IRON WORKERS (SASKATCHEWAN) LOCAL UNION 771

CENTRAL WELFARE TRUST FUND

May 2024

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To All Participants
Iron Workers (Saskatchewan) Local Union 771
Central Welfare Trust Fund

We are pleased to present this updated booklet describing the current benefits and provisions of the Health and Welfare Plan. We urge you to read your booklet carefully to thoroughly familiarize yourself with the benefits that are available to you and your dependents.

The Extended Healthcare, People Connect, Coughlin Care, Visioncare, Prescription Drugs, and Dentalcare Expense Benefits are designed to assist you with the payment of these expenses. It may not pay the total cost of services and supplies. In effect, this Group Insurance Plan shares the payment of your medical and dental bills with you. These Benefits are underwritten on a self-insured basis by the Trust Fund while the Pay Direct Drug Card is coordinated with TELUS and the Weekly Disability Income benefits are also self-insured by the Trust Fund. The Travel Medical Emergency Benefits, Accidental Death & Dismemberment, and Critical Illness (CI) benefits by AIG Insurance Company, and the Life, Dependent Life, Long Term Disability benefits by Sun Life Financial.

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

The Plan Administrator is Coughlin & Associates Ltd., PO Box 764, Winnipeg, Manitoba, R3C 2L4. If you have any questions concerning your benefits or claim procedures, please contact either the Local Union 771 office or the Plan Administrator for this information.

Please note that it is the intention of the Trustees to maintain the current benefits available under the Welfare Plan. The Trustees however, reserve the right to change the benefit portfolio at any time given legislative revisions and/or the utilization costs of the benefits. Insured Participants will be advised accordingly of any required plan revisions.

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

Sincerely,

The Board of Trustees of the
Iron Workers (Saskatchewan) Local Union 771
Central Welfare Trust Fund

Notice Regarding Personal Information

When you apply for coverage under the group benefit plan, Sun Life Financial, AIG, TELUS (Pay Direct Prescription Drug Card provider), and the Plan Administrator, Coughlin & Associates Ltd., set up a file with personal information relevant to your insurance coverage under the plan.

The purpose of this file is to permit these companies to administer all financial services provided to you and to keep information specific to Sun Life Financial 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 and financial security

The files are kept in the offices of the Plan Administrator. The employees of each insurance company and Coughlin have access to the file when required for insurance purposes.

You have certain rights and 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 Coughlin's office.

Privacy

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

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

Highlight of Benefits

Administration Contact: 771admin@coughlin.ca
Claims Contact: winnclaims@coughlin.ca
Disability Contact: **wdisabilityclaims@coughlin.ca**

PARTICIPANTS

Life Insurance

Benefit.....$150,000

Dependent Life Insurance

Benefit.....Spouse - $15,000
.....Child - $10,000

Critical Illness

Members are eligible to a $10,000 flat benefit for any of 27 insured conditions. The Critical Illness benefit ceases at age 70. Please refer to the Critical Illness booklet on the Member Portal prepared by AIG, or contact the Administrator for more information.

Optional Life Insurance

Benefit.....Units of $10,000 to a maximum of $500,000 for Member and/or Spouse
.....Subject to medical evidence requirements with preferred smoker/non-smoker rates

Accidental Death & Dismemberment Insurance

Principal Sum $150,000

Weekly Disability Income (WI) Insurance

Benefit..... 75% of weekly earnings to a maximum benefit of $668/week (E.I. Equivalent)
Commencement.....1st day of accident/
.....1st day hospitalized /8th day sickness

This benefit is taxable and must be reported as income

Maximum Duration.....52 weeks
Basic Reductions.....W.C.B. and C.P.P.

Long Term Disability (LTD) Insurance

Benefit..... $1,000/month (eff. August 1/21)
Commencement..... 52 weeks
Maximum Duration.....To Age 65
All Source Limit.....85% of Pre-Disability Earnings

This benefit is taxable and must be reported as income

Will Preparation

Benefit.....$500 plus applicable taxes for Members in good standing with L.U. 771

This benefit must be provided through either of the following firms:

- ***Steven S. Wilson in Saskatoon or***
- ***Glen Dowling in Regina***

PARTICIPANTS AND DEPENDANTS

Extended Healthcare

Deductible.....Nil
Reimbursement.....100% of eligible expenses
- Semi-Private Hospital Room and Board,
- Paramedical Services including Licensed, Speech Therapists, Osteopath, Chiropractor, Acupuncturist, Naturopath, Audiologist, Dietician, Occupational Therapist, Podiatrist/Chiropodist, Massage Therapist..... Up to $600/person/calendar year
- Physiotherapist (including Athletic Therapy) ..... Up to $1,000/person/calendar year
- Orthotics/Orthopedic Shoes..... Up to $350/12 months
- Ambulance Services
- Hearing Aids..... Up to $3,000/person/5 years

Refer to Extended Healthcare section for more details.

People Connect – Mental Health Resource

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

People Connect provides members and their family members with educational tools, an online assessment, and access to immediate care through virtual therapy. The first virtual counselling session is free, and each additional session is $90 per hour or $45 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

Prescription Drugs (via Pay Direct Drug Card)

Deductible ..... Nil
Reimbursement ..... 100% of eligible drugs subject to 20% mark-up maximum and $15 dispensing fee maximum
Annual Maximum ..... $4,000/family/calendar year
Smoking Cessation Products ..... $500/person/lifetime maximum
for reduced drug pricing refer to People Advantage (PPN) Interactive Brochure on Member Portal)

The Plan is partnering with Pocket Pills, a digital pharmacy, to offer home delivery of prescription drugs. Access to this service can be obtained through https://app.pocketpills.com/coughlin or can be obtained on the Coughlin website at www.coughlin.ca.

Visioncare

Benefit ..... $500/person/24 months
Reimbursement ..... 100% of eligible expenses

Dentalcare

Deductible ..... Nil
Reimbursement ..... 90% for Basic Treatment
..... 80% for Major Treatment
..... 80% for Orthodontics
Fee Schedule ..... Current SDA
Basic and Major combined
Annual Maximum ..... $2,000/person/calendar year
Orthodontic Lifetime Maximum ..... $5,000/Dependant under age 19

Check ups and cleanings are once per person every twelve (12) months

Travel Medical Emergency

Policy Number ..... CMG 9428901

Deductible ..... Nil

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

Maximum Duration .....90 days

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

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

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

Member and Family Assistance Program (MFAP)

Benefit for Office Staff..... - 12 sessions (hour)/individual/ calendar year via Human Solutions

Benefit for Local Union Members ..... - coordinated via CODC
Refer to http://www.codc.ca/pro-care

Please contact the Plan Administrator for more information regarding this benefit.

Hearing Aids

Benefit.....$3,000 maximum/person/5 years

Healthcare Spending Account (HSA)

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

Eligibility .....Local Union 771 Insured Members only

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 (83269) and certificate number (Member ID) off your Prescription Drug card or contact the Coughlin Administrator at vcare-info@coughlin.ca or (204) 942-4438.

