INSULATORS
LOCAL UNION 119

HEALTH AND WELFARE
TRUST FUND

January 2025

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To All Participants
Insulators Local Union 119
Health and Welfare Trust Fund

We are pleased to present this updated booklet describing the current benefits and provisions of the Health and Welfare Plan. We urge each Participant to read the booklet carefully to thoroughly familiarize themselves with the benefits that are available to them and their dependents.

The Healthcare, Visioncare, and Dentalcare Expense Benefits are designed to assist each Participant with the payment of these expenses. They may not pay the total cost of services and supplies. In effect, this Group Insurance Plan shares the payment of the Participant's medical and dental expenses. The Accidental Death & Dismemberment (Policy # GPA 9429829) is underwritten via AIG Insurance Company, the Critical Illness (Policy # CI 9429630) via AIG Insurance Company, the Travel Medical Emergency coverage (Policy # CMG 9428800) via AIG Insurance Company, the Life Insurance, Dependent Life, and Long Term Disability (Policy # 150601) via Canada Life, Weekly Income, Healthcare, Visioncare, and Dentalcare are self-insured by the Trust Fund, while the pay direct prescription drug card is coordinated with Telus eClaims.

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

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 either the Local Union 119 office or the Plan Administrator (Toll Free 1-888-204-1234) for this information.

We are pleased to make these arrangements on behalf of each Participant, and we are certain that the Plan will bring greater security and peace of mind to each Participant and their family.

Sincerely,

The Board of Trustees
Insulators Local Union 119
Health and Welfare Trust Fund

Notice Regarding Personal Information

When applying for coverage under the group benefit Plan, the Insurance Companies, and the Plan Administrator, and Coughlin & Associates Ltd. set up a file with personal information relevant to your insurance coverage under the Plan.

The purpose of this file is to permit the employees of those companies to administer all financial services provided to you and to keep information specific to their 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 and financial security

The files are kept in their offices to have access to these files when required for insurance purposes.

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

Privacy

Effective January 1, 2004, the federal Personal Information Protection and Electronic Documents 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.

Coughlin & Associates Ltd. is committed to respecting your right to privacy and safeguarding your personal information. For more information regarding Coughlin's Privacy Policy, please contact Coughlin & Associates Ltd. directly or via the website www.coughlin.ca.

Highlight of Benefits

Administration Contact: 119admin@coughlin.ca
Claims Contact: winnclaims@coughlin.ca
Disability Contact: wdisabilityclaims@coughlin.ca

PARTICIPANTS

Life Insurance

Principal Sum $70,000
reduces by 50% at age 65
Coverage Ceases ..... Earlier of age 71 or depletion of Hour Bank and/or self-pay period

Please refer to the Life Insurance section for greater detail.

Accidental Death & Dismemberment Insurance

Principal Sum $100,000
Reduces by 50% at age 65
Coverage Ceases ..... Earlier of age 71 or depletion of Hour Bank and/or self-pay period

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

Dependent Life

Spouse $10,000
Child $5,000
Coverage Ceases ..... Earlier of age 71 or depletion of Hour Bank and/or self-pay period

Please refer to the Dependent Life section for greater detail.

Critical Illness

Members are eligible to a $5,000 flat benefit for any of 26 insured conditions. The Critical Illness benefit ceases at age 65. Please refer to the Critical Illness booklet on the Member Portal prepared by AIG, or contact the Administrator for more information.

Weekly Income (Short Term Disability)

Benefit..... 67% of weekly earnings
to a maximum of Employment Insurance (EI) equivalent

Commencement.....1st day of accident/8th day sickness/
1st day hospitalized
Maximum Duration..... .....27 weeks
(subject to EI wrap around)

You must apply for E.I. sickness benefits

This W.I. benefit is non-taxable.

Coverage Ceases .....Earlier of age 71 or depletion of Hour Bank

Please refer to the Weekly Income section for greater detail.

Long Term Disability (LTD)

Benefit (Monthly) $1,900
Commencement..... Following 27 weeks
Maximum Duration.....To Age 65

This L.T.D. benefit is subject to direct offsets (i.e. W.C.B. and C.P.P.).

This L.T.D. benefit is non-taxable.

Coverage Ceases ..... Earlier of age 65 or depletion of
Hour Bank account and/or self-pay period

Please refer to the Long Term Disability section for greater detail.

