OPERATING ENGINEERS OF MANITOBA LOCAL 987

CONSTRUCTION DIVISION

HEALTH & WELFARE TRUST FUND

May 2022

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 Benefits are underwritten by Manufacturer's Life Insurance Company (Manulife), Chubb Life Insurance Company of Canada (Chubb Life), AIG Insurance Company, and Homewood Health. The Prescription Drug Card is coordinated with Express Scripts Canada.

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:

- AIG Insurance Company – Travel Medical Emergency benefits – Policy #CMG 9428860
- People Connect – People Corporation
- Coughlin Care Gold – People Corporation
- Chubb Life – Critical Illness – Policy #CI20001601 and Accidental Death & Dismemberment – Policy #AB10406505
- Employee Family Assistance Program – Homewood Health
- Manulife Financial – Member Life, Dependent Life, Long Term Disability (LTD), Weekly Disability Income (WI), Supplementary Health and Dental benefits – Policy #901837

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 applicable insurance companies, Express Scripts Canada (Drug Card Provider), 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 these companies to administer all financial services provided to you and to keep information specific to their business relationship with you. This includes the following:

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

The files are kept in their offices to allow 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, Express Scripts Canada and Coughlin & Associates Ltd. are committed to respecting your right to privacy and safeguarding your personal information. For more information regarding the Insurers' privacy policies or Coughlin's Privacy Policy, please contact Coughlin & Associates Ltd. directly or via the website www.coughlin.ca for Coughlin's Privacy Policy.

Highlight of Benefits

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

Member Life Insurance

Participants are eligible for an amount of insurance equal to $75,000. Coverage reduces by 50% at age 65.

Life Insurance coverage ceases at age 70. Please refer to Member Life Insurance section for more details.

Dependent Life Insurance

Spouse	-	$10,000
Each Child	-	$5,000

Dependent Life Insurance coverage ceases at age 70. Please refer to Dependent Life Insurance section for more details.

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 Administrator for more information.

Critical Illness (Deluxe Plan)

Participants are eligible to a $15,000 flat benefit once diagnosed with or suffer from one of the 23 insured conditions. The Critical Illness benefit ceases at age 65. Please refer to the Critical Illness booklet prepared by Chubb Life for further information or contact the Plan Administrator.

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 the Plan Administrator for more information.

Accidental Death and Dismemberment Insurance (AD&D)

Participants are eligible for the Principal Sum equal to $100,000. Coverage reduces by 50% at age 65.

Accidental Death and Dismemberment coverage ceases at age 70. Please refer to Accidental Death & Dismemberment Insurance section for more details.

Weekly Disability Income

This benefit is equal to 66 2/3% of weekly earnings, subject to a maximum benefit of $638 per week (equivalent to the Employment Insurance (E.I.) Maximum earnings). Benefits begin on the 1st day of a disability due to an accident/1st day hospitalization (over 24 hours) or on the 8th day of a disability due to sickness. The maximum duration of benefits is 52 weeks.

Note: This benefit is taxable.

Weekly Disability Income coverage ceases at age 65. Please refer to Weekly Disability Income section for more details.

Long Term Disability Income

This benefit is equal to $750 per month, less any income and benefits payable under any Workers Compensation Law or any similar law, subject to the 85% All Source Maximum described in the Long Term Disability section later in this booklet.

Benefits begin once a Qualifying Disability Period of three-hundred and sixty five (365) days has been obtained.

Note: This benefit is taxable.

Long Term Disability Income coverage ceases at age 65. Please refer to Long Term Disability section for more details.

Supplementary Healthcare

Deductible $25 per individual or family per calendar year
(not applicable to hospital, prescription drugs, and visioncare expenses)

Coinsurance ..... 100% of eligible expenses
(subject to Reasonable and Customary limits)
Lifetime Maximum ..... Unlimited

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.

Prescription Drug

(Pay Direct Drug Card via Express Scripts Canada)

Maximum .....$3,000/family/benefit year (April 1 to March 31)

For reduced drug pricing, refer to ***People Advantage (PPN) Interactive Brochure*** *on Member Portal.*

Dispensing Fee Maximum $15/prescription

Reimbursement based on Generic equivalent (unless Doctor indicates medical necessity) and limits pharmacy markup to 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.

Visioncare Maximum Benefit

Eyeglasses and Contact lenses..... $450/individual every 24 consecutive months

Laser Eye Surgery..... $3,000/lifetime
.... ($1,500 per eye)
Eye Examinations..... $75/individual/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, however, coverage will be extended if actively working Union Member. Please refer to Supplementary Healthcare section for more details.

Travel Medical Emergency

Policy Number ..... CMG **9428860**

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.

Employee Family Assistance Program (EFAP)

Benefit..... Per case basis via Homewood Health (1-800-663-1142)

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

Dentalcare

Deductible ..... $50 per individual or family per calendar year

Coinsurance ..... 100% for Basic Services
..... 80% for Major Services
..... 50% for Orthodontic Services

Maximum Benefit ..... $2,000 per individual per calendar year for combined Basic and Major
..... $2,500 per dependent under age 19 per lifetime for Orthodontics

Fee Guide – Benefits are paid in accordance with the 2022 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 age 75, however, coverage will be extended if actively working Union Member. Please refer to Dentalcare section for more details.

