johnstone's Benefits?

Johnstone's Benefits is an independent employee benefits advisor and third party administrator located in North Vancouver B.C. We have over 30 years experience working with employers of all sizes to develop customized employee benefit and retirement plan solutions. We have no contractual obligations to any insurance provider, which allows us to negotiate the most favourable premium costs, benefit provisions, and claims payment settlements on behalf of our clients and their employees. As a third party administrator, we provide administration support in managing employee benefits plans. If you have any questions or concerns with any aspect of this, or any other product, don't hesitate to contact Johnstone's Benefits.

Eligibility and Waiting Period

All permanent full-time employees who reside in Canada and are working at least 20 hours a week are eligible to join the plan for all benefits. Future employees will become eligible for benefits on the following basis:

Benefit	Eligible for coverage on:
All benefits	Immediately upon being eligible for coverage

NOTE: For extended health care benefits, you and your dependents must be insured under the provincial health plan to be covered under these benefits.

Insurance Effective Dates

Insurance for you and your dependents will become effective immediately on the above noted dates if you have completed the necessary enrolment forms and are actively at work.

If you are absent from work for any reason other than statutory or regularly scheduled holidays when you would otherwise become insured, you will be insured on the date you return to work on an active, full-time basis.

Late Applicants

If you do not complete the necessary enrolment forms within 31 days of the eligibility date for you and your dependents, insurance will be effective on the date you and they are approved by the insurer, provided you are actively at work on that day. Medical evidence of good health is required and you will be responsible for any medical expenses involved.

For dental benefits, late applicants are limited to a maximum of \$250 per person for all dental services received during the first 12 months of coverage.

Medical Evidence Requirement

For life and ltd amounts in excess of the no-evidence amounts (as shown in the summary of benefits), medical evidence of good health is required.

As previously noted, medical evidence of good health must be provided at your own expense if you fail to enroll within 31 days of your eligibility date. Contact your plan administrator for the necessary forms. For our purposes, a physician means a legally qualified physician or surgeon, other than the insured or a member of the family.

Coverage for Dependents

The employee's dependent spouse and dependent child who:

- resides in Canada;
- is not a member on active duty of the armed forces of any country.

DEPENDENT SPOUSE

The spouse of the employee, and is **either**:

- a person legally married to the employee;

OR

- a person, whom he or she has been residing with for a period of at least one year and is not legally married to as the spouse, provided that a written request is made by the employee for granting insurance for such named individual, in a form satisfactory to the insurer. Unless this written request is made, the person legally married to the employee is considered to be the dependent spouse. Discontinuance of cohabitation terminates the eligibility of a common-law spouse for dependent status.

DEPENDENT CHILD

An unmarried child, stepchild or legally adopted child **either**:

- of the employee or the legal spouse, who lives with them and is fully dependent on them for support;

OR

- of the employee or the common-law spouse, who is in the care and custody of both, residing with them and being fully dependent on them for support;

AND

- is under age 21 or age 25 if attending an educational institute full-time and will be covered to any age if physically or mentally disabled and incapable of self-sustaining employment.

Dependents effective date of coverage

Subsequent dependents become effective on the date on which they become eligible dependents if they are registered within 31 days of becoming eligible. However, if dependents are hospitalized on the date they are to become eligible, coverage may not be effective until they are no longer hospitalized.

Employees insured under a spouse's plan

This information applies to groups that have extended health care (EHC) and dental care plans.

OPTING OUT

Employees who have alternative coverage under a spouse's plan are permitted to waive coverage under the extended health and dental care plans. The employee must complete a waiver that identifies both the alternative coverage and carriers.

LOSS OF SPOUSE'S COVERAGE

If coverage under your spouse's health or dental care plan terminates, either because the plan terminates or because your spouse becomes ineligible for that plan, you are eligible for immediate coverage under your company's extended health and dental care benefits **provided you apply within 31 days of the date your coverage terminates.**

For any late application (i.e. after 31 days) evidence of insurability will be required for you and your dependents at your expense. Coverage will not be effective until the day such insurability is approved.

CO-ORDINATION OF BENEFITS

When a person has extended health care or dental care coverage under more than one plan, benefits under this plan will be subject to co-ordination so that benefits payable from all plans do not exceed 100% of eligible expenses.

To determine which plan pays first, insurance companies follow the COB guidelines established by the Canadian Health and Life Insurance Association:

- Claims go first to the insurer who provides the employee with coverage. Before payment for your own claim can be made through your spouse's plan, it must first be submitted to your own plan (& vice versa).
- In the case of children the order of payment is determined by the month of birth of the employee and spouse. Regardless of which spouse is older, the plan covering the spouse whose birthday falls earliest in the year will always pay first. For example, if the employee was born in April and the spouse born in January, the spouse's plan will be the first payor of the children's claim.

Insurance Termination Dates

Your coverage will terminate:

- upon termination of the policy
- when you are not in an eligible class
- upon termination of employment
- upon non-payment of premium
- when termination is requested in writing
- at age 65 less the elimination period for the LTD benefit
- when a dependent is no longer eligible

Your dependents' coverage terminates along with yours, or when your dependent no longer qualifies, whichever is earlier.

NOTE: Termination provisions may vary under different benefits. Please refer to the summary of benefits for further details.

Personal Information

When you apply for coverage under the group benefit plan, both Johnstone's and each insurer will open a file with personal information relevant to your insurance coverage under the plan.

These files are necessary to enable the administration of all benefits you are entitled to under the group coverage provided. This includes:

- Underwriting and financial reporting
- Claims adjudication and management
- Internal and external audits
- Preparation of regulatory and statutory reports

These files are kept in the offices of Johnstone's Benefits and the respective insurers. Employees of these organizations have access to these files when required for insurance purposes. You have certain rights of access and correction with respect to the information in your files. A request for access or correction must be in writing and may be sent to us for forwarding to the insurer.

For more information on our privacy policy, go to our website: www.jbenefits.com/privacy.html

Legal Note

These provisions have been added to your booklet to comply with, or in response to, amendments to insurance legislation in certain provinces.

Access to documents

You have the right to request a copy of the policy, your application, and any written statements or other records you have provided to Johnstone's Benefits and the insurer as evidence of insurability (subject to certain limitations).

Legal actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is prohibited unless begun within the time set out in the Insurance Act or other applicable legislation.

Appeals

You have the right to appeal a denial of all, or part, of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit limitation for overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days of the insurer's notice of the overpayment, or within a longer period if agreed to in writing by the insurer. If you fail to fulfill this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit the insurer's right to use other legal means to recover the overpayment.

Underwritten by RBC Insurance Policy Number 82418

Coverage is for the employee only

NOTE: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

In the event of your death, your named beneficiary will be paid in a lump sum the amount of your group life insurance according to the Summary of Benefits. You can change your beneficiary at any time by completing a form available from your employer and returning it to him/her. Any death benefit will be paid to your estate if you should die without naming a beneficiary, or if any named beneficiary should become deceased before you.

Accelerated Benefit

You may elect to receive a portion of the life insurance benefit while living. This benefit when elected will be paid provided you:

- while insured for life insurance benefits, become terminally ill;
- have a medical prognosis of 12 months or less to live;
- request this election, in writing, on a form acceptable to RBC; and
- RBC receives certification which they deem satisfactory, in writing by a physician, that you are terminally ill and have a medical prognosis of 12 months or less to live.

The accelerated benefit is the lesser of 50% of the death benefit, or \$50,000 and is payable in one lump sum to you, once in your lifetime. Premium payment must continue to be paid on the full amount of life insurance. If you qualify for the "Extension of Employee Life Insurance during Total Disability" provision, your life insurance will be extended without further premium payment according to the terms of the policy.

Once this benefit has been paid, the amount of your life insurance will be reduced by the accelerated benefit payment. The remaining life insurance amount will be paid according to the terms of the policy, subject to any reduction and termination provision. Also, any amount you could otherwise convert will be reduced by the accelerated benefit payment.

The accelerated benefit is not available to you if:

- You are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- You are required by a government agency to use this benefit to apply for, get or keep a government benefit or entitlement.

If you elect the accelerated benefit option and have assigned your rights under this policy to an assignee or have made an irrevocable beneficiary designation, RBC must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to payment of the accelerated benefit on your behalf.

