MARINE & SHIPBUILDERS
LOCAL 506
HEALTH BENEFITS PLAN

Hour Bank Eligibility
and
Benefit Summary

Effective June 1, 2025

MARINE & SHIPBUILDERS LOCAL 506
HEALTH BENEFITS PLAN

BOARD OF TRUSTEES

Shawn Sly – Chairman

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LETTER FROM THE TRUSTEES

The Marine and Shipbuilders Local 506 Health Benefits Plan was established to provide health benefits for all eligible members and their covered dependents.

This booklet outlines benefits to which eligible members and their covered dependents may be entitled and outline the procedures to be followed when making claims.

This plan is an Hour Bank system designed for members of Local Union 506. Convyta Partners has been appointed to administer this plan on behalf of the Trustees.

The employers contribute for each hour worked under the collective agreement. These hours are accumulated in your Hour Bank to provide you with coverage when you meet the eligibility requirements as outlined in this booklet.

It is your responsibility to maintain your coverage during periods of unemployment should your Hour Bank drop below the required number of hours to provide monthly coverage. Details of how you self-pay and the coverage available to you are included in this booklet.

Please read this booklet and the Benefits Booklets carefully so that you will have a clear understanding of how your Plan operates for the benefit of you and your family.

Your Trustees want to provide a high level of protection for members and their families, within a cost structure, which can be supported by employer contributions and member self-payments. We welcome your interest and suggestions in the hope that the Plan will always reflect the needs and desires of the majority of the people it serves. As an active member your participation, confidence and support are vital to the Plan.

We encourage you to direct any questions, concerns and suggestions to any of the Trustees or to the Plan Office, c/o Convyta Partners:

Telephone: 1-844-968-7506 Fax: (604) 299-8136
Mailing address: 501-4445 Lougheed Hwy, Burnaby, BC V5C 0E4
Email: ship506@convyta.com Web: ms506benefits.org

GENERAL INFORMATION

This booklet is intended to summarize the principal features of your plan. This booklet, together with the Summary of Benefits and the detailed benefit booklets issued by Pacific Blue Cross and Canada Life ("the Benefits Booklets"), contain a summary of your Plan. The Plan is subject to change at any time. If the Plan changes, the Trustees will send covered members information about the change, including an updated Summary of Benefits.

This booklet does not give the details of your coverage. All rights to benefits are governed by the group insurance contracts and the terms of the Plan, and by the decisions of the Trustees from time to time. For detailed information about your benefits, please see the Benefits Booklets provided by the insurance carriers.

This booklet describes the Plan as of as of June 1, 2025.

1. SCHEDULE OF BENEFITS

The plan provides for the following benefits for **active covered members**:

- Short-Term Disability (STD) benefits for non-occupational disabilities
- Long-Term Disability (LTD)
- Dental Care Benefits
- Extended Health Care (EHC) benefits
- Life Insurance
- Accidental Death & Dismemberment Insurance (AD&D)

All members in good standing of Local 506 are eligible for the Employee and Family Assistance benefit (EFAP).

Eligible retirees are covered for a Death Benefit if they retired as active covered members on or before December 31, 2011.

Please refer to the Summary of Benefits and to the Benefit Booklets for further information.

2. EMPLOYER REPORTS

In accordance with collective agreements between the Marine & Shipbuilders Local 506 and the employers, each employer reports hours to the trust fund.

3. ESTABLISHING COVERAGE IN THE PLAN

To establish coverage in the plan you must:

- be a member in good standing of the local union; and
- be employed by an employer signatory to an agreement with the local union; and
- have a minimum of 250 hours worked as a member within a period of six consecutive months reported and paid to the Plan by a participating employer.

NOTE: Permittees do not qualify for coverage under this Plan. To be covered, they must become members of Local 506.

NOTE: For dependent coverage, you must also have completed application forms for Pacific Blue Cross and Canada Life and filed them with the Plan Office.

Members will be covered on the first of the month after the hours are processed, even if they have not filed application forms. This ensures that you are covered for Dental and Extended Health care, Short-Term Disability, Long-Term Disability, Life Insurance and AD&D as soon as you have accumulated enough hours.

For instance, if your employer reports a minimum of 250 hours on your behalf for January to May, coverage would begin as shown below:

Month Worked	Hours Reported
January	125
February	-
March	-
April	50
May	75
June	lag
July	covered

Any hours reported and not used within the six consecutive month period to establish your eligibility for coverage (that is, hours that are seven months old) will go into the General Fund of the Plan.