Cardiac Program

(Self-Insured via Local 987 Health & Welfare Trust Fund)

Maximum Benefit ..... $350 per Member per calendar year

Provided Member collecting Long Term or Weekly Disability Income benefits, the Health and Welfare Trust Fund will reimburse up to the maximum benefit for a Membership at recognized cardiac program when referred by a physician for a diagnosed condition.

Healthcare Spending Account

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

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

Please refer to ***Healthcare Spending Account*** *section for complete 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 is kept by Coughlin & Associates Ltd., that shows hours worked for a Contributing Employer for which contributions have been made for the purpose of Group Benefits. This account is called an Hour Bank Account.

Initial Eligibility

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

You and your eligible dependents will become insured for coverage **on the first day of the following month once the Plan Administrator has received 400 hours (hours may vary depending on the hourly rate of contribution) within six (6) consecutive months,** provided you are actively at work or available for work on the day you would ordinarily become insured.

For Member Life, Dependent Life, Accidental Death and Dismemberment (AD&D) Insurance, Weekly Disability Income (WI), Critical Illness, Employee Family Assistance Program, and Long Term Disability (LTD) Income benefits:

You and your eligible dependents will become insured for coverage **on the next day of the month once the Member has worked 400 hours within six (6) consecutive months** provided you are actively at work or available for work on the day you would ordinarily become insured.

For Local 987 Non-Member Participants (except for Office Staff of Local 987), this equates to three (3) consecutive months of employment. For Office Staff of Local 987, eligibility may commence immediately given the receipt of applicable monthly contribution and the conditions of employment.

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.

To be eligible for benefits, an enrolment card must be completed.

Ongoing Eligibility

Each month 160 hours (hours may vary slightly depending on the hourly rate of contribution) will be deducted from the Union Member's Account. For Local 987 Non Member Participants, the hours worked should equate to the monthly deduction (see above) as there may not be an accumulation of hours worked. The number of hours in the Union Member's Hour Bank Account may never exceed enough to provide eighteen (18) months of coverage even though they may acquire hours during that period. Excess hours accumulated over this amount will be credited to the general reserves of the Trust Fund.

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 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.

Local 987 Non-Member Participants

Office Staff who are considered full-time (i.e. working 35 hours or greater 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, Union-Affiliated Associations or the Local Union Office.

Office Staff of Local 987 who are considered part-time (i.e. working at least 20 hours and not more than 35 hours per week) and on whose behalf contributions are being made to the Operating Engineers of Manitoba Local 987 Health & Welfare Trust Fund but are not Union Members of Local 987 or any other reciprocating Local will be eligible for all benefit coverage (excluding Disability coverage) while working for the Local Union Office.

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 by withdrawing his/her funds from the Pension Trust Fund via a retirement option.

Eligible Dependents

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 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.

2) 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.

3) Unmarried children who are under age 22, or under age 25 if attending an accredited school, college, or university as a full-time student, including children of the marriage, legally adopted children, and children for whom you have legal guardianship (proof is required). Dependent children must be dependent on you for support and not employed at a regular full time job. With respect to Dependent Life Insurance, dependent children must be over 14 days of age.

4) A child of your spouse provided:

   a) he/she is also your biological child; or
   b) your spouse is living with you and has custody of the child.

5) Any functionally impaired child who was insured as a dependent shall remain insured beyond any limiting age for dependents. For the purposes of insurance, functionally impaired shall mean an unmarried person who was insured as a dependent 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 dependent upon the member for support and maintenance within the terms of the Income Tax Act.

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

If a dependent is confined for medical care or treatment in any institution or at home when coverage would normally start, the dependent 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 Dependents

If your death occurs while you are insured, the Supplementary Healthcare, People Connect, Coughlin Care, Employee Family Assistance Program, Travel Medical Emergency, and Dentalcare coverage for your dependents will continue for a period of twenty-four (24) months. If your surviving children cease to qualify as eligible dependents (as defined earlier), this 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, Dentalcare and Travel Medical Emergency benefits:

If your benefit coverage has previously terminated because of insufficient hours in your Hour Bank Account, you will again become insured on the first day of the month following the receipt of 400 hours (hours may vary depending on the hourly rate of contribution) in your Hour Bank Account within a six (6) consecutive month period.

For Life, Dependent Life, Accidental Death and Dismemberment (AD&D) Insurance, Weekly Disability Income, Employee Family Assistance Program, Critical Illness, and Long Term Disability (LTD) Income benefits:

If your benefit coverage has previously terminated because of insufficient hours in your Hour Bank Account, you will again become insured on the next day following 400 hours worked in your Hour Bank Account within a six (6) consecutive month period.

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

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

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

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

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, 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 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 dependent 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 dependents will terminate:

1) For a Union Member, at the end of the month wherein you do not have at least 160 hours in your Hour Bank Account. However, you may arrange to have your coverage continued for up to thirty-six (36) additional months on a self-paying basis (excluding Disability Income coverage for the last thirty (30) months). The Plan Administrator will contact you with the required self-pay amount.

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 (except for Disability Income coverage which will cease immediately). 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 the applicable benefit termination age or depletion of Hour Bank Account and/or self-pay period.

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

9) For a dependent, once they are no longer qualify as an eligible dependent (please refer to Eligible Dependents section).

