HEALTH AND WELFARE TRUST FUND

May 2022

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To: All Plan Participants
I.B.E.W. Local Union 2085
Health and Welfare Trust Fund

Insurance protection against the financial hardship that so often accompanies unforeseen events such as 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 Participants of the I.B.E.W. Local Union 2085 from these hardships. The Major Medical 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 Travel Medical Emergency benefit is underwritten by AIG Insurance Company, the Employee and Family Assistance Program by Homewood Health, and the Accidental Death & Dismemberment / Critical Illness benefit by Chubb Life Insurance Company of Canada (Chubb Life). Life Insurance, Dependent Life, and Long Term Disability benefits are underwritten by Manulife Financial, while Weekly Income, Major Medical, and Dentalcare are self-insured by the Trust Fund.

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 Platinum 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 financial stability of the Plan. Participants will be advised of such changes accordingly on a timely basis.

The Plan Administrator is Coughlin & Associates Ltd., PO Box 764, Winnipeg, Manitoba, R3C 2L4. If you have any questions concerning your benefits (2085admin@coughlin.ca) or claim procedures (winnclaims@coughlin.ca), or contact the Plan Administrator at (204) 942-4438 or Toll Free 1-888-204-1234.

We are pleased to make these arrangements on your behalf and we 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 I.B.E.W. Local Union 2085
Health and Welfare Trust Fund

This booklet is for your general information only; however, it is not the insurance policy and does not grant or confer any contractual rights. In the following pages, you will find a brief description of the benefits that you and your dependent(s) are entitled to, the rules covering eligibility for these benefits and the procedures that should be followed in the event that it is necessary for you or your dependent(s) to make a claim. The final determination of any claim, question or problem that may arise will be governed by the Group Policies issued by Manulife Financial (901504), Homewood Health, Self-Insured Policy (SI901504), Chubb Life (AB10406513 and CI20003501), AIG Insurance Company (CMG 9428859), along with the Benefits coordinated with People Corporation and by applicable law.

In the event of any variation or discrepancy between the information in this booklet and the provisions of the Master Policies, the latter will prevail.

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided as evidence of insurability, subject to certain limitations.

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation (i.e. Limitations Act, 2002 in Ontario, Quebec Civil Code).

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contact as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days of the Insurer or Coughlin (the Administrator) sending you a notice of the overpayment, or within a longer period if agreed to in writing by the Plan and/or insurer. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit the Plan and/or Insurer right to use other legal means to recover the overpayment.

Notice Regarding Personal Information

When you apply for coverage under the Group Benefit Plan, the Plan Administrator, Coughlin & Associates Ltd., and the Insurers, Manulife Financial, Chubb Life, Homewood Health, and AIG Insurance Company, will set up a file with personal information relevant to your benefit coverage under the Plan.

The purpose of this file is to permit the companies listed above to administer all financial services provided to you, and to keep information specific to the Insurers' and Coughlin's business relationship with you. This includes the following:

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

The files are kept in the office's of these companies so they have access to the file when required for insurance purposes.

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

Privacy

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

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

Highlight of Benefits

Group Policy Numbers
Manulife Financial – 901504
Chubb Life – AB10406513 / CI20003501
Homewood Health
Self-Insured Policy – SI901504
AIG Insurance Company – CMG 9428859

Administration Contact: 2085admin@coughlin.ca
Claims Contact: winnclaims@coughlin.ca

Life Insurance

Benefit..... Under age 65 - $100,000
Age 65-69 - $50,000

Coverage ceases ..... Please refer to Life Insurance section for complete details

Dependent Life Insurance

Benefit..... Spouse - $10,000
.....Child - $5,000

Coverage ceases ..... Please refer to Dependent Life Insurance section for complete details

Optional Life Insurance

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

Accidental Death and Dismemberment (AD&D) Insurance

Principal Sum ..... Under age 65 - $100,000
Age 65-69 - $50,000

Coverage ceases ..... Please refer to AD&D Insurance section for complete details

Weekly Disability Income (W.I.)

Benefit.....66 2/3% of weekly earnings to a maximum of $638 (E.I. maximum) per week

Commencement.....1st day due to injury, hospitalization or day surgery /8th day due to illness

Maximum Duration.....32 weeks (subject to E.I. wrap around from weeks 2 - 16)

Note: You must apply for Employment Insurance (E.I.) sickness benefits. This benefit is non-taxable.

Coverage ceases .....Please refer to W.I. section for complete details

Long Term Disability (LTD) Income

Benefit $1,500/month

- WCB direct offset
- All-source limit is 85%

Qualifying Disability Period..... following 32 weeks

Maximum Benefit Period.....to the earlier of age 65, date that you are no longer disabled or upon retirement

This benefit is non-taxable.

Coverage ceases ..... Please refer to LTD Income section for complete details

Critical Illness

Active and Disabled Members (in benefit) are eligible for a $10,000 flat benefit once diagnosed with or suffering from one of the insured conditions (presently 23 covered). This benefit also includes partial payments for hip or knee replacement as well as a 2nd event benefit for cancer, heart attack or stroke if a Member returns to work for a minimum of 90 days after recovering from the original illness, as well as a cancer reoccurrence benefit. The Critical Illness benefit ceases at age 70.

Please refer to the Critical Illness booklet prepared by Chubb Life for more information. This is available on the Coughlin Member Portal.

Major Medical

Deductible.....$15/person or family/calendar year
(not applicable to Hospital or Visioncare expenses)

Co-insurance:

Prescription Drugs (Pay Direct Drug Card via Express Scripts Canada)
and Visioncare Expenses.....100%

For all other eligible expenses 90%
.....(subject to Reasonable and Customary limits)

Maximum Benefits:

Prescription Drugs (Pay Direct Drug Card) .....$3,500/family/benefit year
(Benefit year: April 1st to March 31st)

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

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

Visioncare..... $400/person/24 months

Laser Eye Surgery $1,000/person/lifetime

Eye Exams ..... 125/person/24 months

Clinical Psychologist .....$1,000/person/calendar year

Massage Therapy.....$1,000/person/calendar year

Chiropractor ..... $1,000/person/calendar year

Remaining Paramedical Services ..... $500/person/calendar year/specialist

Hearing Aids ..... $1,000/person/36 months

Physiotherapy, Athletic Therapy ..... $1,000/person/calendar year

Coverage ceases ..... Please refer to Major Medical section for complete details.

