I.B.E.W.
LOCAL UNION 529

HEALTH & WELFARE
TRUST FUND

January 2025

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To All Members
I.B.E.W. L.U. 529
Health and Welfare Trust Fund:

We are pleased to present this revised booklet which describes the current benefits and provisions provided to the eligible Participants of the I.B.E.W. L.U. 529 Health and Welfare Plan. We urge you to read this booklet thoroughly to become familiar with the benefits that are available to you and your dependants. These benefits will assist you in paying your healthcare and dental expenses but may not cover the total cost of those services and supplies. In effect, this Group Benefit Plan shares the payment of your medical and dental expenses with you.

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

Your Life, Dependent Life, Short Term Disability (STD) and Long Term Disability (LTD) coverage continues to be underwritten by Canada Life, the Travel Medical Emergency, Critical Illness, and Accidental Death & Dismemberment benefits are underwritten by AIG Insurance Company (Global Excel Management), while the Group Benefit Plan continues to self-insure the Dentalcare, Visioncare, Prescription Drugcare and Extended Healthcare benefits.

The plan continues to be administered and have claims paid by Coughlin & Associates Ltd., and the Pay Direct eClaims system co-ordinated with Telus Adjudicare.

Your continued participation in the Plan will maintain greater peace of mind and an increased feeling of security to you and your family.

Sincerely Yours

The Board of Trustees of the
I.B.E.W. L.U. 529
Health and Welfare Trust Fund.

Important Notice

This booklet highlights the principal features of the Plan and is presented as a matter of general information only. Please note that this information is in reference to the governing documents of the Plan:

- Accidental Death & Dismemberment – Policy #GPA 9429838 through AIG
- Critical Illness – Policy #9427461 through AIG
- Travel Medical Emergency – Policy # CMG 9428666 through AIG
- Life, Dependent Life, Weekly Income, and Long Term Disability – Policy #24923 through Canada Life
- Dental, Visioncare, Extended Health, and Prescription Drugs – Policy #58286 (Self-Insured)
- Telus Adjudicare – Group #58286

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

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided as evidence of insurability, subject to certain limitations.

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation (i.e. Limitations Act, 2002 in Ontario, Quebec Civil Code).

Appeals

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

Benefit Limitation for Overpayment

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

Notice Regarding Personal Information

When you apply for coverage under the Group Benefit Plan, the Plan Administrator, Coughlin & Associates Ltd., and the Insurers, Canada Life and AIG., will set up a file with personal information relevant to your benefit coverage under the Plan.

The purpose of this file is to permit these companies to administer all financial services provided to you, and to keep information specific to the Insurers' and Coughlin's business relationship with you. This includes the following:

1. Underwriting and financial reporting
2. Claims adjudication and management
3. Internal and external audits
4. Preparation of regulatory and statutory reports
5. Assisting you in planning your financial security.

The files are kept in their offices so they have access to the file when required for insurance purposes.

You have certain rights of access and correction with respect to the information in your file. A request for access or correction must be in writing and may be sent to the Plan Administrator, Coughlin & Associates Ltd., P.O. Box 764, Winnipeg, Manitoba, R3C 2L4.

Privacy

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

Life Insurance

Benefit.....$75,000
Retired Members $37,500
Members who were retired or disabled prior to July 1/16.....$25,000
Coverage terminates.....no later than age 71

Please refer to the ***Life Insurance*** section for greater details.

Dependent Life Insurance

Benefit.....$10,000 Spouse
.....$3,000 each Child
Coverage terminates.....no later than age 71

Please refer to ***Dependent Life Insurance*** and ***Self-Pay Provision*** sections for greater detail.

Critical Illness

Members are eligible to a $15,000 flat benefit for any of 27 insured conditions. The Critical Illness benefit ceases at age 70. Please refer to the Critical Illness booklet on the Member Portal prepared by AIG, or contact the 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. Please refer to www.coughlin.ca (Privileged section) for more information.

Accidental Death, & Dismemberment

Principal Sum Active Member under age 71 .....$100,000
Principal Sum Retired Member under age 71.....$37,500
Members who were retired or disabled prior to June 1/24 .....$50,000
Members who were retired or disabled prior to July 1/02.....$25,000
Coverage terminates.....no later than age 71

Please refer to ***Accidental Death & Dismemberment*** section for greater detail.

Short Term Disability Income

Benefit.....Equivalent to Employment Insurance (EI) weekly maximum

- Payable weekly from 1st day of accident, 8th day of sickness or the 1st day of hospitalization or day surgery, for a maximum of 52 weeks.
- Subject to E.I. wraparound which you must apply for (weeks 2 – 27)
- Taxable

Coverage terminates.....no later than age 71

Please refer to ***Short-Term Disability Income*** section for greater detail.

Long Term Disability Income

Benefit.....$1,400

- Payable monthly after 365 calendar day waiting period to age 65 or until recovery. Subject to direct offsets (i.e. Workers Compensation, CPP, EIC and Auto Insurance Disability, etc.) and 80% of pre-disability income all source limitation.
- Taxable.

Coverage terminates..... at the earlier of age 65, retirement or cessation of Union Membership. For Office Staff and Permit Workers, coverage terminates on the date Employment ceases with a Certified Employer

Prescription Drugs

Deductible.....Nil
Reimbursement Percentage 80%
Smoking Cessation Products .....$500 lifetime
Calendar Year Maximum.....$1,500 per family
Dispensing Fee Maximum ..... $15 per script
Pharmacy Mark-up Maximum.....20% per script
Coverage terminates.....no later than age 75 with exception, if working, to extent of Hour Bank rundown

Please refer to ***Prescription Drug*** sections for greater detail.

Dentalcare

Dental Fee Guide .....Current Saskatchewan Dental Association Fee Guide
Deductible.....Nil
Reimbursement Percentage (Routine and Major).....80%
Calendar Year Maximum.....$1,500
Adjusted Maximum.....$750
Check-ups and Cleaning.....Once per calendar year
Coverage terminates.....at age 75 with exception, if working, to extent of Hour Bank rundown

Please refer to ***Dentalcare*** section for greater detail.

