INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 870

HEALTH & WELFARE PLAN

February 2024

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To All Members
International Union of Operating Engineers
Local 870
Health & Welfare Plan

We are pleased to present this revised booklet which describes the current benefits and provisions provided to the eligible Participants of the International Union of Operating Engineers Local 870 Health & 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, Accidental Death & Dismemberment, and Long Term Disability (LTD) coverage continues to be underwritten by The Canada Life Assurance Company. The Travel Medical Emergency is underwritten by AIG Insurance Company. The Employee and Family Assistance Program (EFAP) is underwritten by LifeWorks. The Group Benefit Plan self-insures the Short Term Disability (STD), Dentalcare, Visioncare, Prescription Drugs, and Extended Healthcare benefits.

The plan is administered and claims are paid by Coughlin & Associates Ltd.

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
International Union of Operating Engineers Local 870
Health & Welfare Plan

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:

- Travel Medical Emergency (AIG Insurance Company – Policy # CMG 9428827)
- Employee and Family Assistance Program (LifeWorks – Policy # 319431
- People Connect (People Corporation)
- Life, Dependent Life, Accidental Death & Dismemberment, and Long Term Disability (Canada Life – Policy #172970)
- Short Term Disability, Dental, Visioncare, Extended Health, and Prescription Drugcare – (Self-Insured - Policy #56546)
- Telus Adjudicare - Group # 59100

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 (for actions or proceedings governed by the laws of Alberta, British Columbia, and Saskatchewan). The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions

or proceedings governed by the laws of Quebec, the prescriptive period is set out in the 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 or Trust Fund 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

Administration Contact: 870admin@coughlin.ca
Claims Contact: winnclaims@coughlin.ca

Life Insurance

Benefit – Active Members $50,000
Retired Members* $20,000
Coverage terminates ..... no later than age 100

Please refer to the ***Termination of Insurance*** **and** ***Self-Pay Provision*** section for greater details.

** Members who have elected retirement after December 1, 2018 excluding the one-time grandfathering for Members retired December 1, 2013 to December 1, 2018*

Dependent Life Insurance

Benefit..... $5,000 Spouse
..... $2,500 each Child
Coverage terminates ..... no later than age 100

Please refer to ***Termination of Insurance*** and ***Self-Pay Provision*** sections for greater detail.

Accidental Death & Dismemberment Insurance

Principal Sum $50,000
Retired Members* $20,000
Based on Schedule of Losses

Coverage terminates ..... no later than age 100

Please refer to ***Termination of Insurance*** and ***Self-Pay Provision*** sections for greater detail.

** Members who have elected retirement after December 1, 2018 excluding the one-time grandfathering for Members retired December 1, 2013 to December 1, 2018*

Short Term Disability Benefits

Benefit.....$668/week
- 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 37 weeks.
- Subject to E.I. wraparound which you must apply for (weeks 2 – 27)
- Taxable

Coverage terminates..... no later than age 100

If you are disabled for any part of a week, we will pay 1/7 of the amount of the weekly payment for each full day you are disabled.

Please refer to ***Termination of Insurance*** and ***Self-Pay Provision*** sections for greater detail.

Long Term Disability Benefits

Waiting period.....37 weeks
Benefit (via CL plus COLA 2%).....$1,200

- Amount is 60% of your monthly earnings to a maximum benefit of $1,200 or 80% of your pre-disability gross earnings, whichever is less.
- Payable monthly after 37 weeks with EI wrap-around to age 65 or until recovery. Subject to direct offsets (i.e., Workers Compensation, CPP, EI and Auto Insurance Disability, etc.).
- Taxable.

Benefit (via Trust Fund on Ex-gratia basis).....$750

Coverage terminates.....at age 65

Dentalcare Benefits

Dental Fee Guide .....Current Dental Association Fee Guide
Deductible (Routine only).....$25 per individual or family
Reimbursement Percentage (Routine) 100%
Reimbursement Percentage (Major: Dentures & Bridges).....80%
Reimbursement Percentage (Major: Onlays & Crowns) 50%
Reimbursement Percentage (Orthodontic).....50%
Orthodontic Lifetime Maximum $1,000
Combined Routine/Major Calendar Year Maximum $1,500

Coverage terminates.....at age 100 with exception, if working, to extent of Dollar Bank rundown
Retiree Calendar Year Maximum $1,000
Retiree Reimbursement Percentage (Routine) 70%
Retiree Reimbursement Percentage (Major).....50%
Retiree Coverage terminates.....at age 100

Please refer to ***Termination of Insurance*** and ***Self-Pay Provision*** sections for greater detail.

Visioncare Benefits

For Actives and Retirees:
Deductible.....Nil
Reimbursement Percentage 100%
Laser Eye Surgery maximum.....$1,000 lifetime
Eyeglass/Contact Lens/ Prescription Safety Glasses/Prescription Sunglasses Maximum
Adults (every 24-month period).....$300
Dependants (every 12-month period).....$300
Visual Training and Remedial Therapy Lifetime Maximum.....$500
Eye Examination Maximum (every 24-month period).....1 exam
Dependant Eye Examination Maximum (every 12 month period) 1 exam

Coverage terminates .....at age 100 with exception, if working, to extent of Dollar Bank rundown

Please refer to ***Termination of Insurance*** and ***Self-Pay Provision*** sections for greater detail.