Waiver of Premium Benefit

To qualify for the Waiver of Premium Benefit, you must:

- become totally disabled while insured and before reaching age 70,
- be continuously disabled for at least 120 days,
- notify RBC INSURANCE of your total disability within 1 year from the date your total disability started, and
- send proof of your continuous total disability. The first proof must be given to us between the 120th and 365th day after the date your total disability started. Continuing proof of total disability must be given as we may require, at regular intervals. But after two years, we will not require proof more often than once a year.

If it is not possible to give us notice or proof of your total disability within these time limits, it must be given as soon as reasonably possible. But it may not be given more than 3 months later than the time either the notice or proof is otherwise required.

No premium payments are required for your life insurance until your life disability benefit ceases under the termination provisions. The life amount we keep in force for you is that amount in effect on your last day of active employment before disability.

Your life disability benefit will terminate on the earliest of the following dates:

- the date you are no longer totally disabled,
- the date you fail to give us continuing proof of total disability,
- the date you refuse to be examined as required,
- the date you retire.

Conversion Privilege

RBC agrees under the conditions and the time limits explained below to issue a personal life policy without evidence of insurability to:

- you if your life insurance terminates or reduces because you:
 - end employment;
 - change job status and so become ineligible;
 - retire;
 - reach a specified age;
 - change employee class; or
 - no longer meet the requirements described in the “Extension of Employee Life Insurance During Total Disability” subsection.

You may elect to convert a life amount equal to or less than the amount that terminated.

- your dependent if:
 - they lose status as a dependent; or
 - you terminate your life insurance

Your dependent may elect to convert a life amount equal to or less than the amount that terminated.

- an individual if his life insurance terminates because:
 - the life insurance is terminated for that individual's insurance class; or
 - the group policy is amended to exclude life insurance or is terminated.

The maximum life amount that may be converted is the lesser of:

- the terminated life amount less any life amount for which you are or become eligible under any other Group Policy within 31 days after that termination; or
- \$200,000 less the amount of all the individual's other group insurance coverage.

The following will apply to any personal life policy issued under this conversion privilege:

- The premium will be at RBC's standard rate for the premium class to which you belong.
- It will be issued only if application is made within 31 days after your insurance terminates or reduces. The first premium must also be paid within that time.
- It will take effect at the end of the 31 day period during which your application may be made.
- It will be issued without:
 - accidental death and disablement benefits;
 - disability or other supplementary benefits;
 - preferred risk premium rates; or
 - other premium discounts
- The form may be any of the following:
 - a level premium Whole life plan then in use by RBC at your then attained age. You may elect on one year of Preliminary Term Insurance under the level premium Whole Life policy; or
 - your contract of non-convertible yearly renewable Term Life Insurance to the age of 70years.

The converted amount will be in place of the life insurance amount which you were eligible to convert.

If a personal life policy becomes effective for you and you later become approved for Extension of Employee Life Insurance during Total Disability, you:

- must return that personal life policy;
- will not receive any benefits under that personal life policy; and
- will receive a refund of premiums for that personal life policy.

If you die during the 31 day period in which application for a personal life policy may be made, RBC will pay a death benefit. The death benefit will:

- be paid under this group policy and not under the personal life policy; and
- equal the maximum life amount which you might have otherwise converted.

The personal life policy must be returned to RBC without claim, except for a refund of premiums.

Extension of your Life Insurance during Total Disability

(excess life amounts that require higher rates are not included)

Your life insurance may be extended beyond when it would otherwise terminate under the provisions in the Termination of Coverage section provided:

- you, while insured for life insurance benefits and before attaining age 65, become totally disabled;
- the total disability is continuous for at least 120 days;
- you give RBC written notice of your total disability within one year from the date your total disability started; and
- you give proof of the continuous total disability to RBC. The first proof must be furnished between the 120th and the 365th day after the date your total disability started. Continuing proof of total disability must be furnished as RBC may require, at reasonable intervals. But after two years, RBC will not require proof more often than once a year.

If it is not possible to give RBC notice or proof of total disability within these time limits, it must be given as soon as reasonably possible. But it may not be given more than three months later than the time either the notice or proof is otherwise required.

Once proof of total disability is approved by RBC, your life insurance will be extended without further premium payments until it ceases under the termination provisions below.

Your life insurance continued will be the amount in effect on the last day of active employment excluding excess life amounts that require higher rates. But all reductions and termination provisions in effect on the last day of active employment will still apply to that continued amount.

This extension of your life insurance will terminate on the earliest of the following dates:

- the date you are no longer totally disabled;
- the date you fail to furnish continuing proof of total disability;
- the date you refuse to be examined as required;
- your retirement date.

At such time, the Life Insurance conversion Privileges provisions shall apply, to the extent that you lose some or all of your life insurance coverage under this policy.

If you die within one year of the date total disability started without giving RBC the first proof, your death benefit will still be paid to your beneficiary. But RBC must first receive proof of your:

- continuous total disability from the last day of active employment to the date of death; and
- death as explained in the proof provisions of this section.

Termination of Coverage

Insurance coverage will terminate on the earliest of:

- the date the policy terminates,
- the date your employment terminates,
- the date you retire, or
- the day you reach age 70.

Underwritten by Lloyd's of London
Policy Number 10012/93-511

Coverage is for the employee only

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer which may be viewed at the office of the group policyholder (the employer).

You are insured 24-hours a day, worldwide. This coverage provides lump sum, tax-free benefits in the event of an accident causing death, loss of (or loss of use of) limbs, loss of sight, etc. as outlined below.

Specific Loss Benefits Schedule

The "Principal Sum" for which you are covered is shown in the Summary of Benefits of this booklet. When injury results in any of the following losses within 365 days of the accident, the Insurer will pay for:

The **principal sum** for Loss or Loss of Use of

- Accidental Death
- Both Hands
- Both Feet
- Speech and Hearing in Both Ears
- The entire Sight of Both Eyes
- One Hand and One Foot
- One Hand and the Entire Sight of One Eye
- One Foot and the Entire Sight of One Eye

80% of the principal sum for Loss of or Loss of Use of

- One Arm
- One Leg

70% of the principal sum for Loss of or Loss of Use of

- One Hand
- One Foot
- The Entire Sight One Eye
- Speech
- Hearing in Both Ears

35% of the principal sum for Loss of

- Thumb and Index Finger or at Least Four Fingers of One Hand
- All Toes of One Foot

accidental death & disablement

- Hearing in One Ear

Two times the principal sum for total paralysis of

- Both Upper and Lower Limbs (Quadriplegia)
- Both Lower Limbs (Paraplegia)
- Both Upper and Lower Limbs on one side of the body (Hemiplegia)

Indemnity provided under this section for all losses sustained by any one Insured Person as the result of any one accident shall not exceed the Principal Sum, with the exception of quadriplegia, paraplegia and hemiplegia, where indemnity shall not exceed two times the Principal Sum.

Notwithstanding the foregoing, if loss of life due to accidental death occurs within one hundred and twenty (120) days after the date of the accident for which indemnity is payable, indemnity payable under this section shall not exceed the Principal Sum.

Aggregate Limit

\$21,000,000 is the aggregate limit of indemnity for which the Insurer shall be liable under this policy for all losses arising out of any one Accident Event other than an accident to any one aircraft.

The total limit for all Insured Persons in your group involved in any one aircraft accident is \$5,000,000.

Beneficiary

In the event of accidental death, benefits will be paid to your designated beneficiary entered on your enrolment form. All other benefits, with the exception of the Repatriation Benefit and Occupational Training Benefit, described below, are payable to you.

Other AD&D Benefits

Exposure and disappearance

Benefits are payable for losses as provided under the policy due to unavoidable exposure to the elements, when caused by an injury covered by the policy. Also, if you are not found within one year of the sinking or wrecking of the conveyance in which you were riding at the time of the accident, and under circumstances that would otherwise be covered, the Insurer will pay the Accidental Death Benefit.

Repatriation benefit

In the event accidental death occurs more than 50 kilometres away from your home, the cost (up to \$15,000 maximum) or preparation and shipping you to your city of permanent residence, is covered.

Rehabilitation benefit

Up to \$15,000 towards the cost of special training is payable, within 3 Years of the accident, as a result of a claim which qualifies under the "Specific Loss Benefits Schedule", above.

accidental death & disablement

Occupational training benefit

Should you suffer accidental death covered by this policy, up to \$15,000 is payable, within 3 years of the accident, for your spouse to retrain in an occupation which he/she would not otherwise have sufficient qualifications.

