OPERATING ENGINEERS OF MANITOBA LOCAL 987

RURAL MUNICIPALITIES OF DAUPHIN, GILBERT PLAINS, ROLAND, ROSEDALE, AND YELLOWHEAD

HEALTH & WELFARE TRUST FUND

April 2021

Introduction

Insurance protection against the financial hardship that so often accompanies sickness, accident or death is important to all of us. In order to make this protection available to you, a Group Benefit Plan has been arranged to assist in protecting the Plan Participants of the Operating Engineers of Manitoba Local 987 Health and Welfare Trust Fund from these hardships. The Supplementary Healthcare and Dentalcare 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 Benefit Plan shares the payment of your medical and dental bills with you. The Healthcare and Dentalcare Benefits are underwritten by Manulife Financial, Employee Family Assistance Program benefit provided by Homewood Health, and Travel Medical Emergency Benefit is underwritten by RSA Travel Insurance Inc.

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

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

Please note that benefits may change at any time given legislative revisions and/or the costs of providing Plan benefits. You will be advised accordingly of any benefit changes.

The Plan Administrator is Coughlin & Associates Ltd. and their office is located at Suite 1391 –1403 Kenaston Blvd, Winnipeg, Manitoba, R3P 2T5. If you have any questions concerning your benefits or claim procedures, please contact the Plan Administrator at (204) 942-4438 or Toll Free 1-888-204-1234 for this information.

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

Sincerely,

The Board of Trustees of the Operating Engineers
of Manitoba Local 987 Health and Welfare Trust Fund

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Important Notice

This booklet highlights the principal features of the Plan and is presented as a matter of general information only. Please note that this information is in reference to the governing documents of the Plan: Group Policy #901837 of Manulife Financial's Policy issued to the Trustees of Operating Engineers of Manitoba Local 987 Health & Welfare Trust Fund, Homewood Health's Employee Family Assistance Program Policy, People Corporation's Coughlin Care Gold and People Connect, and RSA Travel Insurance Inc.'s Travel Medical Emergency Policy (#1166345).

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

Notice Regarding Personal Information

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

The purpose of this file is to permit their Employees to administer all financial services provided to you and to keep information specific to their business relationship with you. This includes the following:

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

The files are kept in the offices of the Plan Administrator. The Employees of Manulife, RSA, and Coughlin & Associates have access to these files when required for insurance purposes.

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

Privacy

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

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

Highlight of Benefits

Administration Contact: 987admin@coughlin.ca
Claims Contact: winnclaims@coughlin.ca

Optional Life Insurance

Coverage in units of $10,000 to a maximum of $500,000 each (Participant and spouse) subject to medical questionnaire and approval by Insurer. Call Plan Administrator for more information.

Optional Critical Illness

Coverage in units of $5,000 to a maximum of $150,000 for Participant and Participant's spouse subject to medical questionnaire and approval by Insurer. Call Plan Administrator for more information.

Supplementary Healthcare

Deductible .... $25 per individual or family per calendar year
(not applicable to Prescription Drugs, hospital and visioncare expenses)

Coinsurance .... 100% of eligible expenses

Lifetime Maximum .... Unlimited

Prescription Drugs (Pay Direct Drug Card via Express Scripts Canada)
Benefit Year Maximum (April 1 to March 31)............. $ 1,200 per family
Dispensing Fee $15/prescription
Mark-up maximum .... 20% of wholesale cost

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

Smoking Cessation Products .... $500 per person per Lifetime

Fertility Drugs .... $2,500 per person per Lifetime

Paramedical Services .... $500 per person per calendar year per specialist

Speech Therapist/Psychologist .... $1,000 per person per calendar year per specialist

Visioncare Maximum Benefit

Eyeglasses and Contact lenses .... $100 per individual every 24 consecutive months

Eye Examinations .... $50 per individual every 24 consecutive months (every 12 months if under 21 years of age)

Visioncare expenses are not subject to a deductible or coinsurance.

Supplementary Healthcare coverage ceases at age 75 (unless actively working). Please refer to Supplementary 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 $75.00 per hour or $37.50 per 30 minutes and payable via credit card. For reimbursement from the Health and Welfare Trust Fund, please submit the receipt and claim form to Coughlin & Associates for processing.