Visioncare

Deductible.....Nil
Reimbursement Percentage 100%
Laser Eye Surgery maximum.....$500 reimbursed every 24 months while insured under this Plan until claim is fully reimbursed
Eyeglass/Contact Lens/Laser Surgery/ Prescription Safety Glasses Maximum
Members (every 24-month period) $500
Dependants (every 24-month period) $365
Contact Lenses for Special Conditions Lifetime Maximum $500
Visual Training and Remedial Therapy Lifetime Maximum $500
Eye Examination Maximum (every 24-month period).....1 exam

Coverage terminates .....at age 75 with exception, if working, to extent of Hour Bank rundown

Please refer to ***Visioncare*** section for greater detail.

Extended Healthcare

Deductible ..... Nil
Reimbursement Percentage 80%
..... (subject to Reasonable and Customary limits)

Calendar Year Maximum (100% for Paramedical Services):
- Paramedical Services $500/person/specialist
- Registered Nurse ..... $5,000/person/calendar year
- Orthopedic Shoes/Orthotics ..... up to $400/person/calendar year

Coverage terminates ..... at age 75 with exception, if working, to extent of Hour Bank rundown

Please refer to ***Extended Healthcare*** section for greater detail.

Travel Medical Emergency

Benefit Maximum ..... Under 70 $5 Million/per person/lifetime
..... 70 to 74: $2 Million/per person/lifetime
Trip Duration Maximum ..... 90 days
Pre-existing Stability Clause Period ..... None
Coverage terminates for active/retired members ..... at age 75
Policy Number ..... # CMG 9428666

In the event of an emergency, please call from Canada/USA 1-877-207-5018 or collect from anywhere 1-819-566-3940. The emergency telephone numbers are listed on the back of the All-In-One card.

Please refer to ***Travel Medical Emergency*** section or the Brochure for greater detail.

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 $90 per hour or $45 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 Extended Healthcare benefit coverage

vCare – Virtual Healthcare

This online platform provides you and your family with 24/7, personalized medical support wherever you are in Canada. Connect instantly with a healthcare provider for your primary health questions and concerns.

- Unlimited virtual consultations via secure text and video chat, 24/7
- Convenient primary and mental health-care support
- Fill and refill prescriptions, specialist referrals, and lab requisitions
- Coverage for you and your eligible dependents
- Virtual follow-ups with no appointments required
- Health records on the platform, with updates sent to your family doctor with your consent

You can access directly via your mobile Coughlin App. If you want to register, please download via the https://virtualcare.telushealth.com/krabappel/new_signup/email?flow=vcare or download the mobile app (Apple App Store or Google Play).

Healthcare Spending Account (HSA)

Reimbursement ..... 100% of eligible expenses limited to HSA account balance
Eligibility ..... Local Union 529 Insured Members only

Please refer to the ***Healthcare Spending Account*** section for greater detail.

General Information

Eligible Plan Participants

Under this Plan, the following Participants are eligible for coverage:

Active Members

A Union Member in good standing with Local Union 529 on whose behalf contributions are being made to the I.B.E.W. L.U. 529 Health & Welfare Trust Fund.

Permit Workers

Employees of Employers on whose behalf contributions are made but are not Members of the I.B.E.W. L.U. 529 or any reciprocating Local, will be eligible for benefits under this Plan while working for a Certified Employer.

Office Staff

Office Staff of Employers on whose behalf contributions are being made but are not Members of the I.B.E.W. L.U. 529 or any reciprocating Local, will be eligible for benefits under this Plan while working for a Certified Employer.

Retired Member

A Member is considered retired when they have attained age 55 or older and have met one of the following criteria:

- Transferred their funds from the Pension Trust Fund into a retirement option (i.e. Annuity, Prescribed Registered Retirement Income Fund (RRIF) or Variable Benefit)
- Indicated in writing his/her retirement from the trade
- Elected retirement in writing from the Health & Welfare Plan.

Eligibility

An account is kept by the Plan Administrator, Coughlin & Associates Ltd., for each eligible Participant which identifies the hours worked for a Certified Employer for which contributions have been made for the purpose of Group Benefits. This account is called an Hour Bank Account.

Participants on whose behalf contributions to the I.B.E.W. L.U. 529 Health and Welfare Trust Fund are being made and who have accumulated 300 work hours within six (6) months are eligible for insurance on the **first day following the day** they have accumulated 300 hours for Life, Dependent Life, AD&D and LTD insurance.

For all other benefits, Participants are eligible for benefits on the **first day of the month following the month** in which the Plan Administrator has received 300 hours (at the commercial rate) within six (6) months. Office Staff will be eligible for benefits coverage on the first of the month following three (3) consecutive months of employment. **To be eligible for benefits, an enrollment card must be completed.** Once eligible, each month 110 hours (commercial rate) will be deducted from the Union or Permit Worker's Hour Bank Account. For Office Staff, the hours will equate to the monthly deduction (see above) 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 1,320 hours (enough to provide twelve (12) months of coverage even though they may not work any hours during that period). Hours accumulated over this amount (1,320) 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 termination of employment or lay-off, the balance in the Hour Bank Account is forfeited to the general reserves of the Trust Fund unless the Permit Worker becomes a Union Member in good standing with Local Union 529.

You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

Termination of Insurance

Your insurance will terminate when:

- the group policy terminates, or
- on the last day of the month in which you do not have at least 110 hours in your Hour Bank Account and self-payment has not been made, or after paying for the previous months coverage, or
- the date you cease to be an insurable Participant, or

- if you are an Office Staff or Permit Worker, on the date of termination of employment or layoff, or

- If you are a Retired member, on the date of the benefit age restriction of depletion of Hour Bank Account and/or respective self-pay period.

Your dependant's insurance will terminate when:

- your insurance terminates, or

- your dependent is no longer an insurable dependant.