Childcare benefit

Certain losses will qualify for a childcare benefit payment for children enrolled in an accredited ChildCare facility and under the age of 13. This will provide up to \$6,250 per year per child for up to 4 consecutive years.

Seat belt rider

In the event injury occurs while you are a driver or a passenger in a private automobile, the benefit payable will be increased by 10% if it is verified that you were wearing a properly fastened seat belt at the time of the accident.

Home modification benefit

A maximum benefit of \$30,000 is provided towards the cost of alterations to your residence to make it wheelchair-accessible and habitable, in the event injury results in the loss or loss of use of both feet or both legs, quadriplegia, paraplegia or hemiplegia. Expenses must be incurred within 2 years of the Accident causing loss.

Hospital cash benefit

In the event you sustain an injury and that injury requires that you be confined to a hospital as an inpatient, while under the care of a physician or surgeon, the benefit will pay a daily amount of \$50 for each day you are hospitalized, retroactive after a minimum hospital confinement of 72 hours, not to exceed more than 25 days.

Family transport and subsistence benefit

In the event injury occurs and you are confined to a hospital located not less than 250 kilometers from your residence, the benefit will pay for the return fare, economy class transportation, of one member of your immediate family, or a close friend, by the most direct route via common carrier, when the attending physician advises the necessary attendance. The benefit will also pay for the reasonable and necessary expenses incurred by your family member or friend for accommodation and meals, limited to a maximum of \$300 per day inclusive, up to a maximum duration of 10 days. The maximum for the total of all transportation, accommodation and meal expenses shall not exceed a maximum of \$12,500 as the result of any one accident.

Personal mobility benefit

Up to \$50,000 is payable, within 2 years of the accident, for the purchase of a special vehicle with hand controls, lifts for the home or personal vehicle, electric wheelchairs, etc., which are necessary as the result of a loss payable under the "Specific Loss Benefits Schedule".

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Disability fitness benefit

Up to \$7,500 is payable, within 2 years of the accident, for the purchase of special fitness or athletic equipment for the disabled, that would not have been required except for an injury for which benefits are payable under the "Specific Loss Benefits Schedule".

Waiver of premium

If you become totally disabled from performing any work you are capable of, premiums due for this coverage will be waived, after 6 months of continuous disability, until you recover, reach age 65, or the group policy is terminated.

Note: The above benefits shall only be payable under one of the policies issued by the Insurer.

Conversion Privilege

If your coverage under this group plan terminates, because you leave the employ of the company or the group policy terminates, and provided you are under the age of 70, you may convert your amount of coverage, within 60 days, to an individual policy, payable at the individual premium rates for your age, occupation and activities, as prescribed by the Insurer.

Exclusions

This policy does not cover any loss, fatal or non-fatal, caused or contributed to by:

- Suicide, or intentionally self-inflicted injury;
- War, or any act of war (whether declared or undeclared), invasion, acts of terrorism or acts of foreign enemies, civil war, rebellion, revolution or insurrection;
- Active or full time service in the armed forces of any country;
- While flying when you have flight duties (pilot, etc.), or when flying in an aircraft owned, operated or leased by the Policyholder;
- Nuclear reaction, nuclear radiation or radioactive contamination.

**Underwritten by BC Life
Policy Number 901111**

Coverage is for the employee only

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

Benefit

BC LIFE will pay Short Term Disability (STD) benefits when you are totally disabled and prevented from working as a result of a non-occupational accident or sickness for which Workers' Compensation Benefits are not payable.

The elimination period is a period of time, when you are continuously disabled, which must be completed before your claim for Benefits will be considered.

Benefits commence on the day after the elimination period expires or on the first day you were seen and treated by a physician or chiropractor, whichever is later, and will be paid only during periods of disability when you are under his or her regular care and following the treatment prescribed. Certification of disability beyond a six week period must be made by a physician.

The weekly Benefit Amount, the elimination period, and the maximum Benefit period are shown in your Summary of Benefits.

Recurrent disability

Recurrent disability means a disability which is related to or due to the same cause(s) as a prior disability for which you received Benefit payments.

A recurrent disability will be considered part of the prior disability if, after receiving STD benefits, you returned to work on a full-time basis and were able to perform all the essential duties of your occupation for less than two weeks.

Once you have resumed work on a full-time basis and have been at work for two consecutive weeks, any subsequent injury or sickness will be considered a new disability.

Basic Earnings

means the amount the employee normally earns on a regular, formal basis from the employer immediately prior to the date of claim or, for disability benefits prior to the date the period of disability starts. Additional income earned on a regular, formal basis from tips, bonuses, and overtime will be included. If the employee earnings fluctuate, an average will be calculated:

- for the std benefit the average earnings over the preceding 20 week period and for any other benefits, the average earnings over the preceding 12 month period or,
- if income is derived in whole or in part from commissions, the average earnings over the preceding 24 month period, or
- if not employed for the full period, then for the period employed.
- The employee's T4/T4A slips may be required as proof. If any discrepancy arises, premium levels will be adjusted and backdated accordingly. It does not include income from dividends, profit sharing, and deferred compensation.

Graduated return to work

If you return to work on a gradual rehabilitative basis you will have your benefit reduced by 50% of any income earned from the rehabilitative employment. The combined total of your benefit plus the rehabilitative income will not exceed 100% of your earnings prior to the date your disability started.

Benefits will continue for a maximum of one period of disability as outlined under Recurrent Disability, whether due to one or more illnesses.

In consultation with you, your employer, and with your Physician's agreement, BC LIFE will determine your eligibility for this program and its duration.

Coordination with other sources

Your STD payment will be co-ordinated with benefits received from other sources so that the total benefits received, for the same disability, will not exceed your normal take home pay on the date you became totally disabled.

Third party liability

Benefits will be paid for disabilities due to an accident in which a third party is liable. However, you must reimburse BC LIFE when you receive payment from the third party.

Termination of Benefits

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

- you are no longer disabled;
- you are no longer receiving regular medical care and treatment from your physician;
- you fail to submit satisfactory proof of continuing disability as required by BC LIFE;
- you refuse a medical examination by a physician chosen by BC LIFE;
- you are no longer following the treatment recommended for your disability;
- you leave Canada, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan as medically necessary. If you normally reside outside Canada, such treatment must be approved by BC LIFE;
- you perform any work for compensation or profit;
- the end of the maximum benefit period indicated in your benefit schedule;
- you retire;
- you die.

Exclusions

Benefits are not payable for any period of disability arising from any of the following:

- self-inflicted injury or sickness
- participation in a criminal offence
- civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the armed forces of any nation
- a pregnancy related sickness (i) during any period of formal maternity leave and/or parental leave and (ii) during any period in which Employment Insurance (EI) benefits are being paid
- substance abuse, including but not limited to alcoholism or drug addition, unless you are receiving continuing treatment for substance abuse from your physician
- medical or surgical care which is cosmetic, unless considered medically necessary as a result of injury or sickness
- that commenced prior to the date you were otherwise eligible for benefits or during a period when you were not eligible for benefits for any reason, unless BC LIFE agrees in writing
- while you are:
 - in a jail or penitentiary
 - on a leave of absence or paid vacation
 - receiving benefits for the same or related disability from WCB or similar legislation
- if you become disabled during a strike or lockout at your place of employment; however, your right to benefits will be reinstated when the strike or lockout ends.

Claims

- obtain a claim form from your Plan Administrator, as soon as possible after you become totally disabled.
- complete the employee's statement and sign the form on both sides
- return the form to your Plan Administrator for completion of the employer's portion
- have your physician complete and sign the medical portions of the form
- BC Life must receive satisfactory proof of claim within 30 days following the end of the Elimination Period. Failure to submit a claim within the 30 day limit will not invalidate the claim if special circumstances prevail
- BC Life may request supplementary reports to update the medical information on file. Any cost for completion of medical reports will be your responsibility
- Incomplete claim forms will cause a delay in the payment of your benefits.

Underwritten by RBC Insurance Policy Number 82418

Coverage is for the employee only

NOTE: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

How Does RBC Insurance Define Disability?