Prescription Drugs Benefits

Deductible.....Nil
Reimbursement Percentage for Actives 100%
Reimbursement Percentage for Retirees 70%
Smoking Cessation Products .....$500 lifetime
Calendar Year Maximum.....$5000 per person
Dispensing Fee Maximum .....$15 per script
Pharmacy Mark-up Maximum.....20% per script

Coverage terminates..... no later than age 100 with exception, if working, to extent of Dollar Bank rundown

Please refer to ***Termination of Insurance*** and ***Self-Pay Provision*** sections for greater detail.

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.

Preferred Provider Network

Coughlin via People Corporation has implemented a People Advantage preferred provider network whereby if you choose to purchase your prescription drugs at the selected pharmacies, you will receive preferred pricing (lower dispensing fees, mark-up costs). Prescriptions are also available by mail by ordering online through selected pharmacies. Furthermore, while your Plan reimburses brand-name drugs at the cost of the generic equivalent, if you require the brand-name version of a drug through RxHelpOne and InnoviCares programs you may be able to access cheaper pricing to lower your out-of-pocket cost. For more information, please refer to the interactive brochure on the Coughlin Plan Member Portal or on your Union website.

Extended Healthcare

Deductible ..... Nil
Reimbursement Percentage for Actives 100%
Reimbursement Percentage for Retirees 70%
Calendar Year Maximum:
- Psychologist ..... $500/person/calendar year
- Chiropractor ..... $400/person/calendar year
- Massage Therapist ..... $350/person/calendar year
- Physiotherapist, Acupuncturists, Osteopath, Podiatrist/Chiropodist, Reflexologists, Naturopaths & Speech Therapists each ..... $250/person/calendar year

Registered Nurse ..... $25,000/person/calendar year
Orthopedic Shoes/Orthotics ..... up to $150 each/person/calendar year
Coverage terminates ..... at age 100 with exception, if working, to extent of Dollar Bank rundown
Retiree Coverage terminates ..... at age 100

Please refer to ***Termination of Insurance*** and ***Self-Pay Provision*** sections 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 $90.00 per hour or $45 per 30 minutes and payable via credit card. For reimbursement from the Health and Welfare Trust Fund, please submit the receipt and claim form to Coughlin & Associates for processing.

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

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

Coughlin Care Gold Package

- **Virtual Healthcare** (vCare): To register for vCare you can access directly via the secure link ***https://www.vcareregistration.com*** You will require your policy number (56546**)** and certificate number (Member ID) off your Prescription Drug card or contact the Coughlin Administrator at vcare-info@coughlin.ca or (204) 942-4438.

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

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

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

Eligibility .....Local Union 870 Insured Participants and Families

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

Employee and Family Assistance Program (EFAP)

Benefit..... per case basis via LifeWorks

Provides short-term, confidential professional counselling and work life services to Members and their eligible dependents to assist with resolving work and life issues.

For immediate confidential help 24/7/365, call 1-844-671-3327 or go online at www.workhealthlife.com. Enter "*International Union of Operating Engineers Local 870"* in Search for Organization box. Once in, click on "*Register*" to get started.

An EFAP brochure is available on Member Portal or via request from Plan Administrator.

Travel Medical Emergency

Policy Number ..... CMG 9428827

Deductible ..... Nil

Benefit Maximum ..... $5 Million/per person/lifetime

Maximum Duration .....60 days

Coverage ceases ..... Earlier of age 70 or depletion of .....Hour Bank account and/or self-pay period

Contact Number..... Canada/US: 1-877-207-5018 .....Outside Canada/US: 1-819-566-3940

Benefit Reimbursement (Over age 70) .....$125/calendar year (Excludes trip interruption/ baggage insurance)

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.

Healthcare Spending Account

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

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

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

General Information

Eligible Plan 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:

Active Members

A Union Member in good standing with Local 870 on whose behalf contributions are being made to the International Union of Operating Engineers Local 870 Health & Welfare Plan.

Probationary Workers

Employees of Employers on whose behalf contributions are made but are not Members of the International Union of Operating Engineers Local 870 or any reciprocating Local, will be eligible for benefits under this Plan while working for a Certified Employer.

Union Office Staff

Union Office Staff of the Operating Engineers Local 870 on whose behalf remittances are being made will be eligible for benefits under this Plan while working for the Local Union. Upon retirement, provided in benefit at that time, will be allowed to participate in the retiree coverage.

Retired Member / Union Office Staff

A Union Member is considered retired when he/she elects in writing retirement from the trade. If a retired member returns to work after electing retirement, they will remain in the retirement category with contributions received credited to their Dollar Bank account. A member age 55 and over must be in good standing with Local Union 870 for a minimum of 10 years (effective September 1, 2022) and in benefit with International Union of Operating Engineers Local 870 Health & Welfare Trust Fund at the time the member elects in writing retirement from the trade. A Union Office staff is considered retired when she/he indicates in writing of her/his retirement to the Local Union Office.

Eligibility

An account is kept by the Plan Administrator, Coughlin & Associates Ltd., for each eligible Participant which identifies contributions received from a Certified Employer for the purpose of Group Benefits. This account is called an Dollar Bank Account.
Participants on whose behalf contributions to the International Union of Operating Engineers Local 870 Health & Welfare Plan are being made and who have accumulated $500 of work credit within six (6) months are eligible for insurance on the **first day following the day** they have accumulated $500 of work credit for Life, Dependent Life, Accidental Death & Dismemberment (AD&D), Long Term Disability (LTD) and Short Term Disability (STD). 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 $500 within six (6) months.