Travel Medical Emergency

Policy Number ..... CMG 9428859

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 and Family Assistance Program (EFAP)

The EFAP provides confidential, professional assistance for a broad range of personal and family problems. In addition to online resources, it covers counselling (including assessment and referral) for a full spectrum of personal difficulties.

Please refer to the Employee Family Assistance Program section for complete details.

People Connect – Access to Virtual Counselling

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.

Dentalcare

Deductible ..... Nil

Co-insurance:

Basic Services 90%
Major Services 80%
Orthodontic Services 50%

Plan Maximums:

Basic and Major Services (combined) ..... $1,500/person/calendar year

Orthodontics $3,000/person/lifetime
(for dependent children age 18 and under)

Fee Guide ..... 2022 Provincial Fee Guide applicable
to the Participant's province of residence

Coverage ceases ..... Please refer to Dentalcare
section for complete details

Healthcare Spending Account (HSA)

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

Eligibility ..... Local Union 2085 Insured Members only

Coughlin Care Platinum

Eligibility ..... Insured Participants and Families

- **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 (901504) 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)

- **Healthcare Coaching:** Go to https://enroll.ecounsellors.ca/coughlincare From there you will be guided through the sign up process. Be sure to have your Member ID or Prescription Drug Card.

- **Selfhelp Works:** Go to https://portals.selfhelpworks.com/coughlincare/ From there you will be guided through the sign-up process. Be sure to have your Member ID or Prescription Drug Card.

- **SMART(Substance Management and Recovery Treatment):** Go to try.alavida.co/coughlin and click "Sign up". From there you'll be guided through the simple registration process. Be sure to have your Member ID or Prescription Drug Card. number at hand

- **Quikcare Expedited Healthcare:** Call the Quikcare helpline #1-844-900-8357

Refer to ***Coughlin Care Platinum*** section.

Bereavement Benefit (self-insured)

Benefit..... $450 payable for 1 day bereavement upon death of a family member

Eligibility ..... Member must be in good standing with IBEW Local Union 2085 for a minimum of 2 consecutive years.

Note: This benefit is taxable

Please contact the Plan Administrator for further information.

General Information

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

For each Participant, an account is kept by the Plan Administrator 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.

Eligibility

Each month 150 hours (monthly deduction) will be deducted from the Union or Permit Worker's Hour Bank Account. For Office Staff, 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 not exceed 3,600 hours (enough to provide twenty four (24) months of coverage). Excess hours accumulated over 3,600 hours will be credited to the general reserves of the Trust Fund.

A Permit Worker can accumulate hours worked in excess of the monthly deduction; however, upon the date of termination of employment or lay-off, the balance in the Hour Bank Account is forfeited to the general reserves of the Trust Fund unless the Permit Worker becomes a Union Member in good standing with Local Union 2085.

Eligible Participants

Under the 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 I.B.E.W. Local Union 2085 on whose behalf contributions are being made in accordance with the terms of the Collective Agreement to the I.B.E.W. Local Union 2085 Health & Welfare Trust Fund.

Permit Workers

Employees of Contributing Employers on whose behalf contributions are made to the I.B.E.W. Local Union 2085 Health & Welfare Trust Fund, and are not Members of Local Union 2085 or any reciprocating Local will be eligible for benefit coverage while working for a Contributing Employer.

Office Staff

Office Staff of Local Union 2085 and Employees of Contributing Employers (support staff) on whose behalf contributions are made to the I.B.E.W. Local Union 2085 Health & Welfare Trust Fund, and are not Members of Local Union 2085 or any other reciprocating Local will be eligible for benefit coverage while working for Local Union 2085 or a Contributing Employer.

Retired Members

A Union Member is considered Retired when he/she has attained age 55 or older and has either withdrawn his/her funds from the Pension Trust Fund or has indicated in writing to Local Union 2085 of his/her retirement from the trade.

When You Become Insured Initially

For Life, Dependent Life, Accidental Death & Dismemberment, Employee Family Assistance Program, and Long Term Disability (LTD) Income Benefits, **you will become eligible for coverage on the next day following 400 hours worked within twelve (12) consecutive months**.

For Weekly Disability Income (WI), Major Medical Benefits, People Connect (Mental Health), Critical Illness, Travel Medical Emergency, and Dentalcare Benefits, **you will become eligible for coverage on the first day of the following month after the Administrator is in receipt of 400 hours worked within twelve (12) consecutive months**.

Office Staff will be eligible for coverage on the first day of the month following three (3) consecutive months of employment.

If you are unable to work when coverage becomes effective, the effective date of coverage will be postponed until you are actively at work.

An enrolment card must also be completed to be eligible to receive benefits.

Eligible Dependents

Eligible dependents under this Plan shall include:

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

- Your spouse as the result of a valid civil or religious ceremony, or a person (including same-sex partners) whose common-law relationship with you has existed for a minimum period of twelve (12) consecutive months immediately prior to the date on which a claim arose. A common-law relationship must include continuous cohabitation and public representation of married status. A Divorced, separated spouse (with or without a court order or separation agreement) or a person cohabitating with you without public representation of the married status are **not** eligible for coverage.

- You or your spouse's unmarried children from 15 days to age 20 inclusive. As well, dependents aged 21 to 24 inclusive provided they are in full-time attendance at a University or similar institution (evidence of attendance will be required).

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

- A child who is functionally impaired of self-support beyond the limiting age may be continued under the Major Medical and Dentalcare benefits while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. To continue a child under this benefit provision, proof of incapacity must be received by the Insurer within thirty-one (31) days after dependent coverage would otherwise terminate. Additional proof will be required from time to time.

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

Survivor Benefit Provision

Major Medical, Dentalcare, Employee Family Assistance Program, and Emergency Travel Medical coverage for eligible dependents shall continue, without premium payment, following your death up to a maximum of twenty-four (24) months from the date of death.

