SHEET METAL WORKERS AND ROOFERS

LOCAL UNION 511

HEALTH & WELFARE TRUST FUND

January 2021

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Sheet Metal Workers and Roofers
Local Union 511
Health and Welfare Trust Fund

We are pleased to present this updated booklet describing the current benefits and provisions of the Group Benefit Plan. We urge each Participant to read the booklet carefully to thoroughly familiarize themselves with the benefits that are available to them and their dependants.

The Healthcare, Visioncare and Dentalcare Benefits are designed to assist with the payment of these expenses, although they may not cover the total cost of services and supplies. In effect, this Group Benefit Plan shares the payment of your medical and dental expenses with you.

The Life, Dependent Life, and Long Term Disability (LTD) benefits are underwritten by the Canada Life Assurance Company (formerly referred to as Great-West Life). The Accidental Death & Dismemberment (AD&D) benefit is underwritten by Chubb Life Insurance Company of Canada (Chubb Life) and Travel Medical Emergency benefits are underwritten by RSA Travel Insurance Inc. (RSA). The Healthcare, Visioncare, Dentalcare and Weekly Income benefits are self-insured and administered by Coughlin & Associates Ltd., while the pay direct prescription drug card is coordinated with Express Scripts Canada (ESC).

Please note that Plan benefits may change at any time given legislative revisions and/or the financial stability of the Trust Fund. Participants will be advised accordingly and on a timely basis of any benefit changes.

The Plan Administrator is Coughlin & Associates Ltd., PO Box 764, Winnipeg, Manitoba, R3C 2L4. If you have any questions concerning your benefits or claim procedures, please contact either the Local Union 511 office or the Plan Administrator for this information at (204) 942-4438 or Toll Free 1-888-204-1234.

We are pleased to make these arrangements on the behalf of each Participant, and we are certain that the Plan will bring greater security and peace of mind to each Participant and their family.

Sincerely,

The Board of Trustees
Sheet Metal Workers and Roofers Local Union 511

Notice Regarding Personal Information

When applying for coverage under the Group Benefit Plan, Canada Life Assurance Company, Chubb Life, RSA Travel Insurance Inc. (RSA), the Pay Direct Prescription Drug card provider ES Canada, and the Plan Administrator, Coughlin & Associates Ltd., establish a file with personal information relevant to your benefit coverage under the Plan.

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

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

The files are kept in the offices of the Plan Administrator. The Employees of the companies listed above will have access to these files when required for insurance purposes.

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

Highlight of Benefits

Life Insurance

Benefit $60,000
Age 65 to 70 - $30,000

Coverage ceases ..... at age 70

Please refer to the ***Termination of Insurance*** section for complete details.

Dependent Life Insurance

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

Coverage ceases ..... at age 70

Please refer to the ***Termination of Insurance*** section for complete details.

Accidental Death & Dismemberment Insurance (AD&D)

Principal Sum $80,000
Age 65 to 70 - $40,000

Coverage ceases ..... at age 70

Please refer to the ***Termination of Insurance*** section for complete details.

Weekly Income (WI)

Benefit ..... Equivalent to Employment Insurance (EI) weekly maximum subject to EI Wrap-Around

Commencement ..... 1st day accident
8th day sickness/1st day hospitalized

Maximum Duration ..... 26 weeks

Coverage ceases ..... please refer to the ***Termination of Insurance*** section for complete details

Long Term Disability (LTD)

Benefit .....$1,250 per month

- direct offsets (WCB and CPP Disability)
- all-source limit is 85%
- non-taxable

Qualifying Disability Period..... 26 weeks

Maximum Benefit Period .....to age 65 or date that you are no longer disabled

Coverage ceases .....at age 65

Please refer to the ***Termination of Insurance*** section for complete details.

Healthcare

Deductible (not applicable to Drugs).....$25/family/calendar year

Reimbursement Level.....100%
(subject to Reasonable and Customary limits)
Prescription Drugs (Pay Direct Drug Card) ....$2,000/family/benefit year (April 1 to March 31)*
* Manitoba Pharmacare Benefit Year

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

Nursing.....$10,000/person/calendar year

Paramedical Services.....$600/person/calendar year/specialist

Physiotherapy.....$600/person/calendar year

Smoking Cessation Products..... $500/person/lifetime

Coverage ceases ..... please refer to the ***Termination of Insurance*** section for complete details.

People Connect – Mental Health Resource

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

People Connect provides members and their family members with educational tools, an online assessment, and access to immediate care through virtual therapy. The first virtual counselling session is free, and each additional session is $75.00 per hour or $37.50 per 30 minutes and payable via credit card. For reimbursement from the Health and Welfare Trust Fund, please submit the receipt and claim form to Coughlin & Associates for processing.

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

Coverage ceases.....upon cessation of Healthcare benefit coverage

Visioncare

Deductible .....Nil

Reimbursement Level 100%

Eligible Expenses*..... $300/person/24 months (every 12 months for children under age 18)

Eye Exams..... $100/person/24 months (every 12 months for children under age 18)

*Eligible Expenses: Glasses (including prescribed safety glasses), Contact Lenses (OPTOMAP, etc.) and Laser Eye Surgery

Coverage ceases ..... please refer to the ***Termination of Insurance*** section for complete details.

Dentalcare

Deductible .....$25/Family /calendar year
Basic Dental Reimbursement Level 90%
Major Dental Reimbursement Level.....90%
Combined Benefit Maximum.....$1,500/person/calendar year

Fee Schedule.....2021 MDA

Coverage ceases ..... please refer to the ***Termination of Insurance*** section for complete details.