Q: What if I don't file completed application forms?
A: Until you file completed application forms:
Your spouse and dependent children are not covered for EHC, Dental, or dependent life insurance.
If you die the life insurance is paid to your estate and is subject to delay and probate fees.

The Plan Office will notify you as soon as possible after your entitlement to coverage is determined. Once you are covered, 125 hours are deducted each month from your hour bank for coverage and additional hours reported are added to your hour bank.

You may accumulate up to 1,250 hours (ten months coverage) in your hour bank to carry you through periods of unemployment. Any hours in excess will go into the General Fund of the Plan.

4. LAG MONTHS

A time lag is required to operate the hour bank system. Hours earned in a particular month are remitted by Employers during the following month to provide coverage for the following month.

5. SELF PAYMENT

Once coverage is established, you may "top-up" reported hours, if working on a part-time or casual basis, or to continue coverage during periods of unemployment for 18 months maximum (24 months if on CPP disability, WCB wage loss or total disability pension, or on LTD). Anytime your hour bank falls below the 125 hours needed for the next month's coverage, you will receive a Shortage Notice advising you how much to pay to guarantee continued coverage. Be sure to pay by the date indicated. You must remain in good standing with Local 506 in order to self-pay.

Please note:

- You do not have coverage for Short Term Disability (STD) or Long Term Disability (LTD) benefits while you are making full self-payments.
- You cannot self-pay after you have started your Marine & Shipbuilders pension.

Example:

Monthly coverage required	125 hours
Your hour bank balance is	70 hours
Therefore, you are short	55 hours

You must contribute for that month's coverage 55 hours @ $2.76 per hour or $151.80 (rate in effect is subject to change).

DO NOT IGNORE THE SHORTAGE NOTICE!

If you make a self-payment and late hours are reported or other adjustments are found later, all hours will be credited to your hour bank for future coverage.

UNEMPLOYED RATE:

To help unemployed members maintain coverage, the Trustees have established an Unemployed Rate of $1.38 per hour ($172.50 per month).

To apply for the subsidized rate, you must either sign a declaration that you are unemployed and available for dispatch, or else be disabled and on Short-Term Disability (STD) Long-Term Disability (LTD) or EI benefits. Stubs must be provided as proof of EI. The Plan Office can confirm STD or LTD.

<u>If you are on WCB or if 50 employer hours were reported last month, you are not eligible for the unemployed rate, you must pay the standard rate.</u>

DISABLED MEMBERS:

Disabled members of the plan are entitled to disability credits if they have at least two years of continuous service at the onset of disability. For Health Benefits Plan purposes, that is two

consecutive years of at least 450 bargaining unit hours reported in each year while a member of the Union.

While you are on STD benefits you will automatically receive 4 1/6 hours (up to 125 hours per month) for each calendar day you are in receipt of disability benefits. If you are on CPP disability benefits, WCB wage loss or EI sick benefits, you must present your proof of payment promptly and you will be given 4 1/6 hours for each calendar day you are on these benefits. Please be sure to put your name and SIN number on all documents for proper identification.

These hours will help maintain your coverage while sick or disabled for a maximum period of 12 months.

6. TERMINATION OF COVERAGE

Coverage for you and your eligible dependents is always provided on a whole calendar month basis only and will be terminated:

(a) When your hour bank balance falls below the minimum of 125 hours and you fail to make the self-payment required by the specified date.

(b) When you take a withdrawal card from the Union. In that case, coverage will be extended for as long as your banked hours allow at 125 hours per month. The remaining hours that do not make up a full month's coverage will go into the General Fund of the Plan. You will not be permitted to make any self-payments. <u>STD and LTD are not covered during this run-off.</u>

(c) When you become expelled or suspended from the Union. Coverage will be cancelled as of the date on which you are dropped and any hour bank balance will go into the General Fund of the Plan. If you are reinstated, your hours will also be reinstated, effective on your date of reinstatement.

(d) In the event of the death of a member, coverage for the member's spouse and other eligible dependents will

continue for as long as the member's accumulated hour bank allows.

(e) If you move into an exempt position, your employer will continue hourly contributions to this Plan to continue your coverage. After six months, if you are permanently accepted into the exempt position, your coverage through the hour bank will end.

NOTE: Members having coverage terminated will be notified that coverage has terminated at the address shown on the Plan records. It is your responsibility to ensure the Plan has your current address.

