CONSTRUCTION AND SPECIALIZED WORKERS' UNION LOCAL 1258

HEALTH AND WELFARE TRUST FUND

GROUP INSURANCE PLAN

May 2022

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To All Plan Participants
Construction and Specialized Workers' Union Local 1258
Health & Welfare Trust Fund

Insurance protection against the financial hardship that so often accompanies sickness, accident or death is important to all of us. In order to make this protection available to you, a Group Benefit Plan has been arranged to assist in protecting the Participants of the Construction and Specialized Workers' Union Local 1258 from these hardships. The Healthcare and Dentalcare Benefits are designed to assist you with the payment of these expenses, although they may not cover the total cost of services and supplies. In effect, this Group Benefit Plan shares the payment of your medical and dental bills with you. The Benefits are underwritten by The Canada Life Assurance Company (formerly referred to as Great-West Life), Chubb Life Insurance Company of Canada (Chubb Life), Homewood Health, and AIG Insurance Company.

To further assist Members and their families expediently and efficiently, Plan benefits have been expanded to include the People Connect Mental Health Resource along with the Coughlin Care Gold Virtual Benefits which can be accessed remotely via computer, secure text, video chat or telephone.

We urge you to read your booklet carefully to thoroughly familiarize yourself with the benefits that are available to you and your dependants.

Please note that benefits may change at any time given legislative revisions and/or the financial stability of the Plan. You will be advised accordingly of any benefit changes on a timely basis.

The Plan Administrator is Coughlin & Associates Ltd., PO Box 764, Winnipeg, Manitoba, R3C 2L4. If you have any questions concerning your benefits or claim procedures, please contact the Plan Administrator at (204) 942-4438 or Toll free 1-888-204-1234 for this information.

We are pleased to make these arrangements on your behalf and are certain that your participation in the plan will bring greater security and peace of mind to you and your family.

Sincerely,

The Board of Trustees of the
Construction and Specialized Workers' Union Local 1258
Health and Welfare Trust Fund

Important Notice

This booklet is for your general information only and is not the insurance policy. In the pages which follow, you will find a brief description of the benefits to which you and your dependant(s) are entitled to, the rules covering eligibility for these benefits and the procedures that should be followed in the event that it is necessary for you or your dependant(s) to make a claim. The final determination of any claim, question or problem that may arise will be governed by the Group Policies issued by The Canada Life Assurance Company (31228), the Chubb Life (AB10406502 and CI20002401), Homewood Health, and AIG Insurance Company (Travel Medical Emergency) (CMG 9428799) and by applicable law.

In the event of any variation or discrepancy between the information in this booklet and the provisions of the policies, the latter will prevail.

Protecting Your Personal Information

The insurance companies listed on the previous page and the Plan Administrator, Coughlin & Associates Ltd. recognizes and respects every individual's right to privacy. When you apply for coverage or benefits, a confidential file of personal information is established.

The Plan Administrator, Coughlin & Associates Ltd. and the insurance companies use the information to administer the Group Benefit Plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- preparing regulatory reports, such as tax slips

Access to information in your file is limited to the staff of the insurance companies and Coughlin & Associates Ltd., or any authorized persons who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Canada Life, your health care provider, other insurance and reinsurance companies, and Coughlin & Associates Ltd. may also exchange information when the information is needed to administer the Group Benefit Plan.

Privacy

Effective January 1, 2004, the Federal Personal Information Protection and Electronic Document Act (PIPEDA) governs the collection, use and disclosure of all personal data by all Canadian commercial organizations. Thus, every transaction involving the handling of personal data (collection, use, transfer, disclosure, storage, accessing, processing, etc.) has to be conducted in accordance with the Act.

In conjunction with the Insurers, Coughlin & Associates Ltd. are committed to respecting your right to privacy and safeguarding your personal information. For more information regarding the Insurers' privacy policies or Coughlin's privacy policy, please contact Coughlin & Associates Ltd. directly or via the website www.coughlin.ca for Coughlin's privacy policy.

Highlight of Benefits

Administration Contact: 1258admin@coughlin.ca
Claims Contact: winnclaims@coughlin.ca

PARTICIPANTS

Life Insurance

Benefit.....Under age 67 $75,000
.....Age 67 – 70 $37,500
Coverage ceases.....at age 71

Accidental Death & Dismemberment (AD&D) Insurance

Principal Sum .....Under age 67 $75,000
.....Age 67 – 70 $37,500
Coverage ceases.....at age 71

Long Term Disability (LTD)

Benefit.....$1,500/month
- direct offsets (WCB, CPP Disability)
- all-source limitation is 85%
- non-taxable

Qualifying Disability Period..... 112 days
Maximum Benefit Period..... to age 65, date of retirement, or date that you are no longer disabled
Coverage ceases.....at age 65

Critical Illness (Deluxe Plan)

Participants are eligible to a $10,000 flat benefit once diagnosed with or suffer from one of the 23 insured conditions. The Critical Illness benefit ceases at age 70. Please refer to the Critical Illness booklet prepared by Chubb Life for further information or contact the Plan Administrator.

DEPENDANTS

Dependant Life Insurance

Benefit.....Spouse $10,000
..... Each Child (over 14 days of age) $5,000
Coverage ceases.....at age 71

PARTICIPANTS AND DEPENDANTS

Optional Life Insurance

Coverage in units of $10,000 to a maximum of $500,000 for Participant and $500,000 for Participant's spouse subject to medical questionnaire and approval by Insurer. Contact the Plan Administrator for more information.

Optional Critical Illness

Coverage in units of $5,000 to a maximum of $150,000 for Participant and Participant's spouse subject to Medical Questionnaire and approval by Insurer. Contact the Plan Administrator for more information.

Healthcare

Deductible.....$20/person or family/ calendar year
Co-Insurance (all eligible expenses).....100%
Coverage ceases .....depletion of Hour Bank and/or self-pay period

Benefit Maximums

Hospital .....Semi-private room and board

Prescription Drugs .....$2,000/family/benefit year
(Benefit Year: April 1 – March 31)

For reduced drug pricing, refer to ***People Advantage (PPN) Interactive Brochure*** on Member Portal. The Plan is partnering with Pocket Pills, a digital pharmacy, to offer home delivery of prescription drugs. Access to this service can be obtained through https://app.pocketpills.com/coughlin or can be obtained on the Coughlin website at www.coughlin.ca.

Smoking Cessation Products $500/person/lifetime
Nursing.....$25,000/person/calendar year
Paramedical Services .....$500/person/calendar year/specialist

Physiotherapy ..... $600/person/calendar year
Psychologist/Psychotherapy Services ..... $1,500/person/calendar year
Visioncare
Lenses, Frames and prescribed Safety glasses ..... $400/person/24 months
Lenses, Frames or Contact Lens .... $400/dependent under 19/12 months
Laser Eye Surgery (Members only) ..... $2,000 lifetime maximum
Eye Examinations ..... $80/person/24 months
Visual Training/Remedial Therapy ..... $400/person/24 months
..... $400/Dependent under 19/12 months

Termination of coverage is as outlined under ***"Termination of Benefits***" in the "***Eligibility***" section.

Medical Cannabis- While eligible members and/or dependents can choose any licensed producer, interested individuals are encouraged to consider purchasing from Starseed Medicinal Inc, which offers preferential pricing, training and education, and medical oversight and consultation. If interested, please contact Starseed Medicinal Inc at 1-844-756-7333 or visit their website at www.starseed.com

People Connect – Mental Health Resource

Maximum (per person) ..... included under Psychology benefit in Extended Healthcare, Paramedical Services, plus eligible under H.S.A.

People Connect provides members and their family members with educational tools, an online assessment, and access to immediate care through virtual therapy. The first virtual counselling session is free, and each additional session is $75.00 per hour or $37.50 per 30 minutes and payable via credit card. For reimbursement from the Health and Welfare Trust Fund, please submit the receipt and claim form to Coughlin & Associates for processing.

To get started, please visit pcpeopleconnect.com. For additional information, please contact peopleconnect@peoplecorporation.ca.

Coverage Ceases..... upon cessation of Healthcare benefit coverage

Coughlin Care Gold

- **Virtual Healthcare** (vCare): To register for vCare you can access directly via the secure link ***https://www.vcareregistration.com*** You will require your policy number (**31228)** and certificate number

(Member ID) off your Prescription Drug card or contact the Coughlin Administrator at vcare-info@coughlin.ca or (204) 942-4438.