Travel Medical Emergency Coverage (via RSA)

Deductible .....Nil

Maximum Benefit $5,000,000/person/trip

Maximum Duration .....90 days (top-up ins. available for longer periods of travel)

Coverage ceases .....at age 70

Please refer to the Travel Medical Emergency Booklet provided by RSA for further information.

This benefit is on an emergency basis only.

Healthcare Spending Account (H.S.A.)

Reimbursement..... 100% of eligible expenses limited to H.S.A. account balance

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

Please refer to the ***Healthcare Spending Account*** section for complete details.

Highlight of Benefits

Non-Working Plan
(Please refer to Self-Pay Provision section)

Life Insurance

Benefit $30,000
Age 65 to 70 - $15,000

Coverage ceases ..... at age 70

Please refer to the ***Termination of Insurance*** section for complete details.

Dependent Life Insurance

Benefit ..... Spouse - $2,000
Child - $1,000
Coverage ceases ..... at age 70

Please refer to the ***Termination of Insurance*** section for complete details.

Accidental Death and Dismemberment Insurance (AD&D)

Principal Sum $30,000
Age 65 to 70 - $15,000

Coverage ceases ..... at age 70

Please refer to the ***Termination of Insurance*** section for complete details.

Healthcare

Deductible (not applicable to Drugs) ..... $25/family/calendar year

Reimbursement Level 80%

Prescription Drugs (Pay Direct Drug Card) .... $2,000/family/benefit year
(April 1 to March 31)*
* Manitoba Pharmacare Benefit Year

Nursing .....$10,000/person/calendar year

Paramedical Services.....$600/person/calendar year/specialist

Physiotherapy.....$600/person/calendar year

Smoking Cessation Products..... $500/person/lifetime

Coverage ceases ..... please refer to the ***Termination of Insurance*** section for complete details.

People Connect – Mental Health Resource

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

People Connect provides members and their family members with educational tools, an online assessment, and access to immediate care through virtual therapy. The first virtual counselling session is free, and each additional session is $75.00 per hour or $37.50 per 30 minutes and payable via credit card. For reimbursement from the Health and Welfare Trust Fund, please submit the receipt and claim form to Coughlin & Associates for processing.

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

Coverage ceases.....upon cessation of Healthcare benefit coverage

Visioncare

Deductible .....Nil

Reimbursement Level 100%

Eligible Expenses*..... $300/person/24 months

*Eligible Expenses: Glasses (including prescribed safety glasses), Contact Lenses (OPTOMAP, etc.), Laser Eye Surgery, and Eye Exams

Coverage ceases ..... please refer to the ***Termination of Insurance*** section for complete details.

Dentalcare

Deductible ..... $25/family/calendar year

Reimbursement Level
(Basic & Major Services) 75%

Eligible Expenses ..... $1,500/person/calendar year

Fee Schedule..... 2021 MDA

Coverage ceases ..... please refer to the ***Termination of Insurance*** section for complete details

Travel Medical Emergency Coverage

Deductible ..... Nil

Maximum Benefit..... $5,000,000/person/trip

Maximum Duration ..... 90 days
(top-up ins. available for longer periods of travel)

Coverage ceases ..... at age 70

Please refer to the Travel Medical Emergency Booklet provided by RSA for further information.

This benefit is on an emergency basis only.

General Information

The Plan is administered by Coughlin & Associates Ltd. who have been retained for this function by the Board of Trustees.

For each eligible Plan Participant an account is kept by the Plan Administrator that identifies hours worked for a Contributing Employer and contributions that have been made for the purpose of Group Benefits. This account is called an "Hour Bank Account". Please note for Office Staff, the hours worked should equate to the monthly premium requirement as there can be no accumulation of hours worked for these Participants.

Initial Eligibility

A Union Member or Permit Worker will be eligible for Life, Dependent Life, Accidental Death and Dismemberment and Long Term Disability benefits **on the first day following the date 405 hours are worked within twelve (12) consecutive months.**

Subsequently, eligibility for Weekly Income, Healthcare, Visioncare, Dentalcare and Travel Medical Emergency benefits will commence **on the first day of the month following the month in which the Administrator receives 405 hours worked (hours may vary depending on the hourly rate of contribution) within twelve (12) consecutive months.**

For Office Staff, eligibility for all benefits begins on the first day following three (3) consecutive months of employment.

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

AN ENROLMENT CARD MUST BE COMPLETED BY ALL ELIGIBLE PARTICIPANTS TO BE ELIGIBLE TO RECEIVE BENEFITS.

Ongoing Eligibility

Each month 135 hours (hours may vary depending on hourly rate of contribution) will be deducted from each Union Member's or Permit Worker's Hour Bank Account. A Union Member may accumulate up to

1620 hours (enough to provide twelve (12) months of coverage even though they may not work any hours during that period). Hours accumulated over this amount will be credited to the general reserves of the Fund.

A Permit Worker can also 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 Fund unless the Permit Worker becomes a Union Member in good standing with Local Union 511.

Eligible Plan Participants

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

Union Members

A Union Member is a Member in good standing with Local Union 511 on whose behalf contributions are made to the Sheet Metal Workers & Roofers Local Union 511 Health and Welfare Trust Fund.

Office Staff

Office Staff of Local Union 511 and Employees of Contributing Employers (support staff) on whose behalf contributions are made to the Sheet Metal Workers & Roofers Local Union 511 Health and Welfare Trust Fund, but who are not Members of Local Union 511 nor any reciprocating Local, will be eligible for benefits under this Plan while working for a Contributing Employer or Local Union 511.