Union 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, application for group coverage must be completed. Once eligible, each month $230 (i.e. monthly deduction) will be deducted from the Union or Probationary Worker's Dollar Bank account. For Union Office Staff, the remittance will equate to the monthly deduction. A Union Member may accumulate a maximum of $2,760 in their Dollar Bank Account (enough to provide twelve (12) months of coverage even though they may not work any hours during that period). Funds accumulated over this amount ($2,760) will be credited to the General Reserves of the Fund. A Probationary Worker can accumulate work credit in excess of the monthly deduction, however, upon termination of employment or lay-off, the balance in the Dollar 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 870.

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 $230 in your Dollar 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

- no longer a Member in good standing with Local 870, or
- if you are a Probationary Worker, on the date of termination of employment or layoff, or

- If you are a Retired Member or Retired Union Office Staff, on the date of the benefit age restriction or depletion of Dollar 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 (STD) & Long Term Disability (LTD) benefits - If your insurance terminates while you are disabled you will continue to receive STD benefits during that period of disability, up to the maximum noted in the STD benefit description in the Schedule of Benefits. If you continue to remain disabled after the maximum STD has been paid, application may be made for the LTD benefits.

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

Dentalcare - If your insurance terminates due to termination of the Dental 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 Dental 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

Eligibility to self-pay is conditional upon the Member being in good standing with Local 870.

Active and Retired Members and Retired Union Office Staff (excludes Probationary Workers) will be allowed to continue his/her coverage as follows:

On lay-off, when a Member's Dollar Bank falls below $230:

- If your balance is $150 or less your status will be changed from active to non-working, with the self-pay amount of $75.00 deducted from your account to deplete.
- If the balance greater than $150, a top-up payment required to make the $230 deduction.

Subsequently, a self-pay request is made for $75.00 per month (during the 1st 12 months) for full coverage including Disability coverage. Following 12 months of self-payments, a Member may self-pay for a further 6 months at $45.00 per month excluding Disability coverage. The Member's Dollar Bank balance is maintained until he/she returns to work or if not active for 12 months, the balance is forfeited to the General Reserve. If a member reaches the 18th self-payment, their coverage ends unless they either return to work or elect retirement coverage.

On disability, following depletion of a Member's Dollar Bank at $230 per month the member may self-pay at $45.00 per month for full benefit coverage until no longer deemed totally disabled by the provisions of the Plan or Insurer. The Plan subsidizes the difference which reduces when Member is approved for a Life Waiver of Premium. Union Office Staff and Probationary Workers cannot self-pay for coverage on lay-off, however, if deemed totally disabled, coverage may be extended up to age 65 provided the appropriate 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 electing retirement (signed form required), a Member will draw down their Dollar Bank at $230 per month for full coverage. Subsequently, the Member or Union Office Staff has the option to self-pay for 12 months at $75.00 per month including disability then an additional 6 months at $45.00 per month excluding disability for a total of 18 months at Active Member reimbursement percentages. Once the maximum self-pay is reached, the member or union office staff will switch to Retirees coverage with reduced reimbursement percentages (exception Visioncare at 100%) and Life/AD&D benefits. When a member or union office staff elects the Retiree coverage, this choice is non reversible, and if continues to work occasionally the self-pay or deduction remains the same at $184.29 per month ending at age 99.

You will receive a notice to make a self-payment for the following month of coverage. Self-payments must be continuous and consecutive. As self-payments are optional, if you chose not to continue benefit coverage, your coverage will terminate at the end of the month.

The benefits, provisions and applicable deductions and self-pay amounts listed above are subject to Trustee review from time to time and may change at the discretion of the Board of Trustees.

Reinstatement of Insurance

A Union Member whose insurance has terminated will again be eligible following the accumulation of $500 of work credit in the Dollar Bank Account within twelve (12) months from the date of termination.

Specifically, for Union Members, if your insurance terminates because your Dollar Bank account falls below $230, your Dentalcare, Extended Healthcare, Visioncare, Prescription Drugs, EFAP, Travel Medical Emergency, and People Connect benefits coverage will be reinstated on the first day of the month following the date on which the Plan Administrator has received at least $500 of work credit. The Life, Dependent Life, LTD, AD&D and STD benefits coverage will be subject to reinstatement on the date you accumulate $500 of work credit. The $500 must be accumulated in the twelve (12) calendar month period immediately following the date your insurance terminated or the self-pay period ended.

Reciprocal Agreements

Local 870 Members – Union Members working in a jurisdiction other than International Union of Operating Engineers Local 870 and on whose behalf contributions are being made to a Health and Welfare Trust Fund which has entered into a reciprocal agreement with International Union of Operating Engineers Local 870 Health & Welfare Plan should complete a Travel Card and advise the Union or Administrator to reciprocate contributions to their Home Fund. This will assist in maintaining your coverage under the International Union of Operating Engineers Local 870 Health & Welfare Plan.

Travel Card Members - Employees of Employers on whose behalf contributions are made to this Fund but who are Members of other Local Unions. If their Home Local Union Fund has entered into a reciprocal agreement with the International Union of Operating Engineers Local 870 Health & Welfare Plan will not be eligible for benefits but will have all contributions made on their behalf reciprocated to their Home Local Fund after they complete the Travel Card and forward to the International Union of Operating Engineers Local 870 office.