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

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

Coughlin Care Gold

- **Virtual Healthcare** (vCare): To register for vCare you can access directly via the secure link ***https://www.vcareregistration.com*** You will require your policy number (901837**)** and certificate number (Member ID) off your Prescription Drug card or contact the Coughlin Administrator at vcare-info@coughlin.ca or (204) 942-4438.

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

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

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

Eligibility ....Local Union 987 Insured Participants and Families

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

Travel Medical Emergency

For emergency treatment while traveling outside your province of residence

Deductible .... Nil

Maximum Trip Duration .... 90 days (top-up insurance available)

Maximum Benefit .... $5,000,000 per trip

Pre-Existing Condition Period for Retired Members and Active Members Age 70 to 75 inclusive ....90 days

Coverage terminates .... at age 75

Policy Number 1166345

In the event of an emergency, please call from Canada/USA 1-866-870-1898 or Collect from anywhere +819-566-1898. The emergency telephone numbers are listed on the back of the medical assistance card.

Please refer to RSA's Travel Medical Emergency booklet for further details.

Employee Family Assistance Program (EFAP)

Benefit.......................................12 sessions (1 hour)/individual/calendar year via Homewood Health at (1-800-663-1142)

Please contact Coughlin & Associates or access your Member Portal for further information.

Dentalcare

Deductible .... Nil

Coinsurance...100% for Basic Services
80% for Major Services

Maximum Benefit ....$1,000 per individual per calendar year

For any new Employees
hired of the year they
first become insured ....$500 per individual per calendar year

Fee Guide – Benefits are paid in accordance with the 2021 Fee Guide (subject to change) for the province where the service is rendered. Please see the Dentalcare section for a list of eligible expenses

Dentalcare coverage ceases at the earlier of age 75 (unless actively working). Please see Dentalcare section for more details.

General Information

The Group Benefit Plan is administered by a Board of Trustees representing the Participants of Operating Engineers of Manitoba Local 987 and Contributing Employers participating in the Plan.

For each Participant, an account kept by Coughlin & Associates Ltd. will reflect the contribution remittance received from your Contributing Rural Municipality (i.e. Employer) for the purpose of Group Benefits. Effective October 1, 2020 your Employer will remit a flat amount based on your age category (under age 65 and over age 70).

Initial Eligibility

Following satisfaction of the applicable waiting period with your Rural Municipality (i.e. Employer) or on the date of seasonal rehire, notification must be provided by the Employer to Coughlin & Associates before the end of the month with the applicable monthly contribution remittance received no later than the 15th of the next month, in order for your coverage to start the 1st of the following month. Local 987 Non-Member Participants the waiting period is **six (6)** consecutive months of employment. **To be eligible for benefits, all members and non-member participants must complete and submit an Enrolment Card**

For Supplementary Healthcare, People Connect, Coughlin Care, Employee Family Assistance Program (EFAP), Dentalcare and Travel Medical Emergency benefits.

> You and your eligible dependents will become insured for coverage **on the first day of the following month of satisfying your waiting period or date of rehire** provided you are actively at work or available for work on the day you would ordinarily become insured.

If you are unable to work when coverage would be in effect, the effective date of coverage will then be postponed until you are able to work.

Ongoing Eligibility

Each month an amount will be deducted from the Union Member's Account equal to the contribution remittance based on the applicable age category. This is also applicable for Local 987 Non Member Participants.

For Local 987 Non Member Participants coverage ceases immediately upon the date of termination of employment or lay-off.

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 Members

Members deemed "Fulltime" by the Employer and in good standing with Local 987 on whose behalf contributions are made to the Operating Engineers of Manitoba Local 987 Health and Welfare Trust Fund. This includes "Seasonal" members who work on average more than 25 hours weekly.

Local 987 Non-Member Participants

Office Staff or Associates who are considered full-time (i.e. working on average greater than 35 hours per week) and on whose behalf contributions are being made to the Operating Engineers of Manitoba Local 987 Health and Welfare Trust Fund but are not Union Members of Local 987 or any other reciprocating Local will be eligible for benefit coverage while working for a Contributing Employer.

Retired Members

A Union Member is considered Retired when he/she has attained age 55 or older and has indicated retirement to the Plan Administrator or Local 987.

Eligible Dependants

Eligible dependents under this Plan who are Canadian residents and covered under a provincial health insurance program shall include:

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

- Your spouse as the result of a valid civil or religious ceremony, or a person (including same-sex partners) whose relationship with you has existed for a minimum period of twelve (12) consecutive months immediately prior to the date on which a claim arose.