Permit Workers

Employees of Contributing Employers on whose behalf contributions are made to the Sheet Metal Workers & Roofers Local Union 511 Health and Welfare Trust Fund, but who are not Members of Local Union 511 nor any reciprocating Local, will be eligible for benefits under this Plan while working for a Contributing Employer.

Retired Members

A Union Member, in good standing with Local Union 511, is considered retired when he/she has attained age 50 or older and has identified

retirement to the Administrator withdrawing his/her funds from the Pension Trust Fund.

Eligible Dependants

The Participant's eligible dependants consist of:

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

- The Participant's legal spouse, or common-law spouse (including same-sex partner) who is living in a conjugal relationship for a minimum period of twelve (12) consecutive months immediately prior to the date on which a claim arose. Divorced or separated spouses (with or without a court order or separation agreement) are **not** eligible for coverage.

- The Participant's unmarried children from 15 days to 20 years of age, inclusive. As well, dependants under age 25, provided they are in full-time attendance at a University or similar institution (evidence of attendance will be required).

- Stepchildren, and legally adopted children, and the Participant's spouse's children may be included the same as the Participant's own children provided they depend upon the Participant for support and maintenance.

- A child who is physically or mentally incapable of self-support beyond the limiting age may have coverage continued under the Healthcare, Visioncare, and Dentalcare benefits while remaining incapacitated and unmarried, subject to the Participant's own coverage continuing in effect. To continue coverage for a child under this provision, proof of incapacity must be received by the Plan Administrator within thirty-one (31) days after dependent coverage would otherwise terminate. Additional proof will be required from time to time.

No person shall be eligible for dependent coverage while they are in full-time service of any naval, military or air force, or with respect to Group Benefits, while residing outside of Canada and the United States.

Survivor Benefit Provision

Healthcare, Visioncare, Dentalcare, and Travel Medical Emergency coverage for eligible dependants shall continue without a premium payment required, following the death of the Participant up to a maximum of twenty-four (24) months from the date of death; however, no later than they would have normally been covered.

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

Special Note on Effective Date

The effective date of coverage for any Participant (or dependant) shall be the date on which he/she qualifies for coverage in accordance with the aforementioned rules. No coverage or payments are to be made for days of hospitalization which occurred prior to the effective date, or for medical or surgical services rendered prior to the effective date.

The Plan Participant must be actively at work when coverage takes effect; otherwise the coverage will not be effective until they return to work.

NOTE: EACH ELIGIBLE UNION MEMBER IS RESPONSIBLE FOR KNOWING WHAT HIS/HER HOUR BANK ACCOUNT BALANCE IS AT ANY TIME.

Disability Claims

All disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurers (Canada Life and Chubb Life) regardless of whether or not the Participant is eligible to receive Workers' Compensation, Auto Insurance or Employment Insurance 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 and AD&D Insurance Premiums that must be made within twelve (12) months of the date of initial disability to be accepted by the Insurers.

- A Union Member who has been disabled can deplete his/her Hour Bank Account and self-pay for twenty-four (24) consecutive months of coverage for all benefits (excluding Long Term Disability and

Weekly Income) provided that he/she continues to be a Member in good standing with Local Union 511.

- Office Staff and Permit Workers who are disabled may have coverage for all benefits (excluding Long Term Disability and Weekly Income) extended for twenty-four (24) consecutive months from the date of disability provided the required monthly contribution is remitted to the Trust Fund on his/her behalf.

Wage Loss Provision

In the event that a Union Member incurs a total disability while insured but not working and is "running down" his/her Hour Bank Account, or self-paying for ***full*** benefit coverage, the Plan will recognize the Union Member's disability for wage loss benefits (Long Term Disability and Weekly Income) from the scheduled date of return to work, provided that the Union Member is still totally disabled and submits an attending physician's statement certifying continued disability.

Reciprocal Agreements

Local Union 511 Members – Union Members working in a jurisdiction other than Local Union 511 and on whose behalf contributions are being made to a Health and Welfare Trust Fund which has entered into a reciprocal agreement with Sheet Metal Workers & Roofers Local Union 511 Health and Welfare Trust Fund should complete a Transfer Authority form and advise the Local Union or Administrator to reciprocate contributions to the "Home Fund". This will maintain continued coverage under the Sheet Metal Workers & Roofers Local Union 511 Health and Welfare Trust Fund.

Travel Card Members – Employees of Employers on whose behalf contributions are made but who are Members of other Local Unions or Funds and whose Funds have entered into reciprocal agreements with the Sheet Metal Workers & Roofers Local Union 511 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 Sheet Metal Workers & Roofers Local Union 511 office.

Reinstatement of Insurance

If the Union Member's benefit coverage has previously been terminated because of insufficient hours in his/her Hour Bank Account, the Union

Member will again become insured on the first day of the month following receipt of 405 hours in his/her Hour Bank Account provided these hours are worked within a twelve (12) month period. Otherwise, they will be required to meet the eligibility requirements of a new Participant in the Plan. A statement will be mailed to Members advising when their Hour Bank Account falls below 135 hours (hours may vary depending on hourly rate of contribution).

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

Self-Pay Provision

If there are insufficient hours in a Member's Hour Bank Account (i.e. due to a lay-off) to make the monthly deduction for benefit coverage, they will be allowed to continue coverage by making a self-payment (direct contribution) to the Fund. Such self-payment contributions must be continuous and consecutive for a period not to exceed twenty-four (24) consecutive months. The payment must be made prior to the 28th day of the month following the month in which the Hour Bank Account falls below 135 hours (hours may vary depending on hourly rate of contribution). The Plan Administrator will contact the Member if a self-payment is required to maintain coverage. If the Union Member does not remit a self-payment by the required date, the Union Member's 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 511.