Monthly Statements

Once a Member is eligible for coverage, they will begin receiving a monthly statement. The statement will reflect the Member's benefit status, employer's contribution, previous month's Dollar Bank account balance and present Dollar Bank account balance. It should be noted that an amount is deducted from a Member's Dollar Bank account balance each month to pay the premium for benefit coverage. If a Member has insufficient funds in their account, the statement will show the amount required for the Member to pay on a self-pay basis. **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, STD 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 (including layoff during the first 6 months of self-payments), the plan will recognize your disability for wage loss benefits (STD and LTD) from the date of disability provided that you satisfy the definition of totally disability under the plan or Insurer. You will need to provide an attending physician or doctor statement indicating the initial visit date, and medical condition that prevents you from working.

Disability Claims

All disability claims should be recorded with Coughlin & Associates Ltd. and Canada 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. *Proper application must be made for your Long Term Disability and Waiver of Life Insurance premiums 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 or Self-Insured fund, you will be required to reimburse the Insurer or the Operating Engineers Local 870 Health & Welfare Plan 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 or Self-Insured fund.

If you or your dependent receives a lump sum payment under judgement or settlement for benefits which would otherwise be payable by the Insurer or Self-Insured fund, no further benefits will be paid by the Insurer or Self-insured fund 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 or Self-Insured fund.

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

    - age 21to 25 and in full-time attendance at a university or similar institution.

    - Anyone who is in the armed forces full-time is not eligible to be a dependant.

    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.

    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.

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, 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.

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.

Accidental Death & Dismemberment Insurance
(Underwritten by Canada Life)

Coverage

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

Benefit Amount

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

Schedule of Losses

Accidental Death & Dismemberment

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

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%

Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	50%
Loss of Use of One Hand or One Foot	50%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	50%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Canada Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

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

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

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

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

Repatriation Benefit

When injuries result in loss of life of an Insured Person outside 150 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Canada Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $2,500.

Rehabilitation Benefit

When injuries result in a payment being made by Canada Life under any benefit excluding the Loss of Life Benefit, Canada Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $10,000 for special training of an Insured Employee provided:

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

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

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

Family Transportation Benefit

If you are hospitalized more than 150 kilometers from your home as a result of an injury for which benefits are payable under this benefit provision, Canada Life will pay up to $2,000 for transportation and lodging expenses for one family member to join you.

Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses and taxicab and car rental charges are included. Meal expenses are not covered.

Transportation expenses are limited to round trip economy class transportation. If a private vehicle is used, expenses are limited to $.44 per kilometer travelled.

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

Spousal Occupational Training Benefit

If benefits are payable under this benefit provision for your death, Canada Life will pay for expenses associated with your spouse's enrolment in an accredited occupational training program. The purpose of the training program must be to provide the spouse with at least the minimum qualifications required for employment in an occupation for which the spouse would not otherwise qualify.

Canada Life will pay up to 10% of the Principal Sum, or $10,000, whichever is less.

No benefits will be paid for expenses incurred more than 3 years after the accident causing your death, or room or board or other ordinary living, travelling, or clothing expenses.

Special Education Benefit

If benefits are payable under this benefit provision for an injury that requires you to change occupations, Canada Life will pay the tuition fees for enrolling you as a student at a post-secondary institution for training in a new occupation. To qualify for an educational benefit, you must enroll at a post-secondary institution within 365 days after the accident. Canada Life will pay up to $10,000.

No benefits will be paid for tuition expenses incurred before the accident, expenses incurred more than 2 years after the accident causing the injury, or room or board or other ordinary living, travelling, or clothing expenses.

Wheelchair Benefit

If benefits are payable under this benefit provision for an injury that requires the use of a wheelchair for you to be ambulatory, Canada Life will pay for alterations to your principal residence to make it wheelchair

accessible and habitable, and modifications to a motor vehicle you use to make it accessible to and drivable by you.

Benefits for home alterations are payable only if the person or persons making the changes are experienced in home alterations for wheelchairs, and recommended by an organization recognized for providing support and assistance to wheelchair users.

Benefits for vehicle modifications are payable only if the person or persons making the changes are experienced in vehicle modification for wheelchairs, and the modifications are approved by the provincial vehicle licensing authority.

Great-West will pay up to $10,000 for all home and vehicle modifications combined.

No benefits will be paid for expenses incurred more than 365 days after the accident or for subsequent alterations to your home or vehicle after an initial claim for benefits has been made under this wheelchair benefit provision.

Continuance of Coverage

If an Insured Person is: (1) laid off on a temporary basis; (2) temporarily absent from work due to short-term disability; (3) on leave of absence; or (4) on maternity leave, coverage shall be extended for 12 months, subject to the payment of premiums. If an Insured Person assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Exposure and Disappearance

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

How to Claim

Note: In the event of a claim, notice of claim must be given to Canada Life within 30 days from the date of the accident and subsequent proof of claim must be submitted to Canada Life within 365 days from the date of the accidental loss. A claim form can be obtained from the benefits administrator.

Short Term Disability Benefits

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 Insurer (Canada Life) 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.

The availability of work for the member does not affect the determination of "totally disabled",

Benefits for any one disability are payable from the first (1st) day of disability due to injury, hospitalization/day surgery 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 thirty-seven (37) weeks during any one period of disability.

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

- Benefit equivalent to Employment Insurance (EI) weekly maximum
- 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 37 will then again be covered by the Plan.

Note: This benefit is taxable, and taxes will be withheld at source.