Reinstatement of Insurance

If a Union Member's benefit coverage had previously terminated because of insufficient hours in his/her Hour Bank Account and the Union Member has not been out of benefit for a period exceeding six (6) consecutive months, the Union Member will again become insured for Life, Dependent Life, Accidental Death and Dismemberment, Employee Family Assistance Program, and Long Term Disability benefits immediately upon accumulation of 150 hours worked within six (6) consecutive months in the Hour Bank Account.

The Union Member will be also eligible for Weekly Disability Income, Major Medical, People Connect (Mental Health), Critical Illness, Travel Medical Emergency, and Dentalcare benefits on the first day of the following month once the Administrator has received 150 hours in your Hour Bank Account within six (6) consecutive months. A statement will be mailed to you advising when your Hour Bank Account falls below 150 hours. Otherwise, you will have to meet the original eligibility requirements as though you were a new Participant of the Plan.

If a Retired Member returns to work and meets the minimum eligibility requirements of accumulating 150 hours in his/her Hour Bank Account, provided these hours are worked in six (6) consecutive months, the Retired Member would be eligible for all benefit coverage subject to the benefit age restrictions.

Changes in Insurance Benefits

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

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

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

Termination of Insurance

Unless otherwise specified in this booklet, benefit coverage for you and/or your dependents will terminate:

- For a Union Member, at the end of the month wherein you do not have at least 150 hours in your Hour Bank Account. However, you may arrange to have your benefit coverage continued on a self-pay basis as identified in the Self-Pay Provision section on the next page.

- For Permit Workers and Office Staff, at the end of the month following the date of termination of employment or lay-off (except for Long Term Disability Income and Weekly Disability Income coverage which cease immediately). Permit Workers and Office Staff are not eligible to make self-payments.

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

- If you cease to be a Participant in an eligible class.

- If you enter military service.

- If the Group Policy terminates .

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

Self-Pay Provision

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

If there are insufficient hours in a Union Member's Hour Bank Account (i.e. due to lay-off), he/she will be allowed to continue his/her coverage excluding Disability coverage (Weekly Disability Income and Long Term Disability) by making a direct contribution to the Fund. The Plan Administrator will notify the Member if a self-payment is required. Such self-paid contributions must be continuous and consecutive for a period not to exceed twelve (12) months. The payment must be made prior to the twenty-second (22nd) of the month following the month in which the Hour Bank Account falls below 150 hours. If a self-payment is not received by the required date, benefit coverage will be terminated without further notification as identified in the Termination of Insurance section of this booklet.

Eligibility to self-pay is contingent upon the Union Member being in good standing with Local Union 2085.

In order to reinstate the self-paying duration to twelve (12) months, a Union Member must return to employment and work a minimum of 150 hours within six (6) consecutive months.

Retired Members - Following depletion of the accumulated Hour Bank Account and 12 month self-pay period (except Long Term Disability Income and Weekly Disability Income coverage which cease immediately, and with Life and Accidental Death and Dismemberment coverage reducing by 50%), a Member who has been in good standing with the Local Union for 10 consecutive years before the date of retirement is eligible to extend their Health, Dental, Employee Family Assistance Program, and People Connect (Mental Health) coverage up to age 80 and Travel Medical Emergency coverage up to age 75 on a self-pay basis.

Note:

- Long Term Disability Income and Weekly Disability Income coverages are excluded for self-paying Union Members.
- Permit Workers and Office Staff **cannot** make self-payments.

Monthly Statements

Each month a statement is mailed to each Participant (excluding Office Staff). This statement will show the individual'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 from your Hour Bank Account balance each month to pay the premium for your coverage.

If there are insufficient hours in a Union Member's Hour Bank Account, the statement will show the amount required to pay on the "self-pay basis". For all other Participants, if there are insufficient hours in their Hour Bank Account, coverage will cease immediately as self-payments cannot be made to continue coverage. For a Union Member, 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 receiving this statement regularly it is necessary to inform the Plan Administrator of any change of address.

Disability Claims

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

Disability Provision

Disabled Union Member

If a Union Member is disabled and receiving disability payments for six (6) consecutive months and has maintained his/her eligibility status for benefits by either running down his/her Hour Bank Account or making self-payments during this six (6) month period, the Trust Fund will extend coverage for all benefits for an additional six (6) consecutive months with the appropriate premium payments paid by the Trust Fund noting Life, LTD, AD&D, Dependent Life premiums are subject to Waiver of Premium following nine (9) consecutive months of disability. If after this period the Union Member continues to be disabled, coverage for the Major Medical and Dentalcare benefits may continue with the premium payments assumed by the Trust Fund. This provision is subject to review

from time to time and it may change at the discretion of the Board of Trustees due to the financial stability of the Plan. If a Disabled Member refuses to make an application for the Waiver of Premium or is subsequently declined, all coverage (excluding WI and LTD) will only be extended for the remaining balance of the Member's self-pay provision to a maximum of twelve (12) months. Benefits coverage will cease at the earlier of the date of recovery or when the Union Member reaches age 65.

The Union Member is eligible for this extension of coverage only as long as he/she remains a Member in good standing with Local Union 2085.

Disabled Office Staff or Permit Worker

If an Office Staff Member or Permit Worker is receiving disability payments, the Trust Fund will extend coverage for all benefits for twenty-four (24) consecutive months provided appropriate monthly contribution remittances are received by the Trust Fund. Coverage will cease at the earlier of the date of recovery, attainment of the twenty-four (24) month maximum period, if the appropriate monthly contribution remittance is not received within the allowable time or the disabled participant reaches age 65.

Wage Loss Provision (Union Members only)

In the event that you incur a total disability while insured but on lay-off or leave of absence and "running down" your Hour Bank Account, the Plan will recognize your disability for wage loss benefits (W.I. and LTD) from the scheduled date of return to work, provided you are then totally disabled and submit attending physicians' statements certifying continued disability.

REMINDER: **Self-payments do not include W.I. or LTD (disability) benefits.**

Reciprocal Agreements

I.B.E.W. Local Union 2085 Members – Union Members working in a jurisdiction other than I.B.E.W. Local Union 2085, and on whose behalf contributions are being made to a Health and Welfare Trust Fund should complete a Transfer Authority Form and advise the Local Union or Plan Administrator to reciprocate contributions to their "Home Fund". This will maintain coverage under the I.B.E.W. Local Union 2085 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 a Reciprocal Agreement with the I.B.E.W. Local Union 2085 Health and Welfare Trust Fund **will not** be eligible for benefits but will have all contributions made on their behalf reciprocated to their "Home Fund" after they complete the Transfer Authority Form available at the Local Union 2085 office or from the Plan Administrator.