Self-Payment Provision

A Union Member whose benefit coverage is terminated due to insufficient hours in his/her Hour Bank Account may continue to have coverage for him/herself and eligible dependents by making monthly self-payments to the Plan through the Plan Administrator (Coughlin & Associates Ltd.) for thirty-six (36) consecutive months (the first six (6) months for all benefits including WI and LTD and another thirty (30) months for all benefits excluding WI and LTD). Please note if your Hour

Bank account balance is below the required self-payment and you work 35 hours or less in a month, you are required to remit the difference up to the self-payment. If you work greater than 35 hours in a month you are required to remit the difference between the monthly deduction and your Hour Bank account balance, but the payment is not considered a self-payment. The payment must be made prior to the twenty-eighth (28th) of the month following the month in which the Hour Bank Account falls below the required hours. **All benefit coverage while self-paying will cease upon the attainment of age 75.**

A Retired Member who is "running down" his/her Hour Bank Account has coverage for all benefits (excluding WI and LTD). Upon the "running down" of the Hour Bank Account, the Retired Member may make monthly self-payments for only Dentalcare, Travel Medical Emergency, Supplementary Healthcare, People Connect and Coughlin Care coverage up to the attainment of age 75 subject to being in good standing with Local 987 for a minimum period of five (5) consecutive years. Otherwise, the self-pay period is restricted to non-working provision as identified in the paragraph above. **All benefit coverage while self-paying will cease upon the attainment of age 75.**

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' Hour Bank Account balances. It should be noted that an amount is deducted (refer to Ongoing Eligibility) from your Hour Bank Account balance each month to pay the premium for your coverage.

If there are insufficient hours in your Hour Bank 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 regularly 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 Employment Insurance (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.

Disability Provisions

- **Disabled Union Member**

  If a Union Member has been disabled and has been receiving Workers' Compensation, Auto Insurance, Weekly Disability Income Benefits, etc., for at least two (2) consecutive months, the Union Member may be covered by the Plan and will be reassessed following twelve (12) months of disability. This provision is subject to Trustee review from time to time and may change at the discretion of the Board of Trustees due to the financial stability of the Plan. For disabled members in receipt of WCB benefits following twelve months of disability they will be required to remit a self-payment based on the Retired Member's rate in effect. Assuming an approved Waiver of Premium, Life, LTD, AD&D, and Dependent Life coverage will remain in place for a Disabled Member to earlier of age 65 or recovery. If a Disabled Member refuses to make application for the Waiver of Premium or is declined, Life, AD&D, and Dependent Life coverage will only be extended for a further twelve (12) months with all other coverage (excluding WI and LTD) to a maximum of 30 months subject to receipt of the applicable self-payment.

  Benefit coverage will cease at the date that the Union Member is no longer disabled or at age 65.

- **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.

Wage Loss Provision

In the event that an insured Union Member incurs a total disability while on lay-off or leave of absence and is "running down" his/her Hour Bank Account, or subsequently making self-payments for the first six (6) months, the Plan will recognize the disability for wage loss benefits (WI and LTD) from the scheduled date of return to work provided the Union Member is totally disabled and furnishes attending physicians' statements certifying continued disability.

Reciprocal Agreements

Local 987 Members – Union Members working in a jurisdiction other than Local 987 on whose behalf contributions are being made to a Health and Welfare Trust Fund which has entered into a reciprocal agreement with the Operating Engineers of Manitoba Local 987 Health and Welfare Trust Fund should compete a Transfer Authority Form and advise the Local Union and the Plan Administrator to reciprocate contributions to their "Home Fund". This will maintain coverage under the Operating Engineers of Manitoba Local 987 Health and Welfare Trust Fund.

Travel Card Members – Employees of Employers on whose behalf contributions are made but who are Members of other Local Unions or Funds and whose Funds have entered into reciprocal agreements with the Operating Engineers of Manitoba Local 987 Health and Welfare Trust Fund will **not** be eligible for benefits but will have all contributions made on their behalf reciprocated to their "Home Fund" after they complete a Transfer Authority Form.

Third Party Liability

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

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

If you or your dependent receives a lump sum payment under 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 dependent must notify the Plan Administrator of any action commenced against a third party and of any judgment or settlement in the circumstances described above.

Member Life Insurance

Amount of Benefit

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

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

Coverage Ceases

For Union Members, Life Insurance coverage ceases at the earlier of age 70, following depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local 987.

For Local 987 Non-Member Participants, coverage ceases at the earlier of age 70, the date of retirement, termination of employment or layoff.

Waiver of Premium For Disability

If you become totally disabled for twelve (12) consecutive months before age 65, your Life Insurance premiums will be continued without payment of premiums until you cease to be totally disabled or until you reach age 65, whichever occurs first. To qualify, you must be unable to work for compensation or profit or to engage in any business or occupation, and you must submit proof of your continuing disability as may be required by the Insurer.

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 Employment Insurance (E.I.) Disability Benefits. This recording will assist you should your claim with these agencies be declined either immediately or at a future date.

Note: In order to qualify for the Waiver of Premium benefit, you must notify the Plan Administrator within twelve (12) months of your last active day at work and also furnish proof of your disability satisfactory to the Insurer within eighteen (18) months of the last active day at work.