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

You may be eligible to apply for and receive benefits from other sources during the disability. For the purpose of any calculations under this provision, we will automatically reduce the disability payments by the full amount of any benefits you are eligible to apply for and receive, before any income tax and/or any other deductions, under:

- Any Workers' Compensation Act or similar legislation
- The Canada/Quebec Pension Plan

To the extent permitted by law, any automobile insurance plan that does not take income benefits under the Employment Insurance Act (Canada) into account when determining benefits. If you receive a lump sum payment from any of the above, we will divide the payment by the number of weeks for which you would have been eligible to receive the benefit and reduce each of our weekly payments by that amount.

If you have not applied for these other benefits, or if your application has not yet been approved, we may estimate the amount you may be eligible to receive and reduce your payments by that amount. If we are notified in writing that your application for these other benefits, or any appeal, has been declined and we determine that this decision should be subject to appeal, you must file an appeal and we may continue to reduce your payments until we are notified in writing that such appeal has been declined.

When your Short Term Disability payments end

Short Term Disability payments will end on the earliest of the following dates:

- the date you no longer meet the definition of disability;

- the date you do not supply us with appropriate medical documentation showing how the illness or injury prevents the performance of the essential duties of your occupation.

- the date you engage in work for wages or profit (other than in an approved rehabilitation program).

- the date you have received 37 weeks of weekly payments for a continuous period of disability.

- the date you die.

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;

- 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;

- disability during a period you are serving a prison sentence;

- disability resulting from self-inflicted injury, war, or engaging in a riot or insurrection;

- substance abuse unless you are participating in a treatment program approved by us;

- war, rebellion or hostilities of any kind whether or not you are a participant;

- committing a criminal offence or provoking an assault;

- an accident while you were operating a vehicle, vessel or aircraft, if you (a) were impaired by drugs or alcohol, or (b) had a blood alcohol level higher than 80 milligrams of alcohol per 100 milliliters of blood;

- are on a leave of absence, including maternity/parental leave;

- are outside of Canada and the United States, unless we approve the absence;

- are working or engaged in any business or occupation for wages or profit;

- continue to receive a salary from any employer;

- are not under the continuing care of a licensed physician or surgeon;

- are not receiving treatment that we consider appropriate;

- do not attend an examination by a physician of our choice;

- are receiving severance pay, a damages award or other payment due to termination of the employment relationship. If any such payment or award is received in a lump sum, we will stop making Short Term Disability payments for a period equal to the number of weeks the lump sum amount represents relative to your pre-disability earnings.

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 Benefits
(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. Coverage cease no later than age 65.

The availability of work for the member does not affect the determination of "totally disabled".

The plan provides you with a disability benefit to partially replace income lost because of a lengthy disability due to disease or injury. Benefits begin once you satisfy the waiting period and will continue provided you meet the definition of disability defined with the policy or you reach age 65. 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 medically 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 or are no longer deemed disabled.

Benefit Reduction

The purpose of this insurance is to provide some financial assistance when you are disabled, but it is not designed to give you income which would exceed or even equal your normal take home pay when you are working. For this reason, the monthly disability benefit that you receive from this Plan will be reduced by:

1. 92.5% of any disability income payable under a government plan including but not limited to the disability pension to which you are entitled under the Canada/Quebec Plan excluding benefits for dependent children,
2. .Retirement benefits to which he is entitled on his own behalf under (a) the Canada Pension Plan; (b) the Quebec Pension Plan; or (c) a similar plan in another country which has a reciprocal agreement with Canada or Quebec,
3. Benefits under any Workers; Compensation Act or similar law except for (a) permanent partial disability awards that were payable for each of the 12 months before a disability period; and (b) benefits related to employment with another employer,
4. Employer sponsored short term disability or sick leave benefits,
5. Loss of income benefits under an automobile insurance plan, to the extent permitted by law,
6. 50% of earnings received from an approved rehabilitation plan.

If you are receiving other forms of retirement income or disability income, the monthly benefit under this plan will be reduced so that the disability income which you receive from **all** sources does not exceed 80% of your gross monthly earnings at the time you became totally 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 for the purposes of any reduction calculators.

Rehabilitation

As your condition improves, you will want to start doing something, but may find it difficult to return to your former occupation on a full-time basis. An analysis of your skills and abilities by a rehabilitation counselor from the Insurance Company will identify an appropriate rehabilitation program for you. During your rehabilitation, you will receive your regular monthly disability benefit, after subtracting 50% of the monthly earnings which you receive as a result of your rehabilitative employment.

Claims

A claim must be received by the Insurance Company within three (3) months after the end of the qualifying period.

The time limit for starting proceedings against the Insurance Company for payment of any claim under this section is one (1) year from the receipt, by the Insurance Company, of the proof of claim. Any proceeding must be started within that year.

Vocational Rehabilitation Benefits

Vocational rehabilitation involves a work related activity or training strategy that is designed to facilitate a disabled person's return to his job or other gain full employment and is recommended or approved by Canada Life.

In considering whether to recommend or approve a rehabilitation proposal, Canada Life will assess such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to work.

The goal of a rehabilitation plan must be: (1) to return the person to work in the same job; (2) to return the person to work in a modified job with the same employer; or (3) to return the person to work in a different job that capitalizes on transferable skills.

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 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 period in which the person is outside Canada. This exclusion does not apply during the first 30 days of an absence, or if Canada Life pre-authorized the absence prior to the person's departure.

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

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

Disability Claims

All disability claims should be recorded with Coughlin & Associates Ltd. and Canada Life regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance or E.I. Disability benefits. This

recording will assist you should your claim with these agencies be declined. 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.

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 (refer to the Highlight of Benefits section for co-insurance and maximum reimbursement levels as well as the applicable Dental Fee Schedule).