Extended Benefits After Termination

Short Term Disability Income/Long Term Disability Income - If your insurance terminates while you are disabled you will continue to receive Short Term Disability Income benefits during that period of disability, up to the maximum noted in the Short Term Disability Income benefit description in the Schedule of Benefits. If you continue to remain disabled after the maximum Short Term Disability Income has been paid, application may be made for the Long Term Disability benefits.

If you are collecting Long Term Disability benefits at the time of termination, the Long Term Disability benefits will continue as long as you remain disabled.

Dentalcare - If your insurance terminates due to termination of the Dentalcare benefit, any benefits payable under this plan for accidental injuries to natural teeth will continue after termination as long as the accident occurred while the Dentalcare benefit was still in force as is reported to the Plan Administrator within the time shown in the Accident and Sickness Insurance Act of your home province.

Self-Pay Provision

If coverage terminates because the number of hours in your Hour Bank Account falls below 110 hours, Union and Retired Members (excludes Office Staff and Permit Workers) will be allowed to continue his/her coverage as follows:

On disability or lay-off, the Member may self-pay for up to 60 consecutive months for CI, Life, Dependent Life, AD&D, People Connect, Dentalcare, Visioncare, Prescription Drugcare, Travel Medical Emergency, and Extended Healthcare benefits. Please note that Disability benefits (Short Term/Long Term Disability) are excluded while self-paying. Office Staff and Permit Workers cannot self-pay for coverage on lay-off, however, if disabled, coverage may be extended for up to sixty (60) consecutive months provided the appropriate contribution remittance is received by the Trust Fund. It is assumed the disabled Participant will be subject to the Plan's Waiver of Premiums provisions where applicable.

Upon retirement, the Member (Life Insurance and AD&D reduces as outlined in the Schedule of Benefits section, Short Term/Long Term Disability excluded), may self-pay to age 65 for Dependent Life, to age 70 for CI Benefit, to age 71 for Life, and AD&D benefits, and to age 75 for People Connect, Travel Medical Emergency, Dentalcare, Visioncare, and Prescription Drug benefits.

Self-paid contributions must be continuous and consecutive, and the first payment must be made prior to the 22nd of the month following the month in which your Hour Bank Account falls below 110 hours.

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

Eligibility to self-pay is conditional upon the Member being in good standing with Local Union 529.

Reinstatement of Insurance

A Union Member whose insurance has terminated will again be eligible following the accumulation of a minimum of 110 work hours in the Hour Bank Account within 6 months from the date of termination, otherwise full eligibility rules will apply.

Specifically, for Union Members, if your insurance terminates because your Hour Bank Account falls below 110 hours, your STD, Dentalcare, Visioncare, Prescription Drugcare, People Connect, Travel Medical Emergency, and Extended Healthcare benefits coverage will be reinstated on the first day of the month following the date on which the Plan Administrator has received at least 110 work hours. The Pooled Benefits

(CI, Life, Dependent Life, LTD and AD&D) will be subject to reinstatement on the date you accumulate 110 work hours. The 110 work hours must be accumulated in the six (6) calendar month period immediately following the date your insurance terminated or the self-pay period ended.

Reciprocal Agreements

I.B.E.W. L.U. 529 Members – Union Members working in a jurisdiction other than I.B.E.W. L.U. 529 and on whose behalf contributions are being made to a Health and Welfare Trust Fund which has entered into a reciprocal agreement with I.B.E.W. L.U. 529 Health and Welfare Trust Fund should complete a Transfer Authority form and advise the Union or Administrator to reciprocate contributions to their Home Fund. This will maintain coverage under the I.B.E.W. L.U. 529 Health and Welfare Trust Fund.

Travel Card Members - Employees of Employers on whose behalf contributions are made to this Fund but who are Members of other Local Unions or Funds and whose Funds have entered into a reciprocal agreement with the I.B.E.W. L.U. 529 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 I.B.E.W. L.U. 529 office or from the Administrator.

Monthly Statements

Each month a statement is mailed to each Member, showing your benefit status, your employer's contribution, your previous month's Hour Bank Account balance and your present Hour Bank Account balance. It should be noted that an amount is deducted from your Hour Bank Account balance each month to pay the premium for your coverage. Should you have insufficient hours in your account, the statement will show the amount required for you to pay on the self-pay basis. If the required amount is not paid, your benefits will immediately terminate and your coverage will not again become effective until you have satisfied the reinstatement requirements explained above.

In order to assure yourself of receiving this statement regularly, it is necessary to inform the Administrator of any change of address.

Change in Amounts of Insurance

Any change in amounts of a member's insurance (Life, Dependent Life, AD&D, Weekly Income and LTD) will become effective on the date of such change provided that the member is actively at work on the date of the change; otherwise, the increase will become effective on the first date thereafter on which the member is actively at work.

Wage Loss Provision

In the event that you incur a total disability while insured but on layoff or leave of absence, the plan will recognize your disability for wage loss benefits (Weekly Income and LTD) from the scheduled date of return to work, provided you are then totally disabled and furnish attending physicians statements certifying continued disability. It is assumed that you were not making self-payments as Disability coverage would then be excluded.

Disability Claims

All disability claims should be recorded with Coughlin & Associates Ltd. and Canada Life (previously Great-West Life) regardless of whether or not you are eligible to receive Worker's Compensation, Auto Insurance or E.I. Disability benefits. This recording will assist you should your claim with these agencies be declined. In addition proper application will be made relative to a waiver of Life Insurance premiums which is required within 12 months of the date of initial disability.

Third Party Liability

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

Information Update

- Beneficiary appointments should be changed as circumstances change (i.e. marriage status, or dependent children, etc.)

- Change of address should be reported promptly.

CONTACT THE PLAN ADMINISTRATOR REGARDING THE ABOVE

Definition of Dependent

Dependent means:

- Your spouse (legal or common-law)

- Your unmarried children or your spouse's unmarried children who are

  - under 21 years of age, or

  - aged 21 or over and in full-time attendance at a university or similar institution.