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.

Life Insurance

In the event of your death while insured, the amount of your Life Insurance is payable to your designated beneficiary. You may change your beneficiary at any time through written notice to the Plan Administrator, subject to any policy or legal limitations.

Amount of Benefit

You are entitled to the applicable Benefit amount outlined in the Highlight of Benefits section, with the benefit amount reducing by 50% at earlier of retirement or age 65.

Coverage Ceases

Your Life Insurance coverage ceases at the earlier of: age 70; following the 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 2085.

For Permit Workers and Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off, retirement or age 70.

Waiver of Premium for Disability

If you become totally disabled for at least nine (9) consecutive months before age 65, your Life Insurance will be continued without payment of premiums until you cease to be totally disabled or you reach the age of 65, whichever occurs first.

As you are also insured for group Long-Term Disability Insurance (LTD) under this Plan, with a similar waiver of premium, application for the Life, Dependent Life, AD&D, and LTD Waiver of Premiums are applied for on the LTD benefit claim form.

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

Note: In order to qualify for the Waiver of Premium, you must notify the Plan Administrator of your disability within one (1) year of your last active day of work and furnish proof of your disability satisfactory to the Insurer within eighteen (18) months of the last active day of work.

Conversion Privilege

Your Life Insurance continues for thirty-one (31) days following the termination of your coverage. During this thirty-one (31) day period you may be eligible to convert the amount of your Life Insurance to an individual whole life or a convertible one-year term plan or a term to age 65 plan without submitting evidence of health. The premium rate will be determined by your age and class of risk at the time of conversion.

Dependent Life Insurance

Amount of Benefit

In the event of the death of your insured spouse and/or dependent children, the applicable Benefit amount is payable to you as outlined in the Highlight of Benefits section.

Coverage Ceases

Your Dependent Life Insurance coverage terminates at the earlier of age 70, following the 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 2085.

For Permit Workers and Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off, retirement or age 70.

Waiver of Premium for Disability

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

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 whole life plan or a convertible one-year term plan or a term to age 65 plan without submitting evidence of health. The premium rate will be determined by your spouse's age and class of risk at the time of conversion.

Accidental Death and Dismemberment
(Underwritten by Chubb Life)

Coverage

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

Amount of Benefit

You are entitled to the Principal Sum or a portion thereof, as outlined in the Highlight of Benefits section, with the amount reducing by 50% at the earlier of retirement or age 65. The amount of benefit depends on the loss suffered by you and is limited to the percentage of the Principal Sum shown in the Schedule of Losses.

Coverage Ceases

Your Accidental Death & Dismemberment coverage terminates 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 Union 2085.

For Permit Workers and Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off, retirement or age 70.

Schedule of Losses

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within 1 year from the date of the accident, 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.

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:

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

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

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

Family Transportation Benefit

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:

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

- 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

- 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.

Continuance of Coverage

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

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% 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:

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

- 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).

Waiver of Premium for Disability

If you become totally disabled before age 65, the Accidental Death & Dismemberment Insurance may be continued without payment of premiums in the same manner as Life Insurance.

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.

Coverage During Waiver of Premium

While premiums are being waived, Basic Accidental Death and Dismemberment Insurance under the policy on an Insured Employee will continue to be in force. The amount of such insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

"Totally Disabled or Total Disability" with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Employee's regular occupation for 6 consecutive months.

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:

- intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
- declared or undeclared war or any act thereof;
- 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;
- 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);
- 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.

Weekly Disability Income

In the event you become totally disabled due to an injury or illness, you will receive a disability benefit provided you are under the continual treatment of a qualified and licensed physician (Medical Doctor).

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

Benefits for any one disability are payable from the first (1st) day of disability for injury, hospitalization or day surgery and the eighth (8th) day for disease or illness. **But in no event prior to the first day of visit to your physician.** Your benefit will be payable for not more than thirty-two (32) weeks during any one period of disability.

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

- The first one (1) week of disability will be covered by the Plan. The Plan Administrator will advise you to apply for E.I. Disability benefits during the initial 1-week period.

- Weeks 2 to 16 will be covered by E.I. if available, or by the Plan if E.I. is not available.

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

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

The amount of weekly benefits are specified in the Highlight of Benefits section.

Reductions

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

- any other plan or program provided to you by or through the Employer;

- 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.

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 Plan shall not reduce the weekly benefit by that amount.

Coverage Ceases

Eligibility for the Weekly Disability Income benefit terminates at the earlier of the depletion of the Hour Bank Account, the date of retirement, upon attainment of age 65, or if you are no longer a Member in good standing with Local Union 2085.

For Permit Workers or Office Staff, coverage terminates immediately upon the date of termination of employment, retirement, lay-off or age 65.

If you attain age 65 while receiving Weekly Disability Income benefits, the benefits will continue until you have received a total of 15 weeks of benefits or until you are no longer disabled or you retire, whichever comes first.

Exceptions

Benefits are not payable for:

- disability resulting from an intentionally self-inflicted injury;

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

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

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

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

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

Long Term Disability Income

Qualifying Disability Period

The Qualifying Disability Period starts when you first become totally disabled and ends after thirty-two (32) weeks, 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:

- no interruption is longer than two (2) weeks; and
- 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 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 non-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 1/30th of the applicable Gross Monthly Benefit, less any Reductions of Coverage, 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.

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

Maximum Benefit Period

The maximum benefit period shall be to age 65, the date that you are no longer disabled or upon retirement.

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 net 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 excess.

With respect to your participation in a Program of Rehabilitation, total monthly income while disabled cannot exceed one-hundred percent (100%) of net 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 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) any Workers' Compensation law or similar law;

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

   d) any other plan or program of any government or 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.

Reduced Monthly Benefit: If you are eligible for full benefits and you elect a different and lesser paid occupation not related to the Program of

Rehabilitation described below, the gross benefit less reductions shall be further reduced by fifty percent (50%) of the earnings from the lesser paid occupation elected, subject to the **All Source Maximum** described in this section.