PARTICIPANTS AND DEPENDENTS

Healthcare

Deductible.....Nil
Reimbursement.....100% of eligible expenses
..... (subject to Reasonable and Customary limits)
Plan Maximums
Convalescent Hospital.....$10 per day for each of the

first 120 days of confinement
Nursing $10,000/person/lifetime
Hospital Room.....Semi-Private
Physiotherapy.....$600/person/calendar year
Smoking Cessation Products..... …..$500/person/lifetime
Hearing Aids (prescribed by a Physician)..... $1,000/person/5 years
(self-insured via Health & Welfare Plan)
Paramedical Services
(Chiropractor/Osteopath/Naturopath/Chiropodist/Podiatrist/Acupuncturist/ Speech Therapist/ Psychologist, Massage Therapist)
.....$500/person/specialist/calendar year

Prescription Drugs .....$2,500/family/calendar year via TELUS
.....$15 dispensing fee maximum
.....mandatory generic drug substitution unless a medical necessity is indicated by a physician
(applicable documents must be submitted to the Administrator for review)

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.

Prescribed Safety Glasses (Self-Insured) .....For Members only up to $200/24 months

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

Visioncare

Reimbursement.....100% of eligible expenses
Lenses, Frames, and Laser Eye Surgery*
..... $400 / 24 months
(every 12 months for dependent children under age 18)
**Laser Eye Surgery – total charge may be reimbursed over time as long as Member remains in good standing with Local Union 119.*

Eye Examinations.....$80 / 24 months
(every 12 months for dependent children under age 18)

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

Dentalcare

Deductible..... Nil
Reimbursement..... 90% for Routine Treatment & Dentures
75% for Major Treatment

Fee Schedule..... Current SDA
Annual Maximum..... $2,200 per individual
Checkups and cleanings are covered once per person per calendar year.
Coverage Ceases ..... Earlier of age 75 or depletion of Hour Bank account and/or self-pay period

Please refer to the respective section for greater detail.

Travel Medical Emergency

Policy Number ..... CMG 9428800

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.

Coughlin – CarePath (TAL)

Eligibility.....Insured Participants and Families

- **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)

Healthcare Spending Account (HSA)

Reimbursement.....100% of eligible expenses limited to HSA account balance

Eligibility .....Local Union 119 Insured Members only

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

GENERAL INFORMATION

Eligible Participants

Under this Plan, the following Participants are eligible for coverage, provided they are considered a resident of Canada and are covered under a provincial health insurance program.

Union Member

A Member in good standing with Local Union 119 on whose behalf contributions are made to the Insulators Local Union 119 Health and Welfare Trust Fund.

Permit Worker

Employees of Certified Employers on whose behalf contributions are made to the Insulators Local Union 119 Health and Welfare Trust Fund but are not Members of Local Union 119 or any reciprocating Local, will be eligible for benefits under this Plan while working for a Certified Employer.

Office Staff

Office Staff of Certified Employers on whose behalf contributions are made to the Insulators Local Union 119 Health and Welfare Trust Fund but are not Members of the Local Union 119 or any reciprocating Local, will be eligible for benefits under this Plan while working for a Certified Employer.

Retired Members

A Union Member is considered retired when he/she has attained age 55 or older and has either withdrawn his/her funds from the Pension Trust Fund, or has indicated in writing to Local Union 119 of his/her retirement from the trade. When a Union Member has retired, benefit coverage (excluding Disability coverage) will continue until the earlier of the benefit age restriction or depletion of the Member's Hour Bank Account and/or self-pay period provided the Member remains in good standing with Local Union 119.

Eligibility

An account is kept by the Plan Administrator for each eligible Participant which identifies hours worked for a Certified Employer for which contributions have been made for the purpose of Group Insurance. Please note that for Office Staff, the hours worked will equate to the monthly deduction (see below) as there can be no accumulation of hours worked. This account is called an Hour Bank Account.

Each month, 135 hours will be deducted (monthly deduction) from each Participant's Hour Bank Account. A Union Member or Permit Worker may accumulate up to 1,620 hours (enough to provide 12 months of coverage even though they may not work any hours during that period). Hours accumulated over this amount will be credited to the general reserves of the Fund. Furthermore, although a Permit Worker can accumulate hours worked in excess of the monthly deduction, upon the date of cessation of employment or lay-off, the balance in the Hour Bank Account is forfeited to the general reserves of the Fund unless the Permit Worker becomes a Member in good standing with Local Union 119.

A Participant will be eligible for Life Insurance, Accidental Death and Dismemberment Insurance, Critical Illness, and Long Term Disability **on the first day following the date the Participant accumulates 405 hours worked (for Office Staff this equates to three consecutive months of employment) within 6 consecutive months.** Subsequently, eligibility for Weekly Income, Healthcare, Visioncare, Travel Medical Emergency coverage, and Dentalcare benefits will commence **on the first day of the month following the month in which the Plan Administrator has received 405 hours worked within 6 consecutive months. An enrolment card must also be completed to be eligible to receive benefits.**

If a Participant is unable to work when coverage is to become effective, the effective date of coverage will be postponed until the Participant is able to work.