7. RE-QUALIFICATION AFTER TERMINATION

To re-qualify after termination, the conditions outlined in Section 3 must be fulfilled as they must for new members. **YOU MAY NOT RE-QUALIFY BY SELF PAYMENT.**

8. IN CASE OF INJURY OR ILLNESS

If you are injured or become ill, notify your Union office. You will be advised whether or not you are entitled to Short Term Disability (STD). If you are entitled to Short Term Disability Benefits the necessary claim form will be sent to you. If you remain disabled towards the end of the Short Term period, you should apply for Long Term Disability (LTD) benefits.

DISABILITY TIMELINE

Non-Occupational disability:

1. **Weeks 1 to 20 – STD Paid by BC Life**
   a. Be sure to **file your claim promptly** to avoid delays in receiving payments
   b. **Week 12 or earlier** – if your disability is "severe and likely to be prolonged), submit your claim for CPP Disability Benefits. CPP Disability Benefits can be paid starting after 17 weeks of disability, but only if you apply! These benefits are not deductible from your STD

(they will be deducted from your LTD), and they protect your future CPP retirement pension.

c. Week 16 – if still disabled, file your EI claim to avoid delays in starting your EI Sick Benefit

2. Weeks 21 to 35 – EI Sick Benefits paid by EI

a. **Week 27-30** – if still disabled, you should consider applying for "Life Insurance Waiver". This protects your life insurance coverage if you remain disabled. You should receive a letter from the Plan Office. If not, call the Plan Office for details.

b. **Week 31** – if still disabled, advise BC Life you will be applying to re-open your STD claim

3. Weeks 36 to 52 – STD Paid by BC Life

a. **Week 42 – you will receive** a letter from the Plan Office, with **an LTD claim form**.

i. Unless you are confident you will be fit to return to work at 52 weeks or earlier, complete your part of the form, have your doctor complete the Attending Physician's Statement, and **submit the claim**.

ii. You may submit directly to Canada Life, or through the Plan Office. If you submit through the Plan Office, we can help you by checking that everything has been completed properly.

4. Year 2 and 3 – LTD Paid by Canada Life

a. You must be **disabled from "your own occupation"**.

b. If you can be rehabilitated back to your own job or retrained to another job, Canada Life's rehabilitation consultants will work with you to help that happen

5. Years 4, 5 and 6 – LTD Paid by Canada Life

a. You must be **disabled from "any occupation"**.

Occupational disability:

1. **Weeks 1 to Recovery, Rehabilitation, or Permanent Award** – Wage Loss Paid by WCB
   a. Be sure to file your WCB claim promptly to avoid delays in receiving payments
   b. Notify the Union and Plan office that you have a disability. This may help if the disability runs a long time and other benefits such as LTD and Life Insurance Waiver of Premium become applicable. At least, the Plan Office can help you remember what you should be doing to protect your benefits, as outlined in "2" below.

2. **The WCB process is outside the Health Benefits Plan.** BUT, even if you have an occupational disability, there are things you should be doing to protect your benefits.
   a. **Week 12** – if your disability is "severe and likely to be prolonged", submit your claim for CPP Disability Benefits. CPP Disability Benefits can be paid starting after 17 weeks of disability, but only if you apply! These benefits are not deductible from your STD (they will be deducted from your LTD), and they protect your future CPP retirement pension.
   b. **Week 42** – If you have informed the Plan Office about your WCB claim, you will receive a letter from the Plan Office, with an LTD claim form.
      i. Unless you are confident you will be fit to return to work at 52 weeks or earlier, complete your part of the form, have your doctor complete the Attending Physician's Statement, and submit the claim.
      ii. Even if your WCB claim is going smoothly, and even though an LTD claim could be 100% offset by WCB, applications must be made within the proper time frame so that the Life Waiver is in place, as well as protecting yourself if your WCB claim ends in the future while you are still disabled.

iii. You may submit directly to Canada Life, or through the Plan Office. If you submit through the Plan Office, we can help you by checking that everything has been completed properly.

3. **After WCB Wage Loss Ends** – Benefits paid up to the 6th year of disability by Canada Life as described under "non-occupational"

The Short-Term Disability and Long-Term Disability benefits are described in the Benefits Booklets. Other disability benefits are available from this Plan and other sources:

A. COVERAGE CONTINUATION (SHORT-TERM)

If you qualify(*), hours will be credited to your bank while you are disabled and in receipt of Disability Benefits from BC Life Short Term Disability, Workers Compensation Wage Loss or EI Sickness Benefits. You must provide cheque stubs to show what period you were on WCB or EI.