- **Healthcare Navigator**: Assist navigating public health system (# 1-866-883-5956)

- **Cancer Assistance**: Personalized assistance (# 1-866-599-2720)

- **Medical Second Opinion:** Following diagnosis of a serious illness, verification/review of a prescribed treatment and results assessment (1-866-599-5956)

Eligibility ..... Insured Participants and Families

Refer to ***Coughlin Care Gold*** section.

Quikcare (Expedited Healthcare)

-Quikcare: Call the Quikcare helpline #1-844-900-8357

Eligibility ..... Insured Participants and Families

Refer to ***Quikcare-Expedited Healthcare*** section for further details.

Travel Medical Emergency

Policy Number ..... CMG 9428799

Deductible ..... Nil

Benefit Maximum ..... Under 70: $5 Million/per person/lifetime
..... 70 to 74: $2 Million/per person/lifetime

Maximum Duration .....60 days

Coverage ceases ..... Earlier of age 75 or depletion of
.....Hour Bank account and/or self-pay period

Contact Number..... Canada/US: 1-8779-207-5018
..... Outside Canada/US: 1-819-566-3940

Please see the Travel Medical Emergency section for how to make a claim. Or refer to the Travel Medical Emergency Booklet provided by AIG for further information.

Member and Family Assistance Program (EFAP)

Benefit..... individual short-term counselling for a variety of life's challenges via Homewood Health

Please contact the Administrator for more information regarding this benefit or contact Homewood Health directly at 1-800-663-1142.

Dentalcare

Deductible..... $25/person or family/calendar year
Co-Insurance
- Basic Services.....100%
- Major Services 80%
- Orthodontic Services 50%

Benefit Maximums

Basic & Major Expenses (combined).....$2,000/person/calendar year
Orthodontic Expenses.....$2,500/person/lifetime (dependant children 6 -18 years of age only)
Fee Guide.....2022 MDA Fee Schedule
Coverage ceases..... depletion of Hour Bank Account and/or self-pay period

The benefits listed above are subject to Trustee review from time to time and may change at the discretion of the Board of Trustees.

Healthcare Spending Account

Reimbursement.....100% of eligible expenses limited to H.S.A. account balance

Eligibility ..... All Members provided they are in continuous good standing with the Union

The benefits listed above are subject to Trustee review from time to time and may change at the discretion of the Board of Trustees.

General Information

The Plan is administered by the Board of Trustees who retains the services of Coughlin & Associates Ltd. to perform this function.

For each Participant, an account is kept by the Plan Administrator that shows hours worked for a Contributing Employer for which contributions have been made for the purpose of Group Benefits. This account is called an Hour Bank Account.

Initial Eligibility

For Life, Dependant Life, Accidental Death & Dismemberment (AD&D) Insurance, Critical Illness (CI), Employee and Family Assistance Program, and Long Term Disability Income (LTD), you will become eligible for coverage **on the first day following the date on which you have accumulated 280 hours of work within six (6) consecutive months.**

For Healthcare (including Best Doctor's), People Connect, Coughlin Care, Dentalcare, and Travel Medical Emergency you will become eligible for coverage **on the first day following the month on which the administrator has received 280 hours of work (hours may vary slightly depending on the hourly rate of contribution) within six (6) consecutive months.**

Office Staff will be eligible for coverage on the first day following three (3) consecutive months of employment.

If you are unable to work when coverage becomes effective, the effective date of coverage will be postponed until you are able to work.

Also, an enrolment card must be completed to be eligible to receive benefits.

Special Note On Effective Date

The effective date of coverage for any Participant (or dependant) shall be the date on which he/she qualifies for coverage in accordance with the above rules. No coverage or payments are to be made for days of hospitalization which occurred prior to the effective date or for medical or surgical services rendered prior to the effective date.

You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.
NOTE: Each eligible Union Member is responsible for knowing what his/her Hour Bank Account balance is at any time.

Ongoing Eligibility

Each month 140 hours (hours may vary depending on the hourly rate of contribution) will be deducted from the Participant's Hour Bank Account. For Office Staff, the hours worked should equate to the monthly deduction as there may not be an accumulation of hours worked.

The number of hours in the Union Member's Hour Bank Account may not exceed 1,680 hours (enough to provide (12) twelve months of coverage). Excess hours will be credited to the general reserves of the Fund.

A Permit Worker can accumulate hours worked in excess of the monthly deduction; however, upon the date of termination or lay-off, the balance in the Hour Bank Account is forfeited to general reserves of the Trust Fund unless the Permit Worker becomes a Union Member in good standing with an applicable Local Union.

Wage Loss Provision

In the event that a Union Member incurs a total disability while insured but not working and is "running down" his/her Hour Bank Account, the Plan will recognize the Union Member's disability for wage loss benefits (Long Term Disability) from the scheduled date of return to work, provided that the Union Member is still totally disabled and submits an attending physician's statement certifying continued disability.

Eligible Participants

Under the Plan, the following Participants, **provided they are declared residents of Canada and are insured under the applicable Provincial Medicare Plan**, are eligible for coverage:

Union Members
Members in good standing with Local Union 1258 on whose behalf contributions are being made in accordance with the terms of the

Collective Agreement to the Construction and Specialized Workers' Union Local 1258 Health & Welfare Trust Fund.

Permit Workers
Employees of Contributing Employers on whose behalf contributions are being made to the Construction & Specialized Workers' Union Local 1258 Health & Welfare Trust Fund and are not Members of an applicable Local Union under the Construction and Specialized Workers' Union Local 1258 or any reciprocating Local will be eligible for benefit coverage while working for a Contributing Employer.

Office Staff
Office Staff of Local Union 1258 and Employees of Contributing Employers (support staff) on whose behalf contributions are made to the Construction and Specialized Workers' Union Local 1258 Health & Welfare Trust Fund and are not Members of an applicable Local Union under the Construction and Specialized Workers' Union Local 1258 or any reciprocating Local will be eligible while working for an applicable Local Union or Contributing Employer.

Retired Members
A Union Member, in good standing with Local Union 1258, is considered retired when he/she has attained age 50 or older and has identified retirement to the Plan Administrator by withdrawing his/her funds from the Pension Trust Fund.

Eligible Dependants

Eligible dependants under this Plan shall cover:

- A spouse or child who is domiciled (permanent residence) in Canada. However, if a dependant is domiciled outside Canada, such dependant may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

- Your legal spouse or common-law spouse (including same-sex partner) who is living in a conjugal relationship with you for a minimum period of twelve (12) consecutive months immediately prior to the date on which a claim arose. Divorced or separated spouses (with or without a court order or separation agreement) are **not** eligible for coverage.

- Your unmarried children or your spouse's unmarried children who are chiefly dependant on you for support provided they are:

    - under 21 years of age (and over the age of 14 days for dependant life insurance), or
    - 21 years of age or over who are registered students in full-time attendance at a university or similar institution, however, Travel Medical Emergency coverage via AIG ceases at age 26.

- Your unmarried children or your spouse's unmarried children who are physically disabled or mentally incapable of self-support beyond the limiting age may have coverage continued under the Healthcare and Dentalcare benefits while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. To continue coverage for a child under this provision, proof of incapacity must be received by the Plan Administrator within thirty-one (31) days after dependant coverage would otherwise terminate. Additional proof will be required from time to time.

Continuation of Health Benefits for Dependants

In the event of your death while insured, the Healthcare (including Best Doctor's), People Connect, Coughlin Care, Dentalcare, Employee and Family Assistance Program, and Travel Medical Emergency benefits for your dependants will be continued for a period of twenty-four (24) months. If your surviving children cease to qualify as eligible dependants (as defined earlier in this booklet), coverage will terminate on the date they no longer qualify or on the date the policy or benefit terminates, whichever is earlier. Your surviving spouse shall cease to qualify once remarried or on the date the policy or benefit terminates, whichever is earlier.

Reinstatement of Eligibility

If a Union Member's benefit coverage had previously terminated because of insufficient hours in his/her Hour Bank Account, and the Union Member has not been out-of-benefit for a period exceeding six (6) consecutive months, the Union Member will again become insured for Life, Dependant Life, Accidental Death and Dismemberment, and Long Term Disability Income coverage on the first day of the month in which he/she has accumulated 140 hours within six (6) consecutive months in the Hour Bank Account.

The Union Member will be also be eligible for Healthcare (including Best Doctor's), Dentalcare, Employee Family Assistance Program, and Travel Medical Emergency coverage on the first day of the month following the month in which he/she has accumulated 140 hours within six (6) consecutive months. A statement will be mailed to you advising when your Hour Bank Account falls below 140 hours; otherwise, you will have to meet the original eligibility requirements as though you were a new Participant in the Plan.