We pay for the covered dental care charges that are incurred while the person is covered and care was provided by a licensed dentist, dental specialist, denturist, dental hygienist entitled by law to practice independently, anaesthetist or specialist. When we use the term "dentist" in this provision, we intend it to include all of the above.

The deductible is $25 each calendar year. The deductible only applies to Preventative services.

Treatment Plan

- Before your dental service provider 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.

- It is suggested you submit a treatment plan to the Plan Administrator before treatment starts for any Routine or Major Treatment expected to cost more than $500.

- A pre-determination of the benefits payable for the proposed treatment will then be calculated so you know in advance the portion of the cost you will have to pay. Any pre-determination of benefits is only valid for 90 days from its date of issue.

Covered Expenses

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

Routine Treatment

Please Note: A total of three examinations are covered every calendar year:

A. Recall exam
B. Specific Exam
C. Emergency Exam

Initial or complete exam – one every 36 months.
Full-mouth series - one series every 36 months.
Panoramic x-rays - one every 36 months.
Periapical x-rays - one every 36 months
Bite-wing x-rays are covered ONCE in any 12 consecutive months.
Polish - two visits every calendar year.
Fluoride - two visits every calendar year.

Scaling/root planing combined - 8 units per calendar year.
Oral Hygiene Instruction - one instruction is covered in a lifetime.
Space maintainers for dependent children under 14 years of age - one space maintainer per space in a calendar year.

All restoration done to the same tooth will be covered as a single visit to the dentist.

A silver filling is only covered if 24 months have passed since the last restoration to the same tooth. If a bonded silver filling is installed, we will limit to the cost to a non-bonded silver filling.

A white filling is only covered if 24 months have passed since the last restoration to the same tooth.

All necessary anaesthesia during a dental procedure including: general anaesthesia, deep sedation, intravenous sedation and inhalation technique.

Post-surgical care is covered.

Facility fees are NOT covered.

Root Canal therapy - is covered per tooth in a 60 month period.
Retreatment procedures are not covered.

Root Canal therapy includes: treatment plan, pulp vitality test, pulpectomy, open and drain.
Treatment of gums includes: displacement dressing, gingival curettage, gingivectomy, flap surgery, tissue graft.

Periodontal appliance - one appliance is covered per arch (upper or lower) every 24 months. Adjustments up to four every calendar year.

Denture adjustments, repairs, rebase and relines. One rebase or reline is covered every 36 months as long as it is done more than three months after the dentures are inserted.

Tissue conditioning is covered.

Major Treatment

Major restorative services are covered for the replacement of missing teeth or for reconstruction of teeth where basic restorative methods cannot be used satisfactorily. 5 year replacement clause.

Eligible Services include:

Prosthodontic services: removal dentures such as complete upper and lower dentures; partial upper & lower dentures; and bridgework

Transitional Dentures: are temporary dentures used for healing purposes due to the extraction of teeth. Permanent dentures must be inserted within 12 months of the date the temporary dentures were placed.

Implants and Implantology: 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.

Crown lengthening is not covered.

Bridgework repairs/recementation are major services.

NOT COVERED:

No benefit is payable for the replacement of lost, broken, or stolen dentures.

Procedures performed for congenital malformations or for purely cosmetic reasons.
Charges for drugs, pantographic tracings.

Charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint.

Recent duplication of services by the same or different dentist/dental specialist/denturist.

Any extra procedure which would normally be included in the basic service performed.

Crowns and Onlays

Crown lengthening before tooth preparation is not an eligible benefit. The cost of inlays, onlays, crowns and build-up/fillings are only covered if teeth are broken down and it has been more than 60 months since the last crown, inlay, onlay or build-up/filling was installed on that tooth. A porcelain crown on a molar is covered up to the cost of a metal crown. Laboratory processed veneer applications.
*Veneer applications that are done for cosmetic purposes are NOT covered. Retentive pins in inlays, onlays and crowns.

Orthodontic coverage

These are procedures used to correct crooked or misaligned teeth. This includes all necessary dental treatment needed to correct this problem such as examinations, x-rays, models, photographs, reports and surgical exposure of teeth, appliances and adjustments.

We require that a treatment plan prepared by the dentist be sent to us. We will then pay up to 30% of the cost at the beginning of treatment, minus the diagnostic fee. We will calculate the remaining payments by dividing the rest of the cost by the number of months in the treatment plan. We will pay monthly or quarterly, depending on when the dentist bills us or when we receive the receipts. We will not make any advance payments.

The cost of dental treatment that is not an orthodontic service but is needed because of the orthodontic treatment will be included and covered as if it were an orthodontic service.

Limitations

If you enrol more than 31 days after the end of the waiting period for coverage, the maximum amount payable to you for charges incurred during the first twelve months of coverage will be $250. The full coverage offered under this Dental coverage provision will begin after twelve months.

If you enrol for family coverage more than 31 days after the end of the waiting period for coverage or more than 31 days after first acquiring a dependent, the maximum amount payable for each dependent for charges incurred during the first twelve months of coverage will be $250. The full coverage offered under this Dental coverage provision will begin after twelve months.

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:

- dental services or supplies that the covered person is eligible to claim under the Workers' Compensation legislation
- any dental charges not included in the current Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee Guide
- cosmetic procedures
- charges made by a dentist for broken appointments or for completion of claim forms required by Canada Life
- any endodontic treatment which was started before the effective date of coverage
- services or supplies rendered for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction
- the replacement of dental appliances that are lost, misplaced or stolen
- any crowns, bridges or dentures for which tooth preparations were started before the effective date of coverage
- experimental treatment or testing
- any orthodontic services received before the effective date of coverage

Visioncare Benefits

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

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, if they are not covered under the Participant's provincial government plan and provincial law allows the Plan to cover them, for the service provided in the area where the expenses are incurred.