You are disabled when RBC Insurance determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 24 months of payments, you are disabled when RBC Insurance determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

RBC may require you to be examined by a doctor, other medical practitioner or vocational expert of their choice. RBC Insurance will pay for this examination and they can require an examination as often as it is reasonable to do so. RBC may also require you to be interviewed by an authorized RBC Insurance Representative.

How long must you be disabled before you are eligible to receive benefits?

You must be continuously disabled through your elimination period. RBC Insurance will treat your disability as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is the later of:

- 120 days; or
- the date your accumulated sick leave or salary continuation payments end, if applicable.

Can you satisfy your elimination period if you are working?

Yes, provided you meet the definition of disability.

When will you begin to receive payments?

You will begin to receive payments when RBC approves your claim, providing the elimination period has been met. RBC will send you a payment monthly for any period for which they are liable.

What are your monthly earnings?

"Monthly earnings" or "pretax monthly earnings" means your average monthly income, before deductions for federal and provincial taxes, from your Employer in effect just prior to your date of disability. It includes income actually received from commissions but does not include renewal commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer.

Commissions will be averaged for the lesser of:

- the 12 full calendar month period of your employment with your Employer just prior to the date disability begins, or
- the period of actual employment with your Employer.

"Post-tax monthly earnings" means your monthly earnings as defined above, less federal and provincial taxes.

What will RBC use for monthly earnings if you become disabled during a covered absence?

If you become disabled while you are on a covered layoff or leave of absence, RBC will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

How much will RBC insurance pay you if you are disabled and working?

RBC will send you the monthly payment if you are disabled and your monthly disability earnings, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are 20% or more of your indexed monthly earnings, due to the same sickness or injury, RBC Insurance will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, RBC Insurance will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, RBC Insurance will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.

2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount RBC Insurance will pay you each month.

During the first 24 months of disability payments, if your monthly disability earnings exceed 80% of your indexed monthly earnings, RBC Insurance will stop sending you payments and your claim will end.

Beyond 24 months of disability payments, if your monthly disability earnings exceed the gross disability payment, RBC Insurance will stop sending you payments and your claim will end.

RBC Insurance may require you to send proof of your monthly disability earnings at least monthly. They will adjust your payment based on your monthly disability earnings.

As part of your proof of disability earnings, RBC can require that you send them appropriate financial records which they believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, RBC will send you 1/30 of your payment for each day of disability.

How can RBC protect you if your disability earnings fluctuate?

If your disability earnings routinely fluctuate widely from month to month, RBC Insurance may average your disability earnings over the most recent 3 months to determine if your claim should continue.

RBC will not pay you for any month during which disability earnings exceed the amount allowable under the plan.

If RBC Insurance averages your disability earnings, they will not terminate your claim unless:

- During the first 24 months of disability payments, the average of your disability earnings from the last 3 months exceeds 80% of indexed monthly earnings; or
- Beyond 24 months of disability payments, the average of your disability earnings from the last 3 months exceeds the gross disability payment.

What are direct deductible sources of income?

RBC may subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under any Workers' Compensation Act or similar legislation.
2. The amount that you receive or are entitled to receive as disability payments or the amount you receive as retirement payments under:
 - the Canada Pension Plan
 - the Quebec Pension Plan
 - any similar plan or act.

With the exception of retirement payments, RBC Insurance will only subtract deductible sources of income which are payable as a result of the same disability.

What are indirect deductible sources of income?

RBC may subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income payments under any:
 - compulsory benefit act or legislation
 - automobile liability insurance policy, where permitted by legislation
 - other group insurance plan, including association or franchise
 - Governmental retirement system as a result of your job with your Employer.
2. The amount that you:
 - receive as disability payments under your Employer's retirement plan
 - receive as retirement payments under your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are paid based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, RBC Insurance will consider you and your Employer's contributions to be distributed simultaneously throughout your lifetime.

1. The amount that your spouse and children receive or are entitled to received as disability payments because of your disability under:
 - the Canada Pension Plan
 - the Quebec Pension Plan
 - any similar plan or act.
2. The amount that your spouse and children receive as retirement payments because you are receiving retirement payments under:
 - the Canada Pension Plan
 - the Quebec Pension Plan
 - any similar plan or act.
3. The amount that you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

With the exception of retirement payments, RBC Insurance will only subtract deductible sources of income which are payable as a result of the same disability.

What are not deductible sources of income?

RBC Insurance will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- Deferred Profit Sharing Plans (DPSP)

- Registered Retirement Savings Plans (RRSP)
- Registered Retirement Income Funds (RRIF)
- non-qualified plans of deferred compensation or any other similar plan or act
- credit disability insurance
- pension plans for partners
- military pension and disability income plans
- a retirement plan from another Employer
- individual disability income plans
- salary continuation or accumulated sick leave plans

What happens when you receive a cost of living increase from deductible sources of income?

Once RBC Insurance has subtracted any deductible source of income from your gross disability payment, they will not further reduce your payment due to a cost of living increase from that source.

What if RBC insurance determines you may qualify for deductible income benefits?

When RBC determines that you may qualify for benefits under Item(s) 1. and 2. in the direct deductible sources of income section and Item(s) 1. in the indirect deductible sources of income section, they will estimate your entitlement to these benefits. RBC can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1. and 2. in the direct deductible sources of income section and Item(s) 1. in the indirect deductible sources of income section, and appeal your denial to all administrative levels RBC Insurance feels are necessary; and
- sign RBC Insurance's payment option form. This form states that you promise to pay them any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when RBC receives proof:

- of the amount awarded; or
- that benefits have been denied and all appeals RBC Insurance feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, RBC will use a reasonable one.

How long will RBC insurance continue to send you payments?

RBC Insurance will send you a payment each month up to the maximum period of payment. Your maximum period of payment is based on your age at disability as follows:

<u>Age at Disability</u>	<u>Maximum Period of Payment</u>
Less than age 64	To age 65, but not less than 1 year
64 but less than 65	1 year

When Will Payments Stop?

RBC will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis but you choose not to;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan;
- the date you fail to submit proof of continuing disability;
- the date your disability earnings exceed the amount allowable under the plan; or
- the date you die.

What disabilities are not covered under your plan?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries
- active participation in a riot
- loss of a professional license, occupational license or certification
- attempt to commit or commission of a crime under provincial or federal law
- commission of a crime for which you have been convicted under provincial or federal law
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

RBC Insurance will not pay a benefit for any period of disability during which you are incarcerated.

What is a Pre-existing Condition?

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 6 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 6 months just prior to your effective date of coverage; and

- the disability begins in the first 24 months after your effective date of coverage, unless you have been treatment free for a period of 12 consecutive months anytime during the 24 months immediately following your effective date of coverage.

What happens if you return to work full time and your disability occurs again?

If you have a **recurrent disability**, RBC Insurance will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months of the end of your prior claim.

Your recurrent disability will be subject to the same terms of this plan as your prior claim.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the RBC Insurance plan.

What benefits will be provided to your family if you die? (Survivor Benefit)

When RBC Insurance receives proof that you have died, they will pay your eligible survivor a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, no payment will be made.

However, RBC will first apply the survivor benefit to any overpayment which may exist on your claim.

What if you are not in active employment when your employer changes insurance carriers to RBC insurance? (Continuity of Coverage)

When the plan becomes effective, RBC Insurance will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy at the time of change in insurance carriers.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. RBC Insurance will reduce your payment by any amount for which your prior carrier is liable.

What if you become disabled under the RBC insurance plan due to a pre-existing condition? (Continuity of Coverage)

RBC Insurance may send a payment if your disability results from a pre-existing condition and you were:

- in active employment and insured under the RBC Insurance plan on its effective date; and

- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the RBC Insurance plan; or
2. the prior carrier's plan, giving consideration towards continuous time insured under both policies.

If you do not satisfy Item 1 or 2 above, RBC Insurance will not make any payments.

If you satisfy Item 1 or 2 above, RBC will administer your claim according to the RBC Insurance plan provisions. However, your payment will not exceed the prior carrier's benefit percentage, cost of living adjustment benefit, and the lesser of:

- the maximum monthly benefit; or
- the non-evidence limit amount (maximum not subject to evidence of insurability), if you only qualified for this amount.

Your benefits will end on the earlier of the following dates:

- the end of the maximum benefit period under the RBC Insurance plan; or
- the date benefits would have ended under the prior plan if it had remained in force.