  Please Note:

  For health related insurance only, dependent will also mean your unmarried children or your spouse's unmarried children aged 21 or over who are incapable of supporting themselves because of mental or physical handicap and who were insured under this plan on the day before they reached age 21.

Dependent Life Insurance will cover a dependent from 14 days of age.

Unmarried children of your spouse are considered dependents only if

- they are also your children, or

- your spouse is living with you and has custody of the children.

The Plan does not cover:

- children who are working more than 30 hours a week, unless they are full-time students, or

- a spouse or child who is not resident in Canada or the U.S.

For dependent children only, you cannot be covered as a dependent if you are insured under the Plan as a Participant.

Life Insurance
(underwritten by Canada Life)

Amount of Benefit

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

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

Coverage Ceases

Your Life Insurance coverage terminates for Union and Retired Members 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 Union 529.

For Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off, retirement or age 71.

For Probationary Members, coverage terminates at the earlier of the date of termination of probationary membership, date of retirement, depletion of Hour Bank Account, 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 the age of 65, whichever occurs first.

As you are also insured for group Long-Term Disability Insurance (LTD) under this Plan, with a similar waiver of premium, application for the Life, Dependent Life, AD&D, and LTD Waiver of Premiums are applied for on the LTD benefit claim form.

All disability claims should be recorded with Canada Life and Coughlin & Associates Ltd. regardless of whether or not you are eligible for 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.

Note: In order to qualify for the Waiver of Premium, you must notify the Plan Administrator of your disability within one (1) year of your last active day of work and furnish proof of your disability satisfactory to the Insurer within eighteen (18) months of the last active day of work.

Conversion Privilege

Your Life Insurance continues for thirty-one (31) days following the termination of your coverage. During this thirty-one (31) day period you may be eligible to convert the amount of your Life Insurance to an individual plan without submitting evidence of health. The premium rate will be determined by your age and class of risk at the time of conversion.

If interested, please contact Coughlin & Associates Ltd. for further information.

Dependent Life Insurance
(underwritten by Canada Life)

Amount of Benefit

In the event of the death of your insured spouse and/or dependent child(ren), the applicable Benefit amount is payable to you as outlined in the Highlight of Benefits section.

Coverage Ceases

Your Dependent Life Insurance coverage terminates 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 Union 529. Coverage for Retired Members terminates at the earlier of age 65, following the depletion of Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local Union 529.

For Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off, retirement or age 71.

For Probationary Workers, coverage terminates at the earlier of the date of termination of probationary membership, date of retirement, depletion of Hour Bank Account, or age 71.

Waiver of Premium for Disability

If you become totally disabled before age 65, the Dependent Life Insurance may be continued without payment of premiums in the same manner as Life Insurance. The Waiver of Premium under this benefit ceases on the earlier of the date the Waiver of Premium for Life Insurance ceases, or the date the Policy or coverage terminates.

Conversion Privilege

The Dependent Life Insurance continues for thirty-one (31) days following your death or your termination of coverage. During this thirty-one (31) day period your spouse's amount of Dependent Life Insurance may be converted to an individual plan without submitting evidence of health. The premium rate will be determined by your spouse's age at the

time of conversion. You may **not** convert the Insurance for your dependent children.

If interested, please contact Coughlin & Associates Ltd. for further information.

Critical Illness
(Underwritten by AIG)

Eligibility

You will be eligible for coverage if you are a "in benefit" Member of the Policyholder, under age 70. This group coverage is for Member only and is not provided for your spouse or dependent children.

Covered Critical Illness – 100% of Principal Sum for:

- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumor
- Blindness
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dementia, including Alzheimer's Disease
- Heart Attack
- Heart Valve Replacement or repair
- Kidney
- Failure
- Life-Threatening Cancer
- Loss of Independent Existence
- Loss of Limbs
- Loss of Speech
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Occupational HIV Infection
- Parkinson's Disease and Specified Atypical Parkinson Disorders
- Quadriplegia, Paraplegia, Hemiplegia
- Severe Burn
- Stroke

Partial Payment for Coronary Angioplasty – 10% of Principal Sum.

Partial Payment for Non-Threatening Cancer – 25% of Principal Sum for:

- Stage I malignant melanoma of the skin
- Basal or Squamous Cell Carcinoma
- Stage 1 Colon Cancer (T1 or T2)

- Carcinoma in situ
- T1a or T1b Prostate cancer
- Papillary thyroid cancer or follicular thyroid cancer
- Chronic lymphocytic Leukemia classified as Rai stage 0
- Any tumor in the presence of any Human Immunodeficiency (HIV)

Principal Sum

Mandatory Coverage – you are covered for a flat amount of $15,000

Benefit Payment Conditions

Payment of benefits upon the first diagnosis of the Critical Illness listed above, including partial payment, is subject to the following:

- diagnosis is made within Canada;

- diagnosis is made while your coverage is in effect under policy;

- payment is not precluded by general or specific exclusion or limitation set forth in the policy or any failure to meet any condition precedent set out.

- Once 100% of the maximum Principal Sum has been paid, coverage terminates and no further benefits are payable; except as described under Multiple Event Benefit.

Multiple Event Benefit – If you are diagnosed with a Critical Illness for which the Principal Sum has been paid and is then diagnosed with a subsequent Critical Illness, an additional payment equal to the Principal Sum is payable if you have been actively at work for at least 90 days before being diagnosed with a subsequent Critical Illness and the subsequent Critical Illness is a different Critical Illness Group (9 groups) than the initial Critical Illness Group for which the Principal Sum has been. You are eligible for payment of the Principal Sum one time per Critical Illness Group.

Note: For complete details, please contact the Administrator and/or refer to the Critical Illness Program Brochure as prepared by the Insurer, AIG which is available on the Member Portal.

Accidental Death & Dismemberment Insurance
(Underwritten by AIG)

Coverage

Your plan provides 24-hour Accidental Death & Dismemberment benefits for injuries as a result of covered accidents, on or off your job, on business, on vacation, at home, regardless of your health history.