Retired Members Returning to Work

If a Retired Member returns to work and meets the reinstatement eligibility requirements of accumulating 140 hours in his/her Hour Bank Account, provided hours are worked in six (6) consecutive months, the Retired Member would be eligible for all benefit coverage (including Disability coverage) subject to the benefit age restrictions.

Changes in Insurance

If your insurance benefits change because of an amendment to the plan or because of a change in age, class, earnings, dependant status, etc., the new benefits become effective on the date the change affecting your benefits occurred.

When a change results in increased benefits you must be actively at work for an eligible Employer to be eligible for the new benefits. If you are not at work for an eligible Employer on the date the new benefits would otherwise become effective, the change will not become effective until you return to work for an eligible Employer. Increased benefits for a dependant confined in hospital on the date the new benefits would otherwise become effective do not become effective until he or she is released from hospital. In any case, payment for services and supplies received before the date of an increase in benefits will always be based on plan benefits in effect before the change.

Change in Amounts of Insurance

Any change in amounts of your insurance will become effective on the date of such change provided that you are actively at work for an eligible Employer on the date of the change; otherwise, the increase will become effective on the first day thereafter on which you are actively at work for an eligible Employer.

Termination of Benefits

Unless otherwise specified in this booklet, benefit coverage for you and/or your dependants will terminate:

- **Union Member**: at the end of the month wherein you do not have at least 140 hours in your Hour Bank Account. However, you may arrange to have your benefit coverage continued on a self-paying basis. The Plan Administrator will contact you with the required self-pay amount. Please refer to the Extension of Coverage by Self-Payments section for further information.

- **Permit Workers and Office Staff (support staff)**: at the end of the month following the date of termination of employment or lay-off (except for Long Term Disability coverage which ceases immediately). Permit Workers are not eligible to make self-payments; however, please refer to the Extension of Coverage by Self-Payments section for further information on Office Staff self-paying policy.

- **Retired Member**: upon depletion of your Hour Bank Account and self-pay period. Please refer to the Extension of Coverage by Self-Payments section for further information.

- For specific benefits: if you reach the benefit age restriction, please refer to the Highlight of Benefits section.
- If you cease to be a Participant in an eligible class.

- If you enter military service.

- If the Group Policy terminates.

- For the dependant, once they no longer qualify as an eligible dependant. (Please refer to Eligible Dependants section.)

Extension of Coverage by Self-Payments

A **Union Member** whose benefit coverage is terminated due to insufficient hours in his/her Hour Bank Account may continue to have coverage for themselves and any eligible dependants by making monthly self-payments to the Plan for thirty (30) consecutive months for all benefits (excluding Long Term Disability).

A **Retired Member** who is depleting his/her Hour Bank Account has coverage for all benefits (except Long Term Disability). Upon depletion of the Hour Bank Account, the Retired Member may make twelve (12) consecutive monthly self-payments for all benefits (excluding Long Term Disability) subject to benefit age restrictions. **Retired members and retired office staff** who have been insured under the Plan for a minimum of 5 years may self-pay for all benefits (excluding Long Term Disability) for sixty (60) months following depletion of their Hour Bank Account.

Eligibility to self-pay is contingent upon the Participant being in good standing with Local Union 1258.

Before your benefit coverage terminates, the Plan Administrator will inform you of your option to continue your benefit coverage through the self-pay option.

Monthly Statements

Each month a statement is mailed to each Participant. This statement will show the Participant's benefit status, the contributions, and the previous and present months' Hour Bank Account balances. It should be noted that an amount is deducted (refer to Ongoing Eligibility) from your Hour Bank Account balance each month to pay the premium for your coverage.

If there are insufficient hours in your Hour Bank Account, the statement will show the amount required to pay on a "self-pay basis". If the required amount is not paid, the next statement will show you as being out of benefit with a final option to self-pay. If self-payments are not made when required, your coverage will not again become effective until you have satisfied the reinstatement requirements.

In order to ensure you are receiving this statement regularly it is necessary to promptly inform the Plan Administrator of any change of address.

Disability Claims

All disability claims should be recorded with Coughlin & Associates Ltd., Canada Life, and Chubb Life regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance or E.I. Disability Benefits. This recording will assist you should your claim with these agencies be declined either immediately or at a future date. In addition, proper application will be made relative to a Waiver of Life Insurance Premium which is required within twelve (12) months of the date of initial disability.

Disability Provisions

Disabled Union Member

If a Union Member has been disabled and has been receiving Workers' Compensation, Auto Insurance, Weekly Disability Income Benefits, etc., for at least two (2) weeks in any calendar month, no deduction will be made from the Hour Bank Account*. In other words, the Hour Bank Account will be **"frozen"**. Coverage on this basis is available for a maximum period of three (3) consecutive months. Following three (3) consecutive months of coverage, a Disabled Union Member can deplete his/her Hour Bank Account and self-pay for thirty (30) consecutive months, with further twelve (12) month extensions up to age 65, subject to an annual review and approval by the Board of Trustees. This provision is subject to Trustee review from time to time and may change at the discretion of the Board of Trustees.

**Providing the Plan Administrator receives written verification of the disability claim.*

Disabled Permit Worker or Office Staff (Support Staff)

A disabled Permit Worker or Office Staff (support staff) may have coverage extended for thirty (30) consecutive months provided the required monthly contributions are remitted to the Trust Fund on his/her behalf.

Reciprocal Agreements

Construction and Specialized Workers' Union Local 1258 Members

Union Members working in a jurisdiction other than Local Union 1258, and on whose behalf contributions are being made to a Health and Welfare Trust Fund which has entered into a reciprocal agreement with the Construction and Specialized Workers' Union Local 1258 Health and Welfare Trust Fund should complete a Transfer Authority form and advise the respective Local Union or Plan Administrator to reciprocate contributions to their "Home Fund". This will maintain coverage under the Construction and Specialized Workers' Union Local 1258 Health and Welfare Trust Fund.

Travel Card Members

Employees of Employers on whose behalf contributions are made but who are Members of other Local Unions, and whose Funds have entered into a reciprocal agreement with the Construction and Specialized Workers' Union Local 1258 Health and Welfare Trust Fund **will not** be eligible for benefits but will have all contributions made on their behalf reciprocated to their "Home Fund" after they complete the Transfer Authority form available at the respective Local Union offices.

Third Party Liability

If you or your dependant has the right to recover damages from any person or organization with respect to which benefits are payable by the Insurer, you will be required to reimburse the Insurer in the amount of any benefits paid out of the damages recovered.

The term "damages" will include any lump-sum or periodic payments received with respect to (1) past, present or future loss of income; and (2) any other benefits otherwise payable by the Insurer.

If you or your dependant receives a lump-sum payment under judgement or settlement for benefits which would otherwise be payable by the Insurer, no further benefits will be paid by the Insurer until the benefits that would otherwise be payable equal the amount of the lump sum.

If a claim for damages is settled before trial, you will be required to reimburse the Insurer the amount that reasonably reflects the loss of benefits that would otherwise be payable by the Insurer.

You or your dependant must notify the Plan Administrator of any action commenced against a third party and of any judgement or settlement in the circumstances described above.

IMPORTANT: REPORT ALL CHANGES OF BENEFICIARY, DEPENDANT STATUS, AND ADDRESS AS SOON AS POSSIBLE TO THE ADMINISTRATOR.

Life Insurance

Amount of Benefit

In the event of your death while insured, the amount of Life Insurance as outlined in the Highlight of Benefits section is payable to your designated beneficiary.

You may change your beneficiary at any time by written notice to the Plan Administrator, subject to any policy or legal limitations.

Coverage Ceases

For Union Members, coverage ceases at the earlier of age 71, following the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local 1258.

For Permit Workers and Office Staff (support staff), coverage ceases at the earlier of the date of termination of employment, lay-off, self-pay period if eligible, retirement or age 71.

Waiver of Premium for Disability

If you become totally disabled for at least six (6) consecutive months before age 65, your Life Insurance will be continued without payment of premiums until you cease to be totally disabled or you reach age 65, whichever occurs first. You are considered "disabled" if injury or disease prevents you from engaging in your "own" occupation for the two (2) years following your disability or from being gainfully employed in "any" occupation thereafter, and you must submit proof of your continuing disability as may be required by the Insurer.

All disability claims should be recorded with Coughlin & Associates Ltd. and Canada Life regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance or E.I. Disability Benefits. This recording will assist you should your claim with these agencies be declined either immediately or at a future date.