Should you not be working or not be available for work on the first day your coverage would ordinarily become reinstated, the coverage for you and your dependents will be delayed until you return to work or are available for work.

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

If a retired Member returns to work and meets the eligibility requirements, the Retired Member would be eligible for all benefit coverage subject to the benefit age restrictions.

Disability Provision

Disabled Union Member

Disabled Members – Members receiving disability benefits (Workers' Compensation, Autopac, WI, etc.) for at least two weeks in any calendar month will be covered by the Plan for that month but no deduction will be made from his Hour Bank. Coverage on this basis is available for a maximum period of 2 years. Afterwards, Disabled Members may deplete their Hour Bank Account (disabled deduction equivalent to self-pay) and self-pay for 12 months provided approved waiver of premium. Additional 12 months self-pay subject to Trustee approval.

Disabled Permit Workers

A Disabled Permit Workers can extend coverage for twelve (12) consecutive months by either depleting his or her Hour Bank Account accumulation or by submitting the required monthly premium remittance to the Trust Fund.

Disabled Office Staff.

Disabled Office Staff can extend coverage for up to twelve (12) consecutive months, provided the required monthly premium remittance is submitted to the Trust Fund.

Please notify your Plan Administrator when disabled.

Reinstatement of Insurance

If a Union Member's benefit coverage has previously been terminated because of insufficient hours in his/her Hour Bank Account, the Union

Member will again become insured on the first day of the month following the accumulation of 135 hours in his/her Hour Bank Account provided these hours are worked within six (6) consecutive months. Otherwise, the Participant will be required to again meet the eligibility requirements of a new Participant in the Plan.

Note: If a Union Member is not eligible or cannot reinstate within a six (6) consecutive month period, any hours in the Hour Bank Account will be forfeited.

Eligible Dependents

The Participant's eligible dependents consist of:

- A spouse or child who is domiciled (permanent residence) in Canada. However, if a dependent is domiciled outside Canada, such dependent 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.

- The Participant's legal spouse, or common-law spouse (including same-sex partner) who is living in a conjugal relationship 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.

- The Participant's unmarried children from 15 days to 20 years of age inclusive. As well, dependents aged 21 to 25 provided they are in full-time attendance at a University or similar institution (evidence of attendance will be required).

- Stepchildren, foster children and legally adopted children may be included the same as the Participant's own children provided they depend upon the Participant for support and maintenance.

- A child who is physically or mentally incapable of self-support beyond the limiting age may have coverage continued under the health/vision/dental insurance while remaining incapacitated and unmarried subject to the Participant's own coverage continuing in

effect. To continue coverage for a child under this provision, proof of incapacity must be received by the Insurer within thirty-one (31) days after dependent coverage would otherwise terminate. Additional proof will be required from time to time.

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

Termination of Insurance

The insurance for the Participant and the Participant's dependents will terminate:

- for a Union Member, at the end of any month when they do not have at least 135 Hours in their Hour Bank Account. However, a Union Member may self-pay to have his/her insurance continued as identified in the Self-Pay Provision section.

- for Permit Workers and Office Staff, at the end of the month following the date of cessation of employment or lay-off (except for Disability benefits which will cease immediately). Permit Workers and Office Staff are not eligible to make self-payments;

- for a retired Union Member, on depletion of his/her accumulated Hour Bank Account unless he/she opts to extend coverage (excluding disability coverage) via self-paying. Please refer to the Self-Pay Provision section for further information.

- for specific benefits, if the Participant reaches that benefit's age restriction;

- if the Participant enters military service;

- if the Group Policy terminates;

- under Health/Vision/Dental coverage, for a dependent if he/she is no longer an eligible dependent.

Self-Pay Provision

For Union Members/Retired Members only, if there are insufficient hours in your Hour Bank Account to make the monthly deduction for benefit coverage, you will be allowed to continue your coverage by making a self-payment (direct contribution) to the Fund. Such self-payment contributions must be continuous and consecutive for a period not to exceed twelve (12) consecutive months. The payment must be made prior to the 22nd of the month following the month in which the Hour Bank Account falls below 135 hours. Following the twelve (12) month self-pay period, Retired Members can self-pay for a further ten (10) years to maintain Healthcare, Visioncare, Dentalcare, and Travel Medical Emergency coverage up to age 71, provided the Member is in good standing with Local 119 for a minimum of ten (10) consecutive years. If the Member does not remit a self-payment by the required date, the Member's insurance will be terminated without further notification as identified in the **Termination of Insurance** section of this booklet. **Eligibility to self-pay is contingent upon the Member being in good standing with Local Union 119.**

Note:

1) **Weekly Income is excluded for self-paying Union Members.**

2) **Weekly Income and Long Term Disability coverage is excluded for self-paying Retired Members.**

3) For all non-working Union Members who are not disabled, Life Insurance coverage will be extended following twelve (12) consecutive monthly self-payments, up to age 71, provided the Union Member remits the required monthly premium remittance and subject to Union Membership being maintained.