What insurance is available if you end employment? (Conversion)

If you end employment with your Employer, your coverage under the plan will end. You may be eligible to purchase insurance under RBC Insurance's group long term disability conversion policy. To be eligible, you must have been insured under your Employer's group plan for at least 12 consecutive months. RBC will consider the amount of time you were insured under the RBC Insurance plan and the plan it replaced, if any.

You must apply for insurance under the conversion policy and pay the first quarterly premium within 31 days after the date your employment ends.

RBC Insurance will determine the coverage you will have under the conversion policy. The conversion policy may not be the same coverage they offered you under your Employer's group plan.

You are not eligible to apply for coverage under RBC Insurance's group conversion policy if:

- you are or become insured under another group long term disability plan within 31 days after your employment ends;
- you are disabled under the terms of the plan;
- you recover from a disability and do not return to work for your Employer;
- you are on a leave of absence; or
- your coverage under the plan ends for any of the following reasons:
 - the plan is cancelled;
 - the plan is changed to exclude the group of employees to which you belong;
 - you are no longer in an eligible group;
 - you end your working career or retire and receive payment from any Employer's retirement plan; or
 - you fail to pay the required premium under this plan.

Other Services

These services are available from RBC Insurance as part of your RBC Long Term Disability plan.

Worksite Modification

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and RBC Insurance.

When this occurs, RBC Insurance will reimburse your Employer for the cost of the modification, up to the greater of:

- \$1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

Work Life Employee Assistance Plan

Life is all about change, and sometimes you need help managing it. That is why RBC Insurance offers a special service that you, as an eligible employee*, can turn to for help. You will find information and assistance for everything from simple questions to serious issues that can complicate your life at work or at home. What's more, in the event of your untimely death, your immediate family members have complete access to services for up to 90 days from the date of your death.

With a toll-free call to the RBC Work-Life **Employee Assistance Program (EAP)**, you will find solutions to a variety of problems. Every call is answered by an experienced expert or Masters-level counsellor, who can help in a number of ways including:

- Telephone consultations – speak confidentially with an expert counsellor to clarify your needs and identify the best resource for assistance.
- Personalized searches and referrals – help you develop a list of resources in your community.
- Online issue-specific resources – search a variety of topics online.
- Face-to-face counselling – arrange for face-to-face counselling sessions geared toward short term issue resolution.
- Educational materials – provide free booklets, CDs, audio tapes and articles on a wide range of topics.

*Must be participating in the LTD plan.

Comprehensive services to make your life easier

The EAP program can give you information on a broad range of topics. There are resources on parenting and older adults. There is information on personal and work related problems. And there is help with all the little things that demand your attention each and every day.

Everyday issues

- Working through times of change
- Moving to a new community

Emotional well being

- Marriage and family issues
- Mental health issues
- Violence and crisis
- Grief and loss

Financial

- Home buying and renting
- Retirement planning
- Taxes

Addiction and recovery

- Alcohol and drugs
- Gambling
- Eating disorders
- Support groups

Legal

- Legal issues
- Real estate issues

Parenting and childcare

- Adoption
- Pregnancy and infertility
- Finding childcare

Education

- Selecting a school
- Special needs
- Continuing education

Older adults

- Senior health
- Paying for care
- Caregiver resources
- Work
- Adjusting to change
- Stress management

When you need help with work, home, personal, or family issues, the EAP program is there for you and your dependents. This program is part of the Long Term Disability Income Protection plan offered by your employer, and is designed to provide fast and convenient answers and advice on a wide range of topics.

The EAP has counsellors who speak English, French, and other languages upon request. It offers simultaneous translation into more than 140 other languages, as well as Telephone Device for the Deaf (TDD). The program provides 24-hour/7 days a week access. Call toll-free any time, day or night.

English: 1-877-630-6701

French: 1-877-588-1299

TTY/TDD:** 1-877-371-9978

Or visit the Web site at: www.lifebalance.net

English Password and ID: rbceng

French Password and ID: rbcfr

**TeleTypewriter, Telephone Device for the Deaf.

Teladoc

RBC Insurance LTD plan members can call Teladoc when they need:

- A second opinion related to anything from a straightforward surgical procedure to a chronic condition or life-threatening illness.
- Help understanding a diagnosis, treatment plan or medical condition.
- Help finding a leading specialist or treatment facility within or outside of Canada.
- Answers to questions about a medical condition, treatment, test results or a personal health issue.
- Help navigating the healthcare system.

To access the Teladoc bilingual service, 24/7, call the dedicated toll-free line at 1-877-419-2378, or visit online at [Teladoc.ca/rbcinsurance](https://www.teladoc.ca/rbcinsurance)

HR Support Centre Website

RBC Insurance, in partnership with e2R, a leader in employment/labour law and human resource support, to bring you the RBC Insurance HR Support Center website which gives you access to:

- Free ready-to-use HR policies, checklist, and templates
- Free management guides to navigating a variety of HR topics
- Timely updates regarding human resource practices and employment/labour law

To access the HR Support Centre website visit <https://www.rbcinsurance.com/group-benefits/plan-administrator/reference-guide/index.html#hr-support-centre>

Onward

Available exclusively through RBC Insurance (available in AB, BC & ON) For clients with individual or group disability insurance.

This exclusive and innovative service provides enhanced and timely support for clients with a disability claim due to depression, anxiety and other mental health concerns - the leading causes of long term disability in Canada.

This unparalleled value add that may be a life-changer can provide benefits such as:

- Significantly faster access to psychologists, including a series of 12 therapy sessions
- Recommendations by leading psychiatrists to a client's treating physician to confirm and /or change the diagnosis and treatment plan
- Faster recovery resulting in shortened claim duration

Onward by Teladoc helps clients achieve these benefits by providing the following enhanced support:

- One-on-one assistance from an assigned Client Advocate to provide support and guidance throughout the program
- Use of digital technology (through telephone, computer or mobile device) to support clients wherever they feel most comfortable Access to leading psychologists and psychiatrists

Medical Confidence

For clients with individual disability, critical illness or group disability insurance.

Provides your employees with the information they need to understand their medical condition as well as access to the proper care and treatment within an appropriate time frame. Some benefits include:

- Timely access to care and treatment
- Access to the appropriate physician specialists
- More accurate diagnosis
- Shortened recovery time

Medical Confidence's is aligned with the Canadian Health Act and the mission is to empower healthcare consumers with access to one-on-one supports from a Registered Nurse and to over 5,000 qualified Canadian physicians specializing in over 800 areas of sub-specialization. They will help secure the first available appointment and guidance to prepare for it.

Your employee can contact their Disability Claims Specialist at RBC for more information.

When Do You Notify RBC Insurance of a Claim?

RBC encourages you to notify them of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send RBC Insurance written proof of your claim no later than 90 days after the date your disability begins. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

The claim form is available from your Plan Administrator. You must notify RBC immediately when you return to work in any capacity.

When Does Your Coverage End?

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions;
- your 65th birthday;
- the last day you are in active employment except as provided under the covered layoff and leave of absence provisions; or

Layoff or leave of absence

means you are temporarily absent from active employment for a period time that has been agreed to in advance in writing by your employer. Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

long term disability

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

If you are absent from work due to pregnancy leave of absence or parental leave of absence, compassionate care leave of absence or similar leave of absence as provincially or federally allowed, you will be considered in active employment.

If you are on a temporary **layoff**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence layoff begins.

If you are absent from work due to **pregnancy leave of absence or parental leave of absence, compassionate care leave** of absence or similar leave of absence as provincially or federally allowed, you will be considered in active employment.

Underwritten by Pacific Blue Cross Policy Number 901111

Coverage is for employee and dependents

NOTE: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

Eligible Expense

Eligible expense means a charge for any service and/or supply included in this booklet as a benefit that:

- In Pacific Blue Cross's assessment, is a reasonable and customary charge medically necessary for health care and maintenance, or to maintain or restore teeth, and
- was ordered or referred by a physician or dentist, unless otherwise indicated in the benefit description;
- is not a cost normally paid (in whole or part) or provided by a government plan or any other provider of health coverage, and
- is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received.

It does not include any payment to a pharmacy or a Practitioner (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. PharmaCare's low cost alternative and reference drug program will not be applied unless specified in this booklet.

