UNITED ASSOCIATION
LOCAL UNION 254

HEALTH & WELFARE
TRUST FUND

January 2024

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To: All Plan Participants
United Association Local Union 254
Health & Welfare Trust Fund

This booklet has been published to give you an up to date description of the benefits provided by the Fund.

The booklet provides a description of the benefits to which you and your family are entitled, the rules governing eligibility for these benefits, and the procedures that should be followed when making a claim. However, this booklet is not, in itself, a legal contract, so it follows that the terms of the group insurance contract and the governing legislation take precedence in case of dispute.

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 which are available to you and your dependents. While it is our hope that you and your family will enjoy good health, it is comforting to know that these benefits are available when needed.

If at any time you have any questions about the benefits, or would like assistance in filing a claim, please do not hesitate to contact the Fund office where a member of the staff will be pleased to assist you.

Sincerely,

The Board of Trustees of the
United Association Local Union 254
Health & Welfare Trust Fund

Notice Regarding Personal Information

When you apply for coverage under the Group Benefit Plan, the Plan Administrator, Coughlin & Associates Ltd., and the Insurers, The Manufacturers Life Insurance Company, Chubb Life Insurance Company of Canada, 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 offices 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.

Medical Information Bureau (MIB)

MIB Group, Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Manulife Financial or its re-insurers may periodically report information to the MIB. If you apply to receive life, disability or health insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB, upon request, will supply the other insurer with the information on file.

Manulife Financial or its re-insurers may also release information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. All Information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek a correction. Their address is: MIB, 330 University Ave., Suite 501, Toronto, Ontario, M5G 1R7. Tel: (416) 597-0590.

Highlight of Benefits

Group Policy Numbers
Manulife Financial – 4513
Shepell – 1208
AIG Insurance Company. – CMG 9428861
Self-Insured – 4513
Chubb Life - CI20004101
Telus Adjudicare – Group #59269

Administration Contact: 254admin@coughlin.ca
Claims Contact: winnclaims@coughlin.ca
Disability Contact: disabilityclaims@coughlin.ca

Member Life Insurance

Benefit ..... Under age 65 - $100,000
65 and over - $20,000
Retired Members - $10,000

Dependent Life Insurance

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

Note: The amount of Dependent Life Insurance will terminate when your Amount of Member Life Insurance terminates.

Optional Life Insurance

Coverage in units of $10,000 to a maximum of $250,000 for Participant and $200,000 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..... Active Members under age 65 - $100,000

Critical Illness

Members are eligible to a $10,000 flat benefit for any of 23 insured conditions up to the earlier of retirement or age 65. Please refer to the Critical booklet prepared by Chubb Life for further information.

Weekly Disability Income (W.I.)

Benefit ..... Active Members under age 65 - 66 2/3% of weekly earnings to a maximum of $668 (E.I. maximum) per week

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

Maximum Duration ..... 41 weeks, subject to EI Wraparound for weeks 2 - 27

Note: You must apply for employment Insurance (EI) sickness benefits.

Note: This plan pays benefits during the post-natal recovery period of maternity leave.

If a Member is not eligible for EI sickness, the Trust Fund will self-insure the period EI would normally pay to ensure continuous payment while disabled.

Long Term Disability Income

Benefit ..... Under age 60 - $1,800 per month

Waiting Period .....41 weeks

Benefit Duration .....to age 60

Dental Care Benefits

Benefit ..... Under age 75

Covered Charges ..... See Benefit Description for Coverage Details

(All eligible retired members and their dependents may elect Optional Enhanced Benefits)

Fee Guide ..... Current MDA Fee Tariff

Calendar Year Deductible..... Nil

Percentage Payable

Routine Care 100%
Major Care (Dentures, Crowns and Bridgework) 60%*
Orthodontics.....60%

Implants 60%

* Percentage payable increases to 100% if services are the result of an accident and treatment commences within 6 months of the accident. Payable under Health Care Benefits.

Benefit Maximums (per calendar year)

Routine and Major Care (combined maximum) $2,000

Benefit Maximum (per lifetime) (only applicable for Active Members)

Orthodontics $1,300
(for dependent children at least 6 years of age but under age 18)

Implants $2,000

Health Care Benefits

Benefit ..... Under age 75

(All eligible retired members and their dependents are eligible for Ambulance and Vision Care coverage and may elect Optional Enhanced Benefits)

Covered Charges ..... See Benefit Description for Coverage Details

Overall Lifetime Maximum Benefit ..... $100,000, subject to $1,000 restoration annually

Annual Drug Maximum ..... $10,000/family/benefit year (benefit year: April 1st to March 31st)

Calendar Year Deductible ..... Nil

Prescription Drugs ..... Pay Direct Drug Card *

Lifetime Drug Benefit Maximums for:

Weight Loss Aids $200

Smoking Cessation Aids $125

* subject to $15 dispensing fee maximum and 20% mark-up; any excess payment made to pharmacy can be claimed through your Healthcare

Spending Account if available. Fertility and Erectile Dysfunction drugs excluded.

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.

Percentage Payable

Laser Eye Surgery 50%
All Other Covered Charges 100%

Hospital (Within Home Province)

Room and Board Limit ..... semi-private

Rehabilitation Hospital (Within Home Province)

Room and Board Limit ..... semi-private
Maximum Stay (per period of disability) ..... 120 days

Out-of-Hospital Nursing Benefit Maximum
(per calendar year) $10,000

Paramedical Services
(per calendar year)

Podiatrist and Chiropodist ..... $600 combined
Clinical Psychologist $1,200
Physiotherapist, Chiropractor,
Massage Therapist ..... $1,500 combined
Other Practitioners ..... $600 each
(Osteopath, Naturopath,
Acupuncturist, Speech Therapist
and Athletic Therapist*)

* Physician referral required.

Vision Care Benefit Maximums

Lenses and Frames (includes contact lenses) $600
(in any 24-month period, or 12-month period if under age 17)

Prescription Safety Glasses (Member only) $200
..... (in any 24-month period)

Laser Eye Surgery (per lifetime) $1,725

Eye Examinations ..... once per calendar year, except twice per calendar year for those under age 21 or over age 40

Hearing Care Benefit Maximum (per lifetime) $1,600

Foot Care Benefit Maximum (per calendar year)
Orthopedic Shoes and Orthotics (combined maximum) $225

Support Stockings Benefit Maximum (per calendar year) $250

Travel Medical Emergency

Policy Number ..... CMG 9428861

Deductible ..... Nil

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

Maximum Duration ..... 90 days

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

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

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

Member Assistance Program (National Plan UA Canada)

Includes short term, lifestyle and specialty counselling offer through Morneau Shepell (refer to brochure on Union Website) or contact them via 1-833-778-2627 or workhealthlife.com (web or mobile app)

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 $90 per hour or $45 per 30 minutes and payable via credit card. For reimbursement from the Health and Welfare Trust Fund, please submit the receipt and claim form to Coughlin & Associates for processing.