Conversion Privilege

If your Life Insurance coverage terminates, you may be eligible to apply for an individual conversion policy without providing proof of your

insurability. You must apply and pay for the first premium no later than thirty-one (31) days after your group insurance terminates. Please contact the Plan Administrator for more details.

Dependant Life Insurance

In the event of the death of your spouse and/or dependant child(ren) while insured, the amount of Dependant Life Insurance as outlined in the Highlight of Benefits section is payable to you.

Coverage Ceases

For Union Members, coverage ceases at the earlier of age 71, following the depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local 1258.

For Permit Workers and Office Staff (support staff), coverage ceases at the earlier of the date of termination of employment, lay-off, self-pay period if eligible, retirement or age 71.

Waiver of Premium for Disability

If while insured for this coverage, you become disabled and qualify for the Waiver of Premium benefit under your Life Insurance coverage, the Insurer will also waive the payment of Dependant Life Insurance Premiums.

Conversion Privilege

If your insurance terminates, your spouse may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must pay for the first premium no later than thirty-one (31) days after your group insurance terminates. Please contact the Plan Administrator for more details.

Accidental Death and Dismemberment

(Underwritten by Chubb Life)

Coverage

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

Coverage Ceases

Your Accidental Death & Dismemberment coverage terminates at the earlier of age 71, following depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local Union 1258.

For Permit Workers and Office Staff (support staff), coverage ceases at the earlier of the date of termination of employment, lay-off, self-pay period if eligible, retirement or age 71.

Benefit Amount

You are entitled to the Principal Sum or a portion thereof, as outlined on the next page. The amount of benefit depends on the loss suffered by you and is limited to the percentage of the Principal Sum shown in the Schedule of Losses.

Waiver of Premium for Disability

If while insured for this coverage, you become disabled and qualify for the Waiver of Premium benefit under your Life Insurance coverage, the Insurer will also waive the payment of Accidental Death & Dismemberment Premiums.

Conversion Privilege

If your insurance terminates, you may be eligible to convert your policy to an individual plan without providing proof of insurability. You must pay for the first premium no later than thirty-one (31) days after your group insurance terminates. Please contact the Plan Administrator for more details.

Schedule of Losses

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within 1 year from the date of the accident, Chubb Life will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	75%
Loss of Use of One Hand or One Foot	75%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	75%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid

or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

“Brain Death” means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

Quadriplegia, Paraplegia, Hemiplegia and Loss of Use losses are subject to an all policies combined maximum Benefit Amount of $1,000,000.

Repatriation Benefit

When injuries result in loss of life of an Insured Person outside 50 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the

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

(a) such training is required because of such injuries and in order for an Insured Employee to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;

(b) expenses are to be incurred within 2 years from the date of the accident;

(c) no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

When injuries result in an Insured Person confinement as an in-patient in a hospital outside 50 kilometers from an Insured Person's city of permanent residence or outside Canada and requires personal attendance of a "Member of the Immediate Family" as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to an Insured Person, while confined, but not to exceed $15,000.

"Member of the Immediate Family" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, or son-in-law or daughter-in-law.

Spousal Occupational Training Benefit

When injuries result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event an Insured Person sustain an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of

Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to an Insured Person's principal residence to make it wheelchair accessible and habitable; and

2. the one-time cost of modifications necessary to a motor vehicle utilized by an Insured Person to make the vehicle accessible or driveable for an Insured Person.

Benefit payments herein will not be paid unless:

(i) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

(ii) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of an Insured Person's Principal Sum.

Day Care Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of an Insured Person's Principal Sum amount or a maximum of $5,000 per year, on behalf of any dependant child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for 4 consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

"Dependant Child" means the Employee's eligible unmarried natural, legitimate, illegitimate, adopted, step child or common law child who is principally dependant on the Employee or the Employee's Spouse for financial support.

Special Education Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured Person's Principal Sum amount (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of 4 consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by the policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured Person for up to 6 sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $5,000.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and an Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, Chubb Life will pay for each full month, 1% of an Insured Person's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the

reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement Benefit

If an Insured Person suffers a third degree burn due to an accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table, **subject to a maximum benefit payable of $25,000**:

Body Part	**% of Principal Sum Payable**
Face, Neck, Head	10%
Hand & Forearm	25%
Either Upper Arm	15%
Torso (Front or Back)	35%
Either Thigh	10%
Either Lower Leg (below knee)	25%

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, an Insured Person Principal Sum amount will be increased by 10% to a maximum of $25,000

if, at the time of the accident, an Insured Person was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile. "Seat Belt" means those belts that form a restraint system.

Identification Benefit

In the event accidental loss of life is sustained by an Insured Person not less than 150 kilometers from an Insured Person's normal place of residence and identification of the body by a "Member of the Immediate Family" has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

a) transportation by the most direct route to the city or town where the body is located; and

b) hotel accommodation in such city or town, subject to a maximum duration of 3 days.

The reimbursement of such expenses incurred is subject to the accidental Loss of Life benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

"Member of the Immediate Family" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded an Insured Person. If the body of an Insured Person has not been found within 1 year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured Person was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured

Person suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

Funeral Benefit

When injuries covered by this policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial or cremation but shall not exceed $5,000.

The plan does not cover any loss, which is the result of:

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. declared or undeclared war or any act thereof;
3. travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a member of an Insured Person's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;

4. losses occurring while an Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by Chubb Life pro-rata for any such period of full-time active duty);

5. travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of the Accidental Death & Dismemberment portion of the policy.

Long Term Disability

If you become totally disabled before reaching age 65 and are unable to work, you may be eligible for a monthly disability benefit. Although it is not necessary for you to be confined to your house during the entire period of your disability, you must be under the active and continuous care of a licensed physician (Medical Doctor).

All Disability claims should be recorded with The Plan Administrator (Coughlin & Associates Ltd.) and the Insurers (Canada Life and Chubb Life) regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance or E.I. Disability Benefits. This recording will assist you should your claim with these agencies be declined either immediately or at a future date. **The Insurer will not be liable for a Long Term Disability (LTD) claim or which initial notice is submitted more than twelve (12) months after the date of disability.** Provided notice is provided within this twelve (12) month period, proper application will be made relative to a Waiver of Life Insurance Premiums.

Description of Benefit

You will begin receiving disability payments after you have been continuously and totally disabled for a qualifying period of 112 days. Payments are made at the end of each month and continue as long as you are totally disabled, even if the Group Policy terminates, but not beyond the date that you attain 65 years of age, or the date that you are no longer disabled.

"**Totally Disabled**" shall mean you are incapacitated to the extent that you are not able to perform the majority of the usual and customary duties of your occupation. For the initial twenty four (24) months this means that as a result of injury or disease, there is no combination of duties of your current occupation that you can perform that regularly took at least sixty percent (60%) of your time to complete. Following the initial 24-month period, "totally disabled" shall mean that you cannot perform the substantial duties of **any** occupation for which your current education and work experience would qualify you. You are not considered totally disabled unless you are under the active and continuous care of a physician and following the treatment prescribed by the physician for that disability.

The availability of work will not be considered in assessing disability.

If you recover and return to work, but the same disability reoccurs, it will be considered a continuation of the previous disability if the period between disabilities is less than two (2) weeks during the waiting period (i.e. the initial six (6) months following the date of disability) or less than six (6) months during the period when Long Term Disability payments are being made or within twenty-four (24) months after the end of an approved comprehensive rehabilitation program. To be classified as a comprehensive rehabilitation program, the goal must be:

- to return the person to work in a different job that requires extensive or prolonged training; or
- to return the person to work in a self-employed capacity.

A recurrence of disability due to an unrelated cause will be considered a new disability if you have worked at least one (1) day between disabilities.

Amount of Benefit

The Benefit Amount is outlined in the Highlight of Benefits section.

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

- disability or retirement benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan

- benefits under any Workers' Compensation Act or similar law

It should be noted that the Disability payment from this Plan may be reduced so that the monthly Disability and Retirement Income which you received, or are entitled to from all sources does not exceed eighty-five (85%) of your pre-disability net monthly earnings (earnings are net of income tax given that this benefit is non-taxable).

You must apply for all benefits or income for which you may become eligible under any of the following sources with the exception of any retirement benefits (these will only be deducted if you are in receipt of such benefits).