Conversion Privilege

Your Life Insurance continues for thirty-one (31) days following the termination of your coverage. During this thirty-one (31) day period you may convert the amount of your Group Life Insurance, to an individual policy without submitting evidence of health. If interested, please contact Coughlin & Associates ltd. for further information.

Dependent Life Insurance

Amount of Benefit

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

Coverage Ceases

For Union Members, Dependent Life Insurance coverage ceases at the earlier of age 70, following depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local 987.

For Local 987 Non-Member Participants, coverage ceases at the earlier of age 70, the date of retirement, termination of employment or lay-off.

Waiver of Premium For Disability

If, while insured for this coverage, you become disabled and qualify for the Waiver of Premium benefit under your Life Insurance coverage, the Insurer will also waive the payment of Dependent Life Insurance premiums.

Conversion Privilege

The Dependent Life Insurance continues for thirty-one (31) days following your death or your termination of coverage. During this thirty-one (31) day period your spouse's amount of Dependent Life Insurance may be converted to an individual policy without submitting evidence of health. If interested, please contact Coughlin & Associates ltd. for further information.

Accidental Death and Dismemberment Insurance

(underwritten by Chubb Life)

Accidental Death

This benefit is payable to your designated beneficiary upon your death as the result of an accident. It is payable in addition to any Life Insurance benefit for which you may be eligible as a Participant of this Plan. Loss of Life must occur within one (1) year of the accident.

Accidental Dismemberment

This benefit insures each Participant against physical loss or loss of use due to an accident. The loss must occur within one (1) year of the accident.

Amount of Benefit

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

Coverage Ceases

For Union Members, Accidental Death & Dismemberment Insurance coverage ceases at the earlier of age 70, following depletion of your Hour Bank Account and/or self-pay period, or if you are no longer a Member in good standing with Local 987.

For Local 987 Non-Member Participants, coverage ceases at the earlier of age 70, the date of retirement, termination of employment or lay-off.

Waiver of Premium For Disability

If, while insured for this coverage, you become disabled and qualify for the Waiver of Premium benefit under your Life Insurance coverage, the Insurer will also waive the payment of Accidental Death & Dismemberment premiums.

SPECIFIC LOSS SCHEDULE

Accidental Death & Dismemberment

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

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	75%
Loss of Use of One Hand or One Foot	75%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	75%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid

or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

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

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

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

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

Repatriation Benefit

When injuries result in loss of life of an Insured Person outside 50 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the

reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an Insured Employee provided:

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

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

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

Family Transportation Benefit

When injuries result in an Insured Person confinement as an in-patient in a hospital outside 50 kilometers from an Insured Person's city of permanent residence or outside Canada and requires personal attendance of a "Member of the Immediate Family" as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to an Insured Person, while confined, but not to exceed $15,000.

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

Spousal Occupational Training Benefit

When injuries result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event an Insured Person sustain an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1) the one-time cost of alterations to an Insured Person's principal residence to make it wheelchair accessible and habitable; and

2) the one-time cost of modifications necessary to a motor vehicle utilized by an Insured Person to make the vehicle accessible or driveable for an Insured Person.

Benefit payments herein will not be paid unless:

1) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

2) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of an Insured Person's Principal Sum.

Day Care Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of an Insured Person's Principal Sum amount or a maximum of $5,000 per year, on behalf of any dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for 4 consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

"Dependent Child" means the Employee's eligible unmarried natural, legitimate, illegitimate, adopted, step child or common law child who is principally dependent on the Employee or the Employee's Spouse for financial support.

Special Education Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured Person's Principal Sum amount (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of 4 consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by the policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured Person for up to 6 sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $5,000.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and an Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, Chubb Life will pay for each full month, 1% of an Insured Person's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement

but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement Benefit

If an Insured Person suffers a third degree burn due to an accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table, subject to a maximum benefit payable of $25,000:

Body Part	% of Principal Sum Payable
Face, Neck, Head	10%
Hand & Forearm	25%
Either Upper Arm	15%
Torso (Front or Back)	35%
Either Thigh	10%
Either Lower Leg (below knee)	25%

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than

one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, an Insured Person Principal Sum amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, an Insured Person was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile. "Seat Belt" means those belts that form a restraint system.

Identification Benefit

In the event accidental loss of life is sustained by an Insured Person not less than 150 kilometers from an Insured Person's normal place of residence and identification of the body by a "Member of the Immediate Family" has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

1) transportation by the most direct route to the city or town where the body is located; and

2) hotel accommodation in such city or town, subject to a maximum duration of 3 days.

The reimbursement of such expenses incurred is subject to the accidental Loss of Life benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

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

Exposure and Disappearance

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

Conversion Privilege

On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DEATH and DISMEMBERMENT only insurance policy of Chubb Life. The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of Chubb Life. The amount of insurance benefit converted shall not exceed that amount issued during employment up to an all policies combined maximum of $200,000. The individual policy will cover ACCIDENTAL DEATH and DISMEMBERMENT only.

Benefits payable under this section will be limited to only one (1) policy in the event the benefits are contained in two (2) or more policies issued to the Policyholder by Chubb Life (not applicable to the Schedule of Losses, Exposure and Disappearance and Conversion).

Recurrent Disabilities

When an Insured Employee becomes totally disabled again from the same or related causes within 6 months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and Chubb Life will waive the 6 months qualification period.

If the same disability recurs more than 6 months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are

considered separate disabilities if they were separated by a return to work of at least one 1 day.