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

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

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

Eligibility ..... Insured Participants and Families

Refer to Coughlin Care Gold section.

General Information

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

An account is kept, by the Plan Administrator for each eligible Participant which shows hours worked for a certified Employer for which contributions have been made for the purpose of Group Insurance. This account is called an **Hour Bank Account.**

Please note that for Union Staff, the hours worked will equate to the monthly deduction (see below), as there can be no accumulation of hours worked.

Initial Eligibility

Membership in the Plan for Life, Accidental Death and Dismemberment, and Member Family Assistance Program Insurance is open to all Participants (see Eligible Participants section) who are actively employed by a certified Employer or Local Union 771.

A Participant must join the Plan for Life, Accidental Death and Dismemberment, and Member Family Assistance Program Insurance **on the date active employment commences.**

Eligibility for Dependent Life, Weekly Disability Income, Critical Illness and Long Term Disability Insurance will commence on the **first day following the date you have accumulated 405 bank hours worked.**

Subsequently, eligibility for all other benefits will commence **on the first day of the month following receipt of 405 bank hours worked by the Administrator.**

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

An enrollment form must also be completed to be eligible to receive benefits.

Ongoing Eligibility

Each month 135 hours (monthly deduction) will be deducted from each Participant's Hour Bank Account. Only a Union Member may accumulate up to 1,215 hours (enough to provide nine (9) months of coverage even though they may not work any hours during that period) in their Hour Bank Account. Excess hours accumulated over 1,215 hours will be credited to the general reserves of the Fund. Furthermore, although a Probationary Member can accumulate hours worked in excess of the monthly deduction upon the date of cessation of employment or lay-off, the balance in the Hour Bank Account is forfeited to the general reserves of the Fund unless the Probationary Member becomes a Member in good standing with the Local Union 771.

Eligible Participants

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

Union Member

A Member in good standing with the Local Union 771 on whose behalf contributions are made to the Iron Workers' Local Union 771 Central Welfare Trust Fund.

Probationary Member

Employees of certified Employers on whose behalf contributions are made to the Iron Workers Local Union 771 Central Welfare Trust Fund but are not members of the Local Union 771 or any reciprocating local will be eligible for benefits under this Plan while working for a certified Employer, however, benefit coverage will cease immediately upon the date of lay-off or cessation of employment unless the individual becomes a Member in good standing with the Local Union 771.

Union Staff

Employees of the Local Union 771 on whose behalf contributions are made but are not Members of the Local Union 771 will be eligible for benefits under this Plan while working for the Local Union 771. On the date of lay-off or cessation of employment, benefit coverage will cease immediately.

Retired Member

A Union Member is considered retired when he has attained early retirement (age 55 or older) and has either withdrawn his funds from the Pension Trust Fund, or has indicated in writing to the Local Union 771 of his retirement from the Trade. When a Union Member has retired, benefit coverage (includes disability (WI and LTD) for Retirees who return to work (subject to benefit age parameters, LTD ceases at age 65) will continue until the earlier of the benefit age restriction or depletion of the Member's Hour Bank Account. Furthermore, Extended Healthcare, Prescription Drugs, Visioncare, Dentalcare, Coughlin Care (ceases at age 70), Travel Medical Emergency (ceases at age 75), Critical Illness (ceases at age 70), and Member and Family Assistance Program may be extended to age 75 via self-pay, as long as the Retired Member remains in good standing with the Local Union 771. Note: Weekly Income, and LTD benefits all cease immediately upon retirement. If the Retired Member returns to work, coverage can be reinstated subject to re-establishing eligibility and noting benefit age parameters (LTD ceases age 65, TME ceases at age 75, and CI ceases at age 70).

Eligible Dependants

Your eligible dependants consist of:

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

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

- Your unmarried children from birth to 20 years of age inclusive. As well, dependants age 21 to 25 provided they are in full time attendance at a University or similar institution (evidence of attendance will be required).

- Stepchildren, and legally adopted children may be included the same as your own children provided they depend upon you for support and maintenance.

- A child who is physically or mentally incapable of self-support beyond the limiting age may be continued under the Healthcare insurance while remaining incapacitated and unmarried subject to your own coverage continuing in effect. To continue a child under this benefit provision, proof of incapacity must be received by the Insurer within 31 days after dependent coverage would otherwise terminate. Additional proof may be required from time to time.

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

Survivor Benefit Provision

If your death occurs while you are insured, the Extended Healthcare, Visioncare, Dentalcare, Prescription Drugs, Coughlin Care, Travel Medical Emergency, and Member and Family Assistance Program coverage for eligible dependants shall continue without premium payment up to a maximum of 24 months from the date of death.

Reinstatement of Insurance

If your insurance had previously terminated because of insufficient hours in your Hour Bank Account, and you have not been out of benefit for a period exceeding 9 consecutive months, you will again become insured on the first day of the month after the accumulation of 270 hours in your Hour Bank Account. Otherwise, you will have to meet the original eligibility requirements as though you were a new Participant in the Plan.

Changes in Insurance Benefits

Any changes in the amount of your insurance shall become effective on the date of such change provided that you are actively at work on the date of the change; otherwise, the increase shall become effective on the first day thereafter on which you are actively at work.

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

When a change results in increased benefits, you must be actively at work for an eligible Employer to be eligible for the new benefits. If you are not at work for an eligible Employer on the date the new benefits would

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

Termination of Insurance

The insurance for yourself and your dependants will terminate:

- **For a Union Member**, at the end of any month when you do not have at least 135 hours in your Hour Bank Account. However, a Union Member may arrange to have his insurance continued for as long as twelve (12) months on a self-paying basis. Please contact your Plan Administrator for the required self-pay amount.

- **For a Probationary Member and Union Staff,** immediately upon the date of cessation of employment or lay-off, or disability (certain provisions may apply, contact the Plan Administrator for more details). Probationary Members and Union Staff are not eligible to make self-payments.

- **For a Retired Member,** no later than age 75 if self-paying for Extended Healthcare, Prescription Drugs, Visioncare, Dentalcare, People Connect, Coughlin Care, Travel Medical Emergency (ceases at age 75), Critical Illness (ceases at age 70), and Member and Family Assistance Program or depletion of his accumulated Hour Bank Account, as long as he remains a Member in good standing with the Local Union 771. Please note disability coverage is excluded for Retired Members.

- For specific benefits, if you reach the benefit age restriction;

- If you cease to be a Participant in the eligible class;

- If you enter military service;

- If the Group Policy terminates;

- Under the Survivor Benefit provision, if the deceased Participant no longer has any qualified survivors because of legal separation, divorce, death or attainment of the age limit;

- Extended Healthcare, Prescription Drugs, Visioncare, Dentalcare, Coughlin Care, Travel Medical Emergency, and Member and Family Assistance Program coverage for a dependant, if he/she is no longer an eligible dependant.

Self-Pay Provision

Union Members and Retired Members are eligible to self-pay to continue benefit coverage.