Benefit Amount

You are automatically covered for the Principal Sum in the Highlight of Benefits. The amount of benefit depends on the loss suffered by you and is limited to the percentage of the Principal Sum shown in the Table of Losses.

Coverage Ceases

Your Accidental Death & Dismemberment coverage terminates for Union and Retired Members 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 Union 529.

For Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off, retirement or age 71.

For Probationary Members, coverage terminates at the earlier of the date of termination of probationary membership, date of retirement, depletion of Hour Bank Account, or age 71.

Waiver of Premium for Disability

Waives premium payments under the policy if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage

If you are no longer employed or actively working, your coverage shall continue in the following circumstances: (1) during a statutory leave, as set out in applicable provincial, territorial or federal employment standards

legislation or equivalent, but not more than the period required under such legislation, or (2) during the notice period for termination of employment as required by law, provided premiums continue to be paid.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered Loss occurs within 365 days after the date of the accident causing the Loss, the Company will pay the indicated percentage of the Principal Sum as set out in the following Table of Losses. If you sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

Table of Losses

	Percentage Principal Sum Payable
Loss	
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Brain Death	100%
Loss of One Arm or One Leg	80%
Loss of One Hand or One Foot	75%
Loss of The Entire Sight of One Eye	75%
Loss of Thumb and Index Finger of the Same Hand	40%
Loss of Speech and Hearing	100%
Loss of Speech or Hearing	75%
Loss of Hearing in One Ear	66.7%
Loss of Four Fingers of Same Hand	40%
Loss of All Toes of One Foot	25%
Loss of Use	
Loss of Use of Both Arms or Both Hands	100%

Loss of Use of One Hand or One Foot	75%
Loss of Use of One Arm or One Leg	80%
Paralysis	
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two times the Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times the Principal Sum

Additional Benefits

The Benefit Description is a summary only and does not include all of the provisions, sub-limits, conditions and exclusions. Please refer to the AD&D booklet on the Member Portal prepared by AIG for more information.

Policy Exclusions

The policy will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

a) suicide or any attempt thereat;

b) self-inflicted Injury or any attempt thereat;

c) declared or undeclared war or any act thereof;

d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

e) Injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

f) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;

g) travel or flight in or on (including getting in or out of, or on or off of) any aircraft, if you are:

(i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

(ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

(iii) riding as a passenger in an aircraft owned, leased or chartered by the Policyholder;

h) travel or flight in or on (including getting in or out of, or on or off of) any aircraft or craft designed to fly or glide above the Earth's surface:

(i) except as a passenger on a regularly scheduled commercial airline; or

(ii) being used for crop dusting, spraying or seeding, fire-fighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or

(iii) operating to or from off-shore landing sites; or

(iv) used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

j) Injury or Loss sustained if you or your insured eligible dependents are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

k) the commission or attempted commission by you or Injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

l) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and

m) death by natural causes.

Weekly Income Benefits
(Underwritten by Canada Life)

In the event you become totally disabled due to an injury or illness and are unable to perform the essential duties of your occupation, you will receive a disability benefit provided you are under the continual treatment of a qualified and licensed physician (Medical Doctor).

All Disability Claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurers (Canada Life and AIG) regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance, or EI 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 the Waiver of Life Insurance, required within six (6) months of the date of initial disability.

Benefits for any one disability are payable from the first (1st) day of disability due to injury or the eighth (8th) day for sickness **but in no event prior to the first day of visit to your physician**. Your benefit will be payable for not more than fifty-two (52) weeks during any one period of disability.

This benefit provides for an "Employment Insurance (E.I.) Wrap Around" provision whereby:

- The first one (1) week of disability will be covered by the Plan. The Plan Administrator will advise you to apply for E.I. Disability benefits before the end of the initial 2-week period.

- Weeks 2 to 27 will be covered by E.I. if available, or by the Plan if E.I. is not available.

- Weeks 28 to 52 will then again be covered by the Plan.

Note: This benefit is taxable.

If following a period of disability you return to active work for at least two (2) weeks, a recurrence of this disability will be considered a new period of disability.

The amount of Weekly benefits are specified in the Highlight of Benefits section.

Reductions

The amount of any benefit payable under this coverage shall be reduced by any income or benefit payable under:

- any other plan or program provided to you by or through the Employer;
- any other plan or program of any government or of any sub division or agency of the governments including any plan or program established pursuant to a Provincial Automobile Insurance Act.

If you are receiving any income or benefit payable under any government plan or program for an injury or disease totally unrelated to the injury or disease that caused the current disability, the Insurer shall not reduce the weekly benefit by that amount.

Coverage Ceases

Eligibility for Short Term Disability coverage terminates at the earlier of age 71, depletion of the Hour Bank Account, the date of retirement, or if you are no longer a Member in good standing with Local Union 529.

For Office Staff, coverage terminates immediately upon the date of termination of employment, retirement, lay-off or age 71.

Exceptions

Benefits are not payable for:

- disability due to injury or illness while working for pay or profit for which you are covered under Workers' Compensation or similar program, or
- disability due to cosmetic surgery except where the surgery is required to correct a deformity resulting from illness or injury or a congenital defect that interferes with function, or
- disability during a period you are serving a prison sentence, or
- disability resulting from self-inflicted injury, war, or engaging in a riot or insurrection.

Submitting a Claim for Weekly Disability Income

If you are wholly and continuously disabled by bodily injury or sickness and prevented from performing your regular work, and have active coverage for this benefit, you should contact the Claims Adjudicator, Coughlin & Associates, at wdisabilityclaims@coughlin.ca or telephone 1-888-204-1234 for the corresponding forms to apply for this benefit.

Long Term Disability Income
(underwritten by Canada Life)

All Disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurer (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. In addition, proper application will be made relative to a Waiver of Life Insurance Premiums, required within twelve (12) months of the date of initial disability.

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled as defined by the policy or you reach age 65, whichever comes first. Check the Highlight of Benefits for the benefit amount and waiting period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury. If the Plan provides Short Term Disability or Sick Leave benefits that are still being paid when the waiting period ends, the waiting period will be extended until the end of the Short Term Disability or Sick Leave benefit period, but not later than one year after your disability started.

- LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from doing your own job. You are not considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.

- After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medially able to perform, for which you have at least the minimum qualifications, and provides you with an income of at least 60% of your indexed monthly earnings before you became disabled.

- After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of at least 6 months.

- Because your employer contributes to the cost of LTD coverage, benefits are taxable.

- Your LTD insurance terminates when you reach age 65.

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

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 80% of your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

- your income under this plan

- loss of income benefits available through legislation, except for Employment benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law

- disability benefits under a plan of insurance available through membership in an association

- employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program (termination pay and severance benefits are included as employment income under this provision)

Earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and other income listed above, would exceed

your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return a gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

Medical Coordination Benefits

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

Limitations

No benefits are paid for:

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

- Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

- The scheduled duration of a lay-off or leave of absence.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.

- Any period after you fail to participate or cooperate in an approved rehabilitation plan or program.

- Any 12-month period in which you do not live in Canada or at least 6 months.

- Any period of confinement in a prison or similar institution.

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

Conversion Privilege

If you change jobs, you may apply for an individual LTD conversion policy without medical evidence. You must apply and pay the first premium no later than 31 days after you start your new job, and you must start your new job no later than 6 months after you leave your present one. Your application must be acceptable according to Canada Life's underwriting rules in effect for individual disability insurance conversation policies at the time of application. See the Administrator for details.

Prescription Drug Benefits

Prescription Drugcare Benefits provides protection against the cost of medically necessary prescription drugs for which there is no reimbursement from the provincial health plans. Prescription Drugcare Benefits covers only those expenses which are considered reasonable and customary for the drug provided in the area where the expenses are incurred.

Co-insurance Percentage

- The Plan pays 80% of covered drug expenses to a maximum of $1,500 per calendar year per family. Subject to mandatory generic substitution unless a physician indicates a medical necessity, dispensing fee maximum of $15 per script, and 20% markup restriction.

Covered Expenses

- Drugs and medicines requiring the written prescription of a physician and dispensed by a licensed pharmacist including:
  - oral contraceptives
  - anti-obesity
  - injectable drugs when administered by a physician and for which no non-injectable alternative is available, excluding the cost of administration
  - vaccinations
  - insulin, insulin syringe and testing supplies for diabetics
- Smoking cessation products to a lifetime maximum of $500
- Erectile dysfunction drugs (i.e. Viagra) limited to 15 pills per person every 3 months
- Other drugs listed in the current Compendium of Pharmaceuticals and Specialties when prescribed by your physician to treat a diagnosed injury or illness

Limitations

No benefits are paid for:

- contact lens supplies, vitamins, food or food products, skin and hair care products, contraceptive devices, laxatives, antacids and antihistamines, disinfectants, acne therapy, etc. (A complete listing is contained in the Master Policy.)

- medications use to prevent baldness or promote hair growth

- any single purchase of drugs which would not be used within 90 days

- any drug which does not have a drug identification number as defined by Canadian federal legislation

- any drug which is registered under Division 10 of the Regulations to the Food and Drugs Act, Canada

- delivery and transportation charges

- supplies required for recreation or sports that are not medically necessary for regular activities

Please Note: Prescription Drugcare coverage is limited to the deductible amount and co-insurance you are required to pay under your Provincial Pharmacare Plan.

Dentalcare Benefits

Dentalcare Benefits provides protection against the cost of dental services which are often significant and unexpected. To be considered a covered expense, the charge for a particular service must be reasonable and customary for the service provided in the area where the expense is incurred.

Dentalcare Insurance covers necessary dental treatment by a dentist, dental hygienist, or physician or by other qualified personnel under the direct supervision of the dental or medical profession (e.g. dental assistants) and will also cover services rendered by dental specialists, denturologists, denturists, dental hygienists and denture therapists where they are permitted by law to deal directly with the public. If there is no fee schedule for these practitioners in your province, payment will be based on the appropriate General Practitioners' schedule.

Alternate Benefits and Submission of Treatment Plan

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, the Administrator 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.

Note: The proposed course of treatment must be completed within ninety (90) days for the benefit determination to remain valid. Otherwise, it is suggested you submit a new treatment plan; however, please note the participant must be insured at the time treatment is rendered.

Covered Expenses

The following items are considered covered expenses under this Dentalcare Benefit:

Routine Treatment

- oral examinations, polishing of teeth, topical application of fluoride solutions and bite-wing x-rays, once in any calendar year
- scaling of teeth
- full mouth series of x-rays once every 24 months
- extractions and alveolectomy at the time of tooth extraction
- amalgam, silicate, acrylic and composite fillings
- dental surgery
- general anaesthesia and diagnostic x-ray and laboratory procedures required in relation to dental surgery
- endodontics (root canal therapy)
- periodontal treatment
- necessary treatment for relief of dental pain
- 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
- relines and rebases to existing dentures
    - stainless steel crowns

Major Treatment

- crowns (other than stainless steel crowns)

- installation of an initial appliance (bridgework or dentures) if such appliance is required because at least one additional natural tooth was necessarily extracted after the effective date of coverage for the individual

- replacement of existing dentures or bridgework if

  (a) they are required because of the extraction of one or more natural teeth after the effective date of coverage for the individual and the existing bridgework or dentures cannot be made serviceable.

  If the existing bridgework or dentures can be made serviceable, only the expense of the portion of the replacement bridgework or dentures that replaces the extracted teeth is considered a covered expense.

  (b) the existing bridgework or denture is at least 5 years old and cannot be made serviceable

  (c) the existing bridgework or denture was temporarily installed after the effective date of coverage for the individual and is replaced by a permanent appliance

  (d) the replacement bridgework or denture is made necessary as the result of an initial placement of an opposing denture while insured

  (e) the replacement denture or bridgework is made necessary as the result of an accidental bodily injury while insured

- repairs to existing bridgework or dentures

- adjustments to bridgework or dentures after the 3-month post-insertion care period

- treatment involving the use of gold when such treatment cannot be rendered at a lower cost by means of a reasonable substitute consistent with generally accepted dental practice

- 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.