4) Self-payments cannot be made by Permit Workers or Office Staff.

5) The self-pay provision is only available up to age 71.

If you have any questions on self-payment procedures, please call the Plan Administrator Toll Free at 1-888-204-1234.

In order to reinstate the Self-Paying duration to 12 months, an Insured Union Member must return to employment with a Certified Employer and satisfy the reinstatement requirements.

Survivor Benefit Provision

Healthcare, Travel Medical Emergency, Visioncare, and Dentalcare coverage for eligible dependents shall continue without premium payment, following the death of the Participant up to a maximum of twenty-four (24) months from the date of death.

Monthly Statements

Each month, a statement is mailed to each participant (excluding Office Staff). This statement will show the Participant's benefit status, the Employer's or self-payment contribution, the previous Hour Bank Account balance and the present Hour Bank Account balance. It should be noted that an amount is deducted from the Participant's Hour Bank Account balance each month to pay the premium for the Participant's coverage equivalent to 135 hours.

For a Union/Retired Member: if there are insufficient hours in the Union/Retired Member's account, the statement will show the amount required for the Union/Retired Member to pay on a "self-pay basis". If the required amount is not paid, the next statement will show the Union/Retired Member as being "out of benefit" with a final option to self-pay. For Permit Workers, if there is no remittance contribution on their behalf, the statement will show "out of benefit". A Participant's coverage will not again become effective until the Participant has satisfied the Reinstatement requirements.

IN ORDER TO ENSURE EACH PARTICIPANT RECEIVES THIS STATEMENT REGULARLY IT IS NECESSARY FOR EACH PARTICIPANT TO INFORM THE PLAN ADMINISTRATOR OF ANY CHANGE OF ADDRESS.

Wage Loss Provision

In the event that a Union Member incurs a total disability while insured but on lay-off or leave of absence and is "running down" his/her Hour Bank Account, the plan will recognize the Union Member's disability for

wage loss benefits (Weekly Income and LTD) from the scheduled date of return to work, provided the Union Member is then totally disabled and submits an attending physician's statement certifying continued disability.

Disability Claims

All disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurer (Canada Life) regardless of whether or not, the Participant is eligible to receive Workers Compensation, Auto Insurance Benefits or Employment Insurance Disability Benefits. This recording will assist the Participant should their 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 which must be made within twelve (12) months of the date of initial disability to be accepted by the Insurer.

Third Party Liability

If a Participant or dependent has the right to recover damages from any person or organization with respect to which benefits are payable by the Insurer, the Participant will be required to reimburse the Insurer for the amount of any benefits paid out of the damages recovered.

If a Participant or dependent receives a lump-sum payment under judgment 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 was otherwise payable by the Insurer.

A Participant or dependent must notify the Administrator of any action commenced against a third party and of any judgment or settlement in the circumstances described above.

Reciprocal Agreements

Local Union 119 Members – Union Members working in a jurisdiction other than Local Union 119 and on whose behalf contributions are being

made to a Health and Welfare Trust Fund which has entered into a reciprocal agreement with Insulators Local Union 119 Health and Welfare Trust Fund should complete a Transfer Authority form and advise the Local Union or Administrator to reciprocate contributions to the "Home Fund". This will maintain continued coverage under the Insulators Local Union 119 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 or Funds and whose funds have entered into reciprocal agreements with the Insulators Local Union 119 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 Local Union 119 office.

Changes in Insurance Benefits

If the Participant's insurance benefits change because of an amendment to the Plan, or because of a change in the Participant's age, class, earnings, dependent status, etc., the new benefits become effective on the date the change affecting the Participant's benefits occurred.

When a change results in increased benefits, the Participant must be actively at work for an eligible employer to be eligible for the new benefits. If the Participant is not at work for an eligible employer on the date the new benefits would otherwise become effective, the change will not become effective until the Participant returns to work for an eligible employer. Increased benefits for a dependent confined in hospital on the dates the new benefits would otherwise become effective do not become effective until he or she is released from the 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.

Co-Ordination of Benefits

If you or your dependents are insured for similar benefits under another Plan (i.e. Group Life and Health Program, or other arrangements covering individuals in a group), the Insurer will take this into account when determining the amount of medical and dental 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 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 as an Employee/Member pays benefits before the Plan insuring you or your Spouse as a dependent.