If there are insufficient hours (i.e. due to a lay-off) in a Union or Retired Member's Hour Bank Account to make the monthly deduction for benefit coverage, a Union or Retired Member will be allowed to continue his coverage by making a self-payment (direct contribution) to the Fund. For Union Members, such self-paid contributions must be continuous and consecutive for a period not to exceed twelve (12) months. For Retired Members, self-paid contributions must be continuous and consecutive up to age 75 for Extended Healthcare, Dentalcare, Prescription Drugs, Visioncare, Coughlin Care, Travel Medical Emergency (ceases at age 75), Critical Illness (ceases at age 70), and Member and Family Assistance Program benefits only. The payment must be made prior to the 22nd of the month following the month in which the Hour Bank Account falls below 135 hours. If you do not remit your self-payment by the required date, your insurance will be terminated without further notification as identified in the Termination of Insurance section of this booklet.

Eligibility to self-pay is contingent on the Participant being in good standing with Local Union 771.

Probationary Members and Union Staff are not eligible to extend coverage through self-payment.

Monthly Statements

Each month a statement is mailed to each insured Member. This statement will show your benefit status, your Employers or self payment contribution, your previous Hour Bank Account balance and your current Hour Bank Account balance. It should be noted that an amount (135

hours) is deducted from your Hour Bank Account balance each month to pay the premium for your coverage.

For Union or Retired Members, if you have insufficient hours in your account, the statement will show the amount required for you to pay on the "self-pay basis". If the required amount is not paid, the next statement will show you as being out of benefit with a final option to self-pay. Your coverage will not become effective until you have satisfied the reinstatement requirements (see Reinstatement of Insurance section).

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

Disability Claims

All disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurer (Sun Life Financial and AIG) 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, AD&D , and CI Premiums which is required within twelve (12) months of the date of initial disability.

Extension of Coverage

If a Union Member is disabled and receiving disability payments for a period of three (3) consecutive months following the month of disability and the Union Member has maintained continuous eligibility status for benefits by either running out his Hour Bank Account or making self-payments during this three (3) month period, the Trust Fund will extend coverage for all benefits for an additional nine (9) months (if the Union Member is continuously disabled for this period) with the appropriate insurance premiums assumed by the Trust Fund. If the Union Member continues to receive disability benefits after this twelve (12) month period, Extended Healthcare, Visioncare, Dentalcare, Prescription Drug, Coughlin Care, Travel Medical Emergency (ceases at age 70), and Member and Family Assistance Program coverage will be further extended to the earlier of an additional two (2) years, attainment of age 65, or retirement, with all insurance premiums assumed by the Trust Fund. Following the three (3) year subsidization period of benefits (Visioncare, Dentalcare, Coughlin Care, TME (ceases at age 75), Hearing Aids, EFAP, and Drugs)

and depletion of the disabled Member's Hour Bank Account, the disabled Member will be eligible to continue coverage on a self-pay basis to age 75 provided he/she remains disabled (receiving disability benefits from a Long Term Disability Plan, Provincial Automobile Insurance Program, Workers Compensation, or if a Life Waiver is in place) and in good standing with the Local Union 771. Will be reviewed on a yearly basis to confirm disabled. Regardless of the above, this extension of coverage is subject to the financial stability of the Plan and review by the Board of Trustees from time to time.

Wage Loss Provision (Union Members Only)

In the event that a Union Member incurs a total disability while insured but on layoff or leave of absence and "running down" his Hour Bank Account during self-pay period, the plan will recognize the Union Member's disability for wage loss benefits (WI and LTD) from the scheduled date of return to work, provided the Union Member is then totally disabled and submits an attending physician's statement certifying continued disability.

Reciprocal Agreements

Local Union 771 Members – Union Members working in a jurisdiction other than Local Union 771 and on whose behalf contributions are being made to a Health and Welfare Trust Fund which has entered into a reciprocal agreement with Iron Workers (Saskatchewan) Local Union 771 Central Welfare Trust Fund should complete a Transfer Authority form and advise the Union or Plan Administrator to reciprocate contributions to the "Home Fund". This will maintain coverage under the Iron Workers (Saskatchewan) Local Union 771 Central Welfare Trust Fund.

Travel Card Member - Employees of Employers on whose behalf contributions are made but who are Member's of other Local Unions or Funds and whose Funds have entered into reciprocal agreements with the Iron Workers (Saskatchewan) Local Union 771 Central Welfare Trust Fund will not be eligible for benefits but will have all contributions made on their behalf reciprocated to their "Home Fund" after they complete the Transfer Authority form available at Local Union 771 office.

Third Party Liability

If a Participant or dependant has the right to recover damages from any person or organization with respect to which benefits are payable by the

Insurer, the Participant will be required to reimburse the Insurer 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 a Participant or dependant receives a lump sum payment under judgment or settlement for benefits which would otherwise be payable by the Insurer, no further benefits will be paid by the Insurer until the benefits that would otherwise be payable equal the amount of the lump sum.

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

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

Life Insurance for Participants

The amount of your Life Insurance benefit will be paid to your beneficiary upon your death, regardless of the cause.

When you enroll in the Plan, you should name a beneficiary to whom you wish your Life Insurance proceeds paid. Your estate will be your beneficiary if you do not name one. Subject to provincial laws, you may change your beneficiary at any time. Your Plan Administrator or Local Union Office will have the appropriate form to make such a change.

Amount of Benefit

As a Participant of the Plan, you are entitled to an amount of Life Insurance equal to outlined in the Highlight of Benefits section.

Coverage Ceases

For Union Members, Life Insurance coverage terminates following depletion of your Hour Bank Account and/or self-pay period. For Retired Members, coverage terminates following Hour Bank Depletion. For Union Staff or Probationary Members, coverage terminates on the date of cessation of employment or lay-off.

Waiver of Premium for Disability

If you become totally disabled before age 65, your Life Insurance coverage may be continued without payment of premiums, until you cease to be totally disabled or you reach the age of 65, whichever occurs first. After you have been totally disabled for at least six (6) months, you must submit the appropriate claim forms. **These claim forms must be received by the Plan Administrator and subsequently Sun Life Financial** within twelve (12) months of the date of disability. Your premiums will be waived following six (6) continuous months of total disability. Proof of a continuing disability may be required from time to time.

Disability is considered total when it prevents you from performing your regular duties during the qualifying period and the first two (2) years that you are entitled to disability payments. If you are still disabled at the end of this time, disability is considered total when it prevents you from performing any work where the requirements are within the range of your education, training or experience.

If you recover and return to work, but the same disability recurs, it will be considered a continuation of the previous disability if the period between disabilities is less than six (6) months. A recurrence of disability due to an unrelated cause will be considered a new disability if you have worked at least one (1) day between disabilities.

If you are also insured for group Long Term Disability Insurance with Sun Life Financial, total disability will be as defined under the Long Term Disability Insurance. You will only need to submit the claim forms for Long Term Disability Insurance. Premiums for both benefits will be waived when you begin receiving group Long Term Disability payments.