*See "Disabled Members" under Section 5 – Self-Payment for details.

B. OTHER DISABILITY BENEFITS

1. Employment Insurance Sick Benefits
   If you are not eligible for Short Term Disability, you may qualify for Employment Insurance sick benefits. Make application through Employment and Immigration Canada.

2. Canada Pension Plan
   For both occupational and non-occupational disabilities, pensions may be available from the Canada Pension Plan (CPP), provided you satisfy its qualifications. There is a three-month waiting period before benefits begin, and you must be suffering from a severe and prolonged disability. You must apply for these benefits at your local CPP office, listed in the blue pages of your telephone directory.

3. Group Life and AD&D Insurance
   Both your Life and AD&D insurance may be continued to age 65 if you become disabled while covered. See the "Total Disability" paragraphs in the Benefits Booklets.

9. DEPENDENT COVERAGE

A member's registered eligible dependents will be included in the coverage for Basic Medical, Extended Health Care and Dental Care Benefits. Eligible Dependents are:

- the member's spouse; and
- the member's unmarried dependent children to age 19 or any dependent child to age 25 and attending a recognized school or college on a full time basis. A member must be prepared to prove that such a dependent is actually dependent on him/her; or
- the member's children who are physically disabled or mentally challenged (who may be over 19 but are dependent upon the member for support and for whom the member is entitled to an income tax exemption), provided each child was insured under the Plan immediately prior to his or her 19th birthday.
- Dependents coverage terminates when a member's coverage terminates.

"Spouse" means a person who is legally married to, or who has cohabited as a spousal partner with the Member for a period of not less than twelve (12) consecutive months. Discontinuance of cohabitation for a period of more than thirty (30) consecutive days shall terminate the eligibility for benefits of a "common-law or same-sex" spouse. Only one (1) Spouse is eligible for coverage under the Contract at the same time.

Dependents are not covered by the Short Term Disability, Life Insurance, and Accidental Death & Dismemberment Benefits.

Dependent children must be added within sixty (60) days from the date of birth or from the date the child became a dependent,

whichever is later, and spouses within sixty (60) days of the date of marriage.

Dependents not added as above will be covered from the first of the day of the calendar month following the date of application or if specifically requested, from the first day of the month in which application is made.

Newborn or adopted children are NOT automatically registered. You must notify the Plan Office and provide the child's name and date of birth in order to have him or her included in your coverage.

NOTE: For coverage of dependent minor children, in the event of the death of the member, please refer to Item 6 “Termination of Coverage”.

10. ASSOCIATE MEMBERS

Self-employed members of Union Local 506 and employers’ office staff if approved by the Trustees, are eligible to participate in this plan as Associate Members. In order to establish and maintain coverage, the Employers’ Monthly Contribution Report must be submitted along with a payment each month. Shortage Notices are not issued to Associate Members. Associates must pay the full cost of coverage.

11. GENERAL

All correspondence (including self-payment notices) will be assumed to have been delivered unless returned to the Plan by the post office. You are responsible for keeping The Plan Office informed of your correct address. The Trustees will not be responsible for any interruption of coverage caused by your failure to notify them of your change of address.

If you are going to be away from your normal place of residence for any length of time (i.e. on an extended vacation, working out of town, etc.,) please check with The Plan Office prior to leaving to ensure that your coverage will not lapse for any reason during your absence, and if possible, provide a forwarding address.

12. EXCLUSION FROM BENEFITS AND COVERAGE

a. Any member of the Plan who obtains or attempts to obtain, a benefit under the Plan to which he/she is not entitled (including a benefit which is greater than the benefit to which he/she is entitled), by submitting false, misleading or inaccurate information, may, in the discretion of the Trustees:

- be refused payment of every such Benefit; or
- be denied coverage under the Plan; and
- be declared ineligible for further benefits under the Plan; unless the member can establish that any discrepancy in the information submitted was due solely to a bona fide error on his/her part.

b. It is a criminal offense to represent a matter of fact that is known by the person making it to be false and that it is made with fraudulent intent to induce the person to whom it is made to act upon it.

NOTES ON SPECIFIC BENEFITS

13. EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

The Employee and Family Assistance Program (EFAP) provides assessment, referral, and short-term counseling services to members of Local 506 and their families who are experiencing problems in their personal, family, or work lives. This includes problems such as relationship and marital difficulties, separation and divorce, parenting issues, depression, anxiety, and stress, addictions and substance abuse, problem gambling, child- and eldercare issues, and work-related concerns. The EFAP is provided by FSEAP.