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

        - The Plan wherein the person is covered as an active full-time Employee, then
        - The Plan wherein the person is covered as an active part-time Employee, then
        - The Plan wherein 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 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 pays, 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 for 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.

Life Insurance

The amount of the Participant's Life Insurance benefit will be paid to the Participant's designated beneficiary upon his/her death, regardless of the cause.

Please ensure upon enrolment in the plan that a beneficiary is named to whom your Life Insurance proceeds will be paid. If a beneficiary is not named, the Participant's estate will be the beneficiary. Subject to provincial laws, the beneficiary can be changed at any time. Contact the Plan Administrator to obtain the appropriate form to make such a change.

Amount of Benefit

Each Participant of the plan is entitled to an amount of Basic Life Insurance equal to ***the Principal Sum outlined in the Highlight of Benefits section which reduces by 50% at age 65***.

Coverage Ceases

For Union/Retired Members, Life Insurance coverage terminates at the earlier of age 71, following depletion of the Union Member's Hour Bank Account and/or self-pay period or cessation of Union membership. For Office Staff or Permit Workers, coverage terminates upon the earlier of the date of cessation of employment, lay-off or age 71.

Waiver of Premium for Disability

If the Participant becomes totally disabled before age 65, Life Insurance may be continued without payment of premiums, during disability up to age 65. After the Participant has been totally disabled for at least six (6) months, they must submit the appropriate claim forms. **These claim forms must be received by the Plan Administrator and subsequently Canada Life within twelve (12) months of the date of disability**. The Participant's premiums will be waived following six (6) continuous months of total disability. Proof of a continuing disability may be required from time to time.

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.

Premiums will not be waived if, within 12 months of joining the plan, the Participant becomes totally disabled due to a disease or injury for which the Participant obtained medical care prior to joining the plan. This restriction will not apply if after becoming insured the Participant has completed three (3) months of employment without medical care for the disease or injury. Medical care is considered to be obtained if you consult a doctor, use medication on advice of a doctor or receive other medical supplies or services.

Conversion Privilege

If the Participant's Life Insurance terminates on or prior to his 65th birthday, the Participant may be entitled to convert, without evidence of insurability, up to the full amount of his group life Insurance to an individual policy of life insurance. Any interested Members should contact Coughlin & Associates for further information.

If the Participant should die within the 31-day period after termination of insurance, an amount equal to the Group Life Insurance benefit will be paid to the Participant's beneficiary, whether or not the Participant has applied for conversion to an individual life insurance policy.

Dependent Life Insurance

Amount of Benefit

If one of the Participant's dependents dies, Canada Life will pay the applicable benefit (spouse/child) as outlined in the **Highlight of Benefits** section to the Participant.

Coverage Ceases

For Union/Retired Members, Dependent Life Insurance coverage terminates at the earlier of age 71, following depletion of the Union Member's Hour Bank Account and/or self-pay period or cessation of Union membership. For Office Staff or Permit Workers, coverage terminates upon the earlier of the date of cessation of employment, lay-off or age 71.

Waiver of Premium for Disability

If the Participant becomes totally disabled before age 65, the Dependent Life Insurance may be continued without payment of premiums as with Life Insurance.

Conversion Privilege

If the Participant's spouse's insurance terminates on or prior to their 65th birthday the spouse may be eligible to apply for an individual conversion policy without providing proof of insurability. The Participant's spouse must apply and pay the first premium no later than thirty-one (31) days after the Participant's Group Insurance terminates. Any interested Members should contact Coughlin & Associates for further information.

Critical Illness

(Underwritten by AIG – Policy # CI 9429630)

Eligibility

You will be eligible for coverage if you are a "in benefit" Member of the Policyholder, under age 65. 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 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 $5,000

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

(Underwritten by AIG – Policy # GPA 9429829)

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 section if you are under age 65 and 50% of the Principal Sum if you are between ages 65-70. 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

For Union/Retired Members, Accidental Death & Dismemberment coverage terminates at the earlier of age 71, following depletion of the Union Member's Hour Bank Account and/or self-pay period or cessation of Union membership. For Office Staff or Permit Workers, coverage terminates upon the earlier of the date of cessation of employment, lay-off 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 One Hand	40%
Loss of All Toes of One Foot	25%

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

In the event a Participant becomes totally disabled due to an injury or illness the Participant will receive a disability benefit provided the Participant is under the continual treatment of a qualified and licensed physician.

All Disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) regardless of whether or not the Participant is eligible to receive Workers' Compensation, Auto Insurance or Employment Insurance Disability Benefits. This recording will assist the Participant should a claim with these agencies be declined either immediately or at a future date. The Insurer will not be liable for a Long Term Disability claim for which initial notice is submitted twelve (12) months after the date the disabled Participant was last actively at work. In addition, proper application must be made relative to a waiver of Life Insurance Premiums which is required within twelve (12) months of the date of initial disability.