If coverage is terminated due to the Hour Bank Account reducing below the required monthly deduction and you are **not** disabled, you may select from two (2) self-payment options: either *full* coverage or *reduced* coverage (the Non-Working Plan). Please refer to the **Highlight of Benefits, Non-Working Plan** section for more details.

Self-paying Union Members must choose which Plan design they wish before they begin to self-pay. Once the coverage is chosen and the first month's premium has been paid, the selected Plan design cannot be switched while continuously self-paying.

1) Long Term Disability and Weekly Income coverage are excluded for self-paying Union Members who have chosen the Reduced Plan design.

2) Long Term Disability and Weekly Income are excluded for self-paying Retired Members.

3) Self-payments cannot be made by Permit Workers and Office Staff.

If you have any questions on self-payment procedures, please call the Plan Administrator.

Changes in Insurance

If a Member's benefit coverage changes because of an amendment to the Plan, or because of a change in their age, class, dependant status, etc., the new benefits become effective on the date the change affecting the benefits occurs.

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

Termination of Insurance

Benefit coverage for the Participant and their dependants will terminate:

- For a Union Member, at the end of any month wherein he/she does not have at least 135 hours (hours may vary depending on hourly rate of contribution) in his/her Hour Bank Account. However, a Union Member may arrange to have his/her benefit coverage continued on a self-paying basis as identified in the "Self-Pay Provision" in this booklet;

- 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 and Weekly Income benefits which will

cease immediately). Permit Workers and Office Staff are ***not eligible*** to make self-payments;

- For a Retired Member, upon depletion of his/her accumulated Hour Bank Account, he/she may arrange to have benefit coverage continued on a self-paying basis as identified in the "Self-Pay Provision" in this booklet.

- For specific benefits, if the Participant reaches that benefit's age restriction. Please refer to the **Highlight of Benefits** section;

- If the Participant ceases to be a Participant in an eligible class;

- If the Participant enters military service;

- If the Group Policy terminates;

- For a dependant, once they no longer qualify as an eligible dependant. Please refer to the *Eligible Dependants* section.

Third Party Liability

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

If you or your dependant(s) receive 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 were otherwise payable by the Insurer.

You and your dependant(s) 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

(underwritten by Canada Life Assurance Company)

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

Please ensure upon enrolment in the Plan that a beneficiary is named to whom your Life Insurance proceeds will be paid. If a beneficiary is not named, your estate will be the beneficiary. Subject to provincial laws, the beneficiary can be changed at any time. Please contact the Plan Administrator to obtain the appropriate form to make such a change.

Amount of Benefit

You are entitled to an amount of Basic Life Insurance equal to the Benefit outlined in the **Highlight of Benefits** section.

Coverage Ceases

Your Life Insurance coverage reduces by 50% at age 65, and 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 511.

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, your Life Insurance coverage may be continued without payment of premiums, throughout the duration of your disability up to age 65. Once you have been totally disabled for six (6) months, you should contact the Plan Administrator to apply for the Waiver of Premium benefit. As you are also insured for group Long Term Disability (LTD) Insurance under this Plan, with a similar waiver of premium, application for Life and LTD Waivers are applied for on the LTD benefit claim form.

Claim forms must be received by the Plan Administrator and subsequently the Insurer within twelve (12) months of the date of disability. Your Life Insurance premiums will be waived following six (6) continuous months of total disability. *Please refer to the Long Term Disability section for a definition of "totally disabled."* The Insurer may request proof of a continuing disability to be submitted from time to time.

Pre-existing Condition

Premiums will not be waived if, within twelve (12) months of joining the Plan, you become totally disabled due to a disease or injury for which you obtained medical care prior to joining the Plan. This restriction will not apply if, after becoming insured, you have completed ninety (90) continuous days without medical care for disease or injury. "Medical care" is considered to be use of medication or receiving medical supplies or services on the consultation or advice of a physician.

Conversion Privilege

If your Life Insurance terminates you may be entitled to convert, without evidence of insurability, up to the full amount of your Group Life Insurance to an individual policy of life insurance.

If you wish to convert your application for the individual policy of life insurance and payment of the first premium must be made within thirty-one (31) days after the date of termination of the group life insurance.

If your death should occur within the thirty-one (31) day period after termination of insurance, an amount equal to the Group Life Insurance benefit will be paid to your beneficiary, whether or not you have applied for conversion to an individual life insurance policy.

Please contact the Plan Administrator for further information.

Dependent Life Insurance

(underwritten by Canada Life Assurance Company)

Amount of Benefit

If any of your eligible Dependants die while you are insured, the Insurer will pay you the applicable benefit (Spouse or Child) as outlined in the **Highlight of Benefits** section.

Coverage Ceases

Your Dependent Life Insurance 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 511.

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 (the same as Life Insurance).

Conversion Privilege

If your insurance terminates, your Spouse may be eligible to apply for an individual conversion policy without providing evidence of insurability. Your Spouse must apply and pay the first premium no later than thirty-one (31) days after your Group Insurance terminates.

Please contact the Plan Administrator for further information.

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.

Eligibility

All active eligible members under age 70.

Coverage Ceases

Your Accidental Death & Dismemberment benefit reduces by 50% at age 65 and 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 511.

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

Benefit Amount

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

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 (the same as Life Insurance).