Participation in the EFAP is **completely confidential**. No information is disclosed by the EFAP regarding an individual's participation in it absent a signed written release, or in circumstances involving an imminent risk of physical harm, child or elder-abuse, or where ordered by a court of law.

You may call in complete confidence and at no cost to discuss personal and family problems. For first time appointments and counselling, call 1-800-667-0993 or download the FSEAP app or visit www.myfseap.ca. Login using “Marine and Shipbuilders” as the username search and “2bwell” as the password.

14. RESIDENTIAL REHABILITATION

The cost of rehabilitation treatment will be reimbursed to the covered member upon application by the covered member on the following conditions:

- the member has been assessed and placed in a substance abuse rehabilitation program by a qualified professional;
- upon presentation of a receipt for the costs, and certification that the member has successfully completed the program,
- up to 75% of the cost of such program, to a maximum of $4,500 reimbursement;
- each member will only be entitled to one reimbursement,
- and with up to the entire cost (up to $6,000) payable up front in hardship cases, subject to this Board’s and the Union’s satisfaction of the special circumstances and subject to the member signing a reimbursement agreement for the 25% balance.

Payment within the above parameters will be made according to the following guidelines:

- Reimbursement will be made to the person or organization who, according to the receipt, paid the cost of the program.
- If the member and another person or organization shared in the expense, payment to the member will take first priority.
- If more than one person or organization, other than the member, shared in the expense, reimbursement will be made to them pro-rata unless they produce a signed agreement stipulating some other division.

15. RETIRED MEMBERS DEATH BENEFIT

To be eligible for the $5,000 retired members' death benefit, you must be covered on this plan when you take your retirement pension benefits and be a member in good standing with Local 506 upon retirement. The retiree death benefit is for the member only, not for the spouse or dependents.

At their meeting held June 3, 2011, the Trustees agreed to end the Retirees' Life Insurance coverage for new retirees, and at the same time, convert it from life insurance to a death benefit. To be eligible for this benefit, you must be receiving a retirement pension or disability pension with first payment on January 1, 2012 or earlier.

16. "REASONABLE AND CUSTOMARY"

As noted in the Benefits Booklets, PBC does not recognize excluding "Any amount of fees in excess of the usual or recognized fees for the services performed." In other words, PBC applies "reasonable and customary" (R&C) limits to many goods and services.

For some services, such as paramedical practitioners, you can find PBC's R&C limits on their web site. However, some services are more specialized, and PBC does not publish its limits.

There are several reasons for this, including

- Limits change from time to time.
- Limits depend on the specifics of each case - using the current example, there might be a reason why one member's orthotics need to cost more than another member's - that's certainly true of eyeglasses. On the other hand, paramedical charges are more standardized.
- If PBC published a "ceiling" price for everything, sooner or later everyone selling it would know what that was, and make sure they charged at least that much.

What can I do?

Your options, essentially, are

1) Shop around, as you would for anything else, and find out if prices vary.
2) Before agreeing to a large medical expense, ask PBC whether they consider the proposed fee within Reasonable and Customary limits. This is much like what happens when you get pre-approval before major dental work.

17. PRESCRIPTION DRUG COVERAGE

Effective October 1, 2010, all prescription drugs are paid by your Plan. Before that, only drugs recognized by PharmaCare were paid. That produced significant cost savings for the Plan, but the Trustees recognized that members had difficulties understanding and working with the Pharmacare rules.

Be a smart shopper for prescriptions!

The Trustees would like to remind you that some drugs used to treat an illness cost far more than others which work just as well for almost everyone with the same illness. When getting a new prescription, please consider asking your doctor if there is another, cheaper drug which works as well.

Why doesn't the Plan pay the full cost?

The October 2010 change is to make all prescription drugs payable. However, two features which remain in place are the "Low Cost Alternative" (LCA) and "Reference Based Pricing" (RDP).

These mean that in some cases where there is a directly comparable, less expensive drug, reimbursement is based on what that other drug would have cost, instead of on what the drug you were prescribed would cost.

Your pharmacist can explain how that works. If your doctor considers it appropriate, he or she can change your prescription to the Low Cost Alternative drug or to the Reference Drug so that you will be fully reimbursed.

The Trustees are monitoring this change. If you or your family experience any continuing problems with drug coverage, please contact the Trustees or the Plan Office.