Benefits for any one disability are payable from the first (1st) day of disability for injury and the eighth (8th) continuous day of disability for illness, **but in no event prior to the first day of visit to the Participant's physician.** The Participant's benefits will be payable for not more than twenty-seven (27) 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 the Participant to apply for E.I. Disability benefits immediately.

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

Note: Any W.I. benefits collected from this Plan are non-taxable.

"Totally Disabled" shall mean the Participant is incapacitated to the extent that the Participant is not able to perform all of the usual and customary

duties of his/her occupation. A Participant is not considered totally disabled unless he/she is under the active and continuous care of a physician and is following the treatment prescribed by the physician for that disability.

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

Amount of Benefit

A Participant of the plan is eligible for an amount of weekly disability income as outlined in the **Highlight of Benefits** section**,** but in no event higher than 67% of the Participant's basic weekly earnings.

If the Participant is receiving other forms of retirement income or disability income, the weekly benefit under this plan will be reduced so that the disability income which the Participant receives from all sources does not exceed 100% of his/her regular weekly earnings at the time the Participant became disabled. Benefits payable under any individual disability income policy or rider attached to an individual life insurance policy will not be included as disability income.

Coverage Ceases

For Union Members, coverage terminates at the earlier of the end of any month when one does not have the required monthly hour deduction in their Hour Bank Account, upon his/her retirement, or age 71. For Office Staff and Permit Workers, coverage terminates on the date of cessation of employment or lay-off.

Benefits are not payable for:

- injury sustained while working for pay or profit other than with an Employer who is signatory to the Collective Agreement or alternatively a Project Agreement;

- disability resulting from an intentionally self-inflicted injury;

- disability resulting from voluntary participation in a war, riot, insurrection or criminal offense;

- the portion of a period of disability during which a Participant is receiving Workers' Compensation or Auto Insurance benefits, unless proof is submitted to the Insurer that the Participant has been disqualified for such benefits;

- for the portion of a period of disability during which the Participant is unable to earn income due to:

  a) imprisonment in a penal institution; or

  b) confinement in a hospital, or similar institution as a result of criminal proceedings;

- during any leave of absence (including maternity/parental leave).

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

If the Participant becomes totally disabled before reaching age 65 and is unable to work, the Participant is eligible for a monthly disability benefit. Although it is not necessary for the Participant to be confined to his/her house during the entire period of his/her disability, the Participant must be under the care of a physician.

Description of Benefit

A Participant will begin receiving disability payments after he or she has been continuously and totally disabled for a qualifying period of 26 weeks and the Participant's salary continuance plan (i.e. Weekly Income) has expired. Payments are made at the end of each month and continue as long as the Participant is totally disabled, even if the Group Policy terminates, but not beyond the date that the Participant reaches 65 years of age or returns to work. During any period of disability payments, premiums will not be required.

Disability is considered "Total" when it prevents the Participant from performing 60% of his or her regular duties during the qualifying period and the first two (2) years that the Participant is entitled to disability payments. If the Participant is still disabled at the end of this time, disability is considered "Total" when it prevents the Participant from performing any work wherein the requirements are within the range of his/her education, training or experience.

If the Participant recovers and returns 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 one (1) month during the qualifying period or less than six (6) months during the period when disability payments are being made. A recurrence of disability due to an unrelated cause will be considered a new disability if the Participant has worked at least one (1) day between disabilities.

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 take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount. All sources of total monthly income includes:

- 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 take-home pay 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.

Coverage Ceases

For Union Members, Long Term Disability coverage terminates upon attainment of age 65 or retirement, whichever occurs first. For Office

Staff and Permit Workers, coverage terminates on the earlier of age 65 or the date of cessation of employment or lay-off.

Subrogation

If a Participant is entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the Insurer will be subrogated to all rights of recovery of the Participant for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. The Participant shall execute such documents as required by the Insurer.

In the event that the insured Participant provides proof to the Insurer that the said Participant has not recovered full compensation for loss of income, the Insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

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

The term "Compensation" shall include any lump sum or periodic payments which the Participant receives or is entitled to receive on account of past, present or future loss of income.

Waiver of Premium

The Insurer will waive the payment of premiums for the Long Term Disability insurance for each Participant who is receiving benefits under this coverage. Premiums will be waived beginning with the premium for the first full policy month for which benefits became payable and continuing for each full policy month for which benefits are payable.