Covered Expenses

The Plan pays 100% of the following covered expenses:

- 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**. We will cover the cost of one eye examination (including eye refractions) every 12 months for a covered person under age 18, or every 24 months for a covered person age 18 or over.

- We will cover the cost of laser eye surgery ($1,000/person/lifetime),

- Eyeglass frames and lenses, prescribed safety glasses, contact lenses and prescription sunglasses ($300 every 24 months for adults).

- We will pay 50% of the cost of 52 visits per calendar year to a maximum of $500 in the covered person's lifetime for visual training and remedial exercises.

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.

Prescription Drug Benefits

Prescription Drug Benefits provides protection against the cost of medically necessary prescription drugs for which there is no reimbursement from the provincial health plans. Prescription Drug Benefits covers only those expenses which are considered reasonable and customary for the drug provided in the area where the expenses are incurred, provided the Members and eligible dependants are Canadian residents and covered under a provincial health insurance program.

Co-insurance Percentage

- The Plan pays 100% of covered drug expenses to a maximum of $5,000 per calendar year per person. Subject to mandatory generic substitution unless a physician indicates a medical necessity, dispensing fee maximum of $15 per script, and 20% markup restriction.
- For Retirees: the Plan pays 70% of covered drug expenses to a maximum of $5000 per calendar year per person. Subject to mandatory generic substation 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
  - 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

- Viagra and other erectile dysfunction drugs up to 15 pills every 3 months

- Fertility Drugs and other fertility related procedures paid to a medical practitioner or public or licensed private hospital to conceive a child. Coverage is inclusive of expenses for in vitro fertility program,

laboratory tests, x-rays including ultrasound, and subject to a lifetime maximum of $12,000.

- Other drugs listed in the current Compendium of Pharmaceuticals and Specialties when prescribed by your physician to treat a diagnosed injury or illness

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.

Limitations

No benefits are paid for:

- contact lens supplies, vitamins (except injectable), minerals, dietary supplements, food substitutes, infant food or formula, skin and hair care products, contraceptive devices, laxatives, antacids and antihistamines, disinfectants, acne therapy, rubbing alcohol, bandages, cosmetic items, sunscreens, cotton, disinfectants, homeopathic medicines, non-disposable insulin injectors, products which can be bought without a prescription; and spring loaded devises used to hold lancets. . (A complete listing is contained in the Master Policy.)
- 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.

Extended 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. Your Extended Healthcare Benefits are designed to assist you with the payment of your large medical bills. 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. Some expenses, including Prescription Drugs, may require a medical recommendation and further details for claims assessment purposes. The pre-approved expenses require specific information from your attending physician, including diagnosis, duration, and other relevant information pertaining to the nature of the illness and required treatment.

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):

We will cover the difference between the cost of a ward and a semi-private room in a hospital. Room charges for outpatients will not be covered. The hospital stay must be because of illness, injury or pregnancy.

B. MEDICAL EXPENSES:

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

2. We will cover the cost of a licensed ambulance or other emergency service that transports the covered person to and from the nearest hospital that is able to give the necessary treatment. This covers travel between hospitals. If transportation is not provided by a licensed ambulance, we may also cover the cost of a person accompanying the covered person, if it is medically necessary.

3. The first $200 of eligible costs for certain diagnostic tests, radium treatments and x-rays in the covered person's home province when coverage is not covered by a Provincial Plan. Additional eligible costs over $200 per calendar year will be reimbursed at 50%.

4. Oxygen.

   Support Stockings prescribed by a physician and up to two pairs of surgical stockings each calendar year. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed.

6. Services of a registered nurse, licensed practical nurse or registered nursing assistant. Maximum $25,000 per calendar year. (Supporting medical evidence will be required.)

7. Services of a Physiotherapist, Acupuncturist, Osteopath, Podiatrist/Chiropodist, Reflexologist, Naturopath and Speech Therapist. Maximum $250 per individual per calendar year per specialist.

8. Services of a licensed Chiropractor . Maximum $400 per individual per calendar year.

9. Services of a licensed Massage Therapist. Maximum $350 per individual per calendar year.

10. Services of a licensed Clinical Psychologist. Maximum $500 per individual per calendar year.

11. Custom made Orthopedic Shoes prescribed by a physician, podiatrist or chiropodist, when no other method such as orthotics and/or off-the-shelf orthopaedic shoes can correct the problem. We will not cover modifications to shoes. Maximum of $150 per individual per calendar year. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed.

12. Hearing Aids and repairs (excludes batteries). Maximum $2,000 every 60 months.

13. Foot orthotics prescribed by a physician, podiatrist or chiropodist. They must be determined as being necessary by a biomechanical examination and be custom made. They must be required to carry out regular daily living activities and not just for sports or recreation. Maximum of $150 per individual per calendar year.