SUMMARY OF BENEFITS

The following tables summarize your plan:

GROUP LIFE INSURANCE

Insured by: Canada Life
(GROUP 154668)

INSURED AMOUNT
$100,000 (Member)
$2,000 (Spouse)
$1,000 (Child)

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

	PRINCIPAL SUM
Member Only	$100,000 (Member)

SHORT TERM DISABILITY (STD)

Self-Insured by Trust:
(Blue Cross Life Policy # 903506)

PAYMENT TYPE	MAXIMUM PAYMENT	MAXIMUM PERIOD
Flat benefit	$734 per week	52 weeks*

(*20 weeks BC Life, 15 weeks EI, 17 weeks BC Life)
Disability benefits paid by BC Life are a taxable benefit. BC Life will deduct the appropriate amount from your payments.

LONG TERM DISABILITY (LTD)

Insured by: Canada Life
(GROUP 154668)

PAYMENT	MAXIMUM PAYMENT	MAXIMUM PERIOD
Flat benefit	$2,750/month	For 5 years or up to age 60

reduced by WCB payments, and subject to 80% overall maximum so the total of all disability income you receive (including LTD, WCB, CPP and others as listed in the booklet) is no more than 80% of pre-disability earnings. Disability benefits paid by Canada Life are a taxable benefit. Canadaf Life will deduct the appropriate amount from your payments.

EXTENDED HEALTH CARE (EHC)

Insured by: Pacific Blue Cross
(Policy # 903506)

TYPE OF EXPENSE	%	MAX	PERIOD*
PRESCRIPTION DRUGS	100%	-	-
HOSPITAL	100%	-	-
ACUPUNCTURIST	100%	$250	year
CHIROPRACTOR	100%	$500	year
NATUROPATH	100%	$200	year
PODIATRIST	100%	$200	year
SPEECH THERAPIST	100%	$100	year
PHYSIOTHERAPIST	100%	-	-
MASSAGE PRACTITIONER	100%	-	-
WIGS AND HAIRPIECES	100%	$500	lifetime
HEARING AIDS	100%	$1,500	60 months
VISION CARE – incl. eye exams	100%	$450	24 months
OVERALL FINANCIAL LIMIT		no limit	

*Note: For EHC financial limits and deductibles, each “year” runs from January 1 to December 31. For limits expressed in months, the period for each covered person runs from the initial service date – i.e. first purchase while a covered member. This date is not reset so long as the person remains covered.

PACIFIC BLUE CROSS MEDI-ASSIST TRAVELLERS ASSISTANCE

Worldwide emergency medical assistance
for active (non-retired) members only

MEDICAL SERVICES PLAN (MSP-BC)
(Group 3135068)

Basic Medical (MSP-BC), sponsored by BC Provincial Government

DENTAL BENEFITS
Self-Insured by Trust: (Pacific Blue Cross GROUP D903506)

ACTIVE MEMBERS	%	YEARLY* DOLLAR MAXIMUM
DIAGNOSTIC & PREVENTATIVE	100%	No maximum for diagnostic,
RESTORATIVE	90%	preventative & restorative
CROWNS & BRIDGES	75%	$5,000/person maximum for
DENTURES	90%	dentures, crowns & bridges
ORTHODONTICS	75%	$5,500 lifetime/person

"CONTACT" EMPLOYEE AND FAMILY ASSISTANCE PROGRAM
Provided by FSEAP

You may call CONTACT in complete confidence and at no cost to discuss personal and family problems. Call 1 800-667-0993 or download the FSEAP app or visit www.myfseap.ca. Login using "Marine and Shipbuilders" as the username search and "2bwell" as the password.

RETIREE DEATH BENEFIT
Self-insured by the Trustees

ELIGIBILITY	COVERED AMOUNT
If covered at retirement, with first pension cheque on January 1, 2012 or earlier.	$5,000 (Member Only)

FURTHER INFORMATION

If, after studying this booklet and the Benefits Booklets, you have any questions regarding your plan please contact the Plan Administrator by mail, telephone, fax, or Email at:

MAILING ADDRESS

MARINE & SHIPBUILDERS LOCAL 506
HEALTH BENEFITS PLAN
c/o Convyta Partners
501 – 4445 Lougheed Hwy
Burnaby, BC V5C 0E4

Telephone: 1-844-968-7506
Fax: 604-433-8894
Email: ship506@convyta.com
Webpage: http://ms506benefits.org

INSURERS

Canada Life
(Group Life Insurance, Accidental Death & Dismemberment, Long Term Disability)

Pacific Blue Cross and Blue Cross Life
(Extended Health Care, Dental and Short Term Disability)

Revised February 5, 2026