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:

- your regular occupation on a part-time basis;
- a formal vocational training program; or
- 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 Gross Benefit less reductions 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:

- the date that you cease to be Totally Disabled;
- the date that you complete the rehabilitation program; or
- 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) months after your return to active work, you would be considered disabled for one continuous period. If you return to active work for one (1) full day and become disabled from different and unrelated causes, you will begin a new period of disability.

Coverage Ceases

Eligibility for Long Term Disability Income benefit coverage terminates at the earlier of age 65, the depletion of the Hour Bank Account, the date of retirement, or if you are no longer a Member in good standing with Local Union 2085.

For Permit Workers or Office Staff, coverage terminates immediately upon the date of termination of employment, retirement, lay-off or age 65.

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) 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. However, you can fulfill your qualifying period during a strike.

Major Medical Benefit

The Major Medical Benefit is designed to assist you with payment of your medical bills. It may not pay the total cost of medical services and supplies. In effect, the Plan shares with you the payment of your medical bills.

The Major Medical Benefit covers only those expenses which are considered reasonable and customary for the service provided, in the area where the expenses are incurred, provided you are resident in Canada.

Participant and Dependent Coverage

In the event that you incur in a calendar year any of the Eligible Expenses, you will be paid ninety percent (90%) of the expenses, in excess of the Medical Deductible for that year.

For Prescription Drugs and Visioncare expenses, the level of reimbursement is one-hundred percent (100%) subject to the maximums outlined in the Highlight of Benefits section in this booklet.

Coverage Ceases

Your Major Medical coverage terminates at the earlier of age 75, following the 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 2085. Actively Working Members are eligible to have their Major Medical coverage extended past age 75 up to the extent of the Member's Hour Bank Account with no ability to self-pay. Coverage will terminate at age 80 for Retired Members who qualify for the extension in coverage.

For Permit Workers and Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off or retirement.

Medical Deductible

The Medical Deductible is that portion of the Eligible Expenses that is deducted from either you or your dependent's first eligible claim submitted in any year. The Medical Deductible is $15 per person or family per calendar year and is not applicable to Hospital or Visioncare expenses.

Eligible Expenses

The following is a list of eligible expenses:

Hospital Expenses in Canada

Charges for room and board for each day of confinement up to the difference between the amount provided under the Provincial Hospital Act and the semi-private charge (or private charges, if certified necessary by your attending physician). The calendar year deductible shall not apply to the above charges.

Prescription Drug Expenses in Canada

Charges for any medically necessary drugs or medicine which by law requires a physician's prescription for purchase including oral contraceptives and preventative vaccines (excluding physician's fees), but shall not include any charge for off-the-shelf preparations which may be purchased without a physician's prescription up to $3,500 per family per Benefit Year (April 1st to March 31st).

Smoking cessation aids which require a physician's prescription are covered to a maximum of $400 for the first course of treatment, and for the second course of treatment, fifty percent (50%) of cost to a maximum of $200 per person. Nicotine patches and Nicorette gum are also covered subject to a lifetime maximum of $250.

Prior Authorization Drug Program

Effective October 1, 2019, prescription drugs requiring prior authorization will be managed by Express Scripts Canada's (ESC) team of clinical experts.

How it works:

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

2) Form must be sent to ESC for review: You or your physician should fax or mail the completed form to Express Scripts Canada. Note that forms cannot be accepted by e-mail due to privacy reasons.

Fax:

Express Scripts Canada – Clinical Services
1 (855) 712-6329 or (905) 712-6329

Mail:

Express Scripts Canada – Clinical Services
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

3) ESC experts process the request: Express Scripts Canada's clinical experts will then review and process your request. Using clinical criteria, such as Health Canada's approved indications and other supporting evidence based protocols and research will serve to determine the outcome of your request.

4) Decision is confirmed: You will generally be notified of approval or denial by mail within 48 hours following receipt of the form, however where a more extensive evaluation is required this process could take up to 3 weeks.

Once you have made a pre-authorization request, if you have any questions, please feel free to contact Express Scripts Canada Member Contact Center toll-free at 1 855-550-MEDS (6337), Monday to Saturday, 7:30 a.m. to 9 p.m. ET.

Extended Health Expenses

1) Charges for licensed Convalescent Care Facility.

2) Charges for the services of a licensed speech therapist, osteopath or podiatrist up to a maximum eligible expense of $500, in excess of the provincial plan, per person per calendar year per specialty and subject to reasonable and customary limits per visit/duration of visit.

3) Physiotherapy (inclusive of Athletic Therapy), Massage Therapy, and Chiropractors each to a maximum of $1,000 per person per calendar year per specialty and subject to reasonable and customary limits per visit/duration of visit.

4) Charges for a clinical psychologist up to $1,000 per calendar year and subject to reasonable and customary limits per visit/duration of visit.

   * includes the following therapists as eligible expense:

   - CCC, Canadian Certified Counsellor
   - RCC, Registered Clinical Counsellor
   - RMFT, Registered Marriage and Family Therapist
   - RPC, Registered Professional Counsellor
   - RPsych, Registered Psychologist
   - ATR, Registered Art Therapist
   - RP, Registered Psychotherapist
   - RSW, Registered Social Worker
   - RSSW, Registered Social Service Worker
   - RCSW/LCSW, Registered/Licensed Clinical Social Worker

5) Charges for the services of a registered nurse (R.N.) provided such nurse is not a resident in your home or a relative of your family. At age 65 or retirement, coverage for nursing services are limited to $3,000 per calendar year.

6) Charges for rental (or, at the Plan's option, purchase) of medical supplies and appliances prescribed by a physician for a specific medical condition. (Additional information may be required.).

7) Charges for the purchase of prostheses.

8) Charges for professional ambulance service, including scheduled airline or railroad to the nearest hospital qualified to provide the necessary treatment.

9) Charges for outpatient hospital services and supplies.

10) Charges for diagnostic, laboratory tests and x-ray expenses not covered by a provincial plan to a maximum of $500 per calendar year.