Premiums will not be waived if, within twelve (12) months of joining the Plan, you become totally disabled due to a condition which originated twelve (12) months prior to joining the Plan. This restriction will not apply if after becoming insured you have completed three (3) months of employment without any absence due to such condition.

Conversion Privilege

If your Life Insurance coverage terminates because you change jobs or retire, you may convert up to the full amount of your Group Life Insurance to an individual whole life or a convertible one-year term plan or a term to age 65 plan without submitting evidence of insurability. The premium rate will be determined from your age and class of risk at the time of conversion. Should you die within 31 days after your insurance terminates, an amount equal to your Group Life Insurance benefit will be paid whether or not you have applied for a converted policy.

Dependent Life Insurance

Amount of Benefit

If one of your dependants dies, Sunlife Financial will pay you the Dependent Life Insurance as outlined in the Highlight of Benefits section.

Coverage Ceases

For Union Members, Dependent Life Insurance coverage terminates following depletion of your Hour Bank Account and/or self-pay period. For Retired Members, coverage terminates following Hour Bank Depletion. For Union Staff or Probationary Members, coverage terminates on the date of cessation of employment or lay-off.

Waiver of Premium for Disability

If you become totally disabled before age 65, the Dependent Life Insurance may be continued without payment of premiums the same as your Life Insurance.

Conversion Privilege

If your spouse's insurance terminates, she/he may be eligible to apply for an individual conversion policy without providing proof of insurability. Your spouse must apply and pay the first premium no later than 31 days after your Group Insurance terminates.

Critical Illness

(Underwritten by AIG – Policy # CI 9428112)

Eligibility

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

Covered Critical Illness – 100% of Principal Sum for:

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

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

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

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

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

Principal Sum

Mandatory Coverage – you are covered for a flat amount of $10,000

Benefit Payment Conditions

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

- diagnosis is made within Canada;

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

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

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

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

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

Accidental Death and Dismemberment Insurance for Participants

Coverage

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

Benefit Amount

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

Coverage Ceases

For Union Members, Accidental Death & Dismemberment Insurance terminates following depletion of your Hour Bank Account and/or self-pay period. For Retired Members, coverage terminates following Hour Bank Depletion. For Union Staff or Probationary Members, coverage terminates on the date of cessation of employment or lay-off.

Waiver of Premium for Disability

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

Continuance of Coverage

If you are no longer employed or actively working, your coverage shall continue in the following circumstances: (1) during a statutory leave, as set out in applicable provincial, territorial or federal employment standards legislation or equivalent, but not more than the period required under such legislation, or (2) during the notice period for termination of employment as required by law, provided premiums continue to be paid.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

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

Table of Losses

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

Paralysis	
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two times the Principal Sum
Hemiplegia	Two times the Principal

(total paralysis of upper and lower limbs of one side of the body)	Sum

Additional Benefits

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

Policy Exclusions

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

(a) suicide or any attempt thereat;

(b) self-inflicted Injury or any attempt thereat;

(c) declared or undeclared war or any act thereof;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) death by natural causes.

Weekly Disability Income for Participants

In the event you become totally disabled due to an injury or illness 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 (Sun Life Financial) 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 which is required within twelve (12) months of the date of initial disability.

Benefits for any one disability are payable from the 1st day of disability for injury and hospitalization or the 8th continuous day of disability for illness. **But in no event prior to the first day of visit to your doctor.** Your benefit will be payable for not more than 52 weeks during any one period of disability, except as outlined in the Highlight of Benefits section.

Note: Any benefits collected are taxable and must be reported as income.

Totally disabled shall mean the Participant is incapacitated to the extent that the Participant is not able to perform all of the usual and customary duties of his/her occupation. A Participant is not considered totally disabled unless he/she is under the active and continuous care of a physician and is following the treatment prescribed by the physician for that disability.

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

Amount of Benefit

As a Participant of the Plan, you are eligible for an amount of weekly disability income as outlined in the Highlight of Benefits section.

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

For Union Members, Weekly Disability Income coverage terminates on your retirement. For Union Office Staff or Probationary Members, coverage terminates on the date of cessation of employment or lay-off.

Benefits are not payable for:

- disability resulting from an intentionally self-inflicted injury;

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

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

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

  a) imprisonment in a penal institution; or

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

- during any leave of absence (including maternity leave) as defined below.

Leave of Absence shall mean a period of time away from work mutually agreed to by the Employer and Participant. In the case of maternity leave of absence, the leave shall begin on the earliest of

i) the elected start date of the maternity leave,

ii) the date of delivery or

iii) the date the Employer may require the leave of absence to commence if the Participant's performance is affected by the pregnancy.

Such leave shall terminate on the later of the date defined by Provincial of Federal Statute, or the date agreed to between the Employer and Participant.

Offsets

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

a) any other plan or program provided to the Participant by or through the Employer;

b) any other plan or program of any government or the crown or of any subdivision of the government or the crown, including any plan or program established pursuant to a provincial automobile insurance act.

Notwithstanding the above, the Weekly Disability Income benefit will not be payable if a Participant is eligible for payments as a result of coverage from a Provincial Automobile Insurance Program.

If a Participant is receiving any income or benefit payable under any government plan or program of an injury or disease totally unrelated to the injury or disease that caused the current disability, the Insurer shall not reduce the weekly benefits by that amount.

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 (204) 942-4438 or Toll Free 1-888-204-1234 for the corresponding forms to apply for this benefit.

Long Term Disability Insurance for Participants

If you become totally disabled before you reach age 65 and are unable to work, you are eligible for a monthly disability benefit. Although it is not necessary for you to be confined to your house during the entire period of your disability, you must be under the care of a physician.

Description of Benefit

You will begin receiving disability payments after you have been continuously and totally disabled for a qualifying period of 52 weeks and your salary continuance plan (i.e. Weekly Disability Income) has expired. Payments are made at the end of each month and continue as long as you are totally disabled, even if the Group Policy terminates, but not beyond the date that you reach 65 years of age. During any period of disability payments, premiums will not be required.

Disability is considered **"total disability"** when it prevents you from performing your regular duties during the qualifying period and the first two (2) years that you are entitled to disability payments. If you are still disabled at the end of this time, disability is considered **"total disability"** when it prevents you from performing any work where the requirements are within the range of your education, training or experience.

If you recover and return to work, but the same disability recurs, it will be considered a continuation of the previous disability if the period between disabilities is less than one (1) month during the qualifying period or less than six (6) months during the period when disability payments are being made. A recurrence of disability due to an unrelated cause will be considered a new disability if you have worked at least one (1) day between disabilities.

Amount of Benefit

As a Participant of this Plan, you are eligible for an amount of monthly disability income as outlined in the Highlight of Benefits section.

It should be noted that the disability payment from this plan may be adjusted so that the monthly disability and retirement income which you receive from all sources does not exceed 85% of your pre-disability earnings (earnings are net of income tax for non-taxable benefits).