To get started, please visit pcpeopleconnect.com.

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 (4513) 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.

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Healthcare Spending Account (H.S.A)

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

Optional Enhanced Dental Care Benefits for Retired Members

(Administered by the Trust Fund, not underwritten by Manulife Financial)

Covered Charges .....See Optional Enhanced Dental Care Benefits for Coverage Details)

Fee Guide ..... Current MDA Fee Tariff

Amount

Calendar Year Deductible..... Nil

Percentage Payable

Routine Care 100%
Major Care (Dentures, Crowns and Bridgework) 60%*

* Percentage payable increases to 100% if services are the result of an accident and treatment commences within 6 months of the accident. Payable under Health Care Benefits.

Benefit Maximums (per calendar year)

Routine and Major Care (combined maximum)..... $2,000

Optional Enhanced Health Care Benefits for Retired Members

(Administered by the Trust Fund, not underwritten by Manulife Financial)

Covered Charges .....See Optional Enhanced Health Care Benefits for Coverage Details) *

* Note: Vision and Ambulance services are covered under standard benefit plan (refer to Health Care Benefits for details)

Overall Lifetime Maximum Benefit*.....$100,000

Calendar Year Deductible.....Nil

Calendar Year Drug Benefit Maximum .....$3,000/family/benefit year (benefit year: April 1st to March 31st)

Prescription Drugs ..... Pay Direct Drug Card *

Lifetime Drug Benefit Maximums for
Weight Loss Aids.....$200
Smoking Cessation Aids $125

* subject to $15 dispensing fee maximum and 20% mark-up; any excess payment made to pharmacy can be claimed through your Healthcare Spending Account, if available. Fertility and Erectile Dysfunction drugs excluded

Percentage Payable
All Covered Charges.....100%

Hospital (Within Home Province)
Room and Board Limit .....semi-private

Rehabilitation Hospital (Within Home Province)
Room and Board Limit.....semi-private
Maximum Stay (per period of disability..... 120 days

Out-of-Hospital Nursing Benefit Maximum (per calendar year).....$10,000

Health Practitioners' Benefit Maximums (per calendar year)
Podiatrist and Chiropodist .....$500 combined
Clinical Psychologist.....$1,000
Physiotherapist, Chiropractor, Massage Therapist.....$1,200 combined

Other Practitioners ..... $500 each
(Naturopath, Osteopath, ... Acupuncturist,
Speech Therapist and Athletic Therapist*)

* Physician referral required.

Hearing Care Benefit Maximum (per lifetime) $800

Foot Care Benefit Maximum (per calendar year)
Orthopedic Shoes and Orthotics (combined maximum) $225

General Information

Member Eligibility

A member means a member in good standing of Local 254 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada and member means an associate participant* who is employed by an Employer in a job class covered by a labour contract or agreement with the Union.

A member also means a retired member, certified as such by the Union and receiving a pension from the U.A. Local 254 Pension Fund and who:

- retired before January 1, 1990; or

- retired on or after January 1, 1990 and is a member in good standing of U.A. Local 254 on the date of retirement, or on the date there are no longer any hours remaining in the member's Hour Bank, if later.

Retired members are eligible for Member Life Insurance, Ambulance and Vision Care Benefits at no cost, but may self-pay for Optional Enhanced Health Care and Dental Care Benefits.

* An associate participant means a person who is not a member of U.A. Local 254, but is employed by an employer that is required to contribute to the Fund for that person at the rate or rates specified in a Collective Agreement between the employer and U.A. Local 254.

To be eligible for coverage you must be:

- a member in good standing of U.A. Local 254 or an associate participant, who has completed an enrollment card and who performs work within the jurisdiction of the Union; or a retired member, certified as such by the Union:

    - in a class shown in the Schedule; and
    - covered under a Provincial Health Insurance Plan.

You will become eligible for coverage on the first day of the second month following the accumulation of at least 375 credited hours of covered employment in your Hour Bank.

Once you become eligible, additional hours reported will be credited to your Hour Bank, and each month 125 credited hours (currently equivalent to $242.50) will be deducted from your Hour Bank for coverage. You may accumulate up to a maximum of 1500 hours, which will provide you with 12 months of coverage after you have stopped working.

If your insurance terminates because of not enough credited hours, you will be eligible for reinstatement of insurance on the first day of the second month following the accumulation of at least 250 credited hours of covered employment in your Hour Bank.

For Active Union Members only: If, on the last day of any month you do not have at least 125 credited hours in your Hour Bank you may elect to continue your benefits (excluding the Member Weekly Disability Benefit and the Member Long Term Disability Benefit) by making a self-payment to the Administrator of the Fund, but such election may not be made more than 24 consecutive months and not beyond age 70.

If you are an eligible member or associate participant who becomes disabled due to illness or injury and is in receipt of:

- Member Weekly Disability or Member Long Term Disability Benefits;
- sickness benefits from Employment Insurance; or
- Workers' Compensation benefits;

the Fund will cover you at no cost for up to 52 weeks.

After this 52 week period of coverage provided by the Fund, you may make self -pay payments to the Fund, for up to and including the month in which your 70th birthday occurs, provided:

- you were eligible for benefits on the date you became disabled;
- you are receiving disability benefits from the U.A. Local 254 Pension Plan, the Canada Pension Plan or under the Workers' Compensation Act; and
- you are a member in good standing of U.A. Local 254.

* Members are responsible for reporting all EI and W.C.B. benefits in order to receive coverage at no cost for up to 52 weeks.

Dependent Eligibility

To be eligible for coverage your dependent must be a Canadian resident and covered under a provincial health insurance program. This includes:

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 dependent becomes eligible for coverage when you become eligible or, if acquired later, upon becoming your dependent.

You must be covered in order for your dependents to be covered.

Dependent means a spouse or unmarried child at least 14 days of age (for Dependent Life Insurance only) but under 21 (25, if regularly attending school on a full time basis) and solely dependent upon the member for support.

Spouse means a husband or wife by virtue of a religious or civil marriage ceremony; except that, a person living with the member will be deemed to be the member's spouse, if such person:

- is publicly represented as the member's spouse; and
- has been living with the member for a period of at least 1 continuous year if neither are married; or
- has been living with the member for a period of at least 3 consecutive years if either remains legally married to another person.

Only one person can qualify as a spouse at any time.

Child means:

- a natural or legally adopted child; or

- a step-child or other child, who is dependent upon the member for support and lives with the member in a regular parent-child relationship; or

- an unmarried child beyond the above referenced age restrictions that is incapable of self-sustaining employment by reason of functional impairment, became so incapacitated prior to attainment of the limiting age, and is chiefly dependent upon you for support and maintenance.