11) Orthotic/Orthopedic shoes to a maximum of $200 every twelve (12) months, provided they are custom made and prescribed by a physician, podiatrist, or chiropodist for a diagnosed condition. The prescription must include the diagnosis. Note that coverage is limited to reasonable and customary limits and are on a

reimbursement basis – assignment of benefits to the provider is not allowed.

12) Charges for support stockings to a maximum of $200 per person per calendar year provided they are prescribed by a physician for a specific medical condition and includes the compression factor required. Note that coverage is limited to reasonable and customary limits and are on a reimbursement basis – assignment of benefits to the provider is not allowed.

Visioncare Expenses

Charges for necessary visual supplies recommended by a duly qualified optometrist or ophthalmologist subject to the following maximum:

1) Eye examinations, subject to a maximum eligible expense of $125 per person in any twenty-four (24) month period.

2) Eyeglasses or contact lenses to a maximum of $400 in any twenty-four (24) month period.

3) Laser eye surgery subject to a $1,000 lifetime maximum.

Charges payable under this benefit for contact lenses will be limited to charges incurred by an insured individual following cataract surgery or if visual acuity in the better eye cannot be improved to 20/40 by the use of conventional type lenses but can be improved to 20/40 or better by the use of contact lenses. Such charges are subject to a maximum eligible expense of $200 in any twenty-four (24) month period.

Visioncare expenses are not subject to the deductible.

Exclusions

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

1) Charges which are considered as insured services of any provincial government plan.

2) Charges for general health examinations.

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 a surgical procedure by a physician other than as provided under **outside of Canada** expenses.

5) Charges not specified in the list of eligible expenses.

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

7) Charges for dental work where a third party is responsible for payment of such charges.

8) Charges for transport or travel, other than as specifically provided under eligible expenses.

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

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

11) Charges which would not normally have been incurred but for the presence of this insurance or for which the Participant or dependent is not legally obligated to pay.

12) Charges which the Plan is not permitted by any law or regulation to cover.

13) Expenses incurred for anyone who is not insured under the Provincial Medicare Plan.

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 9428859

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.

Employee and Family Assistance Program

Your Employee and Family Assistance Program

From time to time we all face difficult or stressful events in our lives. Most of the time, we handle these personal challenges fairly well. Other times, our personal problems can become large enough that they begin to interfere with our effectiveness, happiness or safety, both at work, and at home.

Your Employee and Family Assistance Program (EFAP) provides confidential, professional assistance for a broad range of personal and family problems. While the program can be used for crisis intervention, the ideal time to use the program is before problems escalate or become unmanageable.

The Employee and Family Assistance Program is a pro-active option for helping you manage your personal health and happiness.

What Services Are Available To Me?

Your EFAP offers you and your eligible dependents short-term counselling in person, by phone or through the internet at www.homewoodhealth.com.

What Does My Program Offer?

Your EFAP covers counselling, in addition to assessment and referral when required, for a full spectrum of personal difficulties including, but not limited to:

- work-related stress
- relationship and family problems
- separation/divorce/custody
- financial and legal difficulties
- alcohol and drug dependency
- gambling and other addictions
- eating disorders
- difficulties with children
- psychological disorders

- anger management
- sexual harassment and abuse
- bereavement
- aging parents
- child/elder care resources
- retirement planning

How Does My Program Work?

Call Homewood Health and we will assist you in setting up an appointment at a time and office location convenient to you.

Your counselor will work with you to address your specific concerns and help you develop efficient and practical solutions.

If longer term counselling, hospital treatment, or specialized services are required, your counselor will arrange an appropriate referral and follow-up with you.

Who Provides My Counselling?

All Homewood Health health professionals are registered psychologists or registered counselors chosen specifically for their extensive experience in dealing with a variety of psychological health issues.

They provide a non-judgmental and unbiased source of expertise and support, will listen carefully to your concerns and will help guide you toward positive outcomes.

Is The EFAP Confidential?

Yes, the EFAP is a confidential service. Homewood Health counselors are required by law to maintain the strictest confidentiality. No one who inquires about or receives services under this plan will be identified to anyone without your written approval.

Who Do I Contact?

To speak with someone confidentially, call Homewood Health at 1-800-663-1142.

Another way to reach us is through our website. Scroll down our home page to the Quick Links and click on "Help and Counselling" to book an appointment.

Childcare and Eldercare Services

The Child and Elder Care program provides information about personal and family care providers in Canada. This service can be used to generate customized online reports with in-depth service descriptions and provides instant access to quality checklists, financial aid information, advice, and more.

Financial Counselling

Counselling can be provided for the following:

- debt crisis management
- preventative money and debt management
- cost of living analysis
- financial options related to separation and divorce
- illness and disability
- workforce transition and job loss
- early or planned retirement

Legal Counselling

The legal service provides two options:

- a telephone consultation through Lawline, an exclusive service provided by Homewood Health, or

- in our domestic service locations you can select a lawyer under contract with Homewood Health to provide legal consultation.

For Immediate Response North America Wide:

English 1-800-663-1142
French 1-866-398-9505
Hearing Impaired.....1-888-384-1152

International Access:

(Call Collect) 604-689-1717

Homewood Health is an industry leader and benchmark provider in-human solutions for organizations and their employees.

Homewood Health sets the standard for services such as EFAP, health strategy and planning, disability management, employee selection and development, and workplace conflict resolution.

Dentalcare Benefit

Although the Dentalcare Benefit may not pay all your family dental costs, it has been designed to provide substantial assistance, both for routine care and for expensive and unforeseen treatment.

To be considered as a "covered expense", a dentist's charge for a particular service must be reasonable and customary for the service provided in the area where the expense is incurred. Basic Services or Major Services will be limited to the maximums specified in the Highlight of Benefits section at the applicable provincial dental fee schedule rate.

Participant and Dependent Coverage

In the event that you incur any of the eligible expenses listed in this section, you will be covered as per the Highlight of Benefits section.

Coverage Ceases

Your Dentalcare coverage terminates at the earlier of age 75, following the 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 2085. Actively Working Members are eligible to have their Dental coverage extended past 75 up to the extent of the Member's Hour Bank account with no ability to self-pay. Coverage will terminate at age 80 for Retired Members who qualify for the extension in coverage.