For Union Members, Long Term Disability Insurance coverage terminates upon attainment of age 65 or retirement whichever occurs first. For Union Office Staff or Probationary Members, coverage terminates on the earlier of age 65 or date of cessation of employment or lay-off.

All sources of total Monthly income includes:

a) Long Term Disability benefits under this Plan;

b) Income or benefits specified below, including any income or benefit from a different or lesser paid occupation;

c) Income from the Program of Rehabilitation.

d) Income payable to the Participant under a pension or retirement plan of the Employer, or any plan or arrangement resulting in the payment of any salary, wage or other payment by the Employer to the Participant during the total disability;

e) Income or benefit payable under:

   a) any other plan or program provided to the Participant by or through the Employer. Such plan or program includes any permanent and total disability benefit of Group Life Insurance for which the Participant could have elected not to apply.

   b) any Workers' Compensation law or similar law;

   c) the Canada Pension Plan or Quebec Pension Plan primary benefits.

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

A Participant must apply for all benefits or income for which he/she may become eligible under any of the preceding sources.

If a Participant is receiving any income or benefits payable under any government plan or program for an injury or disease totally unrelated to the injury or disease that caused the current disability, the Insurer shall not reduce the gross monthly benefit by that amount.

This benefit is taxable to the receiving Participant.

Subrogation

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

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

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

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

Waiver of Premium

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

Rehabilitation

As your condition improves, if it does not allow you to return to your job on a full-time basis, you might be able to work on a part-time basis or take a less demanding job. Inform Sun Life Financial of this and it may qualify as a rehabilitation program. If it does, you will continue to receive your

regular monthly disability benefit less 50% of your monthly earnings, during your rehabilitation.

If Your Long Term Disability Terminates

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

Exclusions and Limitations

The Long Term Disability benefit is not payable if your disability results from:

- intentionally self-inflicted injuries;
- civil disorder or war;
- the use of drugs or alcohol unless certified as being actively supervised by and receiving continuing treatment from a rehabilitation centre or a provincially designated institution;
- any condition which originated 12 months prior to joining the plan where disability commences within 12 months of joining the plan, except if after becoming insured you have completed 3 months of employment without any absence due to such condition.

You are not considered totally disabled unless you are under the active and continuous care of a physician whom Sun Life considers to be appropriate to your total disability and you are following the treatment prescribed by the physician for that disability.

Extended Healthcare for Participant and Dependants

Supplementary Hospital Benefit

Definitions

Hospital means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by us. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges means those who are usually made to a person without insurance for the items of expense listed under Eligible Expenses. Reasonable and customary also is a term used to refer to the commonly charged or prevailing fees for healthcare services within a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for that particular service with that specific community.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for accommodation in a hospital, limited to the difference between the charges for public ward and semi-private room for each day of hospitalization.

Exclusions

No benefit is payable for:

1. Expenses incurred under any of the conditions listed on the Extended Healthcare Insurance Provision page as an Exclusion.

2. Drugs which are listed in the "Monographs of Pharmaceuticals and Specialties" section of the current Compendium of Pharmaceuticals and Specialties of the Canadian Pharmaceutical

Association, excluding the following items unless they legally require a prescription.

Supplementary Healthcare Benefit

Definitions

Acupuncturist means a person who is listed on the appropriate provincial registry.

Audiologist means a member of the Canadian Speech & Hearing Association or of any provincial association affiliated therewith.

Chiropodist/Podiatrist means a person licensed by the appropriate provincial licensing authority.

Chiropractor means a member of the Canadian Chiropractic Association or of a provincial association affiliated with it.

Hospital means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by us. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Naturopath means a member of the Canadian Naturopathic Association or any provincial association affiliated with it.

Occupational Therapist means a person licensed by the appropriate provincial licensing authority.

Osteopath means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association or a person who holds a Diploma in Osteopathic Manual Practice (DOMP).

Physiotherapist (inclusive of Athletic Therapist) means a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it.

Psychologist means a permanently certified psychologies who is listed on the appropriate provincial registry in the province in which the service is rendered.

Reasonable and customary charges means those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Registered Dietician means a person licensed by the appropriate provincial licensing authority.

Registered Massage Therapist means a person licensed by the appropriate provincial licensing body or in the absence of a provincial licensing body, a person whose qualifications we determine to be comparable with those required by a licensing body.

Registered Nurse/Registered Nursing Assistant/Certified Nursing Assistant/Licensed Practical Nurse/Registered Practical Nurse means a nurse, nursing assistant or practical nurse or certified nursing assistant who is listed on the appropriate provincial registry.

Social Worker means a person who holds a Master of Social Work (MSW) degree from an accredited university.

Speech Language Pathologist means a person who holds a master's degree in Speech Language Pathology and is a member or is qualified to be a member of the Canadian Speech and Haring Association or any provincial association affiliated with it.

Eligible Expenses

To be eligible, the expenses must be medically necessary for the treatment of disease or injury and prescribed by a physician, unless otherwise specified.

Eligible expenses are the reasonable and customary charges for the items of expense listed below.

1. the services of a registered nurse (R.N.), registered nursing assistance (R.N.A.), certified nursing assistant (C.N.A.), licensed practical nurse (L.P.N.) or registered practical nurse (R.P.N.) when provided in the patient's home, limited to a maximum of $10,000 every 3 calendar years. To qualify as an eligible expense, the

patient's treatment must require the level of expertise of an R.N., R.N.A., C.N.A., L.P.N., or R.P.N.

2. the services of the following practitioners, limited to maximum of $600 per calendar year for each practitioner and are subject to reasonable and customary limits per visit/duration of visit. A physician's prescription is not required.

   - a registered massage therapist,
   - an acupuncturist,
   - an occupational therapist,
   - an audiologist,
   - a registered dietitian,
   - a speech language pathologist,
   - a chiropractor, including one x-ray examination per calendar year,
   - an osteopath, including one x-ray examination per calendar year,
   - a naturopath, and
   - a podiatrist or chiropodist, including one x-ray exam per calendar year.

   Where applicable, expenses for practitioners' services eligible under a provincial health care plan will not be reimbursed until expenses exceed the annual maximums under the member's or insured dependant's provincial plan.

1. The services of a psychologist or social worker (and similar qualified specialists), limited to a combined maximum of $1,000 per calendar year. A physician's prescription is not required.

2. The services of a physiotherapist (including Athletic Therapist), limited to a maximum of $1,000 per calendar year. A physician's prescription is not required.

3. Custom made orthopedic shoes, orthopedic modifications to shoes, and orthotics, when prescribed by a physician, podiatrist, chiropodist or chiropractor, limited to a combined maximum of $350 in a calendar year. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed.

4. Hearing aids and repairs to them, excluding batteries, limited to a maximum of $3,000 for eligible expenses incurred during a 5 year period.

5. The services of a dental surgeon, including dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means, provided the services are performed within 12 month of the accident but excluding services required in conjunction with such fracture or injury due to a condition that existed before the accident. A physician's prescription is not required.

6. Licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.

7. Emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, and, if the patient requires the services of a registered nurse during the flight, the services and return air fare for a registered nurse.