Please report all changes of beneficiary, dependent status and address to the Plan Administrator as soon as possible.

Maternity Leave

For details on benefit coverage while on maternity leave, please contact your Plan Administrator.

Wage Loss Provision

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

Termination of Coverage

Coverage for you and your dependents will terminate on the earliest of:

- the end of the month in which there is less than 125 credited hours in your Hour Bank;

- the date you are no longer a member in good standing with the Union;

- the date premium payments cease; or

- the date this plan is discontinued.

Coverage for your dependents will terminate on the date such dependents cease to be eligible.

Retired Members Returning to Work

When you elect retirement, your benefit coverage will adjust to the Retiree benefit coverage design following the depletion of your Hour Bank Account. While running down your Hour Bank Account, any new hours worked will continue to be added to your Hour Bank provided it has not been exhausted. Once your coverage changes to the Retiree benefit coverage, it will then remain at that Plan design even if you continue to work additional hours. If you are self-paying for Retiree Optional Enhanced coverage, you will be reimbursed for self-payments up to a maximum of the additional contributions that have been paid into the Plan on your behalf for hours worked in that year.

For Active Members Only: Continuation of Health Care and Dental Care Benefits After Your Death (Survivor Benefits)

Your dependents who are covered under this plan at the time of your death will continue to be covered for up to 24 months at no cost, but not beyond the earliest of:

- the date such dependents cease to be eligible;
- the date your spouse remarries (children will continue to be covered); or
- the date coverage for your dependents terminates for any reason.

Upon your death, benefits are payable to your spouse, if living, or to your dependent children (or legal guardian).

Please contact the Plan Administrator for details.

For Retired Members Only*: Continuation of Health Care Benefits (Ambulance and Vision Care Only) After Your Death

Your dependents who are covered under this plan at the time of your death will continue to be covered at no cost, but not beyond the earliest of:

- the date such dependents cease to be eligible;

- the date your spouse remarries (children will continue to be covered);
- the date such dependents are no longer receiving pension benefits from U.A. Local 254; or
- the date coverage for your dependents terminates for any reason.

Upon your death, benefits are payable to your spouse, if living, or to your dependent children (or legal guardian).

*Applies to retired members who were members in good standing of U.A. Local 254 on the date of their death.

For Retired Members Only*: Continuation of Optional Enhanced Benefits After Your Death

Your dependents who are covered under this plan at the time of your death will continue to be covered provided a self-payment continues to be paid, but not beyond the earlier of:

- the date such dependents cease to be eligible;
- the date your spouse remarries (children will continue to be covered);
- the date such dependents are no longer receiving pension benefits from U.A. Local 254; or
- the date coverage for your dependents terminates for any reason.

Access to Plan Documents

You or any of your covered dependents have the right to request a copy of any or all of the following items:

- the sections of any Group Policy and/ or Plan Document that apply to you and your dependents;
- your application for group benefits; and
- any Evidence of Insurability you submitted as part of your application for benefits.

The Administrator reserves the right to charge you for such documentation after your first request.

Member Life Insurance

Death Provision

If you die while covered, your Member Life Insurance will be paid to your designated beneficiary(ies), if living, otherwise to your estate.

Disability Provision (does not apply to retired members)

If you:

- become Totally and Permanently Disabled while covered;
- continue to be so disabled for the next 30 weeks; and
- are under age 65;

the Member Life Insurance for which you were covered at the time you became so disabled will continue while you are so disabled, but not beyond your 65th birthday, subject to any reduction or termination indicated in the Schedule due to a change in class. You must submit proof satisfactory to Manulife Financial, within 12 months of the date you cease active work, that you are so disabled. From then on you must submit proof satisfactory to Manulife Financial, as required, that you are still so disabled.

Totally and Permanently Disabled means that solely because of an illness or injury, you are unable:

- during the Waiting Period and for the next 24 months to perform the essential duties of your own occupation (type of work, not just your own job); and
- from then on, to work at any occupation for which you are, or may reasonably become, fitted by education, training or experience.

The availability of employment will not be considered in the assessment of your disability.

Conversion Option

If your Group Benefits terminate or reduce, you may be eligible to convert your Member Life Insurance coverage to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Member Life Insurance. If you die during this 31 -day period, the amount of Member Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Extension of Benefit

If you die within 31 days of the date your Member Life Insurance terminates, the amount you could have converted will be paid as a death benefit under this plan even if you did not apply for conversion.

Dependent Life Insurance

Death Provision

If your dependent dies while covered, Dependent Life Insurance will be paid to you, if living, otherwise to your estate.

Disability Provision

If your Member Life Insurance is being continued under the Disability Provision, Dependent Life Insurance will also continue with no further premium required.

Conversion Option

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your application for the individual policy, along with the first monthly premium, must be received by Manulife Financial, within 31 days of the termination date. If your spouse dies during this 31 -day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for spousal coverage.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Extension of Benefit

If your spouse dies within 31 days of the date Dependent Life Insurance terminates, the amount that could have been converted will be paid to you as a death benefit under this plan even if no application for conversion was made.

Accidental Death and Dismemberment

If you sustain an accidental bodily injury while covered and if a covered loss occurs as a direct result, and within 1 year, of the accident, the following will be paid to you, if living, otherwise to your beneficiary(ies), if living, or to your estate:

For Loss Of	**Percentage Of Amount Covered**
Life	100%
Both hands or both feet	100%
Both arms or both legs	100%
Sight of both eyes	100%
Sight of one eye	66-2/3%
Speech and hearing	100%
Speech or hearing	66-2/3%
Hearing in one ear	16-2/3%
Thumb and index finger, or 4 fingers, of one hand	33-1/3%
All toes of one foot	12-1/2%
Quadriplegia (total paralysis of both upper and lower limbs)	200%
Paraplegia (total paralysis of lower limbs)	200%
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	200%

For Loss Of, or Loss Of Use Of	
One arm or one leg	75%
One hand or one foot	66-2/3%

No more than the largest percentage shown for a body member will be paid for the loss of more than one part thereof.

Not more than 100% will be paid for all losses sustained in any one accident, except for the paralysis benefits as noted above.

Loss as above used with reference to:

- quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs;

- hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;

- arm or leg means complete severance through or above the elbow or knee joint;

- thumb or finger means complete severance through or above the first phalange;

- toes means complete severance of both phalanges;

- eye means the irrecoverable loss of the entire sight thereof;

- speech means complete and irrecoverable loss of the ability to utter intelligible sounds; and

- hearing means complete and irrecoverable loss of hearing in both ears.

Loss of use as above used means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss is determined to be permanent.

Exposure and Disappearance

Loss due to exposure will be deemed to be accidental if the exposure was a direct result of an accident.

If you disappear as a direct result of the accidental disappearance, wrecking or sinking of the conveyance in which you were an occupant, accidental death will be deemed to have occurred; provided, there is no evidence within 1 year thereafter that you are still alive.