Exclusions

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid for the following:

- cosmetic treatment, experimental treatment, dietary planning, oral hygiene instructions, plaque control, congenital or developmental malformation

- expense of dentures which have been lost, mislaid or stolen

- charges for dental treatment involving the use of gold which are in excess of the charges that would have been made if a reasonable substitute could have been used

- charges made by a dentist for broken appointments or for completion of claim forms required by Canada Life

- orthodontic treatment

- services or supplies rendered for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction

- covered expenses for treatment of accidental injury to natural teeth completed more than 12 months after the accident

Visioncare

Visioncare Benefits cover services and supplies rendered or prescribed by an ophthalmologist or an optometrist. Visioncare Benefits cover only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred.

Covered Expenses

The Plan pays 100% of the following covered expenses:

- Visual training or remedial therapy to correct faulty visual skills **but only for residents of a province in which the Medical Care Insurance Plan does not cover these services in whole or in part**.

- Eye examinations (including refractions) **but only for residents of a province in which the Medical Care Insurance Plan does not cover these services in whole or in part**. Benefits for these expenses are limited to 1 exam in any 24-month period.

- Eyeglass frames and lenses, prescribed safety glasses, contact lenses (selected in place of lenses and frames) when required for an initial lens prescription or a change in a lens prescription, or laser eye surgery. For laser eye surgery, the participant can claim up to the maximum benefit every 24 months until the entire cost of surgery has been reimbursed provided you remain eligible under this Plan.

- Contact lenses which are prescribed because the regular surface of the lens of the eye (the cornea) is impaired in some way and visual acuity cannot be improved to at least the 20/40 level in the better eye with ordinary eyeglasses.

Services Not Paid for by Visioncare Benefits

In addition to the limitations outlined in the **General Limitations** section at the back of this booklet, no benefits are paid for the following:

- eye tests or examinations required by an employer, school or government for screening purposes

- artificial eyes or sunglasses

Extended Healthcare

Your Extended Healthcare Benefits are designed to assist you with the payment of your large medical bills. This Insurance covers only those expenses which are considered reasonable and customary for the service provided, in the area where the expenses are incurred.

Covered Expenses

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

A. HOSPITAL EXPENSES (above those paid by your Provincial hospital plan):

1. 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.

2. Other hospital services and supplies

3. Semi-Private Hospital Room and Board accommodation.

B. MEDICAL EXPENSES:

1. Physician's services for treatment provided outside the province in which you reside.

2. Ambulance (including licensed air ambulance subject to a maximum equal to economy airfare for the insured).

3. Diagnostic laboratory, x-ray and radiotherapy services not covered by a Provincial Plan to a maximum of $500 per individual per calendar year.

4. Oxygen.

5. Blood and Blood Products.

6. Services of a registered nurse, licensed practical nurse or registered nursing assistant. Maximum $5,000 per calendar year. (Supporting medical evidence will be required.)

7. Services of a Physiotherapist. Maximum $500 per individual per calendar year and subject to Reasonable and Customary limits per visit/duration of visit. No amount will be paid for any visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.

8. Services of a licensed Chiropractor, Osteopath, Chiropodist, Podiatrist, or Massage Therapist. Maximum $500 per individual per calendar year per specialty and subject to Reasonable and Customary limits per visit/duration of visit. No amount will be paid for any visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.

9. Services of a licensed Speech Therapist. Maximum $500 per individual per calendar year and subject to Reasonable and Customary limits per visit/duration of visit. No amount will be paid for any visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.

10. Services of a licensed Clinical Psychologist. Maximum $500 per individual per calendar year and subject to Reasonable and Customary limits per visit/duration of visit. No amount will be paid for any visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.

11. Charges for orthopedic shoes and orthotics prescribed by a licensed physician, podiatrist or chiropodist which have been specially designed and molded by an orthotist, pedorthist, podiatrist, or chiropodist for the insured individual and are required to correct a diagnosed (by a physician, podiatrist or chiropodist) physical impairment. Note that coverage is limited to reasonable and customary limits and are on a reimbursement basis – assignment of benefits to the provider is not allowed. Maximum of $200 per shoe or $400 per individual per calendar year.

12. Hearing Aids (excludes batteries and routine maintenance). Maximum $1,000 every 60 months.

13. Rental of, or if medically necessary, purchase and repairs of the following items when prescribed for a specific medical condition. (Additional information may be required.):

    - aerosol equipment, mist tents, and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma;
    - apnea monitors for respiratory irregularities;
    - artificial eyes including repair and replacement;
    - artificial limbs including repair and replacement, but excluding myoelectrical limbs;
    - artificial kidney machine and supplies, to a maximum of 1 machine per life-time;
    - bed rail;
    - braces with rigid supports, excluding lumbar supports;
    - canes, crutches, and walkers;
    - casts;
    - catheters;
    - cervical collar;
    - colostomy apparatus and supplies;
    - diabetic supplies, excluding alcohol and alcohol swabs;
    - glucometer, to a maximum of $400 per lifetime;
    - head halter;
    - ileostomy apparatus and supplies;
    - intermittent positive pressure breathing machine;
    - iron lung;
    - medical supplies required for the treatment of burns;
    - medical supplies required for the treatment of varicose veins, to a maximum of $200 per calendar year;
    - pacemaker;
    - prostheses and supplies required as a result of mastectomy, to a maximum of $200 per calendar year;
    - shoulder harness;
    - splints, excluding dental splints;
    - standard wheelchair, excluding electric wheelchair;
    - stump socks;
    - traction apparatus;
    - cranial prosthesis (wig and hairpiece) if medically necessary to a maximum of $250.