8. Intraocular (foldable) lenses following cataract surgery.

9. Trusses and crutches.

10. Plaster of paris or fiberglass casts.

11. Canes, walkers and parapodiums.

12. Braces, provided they are not solely for athletic use.

13. Splints and cervical collars.

14. Artificial limbs or other prosthetic appliances.

15. Oxygen.

16. Intermittent positive pressure breathing machines.

17. Continuous positive airway pressure machines (CPAP)

18. Apnea monitors, mist tents and nebulizers.

19. Wheelchairs, including repairs, and rechargeable batteries for covered wheelchairs.

20. Hospital beds, bed rails, trapeze bars, head halters and traction apparatus.

21. Elevated toilet seats, shower chairs, bathtub rails and standard commodes.

22. Cleft palate obturators.

23. Catheters and catheterization supplies.

24. Extremity pumps for lymphedema or severe postphlebitic syndrome.

25. Custom made burn garments and medicated dressings.

26. Food substitutes that must be administered through a tube feeding process. Tube feeding pumps and pump sets are also covered.

27. Custom made pressure supports for lymphedema.

28. The following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:

    - laboratory tests
    - ultrasounds
    - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, limited to a combined maximum of $500 in a calendar year

29. Blood, glucose monitors, limited to a maximum of $150 for eligible expenses incurred during a 5 year period.

Exclusions

No benefit is payable for:

1. expenses incurred for anyone who is not insured under the Provincial Medicare Plan,
2. expenses for the services of a homemaker,
3. expenses for items purchased solely for athletic use,
4. dental expenses, except those specifically provided under Eligible Expenses for treatment of accidental injuries to natural teeth,

5. utilization fees which are imposed by the provincial health care plan for the use of a service,
6. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Prescription Drugs Benefit for Participant and Dependants

If your dependant is insured for Prescription Drug benefits under another policy, payment under the other policy must be made first, if

1. your dependant is insured under the other policy as an insured person or
2. the birthday of the other insured person is earlier in the calendar year than your birthday.

For Union Members, the Prescription Drug coverage terminates following depletion of your Hour Bank Account and/or self-pay period. For Union Staff or Probationary Members, coverage terminates on the date of cessation of employment or lay-off.

Prescription Drugs Expenses

A Pay Direct Prescription Drug Card (coordinated with TELUS) is available to all Plan Participants, covering up to the allowable reimbursement maximum (as outlined in the Highlight of Benefits section) of the reasonable and customary changes for the following drug expenses, provided they are prescribed by a physician or dentist and dispensed by a registered pharmacist or physician.

1. Needles, syringes and chemical diagnostic aids for the treatment of diabetes.
2. Drugs, including vaccines and anti-obesity drugs, which are listed in the "Monographs of Pharmaceuticals and Specialties" section of the current Compendium of Pharmaceuticals and Specialties of the Canadian Pharmaceutical Association

   Reimbursement will be subject to the following:

   1. $15 dispensing fee maximum per prescription
   2. 20% pharmacy markup restriction
   3. Mandatory generic drug substitution unless a physician indicates a medical necessity

3. Smoking cessation products subject to a lifetime maximum of $500 per person.
4. Erectile Dysfunction drugs subject to a calendar year maximum of $600.

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.

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.

PRIOR AUTHORIZATION DRUG PROGRAM

Prescription drugs requiring prior authorization will be managed by TELUS's Team of experts.

How it works:

Doctor prescribes prior authorization drug: If you or your eligible dependent is prescribed a drug that is on the list of drugs requiring prior authorization (you may access the list on Coughlin's member portal at: www.coughlin.ca), your doctor must complete the Request for Prior Authorization form also available on the member portal or it can be requested from the Plan Administrator. It's important that the form be completed in its entirety as missing or partial information can result in a delay or a declined request.

Continuation of Coverage on Termination

Prescription Drug coverage would normally cease when your insurance terminates. If you or any of your insured dependants are totally disabled

when your insurance terminates, Healthcare benefits for the disabled person will continue during that disability for up to 90 days but only with respect to expenses incurred for the treatment of the disability and provided this benefit continues in force.

Limitations and Exclusions

The Prescription Drugs benefits are designed to reimburse you only for your out-of-pocket expenses. No reimbursement will be made for expenses resulting from:

- services covered under the Workers' Compensation Act or any other statute;
- intentionally self-inflicted injuries;
- services required as a result of civil disorder or war;
- services for which payment is the legal liability of any other party;
- drugs expenses which are experimental;
- Excluding the following items unless they legally require a prescription.

    a. publicly advertised items or products which, in the Plan Administrator's opinion, are household remedies.
    b. contact lens care products
    c. contraceptives (other than oral)
    d. diets and dietary supplements
    e. protein supplements
    f. therapeutic nutrients
    g. infant foods
    h. lozenges
    i. mouth washes
    j. non-medicated shampoos
    k. sugar and salt substitutes
    l. skin cleansers including soaps
    m. skin protectives and emollients
    n. surgical supplies
    o. vitamins and minerals (except haematinics)
    p. diagnostic aids
    q. medications used to prevent baldness or hair growth

Visioncare Benefit for Participants and Dependants

For Union Members, the Visioncare Benefit coverage terminates following depletion of the Member's Hour Bank Account and self-pay period. For Union Staff or Probationary Members, coverage terminates on the date of cessation of employment or lay-off.

Visioncare Expenses

You may recover up to the allowable reimbursement maximum (as outlined in the Highlight of Benefits section) of the reasonable and customary charges for the following Visioncare expenses:

1. eye examinations by an optometrist, eyeglasses (sunglasses not included) or contact lenses, prescribed safety glasses, replacing lenses, including repairs, subject to maximum outlined in the Highlight of Benefits section.

2. new lenses at any time if required by prescription change and prescribed by an ophthalmologist or optometrist, subject to a maximum of $75.

3. eyeglasses and contact lenses certified by an ophthalmologist as necessary due to a surgical procedure or the treatment of keratoconus, limited to $200 for the nonsurgical treatment of keratoconus for the lifetime of each insured Participant and each insured dependant and $200 for each surgical procedure.

Continuation of Coverage on Termination

Visioncare Benefit coverage would normally cease when your insurance terminates, but if you or any of your insured dependants are totally disabled when your insurance terminates, Healthcare benefits for the disabled person will continue during that disability for up to 90 days but only with respect to expenses incurred for the treatment of the disability and provided this benefit continues in force.

Limitations and Exclusions

The Visioncare Benefit coverage is designed to reimburse you only for your out-of-pocket expenses. No reimbursement will be made for expenses resulting from:

- services covered under the Workers' Compensation Act or any other statute;
- intentionally self-inflicted injuries;
- services required as a result of civil disorder or war;
- services for which payment is the legal liability of any other party;
- services payable under any government plan;
- expenses for sunglasses.

Dentalcare Benefits for Participants and Dependants

Your Group Insurance Plan provides Dentalcare benefits for Participants and eligible dependants. This benefit reimburses you for some of the reasonable and customary charges you incur for necessary dental services (refer to the Highlight of Benefits section for co-insurance and maximum reimbursement levels as well as the applicable Dental Fee Schedule).