- Unmarried children who are under age 22, or under age 25 if attending an accredited school, college, or university as a full-time student. Dependent children must be dependent on you for support and not employed at a regular full time job.

- A child of your spouse provided:
    - i. he/she is also your biological child; or
    - ii. your spouse is living with you and has custody of the child.

- Any functionally impaired child who was insured as a dependant shall remain insured beyond any limiting age for dependants. For the purposes of insurance, functionally impaired shall mean an unmarried person who was insured as a dependant prior to becoming functionally impaired who is not receiving payments from an aid program and is incapable of self-sustaining employment due to a functional impairment specified in a government regulation and who is wholly dependant upon the member for support and maintenance within the terms of the Income Tax Act.

- Divorced or separated spouses (with or without a court order or separation agreement) are **not** eligible for coverage.

If a dependant is confined for medical care or treatment in any institution or at home when coverage would normally start, the dependant will not be covered until given a final release by the physician from all such confinement.

IMPORTANT:

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

Continuation of Benefits for Dependants

If your death occurs while you are insured, the Supplementary Healthcare, People Connect, Coughlin Care, EFAP, Travel Medical Emergency, and Dentalcare coverage for your dependants will continue for a period of twenty four (24) months. If your surviving children cease to qualify as eligible dependants (as defined earlier), any coverage continuing after your death will terminate on the earlier of the date they no longer qualify or the date that the policy or benefit terminates. Your surviving spouse shall cease to qualify on the earlier of the date of re-marriage or the date the policy or benefit terminates.

Reinstatement of Eligibility

For Supplementary Healthcare, People Connect, Coughlin Care, EFAP Dentalcare and Travel Medical Emergency benefits.

> If your benefit coverage has previously terminated because of a seasonal lay-off and you chose not to self-pay to continue coverage, you will again become insured on the first day of the month following your return to work if the Plan Administrator has received notification of your rehire in such month and the applicable monthly contribution remittance received no later than the 15th of the next month **provided your return to work is within 6 months**.

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

Changes in Insurance Benefits

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

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

received before the date of an increase in benefits will always be based on Plan benefits in effect before the change.

Termination of Insurance

Coverage for you and your eligible dependants will terminate:

1. For a Union Member, the last day of the month following the month wherein you have officially terminated. However, you may arrange to have your coverage continued on a self-pay basis as identified in the Self-Payment Provision of this Booklet.

2. If you cease to be a Member of the Union.

3. For Local 987 Non-Member Participants, at the end of the month following the date of termination of employment or lay-off. Local 987 Non-Member Participants are not eligible to make self-payments.

4. If you enter military service.

5. If the Group Policy terminates.

6. If you discontinue any required contributions.

7. When you attain age 75 - with respect to Travel Medical Emergency coverage.

8. When you attain age 75 (unless actively working) with respect to Supplementary Healthcare, EFAP, and Dentalcare Benefits.

9. The date you become eligible for other Group Insurance benefits similar to those for which you are covered under this Plan.

10. For a dependant, once they no longer qualify as an eligible dependant (please refer to Eligible Dependants section)

Self-Payment Provision

A Union Member under the age of 75 whose benefit coverage is terminated due to seasonal lay-off or disability may continue to have coverage for him/herself and eligible dependants by making monthly self-payments to the Plan through the Plan Administrator (Coughlin & Associates Ltd.) for eighteen (18) consecutive months. If the Union

Member is disabled, the self-pay period is extended to 36 months provided proof of disability (WCB, Autopac, LTD, etc.) submitted as requested. The self-payment must be made prior to the twenty-eighth (28th) day of the month following the month you stopped working.

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

Eligibility to self-pay is contingent upon the discretion of the Union, whereby the Union and Retired Member must remain in good standing with Local 987.

Monthly Statements

Each month a statement is mailed to each Participant (excluding Local 987 Non-Member Participants). This statement will show the Participant's benefit status, the Employer's contribution, and the previous and present months' Account balances. It should be noted that an amount is deducted (refer to Ongoing Eligibility) from your Account balance each month to pay the premium for your coverage.

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

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

Disability Claims

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

Disability Provision

- **Disabled Local 987 Member**

  A disabled Local 987 Union Member may have coverage extended for up to thirty-six (36) months from the date of disability provided

self-payments are made to the Plan through the Plan Administrator (Coughlin & Associates Ltd.) and proof of disability provided as requested.