Conversion Privilege

If your insurance terminates, you may be eligible to apply for an individual conversion policy without providing evidence of insurability. You must apply and pay the first premium no later than thirty-one (31) days after your Group Insurance terminates.

Please contact the Plan Administrator for further information.

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.

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

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

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

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

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

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

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

Repatriation Benefit

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

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any

benefit excluding the Loss of Life Benefit, Chubb 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:

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

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

Benefit payments herein will not be paid unless:

(i) 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

(ii) 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 amount.

Day Care Benefit

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

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

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

Special Education Benefit

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

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

Bereavement Benefit

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

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

In-Hospital Confinement Monthly Income Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and an Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, Chubb Life will pay for each full month, 1% of an Insured Person's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the

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

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

Cosmetic Disfigurement Benefit

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

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

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, an Insured Person Principal Sum amount will be increased by 10% 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:

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

b) 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.

Funeral Benefit

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

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

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

2. declared or undeclared war or any act thereof;

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

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

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

Weekly 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 continuous treatment of a qualified and licensed physician and medical information supports total disability.

All Disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurers (Canada Life and Chubb) regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance or Employment Insurance Disability Benefits. This recording will assist you should a claim with these agencies be declined either immediately or at a future date.

Benefits for any one disability are payable from the first (1st) day of disability for injury or day surgery/hospitalization and the eighth (8th) continuous day of disability for illness, but in no event prior to the first day of visit to your physician. Your benefit will be payable for no longer than twenty-six (26) weeks during any one period of disability.

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

- The first one (1) weeks of disability will be covered by the Plan. The Plan Administrator will advise you to apply for E.I. Disability benefits immediately.
- Weeks 2 to 16 will be covered by E.I., if available or by the Plan if E.I. is not available.
- Weeks 17 to 26 will be covered by the Plan.

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

You are considered "totally disabled" when you are incapacitated to the extent that you are not able to perform the majority of the usual and customary duties of your occupation. You are not considered totally disabled unless you are under the active and continuous care of a physician, and following the treatment prescribed by the physician for that disability.

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

Amount of Benefit

The Benefit amount is outlined in the Highlight of Benefits section.

If you are receiving other forms of Retirement or Disability Income, the Weekly Income benefit under this Plan will be reduced so that the Disability Income that you receive from all sources does not exceed 100% of your regular weekly earnings at the time you became disabled. Benefits payable under any individual Disability Income Policy or rider attached to an individual Life Insurance policy will not be included as Disability Income.

Coverage Ceases

Eligibility for Weekly Income benefit coverage terminates at the earlier of the depletion of your Hour Bank Account and/or self-pay (full option) period, the date of retirement or if you are no longer a Member in good standing with Local Union 511.

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

Benefits are not payable for:

- injury sustained while working for pay or profit other than with an Employer who is signatory to the Collective Agreement or alternatively a Project Agreement;
- disability resulting from an intentionally self-inflicted injury;
- disability resulting from voluntary participation in a war, riot, insurrection or criminal offense;
- the portion of a period of disability during which you are receiving Workers' Compensation or Auto Insurance benefits, unless proof is submitted to the Insurer that you have been disqualified for such benefits;
- the portion of a period of disability during which you are unable to earn income due to: imprisonment in a penal institution; or confinement in a hospital, or similar institution as a result of criminal proceedings.
- the portion of a period of disability during any leave of absence (including maternity/parental leave).

Long Term Disability

(underwritten by Canada Life Assurance Company)

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

All Disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) and the Insurers (Canada Life and Chubb Life) regardless of whether or not you are eligible to receive Workers' Compensation, Auto Insurance or Employment Insurance Disability Benefits. This recording will assist you should a claim with these agencies be declined either immediately or at a future date. **The Insurer will not be liable for a Long Term Disability (LTD) claim for which initial notice is submitted more than twelve (12) months after the date of disability.** Provided notice is submitted within this twelve (12) month period, proper application will be made relative to a Waiver of Life and AD&D Insurance Premiums.

Description of Benefit

You will begin receiving disability payments after you have been continuously and totally disabled for a qualifying period of twenty-six (26) weeks and your Weekly Income benefit has expired. Payments are made at the end of each month and continue as long as you are totally disabled, even if the Group Policy terminates, but not beyond the date that you attain 65 years of age or the date that you are no longer disabled.

"Totally Disabled" shall mean you are incapacitated to the extent that you are not able to perform the majority of the usual and customary duties of your occupation. For the initial 24 months this means that as a result of injury or disease, there is no combination of duties of your current occupation that you can perform that regularly took at least seventy five percent (75%) of your time to complete. Following the initial 24-month period, "totally disabled" shall mean that you cannot perform the substantial duties of **any** occupation for which your current education and work experience would qualify you. You are not considered totally disabled unless you are under the active and continuous care of a physician and following the treatment prescribed by the physician for that disability.

The availability of work will not be considered in assessing disability.

If you recover and return to work, but the same disability reoccurs, it will be considered a continuation of the previous disability if the period between disabilities is less than two (2) weeks during the waiting period (i.e. the initial six (6) months following the date of disability) or less than six (6) months during the period when Long Term Disability payments are being made or within twenty-four (24) months after the end of an approved comprehensive rehabilitation program. To be classified as a comprehensive rehabilitation program, the goal must be:

- to return the person to work in a different job that requires extensive or prolonged training; or
- to return the person to work in a self-employed capacity.

A recurrence of disability due to an unrelated cause will be considered a new disability if you have worked at least one (1) day between disabilities.