Funeral Benefit

When injuries covered by this policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial or cremation but shall not exceed $5,000.

The plan does not cover any loss, which is the result of:

1) intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;

2) declared or undeclared war or any act thereof;

3) travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a member of an Insured Person's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;

4) losses occurring while an Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by Chubb Life pro-rata for any such period of full-time active duty);

5) travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of the Accidental Death & Dismemberment portion of the policy.

How to Claim

Note: In the event of a claim, notice of claim must be given to Chubb Life within 30 days from the date of the accident and subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident. A claim form can be obtained from the benefits administrator.

Weekly Disability Income

In the event you become totally disabled (refer to Long Term Disability section for definition) due to a non-occupational injury or sickness 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 Manulife and Coughlin & Associates Ltd. regardless of whether or not you are eligible for Workers' Compensation, Auto Insurance or Employment Insurance (E.I.) Disability Benefits. This recording will assist you should your claim with these agencies be declined either immediately or at a future date.

The Insurer will consider the first sixteen (16) weeks of benefit. No benefits are payable by the Insurer during the next fifteen (15) week period during which Employment Insurance benefits will commence, unless the Participant provides proof he/she is not eligible for such benefits. However, during this period, the weekly benefit payable shall not exceed the prevailing maximum benefit applicable under the Employment Insurance Act, as of commencement, that you would have received if you had not been disqualified. The Insurer will pay benefits for the remaining weeks of the benefit period.

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

Coverage Ceases

For Union Members, Weekly Disability Income coverage ceases at the earlier of age 65, following the depletion of your Hour Bank Account and/or self-pay period of six (6) months, the date of retirement, or if you are no longer a Member in good standing with Local 987.

For Local 987 Non-Member Participants, coverage ceases at the earlier of age 65, date of retirement, termination of employment, or lay-off. Part-time Local 987 Non-Member Participants are not eligible for Weekly Disability Income coverage.

Offsets To Benefits

The amount payable to you under this benefit is calculated by deducting from your benefit any other sources of income as specified in the Master Policy, which includes any other disability or pension programs or any amounts payable under an Automobile Insurance Plan.

Exclusions

Benefits are not payable for disabilities arising from the following:

1) for the portion of a period of disability during which you are not under treatment by a physician;

2) intentionally self-inflicted injuries;

3) voluntary participation in a war, riot, insurrection, or criminal offense;

4) for the portion of a period of disability during which you are

    a) imprisoned in a penal institution; or

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

5) any period of disability, or portion thereof, during any leave of absence (including maternity leave).

Benefits will not be payable for:

1) a disability which commences on or after the date a strike or lay-off begins, subject to any provincial Employment or Labour Standards Act;

2) the portion of a period of disability during which you are eligible to receive benefits under any Workers' Compensation Law or any similar law; unless due proof is submitted to the Insurer that you have been disqualified for such benefits.

Subrogation

If you are 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, and for which benefits are paid or payable, the Insurer will be subrogated to all your rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the Insurer. You shall execute such documents as required by the Insurer.

In the event you provide proof to the Insurer that you have 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 you choose to settle the matter prior to judicial determination, it is understood 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 you receive or are entitled to receive on account of past, present or future loss of income.

Long Term Disability

Qualifying Disability Period

The Qualifying Disability Period starts when you first become totally disabled and ends after three-hundred and sixty-five (365) days, provided the disability is continuous and you are under age 65. If the disability is not continuous, the days that you are disabled will be accumulated to satisfy the qualifying disability period provided:

1) no interruption is longer than two (2) weeks; and

2) the disabilities arise from the same or related disease or injury.

The qualifying disability period will be the greater of the period outlined above, or the duration of Weekly Disability Income Benefit if applicable.

Amount of Benefit

If you become totally disabled before age 65 because of a disease or accidental injury, the Insurer will pay a monthly benefit during the applicable benefit period. The amount of the monthly benefit is specified in the Highlight of Benefits Section, **less any income and benefits payable under any Workers' Compensation Law or similar law**, and subject to the All Source Maximum (where applicable). Proof must be submitted to the Insurer that you became totally disabled while insured and have been continuously disabled during the qualifying disability period.

This benefit is taxable to the receiving Participant.

"**Totally Disabled**", for the first twenty-four (24) consecutive months of benefit payment, shall mean you are incapacitated to the extent that you are not able to perform any and every duty of your occupation or employment. After such twenty-four (24) months, "Totally Disabled" shall mean you are incapacitated to the extent that you are not able to perform any and every duty of any occupation or employment for which you are reasonably qualified by education, training or experience.

The benefit for a period which is less than a full calendar month shall be $1/30^{th}$ of the applicable Gross Monthly Benefit, less any income and benefits payable under any Workers' Compensation Law or similar law, multiplied by the number of days in said period.

Benefits will be payable for each month or partial month that such total disability continues beyond the applicable qualifying disability period. Benefits will not be payable for more than the applicable maximum benefit period specified in this section.

Reductions of Coverage

The amount of the monthly benefit specified in the Highlight of Benefits Section shall be reduced as follows.

1) by the amount of any income of benefit payable under any Workers' Compensation law or similar law.

The monthly benefit may also be reduced subject to the All Source Maximum described in this section.

All Disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurer (Manulife) regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance or Employment Insurance (E.I.) Disability Benefits. This recording will assist you should your claim with these agencies be declined either immediately or at a future date. In addition, proper application will be made relative to a Waiver of Life Insurance Premiums, required within twelve (12) months of the date of initial disability.

Maximum Benefit Period

The maximum benefit period shall be to age 65.

Benefits may be payable after your attainment of age 65 if you satisfy the qualifying disability period while age 64, in which case the maximum benefit period shall be twelve (12) consecutive months. In no event shall benefits be payable after your death, recovery, or attainment of age 66.

All Source Maximum

Your total monthly income while disabled cannot exceed eighty-five percent (85%) of gross monthly earnings as of the date disability commences. If the total income exceeds eighty-five percent (85%), the Long Term Disability Income benefit will be reduced by the amount of such excessWith respect to your participation in a Program of Rehabilitation, total monthly income while disabled cannot exceed one-

hundred percent (100%) of gross monthly earnings as of the date disability commences. If total income exceeds one-hundred percent (100%), the Long Term Disability Income benefit will be reduced by the amount of such excess.

Total monthly income includes:

1) a) Long Term Disability benefits under this Plan;

   b) income or benefits specified under Reductions of Coverage and 2) and 3) below, including any income or benefit from a different or lesser paid occupation;

   c) with respect to your participation in a Program of Rehabilitation, income from the program of Rehabilitation;

2) Income payable to you 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 you during the total disability;

3) Income or benefit payable under:

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

   b) the Canada Pension Plan or Quebec Pension Plan primary benefits;

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

You must apply for all benefits or income for which you may be or may become eligible for under any of the preceding sources.

If you are receiving any income or benefit payable under any government plan or program for an injury or disease totally unrelated to the injury or

disease that caused the current disability, the Insurer shall not reduce the gross monthly benefit by that amount.

Benefits During Program of Rehabilitation

The Insurer may recommend that a program of rehabilitation is appropriate for you. The Insurer will notify you in writing of its approval of the program and the extent, if any, of its support during such program.

Any of the following may be eligible for consideration as a rehabilitation program:

1) your regular occupation on a part-time basis;

2) a formal vocational training program; or

3) any other training program deemed suitable by the Insurer.

Long Term Disability benefits will continue to be payable to you when participating in a rehabilitation program approved by the Insurer for up to twenty-four (24) consecutive months.

Expenses incurred by you in connection with the program and for which you have received prior approval from the Insurer will be reimbursed by the Insurer provided that, in the Insurer's opinion, they are reasonable and customary. Expenses which are payable through government programs or a third party insurer shall not be reimbursed by the Insurer.

Reduced Monthly Benefit: The Monthly Benefit less any income or benefits payable under any Workers' Compensation Law or similar law will be further reduced by fifty percent (50%) of any earnings received from employment under the rehabilitation program, subject to the **All Source Maximum** as defined in this section.

Your involvement in a rehabilitation program will cease on the earliest of the following dates:

1) the date that you cease to be Totally Disabled;

2) the date that you complete the rehabilitation program; or

3) the date it is determined by the Insurer that you are not participating in the rehabilitation program to the extent previously agreed upon by your Insurer.

Frozen Benefits

Your monthly benefit shall not be reduced due to a government plan or program cost-of-living adjustment occurring after the date on which benefits became payable.

Continuous Period of Disability

If you were receiving Long Term Disability benefits and became disabled from the same or related causes within six (6) month(s) after your return to active work, you would be considered disabled for one continuous period. If you return to active work for one full day and become disabled from different and unrelated causes, you will begin a new period of disability.

Coverage Ceases

For Union Members, Long Term Disability Income coverage terminates at the earlier of age 65, following depletion of the Hour Bank Account and/or self-pay period of six (6) months, your date of retirement, or if you are no longer a Union Member with the Local 987.

For Local 987 Non-Member Participants, coverage ceases at the earlier of age 65, date of retirement, termination of employment or lay-off. Part-time Local 987 Non-Member Participants are not eligible for Long-Term Disability Income coverage.

Waiver of Premium

The Insurer will waive the payment of premiums for the Long Term Disability Income for when you are 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.

Extension of Benefits

If the policy or Long Term Disability Income benefit terminates and you are totally disabled at such termination, the Insurer continues to be liable as though the coverage remained in force.

If a disability recurs within six (6) continuous months after termination of this benefit, the Insurer will continue to pay benefits to you but only for the remainder of the original maximum benefit period. Such disability

must have been caused by an accident or sickness that occurred before termination. The Insurer shall not be liable for benefits after termination of either the contract or Long Term Disability Income benefit once a replacing Insurer is bound contractually or as a matter of law.

Subrogation

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

In the event that you provide proof to the Insurer that you have 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 you choose to settle the matter prior to judicial determination, you understand 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 you receive or are entitled to receive on account of past, present or future loss of income.

Appeal Procedure

If you appeal the denial/termination of a Long Term Disability claim, you must submit a written notice of appeal to the Insurer. The notice must be submitted to the insurer within sixty (60) days of the date of the Insurer's denial/termination notice. Medical or other supportive documentation must be submitted to the Insurer within six (6) months of the date of the denial/termination notice. Expenses incurred in connection with obtaining the supportive documentation are your responsibility.