- **Disabled Local 987 Non-Member Participant**

  A disabled Local 987 Non-Member Participant may have coverage extended for twelve (12) months from the date of disability provided the required monthly contribution is remitted to the Trust Fund on his/her behalf and proof of disability provided as requested.

Third Party Liability

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

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

If you or your dependant receives a lump sum payment under 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.

You or your 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.

Supplementary Healthcare

In the event you or your dependant(s) incur in a calendar year any of the Eligible Expenses listed below, you will be paid up to 100% of the Benefit Maximum of such expenses in excess of the Medical Deductible for that year.

Medical Deductible

The Medical Deductible is that portion of the Eligible Expenses which you are required to satisfy in any year before you receive benefits. The Medical Deductible is $25 per individual or family per calendar year and is deducted from the first eligible claim submitted for assessment in each calendar year.

Lifetime Maximum Benefit

The total lifetime benefit payable in respect to you or your dependants is outlined in the Highlight of Benefits section.

Coverage Ceases

For Union Members, Supplementary Healthcare coverage ceases at the earlier of age 75 (unless actively working), the date of termination of employment, the date of retirement, and/or following the depletion of the self-pay period or if you are no longer a Union Member in good standing with the Local 987.

Local 987 Non-Member Participants coverage ceases at the earlier of age 75, the date of retirement, the date of termination of employment or lay-off.

Eligible Expenses

The following is a list of eligible expenses:

Prescription Drug Expenses

Subject to the benefit maximum identified in the Highlight of Benefits section of this booklet, including reasonable and customary charges incurred for medically necessary drugs and medicines which:

1) are dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines;

2) are prescribed by a physician or other professional authorized by provincial legislation to prescribe drugs for the treatment of a diagnosed illness or injury.

Note: Smoking cessation aids containing nicotine are covered, subject to a lifetime maximum benefit of $500 per individual. Fertility drugs and treatment are covered, subject to a lifetime maximum benefit of $2,500 per individual. Viagra and other erectile dysfunction drugs are covered and are included in the annual benefit maximum for Prescription Drug Expenses.

Reimbursement also subject to:

1) a $15 dispensing fee maximum per prescription;

2) 20% pharmacy markup restriction;

3) mandatory generic substitution unless a physician indicates a medical necessity.

No benefit shall be payable for:

1) vitamins, vitamin supplements, dietary supplements, or diet foods.

2) food and food products, including infant formula, infant foods, and salt and sugar substitutes.

3) general products or any other product which can be sold at any retail outlet including, but not limited to, such items as contact lens care, non-medicated shampoo, toothpaste, skin protectors, emollients and soaps.

4) any single purchase of drugs which would not reasonably be used within ninety (90) days from the date of purchase.

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.

Supplementary Health Expenses

The following is a list of eligible expenses which are covered to the extent that they are Reasonable and Customary, as determined by Manulife Financial; and they are not insured under the Provincial Plan or any other government-sponsored program. Reasonable and Customary is a term used to refer to the commonly charged or prevailing fees for healthcare services with a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for that particular service with that specific community.

1) Charges for a licensed Convalescent Care Facility subject to a daily maximum benefit of $10 per day for semi-private or private accommodation for not more than 120 days of confinement per disability. Confinement must begin following a minimum of three (3) consecutive days of hospital confinement and prior to the insured's 65 birthday;

2) Charges for the services of a certified registered or licensed Osteopath, Chiropractor, Physiotherapist/Athletic Therapist, Naturopath, Podiatrist or Chiropodist, Masseur* or Christian Science practitioner up to a maximum benefit identified in the Highlight of Benefits section of this Booklet, in excess of the provincial plan, per individual per calendar year per practitioner and are subject to Reasonable and Customary limits per visit/duration of visit.

   * The Massage Therapist must have a Government Registration Number and a minimum of two (2) years study at a recognized Massage Therapy School.

   Charges for the services of a licensed Speech Therapist or Clinical Psychologist/Qualified Social Worker (and similar qualified Specialists) (eff. Jan. 1/16) up to a maximum benefit identified in the Highlight of Benefits section of this Booklet in excess of the provincial plan, per individual per calendar year per specialty and subject to Reasonable and Customary limits per visit/duration of visit.