Repatriation Benefit

When injuries result in loss of life outside 200 km from your permanent city or town of residence and for which the death benefit is payable, payment will be made for the actual expenses incurred, but not more than $10,000, for preparing your body for burial and shipment to your city or town of residence.

Transportation of A Family Member

If you are confuted in a hospital as a result of an accident for which a benefit may be payable while you are more than 200 km from your permanent place of residence and the attending physician recommends the personal attendance of a member of your immediate family, an amount equal to the actual expenses incurred, but not more than $10,000, will be paid for round-trip transportation by the most direct route by a licensed common carrier for one Immediate Family Member to you. Immediate Family Member means your spouse (or common-law spouse) or a parent, grandparent, child over age 18, brother or sister.

Disability Provision

While premiums are waived under the Member Life Insurance Disability Provision, your Accidental Death and Dismemberment Benefit will also be continued without payment of premium while the Accidental Death and Dismemberment contract is in force, but not beyond your 65th birthday.

Rehabilitation Benefit

If a benefit, other than a benefit for loss of Life, becomes payable an additional benefit equal to the reasonable and necessary expenses actually incurred up to a limit of $10,000 will be paid for your special training, provided:

- such training is required because of the injuries sustained in the accident and in order for you to be qualified to engage in an occupation in which you would not have been engaged except for such injuries;

- expenses are incurred within two years from the date of the accident; and

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

Seat Belt Benefit

If while insured you are a passenger or driver of a private passenger type automobile and are involved in an accident for which a benefit is payable, the benefit will be increased by 10% if you were wearing a seat belt

properly fastened. Verification of actual use of the seat belt must be part of the official report of the accident or certified by the investigating police officer.

Day Care Benefit

If the death benefit becomes payable for the accidental loss of your life Manulife Financial will pay the lesser of the following amounts for each dependent child who is under age 13 and is currently enrolled or becomes enrolled in an accredited day care centre within 90 days following your death:

- the actual charges made by such day care centre per year with respect to such child;
- 3% of the death benefit;
- $5,000 per year.

Such amount will be payable annually for a maximum of four consecutive annual payments while the child continues to be enrolled in an accredited day care centre and under age 13.

Home Alteration and Vehicle Modification Benefit

If you receive a benefit for accidental loss, other than death, and are subsequently required to use a wheelchair to be ambulatory due to the same cause for which the benefit became payable, upon presentation of proof of payment, Manulife Financial will pay:

- the one-time cost of alterations to your residence, to make it wheelchair accessible and habitable, if carried out by an experienced individual in such alterations and recommended by a recognized organization providing support and assistance to wheelchair users; and
- the one-time cost of modifications necessary to a motor vehicle owned by you, to make the vehicle accessible or driveable for you, if carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities;

up to a combined maximum of $10,000, provided these are made on your behalf.

Limitations

No amount will be paid for a loss that results from or is contributed to by:

- war, whether declared or not;
- suicide or attempt thereat, while sane or insane;
- self-inflicted injury, while sane or insane;
- active full-time service in the armed forces of any country;
- travelling or flying in, or descending from, any kind of aircraft, as a pilot, operator or member of the crew. However, insurance will include injury sustained while you are riding as a passenger with no duties whatsoever, in or on, boarding or alighting from any aircraft having a current and valid air worthiness certificate, or from any transport type aircraft operated by the transport command of the Canadian Armed Forces Air Transport Command or by the similar Transport Service of any country but excluding while flying in any aircraft owned or operated by the employer.

Weekly Disability Income

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

Disabled means that solely because of either an illness or accidental injury that is non-occupational, you cannot perform your usual and customary duties.

All Disability claims should be recorded with the Plan Administrator (Coughlin & Associates Ltd.) 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.

Weekly Disability Income coverage commences on the 1st day of disability resulting from a non-occupational accident or 8th day of disability resulting from sickness. The Plan is integrated with Employment Insurance (EI) thereby following the initial 7 days of disability; Plan Members will be required to apply for Employment Insurance Sickness benefits for up to the next 26 weeks of disability.

Should EI Sickness benefits be exhausted, and a member continues to be unable to return to work due to disability, the Plan could provide additional disability benefits. Weekly Disability Income benefits are payable for no longer than forty-one (41) weeks in total during any one period of disability.

Subsequent Disability

A new Waiting Period and Benefit Duration will start, if you return to active full-time work for:

- a period of 2 weeks before you again become Disabled because of the same or a related cause; or
- 1 full day before you again become Disabled because of a different or an unrelated cause.

Third Party Liability

If you receive benefit payments under this plan for loss of income for which there may be a cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will entitle the Self-Insured Trust to be reimbursed for any amount(s), including interest, you recover from a third party for:

- loss of income; or
- medical or dental expenses;

which, together with any amount(s) paid or payable under any of the Benefits of this plan, would exceed your actual loss.

Following notification to the Plan Administrator of payment by a third party of any judgment or settlement, further disability payments under this plan will terminate until the Self-Insured Trust has been reimbursed the amount set out in the Reimbursement Agreement.

If a lump sum payment is made under judgment or settlement for loss of future income, no further disability benefits will be paid until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

Limitations

No benefit will be paid for:

- any day you do any kind of work for pay or profit;
- illness or injury for which benefits are payable under Workers' Compensation or Automobile Insurance Act;
- the period you are entitled to pregnancy or parental leave by statute, contract or employer agreement; except where benefits are provided during the post -natal recovery period.

No benefit will be paid for any Disability that results from or is contributed to by:

- war, whether declared or not;

- insurrection, rebellion or participation in a riot or civil commotion;

- purposely self-inflicted injury; or

- your commission of, or attempt to commit, an assault or a criminal offence.

The Administrator may require you to report for a medical examination as often as is reasonable, by a licensed doctor (M.D.) of their choice. Failure to report for a medical examination may result in termination of your benefit payments.

Extension of Benefit

If you are Disabled on the date your coverage terminates, you will be entitled to the same benefit as though your coverage had not terminated.

Submitting a Claim for Weekly Disability Income

If you are wholly and continuously disabled by bodily injury or sickness and prevented from performing your regular work, and have active coverage for this benefit, you should contact the Claims Adjudicator, Coughlin & Associates, at disabilityclaims@coughlin.ca or telephone 1-888-613-1234 for the corresponding forms to apply for this benefit.

Long Term Disability

If you become Totally Disabled while covered and are:

- seen by, and treated by, a licensed doctor (M.D.) within 31 days of the date you became Totally Disabled; and

- absent from work for more than the Waiting Period

monthly benefit payments will be made to you for the period following the Waiting Period for as long as you are:

- Totally Disabled;

- under the ongoing care of a licensed doctor (M.D.); and

- residing in Canada, unless prior approval to the contrary is obtained from Manulife Financial;

but not beyond the end of the month in which the Benefit Duration is completed.