Physician

means an individual who is duly qualified and licensed to practice medicine or surgery, or both, in the area where the service is provided, but excludes a Physician residing with or related to you or your Dependent.

Practitioner

means an individual who is currently licensed, certified, or registered to practice a profession in the area where the care or service is provided.

In-province/territory eligible expenses

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician. Unless otherwise indicated, the maximums included here are on a per person basis.

Hospital

The additional charge for private or semi-private room accommodation in a hospital or the extended care unit of a hospital, over and above the amount allowed by any Government plan for normal daily public ward accommodation in Hospital.

Charges for the rental of a telephone, television or similar equipment are not covered.

Nursing

Upon referral by a physician, charges for the services of a registered nurse for private duty care (other than a nurse who ordinarily resides with or is related to the insured) in the management of an acutely ill patient while in a person's home, based on the schedule of fees of the Registered Nurses' Association of that province, limited to \$10,000 per calendar year or \$25,000 lifetime, whichever occurs first.

The services must be rendered by a nurse who is currently registered with the Registered Nurses' Association of your Province of residence.

Emergency Ambulance

- 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, only when the original hospital has inadequate facilities.
- Charges for an attendant when medically necessary.

Ambulance charges for work related illness or injury, assessed by the Workers' Compensation Board to be the responsibility of the employer, are not covered.

Drugs and Medicines

Charges for drugs and medicines in a quantity we consider reasonable, and

1. which are dispensed by a pharmacist, Physician, or a Dentist, including:
 - insulin preparations, testing supplies, needles, and syringes for diabetics
 - vitamin B12 for the treatment of pernicious anemia
 - allergy serums when administered by a Physician, or
2. which legally require a prescription from a medical provider legally authorized to do so, including
 - contraceptives
 - drugs for smoking cessation products \$400 every 24 months

Practitioners

Professional services of the following Practitioners to the maximum amounts as specified in the summary of benefits per calendar year, but excluding appliances and tray fees.

- acupuncturist;
- chiropractor and chiropractor x-rays (combined);
- clinical psychologist and registered clinical counsellor combined*;
- massage practitioner;
- naturopath;
- physiotherapist;
- podiatrist;
- speech language pathologist.

*Please ensure the psychologist or clinical counsellor is a registered psychologist or registered clinical counsellor. Visits to psychologists or clinical counsellors who are not registered will not be eligible for reimbursement.

Benefits may not be payable until the government plan concerned has paid the yearly maximum.

Dental Accidents

Dental treatment, by a Dentist, which is required, performed, and completed within 52 Weeks after an accidental injury which occurred while covered under this EHB Plan, for the repair or replacement of natural teeth or prosthetics.

"Accidental"

means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth. We pay benefits based on eligible dental services and financial limits in our current Fee schedule, and we pay the fees in our current Fee schedule or, if applicable, the Fee guide in the province/territory of service.

Medical Aids and Supplies

Charges for the following:

- oxygen, blood and blood plasma;
- ostomy and ileostomy supplies;
- walkers, canes and cane tips, crutches, splints, casts, collars and trusses, but not elastic or foam supports;
- rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes and mastectomy forms). Myoelectrical limbs are excluded, but Pacific Blue Cross will pay the equivalent of a standard prostheses;
- mastectomy brassieres to a maximum of \$250 per calendar year;
- stump socks to a maximum of \$250 per calendar year;

- surgical stockings to a maximum of \$250 per person per calendar year;
- wigs and hairpieces when required as a result of medical treatment or injury. The maximum benefit payable during the lifetime of the person being supplied is \$500;

Standard durable medical equipment

Pre-authorization is required from Pacific Blue Cross for expenses in excess of \$5,000.

Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long term disability, purchase of these items from a medical supplier may be considered. Repairs to purchased items are covered, and replacement only when the item can no longer be made functional. Pacific Blue Cross may require trade-in or return of replaced equipment.

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

Standard durable equipment includes:

- manual wheelchairs, manual type hospital beds and necessary accessories - electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating the manual wheelchair, otherwise Pacific Blue Cross will pay the manual equivalent;
- speech processors and headsets when prescribed for profound deafness subject to a maximum of \$4,000 in a 5 calendar year period;
- 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;
- transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

Orthopaedic shoes and foot orthotics

- when prescribed by a Physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear to a maximum as specified in the summary of benefits. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg
- when prescribed by a Physician, podiatrist, chiropractor, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics to a maximum as specified in the summary of benefits. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet

Hearing Aids

Hearing aids and repairs, when prescribed by a Physician or supplied by a recognised Audiologist on the recommendation of a physician, to a maximum as specified in the summary of benefits. (excluding batteries, recharging devices, or other such accessories). Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

Vision Care

Charges for the purchase of eyewear when prescribed by a Physician or legally authorized optical provider, and/or repair of eyewear and charges for contact lens fittings when performed by a Physician or legally authorized optical provider, to a maximum as specified in the summary of benefits. Charges for non prescription eyewear are not covered.

Eye Exams

Coverage is for you and your dependents. Please note that in order to be an eligible expense, the examination must be performed by a licensed ophthalmologist or optometrist.

Disease Support Programs

This benefit offers you and your Dependents faced with a cancer diagnosis the opportunity to obtain tools to improve recovery and survival during and after cancer treatment. A team of Physicians and health care practitioners work with the patient to assist in recovery, improve quality of life and help prevent cancer recurrence. The programs are supported by current research and are intended to integrate with conventional treatments.

Services available, including but not limited to:

- Support groups.
- Tools for patient to take charge of their health.
- Natural approaches to prevention and treatment.
- Multidisciplinary team of Physicians and health care practitioners.
- Individualized cancer survivorship plan.

Conditions and Limitations:

- Diagnosis of cancer by patient's Physician.
- The cancer diagnosis must have occurred within 24 months of referral by the Physician to the program.
- Any service covered by the Government plan is ineligible for reimbursement.
- The lifetime maximum benefit is \$300 per covered person.

For additional information visit the website at www.inspirehealth.ca or to arrange an appointment call 604 734-7125.

Out-Of-Province Non-Emergency Expenses

Pacific Blue Cross will reimburse non-emergency eligible expenses incurred out-of-province as if these expenses were incurred in the person's province of residence, subject to the deductible, in-province reimbursement percentage, and the maximums. Pacific Blue Cross will not reimburse any expenses payable or provided under a Government plan.

Out-Of-Province Emergency Expenses

While travelling outside your normal province of residence, benefits are payable for the following eligible expenses **incurred in an emergency only and ordered by the attending physician**.

Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other provider of health coverage are NOT eligible.

1. Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the required treatment essential to the patient;
2. The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days:
 - a. if reasonably possible Pacific Blue Cross should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, Pacific Blue Cross has the right, with the approval of the attending physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the health of the patient, the 90 day limit will be extended with Pacific Blue Cross's express written consent;
3. Services of a physician and laboratory and X-ray services;
4. Prescription drugs in sufficient quantity to alleviate an acute medical condition;
5. Other emergency services and/or supplies, if Pacific Blue Cross would have covered them inside your province of residence.
6. Charges, limited to the most economical means of transportation, for a dependent child under 16 years of age to his or her place of residence in Canada in the event that you, and/or your spouse are hospitalized and the child is left unattended. Arrangements for an escort to accompany the child will be made, if necessary.
7. Charges, limited to the cost of one-way economy fare air transportation, for the delay of the return trip of you or your spouse due to the hospitalization of another insured person with whom they are travelling.
8. Charges, limited to return economy fare air transportation, for one immediate family member to visit you or your spouse or your dependent if hospitalized. You or your dependent must have been travelling alone and are confined to a hospital for more than 7 days. An immediate family member is defined as a spouse, child, parent, brother, sister, or a person with whom the insured person normally resides.
9. Charges relating to items 6,7,8 are limited to a combined maximum expense of \$5,000 per family per medical emergency.
10. Charges for accommodation for convalescence following hospitalization to a maximum of \$75 per day per patient for a maximum of 5 days per medical emergency.