If the above provision is in conflict with the applicable law of your province of residence, the provision shall be deemed amended to conform with the minimum requirements of that law.

Exclusions and Limitations

No benefits are payable to you for any total disability commencing within six (6) months of your effective date of insurance if the disability is caused or contributed to by, or is a consequence of, a sickness or injury for which you received medical treatment or services or have taken prescribed medication at any time or times within ninety (90) days before the effective date of insurance.

No benefit shall be payable:

1) for any portion of a period of disability unless you are receiving ongoing supervision/ treatment by a physician deemed appropriate by the Insurer for the impairment which is causing the disability. You will not be paid for any portion of a period of disability during which you do not participate in the treatment program recommended by said physician;

2) for any portion of a period of disability during which you are receiving treatment by a therapist unless such treatment is recommended by a physician deemed appropriate by the Insurer;

3) for any portion of a period of disability resulting from substance abuse, including alcoholism and drug addition, unless you are participating in a recognized substance withdrawal program;

4) for disability resulting from injury or disease which occurred while you are on active duty in the armed forces of any country, state, or international organization or for disability resulting from war or an act of war, whether declared or undeclared;

5) for disability resulting from participation in the commission of a criminal offence;

6) for the portion of a period of disability during which you are:

   a) imprisoned in a penal institution; or

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

7) for a disability resulting from an accident which occurs while you are operating a motor vehicle and your blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%);

8) for a disability resulting from an intentionally self-inflicted injury or disease or attempted self-destruction, whether you are deemed sane or insane;

9) any period of disability, a portion thereof during any leave of absence (including maternity leave);

10) to you, if you refuse to participate in a rehabilitation program which is deemed appropriate by the Insurer, the attending physician or on the advice of independent medical opinion;

11) for a disability that commences on or after the date a strike commences, subject to any Provincial Employment or Labour Standards Act.

Disability Case Management Program

Manulife has developed a Disability Case Management program. The purpose of this program is to assist you, in the event you become totally disabled and qualify for benefits, to return to productive employment. Their Disability Case Management team includes medical consultants, claim adjudicators and field co-ordinators. This team will work with you, your Employer and your physician to assist you to recover and return to the workplace.

Rehabilitative Employment

If you are disabled, the Insurer may recommend that you undergo some suitable rehabilitative training program which would take into account the nature and limitations of your disability. Further details on this aspect will be provided in the event you become disabled.

Supplementary Healthcare

In the event you or your dependent(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. Some expenses, including Prescription Drugs, might require a medical recommendation and further details for claims assessment purposes. The pre-approved expenses require specific information from your attending physician, including diagnosis, duration, and other relevant information pertaining to the nature of the illness and required treatment.

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. Please note any Prescription Drug or Visioncare claim is not subject to a deductible.

Lifetime Maximum Benefit

The total lifetime benefit payable in respect to you or your dependents 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), following depletion of your Hour Bank Account and/or 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, 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, and 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.

Reimbursement subject to the following:

1) Pharmacy markup limited to 20% of the whole sale cost;

2) $15.00 per prescription dispensing fee maximum;

3) Up to the lowest generic equivalent drug cost unless a Physician indicates a medical necessity.

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 yearly benefit maximum for Prescription Drug Expenses.

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 of $600, 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 (MTAM, LCSP or AMTWP, etc.).

   Charges for the services of a licensed Speech Therapist or Clinical Psychologist (including services performed by a registered social worker and other similar qualified Specialists) up to a maximum benefit of $1,000 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, purchase) 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 a semi-private hospital room.

12) 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;

13) 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:

1) reasonable and customary charges for ward accommodation;

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

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

4) 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 $75 per examination in any period of twenty-four (24) consecutive months (12 months if under 21 years of age);

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 $450 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) Laser Eye Surgery subject to a $3,000 lifetime maximum ($1,500 per eye);

5) 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 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).

Dentalcare

Please refer to the Highlight of Benefits section of this booklet for co-insurance and applicable benefit maximums for Basic, Major, and Orthodontic expenses.

Dental Deductible

The Dental Deductible for a calendar year is that portion of the Eligible Expenses which you are required to satisfy each year before you receive benefits. The Dental Deductible is $50 per individual or family per calendar year and is deducted from the first eligible claim submitted in each calendar year.

Coverage Ceases

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

For Local 987 Non-Member Participants, coverage ceases at the earlier of age 75, the date of retirement, and cessation of employment 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, Manulife 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.

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.

1) The following services (a) to (f) inclusive, each limited to once every 9 months;

   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 2 calendar years.

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.

8) Passive space maintainers for dependent children only.

9) 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.

Dependent Orthodontic Services

Coverage is available for dependent children under age 19 as identified in the Highlight of Benefits section.

Coverage will be provided to the date of completion provided treatment commenced prior to attainment of age nineteen (19).

A treatment plan prepared by the attending Orthodontist must be submitted to the Plan Administrator for approval.

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 dependent were advised to

receive treatment or for which treatment first begun before you or your dependent 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 dependent 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;

Travel Medical Emergency
(Underwritten by AIG/ Global Excel)

Travel assistance is provided by Global Excel Management Inc. With centres worldwide they will:

- help locate the most appropriate medical facility for you.
- confirm coverage with AIG Insurance Company of Canada and assure the hospital that you are covered.
- guarantee payment for hospitalization, if necessary.
- arrange for admission to a hospital.
- provide translation services.
- contact your own doctor for recommendations, when required.
- contact your family and employer, when required.
- arrange for/co-ordinate emergency medical evacuation. and
- co-ordinate your return home.