Totally Disabled means that solely because of an illness or accidental bodily injury, you are unable:

- during the Waiting Period and for the next 24 months to perform the essential duties of your own occupation (type of work, not just your own job); and

- from then on, to work at any occupation for which you are, or may reasonably become, fitted by education, training or experience.

The availability of employment will not be considered in the assessment of your disability.

Recurrent Disability

Any 2 periods of Total Disability that are:

- due to the same or a related cause; and

- separated by return to active full-time work for less than 6 months (30 days during the Waiting Period);

will be deemed to be 1 period of Total Disability with only the initial Waiting Period applying, provided the first period begins while you are covered under this Benefit.

Benefit Offsets

Your benefit will be reduced by 40% of any income payable (or would have been payable had you applied for it):

- from any job for pay or profit (except under an approved rehabilitation or partial disability program); or

- because you are disabled or retired under any plan required or provided by a government or pursuant to a statute, such as, but not limited to, Workers' Compensation, any Automobile Insurance Act and the Canada or Quebec Pension Plan (CPP/QPP), excluding income payable for your spouse, children or other dependents; or

- under any other group coverage, Benefit, pension or other arrangement for members of a group (whether on an insured basis or not); and

by any amount necessary to limit to 85% of pre -disability take-home pay (i.e., Earnings less any Provincial or Federal Income Tax deducted) the income payable:

- as a Long Term Disability Benefit;

- from all of the sources mentioned above; and

- for your spouse, children or other dependents because you are disabled or retired under any plan required or provided by a government or pursuant to a statute.

Should you receive income from any of the above sources payable:

- as a retroactive award, benefit payments will be adjusted to reflect any overpayment that may have been made;

- other than monthly, such income will be converted to a monthly basis; or

- in a lump sum payment for loss of future income, no further benefits will be paid until such time as the sum of the benefit payments otherwise payable equals the amount of each sum.

Your benefit will not be reduced by income payable from:

- a CPP/QPP cost of living increase that occurs after the date you became Totally Disabled under this Benefit;

- disability or retirement benefits at the level that you were receiving them prior to the date you became Totally Disabled under this Benefit; or

- any individual disability insurance, exclusive of accident benefits payable under an automobile policy.

Recovery of Benefits

If you receive a benefit under this plan in excess of what should have been paid, Manulife Financial has the right to recover the amount of such excess from you or deduct it from future monthly benefits payable to you.

Rehabilitation

If you recover enough from your disability to be able to work full-time or part-time at any job under a rehabilitation program approved in writing by Manulife Financial, you will still be deemed to be Totally Disabled and your benefit will only be reduced by the greater of:

- 50% of the income you receive from such rehabilitative work; or

- the amount needed to keep your disability benefit income plus your rehabilitative income at the same level as your pre - disability take-home pay (i.e. Eamings less any Provincial or Federal Income Tax deducted).

If you refuse to participate in a rehabilitation program recommended by Manulife Financial, your benefit payments will be terminated.

Partial Disability

If you are Totally Disabled but able to work under a program approved in writing by Manulife Financial and perform at any time:

- during the Waiting Period and the next 24 months:
    - any of the duties of your own occupation on a part-time basis; or
    - the duties of any other occupation on a full-time or part-time basis; or
- from then on:
    - the duties of any occupation on a part-time basis;

you will still be entitled to a benefit, which will only be reduced by the greater of:

- 50% of the income you received from such work; or
- the amount needed to keep your disability benefit income plus the income you receive from such work at the same level as your pre- disability take-home pay (i.e. Earnings less any Provincial or Federal Income Tax deducted).

Third Party Liability

If you receive benefit payments under this plan for loss of income for which there may be a cause of action against a third party, you will be required to complete a Reimbursement Agreement. This will entitle Manulife Financial to be reimbursed for any amount(s), including interest, you recover from a third party for:

- loss of income; or
- medical or dental expenses;

which, together with any amount(s) paid or payable under any of the Benefits of this plan, would exceed your actual loss.

Following notification to Manulife Financial of payment by a third party of any judgment or settlement, further disability benefit payments under

this plan will terminate until Manulife Financial has been reimbursed the amount set out in the Reimbursement Agreement.

If a lump sum payment is made under judgment or settlement for loss of future income, no further disability benefits will be paid under this plan until such time as the sum of the benefit payments otherwise payable equals the amount of such lump sum.

Exclusions and Limitations

Benefit payments may be terminated if you:

- fail to provide proof of ongoing disability when requested to do so;
- refuse or fail to complete and return or comply with the terms of the Reimbursement Agreement in accordance with the Third Party Liability provision;
- fail to report for a medical examination, as often as may reasonably be required, by a licensed doctor (M.D.) of Manulife Financial's choice; or
- are not receiving accepted standard professional treatment for the condition being treated and, where appropriate, treatment by a relevant and certified specialist.

No benefit will be paid for the period you are entitled to pregnancy or parental leave by statute, contract or employer arrangement.

No benefit will be paid for any disability that results from or is contributed to by:

- war, whether declared or not;
- insurrection, rebellion or participation in a riot or civil commotion;
- purposely self-inflicted injury;

- your commission of, or attempt to commit, an assault or criminal offence;

- chronic alcoholism, or use of narcotics, barbiturates or hallucinogens, unless you are receiving ongoing active professional treatment deemed appropriate for the condition being treated; or

- a pre-existing condition as described below.

Pre-existing Condition Limitation

If during the first 12 months that you are covered, you become Totally Disabled, directly or indirectly, because of an illness or injury for which you:

- received medical treatment, consultation, care or service including diagnostic tests; or

- took prescribed drugs;

during the 90 -day period before the date you became covered, no benefit payments will be made.

If, after the first 12 months that you are covered, but before you have been covered 24 months, you again become Totally Disabled because of the same or a related cause, you must:

- have returned to active full-time work for at least 6 months; and

- be absent from work for more than the Waiting Period;

before benefit payments will be made.

Waiver of Premium

No premium is required for this Benefit during a period for which you are entitled to receive benefit payments.

Extension of Benefit

If you are Totally Disabled on the date your coverage terminates, you will be entitled to the same benefit as though your insurance had not terminated.

Dental Care

Percentage Payable

Covered Charges are charges up to the amount shown in the approved Fee Guide for needed dental care, services or supplies, as described below, and received while the person is covered, for either a disease or injury that is non -occupational:

Routine Care

Charges up to the Benefit Maximum for:

- oral exams, including the cleaning of teeth, but not more than once every 6 months;
- bitewing x-rays;*
- topical application of sodium or stannous fluoride (where such application is necessary for the maintenance of sound dental health);*
- scaling and root planing (limited to 10 units per calendar year for all procedures combined, however children under 13 years of age are limited to 1 unit every 6 months for all procedures combined);
- occlusal equilibration (limited to 8 units per calendar year);

* Charges are limited to not more than once in any period of 5 consecutive months or more than twice in any calendar year.