11. Charges for commercial accommodation and meals for an immediate family member while staying with a hospitalized member or dependent to a maximum of \$100 per day up to 7 days per family per medical emergency.
 - a. Limitation: Expenses only apply if the immediate family member had to travel to visit the patient, or if the immediate family member had to extend his or her stay beyond the scheduled date of his or her return trip.
12. Charges relating to the return of your vehicle (excluding commercial transport vehicles) to your place of residence or the nearest appropriate rental agency in the event you are unable to return it due to a medical emergency to a maximum of \$500 per medical emergency.
13. Charges for the repatriation of a deceased member and/or dependent to their place of residence to a maximum of \$5,000. In the event the deceased person is cremated outside their province of residence, charges are limited to \$1,500.

The exchange rate on foreign currency is payable at the average rate quoted by selected financial institutions in Vancouver, British Columbia, for the date on which the expense was incurred. Fluctuations in exchange rates are not Pacific Blue Cross's responsibility.

Emergency travel assistance

In emergencies which occur while you and/or your dependents are travelling, Medi-Assist will coordinate the following services to:

- locate the nearest appropriate medical care;
- obtain consultative and advisory services (including second medical and surgical opinions and review of appropriateness, quality and costs of hospitalization and outpatient procedures) from medical advisors under agreement with Medi-Assist;
- investigate, arrange and coordinate medical evacuations and related transportation needs;
- investigate, arrange, and coordinate the repatriation of remains;
- replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid required by you and/or dependent in distress.

Your Pacific Blue Cross worldwide emergency Medi-Assist card provides instant information on how to contact Medi-Assist. Call the nearest Medi-Assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to Medi-Assist. Have your EHC ID number and Medi-Assist group number ready for personal identification – both numbers are required.

Exclusions and Limitations

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

- except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, X-rays, hospital coinsurance, vitamins and/or minerals, contraceptives, fertility drugs, drugs and supplies for smoking cessation, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports,

transportation charges incurred for elective treatment and/or diagnostic procedures, or for health or health examinations of any kind;

- general anaesthetic, medications used to prevent baldness or promote hair growth, food and mineral replacements or supplements, HCG injections, drugs not approved for sale and distribution in Canada, medications available without a prescription;
- except as specifically included in this booklet: contraceptives, drugs and supplies for smoking cessation, fertility drugs, and any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
- allergy testing or therapy unless rendered by a naturopath;
- personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic purposes, public ward accommodation, rest cures and medical laboratory tests;
- charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or 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;
- out of province expenses incurred due to elective treatment and/or diagnostic procedures, or complications related to such treatment;
- out of province expenses incurred due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date;
- charges incurred outside the province/territory of residence for continuous or routine medical care normally covered by the Government plan in the person's province/territory of residence;
- transportation charges incurred for elective treatment and/or diagnostic procedures, or for health or health examinations of any kind;
- expenses of a dependent hospitalized at the time of enrolment;
- services performed by any physician who is related to or resident with you or your spouse;
- any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for the treatment of an existing illness or injury;
- fees for ambulance services when an ambulance is called but not used;
- ambulance charges for work related illness or injury assessed by Workers' Compensation Board to be the employer's responsibility;
- Retroactive coverage and payment of any expense, including expenses that receive special authorization from Pharmacare;
- any other item not specifically included as a benefit.

Conversion to Individual Plan

Should your Extended Health Care group coverage terminate for any reason, you may purchase a Pacific Blue Cross Personal Plan if you live in British Columbia, or a Personal Plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by Pacific Blue Cross or Blue Cross within 60 days of the date your group plan terminates. To be eligible to convert, you must have had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for Pacific Blue Cross Personal Plan membership under the conversion option, the "pre-existing conditions" exclusion in the Personal Plan will be waived. A "pre-existing condition" is any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12 month period before you apply for the Personal Plan.

Survivor Benefit

If in the event of your death, dependent coverage under this policy contract will continue without further payment of contributions until the earliest of the following occurs:

- 24 months after the date of your death
- the date the person ceases to be a dependent other than as a result of your death
- the date the policy contract is terminated
- the date the dependent becomes eligible for coverage under a similar group plan.

Information for claiming Pharmacare expenses may be obtained from your pharmacist.

Claiming Procedures

Claim procedures – pay direct

For Prescription Drugs and Medicines Only

Most British Columbia pharmacies are connected to Bluenet, an electronic processing system, to handle your claims at the time of purchase.

Pacific Blue Cross will pay the pharmacist directly for covered expenses - you do not need to submit a claim to them. The pharmacist will charge you only for amounts NOT covered by Pacific Blue Cross.

To use Bluenet at participating pharmacies, identify yourself as a Bluenet member and show the pharmacist your Pacific Blue Cross Extended Health Benefits ID card.

If the pharmacy does not have Bluenet OR if you do not use Bluenet for any reason, submit a claim form and receipts in the manner described below.

Electronic claims

1. When submitting an electronic claim you must:
 - a. complete the claim form online and submit it electronically to us
 - b. keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to us
 - c. if the claim is selected for review by us, you must submit the original receipts and supporting documentation to us within 21 calendar days. If we do not receive this information within this time, your claim will be refused.
2. We reserve the right to remove your ability to submit electronic claims if you provide false, incomplete or misleading claims information. In such circumstances you will have to submit paper claims with supporting receipts and documentation.
3. You must provide explanation or proof to support the claim or any other information we consider necessary.
4. We must receive an electronic claim by December 31st of the calendar year following the year in which the expense was incurred. If your electronic claim is selected for review by us, we will accept the original receipts and supporting documentation after the December 31st deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission. We will not accept a faxed or scanned claim form and/or receipts.
5. Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Claims procedures – paper claims

- Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. We will send you a remittance statement for your records each time you submit a claim.
- If you have Duplicate coverage, please review the Coordination of Benefits section under General Information. Two separate claim forms (one for the primary plan and one for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.
- Certain medical expenses are covered under the government plan. If you submit your claim to us before you submit your claim to the government plan, we will deduct what the government plan would normally pay (e.g. PharmaCare expenses) from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer. Information for claiming PharmaCare expenses may be obtained from your pharmacist.
- Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
 - a) Obtain a claim form from your Plan Administrator or on our website at www.pac.bluecross.ca
 - b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).

extended health care

- c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **December 31st** of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.

Example: We must receive your receipts for 2022 before December 31, 2023.

We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

value-added services with Blue Cross -- Blue Advantage

Coverage is for employees and dependents

Your Pacific Blue Cross membership offers you special advantages.

Even with extended health care coverage, sometimes it's a struggle to pay for health and dental products and services. Prices vary widely and can exceed the coverage provided under your benefit plan.

Through the Blue Advantage™ program, Pacific Blue Cross members can save on medical, vision care, and many other products and services offered by participating providers across Canada. The program is unique because it provides discounts at point-of-sale on the total cost of products and services from participating providers across Canada, regardless if the item is covered under your benefit plan.

How does Blue Advantage work?

It's easy. Present your Pacific Blue Cross ID card and mention the Blue Advantage program to the participating provider.

What kinds of products and services are eligible?

Eligible products and services include:

- Vision care products
- Medical supplies and equipment
- Dental products
- Hearing products and services
- Health and wellness products and services

Pacific Blue Cross is continually adding new providers to the program. Visit www.blueadvantage.ca to see the current list of eligible products and services currently offered. Note that the list of providers and the type of savings available are subject to change without notice. This service is designed to offer members savings that are not available elsewhere, and does not suggest a preferred product or company. Providers may not offer Blue Advantage savings on products that are subject to other sales or coupon promotions.

value added services with Johnstone's Benefits

Clearly and Iris Discount Program

Coverage is for employees and dependents

What this benefit offers

Johnstone's Benefits members will receive a further 15% discount off of Clearly.ca (formerly Clearly Contacts) already discounted prices. Clearly is one of the largest contact lens and eyeglass suppliers in North America. Canadian-owned and based in Vancouver, they specialize in delivering replacement contact lenses and eyeglasses directly to your door at up to 50% less than retail cost.

How the Clearly discount works

Place your order online at www.clearly.ca, or by phone (1-866-414-2326). **Don't forget to use the coupon code of "BLUECROSS19" to receive an additional discount.**

10% off any purchase of contact lenses, free standard shipping

25% off all eyeglass frames, free base lens and free standard shipping

Excluded Brands: Ray-Ban, Oakley, Bolon, Arnette, Coach, Michael Kors, Polo, Ralph Lauren, Tory Burch, Versace, Emporio Armani, Ralph by Ralph Lauren, Dior, and Vogue. Other brands may be included to this list at any time.