How to Claim

If you require emergency medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately. If circumstances prevent you from calling Global Excel Management Inc. right away, you should contact them as soon as you can. Global Excel Management Inc. will help ensure that you receive the medical care you need and, if possible, will make claims payment arrangements directly with the hospital or service provider.

If you contact GLOBAL EXCEL MANAGEMENT INC. right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

If you are not able to contact Global Excel Management Inc. before being billed for the charges, or if your medical needs are minor in nature (i.e., costing less than $500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip. In any case, your claim should be submitted no later than 90 days after the expense was incurred. Global Excel Management Inc. and the insurance company are not responsible for dealing with any payment reminders or collection notices that you receive from medical providers.

To make a claim for out-of-pocket expenses, contact a Global Excel Management Inc. operator at:

From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

Give the operator your name and your Policy Number: CMG 9428860

The operator will send you a claim form. When you complete the form, provide the patient's name and provincial health plan number and your certificate number. Be sure to attach detailed statements and original receipts showing the services rendered and the charges for each service. Mail your completed claim form and attachments to:

Global Excel Management Inc.
73 Queen Street
Lennoxville, QC, J1M 1J3

Please make sure you obtain your medical records, statements, or detailed receipts at the time of treatment and/or discharge, to submit with your claim. All claims must be submitted to Global Excel Management Inc. as soon as possible, and no later than 90 days after the expense was incurred.

Healthcare Spending Account

Purpose

To assist Union Members and their families in offsetting Healthcare and Dentalcare expenses incurred above and beyond the coverage presently provided by the Operating Engineers Local Union 987 Health & Welfare Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums). Allocations are reviewed annually subject to the discretion of the Trustees considering the financial stability of the Plan.

Claims Procedures

For reimbursement through your H.S.A., just submit your original receipt or Insurer claims summary statement with a claim form to the Plan Administrator, Coughlin & Associates Ltd., no different than for regular claims covered by the Group Insurance Plan. Please note that the Health and Dental claim forms have been updated to allow for any remaining Health, Vision, or Dental benefit expenses not covered by the Basic Plan to automatically be applied to the extent of your Healthcare Spending Account, if any, unless you indicate on the applicable claim form that you do not want to have Coughlin apply remaining claims expenses automatically to your H.S.A. Please note that 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 (summary statement from your spouse's Insurer), to Coughlin in order to have the remaining portion applied to your H.S.A. For Dental claims submitted directly by your Dentist (i.e. no claim form submitted), you will need to contact Coughlin's directly if you do wish to use your H.S.A. balance.

Eligibility

For Union Members who are no longer in benefit (i.e. Retirees, Non-Working Members, Disabled), you may still make claims against your Healthcare Spending Account balance following your last day of coverage under the Group Insurance Plan provided you maintain your good standing as a Member of the Local Union 987.

Termination

In the event of termination of Membership from Local Union 987, 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 dependents as follows:

1) Spouse – until the balance of the Healthcare Spending Account is depleted.

2) Dependent Children – until they no longer qualify as dependents under the Group Insurance Plan or the balance of the Healthcare Spending Account is depleted.

Reinstatement

Reinstatement of a Union Member's Healthcare Spending Account is not applicable as it is a requirement that a Member maintain a positive status with Local Union 987 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.

List of Eligible Medical Expenditures

A list of eligible medical expenses is available via the Plan Member Portal on the Plan Administrator's website at www.coughlin.ca, or alternatively, you can contact Coughlin & Associates Ltd. directly and request a list be mailed to you.

To determine the outstanding balance in a Member's individual HSA, the Member should refer to his/her latest claims cheque record, monthly Member statement, or alternatively contact the Plan Administrator at (204) 942-4438 or Toll Free 1-888-204-1234, or alternatively via the Plan Administrator's website at www.coughlin.ca by clicking on "Logon" and entering a temporary password detailed on your claims summary.

Co-Ordination of Benefits

If you or your dependents 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).

1) 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.

2) 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 Dependent Spouse**

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

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

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

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

c) The Plan where the person is covered as a Retiree.

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

  The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same 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:

1) The Plan of the parent with custody of the child pays, then

2) 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 Dependent Child) , then

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

4) 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).

5) 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.

6) 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:

1) As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.

2) Submit all necessary claim forms and original receipts to the Primary Carrier.

3) Keep a photocopy of each receipt until your claim has been settled and for submission to Secondary Carrier.

4) Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms to the Secondary Carrier for further consideration of payment, if applicable.

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.

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.

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

Chubb Life Insurance Company of Canada
Policy # AB10406505
Policy # CI20001601

AND

Homewood Health

AND

People Corporation

AND

AIG Insurance Company
Policy # CMG 9428860

AND

Pay Direct Drug Card Provider – ES Canada

THE PLAN IS ARRANGED AND ADMINISTERED BY:

Coughlin & Associates Ltd.
Employee Benefits Specialists
Post Office Box 764
Winnipeg, Manitoba
R3C 2L4
Telephone: (204) 942-4438
Fax: (204) 943-5998
Email: 987admin@coughlin.ca