- full mouth series of x-rays as part of a general examination, but not more than once in any 24 consecutive months;
- other dental x-rays;
- fillings (including white fillings);
- extractions;
- consultations with a specialist when required by a dentist;

- pit and fissure sealants (where necessary for the maintenance of sound dental health);

- habit breaking appliances (devices designed to break such habits as thumb sucking or grinding of teeth);

- oral surgery, including excision of impacted wisdom teeth;

- antibiotic drug injections;

- anaesthesia and its administration;

- space maintainers and prefabricated full coverage restorations for primary teeth;

- repair, relining or rebasing of dentures;

- repair, resurfacing or recementing of crowns, inlays, onlays or bridges;

- occlusal guards in connection with periodontal treatment or bruxism;

- periodontic treatment for disease of the bone and gums of the mouth, including tissue grafts and occlusal guards, but not athletic guards; and

- endodontic treatment, including root canal therapy.

Major Care

Dentures

Charges up to the Benefit Maximum for:

- first installation, including adjustments, of partial permanent or full temporary or permanent removable dentures to replace 1 or more natural teeth extracted while the person is covered;

- denture adjustments that occur more than 3 months after installation;

- replacement of an existing partial or full removable denture, if it:
    - was installed at least 5 years before and cannot be made serviceable; or
    - is a temporary full denture which replaces 1 or more natural teeth

- extracted while the person is covered and for which replacement by a permanent denture is required and takes place within 1 year from the date the temporary denture was installed; and

- addition of teeth to an existing partial denture, if required to replace 1 or more natural teeth extracted while the person is covered.

Crowns and Bridgework

Charges up to the Benefit Maximum for:

- inlays, onlays, gold fillings and crowns;

- first installation of fixed bridgework, including crowns to form abutments, to replace 1 or more natural teeth extracted while the person is covered; and

- replacement of existing bridgework, but only if it was installed at least 5 years before and cannot be made serviceable.

Orthodontics

Charges for dependent children at least 6 years of age but under age 18 up to the Benefit Maximum for:

- diagnostic procedures, including models;

- therapy and appliances; and

- correction of malocclusion.

Implants

Implants: services or supplies for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants, up to the Benefit Maximum.

Other Practitioners

Services or supplies must be rendered and dispensed by a licensed dentist, except that:

- scaling and cleaning of teeth may be done by a licensed dental hygienist; and

- installation, adjustment, repair, relining or rebasing of full dentures, may be done by a denturist, denture therapist, technician or mechanic, who is registered and practising within the scope of his license.

Charges for such care, services and supplies will be deemed to be Covered Charges up to the lesser of:

- the amount shown in the practitioner's fee guide of the Province where the charges are incurred; or

- the Fee Guide for dentists.

Reasonable and customary charges by an anaesthetist for the administration of a general anaesthetic in connection with a covered dental procedure will be deemed to be covered charges.

Alternative Services

If alternative services may be performed for the treatment of a dental condition, the maximum amount payable will be the amount shown in the Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

Predetermination of Benefits

If charges for a planned course of treatment by a licensed dentist would exceed $500, proposed details and x-rays should be submitted to the Plan Administrator for approval. Failure to do so may result in payment of a lesser benefit amount because of the difficulty in determining the need for such treatment after it has been provided. Dental x-rays will be promptly returned to the dentist.

Course of Treatment means one or more services rendered by one or more dentists for the correction of a dental condition diagnosed as a result of an oral exam starting on the date the first service to correct such condition is rendered

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Limitations

No amount will be paid for charges for:

- dental care which is cosmetic;
- completion of claim forms;
- broken appointments;
- dental care covered under a medical plan provided by an employer or government;
- which, in the absence of coverage, there would be no charge;
- space maintainers and prefabricated full coverage restorations for permanent teeth;
- oral hygiene instruction or nutritional counselling;
- protective athletic appliances;
- prostheses, including crowns and bridgework, and the fitting thereof which were ordered while the person was not covered, or which were ordered while the person was covered but which were formerly installed or delivered after this Benefit is discontinued or more than 31 days after termination of coverage for any other reason;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction; or
- replacement of a lost or stolen prosthesis.

Health Care

Percentage Payable

Covered Charges are reasonable and customary charges for needed medical care, services or supplies, as described below, and received while the person is covered, for either an illness or injury that is non - occupational or for pregnancy, up to the Overall Lifetime Benefit Maximum:

1. Hospital (Within Home Province)

Daily charges in excess of the ward rate up to the Room and Board Limit plus user fees.

- A hospital is a place that:
    - chiefly provides inpatient medical care of the injured, sick or chronically ill;
    - has a staff of licensed doctors (M.D.) and 24-hour nursing care by registered nurses (R.N.); and
    - is approved as a hospital for payment of the ward rate under the Provincial Health Plan.

2. Rehabilitation Hospital (Within Home Province)

Daily charges in excess of the ward rate up to the Room and Board Limit plus user fees, but not beyond the Maximum Stay. Confinement must begin within 14 days of hospital discharge. A new Maximum Stay will apply if the covered person has not been confined in a rehabilitation hospital for at least 120 days.

- A rehabilitation hospital is a place that:
    - has a transfer arrangement with hospitals;
    - provides inpatient nursing care (that meets minimum Provincial regulations) for the rehabilitation stage of an injury or illness; and
    - is approved as a rehabilitation hospital for payment of the ward rate under the Provincial Health Plan.

3. Ambulance

Charges in excess of the amount payable under the covered person's Provincial Health Plan for professional licensed ambulance service, including air or rail ambulance service subject to prior approval ofthe Administrator, to transport the covered person:

- from the place of injury (or where illness struck) to the nearest hospital where treatment is available;
- directly from the first hospital where treatment is given to the nearest hospital for needed specialized treatment not available at the first hospital; or
- from a hospital to a convalescent/rehabilitation hospital.

4. Out -of -Hospital Nursing

Charges for home nursing care, up to the Benefit Maximum, by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) who:

- is not a member of your family; and
- does not normally live in your home;

when ordered by a licensed doctor (M.D.) as medically necessary for a disability that requires the specialized training of an R.N. or L.P.N.

5. Health Practitioners

Charges, including x-ray charges, up to the Benefit Maximums by a practitioner who is registered and legally practising within the scope of his license as:

- a chiropractor, naturopath, podiatrist, chiropodist, osteopath, massage therapist, acupuncturist, psychologist (or social worker), physiotherapist or speech therapist; or
- an athletic therapist, when treatment is prescribed by a licensed doctor (M.D.) as to duration and type.

No amount will be paid for any visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.

6. Dental Care For Accidental Injury

Charges for dental care by a licensed dentist for the prompt repair of sound natural teeth when required for a non -occupational accidental injury, external to the mouth, that occurs while the person is covered.