If Your Long-Term Disability Terminates

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

Conversion Privilege

If the Participant changes jobs, he or she may apply for an individual Long Term Disability Policy without any medical tests. The Participant must apply and pay the first premium no later than thirty-one (31) days after starting his/her new job, and the Participant must start his/her new job no later than six (6) months after leaving his/her present one.

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.

Healthcare

All expenses will be reimbursed at the level shown and may be subject to plan maximums and frequency limits as outlined in the **Highlight of Benefits** section.

The Plan covers reasonable and customary charges for the following services and supplies, provided the Member and eligible dependents are Canadian residents and covered under a provincial health insurance program.

Coverage Ceases

For Union Members, coverage terminates at the earlier of age 75, or depletion of Hour Bank and/or self-pay period. For Office Staff and Permit Workers, coverage terminates on the earlier of the date of cessation of employment, retirement or lay-off.

Covered Expenses

- Doctor's services outside your province of residence.

- Ambulance transportation to the nearest centre where adequate treatment is available.

- Charges, including x-ray charges, up to the Benefit Maximums by a
- practitioner who is registered and legally practicing within the scope of his license including; a chiropractor, naturopath, podiatrist/chiropodist, osteopath, massage therapist, acupuncturist, psychologist (or social worker), physiotherapist or speech therapist, 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.

- Accidental Dental benefit for accidental injury to natural teeth. (Dental Services must be completed within six (6) months from the date of accident).

- Diagnostic x-rays and lab tests; radio-active materials.

- Rental, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a doctor for a specific medical condition. (Additional information may be required.)

- Prescription drugs and medicines including oral contraceptives, anti-obesity drugs, and fertility drugs requiring the written prescription of a Physician, injectable drugs when administered by a Physician, preventative vaccines (excluding Physician fees), and Viagra and other erectile dysfunction drugs.

  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.

- Insulin, insulin syringes, blood letting devices, lancets, and home chemical testing supplies for diabetics.

- Out-of-hospital services of a registered nurse, licensed practical nurse or registered nursing assistant who is not a member of your family, but only if the patient requires the specific skills of a trained nurse, subject to a lifetime maximum of $10,000.

- Oxygen and its administration.

- 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

- Confinement in an Intensive Care Unit.
- Services and supplies received during a hospital confinement.
- Out-patient treatment.
- Room and board in a convalescent hospital provided the confinement is primarily for rehabilitative or convalescent care and follows a minimum 3-day confinement in hospital.
- Smoking cessation products up to a $500 lifetime maximum per person.

Limitations

No benefits are paid for:

- Delivery, transportation and administration charges.
- Services and supplies required for recreation or sports which are not medically necessary for regular daily living activities.
- Chronic or custodial care.
- Vitamins, food products, salt / sugar substitutes, contraceptive preparations and devices.
- Medications use to prevent baldness or promote hair growth.
- Any single purchase of drugs which would not reasonably be used within 90 days.
- Any drug or item which does not have a drug identification number as defined by Canadian legislation, and drugs that are registered under Division 10 of the Regulations of the Food and Drugs Act of Canada.
- Services covered under the Workers' Compensation Act or other statute.

- Services for which payment is the legal liability of any other party.
- Charges which are considered insured services of any provincial government plan.
- Expenses incurred for anyone who is not insured under the Provincial Medicare Plan.

Visioncare

Benefits are subject to plan maximums and frequency limits as outlined in the **Highlight of Benefits** section.

The plan covers reasonable and customary charges for the following services and supplies, if they are not covered under the Participant's provincial government plan and provincial law allows the Insurer to cover them.

Coverage Ceases

For Union Members, coverage terminates at the earlier of age 75, or depletion of Hour Bank and/or self-pay period. For Office Staff and Permit Workers, coverage terminates on the earlier of the date of cessation of employment, retirement or lay-off.

Covered Expenses

- Eyeglasses, prescription safety glasses, prescription sunglasses, contact lenses, or Laser Eye Surgery*.

* Laser eye surgery (total initial charge may be reimbursed over time, as long as the Participant remains in good standing, and limited to Visioncare maximum every 24 months).

- Eye exams.
- Contact lenses when the cornea is impaired so that visual acuity cannot be improved to at least the 20/40 level in the better eye with eye glasses to a maximum of $200.

Note: An additional $200 is payable for Member only towards prescription safety glasses, every 24 months

Limitations

No benefits are paid for:

- artificial eyes or sunglasses.
- services covered under the Workers' Compensation Act or other statute.
- services for which payment is the legal liability of any other party (including Government Plans).

Coughlin CarePath

Access to Healthcare Navigation and Medical Second Opinion are through Compass Health Care Navigation at 1-866-883-5956 and for 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).

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. Health Care 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

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

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

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 9428800

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.

Dentalcare

All expenses will be reimbursed at the level shown and are subject to Plan maximums and frequency limits as outlined in the **Highlight of Benefits** section.