For Permit Workers and Office Staff, coverage terminates at the earlier of the date of termination of employment, lay-off or retirement.

Extension of Benefits

When charges are incurred prior to the termination of insurance, dental expenses in connection with dentures, crowns, or endodontic work and completed within thirty (30) days of termination will be considered as incurred prior to termination.

Alternative Benefits and Submission of Treatment Plan

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

As a service to you, the Plan Administrator will advise you in advance of the amount of liability for any proposed course of treatment. To use this service, simply have your dentist complete a treatment plan. **Where a proposed course of treatment will exceed $500, a treatment plan should be submitted in advance to the Plan Administrator.**

Note: The proposed course of treatment must be completed within ninety (90) days for the benefit determination to remain valid. Otherwise, it is suggested you submit a new treatment plan; however, please note the participant must be insured at the time treatment is rendered.

Eligible Expenses

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the Fee Guide as outlined in the Highlight of Benefits section.

Basic Preventative and Restorative Services

1) Oral examinations, scaling and cleaning of teeth once in any twelve (12) month period (once in any six (6) month period for dependent children under age 18).

2) Topical application of sodium or stannous fluoride, once in any twelve (12) month period (once in any six (6) month period for dependent children under age 18).

3) Dental x-rays: One set of full mouth during any twenty-four (24) month period (one set during any twelve (12) month period for dependent children age 18 and under). One Bitewing set during any twelve (12) month period (one set during any six (6) month period for dependent children age 18 and under).

4) Extractions.

5) Fillings: amalgam, porcelain or plastic and replacement after twelve (12) months.

6) Anesthetics and injections of antibiotic drugs.

7) Treatment of periodontal and other diseases of the gums and tissues of the mouth.

8) Space maintainers.

9) Drugs and medicines on written prescription by a dentist and dispensed by a licensed pharmacist.

Major Restorative Services

1) Endodontic treatment including root canal therapy.

2) Crowns, if teeth cannot be restored satisfactorily by the use of a filling material, and gold inlays, if no other material is satisfactory.

3) Replacement of crowns, provided a period of at least twelve (12) months has elapsed since the last date on which the crowns were provided.

4) Initial installation of fixed bridgework. (Please see Exclusions and Limitations regarding pre-existing extractions.)

5) Alteration of or, replacement of fixed bridgework, when existing one cannot be serviceable and when necessitated as a result of an additional extraction provided the individual has been insured for a period of at least twelve (12) months when the charge for replacement is incurred and a period of at least five (5) years has elapsed since the last date on which bridgework was provided or replaced.

6) Provision of dentures and the repair of dentures. (Please see Exclusions and Limitations regarding pre-existing extractions.)

7) Relining or any adjustments required to be made to new dentures, provided a period of at least six (6) months has elapsed since the last date on which dentures were provided.

8) Replacement of dentures, provided the individual has been insured for a period of at least twelve (12) months when the charge for replacement is incurred, the existing dentures cannot be made serviceable and a period of at least five (5) years has elapsed since the last date on which dentures were provided or replaced.

9) Implant dental surgery and related oral services such as abutment insertion, ridge augmentation, bone preservation;

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

Dependent Orthodontic Services

Coverage is available for dependent children age 18 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

1) Payments will not be made for any dental procedure in respect of any injury or dental disease for which you or your dependent was advised to receive treatment or for which treatment first began before you or your dependent became insured for that dental procedure. Payment will not be made for any dental procedure in respect of teeth extracted, lost, or fractured before you or your dependent became insured for that procedure except for appliance replacement as specifically stated under Eligible Expenses.

2) Services or supplies that are primarily for cosmetic dentistry.

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

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

5) Any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or filling in of forms.

6) Any charges resulting from any intentionally self-inflicted injury.

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

8) Any charges 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.

9) Any hospital charges for room and board and related services and supplies.

10) Any dental examinations required by a third party.

11) Diagnostic procedures in connection with any benefit categories excluded as eligible expenses.

12) Services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease.

Healthcare Spending Account

Purpose

For Union Members and their families to offset Healthcare, Visioncare and Dentalcare expenses incurred above and beyond the coverage presently provided by the I.B.E.W. Local Union 2085 Health and Welfare Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums).

Eligibility

Participation will be extended to all Members in good standing with Local Union 2085. The Healthcare Spending Account (H.S.A.) allocation is funded on an hourly basis as per the Collective Agreement. The ongoing monthly H.S.A. allocation to each individual Union Member account will be based on the hours worked. **It is understood that to be eligible for the allocation, the individual must be a Member in good standing with Local Union 2085.**

For Union Members who are no longer in benefit, you may still make claims against your Healthcare Spending Account balance provided you maintain your good standing as a Member of Local Union 2085.

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

The Healthcare Spending Account cannot be used for making self-payments or cash withdrawals. For a list of eligible items, please refer to the Plan Member Portal on the Plan Administrator's website (www.coughlin.ca)

Termination of Membership

In the event of termination of Membership with Local Union 2085, 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 to the earliest of the following:

- upon depletion of the Healthcare Spending Account, or
- upon ineligibility of the surviving dependents.

Reinstatement

Reinstatement of a Union Member's Healthcare Spending Account is **not** applicable as it is a requirement that the Union Member maintains as a Member in good standing with Local Union 2085 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.

Coverage

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

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

List of Eligible Medical Expenditures

A link to CRA which provides a list of eligible medical expenses is available via the Plan Member Portal on the Plan Administrator's website at www.coughlin.caor alternatively, directly on the Canada Revenue Agency website under "Details of Medical Expenses" (or by accessing the CRA website via the link www.cra-arc.gc.ca, and searching eligible medical expenses).

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.

Coughlin Care Platinum

Access to Healthcare Navigation and Medical Second Opinion are through Compass Health Care Navigation at 1-866-883-5956 and for Cancer Assistance at 1-866-599-2720. You will be asked to provide your name, Member ID (can be obtained from your Drug Card), your Union Local and possibly your Provincial Healthcare # (depending on the nature of your call).