7. Diagnostic Laboratory and X -Ray Expenses

8. Drugs

Charges for drugs, including oral contraceptives, necessary hormone and allergy injections, weight loss aids and smoking cessation aids (including Natural Health Products licensed for sale in Canada by Health Canada) up to the Lifetime Drug Benefit Maximums, prescribed by a licensed doctor (M.D.) or licensed dentist, or other professional authorized by provincial legislation to prescribe drugs and dispensed by a registered pharmacist or licensed doctor (M.D.) legally authorized to dispense such drugs, that regardless of their legal status are not normally obtainable except by prescription. Fertility drugs, oral drugs to treat erectile dysfunction, and vaccines are not covered.

The Plan is partnering with Pocket Pills, a digital pharmacy, to offer home delivery of prescription drugs. While the Plan will benefit from the lower dispensing fees they charge compared to most other pharmacies, it is the convenience of this provider and ease of their online platform that we wish to highlight. Furthermore, shipping and med-packs through Pocket Pills is provided at no additional charge. Access to this service can be obtained through https://app.pocketpills.com/coughlin or can be obtained on the Coughlin website at www.coughlin.ca.

9. Durable Medical Equipment and Supplies

Charges for supplies and the rental of or, at the Administrator's option, the purchase of durable medical equipment of the type and model adequate for the covered person's medical needs based on the nature and severity of the disability, such as, but not limited to:

- hospital beds, wheelchairs, canes, crutches, walkers and trusses;

- rigid or semi-rigid braces for back, neck, arm or leg and non – dental prostheses such as artificial limbs and eyes; including replacement if required because of a change in physical condition;
- respiratory equipment, including oxygen;
- kidney dialysis equipment;
- contact lenses or glasses following cataract surgery (limited to 1 pair per lifetime); and
- splints, casts, catheters, and hypodermic needles;

but excluding personal comfort, convenience, exercise, safety, self-help or environmental control items, or items which may also be used for non-medical reasons, such as, but not limited to:

- heating pads or lamps, communication aids, air conditioners or cleaners, and whirlpool baths or saunas.

Before incurring any major expenses you should submit details to the Plan Administrator to determine to what extent benefits are payable. In any event, a letter will be required from a licensed doctor (M.D.) describing the nature of the disability and the type, medical need and estimated duration of any required durable medical equipment.

10. Vision Care

Charges for lenses and frames and contact lenses, including safety glasses (member only), or laser eye surgery, when prescribed by an ophthalmologist or optometrist, up to the Benefit Maximums. No amount will be paid for sun glasses, anti - reflective coatings, or for tints.

Charges for eye examinations including refractions or for visual training and therapy, by a practitioner who is registered and legally practising within the scope of his license as an ophthalmologist or optometrist. No amount will be paid for any visit for which any amount is payable under the covered person's Provincial Health Plan, unless permitted by law.

11. Hearing Care

Charges for hearing aids, excluding batteries, when provided by a certified, clinical audiologist, up to the Benefit Maximum.

12. Foot Care

Charges up to the Benefit Maximum for orthopedic shoes (including repairs) and orthotics which have been specially designed and molded for the covered person and are required to correct a diagnosed physical impairment, provided that the following information is supplied:

- a diagnosis, including a list of symptoms and the primary complaint;
- a description of the physical findings from the clinical examination;
- a brief description of the abnormal walking pattern associated with the diagnosis; and
- confirmation that the product has been custom-made.

Your orthopedic shoes and orthotics must be prescribed on an annual basis. Note that coverage is on a reimbursement basis – assignment of benefits to the provider is not allowed.

For information on eligible prescribing and dispensing providers, please contact your Benefits Administrator.

13. Support Stockings

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

Restoration of Overall Lifetime Benefit Maximum

On each January 1, up to $1,000 of the Overall Lifetime Benefit Maximum which has been paid will be restored provided the covered person has been eligible for benefits for at least one year.

Limitations

No amount will be paid for care, services or supplies:

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

- for drugs, sera, or injectable drugs when administered in a hospital setting, whether administered on an inpatient or outpatient basis; except as provided under Out -of -Province;

- if the payment is prohibited by law;

- that a covered person may obtain as a benefit under any governmental plan or law;

- for which no charge would have been made in the absence of this coverage; or

- for dental work, except as provided under Dental Care For Accidental Injury.

No amount will be paid for any charge incurred that results from or is contributed to by:

- war, whether declared or not;

- insurrection, rebellion or participation in a riot or civil commotion;

- purposely self-inflicted injury; or

- the covered person's commission of, or attempt to commit, an assault or a criminal offence.

Extension of Benefits

If a covered person is Totally Disabled on the date coverage under these Benefits terminates, entitlement to benefits will be the same as though such coverage had not terminated, for as long as such person remains continuously so disabled, but not beyond the earlier of:

- the date such person becomes covered under any other group - type plan providing similar coverage; or

- 3 months.

Totally Disabled means:

- for a member, that such person cannot, because of illness or injury, engage in such person's regular occupation and is not working for pay or profit; and

- for a dependent, that such person cannot, because of illness or injury, engage in most of the normal activities of a person of the same age and sex.

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 # (4513) 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 Advanced Expedited Healthcare

Access to 5 diagnostic services and 15 specialist physicians within 72 hours through healthcare clinics across Canada (Manitoba residents are required to travel at their cost due to limitations of local private services).

Diagnostics:	**Specialists:**	
• MRI • CT Scan • Ultrasound • Endoscopy • Colonoscopy	• Ear, Nose & Throat • Orthopedics • Ophthalmology • Rheumatology • Urology • Dermatologist • Endocrinologist • Gynecologist • Podiatrist • Respirologist	• Neurosurgery • General Surgery Referral • Neurology • Gastroenterology • Cardiology

Allows those immediate access to diagnostic scans and specialist consultations noted above 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.

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 9428861

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.

People Connect - Mental Health Resource

People Connect provides members and their family members with educational tools, an online assessment, and access to immediate care through virtual therapy. The first virtual counselling session is free, and each additional session is $90 per hour or $45 per 30 minutes and payable via credit card.

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

For the purpose of this benefit, the Clinical Psychology benefit (within the combined paramedical practitioners) 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

Healthcare Spending Account

Purpose

For Union Members and their families to offset Health Care, Vision Care and Dental Care expenses incurred above and beyond the coverage presently provided by the United Association Local Union 254 Health and Welfare Trust Fund (i.e. coverage not included in Plan parameters and expenses in excess of Plan maximums).

Claims Submission

For claims submitted via paper claim, any remaining Health, Vision, or Dental benefit expenses not covered by the basic Plan will automatically be applied to the extent of your H.S.A., if any, unless you indicate otherwise on the applicable claim form.