Amount of Benefit

The Benefit Amount is outlined in the **Highlight of Benefits** section.

Other Income

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

· disability or retirement benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan

· benefits under any Workers' Compensation Act or similar law

There is a further reduction of your LTD benefit if the total of the income listed below exceeds **85%** of your indexed monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

· your income under this plan

· loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law

- disability benefits under a plan of insurance available through membership in an association

- employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program (termination pay and severance benefits are included as employment income under this provision)

Earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, would exceed your indexed monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

You must apply for all benefits or income for which you may become eligible under any of the following sources with the exception of any retirement benefits (these will only be deducted if you are in receipt of such benefits).

This benefit is non-taxable to the receiving Participant.

Coverage Ceases

Eligibility for Long Term Disability coverage terminates at the earlier of age 65, following depletion of your Hour Bank Account and/or self-pay (full option) period, or if you are no longer a Member in good standing with Local Union 511.

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

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, and for which benefits are paid or payable, the Insurer will be subrogated to all 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.

Waiver of Premium

The Insurer will waive the payment of premiums for Long Term Disability Insurance for you if you are receiving benefits under this coverage. Premiums will be waived beginning with the premium for the first month for which benefits became payable and continue while the benefits are payable.

Rehabilitation

As your condition improves, you will want to return to work. If your condition does not allow for a return to your job on a full-time basis, you may be able to work on a part-time basis or take a less demanding job. Inform the Insurer and Plan Administrator as you may qualify for a rehabilitation program.

If Your Long Term Disability Terminates

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

Conversion Privilege

If you change jobs, you may apply for an individual Long Term Disability Policy without any medical tests. You must apply and pay the first premium no later than thirty-one (31) days after starting your new job, and you must also start your new job no later than six (6) months after leaving your present one.

Exclusions and Limitations

No benefits are paid for:

- A disability that begins before your insurance starts or after it ends.

- A disability arising from a disease or injury for which medical care was received before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for one (1) year, or you have not had medical care for the disease or injury for a continuous period of ninety (90) days ending on or after the date your insurance took effect.

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

- Any period of prison confinement.

- Any period in which you do not co-operate with an approved rehabilitation plan or program. Depending on the severity of the condition, the Plan may require you to be under the care of a specialist. For substance abuse, treatment must include participation in a recognized substance abuse withdrawal program.

- Any twelve (12) month period during which you do not live in Canada for at least six (6) months.

Healthcare

All expenses will be reimbursed at the level shown and may be subject to plan maximums and frequency limits as outlined in the **Highlight of Benefits** section or as identified below.

The Plan covers reasonable and customary charges for the following services and supplies, if they are not covered under your provincial government plan and provincial law permits them to be covered.

Coverage Ceases

Your Healthcare benefit coverage terminates at the earlier of 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 511.

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

Covered Expenses

- Drugs and medicines prescribed by your physician, surgeon or dentist for the treatment of injury or illness and dispensed by a licensed pharmacist. Oral contraceptives prescribed by a physician are covered. Coverage is subject to a $15 dispensing fee maximum per prescription, 20% pharmacy markup restriction, and mandatory generic substitution unless a physician indicates a medical necessity.

- Physiotherapy services performed by a licensed physiotherapist.

- Paramedical services performed by a licensed Chiropractor, Speech Therapist, Naturopath, Osteopath, Acupuncturist, Chiropodist, Podiatrist, Massage Therapist or Psychologist (and similar qualified Specialists) and subject to Reasonable and Customary limits per visit/duration of visit.

- Ambulance transportation to the nearest centre where adequate treatment is available.

- Diagnostic tests and radiological treatments including x-rays, laboratory tests and radium treatment.

- Rental, or at the Plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician for a specific medical condition. (Additional information may be required.)

- Injectable drugs administered by a physician for which no reasonable non-injectable alternative is available.

- Insulin, insulin syringes, blood-letting devices, lancets, and home chemical testing supplies for diabetics.

- Out-of-hospital services of a registered nurse, licensed practical nurse or registered nursing assistant who is not a member of your family, but only if the patient requires the specific skills of a trained nurse, subject to a maximum of $10,000 per person per calendar year.

- Oxygen services when prescribed by a physician.

- Services and supplies received during a hospital confinement.

- Out-patient treatment.

- Room and board in a convalescent hospital provided the confinement is primarily for rehabilitative or convalescent care and is limited to $10 per day for a maximum of one hundred and twenty (120) days, beginning on the first day of care.

- Smoking cessation products subject to a written medical recommendation from a physician.

- Custom-made foot orthotics and custom-fitted orthopedic shoes prescribed by physician or podiatrist to a maximum of $300 per person every twelve (12) months. 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.

- Surgical stockings, up to 4 pairs per person per calendar year, when prescribed by a physician for the treatment of a medical condition. 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.

- Wigs and hair pieces, if medically necessary as a result of chemotherapy under written recommendation by a physician, to a lifetime maximum of $200 per person.

- Initial pair of frames and corrective prosthetic lens, for each eye, prescribed after cataract surgery.

- Viagra and other erectile dysfunction drugs.

Limitations

No benefits are paid for:

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

- Delivery, transportation and administration charges.

- Services and supplies required for recreation or sports that are not medically necessary for regular daily living activities.

- Chronic or custodial care.

- Vitamins, food products, salt/sugar substitutes, contraceptive preparations, excluding prescribed oral contraceptives.

- Any single purchase of drugs that would not reasonably be used within ninety (90) days.