14. Rental of, or if medically necessary, purchase and repairs of the following items:

- nebulizers to administer asthma medication;
- apnea monitors for respiratory irregularities;
- walkers, braces, artificial limbs and eyes, and other prosthetic devises that we approve. As the cost of these items varies greatly, we recommend that you contact us before purchasing a devise. We will ask you for the written information that we require to determine how much of the cost we will cover based on the least expensive device that is medically adequate and, once it is provided, we will advise you of the amount we will cover;
- grab bar;
- canes, crutches;
- casts;
- diabetic supplies, flash glucose monitoring machines excluding alcohol and alcohol swabs;
- one insulin pump for each insured person per lifetime;
- blood glucose monitor;
- ileostomy apparatus and supplies;
- intermittent positive pressure breathing machine;
- breast prostheses after a mastectomy, including replacement(s) every two calendar years, and two surgical bras in a calendar year
- splints, excluding dental splints;
- standard manual wheelchair or electric wheelchairs, hospital beds and other temporary therapeutic equipment that we approve. We may cover the cost of purchasing this equipment if we determine that it is more economical than renting. We must approve the purchase before it is made. We will pay for the least expensive device that is medically adequate. Spare parts or alternative supplies are not covered;
- stump socks (up to a maximum of 6 each calendar year);
- cranial prosthesis (wig and hairpiece) if medically necessary to a maximum of $250 in the covered person's lifetime following chemotherapy or radiation treatment or for total hair loss from alopecia totals, a medical condition where all of the hair is lost;.
- T.E.N.S. machine (for chronic pain) up to a lifetime maximum of $700 for each insured person.

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 that 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.

12. Air conditioners or purifiers.

13. Blood Pressure Kits.

14. Breast Pumps.

15. Craftmatic, Ultramatic or other lifestyle beds.

16. Exercise equipment, machines or programs.

17. Home or car modifications (for example, ramps or lifts).

18. Humidifiers.

19. Mattresses (except for standard mattresses with approved hospital beds).

20. Obus Formes or orthopaedic pillows.

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 9428827

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

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 870. 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 Operating Engineers Local 870 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 870.

Termination

In the event of termination of Membership from Local 870, 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 870 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.

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

Coughlin Care Gold

Virtual Healthcare (vCare):

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

To enroll for vCare, you will be required to provide your Policy # (56546) and Certificate # (Member ID) – these can be obtained from your Prescription Drug card. If you do not have these, they can be provided by the Plan Administrator.

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

Healthcare Navigation:

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

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

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

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

Cancer Assistance:

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

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

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

Medical Second Opinion:

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

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

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

Employee and Family Assistance Program (EFAP)

Your EFAP benefit via LifeWorks is a confidential and voluntary support service that can help you take the first step towards change. They will help you find solutions to all kinds of challenges at any age and stage of your life. You and your immediate family members (as defined in your employee benefit plan) can access immediate and confidential support in a way that is most suited to your preferences, comfort level and lifestyle.

Your EFAP is completely confidential within the limits of the law. No one, including your employer, will ever know that you have used the service unless you choose to tell them.

There is no cost to use your EFAP, this benefit is provided to you by your employer. You can receive a series of sessions with a professional and if you need more specialized or longer-term support, your EFAP can suggest an appropriate specialist or service that is best suited to your needs. While fees for these additional services are your responsibility, they may be covered by your provincial or organizational health plan.

Professional EFAP Counselling Services

- Achieve Well-Being – Stress, Mental Health Concerns, Grief and Loss, Crisis Situations
- Manage Relationships and Family – Communication, Separation and Divorce, Parenting
- *Deal with Workplace Challenges* – Stress, Performance, Work-life Balance
- Tackle Addictions – Alcohol, Drugs, Tobacco/Nicotine, Gambling.
- Find Child and Elder Care Resources – Childcare, Schooling, Nursing/ Retirement
- Get Legal Advice – Family Law, Separation/Divorce, Custody
- Receive Financial Guidance – Debt Management, Bankruptcy, Retirement

Accessing your EFAP

24-hour, 7-days-a-week secure and confidential access to a range of EFAP support services, call 1-844-671-3327 or via **workhealthlife.com** with Online Access. Enter "*International Union of Operating Engineers Local 870"* in Search for Organization box. Once in click on "*Register*" to get started. Service fully bilingual in English and French.

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 as 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.

Continuation of Health Benefits for Dependents

If you die, the Health benefits (Prescription Drugs, Dentalcare, Visioncare, Travel Medical Emergency, EFAP, People Connect, and Extended Healthcare) for your dependents may continue until your spouse remarries, no longer qualify as an eligible dependent, or until the 24 month survivor benefits month anniversary of your death, whichever is earlier.

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.

Extended Health, Prescription Drugs, Visioncare, and Dentalcare
Claims for these benefits must be submitted within eighteen (18) months of the date incurred.

Short Term Disability (STD)
A claim for STD benefits must be submitted within six (6) months of the end of the qualifying disability period.

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

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 # 59100
3) Individual certificate number (printed on your card)

Health :

1) Bin #34 on Telus Adjudicare network
2) Group Number # 59100
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, Accidental Death & Dismemberment, and Long Term Disability benefits, this Plan is underwritten by:

For Dentalcare, Visioncare, Prescription Drugs, and Extended Healthcare benefits, this Plan is underwritten by:

For People Connect benefit, the Plan is underwritten by:

For Travel Medical Emergency benefit, this Plan is underwritten by:

For Employee Family Assistance benefit, this Plan is underwritten by:

and arranged and administered by:

PO Box 764
Winnipeg, Manitoba R3C 2L4
Phone: (204) 942-4438
Toll Free: 1-888-204-1234
Fax: (204) 943-5998
Email: 870admin@coughlin.ca
Disability Claim Inquiries:
Email: wdisabilityclaims@coughlin.ca