All sources of total monthly income includes:

- Long Term Disability benefits under this plan;
- Income from a Program of Rehabilitation;
- Income payable to the Participant under a pension or retirement plan of the employer, or any plan or arrangement resulting in the payment of any salary, wage or other payment by the employer to the Participant during the total disability;
- Income or benefit payable under:

    a) any other plan or program provided to the Participant by or through the employer. Such plan or program includes any permanent and total disability benefit of group life insurance for which the Participant could have elected not to apply;

    b) any other plan or program of any government or the Crown, or of any subdivision or agency of the government or the Crown, including any plan or program established pursuant to the Provincial Automobile Insurance Act. The Insurer shall not reduce the monthly benefit in respect of benefits payable by the Employment Insurance Commission.

This benefit is non-taxable to the receiving Participant (excluding Members working under Pipeline Agreement given entirely Employer funded).

Coverage Ceases

Eligibility for Long Term Disability coverage terminates at the earlier of age 65, following depletion of your Hour Bank Account, the date of retirement, or if you are no longer a Member in good standing with Local 1258.

For Permit Workers and Office Staff, coverage terminates immediately upon the date of termination of employment, lay-off, retirement or age 65.

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the

disability, and for which benefits are paid or payable, the Insurer will be subrogated to all rights of your recovery for loss of income to the extent of the sum of benefits paid of payable by the Insurer. You shall execute such documents as required by the Insurer.

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

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

Waiver of Premium

The Insurer will waive the payment of premiums for Long Term Disability Insurance for you if you are receiving benefits under this coverage. Premiums will be waived beginning with the premium for the first month for which benefits became payable and continue while the benefits are payable.

Rehabilitation

As your condition improves, if your condition does not allow for a return to your job on a full-time basis, you may be able to work on a part-time basis or take a less demanding job. Inform the Insurer and Plan Administrator as you may qualify for a rehabilitation program.

If your Long Term Disability Benefit Terminates

If your Long Term Disability benefit terminates while you are totally disabled, you will continue to be eligible for this benefit as if it were still in force.

Conversion Privilege

If you change jobs, you may apply for an individual Long Term Disability Policy without any medical tests. You must apply and pay the first premium no later than thirty-one (31) days after starting your new job, and you must also start your new job no later than six (6) months after leaving your present one.

Exclusions and Limitations

No benefits are paid for:

- A disability that begins before your insurance starts or after it ends.

- A disability arising from a disease or injury for which medical care was received before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for one (1) year, or you have not had medical care for the disease or injury for a continuous period of ninety (90) days ending on or after the date your insurance took effect.

- Disability arising from war, insurrection, or voluntary participation in a riot.

- Any period of prison confinement.

- Any period in which you do not co-operate with an approved rehabilitation plan or program. Depending on the severity of the condition, the Plan may require you to be under the care of a specialist. For substance abuse, treatment must include participation in a recognized substance abuse withdrawal program.

- Any twelve (12) month period during which you do not live in Canada for at least six (6) months.

Healthcare Benefits

Your Healthcare Benefits are designed to assist you with the payment of your medical bills; they do not pay the total cost of medical services and supplies. In effect, the Insurance company shares with you the payment of your medical bills. The Healthcare Benefits cover only those expenses which are considered reasonable and customary for the service provided, in the area where the expenses are incurred, provided you are a resident of Canada. Reasonable and Customary is a term used to refer to the commonly charged or prevailing fees for healthcare services with a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for that particular service with that specific community.

The Healthcare benefits consist of three types of expenses: Hospital Expenses, Medical Expenses and Visioncare Expenses.

- You are responsible for the Healthcare deductible as outlined in the Highlight of Benefits section. The Healthcare deductible is that portion of the Eligible Expenses that is deducted from your first eligible claim submitted in any calendar year. Once the deductible has been settled, all Eligible Expenses will be reimbursed to the applicable maximums as listed in the Highlight of Benefits section.

- The Healthcare deductible will be applied to the following calendar year, should you incur expenses in the last 3 months of that calendar year and no claims were paid for that calendar year.

- The maximum benefit for each person is unlimited for the Hospital and Medical Expenses except where specific coverage maximums are noted elsewhere within these pages.

Coverage Ceases

For Union Members, coverage ceases at retirement following the depletion of your Hour Bank Account and/or the self-pay period, or if you are no longer a Member with Local 1258.

For Permit Workers and Office Staff (support staff), coverage ceases upon the earlier of the date of termination, self-pay period if eligible, lay-off or retirement.

Eligible Expenses

The expenses for the following services and supplies are covered by your Healthcare Benefits:

Hospital Expenses:

(In addition to those paid by your Provincial Health plan)

- Convalescent hospital care provided the confinement is:

  i) recommended by your physician
  ii) is not for custodial care, and
  iii) follows a 3-day confinement in a hospital as a registered bed-patient and is for the same condition.

- Semi-Private Hospital Room and Board accommodation.

- Nursing home accommodation for acute, convalescent, or palliative care (i.e. the government authorized co-payment).

Medical Expenses:

- Physicians' services for treatment provided outside the province in which you reside.

- Treatment by x-ray, radium and radioactive isotopes.

- Oxygen and its administration

- Blood transfusions

  - Prescription drugs and medicines including oral contraceptives requiring the written prescription of a Physician, injectable drugs when administered by a Physician, preventative vaccines (excluding Physician fees).

  The Plan is partnering with Pocket Pills, a digital pharmacy, to offer home delivery of prescription drugs. While the Plan will benefit from the lower dispensing fees they charge compared to most other pharmacies, it is the convenience of this provider and ease of their online platform that we wish to highlight. Furthermore, shipping and med-packs through Pocket Pills is provided at no additional charge. Access to this service can be obtained through

https://app.pocketpills.com/coughlin or can be obtained on the Coughlin website at www.coughlin.ca.

- Services of a Registered Nurse, Licensed Practical Nurse or registered nursing assistant.

- Services of a licensed Physiotherapist, Chiropractor, Osteopath, Chiropodist, Podiatrist, Naturopath or Christian Science practitioner, Psychologist (and similar qualified Specialists), Speech Therapist. The benefit maximums are identified in the Highlight of Benefits section and are per practitioner and subject to Reasonable and Customary limits per visit/duration of visit.

- Ambulance (including licensed air ambulance).

- Medical equipment, when prescribed by a physician, either the rental cost, or at the Administrator's discretion, the cost of purchase; items such as breathing equipment (i.e. CPAP machines or nebulizers), mobility aids (i.e. wheelchairs or canes), or other medical supplies such as hospital beds, bathtub rails, shower chairs, or intraocular lens following cataract surgery, subject to reasonable and customary amounts.

- Splints, trusses, braces, crutches, casts, artificial limbs and eyes and any other prosthetic devices required as medically necessary.

- Surgical brassieres maximum 2 per person every 12 months.

- Orthopedic Shoes or orthotics prescribed by a licensed physician which are specifically designed and constructed for the individual. $300/person/12 months. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed.

- Diabetic supplies such as insulin, insulin syringes, lancets, insulin injection devices such as Novolin-pens and test strips.

- Prescribed, custom-made graduated compression hose when prescribed by a physician for a diagnosed medical condition including the required compression factor. Maximum 4 pairs/person/calendar year. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed.

- Prescribed colostomy and ileostomy supplies.

- Blood glucose monitoring machines. Maximum 1 machine/person/48 months.

- Transcutaneous nerve stimulators for the control of chronic pain, when prescribed by a physician. Maximum $700/person/lifetime.

- Hearing Aids prescribed by a licensed physician. Maximum $800 every 60 months.

- Dental surgery performed out of hospital for certain specific procedures. Please contact the Plan Administrator for more details.

- ***Retired members (including eligible dependents age 18 and older) and disabled members receiving Long Term Disability benefits*** will be covered for medical cannabis up to $1,500 per family per calendar year effective January 1, 2021. To be eligible, the retired member (inclusive of eligible dependents age 18 and older) and disabled members receiving Long Term Disability benefits must have a physician's written prescription and purchase from a licensed producer.

Visioncare Expenses:

This component of the Healthcare Benefits is designed to assist you with the payment of your eyecare expenses when prescribed by an ophthalmologist or optometrist. It does not necessarily pay the total cost of eyecare services and supplies. In effect, the Insurance company shares with you the payment of these expenses. Visioncare Expenses covered by your Healthcare Benefits are only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

The following items are Eligible Expenses under this provision are subject to the benefit maximums outlined in the Highlight of Benefits section.

- Routine eye examinations.

- Eyeglass frames and lenses (including prescribed safety glasses) or laser eye surgery, when performed by a licensed ophthalmologist up.

- Laser Eye Surgery.

- Contact lenses (up to $375/person/lifetime if prescribed). The regular surface of the lens of the eye (the cornea) is impaired in some

way, and visual acuity can be improved to at least a 20/40 level with contact lenses but not with ordinary glasses.