Expenses Not Covered

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

2. Injury or illness due to war or of engaging in a riot or insurrection.

3. Hearing tests.

4. Pregnancy tests.

5. Routine medical examinations.

6. Delivery and transportation charges.

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

8. Illness or injury for which you are covered under Worker's Compensation or similar program.

9. Treatment in a government hospital.

10. Services to which the patient is entitled without charges, or for which there would be no charge if there were no insurance.

11. Services or portion thereof provided under any government sponsored hospital or medical-care program.

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

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 9428666

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.

Healthcare Spending Account

Purpose

To assist Union Members and their families in offsetting Healthcare and Dentalcare expenses incurred above and beyond the coverage presently provided by the I.B.E.W. Local Union 529 Health & Welfare Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums). Allocations are intended to be made every 24 months, subject to the discretion of the Trustees considering the financial stability of the Plan, etc.

Claims Submission

For claims submitted via paper claim, any remaining Health, Vision, or Dental benefit expenses not covered by the basic Plan will automatically be applied to the extent of your H.S.A., if any, unless you indicate otherwise on the applicable claim form.

For online submissions via the Claims Member Portal or Coughlin Mobile App, you must select (i.e. toggle) to apply to your H.S.A.

For claims submitted electronically (eClaim) from a Provider's office (i.e. no claim form submitted) on behalf of you or your eligible dependents, the H.S.A. will not be applied automatically unless you contact Coughlin prior to claims submission at the Provider's office to request any remaining balance to be applied to your H.S.A. balance.

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 to Coughlin along with a summary statement from your spouse's Insurer, to be applied to your H.S.A.

Obtaining H.S.A. Balance

You can obtain your remaining H.S.A. balance by the following 3 options:

1) By contacting the Plan Administrator
2) Online through the claims Member Portal at www.coughlin.onlineclaimsaccess.net

3) Coughlin Mobile App obtained from the Google Play or the Apple App store

Please note that Members cannot utilize their account for cash withdrawals or pay a provider directly (i.e. the account balance must be used to reimburse Vision, Health or Dental related expenses). Furthermore, Members must remain in good standing with the Local Union to be eligible for the balance in their H.S.A.. Upon termination as a Union Member, any remaining balance in your account will be forfeited back to the Plan and not reallocated.

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 529.

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 529, 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 529 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.

Coordination of Health Benefits

If you and your dependants are insured for similar benefits under another Plan (e.g. Group Life and Health Program, or other arrangements covering individuals in a group), will be taken 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 the "Secondary Carrier" (i.e. responsible for making the payment to cover the remaining eligible expense).

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

If your Spouse's Plan does provide 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 Spouse:**

  The Plan insuring you or your Spouse and 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 Dependent 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 birthdates, the Plan covering the parent whose first name begins with the earliest 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 Dependent 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 Dependent Child).

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

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.

- 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 all necessary claim forms to the Secondary Carrier for further consideration of payment, if applicable.

General Limitations

Your Health Benefit does not cover services and supplies in the following situations:

- services or portion thereof provided under Workers' Compensation or similar program
- services received in a government hospital
- services to which the patient is entitled without charge, or for which there would be no charge if there were no insurance
- services or portion thereof provided under any government sponsored hospital or medical care program
- aesthetic surgery (cosmetic surgery for beautification purposes)
- services furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits
- services received from a dental or medical department maintained by the employer, a mutual benefit association, trustee or similar type of group
- service, including part-time or temporary service, in the armed forces of any country
- services required due to war (declared or undeclared), insurrection, or participation in a riot
- services required due to any intentional self-inflicted injury or disease, while sane or insane

Continuation of Health Benefits for Dependents

If you die, the Health benefits (Prescription Drugcare, Dentalcare, Visioncare, Travel Medical Emergency, and Extended Healthcare) for your dependents will be continued for a period of 2 years.

- If your surviving children cease to qualify as eligible dependents (as defined earlier in this booklet), the Health benefits being continued after your death will terminate on the date they no longer qualify.

- If a dependent is disabled on the date insurance under the continuation terminates, his/her insurance payments will be continued until the earliest of the following:

  - the date the disability ends,

  - the date your dependent has received maximum benefits,

  - 90 days from the date the insurance terminated.

  Please Note: If your dependent is in the hospital on the last day of this 90-day period, insurance payments for that dependent will be continued until the hospital confinement ends or until maximum benefits have been paid.

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.

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

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.

Travel Medical Emergency *(refer to TME Section for more detail)*
If you are not able to contact GEM 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

Member Portal – Electronic Claims

Coughlin & Associates Ltd. offers plan members the option to submit claims for prescription drugs, health and dental online. To access this service, please register at Coughlin's plan member portal at https://coughlin.onlineclaimsaccess.net/ or download the mobile app from the App Store or Google Play. Once you are on the portal or have accessed the app:

- Follow the on-screen instructions and provide your group and certificate numbers, both of which can be found on your all-in-one benefits card.

Once registered, click *Submit a Claim* to get started with online claiming.

Point of Sale Claims Submission

For Drug, Dental, and select Health claims you may use your all-in-one Benefits Card for direct bill payment (POS). Your claims can be submitted through a Point-Of-Service (POS) claims system provided by an approved list of healthcare providers. The following information (found on your all-in-one Benefits Card) must be provided to the provider:

Dental:

1) Bin # 000034 on Telus Adjudicare network
2) Group Number # 58286
3) Individual certificate number (printed on your card)

Health :

1) Bin #34 on Telus Adjudicare network
2) Group Number # 58286
3) Individual certificate number (printed on your card)

Dentalcare and Health claims must be made within eighteen (18) months from the date of service.

Pre-Authorized Deposit (PAD)

Pre-authorized Deposit is the fastest way for plan members to receive claim reimbursements. Claim reimbursement deposits can be made into your bank account within two to five business days following the approval of

your claim and eliminate both the wait for cheques to arrive by mail and the trip to the bank.

To enroll in the PAD program:

- Login to Coughlin's plan member portal
- Click on your profile icon  and select *Direct Deposit*

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

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.

For Life, Dependent Life, Short Term Disability and Long Term Disability, this Plan is underwritten by

www.canadalife.com

and arranged and administered by:

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