- Any drug or item which does not have a drug identification number as defined by Canadian legislation and drugs registered under Division 10 of the Regulations of the Food and Drugs Act of Canada.

- Services covered under the Workers' Compensation Act or other statute.

- Services for which payment is the legal liability of any other party (including Government Plans).

- Vaccines.

- Anti-Obesity drugs.

- Fertility Drugs.

Visioncare

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

The Plan covers reasonable and customary charges for the following services and supplies, if they are not covered under your provincial government plan and provincial law permits the Insurer to cover them.

Coverage Ceases

Your Visioncare benefit coverage terminates at the earlier of 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 511.

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

Covered Expenses

The following benefits are covered:

- Eyeglasses, prescription safety glasses or contact lenses;
- Eye exams: One (1) routine eye examination (including eye refractions) at a reasonable and customary cost; and
- Laser eye surgery.

Please note: If there is a medical complication with eyes (i.e. glaucoma, diabetic retinopathy, etc.), routine eye examinations are covered by Manitoba Health.

Additionally, one (1) set of contact lenses up to a lifetime maximum of $240 if the cornea is impaired so that visual acuity cannot be improved to at least the 20/40 level in the better eye with eyeglasses.

Limitations

No benefits are paid for:

- artificial eyes or sunglasses.
- services covered under the Workers' Compensation Act or other statute.
- services for which payment is the legal liability of any other party (including Government Plans).

Dentalcare

All expenses will be reimbursed at the level shown and are subject to Plan maximums and frequency limits as outlined in the **Highlight of Benefits** section or as identified below.

The Plan covers reasonable and customary charges to the extent they do not exceed the dental fee guide level indicated in the **Highlight of Benefits** section.

Coverage Ceases

Your Dentalcare benefit coverage terminates at the earlier of 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 511.

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

Alternate Benefits and Submission of Treatment Plan

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

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

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

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

Note: The proposed course of treatment must be completed within ninety (90) days for the benefit determination to remain valid. Otherwise,

it is suggested you submit a new treatment plan; however, please note the participant must be insured at the time treatment is rendered.

Routine Treatment

- The following preventative services are covered no more than once in any calendar year separated by at least 11 months (once in any six (6) month period for dependants under age 16):
  - oral examinations
  - polishing of teeth
  - bite-wing x-rays
  - fluoride application
- Scaling of teeth.
- Full mouth series of x-rays once every twenty-four (24) months.
- Extractions including surgical removal of impacted teeth and surgical preparation of dental models for prosthetic appliances and alveolectomy at the time of tooth extraction.
- Surgical removal of tumors and cysts, neoplasms, incision and drainage of abscesses.
- Amalgam, silicate, acrylic and composite fillings.
- Dental surgery, including related diagnostic x-rays, lab procedures, and anesthesia.
- Endodontic treatment (root canal therapy).
- Periodontic treatment (treatment of gum disease).
- Space maintainers for missing primary teeth, and habit-breaking appliances.
- Necessary treatment for relief of dental pain and the cost of medication and its administration when provided by injection in the dentist's office.

- Denture relines and rebases to existing dentures, limited to one every three (3) years.

Major Treatment

- Denture repairs.

- Crowns, inlays and gold foil fillings.

- Initial bridgework when required to replace a tooth that has been extracted while the person is covered.

- Initial partial or complete dentures when required to replace one or more teeth extracted while the person is covered.

- Replacement crowns, bridgework or dentures provided the existing appliance is at least five (5) years old and cannot be made serviceable.

- 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.

Extension of Benefits

If you or your dependant has an impression taken or a tooth prepared for an appliance while insured and the coverage ceases because of termination of employment, the coverage will be deemed to continue in force for ninety (90) days for charges incurred under that treatment.

Exclusions

Covered Dental Expenses do not include and no payment is made for:

- Duplicate x-rays, custom fluoride appliances, any oral hygiene instruction and nutritional counseling.

- The following endodontic services – root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra-coronal implants.

- The following periodontal services: desensitization, topical application of antimicrobial agents, sub-gingival periodontal irrigation, charges for post-surgical treatment and periodontal re-evaluations.

- The following oral surgery services: surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoplasty, gingivoplasty and stomatoplasty) and alveoplasty and gingivoplasty performed in conjunction with extractions. Services for remodeling and recontouring oral tissues will be covered under Major Coverage.

- Hypnosis or acupuncture.

- Veneers, recontouring existing crowns, staining porcelain and inlays.

- Crowns or inlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings.

- Orthodontic coverage.

- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

  If overdentures are provided, coverage will be limited to standard complete dentures.

  If initial bridgework is provided, coverage will be limited to a standard partial denture and restoration of abutment teeth when required for purposes other than bridgework.

  If additional bridgework is performed in the same arch within sixty (60) months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework.

Benefits will be limited to standard dentures or bridgework when equilibrated and gnathic dentures, dentures with stress breakers, precision and semi-precision attachments, dentures with swing-lock connectors, partial overdentures and dentures and bridgework related to implants are provided.

- Expenses private plans are not permitted to cover by law.
- Services and supplies that do not represent reasonable treatment.
- Treatment performed for cosmetic purposes only.
- Congenital defects or developmental malformations in people 19 years of age or over.
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain.
- Expenses arising from war, insurrection, or voluntary participation in a riot.