- Visual Training / Remedial Therapy

Exclusions and Limitations

The list of eligible expenses shall not include the following:

- Expenses incurred for anyone who is not insured under the Provincial Medicare Plan.

- Cosmetic surgery or hospital confinement for cosmetic surgery, except to correct deformities resulting from illness or injury or such congenital defects that interfere with function. Also, services and supplies received primarily for cosmetic purposes are not covered;

- Dental services, except as noted;

- Injury or illness due to war or related to engaging in a riot or insurrection;

- Hearing tests;

- Pregnancy tests;

- Routine medical examinations;

- Eye tests or examinations requested by an employer, school or government for screening purposes;

- Sunglasses;

- Delivery and transportation charges;

- Services and supplies which are required for recreation or sport but which are not medically necessary for regular activities;

- Charges which are considered an insured service of any provincial government plan;

- Charges for general health examinations, and examinations required for use of a third party;

- Accommodation in a personal care home;

- Hospital or nursing care for conditions where significant improvement or deterioration is unlikely within the next 12 months (i.e. chronic care);

- Charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;

- Charges for any medical treatment or surgical procedure by a physician other than as provided under Out of Province Referral Expenses;

- Charges for transport or travel, other than as specifically provided under Eligible Expenses;

- Charges not specified in the foregoing list of eligible medical expenses;

- Charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of this license;

- Charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;

- Charges which are from an occupational injury or disease covered by any Workers' Compensation law or similar legislation;

- Charges which would not normally have been incurred but for the presence of this insurance or for which you are not legally obligated to pay;

- Charges which the Insurer is not permitted, by any law or regulation, to cover;

- Charges for dental work wherein a third party is responsible for payment of such charges;

- Charges for bodily injury resulting directly or indirectly from war or an act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;

- Charges for services or supplies resulting from any intentionally self-inflicted wound;

- Charges for drugs, sera, injectable drugs or supplies which are not approved by Health Canada or are experimental or limited in use whether or not so approved;

- Charges for homeopathic preparations, drugs for erectile dysfunction. Any costs for the administration of an injection or vaccine.

- Charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;

- Charges made by a physician for travel, broken appointments, communication, costs, filling in of forms, or physicians supplies.

Coughlin Care Gold

Virtual Healthcare (vCare):

Personalized medical support with healthcare providers via secure text and video chat to address your healthcare needs from the comfort of your home or any other convenient location

To enroll for vCare, you will be required to provide your Policy # (31228) and Certificate # (Member ID) – these can be obtained from your Prescription Drug card. If you do not have these, they can be provided by the Plan Administrator.

To register, you must go to the vCare link on the Union or Coughlin websites or you can access directly via the secure link ***https://www.vcareregistration.com*** When registering, you will be required to create your individual password. We highly recommend you do not use a work email address, as office firewalls may inadvertently black access to the app. Please note to support this app your phone must be a minimum Android 5.0 or iPhone iOS 12.

Healthcare Navigation:

Assistance with navigating the public healthcare system, providing a single point of contact throughout diagnosis, treatment, and rehabilitation to ensure continuity of care. Healthcare Navigation provides access to a nurse who
will be the single point of contact through the healthcare journey, by providing:

- Assessments and treatment plans
- Booking of appointments
- Pre-appointment prep
- Follow-up appointments
- Ensure continuity of care and coordination of benefits
- Explanation of options
- Completion of paperwork
- Review of results
- Assist with alternative treatments

Access to Healthcare Navigation is through Compass Health Care Navigation at 1-866-883-5956. You will be asked to provide your name,

Member ID (can be obtained from your Drug Card), your Union Local and possibly your Provincial Healthcare # (depending on the nature of your call).

Cancer Assistance:

Cancer Assistance pairs the member with a highly trained oncology nurse who will work with the patient to ensure the current cancer treatment is delivered in a timely manner.

- Individualized case management for all types and stages of cancer
- Ensure best practices are followed
- Provides assessment of cancer treatment approach
- Reviews results and answers questions and explanations of tests and treatments
- Nurses are assigned to clients based on their subspecialty allowing for deeper knowledge of their specific cancer type

Access to Cancer Assistance at 1-866-599-2720. You will be asked to provide your name, Member ID (can be obtained from your Drug Card), your Union Local and possibly your Provincial Healthcare # (depending on the nature of your call).

Medical Second Opinion:

Offers consultation and recommendations through Cleveland Clinic to confirm the best course of action about your treatment plans or options

- Ensure diagnosis is correct
- Receive comprehensive healthcare reports
- Works directly with the patient's personal physician
- Ensure optimal treatment plans
- Options on alternative treatment

Access to Medical Second Opinion is through Compass Health Care Navigation at 1-866-883-5956. You will be asked to provide your name, Member ID (can be obtained from your Drug Card), your Union Local and possibly your Provincial Healthcare # (depending on the nature of your call).

Quikcare- Expedited Healthcare

Access to 3 diagnostic services and 10 specialist physicians within 72 hours through healthcare clinics across Canada (Manitoba excluded due to no privatization).

- MRI
- CT Scan
- Ultrasound
- Ear, Nose & Throat
- Orthopedics
- Ophthalmology
- Rheumatology
- Urology
- Neurosurgery
- General Surgery
- Neurology
- Gastroenterology
- Cardiology

Allows those immediate access to diagnostic scans (MRI/CT Scans) and specialist consultations with the cost fully covered within 72 hours. When physician recommends a diagnostic procedure or refers to a specialist, Quikcare will liaise with you to obtain documentation and then utilize a network of specialists and diagnostic imaging services to coordinate and pay for the required services.

Quikcare is integrated with the Healthcare navigator. More information can be found on the Healthcare Navigator in the *Coughlin Care Gold* section.

1. **Call QuikCare Platinum Helpline:** When you receive a physician's diagnostic requisition or a physician's referral letter for a specialist, simply call the QuikCare Platinum helpline at 1-844-900-8357.

2. **Expedited Health Care:** QuikCare will arrange the required expedited health care and will advise you or your eligible dependents of the appointment time and location.

3. **Case Management** Our Case Management team will coordinate with you or your eligible dependents to obtain the required documentation and assist you in every step.

4. **Follow Up:** Following the scan or specialist appointment our Case Management team will follow up and ensure the results are sent to your physician and to arrange any further treatment.

Dentalcare Benefits

Benefit

You are responsible for the Dentalcare deductible as outlined in the Highlight of Benefits section. The Dentalcare deductible is that portion of the Eligible Expenses that is deducted from your first eligible claim submitted in any calendar year. Once the deductible has been settled, all Eligible Expenses will be reimbursed as per the co-insurance and benefit maximums listed in the Highlight of Benefits section.

Coverage Ceases

For Union Members, coverage terminates at retirement following the depletion of your Hour Bank Account and/or the self-pay period, or if you are no longer a Member with Local 1258.

For Permit Workers and Office Staff (support staff), coverage ceases upon the earlier of the date of termination, self-pay period if eligible, lay-off or retirement.

Alternate Benefit and Pre-Authorization of Treatment

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, Canada Life reserves the right to determine eligible expenses on the basis of an alternate benefit.

Before your dentist starts a course of treatment, he/she will, upon request, prepare a "treatment plan" – a written report describing his/her recommendations as to necessary treatment and cost.

1) You will be required to submit a treatment plan to the Administrator before treatment starts for any Routine or Major Treatment expected to cost more than $500. This enables the Administrator to determine in advance the benefits payable for the proposed treatment, and this allows you to know any portion of the cost you will have to pay.

2) If you do not submit a "treatment plan" where required, you may find that your claim, or a portion of it, may not be covered.

Eligible Expenses

Basic Treatment

The following preventative services are covered no more than once in any calendar year provided that a period of at least eleven (11) consecutive months has elapsed since the last time such service was rendered:

- oral examination;
- polishing of teeth;
- bite-wing x-rays;
- topical application of fluoride solutions

- Complete examination, once every 3 years.

- Full mouth series of x-rays, provided that a period of at least twenty-four (24) consecutive months has elapsed since the last series of x-rays was performed.

- Extractions and alveolectomy at the time of tooth extraction.

- Amalgam, silicate, acrylic and composite fillings.

- Dental surgery including diagnostic x-ray and laboratory procedures.

- General anesthesia in relation to dental surgery.

- Endodontic treatment (root canal therapy).

- Periodontic treatment (treatment for gum disease).

- Necessary treatment for relief of dental pain and the cost of medication and its administration when provided by injection in the dentist's office.