There is no limit to how often the discounts can be used. The discount is applied directly at the point of sale, so there are no additional forms to complete in order to take advantage of the savings. As this is a value-added benefit, there is no cost to use this benefit.

NOTE: Not valid with other coupons, discount sales, or special promotion items. The Clearly Program is subject to change or cancelation without notice.

Iris

Did you know Johnstone's Benefits is a member of the IRIS Advantage Program?

This entitles you to exclusive benefits that are combinable with your extended health plan. There is no cost to you, it is easy to register and you receive all the benefits IRIS offers like direct billing to your insurance, interest-free financing, IRIS No Matter What Guarantee and more!

Go to <http://www.iris.ca/advantage>

Enter your Access Code: **JOHNINS**

Complete your registration form and submit

Underwritten by Pacific Blue Cross Policy Number 901111

Coverage is for employee and dependents

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

Payment of Benefits

Pacific Blue Cross pays benefits based on dental services, financial limits and treatment frequencies in the fee schedule. They apply reasonable and customary limits to fee items as applicable.

Pacific Blue Cross applies the reimbursement percentage shown in the Schedule of Benefits to the fees shown in the fee schedule or fee guide as follows:

- For services performed in British Columbia or outside Canada, if your province of residence is British Columbia – the fees in the fee schedule
- For services performed in Canada but outside British Columbia – the fees in the fee guide in the province or territory of service
- For services performed outside of Canada, if your province or territory of residence is not British Columbia – the fees in the fee guide in your province or territory of residence.

Fees in excess of the amount shown in the applicable fee schedule or fee guide are your responsibility.

Basic Preventive & Restorative Services - Plan A

This covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible expenses include, but are not limited to, the following basic services for each person:

Diagnostic

- complete oral examinations - 1 per lifetime by a general practitioner and 1 per lifetime by a specialist
- specific oral examinations
- recall examinations
- consultations (as a separate appointment)
- x-rays:
 - diagnostic
 - panoramic – limits may apply
 - complete mouth series – 1 in a 3 year period

All x-rays combined shall not exceed the dollar limit for a complete mouth series

- Diagnostic models – 1 set in a calendar year

Preventive

- scaling, root planing and gingival curettage – a combined yearly limit shown in Pacific Blue Cross's fee schedule
- polishing
- topical fluoride – 2 in a calendar year
- fixed space maintainers
- preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit

Restorative

- fillings:
 - amalgam (silver) fillings
 - composite (tooth-coloured) fillings on anterior or bicuspid teeth only
- stainless steel crowns on primary and permanent teeth – once per tooth in a 2 year period

Endodontics

- treatment of diseases of the pulp chamber and pulp canal, including, but not limited to, root canals

Periodontics

- treatment of diseases of the soft tissue (gum) and bones surrounding and supporting the teeth (including occlusal adjustment, gingival curettage, and root planing), but excluding bone and tissue grafts
- root planing, scaling, and gingival curettage – a combined yearly limit shown in our fee schedule
- osseous surgery – 1 per sextant in a 5 year period
- bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards.)

Prosthetic Repairs

- removal, repairs and recementation of fixed appliances
- rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period
- tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
- gold foil – only when used to repair existing gold restorations

Surgical

- extractions
- other routine oral surgical procedures

- anaesthesia in conjunction with surgery shall not exceed the dollar limit shown in the *Pacific Blue Cross Fee Schedule*.

Any fees in excess of the fee schedule are your responsibility.

Major Restorative Services – Plan B

These services are required for the replacement of missing teeth or for reconstruction of teeth where basic restorative methods cannot be used satisfactorily. Mounted x-rays and diagnostic casts may be required for PBC's approval, subject to the conditions as outlined in the fee schedule.

Eligible expenses include, but are not limited to, the following:

Prosthodontic services

- removable upper and lower dentures (complete or partial)
- fixed bridges

Restorative services

- inlays and onlays
- veneers
- crowns and related services

Limitations

- Only 1 major restorative service involving the same tooth will be covered in a 5 year period.
- Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
- No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
- Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in the fee schedule. Where other material would suffice, the patient will be responsible for the difference between the cost of the chosen material and the cost of the alternative material.

Any fees in excess of the fee schedule are your responsibility.

Orthodontics – Plan C

Benefits are payable for orthodontic services performed on or after the effective date of coverage for adults and dependent children.

Limitations

- the lifetime benefit maximum under Plan C is shown in your Summary of Benefits
- no benefit is payable for the replacement or repair of appliances which are lost, broken or stolen.
- Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered

- Treatment performed solely for splinting is not covered.
- the date the dependent becomes eligible for coverage under a similar group plan.

Emergency Dental Care Outside Your Province of Residence

Eligible dental services will be covered when provided by a dentist, dental specialist, or denturist in an emergency, while you or your dependent is travelling outside your province of residence. Payment will be based on the fee schedule or fee guide, whichever is applicable (see Summary of Benefits for details). Itemized dental procedures must be provided with the claims.

Exclusions

The following are NOT included as eligible expenses:

- 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, or grafts.
- Charges for implants, or services performed in conjunction with implants, except as indicated in the fee schedule.
- Anesthesia not done in conjunction with surgery, and charges for facilities, equipment, and supplies.
- Charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint.
- Incomplete or temporary procedures.
- Recent duplication of services by the same or different dentists, dental specialist, or denturist.
- Any extra procedure which would normally be included in the basic service performed.
- Items not listed in the fee schedule and fees in excess of those listed in the fee schedule or fee guide.
- Services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits.
- Any item not specifically included as a benefit.
- Travel expenses incurred to obtain dental treatment.

Conversion to Individual Plan

Should your Extended Health Care group coverage terminate for any reason, you may purchase a Pacific Blue Cross Personal Plan if you live in British Columbia, or a Personal Plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by Pacific Blue Cross or Blue Cross within 60 days of the date your group plan terminates. To be eligible to convert, you must have had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for Pacific Blue Cross Personal Plan membership under the conversion option, the "pre-existing conditions" exclusion in the Personal Plan will be waived. A "pre-existing condition" is any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12 month period before you apply for the Personal Plan.

Survivor Benefit

If in the event of your death, dependent coverage under this policy contract will continue without further payment of contributions until the earliest of the following occurs:

- 24 months after the date of the member's death
- the date the person ceases to be a dependent other than as a result of the member's death
- the date the policy contract is terminated
- the date the dependent becomes eligible for coverage under a similar group plan.

Claim Procedures

1. Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment**. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.
 - We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment received later than **1 year** from the date the service is performed.
2. We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:
 - name of the Dentist
 - name and birthdate of the person receiving the dental care
 - your group, ID, and Dependent(s) numbers (this information is on your ID card)
 - your home mailing address
 - whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.
3. Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:
 - If you have paid your Dentist directly, **we will reimburse you the benefit amount** when we receive:
 - a claim form signed by the patient that is either submitted with a receipt or is signed by the dental provider showing the services performed and the fee charged, or

- for pay direct claims, **we will pay the benefit amount to the Dentist** directly for services provided under this benefit plan when We receive:
 - a claim form showing the services performed and the fee charged, signed by the patient and the dental provider, or
 - an electronic claim showing the services performed and the fee charged. The dental provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the provider and Blue Cross.

To claim orthodontics

RECEIPTS

Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.

CLAIMING DEADLINES

- We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
- Reimbursement is made if the complete and correct claims information is received within **1 year** of the due date. However, no benefit is payable for claims not received within 1 year of the due date.

TREATMENT PLAN

- Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.
- If the payment schedule or treatment changes, we require a revised treatment plan for review.
- We will retain your treatment plan on file. If we do not have your treatment plan on file we are unable to pay:
 - your initial fee/down payment
 - your monthly/quarterly fees
 - one time appliance fees
- Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

MONTHLY OR QUARTERLY FEES

- If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us which are over 1 year old will not be reimbursed.
- If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.
- As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

phone: (604) 980-6227
toll free: 1 800 432-9707

www.jbenefits.com

At Johnstone's Benefits, we work with employers of all sizes to customize employee benefit and retirement plans. We have no contractual obligations to any insurers, which allows us to negotiate the most favourable premium costs, benefit provisions, and claim payment settlements for our clients and their employees.



Your Independent Employee Benefits Advisor
and Third Party Administrator