Charges for x-rays are covered up to a total maximum benefit of $20 per calendar year for all specialties combined;

3) Charges for the services of a Registered Nurse (R.N.) Nursing Assistant (C.N.A., R.N.A., R.P.N., L.P.N., or L.N.A.) or a member of the Victorian Order of Nurses (V.O.N.) which are rendered while the insured is not confined to a hospital subject to an overall maximum benefit of $10,000 in any calendar year provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and only if medically necessary;

4) Charges for rental (or, at the Insurer's option, purchase) of durable medical or surgical equipment required for therapeutic purposes and as approved by the Insurer;

5) Charges for rental (or, at the Insurer's option, purchases) of braces and crutches and the purchase of prostheses;

6) Charges for professional ambulance services, other than airline, to and from the nearest hospital qualified to provide the necessary treatment;

   Emergency transportation within the Insured's province of residence by airline to and from the nearest hospital qualified to provide the necessary treatment. Such emergency transportation is subject to a maximum benefit equal to the economy airfare for the Insured and, if medically required, a medical attendant who is neither a resident in your home nor a relative of your family;

7) Charges for necessary dental treatment required as the result of an accidental injury to natural teeth provided the accident occurred while insured under this coverage, subject to a maximum benefit of $5,000 per accident. As determined by the Insurer, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within twelve (12) months of the accident to be considered a covered medical expense;

8) Charges for orthopedic shoes and orthotics prescribed by a licensed physician, podiatrist or chiropodist which have been specially designed and molded by an orthotist, pedorthist, podiatrist, or chiropodist for the Insured individual and are

required to correct a diagnosed (by a physician, podiatrist or chiropodist) physical impairment. The maximum benefit is $200 per shoe and an overall maximum benefit of $400 in any calendar year. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed;

9) Charges for laboratory tests and x-rays not covered by any provincial government plan, subject to a maximum benefit of $500 per individual per calendar year;

10) Charges for purchases of hearing aids (excluding batteries), subject to a maximum benefit of $500 per individual in any four (4) consecutive years;

11) Charges for compression stockings when prescribed by a physician for a diagnosed medical condition including the required compression factor, to a maximum of 2 pairs per calendar year. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed;

12) Wigs as a result of chemotherapy treatment or some other disease that causes hair loss, up to $250 per lifetime.

Out-of-Country Referral Expenses (outside Canada)

If you are under age 65 and are referred by a physician for non-emergency treatment which is not available in Canada and for which there is no medically sufficient alternate treatment available in Canada, the following expenses in excess of any provincial government plan allowance are covered, provided they are eligible for reimbursement in whole or in part by the provincial government plan. Expenses incurred outside Canada are subject to a lifetime maximum benefit of $1,000,000.

1) reasonable and customary charges for semi-private accommodation;

2) reasonable and customary charges for the services of a physician;

3) reasonable and customary charges for hospital services and supplies furnished during hospitalization, and for x-ray examinations and laboratory tests related to medical treatment rendered without hospitalization.

Out of Province Referral Expenses (Inside Canada)

If you are referred to a physician or to a hospital outside your province of residence but inside Canada for medically necessary treatment which is unavailable in your province of residence, and for which there is no medically sufficient alternate treatment available in your province of residence, and which is eligible for reimbursement in whole or in part by a provincial medical plan, the following expenses in excess of any government plan are covered:

i) reasonable and customary charges for ward accommodation;

i) reasonable and customary charges for services of a physician;

ii) reasonable and customary charges for hospital services and supplies furnished during hospitalization;

iii) reasonable and customary charges for x-ray examinations and laboratory tests related to medical treatment ordered without hospitalization

Visioncare Expenses

Charges for Visioncare expenses are as follows:

1) Eye examinations performed by a qualified optometrist or ophthalmologist. The maximum benefit is identified in the Highlight of Benefits section of this Booklet.

2) Lenses and frames for eyeglasses (including tinting, photograying and hardening of lenses), prescribed safety glasses or contact lenses are covered, subject to a maximum benefit of $100 per individual in any period of twenty-four (24) consecutive months;

3) Contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, provided visual acuity cannot be improved to at least 20/40 level by spectacle lenses, subject to a maximum benefit of $200 in any period of twenty-four (24) consecutive months;

4) Visual Training, subject to a maximum benefit of 50% of the charges for the service.