- Space maintainers for missing primary teeth, and habit-breaking appliances.

- Consultations required by the attending dentist.

- Dentures, relines and rebases to existing dentures.

Major Treatment

- Provisions of crowns.

- Implant dental surgery and related oral surgical services such as abutment insertion, ridge augmentation, bone preservation; implant related periodontal surgery; and subsequent implant retained appliance. Should implants and/or related services be obtained, reimbursement will be considered but only up to the maximum that would have been paid for the least costly professionally adequate treatment to restore the entire arch, such as prosthetic devices (crowns, denture and/or bridgework) as defined under the Alternate Benefit provisions, subject to the coinsurance applicable to the treatment determined to be eligible.

- Initial prosthodontic appliances (i.e. fixed bridge restorations, removable partial or complete dentures) are covered only when the appliances are required because at least one additional natural tooth was necessarily extracted after the date the insured's coverage became effective.

- Replacement of an existing prosthodontic appliance is covered when:

  - the replacement appliance is required because at least one natural tooth was necessarily extracted after the date the insured's coverage became effective and the existing appliance could not have been made serviceable. If the existing appliance could have been made serviceable, only the expense for that portion of the replacement appliance which replaces the teeth extracted after the insured's coverage became effective will be covered.

  - the existing appliance was installed after the date the individual first became insured and the existing appliance must be 5 years old and cannot be made serviceable; or

  - the existing appliance was installed while being insured under the Plan at least five years prior to its replacement and the existing denture cannot be made serviceable; or

  - the replacement appliance replaces an existing appliance which was temporarily installed after the date the member first became insured under this Benefit Provision. In respect of the person requiring the replacement appliance, in this event such replacement

appliance shall be considered a permanent (as opposed to temporary) installation.

- the replacement appliance is required as the result of the installation of an initial opposing denture after the date the member became insured under this Benefit Provision in respect of the person requiring the replacement appliance.

- the replacement appliance is required as the result of accidental dental injury which occurs after the date the member first became insured under this Benefit Provision in respect of the person requiring the replacement appliance.

- Repairs to existing dentures; repairs/ recementation or rebonding of onlays, crowns and bridgework.

- Procedures involving the use of gold if such treatment could not have been rendered at lower cost by means of a reasonable substitute consistent with generally accepted dental practice.

  If such treatment could have been rendered at lower cost by means of a reasonable substitute, only the expenses that would have been insured for treatment by means of the reasonable substitute shall be covered.

Orthodontic Treatment

- Orthodontic treatment (the correction of malocclusions) for dependant children who are at least 6 years of age but not more than 18 years of age at the time treatment commences.

Exclusions and Limitations

Expenses incurred for the following shall in no event be Eligible Expenses:

- Services and supplies, or portions thereof, which are covered by a government health plan or any other government plan.

- Services and supplies for which a government or government agency prohibits the payment of benefits.

- Services and supplies provided by a dental or medical department maintained by the Employer, a mutual benefit association, labour union, trustee or similar type of group.

- Services and supplies required as the result of an intentionally self-inflicted injury, or as the direct result of war (declared or undeclared) or of engaging in a riot or insurrection.

- Services and supplies rendered for dietary planning for the control of dental caries, for plaque control, or for oral hygiene instructions.

- Services and supplies rendered principally for cosmetic purposes including, but not limited to, facings on crowns or pontics posterior to the second bicuspids.

- Services and supplies rendered for the correction of any congenital or developmental malformation.

- Services and supplies rendered for a full mouth construction, for a vertical dimension correction, or for correction of a temporal mandibular joint dysfunction.

- Dental treatment which is not yet approved by the Canadian Dental Association or which is clearly experimental in nature.

- Dentures which have been lost, mislaid or stolen.

- Charges for broken appointments or the completion of claim forms required by the Insurer.

- If alternate services may be performed for the treatment of a dental condition, the amount included as an Eligible Expense will be the amount specified for the least expensive service or supply which, as determined by the Insurer, will produce professionally adequate results.

Healthcare Spending Account

Purpose

The Trustees have implemented a Healthcare Spending Account (H.S.A.) with allocations made to Members in good standing with Local Union 1258.

Allocations are subject to the discretion of the Trustees, subject to the financial stability of the Plan, C.R.A. regulations, etc. If you are entitled to an H.S.A. allocation this H.S.A. will assist Union Members and their families in offsetting Healthcare and Dentalcare expenses incurred above and beyond the coverage presently provided by the Construction & Specialized Workers Union Local 1258 Health & Welfare Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums).

Claims Procedures

For reimbursement through your H.S.A., just submit your original receipt or Insurer claims summary statement with a claim form to the Plan Administrator, Coughlin & Associates Ltd., no different than for regular claims covered by the Group Insurance Plan. Please note that any remaining Health, Vision, or Dental benefit expenses not covered by the Basic Plan will automatically be applied to the extent of your Healthcare Spending Account unless you indicate otherwise. Please note that if you are submitting claims that require redirection to your spouse's plan for coordination of benefits, we will not automatically apply to your H.S.A. Subsequently, any remaining balance following coordination of benefits with your spouse's plan will need to be submitted (summary statement from your spouse's Insurer), to Coughlin in order to have the remaining portion applied to your H.S.A. For Dental claims submitted directly by your Dentist (i.e. no claim form submitted), you will need to contact Coughlin's directly if you do wish to use your H.S.A. balance.

Eligibility

For Union Members who are no longer in benefit (i.e. Retirees, Non-Working Members, Disabled), you may still make claims against your Healthcare Spending Account balance following your last day of coverage under the Group Insurance Plan provided you maintain your good standing as a Member of the Local Union 1258.

As per Canada Income Tax Technical interpretation (9431185) regulations, the Healthcare Spending Account is subject to forfeiture every 24 months.

Termination

In the event of termination of Membership from Local Union 1258, the remaining Healthcare Spending account balance will be immediately forfeited to the Trust Fund.

Death

In the event of a Union Member's death, coverage will be extended to the surviving dependants as follows:

1. Spouse – until the balance of the Healthcare Spending Account is depleted.
2. Dependent Children – until they no longer qualify as dependants under the Group Insurance Plan or the balance of the Healthcare Spending Account is depleted.

Reinstatement

Reinstatement of a Union Member's Healthcare Spending Account is not applicable as it is a requirement that a Member maintain a positive status with Local Union 1258 at all times.

Marital Separation / Divorce

As per the provisions for the insured benefits, the Healthcare Spending Account will not be extended to the spouse following separation or divorce. Alternatively, eligible dependent children will continue to be eligible for participation at the discretion of the Union Member.

List of Eligible Medical Expenditures

A list of eligible medical expenses is available via the Plan Member Portal on the Plan Administrator's website at www.coughlin.ca, or alternatively, directly on the Canada Revenue Agency website under "Details of Medical Expenses".

To determine the outstanding balance in a Member's individual HSA, the Member should refer to his/her latest claims cheque record, or contact the Plan Administrator at (204) 942-4438 or Toll Free 1-888-204-1234, or alternatively via the Plan Administrator's website at www.coughlin.ca by clicking on "Logon" and entering a temporary password detailed on your claims summary.

Co-Ordination of Benefits

If you or your dependants are insured for similar benefits under another Plan (i.e. Group Health Program, or other arrangements covering individuals in a group), the Insurer will take this into account when determining the amount of expenses payable under this Plan.

This process is known as Co-ordination of Benefits. It allows for reimbursement of insured medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred provided the expense is eligible under both plans.

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e. responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e. responsible for making the payment to cover the remaining eligible expense).

- If your Spouse's Plan does not allow for Co-ordination of Benefits, it will be considered as the Primary Carrier, and it will be responsible for making the initial payment toward the eligible expense.

- If your Spouse's Plan does allow for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

  - For Claims incurred by you or your Dependant Spouse:

    The Plan insuring you or your Spouse as an Employee/Member pays benefits before the Plan insuring you or your Spouse as a dependent.

  In situations where you or your Spouse have coverage as an Employee/Member under more than one Plan, the order of benefit payment will be determined as follows:

  - The Plan where the person is covered as an active full-time Employee, then

  - The Plan where the person is covered as an active part-time Employee, then

- The Plan where the person is covered as a retiree.

- For Claims incurred by your Dependant Child:

  The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

However, if you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then

- The Plan of the spouse of the parent with custody of the child (i.e. if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependant Child), then

- The Plan of the parent not having custody of the child, then

- The Plan of the spouse of the parent not having custody of the child (i.e. if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependant Child)

- A claim for accidental injury to natural teeth will be considered determined under Extended Health Care Plans with accidental dental coverage before it is considered under a Dental Plan.

- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.

- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt until your claim has been settled and for submission to secondary carrier.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with a photocopy of original receipts and all necessary claim forms to the Secondary Carrier for further consideration of payment, if applicable.

Travel Medical Emergency
(Underwritten by AIG/ Global Excel)

Travel assistance is provided by Global Excel Management Inc. With centres worldwide they will:

- help locate the most appropriate medical facility for you.
- confirm coverage with AIG Insurance Company of Canada and assure the hospital that you are covered.
- guarantee payment for hospitalization, if necessary.
- arrange for admission to a hospital.
- provide translation services.
- contact your own doctor for recommendations, when required.
- contact your family and employer, when required.
- arrange for/co-ordinate emergency medical evacuation. and
- co-ordinate your return home.

How to Claim

If you require emergency medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately. If circumstances prevent you from calling Global Excel Management Inc. right away, you should contact them as soon as you can. Global Excel Management Inc. will help ensure that you receive the medical care you need and, if possible, will make claims payment arrangements directly with the hospital or service provider.

If you contact GLOBAL EXCEL MANAGEMENT INC. right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

If you are not able to contact Global Excel Management Inc. before being billed for the charges, or if your medical needs are minor in nature (i.e., costing less than $500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip. In any case, your claim should be submitted no later than 90 days after the expense was incurred. Global Excel Management Inc. and the insurance company are not responsible for dealing with any payment reminders or collection notices that you receive from medical providers.

To make a claim for out-of-pocket expenses, contact a Global Excel Management Inc. operator at:

From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

Give the operator your name and your Policy Number: CMG 9428799

The operator will send you a claim form. When you complete the form, provide the patient's name and provincial health plan number and your certificate number. Be sure to attach detailed statements and original receipts showing the services rendered and the charges for each service. Mail your completed claim form and attachments to:

Global Excel Management Inc.
73 Queen Street
Lennoxville, QC, J1M 1J3

Please make sure you obtain your medical records, statements, or detailed receipts at the time of treatment and/or discharge, to submit with your claim. All claims must be submitted to Global Excel Management Inc. as soon as possible, and no later than 90 days after the expense was incurred.

How to Make a Claim

Time Limitations

Life Insurance
Claims must be submitted within twelve (12) months of the date of loss.

AD&D
Notice of claim must be submitted within thirty (30) days of the accident, and proof of claim submitted within ninety (90) days of the accident. However, these time limitations may be extended up to twelve (12) months from the date of accident, if deemed not reasonably possible to provide notice or proof within the applicable period.

Major Medical, Visioncare and Dentalcare
Claims for these benefits must be submitted within eighteen (18) months of the date incurred.

Long Term Disability Income
A claim for the waiver of premium benefit and Long Term Disability benefits must be submitted within twelve (12) months of the date disabled.

Critical Illness
Notice of claim must be submitted within 30 days from the date of the accident, the beginning of the disability and subsequent proof of claim must be submitted within 90 days from the date of the accident. Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will Insurer accept notice of claim beyond one year.

Coughlin Plan Member Portal

You can log in to the Coughlin Plan Member Portal at www.coughlin.ca and view your personal benefits and claims account. You can:

- Manage your profile, including updating your mailing address, telephone number, email address, updating your language of preference, signing up (or updating) for Pre-Authorized Deposit, and viewing your dependant information.

- View your claims history and the status of claims, print explanation of benefits statements, view your benefit accumulations/maximums and view your booklet (where applicable).
- Download and print claim submission and administrative forms.

Pre-Authorized Deposit (PAD)

Eligible reimbursements for extended health and dental care claims can be deposited directly into your bank account within two to five days following their approval. There are two easy options to enrol in Coughlin & Associates Ltd.'s PAD program:

1. Member Portal

   Login to the secure Member Portal at www.coughlin.ca
   Click the Pre-Authorized Deposit link on the welcome page and follow the simple instructions.

2. Pre-Authorized Deposit (PAD) Form

   Complete, sign and return a PAD form (forms are available on Coughlin's website) to:

Fax:	204-943-5998
Email:	wpgadminrequests@coughlin.ca
Address:	Coughlin & Associates, P.O. Box 764, Winnipeg, MB, R3C 2L4

To be eligible for PAD, deposits must be made to an accredited Canadian financial institution. Please note that lines of credit are not accepted.

Drug Claims

You can pay for your prescription drugs at any retail pharmacy in Canada directly through your drug plan using the pay-direct drug card from Express Scripts Canada (ESC) and Coughlin & Associates Ltd.

With the pay-direct drug card, your prescription drug claims will be processed on-the-spot. There are no forms to complete and no payment required unless the claim exceeds the benefit maximums of this Plan. Simply present the card to your pharmacist when you purchase prescription drugs. Your claim payment will be processed immediately.

The card can be used by you as well as your spouse and eligible dependants. The pay-direct drug card is designed to cover only prescription drug costs.

Present the pay-direct drug card to your pharmacist when you purchase prescription drugs. The prescription data will be submitted electronically to ESC and your drug claim will be assessed in seconds while you wait. When your claim is approved, the pharmacist will return the card to you.

The card can be used at any pharmacy in Canada.
If you have listed dependents, you will receive two cards; one for you and one for your spouse. Note: Only the name of the covered employee appears on the card. An additional card will be issued in the dependant's name for eligible dependants over age 21 and in full-time attendance at college or university.

Submit Your Claims Electronically

Vision care and paramedical services claims can be submitted directly through the Coughlin Plan Member Portal. Your claim will be adjudicated within two business days.

Some important points to remember:

- The maximum amount that can be claimed is $1,000 for vision care and $500 for paramedical services per claim transaction per covered person. You may not submit a claim for yourself and another person, such as a dependant, at the same time.
- You must be registered with Coughlin's Pre-authorized Deposit plan before the service will be activated.
- Claims are audited randomly. Be sure to keep your claim receipts for one year. If you receive an audit notice, please submit the requested original claim receipts within the timeframe indicated.

Extended Health Care Claims

If you incur eligible extended health care expenses, complete the appropriate claim form and return it, along with any original receipts, to Coughlin & Associates Ltd. In co-ordination of benefits situations where Coughlin is the secondary payer, the original explanation of benefits form of the primary insurer and copies of the relevant receipts or dental claim forms must be submitted.

Claim forms may be obtained from the Administrator or Union Office or from Coughlin's website at www.coughlin.ca.

Note: Original claims receipts will be retained by Coughlin. It is recommended that you photocopy receipts prior to submitting claims.

Dental Claims

Coughlin will process your dental claim using the electronic data interchange (EDI) claims processing service. With EDI, your dental claim can be sent directly from your dental office to our claims department for adjudication.

Our EDI service uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association. With Telus, you can be assured that the information contained in your dental claim will be transmitted to Coughlin quickly, safely and confidentially right from your dentist's office.
To take advantage of Coughlin's EDI service, please inform your dentist that Coughlin is your plan administrator and present them with the following security codes:

- the Coughlin Telus carrier identification number (also known as the BIN number) is **610105 on the Telus network**;
- your unique member identification number; and
- the policy number (31228) of your group benefit plan.

Your unique member identification number can be found on your monthly statement. The Administrator can also provide you with your member identification number.

Pre-Authorization

For treatment where the estimated cost is $500 or more, predetermination of costs should be obtained from the Plan Administrator.

Have your dentist/denturist complete the appropriate form or section. Mail the form to the Plan Administrator.

For a proposed treatment plan which includes crown or bridgework, please ask your dentist to send the applicable x-rays with the form.

A letter will be sent to the dentist/denturist with a copy to you, showing how much the Plan will pay.

When your dental care claim is submitted electronically, it will be processed within two to four business days.

If your dental office is not set up with EDI, the dental office must submit a Dental claim form completed and signed by the dentist, satisfactory to the Administrator.

Claims Inquiries

If you have any claim questions kindly direct to winnclaims@coughlin.ca

THIS PLAN IS UNDERWRITTEN BY:

The Canada Life Assurance Company
Policy #31228 (www.canadalife.com)

AND

Chubb Life Insurance Company of Canada
Policy #AB10406502
Policy #CI20002401

AND

AIG Insurance Company
Policy #CMG 9428799

AND

Homewood Health

THIS PLAN ARRANGED AND ADMINISTERED BY:

Coughlin & Associates Ltd.
Employee Benefits Specialists
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Winnipeg, Manitoba
R3C 2L4
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