Accidental Dental

Charges by a legally licensed dentist for the following treatment necessitated by a direct blow to your mouth and not by an object willingly or unwillingly placed in the mouth, which occurred while you are insured under this benefit, received within twelve (12) months of the accident, provided that the charges do not exceed the current Dental Association Schedule of Fees for General Practitioners in the province of residence:

- dental treatment of injuries to natural teeth or
- replacement of natural teeth

The Plan will pay for the least expensive treatment that will provide a professionally adequate result. If treatment is to be received more than ninety (90) days after the accidental blow, a treatment plan must be submitted to the Administrator within ninety (90) days of the accident.

Accidental Dental is covered at 100% and is not subject to an Annual Maximum.

No benefits will be paid for:

- treatment performed more than twelve (12) months after the accident.

- denture repair or replacement.

- orthodontic diagnostic services or treatment.

Healthcare Spending Account

Purpose

The Trustees have implemented a Healthcare Spending Account (H.S.A.) with allocations made to Members in good standing with Local Union 511.

Allocations are subject to the discretion of the Trustees annually considering the financial stability of the Plan, C.R.A. regulations, etc. If you are entitled to an H.S.A. allocation this H.S.A. will assist Union Members and their families in offsetting Healthcare and Dentalcare expenses incurred above and beyond the coverage presently provided by the Sheet Metal Workers and Roofers Local Union 511 Health & Welfare Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums).

Claims Procedures

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

Eligibility

For Union Members who are no longer in benefit (i.e. Retirees, Non-Working Members, Disabled), you may still make claims against your Healthcare Spending Account balance following your last day of coverage

under the Group Insurance Plan provided you maintain your good standing as a Member of the Local Union 511.

As per Canada Income Tax Technical interpretation (9431185) regulations, the Healthcare Spending Account is subject to forfeiture every 24 months.

Termination

In the event of termination of Membership from Local Union 511, the remaining Healthcare Spending account balance will be immediately forfeited to the Trust Fund.

Death

In the event of a Union Member's death, coverage will be extended to the surviving dependants as follows:

1. Spouse – until the balance of the Healthcare Spending Account is depleted.
2. Dependent Children – until they no longer qualify as dependants under the Group Insurance Plan or the balance of the Healthcare S pending Account is depleted.

Reinstatement

Reinstatement of a Union Member's Healthcare Spending Account is not applicable as it is a requirement that a Member maintain a positive status with Local Union 511 at all times.

Marital Separation / Divorce

As per the provisions for the insured benefits, the Healthcare Spending Account will not be extended to the spouse following separation or divorce. Alternatively, eligible dependent children will continue to be eligible for participation at the discretion of the Union Member.

List of Eligible Medical Expenditures

A 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.ca, or alternatively, directly on the Canada Revenue Agency website under "Details of 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.

Travel Medical Emergency
(Underwritten by RSA)

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

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

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

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

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

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

Co-Ordination of Benefits

Order of Benefit Payment

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

- If your Spouse's Plan does not provide for Co-Ordination of Benefits, it will be considered as the Primary Carrier, and it 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/Participant pays benefits before the Plan insuring you or your Spouse as a dependant.

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

    - The Plan where the person is covered as an active full-time Employee/ Participant, then
    - The Plan where the person is covered as an active part-time Employee/ Participant, then
    - The Plan where the person is covered as a Retiree.

  - For Claims incurred by your Dependent Child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays the benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

    However, if you and your Spouse are separated or divorced, the following order of access to benefits 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 benefits for the Dependent Child), then

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

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

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

Submitting a Claim for Co-ordination of Benefits

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

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

How to Make a Claim

Time Limitations

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

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

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

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

Coughlin Plan Member Portal

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

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

Pre-Authorized Deposit (PAD)

Eligible reimbursements for extended health and dental care claims can be deposited directly into your bank account within two to five days

following their approval. There are two easy options to enrol in Coughlin & Associates Ltd.'s PAD program:

1. Member Portal

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

2. Pre-Authorized Deposit (PAD) Form

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

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

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

Drug Claims

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

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

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

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

The card can be used at any pharmacy in Canada.

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

Submit Your Claims Electronically

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

Some important points to remember:

- The maximum amount that can be claimed is $1,000 for vision care and $500 for paramedical services per claim transaction per covered person. You may not submit a claim for yourself and another person, such as a dependant, at the same time.
- You must be registered with Coughlin's Pre-authorized Deposit plan before the service will be activated.
- Claims are audited randomly. Be sure to keep your claim receipts for one year. If you receive an audit notice, please submit the requested original claim receipts within the timeframe indicated.

Extended Health Care Claims

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

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

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

Dental Claims

Coughlin will process your dental claim using the electronic data interchange (EDI) claims processing service. With EDI, your dental claim

can be sent directly from your dental office to our claims department for adjudication.

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

- the Coughlin Telus carrier identification number (also known as the BIN number) is **610105 on the Telus network**;
- your unique member identification number; and
- the policy number (180219) of your group benefit plan.

Pre-Authorization

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

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

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

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

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

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

The Plan is Arranged and Administered by:

COUGHLIN & ASSOCIATES LTD.

P.O. Box 764
Winnipeg, MB R3C 2L4
Phone: (204) 942-4438
Fax: (204) 943-5998
Toll Free: 1-888-204-1234
E-mail: webmaster@coughlin.ca

Pay Direct Prescription Drug Card Provider by:

ES Canada

Benefits are Insured via:

CANADA LIFE ASSURANCE COMPANY

Policy #138889

www.canadalife.com

and

CHUBB LIFE INSURANCE COMPANY OF CANADA

Policy #AB10406503

and

RSA TRAVEL INSURANCE INC.

Policy #1058921

and

SHEET METAL WORKERS & ROOFERS LOCAL UNION 511 HEALTH & WELFARE PLAN

Policy #180219