Exclusions

The foregoing list of eligible expenses shall not include any of the following:

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

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

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

4) Charges for medical treatment or surgical procedures by a physician other than as provided under Outside Canada Referral Expenses and Out of Province Referral Expenses (inside Canada);

5) Charges for transport or travel, other than as specifically provided under eligible expenses;

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

7) Charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his/her license;

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

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

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

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

12) Charges for dental work wherein a third party is responsible for payment for such charges;

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

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

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

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

17) Charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies.

18) Charges for hospital accommodations in Canada.

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

Coughlin Care Gold

Virtual Healthcare (vCare):

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

To enroll for vCare, you will be required to provide your Policy # (901837) 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).

Travel Medical Emergency
(Underwritten by RSA)

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances occurring while you are temporarily traveling outside your province or territory of residence. It is important that you read and understand your plan before you travel. **Please contact Coughlin & Associates for further information or access your Member Portal to review the Travel Booklet.**

The insurer has contracted Global Excel Management Inc. (called "Global Excel") to provide medical assistance and claims services under this policy.

IN THE EVENT OF AN EMERGENCY
YOU MUST CALL GLOBAL EXCEL IMMEDIATELY
From Canada / USA 1-866-870-1898
Collect from anywhere +819-566-1898
The emergency telephone numbers are listed on the back of the medical assistance card provided

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. **It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.**

If you incur expenses without prior approval by Global Excel, such expenses will be covered, except where the policy expressly requires the prior approval or authorization of Global Excel, on the basis of the reasonable and customary costs that would have been payable for such expenses by the insurer in accordance with the terms and conditions of the policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the reasonable and customary costs reimbursed by the Insurer.

Before travelling outside of province/country if you have any doubts concerning the extent of your Group Travel Medical Emergency coverage due to recent medical treatment (i.e. cancer, pregnancy, etc.) or illness, you should contact the Administrator to follow-up with the Insurer, RSA (Global Excel) to confirm coverage.

Dentalcare

In the event you incur in a calendar year any of the Eligible Expenses listed below, you will be paid 100% for Basic Services and 80% for Major Services.

Maximum Benefit

The total benefits payable are subject to the maximum specified in the Highlight of Benefits section.

Coverage Ceases

For Union Members, Dentalcare coverage ceases at the earlier of age 75 (unless actively working), the date of termination of employment, the date of retirement, and/or following depletion of the self-pay period, or if you are no longer a Member in good standing with Local Union 987.

For Local 987 Non-Member Participants, coverage ceases at the earlier of age 75, the date of termination of employment, date of retirement or lay-off.

Extension of Benefits

No benefits for Eligible Expenses will be paid for claims incurred after the termination of the Master Policy or after your insurance under this coverage ceases unless you die while insured. In this regard, please refer to the Continuation of Benefits section.

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 Manufacturer's Life Insurance Company 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.

- **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.

- 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.

Eligible Expenses

Charges for the following supplies and services are considered Eligible Expenses.

Basic Services

If they do not exceed the fee level of the applicable provincial fee schedule as outlined in the Highlight of Benefits section. Further details may be found in the Master Policy.

1. The following services (a) to (f) inclusive, each limited to once per nine month period;

    a) routine oral examinations
    b) one unit of polishing
    c) posterior, bilateral and bite-wing x-rays
    d) topical application of fluoride solutions
    e) study casts
    f) oral hygiene instruction

2. Full-mouth series of x-rays; limited to one set in any 24 month period.

3. Routine extractions and surgical removal of teeth.

4. Silver amalgam, silicate or synthetic restorations (fillings) or stainless steel crowns.

5. Endodontic treatment (root canal therapy)

6. Anesthesia where reasonably and customarily required in connection with other covered procedures.

7. Treatment for Periodontics and other diseases of the gums and tissues of the mouth, including preventative scaling, limited to a Reasonable and Customary amount of units

8. Passive space maintainers for dependant children only.

9. Denture repairs including addition of new teeth.

10. Relining and rebasing of existing dentures (limited to once every 3 years).

11. Laboratory charges – are limited to 60% of the professional fee.

Major Services

1. *Removable Prosthetic Devices*: The initial installation of partial or full dentures, subject to the pre-existing condition limitations of teeth missing, extracted or fractured prior to becoming insured.

Replacement of existing dentures is not covered except if:

(a) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan; or

(b) The replacement is more than twelve (12) months after the individual became insured under this coverage, and the existing dentures are at least five (5) years old and no longer serviceable.

Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

2. *Extensive Restorative Dentistry*: Those procedures, including gold inlays, onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with silver amalgam, silicate or synthetic restorations, benefits will be determined based on the usual costs of such a restoration. Such procedures are subject to the pre-existing condition limitations on teeth missing, extracted, or fractured prior to becoming insured.

3. *Fixed Prosthetic Devices*: The initial installation of fixed prosthetic devices subject to the pre-existing condition limitations on teeth missing, extracted or fractured prior to becoming insured.

   Recementing and replacement of the facing or veneer of the fixed prosthetic device.

   The replacement of existing fixed prosthetic devices is not covered except if:

   (a) The replacement is required because of extraction, loss or fracture of one or more sound natural teeth after the individual became insured under this plan or

   (b) The replacement is more than 12 months after the individual became insured under this coverage, and the existing fixed prosthetic device is at least 5 years old and no longer serviceable.

4. Laboratory charges - are limited to 60% of the professional fee.

5. Implants and/or Related Service – 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 and Limitations

Payments will not be made for any dental procedure in respect of any injury or dental disease for which you or your dependant were advised to receive treatment or for which treatment first begun before you or your dependant became insured for that dental procedure. Payments will not be made for any dental procedure in respect of teeth missing, extracted or fractured before you or your dependant became insured for that procedure except for appliance replacement as specifically stated under Eligible Expenses.

No benefit will be payable for the initial installation (or addition) of prosthetic devices unless such installation (or addition) is required primarily due to teeth that were missing, extracted or fractured after becoming insured under this plan for prosthetic devices.

No benefit is payable for the following:

1. Services or supplies that are primarily for cosmetic dentistry;

2. Services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his/her license;

3. Any charge for an injury resulting from war, riot, insurrection or participation in a criminal act;

4. Any miscellaneous charges such as counseling or instruction, travel, broken appointments, communication costs or filling in of forms;

5. Any charge resulting from any intentionally self-inflicted injury;

6. Any services covered in whole or in part by any government plan, services for which no charge is made, or services which the Insurer is not permitted by law to cover;

7. Any charge for services which would not normally have been incurred, but for the presence of this insurance, or for which you are not required to pay;

8. Any dental examinations required by a third party;

9. Diagnostic procedures in connection with any benefit categories excluded as eligible expenses;

10. Any services or supplies in connection with Orthodontics.

Co-Ordination of Benefits

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

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

Order of Benefit Payment

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

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

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

  - **For Claims incurred by you or your Dependant Spouse**

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

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

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

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

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

- **For Claims incurred by your Dependant Child**

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

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

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

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

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

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

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

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

Submitting a Claim for Co-ordination of Benefits

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

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

How To Make A Claim

Time Limitations

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

Coughlin Plan Member Portal

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

- Manage your profile, including updating your mailing address, telephone number, email address, updating your language of preference, signing up (or updating) for Pre-Authorized Deposit, and viewing your dependant information.
- View your claims history and the status of claims, print explanation of benefits statements, view your benefit accumulations/maximums and view your booklet (where applicable).
- Download and print claim submission and administrative forms.

Pre-Authorized Deposit (PAD)

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

1. Member Portal

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

2. Pre-Authorized Deposit (PAD) Form

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

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

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

Drug Claims

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

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

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

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

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

Submit Your Claims Electronically

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

Some important points to remember:

- The maximum amount that can be claimed is $1,000 for vision care and $500 for paramedical services per claim transaction per covered person. You may not submit a claim for yourself and another person, such as a dependant, at the same time.

- You must be registered with Coughlin's Pre-authorized Deposit plan before the service will be activated.
- Claims are audited randomly. Be sure to keep your claim receipts for one year. If you receive an audit notice, please submit the requested original claim receipts within the timeframe indicated.

Extended Health Care Claims

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

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

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

Dental Claims

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

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

- the Coughlin Telus carrier identification number (also known as the BIN number) is **610105 on the Telus network**;
- your unique member identification number; and
- the policy number (901837) of your group benefit plan.

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

Pre-Authorization

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

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

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

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

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

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

Claims Inquiries

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

THIS PLAN IS UNDERWRITTEN BY:

Manulife Financial
Policy #901837

And

RSA Travel Insurance Inc.
Policy #1166345

AND

Homewood Health

AND

People Corporation

THE PLAN IS ARRANGED AND ADMINISTERED BY:

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Employee Benefits Specialists
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