If your dependant is insured for Dentalcare Insurance benefits under another policy, payment under the other policy must be made first if:

1. your dependant is insured under the other policy as an insured person, or

2. the birthday of the other insured person is earlier in the calendar year than your birthday.

For Union Members, the Dentalcare coverage terminates following depletion of your Hour Bank Account and/or self-pay period. For Probationary Members or Union Staff, coverage terminates on the date of cessation of employment or lay-off.

Alternate Benefits and Submission of Treatment Plan

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

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

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

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

Note: The proposed course of treatment must be completed within ninety (90) days for the benefit determination to remain valid. Otherwise, it is suggested you submit a new treatment plan.

Limitations and Exclusions

- services payable under the Workers' Compensation Act or any other statute;
- intentionally self-inflicted injuries;
- services required as a result of civil disorder or war;
- services for which payment is the legal liability of any other party;
- services other than those performed by a dentist, except those services which may be performed by legally qualified personnel under the supervision of a dentist or a paradental practitioner;
- services payable under any government plan.

Preventative Procedures (90% co-insurance)

(a) examination and diagnosis:

⇒ oral examination,
⇒ recall oral examination, (once every twelve (12) months),
⇒ special oral examination,
⇒ treatment planning,
⇒ emergency and unusual services,
⇒ consultation,
⇒ house call, institutional call, office visit

(b) tests and laboratory examinations:

⇒ biopsy of oral tissue,
⇒ pulp vitality test

(c) radiographs:

⇒ periapical (one complete series every two (2) years,
⇒ occlusal,
⇒ bitewing (once every six (6) months),

⇒ extra oral,
⇒ sialography,
⇒ fistulography,
⇒ cystography,
⇒ radiopaque dyes to demonstrate lesions,
⇒ panoramic (once every 2 years),
⇒ interpretation of radiographs received from another source,
⇒ Tomography

(d) preventive services:

⇒ dental prophylaxis (once every twelve (12) months),
⇒ topical application of fluoride phosphate (once every twelve (12) months),
⇒ pit and fissure sealant, (for children under 19 years of age),
⇒ caries control,
⇒ interproximal discing

(e) space maintainers

(f) plastic fillings:

⇒ amalgam,
⇒ silicate,
⇒ acrylic or composite resin,
⇒ transitional restoration of fractured anterior
⇒ steel crown - primary teeth,
⇒ cement

(g) endodontics:

⇒ pulpcapping,
⇒ pulpotomy,
⇒ root canal therapy,
⇒ periapical services,
⇒ other endodontic procedures,
⇒ emergency procedures

(h) periodontic:

⇒ non surgical services,

⇒ occusal equilibration (not exceeding eight (8) time units every year),
⇒ scaling and dentition

(i) relining and rebasing of dentures

(j) surgical services:

⇒ uncomplicated removals
⇒ surgical removals and repositioning,
⇒ surgical excision,
⇒ surgical incision,
⇒ fractures,
⇒ lacerations,
⇒ Frenectomy,
⇒ miscellaneous surgical services

(k) anesthesia in connection with oral surgery and drug injections

Restorative Procedures (80% co-insurance)

(a) crowns, inlays, onlays:

⇒ gold foil restorations,
⇒ metal inlay restorations,
⇒ porcelain inlay restoration,
⇒ crowns,
⇒ other restorative services,
⇒ hemisection

(b) fixed bridgework:

⇒ bridge pontics,
⇒ retainers,
⇒ abutments,
⇒ other prosthetic services

(c) partial and complete dentures:

⇒ complete dentures,
⇒ partial dentures,

⇒ partial denture additions

(d) examinations:

⇒ oral examination,
⇒ temporomandibular joint x-rays,
⇒ diagnostic casts,
⇒ prosthodontic evaluation

(e) replacement of an existing denture, bridgework, crown, inlay, onlay, or periodontal splinting where the existing prosthesis is at least five (5) years old, subject to a maximum eligible expense of the value and quality of the prosthesis being replaced;

(f) the addition of teeth to an existing partial denture or fixed bridgework where the addition is required to replace one (1) or more teeth removed while the claimant is insured under this restorative benefit;

(g) laboratory charges for eligible restorative expenses, but not exceeding 66 2/3% of the dentist's professional fee for the procedure in the applicable fee guide.

(h) Periodontics:

⇒ surgical services,
⇒ post surgical treatment,
⇒ adjunctive procedures,
⇒ post treatment evaluation

(i) repairs and adjustments

⇒ recementing crown,
⇒ adjustment to denture,
⇒ repairs to dentures,
⇒ addition of tooth,
⇒ remake partial dentures,
⇒ repairs to bridges

(j) major surgery:

⇒ alveoplasty

⇒ excision of tumor
⇒ dislocations
⇒ 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.

Should implants and/or related services be obtained, reimbursement will be considered but only up to the maximum that would have been paid for the least costly professionally adequate treatment to restore the entire arch, such as prosthetic devices (crowns, denture and/or bridgework) as defined under the Alternate Benefit provisions, subject to the coinsurance applicable to the treatment determined to be eligible.

Exclusions

No benefit is payable for:

1. services which are cosmetic in nature;

2. dentures and bridgework (including crowns and inlays forming the abutments) to replace a tooth or teeth removed before the insured person or dependent became insured under this benefit, or to replace a tooth or teeth congenitally missing.

3. crowns and onlays, placed on a tooth not functionally impaired by incisal or cuspal damage,

4. dentures which have been lost, stolen or mislaid;

5. prosthetic devices which are ordered while the insured person or dependent is insured under this benefit but are installed after termination of this benefit,

6. replacement of dentures, bridgework, crowns, inlays, onlays or periodontal splinting and addition of teeth to existing dentures or bridgework except as provided under Eligible Expenses.

Orthodontic Benefit (80% co-insurance)

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense incurred by an insured dependent child under age 19 for the treatment of malocclusion or for orthodontic treatment.

Procedures

(a) observation, adjustment:

- ⇒ oral examination,
- ⇒ skull and facial bone survey,
- ⇒ cephalometric radiographs,
- ⇒ hand and wrist radiographs,
- ⇒ diagnostic cast,
- ⇒ surgical services,
- ⇒ observation, adjustment,
- ⇒ repairs, alternations,
- ⇒ active appliances for tooth guidance or uncomplicated tooth, movement,
- ⇒ retention appliances,

(b) control of oral habits:

- ⇒ appliances,
- ⇒ adjustments, repairs, maintenance,

(c) comprehensive treatment

(d) anesthesia (if performed in conjunction with oral surgery):

- ⇒ general anesthesia,
- ⇒ deep sedation,
- ⇒ conscious sedation,

(e) laboratory procedures

Exclusions

No benefit is payable for:

1. expenses for replacement of orthodontic appliances which have been lost, stolen or mislaid;

1. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction;

2. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Travel Medical Emergency

(Underwritten by AIG/ Global Excel – Policy # CMG 9428901)

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 9428901

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

For Union Members and their families to offset Healthcare and Dentalcare expenses incurred above and beyond the coverage presently provided by the Iron Workers (Saskatchewan) Local Union 771 Central Welfare Trust Fund Group Insurance Plan (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

The Healthcare Spending Account allocation is provided on an hourly basis as per the Collective Agreement. Presently the allocation to each individual Union Member account is based on an Employer contribution remittance of $0.50 per hour worked subject to an H.S.A. limit of $10,000 per Member account**. It is understood that to be eligible for the allocation, the individual must be in good standing with the Local Union 771.**

For Union Members who are no longer in benefit (i.e. Retirees, Non-Working Members, Disabled), you may still make claims against your Healthcare Spending Account balance following your last day of coverage under the Group Insurance Plan provided you maintain your good standing as a Member of the Local Union 771.