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 # (901504) 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. As a first-time user, you will then be redirected to download the app from Google Play or the iOS store, and will then require your email address and password to access vCare. 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. Health Care Navigation provides access to a nurse who
will be the single point of contact through the healthcare journey, by providing:

- Assessments and treatment plans
- Booking of appointments
- Pre-appointment prep

- Follow-up appointments
- Ensure continuity of care and coordination of benefits
- Explanation of options
- Completion of paperwork
- Review of results
- Assist with alternative treatments

Cancer Assistance:

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

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

Medical Second Opinion:

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

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

Self Help Works

An innovative suite of seven online learning programs designed to assist members and their families in making positive behavior changes.

- Online video-based coaching
- Led by industry experts
- Library section with access to support tools
- Integration with wearable technologies

Programs:

- LivingLean (Weight Loss & Nutrition)
- LivingEasy (Stress & Resiliency)
- LivingFree (Smoking Cessation)
- LivingWell (Diabetes Management)
- LivingSmart (Alcohol)
- LivingFit (12-Week Walking)
- LivingWellRested (Sleep)

Healthcare Coaching

Obesity management and coaching, with a focus on diabetes and cardiovascular issues (high blood pressure or high cholesterol), which includes:

- A health assessment
- A nutritional assessment
- Health coaching with a Registered Dietitian
- Action Plan for nutrition and physical activity
- Targeted Resources

SMART Substance Management and Recovery Treatment

Online virtual CBT (Cognitive Behavior Therapy) based program for all forms of substance abuse, with 24/7 access to care workers. Accessible from any computer, tablet or smartphone, the program includes:

- Substance use awareness self-assessment
- Daily Notification and self-tracking tools
- Regular check-ins with a SMART coach
- Access to a registered addiction counsellor
- Medical assessment with board-certified addition physician
- Pharmacotherapy (when applicable, as determined by a licensed physician)

This confidential, customizable, easy-to-use program gives you access to coaching therapy, and medical support offered by a team of licensed practitioners.

Quikcare-Expedited Healthcare

Access to 3 diagnostic services and 10 specialist physicians within 72 hours through healthcare clinics across Canada (Manitoba residents are required to travel due to limitations of local private services).

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

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

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

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

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

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

Coordination of Benefits

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

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

Order of Benefit Payment

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

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

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

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

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

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

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

- The Plan wherein the person is covered as an active part-time Employee, then
- The Plan wherein the person is covered as a retiree.

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

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

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

- The Plan of the parent with custody of the child pays, then
- The Plan of the spouse of the parent with custody of the child (i.e. if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay for benefits for the dependent child), then
- The Plan of the parent not having custody of the child, then
- The Plan of the spouse of the parent not having custody of the child (i.e. if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).
- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.

Submitting a Claim for Co-Ordination of Benefits

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

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

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

- **Keep a photocopy of each receipt until your claim has been settled.**

- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and copies of relevant receipts and/or dental 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.

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

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

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

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 and viewing your dependant information.

- Auto-enroll in Pre-Authorized Deposit by entering your banking information directly on the portal. You also have the ability to change your banking information directly on the portal. Your changes will be live immediately – no processing delay. Members will also receive an e-mail notification if any changes are made to their banking 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. In order to enrol in Coughlin & Associates Ltd.'s PAD program:

- Auto-enroll in PAD by entering your banking information directly on the portal. You also have the ability to change your banking information directly on the portal. Your changes will be live immediately – no processing delay. Members will also receive an e-mail notification if any changes are made to their banking information; or

- Print the PAD form from the Coughlin Plan Member Portal or at www.coughlin.ca. Complete and return the form with a void cheque to Coughlin.

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.

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.

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 to four 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 claim receipts within the timeframe indicated.

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 (901504) of your group benefit plan.

The Administrator can provide you with your member identification number or it is also indicated on your drug card.

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, provided your coverage is up-to-date.

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

Questions and Answers

1. **How do I become covered under the Plan?**

   Once hours that you have worked for a Contributing Employer have been reported to the Plan Administrator, an "Hour Bank" Account is established for you.

   An Application for Group Coverage must be completed immediately and returned to the Plan Administrator. Blank applications are available at your Local Union Office or from the Plan Administrator.

2. **What is the individual's "Hour Bank" Account?**

   This is an account kept by the Plan Administrator for each Participant who works for a Contributing Employer. Contributions to the Plan are based on each hour worked. These contributions will be allocated to the Hour Bank Account. For Non-Union Participants, the hours worked should equate to the required monthly deduction as there may not be an accumulation of hours worked. Each month while insured, your account will be deducted the amount necessary to cover the monthly premium. The additional contribution, if any, will accumulate in your Hour Bank Account up to a maximum of 3,600 hours (or twenty-four (24) months of coverage).

3. **Is a medical examination necessary to get this insurance?**

   No! All benefits for you and your dependents are available without any test of insurability.

4. **When do my dependents get coverage under this Plan? What benefits do they qualify for?**

   Your dependents become covered for Life and Health Insurance Benefits at the same time you become eligible.

5. **What happens if I move from one Employer in the Industry to another?**

If your new Employer is required to make contributions, your Hour Bank Account will continue to be credited with hours reported. Your benefits are portable within the Industry.

6. Once I am covered, how do I know if I have sufficient hours in my Hour Bank Account to pay for my coverage in future months?

The Local Union and the Plan Administrator will have the latest Hour Bank Account balances for each eligible Participant. Note: Each eligible Participant is responsible for knowing his/her Hour Bank Account balance at any time.

7. Do I have to be under a Physician's care in order to qualify for Weekly Disability Income benefits?

Yes! You must see a physician as soon as possible if you have been injured or are sick enough to be unable to work. If you delay going to a physician, your claim could be refused, reduced, or held up for further investigation.

8. If I am disabled before my effective date of insurance, will I receive Weekly Disability Income benefits?

No. Weekly Disability Income payments will not be made for disabilities which commenced prior to the effective date of your insurance.

THIS PLAN IS UNDERWRITTEN BY:

Manulife Financial

AND

AIG Insurance Company

AND

Homewood Health

AND

Chubb Life Insurance Company of Canada

AND

I.B.E.W. Local Union 2085 Health & Welfare Trust Fund

AND

Express Scripts Canada
(Pay Direct Prescription Drug Card provider)

THE PLAN IS ARRANGED AND ADMINISTERED BY:

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Employee Benefits Specialists
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