The Plan covers reasonable and customary charges to the extent they do not exceed the dental fee guide level indicated in the **Highlight of Benefits** section.

Coverage Ceases

For Union Members, coverage terminates at the earlier of age 75, or depletion of Hour Bank and/or self-pay period. For Office Staff and Permit Workers, coverage terminates on the earlier of the date of cessation of employment, retirement or lay-off.

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.

Routine Treatment

- The following preventative services are covered no more than once in any calendar year.
    - oral examinations
    - polishing of teeth
    - bite-wing x-rays
    - fluoride application
    - oral hygiene instruction
- 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, including related diagnostic x-rays, lab procedures, and general anaesthesia.
- Endodontic treatment (root canal therapy).
- Periodontic treatment (treatment of gum disease).
- Space maintainers for missing primary teeth, and habit-breaking appliances.
- Necessary treatment for relief of dental pain and the cost of medication and its administration when provided by injection in the dentist's office.

- Stainless steel crowns.

- Denture relines and rebases to existing dentures.

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

- Replacement of an existing prosthodontic appliance (i.e. removable partial or complete dentures) is covered only when:

  - it is required because of the extraction of one or more natural teeth after the claimant's coverage became effective and the existing appliance cannot be made serviceable.

    Note: If the existing appliance could have been made serviceable, only the expense for that portion of a replacement appliance which replaces the teeth extracted after the claimant's coverage became effective shall be covered.

  - the existing appliance is at least five (5) years old and cannot be made serviceable.

  - a permanent appliance is required to replace a temporary appliance made after the claimant's coverage became effective and was installed, providing installation was within twelve (12) months after the installation of the temporary appliance.

  - the replacement is required as a result of an initial placement of an opposing denture while covered.

  - the replacement is required as the result of an accidental injury while covered.

- Adjustment to an initial or replacement prosthodontic appliance (i.e. removable partial or complete dentures) after the 3-month post-insertion care period.

- Repairs and adjustments to dentures.

Major Treatment

- Crowns and inlays.

- Initial prosthodontic appliances.

- 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.

- Replacement of an existing prosthodontic appliance, (i.e. fixed bridge restoration) is covered only when:

  - it is required because of the extraction of one or more natural teeth after the claimant's coverage became effective and the existing appliance cannot be made serviceable.

    Note: If the existing appliance could have been made serviceable, only the expense for that portion of a replacement appliance which replaces the teeth extracted after the claimant's coverage became effective shall be covered.

  - the existing appliance is at least five (5) years old and cannot be made serviceable.

  - a permanent appliance is required to replace a temporary appliance made after the claimant's coverage became effective and was installed, providing installation was within twelve (12) months after the installation of the temporary appliance.

- the replacement is required as the result of an accidental injury while covered.

- Repairs and recementing of crowns, inlays or existing bridgework.

- Treatment involving gold if there is no substitute available.

Limitations

No benefits are paid for:

- Cosmetic treatment, experimental treatment, dietary planning, plaque control, congenital or developmental malformation.

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

- Services and supplies rendered for facings on crowns or pontics posterior to the second bicuspid.

- Lost or stolen dentures.

- Charges for treatment involving gold in excess of the charges for a reasonable substitute.

- Charges for missed appointments or completion of claim forms.

- Full mouth reconstruction, vertical dimension correction, or correction of temporomandibular joint dysfunction.

- Treatment of accidental injury to natural teeth completed more than 12 months after the accident.

- Orthodontic treatment.

- Services payable under the Workers' Compensation Act or other statute.

- Services for which payment is the legal liability of any other party (including Government Plans).

- Services other than those performed by a dentist or dental hygienist, except those services which may be under the direct supervision of a Dentist as dental practitioner.

- 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

Subject to the financial stability of the Trust Fund, and at the discretion of the Trustees, a Healthcare Spending Account (H.S.A.) may be made from time to time to Members in good standing with Local Union 119. This H.S.A. will assist Union Members and their families up to their entitlement in offsetting Healthcare and Dentalcare expenses incurred above and beyond the coverage presently provided by the Insulators Local Union 119 Health & Welfare Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums).

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 119.

Termination

In the event of termination of Membership from Local Union 119, 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 119 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.

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.

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 # 58786
3) Individual certificate number (printed on your card)

Health :

1) Bin #34 on Telus Adjudicare network
2) Group Number # 58786
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.

The Insulators Local Union 119
Health and Welfare Trust Fund

is Underwritten by:

CANADA LIFE ASSURANCE COMPANY
www.canadalife.com

and

AIG INSURANCE COMPANY

arranged by:

COUGHLIN & ASSOCIATES LTD.