As per Canada Revenue Agency (CRA) regulations, the Healthcare Spending Account is subject to annual forfeiture and subsequent reallocation given the Plan's continued positive financial stability.

Termination

In the event of termination of Membership from Local Union 771, 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.

Reinstatement

Reinstatement of a Union Member's Healthcare Spending Account is not applicable as it is a requirement that a Member maintain a positive status with Local Union 771 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.

Coverage

Benefit coverage may be extended to all Health Insurance claims inclusive of the benefits listed below to the extent that the claims for these benefits can be charged against the Union Member's Healthcare Spending Account until its depletion.

1. Health Insured benefits;
2. Visioncare;
3. Dentalcare;
4. Eldercare.

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 # (83269) and Certificate # (Member ID) – these can be obtained from your Prescription Drug card. If you do not have these, they can be provided by the Plan Administrator.

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

Healthcare Navigation:

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

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

Access to Healthcare Navigation is through Compass Health Care Navigation at 1-866-883-5956. You will be asked to provide your name, Member ID (can be obtained from your Drug Card), your Union Local and

possibly your Provincial Healthcare # (depending on the nature of your call).

Cancer Assistance:

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

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

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

Medical Second Opinion:

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

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

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

Quikcare- Expedited Healthcare

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

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

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

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

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

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

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

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

How to Make a Claim

Time Limitations

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

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

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

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

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

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

Member Portal – Electronic Claims

Coughlin & Associates Ltd. offers plan members the option to submit claims for prescription drugs, health and dental online. To access this service, please register at Coughlin's plan member portal at

https://coughlin.onlineclaimsaccess.net/ or download the mobile app from the App Store or Google Play. Once you are on the portal or have accessed the app:

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

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

Point of Sale Claims Submission

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

Dental:

1) Bin # 000034 on Telus Adjudicare network
2) Group Number # 58785
3) Individual certificate number (printed on your card)

Health :

1) Bin #34 on Telus Adjudicare network
2) Group Number # 58785
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.

Co-Ordination of Benefits

If you or 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), Sun Life Financial will take this into account when determining the amount of expenses payable under this Plan.

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

Order of Benefit Payment

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

- If your Spouse's Plan does not 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 Dependent Spouse:**

      The Plan insuring you or your Dependent Spouse as an Employee/Participant pays benefits before the Plan insuring you and your Spouse as a dependant.

      In situations where you or your Spouse have coverage as an Employee/Participant under more than one (1) 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 the benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

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

  - the Plan of the parent with custody of the child, then
  - The Plan of the spouse of the parent with custody of the child (i.e. if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the 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).
  - 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 or ask the Primary Carrier to return the original receipts to you once 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 and receipts to the Secondary Carrier for further consideration of payment if applicable.

Group Optional Term Life Insurance

You may wish to purchase additional Life Insurance under the Group Optional Term Life Insurance.

Monthly Premium Rates

Premiums for the *Group Optional Term Life Insurance* coverage are based on your sex, age and smoking habits. See the table for applicable premium rates.

MONTHLY PREMIUM FOR EACH UNIT OF $10,000 OF LIFE INSURANCE				
Age of Employee or Spouse	**Male Non-Smoker**	**Male Smoker**	**Female Non-Smoker**	**Female Smoker**
To age 34	.60	1.00	.50	.70
35 – 39	.70	1.30	.60	1.00
40 – 44	1.00	2.10	.90	1.60
45 – 49	1.90	3.90	1.60	2.70
50 – 54	3.30	6.50	2.70	4.40
55 – 59	6.10	11.20	4.30	6.70
60 – 64	8.60	15.10	5.70	8.40
65 – 69	11.70	19.60	7.90	10.80

For example, a woman who is a non-smoker and under the age of 35 could qualify for $30,000 of life insurance coverage for $1.50 per month. A male, non-smoker in the same age range would pay $1.80 per month for the same amount of life insurance coverage.

How to qualify for *Group Optional Term Life Insurance*

To be eligible, you must be a Member in good standing with the Local Union. You continue to be eligible during periods of lay-off or unemployment provided you are a Member in good standing.

Available in units of $10,000, *Group Optional Term Life Insurance* can provide up to **$500,000** of additional life insurance coverage for you and your spouse.

Your *Group Optional Term Life Insurance* coverage will become effective when your application for insurance is approved. For your convenience, premiums are remitted monthly, in advance.

Your spouse can also own *Group Optional Term Life Insurance*

To enrol your spouse in the *Group Optional Term Life Insurance* program, simply have him or her complete and sign the spousal portion of the attached application.

Other important benefits

The *Group Optional Term Life Insurance* program offers other important features, including the following benefits:

Free, 31-day conversion. If you change your occupation, you may convert your *Group Optional Term Life* coverage to an individual insurance plan from Canada Life within 31 days of termination, **without** evidence of insurability or medical examination.

Coverage to age 65. *Group Optional Term Life Insurance* coverage is available to age 65. You may reduce your amount of coverage whenever it is desirable without incurring a penalty.

How To Apply

To apply for *Group Optional Term Life Insurance* coverage, simply visit our website at www.coughlin.ca and click the link to download an application, or contact the office below and request an application:

Group Optional Term Life Insurance
Coughlin & Associates Ltd.
Toll Free: 1-888-613-1234, ext. 4288
Email: vollife@coughlin.ca

This booklet highlights the principal features of the plan, but the Group Policies for Sun Life Financial (no. 83269), AIG Insurance Company (Travel no. CMG 9428901, Critical Illness no. CI 9428112, and Accidental Death & Dismemberment no. GPA 9429841), and the self-insured document for Prescription Drugs, Extended Healthcare, Visioncare, Dentalcare, and Weekly Disability Insurance benefits, issued to the Trustees of the Iron Workers (Saskatchewan) Local Union 771 Central Welfare Trust Fund are the governing documents. In the event of any variation between the information in this highlight and the provisions of the policies, the later will prevail.

BOARD OF TRUSTEES

Management Trustees	**Labour Trustees**
Dana Paidel	Wayne Worrall
Skip Wright	Kim Zimmerman
	Steve Seager

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