For online submissions via the Claims Member Portal or Coughlin Mobile App, you must select (i.e. toggle) to apply to your H.S.A.

For claims submitted electronically (eClaim) from a Provider's office (i.e. no claim form submitted) on behalf of you or your eligible dependents, the H.S.A. will not be applied automatically unless you contact Coughlin prior to claims submission at the Provider's office to request any remaining balance to be applied to your H.S.A. balance.

If you are submitting claims that require redirection to your spouse's plan for coordination of benefits, we will not automatically apply to your H.S.A. Subsequently, any remaining balance following coordination of benefits with your spouse's plan will need to be submitted to Coughlin along with a summary statement from your spouse's Insurer, to be applied to your H.S.A.

Obtaining H.S.A. Balance

You can obtain your remaining H.S.A. balance by the following 3 options:

1) By contacting the Plan Administrator
2) Online through the claims Member Portal at www.coughlin.onlineclaimsaccess.net
3) Coughlin Mobile App obtained from the Google Play or the Apple App store

Please note that Members cannot utilize their account for cash withdrawals or pay a provider directly (i.e. the account balance must be used to reimburse Vision, Health or Dental related expenses). Furthermore, Members must remain in good standing with the Local Union to be eligible for the balance in their H.S.A.. Upon termination as a Union Member, any remaining balance in your account will be forfeited back to the Plan and not reallocated.

Eligibility

Healthcare Spending Account allocations are granted by the Plan Trustees based on the financial health of the Health & Welfare Trust. Following allocation, any amounts remaining after 12 months are forfeited back to the Trust Fund, as per the requirements of the Income Tax Act. **It is understood that to be eligible for an H.S.A. allocation, the individual must be a Member in good standing with Local Union 254.**

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 254.

Coverage

Coverage may be extended to claims for the benefits listed below to the extent of the Union Member's Healthcare Spending Account balance.

- Health Care benefits;
- Vision Care benefits;
- Dental Care benefits;

Participation will be extended to all Members in good standing with a Local Union 254. The Healthcare Spending Account (H.S.A.) allocation is funded through allocations as determined by the Plan Trustees. Allocations will be provided when it is determined to be affordable to the Plan. **It is understood that to be eligible for the allocation, the individual must be a Member in good standing with Local Union 254.**

Termination

In the event of termination of Membership with Local Union 254, 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; or
- upon the required forfeiture of any remaining balance.

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 254 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.

Coordination of Benefits

(Health Care and Dental Care Benefits only)

If a person covered under this plan is also covered under another plan, benefits under all plans are adjusted so as to limit the combined payment to 100% of the total allowable expense.

The manner in which this is done is to determine which plan pays first (and thus determine where to submit the claim first) and which plan(s) pays next.

The plan that does not have a coordination of benefits provision pays before the plan that does (most, if not all, Insurance Company plans have such a provision).

The plan that covers the person as:

- other than a dependent pays before the plan that covers such person as a dependent;

- or a dependent child of the parent, covered as an employee or member, whose birthday occurs first during the calendar year, pays first.

If priority cannot be established in the above manner, the benefits shall be pro -rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

To implement this provision, the Administrator may:

- subject to the consent of the covered person, if required by law, obtain from or release to any other person, corporation or organization any information deemed to be needed; or

- pay to or recover from any other person, corporation or organization any excess payment; any payment so made will be deemed to be benefits paid and, to the extent of such payments, will fully discharge the Administrator and the Self-Insured Trust from all liability under this plan.

Summary for Retired Members

(This is only a summary of the eligibility and benefit details provided throughout this booklet)

Eligibility

A retired member is automatically eligible for Health and Welfare benefits if certified as such by the Union and is receiving a pension from the U.A. Local 254 Pension Fund and who:

- retired before January 1, 1990; or
- retired on or after January 1, 1990 and is a member in good standing of U.A. Local 254 on the date of retirement, or on the date there are no longer any hours remaining in the member's Hour Bank, if later.

Benefits

The following benefits are available at no charge to you and your dependents:

- Member Life insurance of $10,000;
- Professional ambulance services at 100% of the charges; and
- Vision Care at 100%, (excluding Laser Eye Surgery) up to the following maximums:
    - $600 for lenses and frames (including contact lenses) once every 24 months for a person age 17 or over and once every 12 months for a person under age 17
    - Laser Eye Surgery, payable at 50% to a lifetime maximum of $1,725
    - Eye examinations to assess visual acuity, limited to:
        - Twice per calendar year for those under age 21
        - Once per calendar year for those between their 21st and 40th birthdays
        - Twice per calendar year for those over age 40

Retiree Benefits - Optional Enhanced Benefits
(Administered by the Trust Fund, not underwritten by Manulife Financial)

You may apply for enhanced Health Care and Dental Care benefits for which there is a monthly charge. However, you must do so within two months of the depletion of your Hour Bank account. The cost is $125.00 per month and that cost could change from time to time.

The enhanced Health Care benefits (excluding Ambulance and Vision Care which are provided to you without a monthly charge) are similar to that of active members of the Health and Welfare Plan. However, drug claims are limited to a maximum of $2,500 per family per benefit year (April 1 – March 31), and you must apply to Pharmacare each year. Furthermore, Paramedical services are limited to $500 per practitioner, or as otherwise identified herein, and hearing aids are limited to $800 per lifetime.

You would be covered for the same Dental Care benefits that are available under Routine and Major Care for active members of the Health and Welfare Plan, up to a maximum of $2,000 per individual, per calendar year. However orthodontics and implants are not covered.

If you die while covered for benefits under the plan, your surviving spouse can continue coverage by paying direct.

Note: You will also have the option of deducting the $125.00 per month cost from your pension payments. This should be coordinated with the Administrator upon your retirement.

How to Make a Claim

Time Limitations

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

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

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

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

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

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

Member Portal – Electronic Claims

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

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

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

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

Point of Sale Claims Submission

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

Dental:

1) Bin # 000034 on Telus Adjudicare network
2) Group Number # 59269
3) Individual certificate number (printed on your card)

Health :

1) Bin #34 on Telus Adjudicare network
2) Group Number # 59269
3) Individual certificate number (printed on your card)

Dentalcare and Health claims must be made within eighteen (18) months from the date of service.

Pre-Authorized Deposit (PAD)

Pre-authorized Deposit is the fastest way for plan members to receive claim reimbursements. Claim reimbursement deposits can be made into your bank account within two to five business days following the approval of your claim and eliminate both the wait for cheques to arrive by mail and the trip to the bank.

To enroll in the PAD program:

- Login to Coughlin's plan member portal
- Click on your profile icon and select *Direct Deposit*

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

Pre-Authorization

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

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

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

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

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 associate 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 1,500 hours (or twelve (12) 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

Chubb Life Insurance Company of Canada

THE PLAN IS ARRANGED AND ADMINISTERED BY:

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